Evidence In-Sight:
Access to child and youth mental health services

Date: August 26th, 2015
This report was researched and written to address the following three questions:

- How is access conceptualized in the literature with regard to child and youth mental health?
- What are best practices and current models for access?
- What is currently working to support access in the field of child and youth mental health?
- What are some core components of access in other sectors (e.g. health care)?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. Overview of inquiry

This report was written for a youth service organization interested in developing a clear understanding of the current state of “access” with recommendations for changes to their current practice. The objective is to reduce the frustration and time delays in matching service users with appropriate services and improving outcomes for children, youth and families. Related topics include existing pathways, criteria for admission, different definitions of what access means, issues surrounding first entry, and re-assessment and wait list implications. This report excluded information on centralized telephone intake systems as the requesting agency already had information on these systems.

2. Summary of findings

- Research on the topic of access is limited; many researchers in the field report that while barriers to access are well documented, access itself has not been well conceptualized.
- Access in the child and youth mental health context concerns how children, youth and their families gain entry to the appropriate services through the service system. Access is generally influenced by a variety of factors such as time, cost and type of services being accessed.
- The majority of research focuses on primary care providers as the most common access point in the adult mental health sector.
- Currently, there are many different access models in the field that vary in their approach, goals, components and strategies.
- For any model of access to be effective, sectors should work closely together to follow similar strategies.

3. Answer search strategy

- Search Terms Access PLUS child and youth, mental health, models, implementation, best practices, pathways to care, social networks, multi-sectorial, centralized, decentralized, system level

4. Findings

4.1 Conceptualizing access

In the mental health field, proper access to services has become a priority for families, agencies and communities (Mental Health Commission of Canada, 2012). As children, youth and families report barriers to services, agencies try to manage demand by improving access to these supports (Davidson et al., 2010). Much of the research regarding access has focused on the barriers that prevent individuals and families from receiving services, and much less research has focused on ways of addressing these barriers, or information on how systems can improve their access standards. Because of this, much of this report has been guided by literature from the health care field more generally, as mental health can be understood as a critical element within the broader context of health.

MCYS, pathways and coordinated access

The Ministry of Children and Youth Services (MCYS), which funds much of Ontario’s child and youth mental health (CYMH) sector, has placed an explicit emphasis on improving access to services. A key goal of the Moving on Mental
Health framework (2012) focuses on helping individuals and families navigate through the service system and creating clear pathways to care. In the subsequent Child and Youth Mental Health Service Framework (2013), MCYS outlines the minimum expectations for delivering mental health services. The framework sets out key processes to supporting children, young people and families from first contact to conclusion of services. While MCYS does not define access specifically in their document, it does explore two related topics: pathways to care and coordinated access.

Pathways to care describe how families and youth get to the appropriate services through the child and youth mental health service system. The service framework aims to address this by establishing clear paths to, through and out of care. Children and youth access services using many different pathways such as school, hospitals, friends and primary care. Because of this, services should not focus on one pathway to care but instead focus on making services easier to access.

Coordinated access is a community-based approach to help children, youth and families receive effective and timely mental health services. This process aims to minimize service gaps and duplication between service providers and sectors by establishing a seamless referral process. Agencies that serve children and youth with mental health concerns work together and collaborate to support young people and families in accessing services. Children and youth needing services are matched with programs that would best suit their needs while being the least invasive option. In the service framework, MCYS describes three minimum expectations to implement coordinated access:

- Clear pathways between sectors are set to help children, families and youth navigate through the service system.
- The lead agency and all child and youth mental health (CYMH) agencies communicate and collaborate with community partners to inform the approach to access to service.
- The impact of this collaboration is held accountable among service providers. This means that services offered to children, youth and families should be regularly reviewed and evaluated.

These expectations emphasize the need for collaboration and accountability between sectors and agencies. MCYS' vision for an accessible system focuses on establishing and/or enhancing partnerships across agencies to offer clear, effective and easy-to-navigate pathways for people who need services.

There are three dimensions to consider when understanding health care access (Boyle, Appleby & Harrison, 2010; McIntye, et al., 2009):

- **Physical access** is concerned with the availability, location, capacity and resources of services. This is usually the most obvious dimension of access, as a deficit here is measurable and tangible.
- **Affordability** is concerned with the cost of services for both the service provider and the individual. This includes cost of program, treatment and aftercare.
- **Acceptability** is concerned on how services fit with the individual’s culture, beliefs and personality. According to McIntye et al. (2009), this is an understated component of access, as there are instances where services are available in a community, but do not resonate or align with the individual’s beliefs or culture.

As each of these dimensions influences the accessibility of services, organizations should consider all three when implementing a plan for access.
4.2 Components of access

In the health care literature, several components of access are discussed as important elements of the service system. Like parts of an engine, each component must work together with others to perform. Research highlights many different factors that will influence a person’s decision to seek help and access services in a timely and efficient manner, such as their personality, perceived benefits, and social support (O’Connor, Martin, Weeks, & Luzian, 2014). Mental health literature in particular highlights three central components of access: wait times, barriers and access points.

Wait times

**Wait time** is defined as the amount of time between requesting services and receiving services (Davidson et al., 2010). The Canadian Psychiatric Association recommends that referral time to specialists take between two to four weeks (Canadian Psychiatric Association, 2006), but realistically, this can take several months to even years (Robotham & James, 2009). In fact, an estimated 40 percent of children and youth seeking mental health services currently wait a year or longer before receiving care (Children’s Mental Health Ontario, 2015). This is particularly frustrating as 70 percent of mental health issues emerge during adolescence (Children’s Mental Health Ontario, 2015) and may increase in severity over time if left untreated (Shiner et al., 2009). A survey of agencies providing child and adolescent mental health services in Canada found that current practice does not meet the Canadian Psychiatric Association’s standards in wait times, particularly for routine care (Kowalewski et al., 2008).

Barriers to services

In access literature, **barriers to services** are a recurrent theme. These are factors that negatively influence the ability of an individual to seek help (Boyle et al., 2010) and relate to the aforementioned dimensions of access (availability, affordability, acceptability) by creating deficits. For example, if a rural setting has little-to-no mental health services in the area (a deficit in availability), this would be a barrier to mental health service for individuals seeking help (Boyle et al., 2010; McIntye et al., 2009). For more information on wait times and barriers, please refer to the Centre’s 2010 background paper on Access & Wait Times in Child and Youth Mental Health.

Access points

In every service system or community there are key **access points** (Davidson et al., 2010). These are people, services or organizations that act as a first point of contact to mental health treatment (Steel et al., 2006). Once an individual is empowered to seek help, there are a variety of access points s/he may pursue. For the purposes of this report only mental health agencies, primary care providers and schools will be explored.

**Mental health agencies**

In an accessible system, mental health agencies have a unique role as an entry point. Unlike the physical health care sector where entry points for specific symptoms and conditions are well mapped, mental health agencies typically have pathways that are much more vague (Boyle et al., 2010). For example, a patient suffering from a physical health concern would most likely access a primary care physician or urgent care facility, depending on severity of symptoms and availability of services. The care providers at this establishment may treat the client directly or refer to a specialist or hospital depending on the presenting issue(s). There isn’t such clarity when it comes to mental health issues. For example, if a young person is suffering from mild to moderate feelings of depression, how do they know where to go? In both instances, time is critical to ensuring successful outcomes, but finding access to mental health supports can take dramatically longer compared to finding solutions for physical health concerns (Kowalewski et al., 2008).
Researchers in the health field report that this issue is the result of the tendency to view mental health as separate from physical health, when in fact both are interconnected and influence each other (Boyle et al., 2010; Hoag & McQillen, 2013). In response, there has been a push for community systems to collaborate together across systems of health and mental health (MCYS, 2013; British Columbia Ministry of Health, 2012), since collaboration allows organizations to combine their services with other agencies in the community to treat clients effectively and refer people to the right help.

**Primary care providers**

In an Australian study on first contact with mental health services, researchers found that out of a sample of 146 participants, primary care providers (PCPs) were the most popular first access point (45%), followed by self-referrals (13%), hospitals (12%), police (11%), religious personnel (5%) and other pathways (5%) (Steel et al., 2006). Other research has found similar results for mental health access overall, suggesting that PCPs play a crucial role in mental health access since they are the most popular point of entry (Volpe, et al., 2014). Indeed, much of the mental health access research has focused on how best to equip PCPs to respond to mental health inquiries (Aupont et al., 2012). The most common suggestion across the literature is for PCPs to collaborate with mental health agencies and professionals. While PCPs are well versed in a variety of health concerns, their time, resources and mental health expertise may be limited, so directly addressing mental health concerns on their own is likely not ideal. Collaborating with mental health specialists allows PCPs to respond to mental health cases more efficiently by consulting with specialized services such as psychiatrists, psychologists or social workers (Aupont, Doerfler, Connor, Stille, Tsiminetzky & McLaughlin, 2012). This collaboration significantly improves the quality of primary mental health care and access to specialist mental health services (Kisely, Duerden, Shaddick & Jayabarathan, 2006; Power et al., 2007).

Other recommendations such as learning modules focused on child and youth mental health have also shown to be an effective and helpful tool for PCPs. A study on mental health training provided to family physicians in British Columbia found that modules significantly enhanced physician knowledge of child and youth mental disorders, increased physicians confidence in identifying and treating disorders and increased collaboration between community partners (Garcia-Ortega, et al., 2013). Professional organizations such as the College of Family Physicians of Canada serve as a popular resource for physicians needing support on mental health topics (The College of Family Physicians of Canada, 2015).

While the demand for child and youth psychiatric services have increased nationally (Bostelaar, 2014), the shortage of child and youth psychiatrists to meet those needs is problematic (Thomas & Holzer, 2006). As a result, many organizations have focused on psychiatric nurses to provide care and reach a wider population (Kolko et al., 2010). Research suggests that psychiatric nurses are more likely to live in rural areas than psychiatrists and therefore have the potential to increase access to quality mental health care in these regions. Similar positions have been introduced in England for the same rationale. For instance, primary mental health workers have been effective in helping to close the service gap between primary care staff and specialist services (Hickey, Kramer & Garralda 2010).

**Schools**

Literature suggests that schools play an important role as a mental health access point for children and youth. For example, mental health disorders often have their first onset during childhood and adolescence (National Institute of Mental Health, 2005), during a time where children and youth spend much of their time in school. Educators report that
mental illness impacts academic performance, and identify child and youth mental health as a key issue affecting this (Santor, Short, & Ferguson, 2009). Studies have found that school-based programs with youth-friendly professionals greatly improve the child or youth’s access to care, and integrate multiple community partners to collaborate on treatment (Clayton, Chin, Blackburn & Echeverria, 2010; Soleimanpour, Geierstanger, Kaller). Mental health care in schools may come in the form of screening initiatives (Husky et al., 2010), special topic program such as suicide prevention (Kataoka, Stein, Nadeem & Wong, 2007), or school-based health centres (Clayton et al., 2010). Mental health promotion is also an opportunity to encourage positive mental health, and showcase accessible local resources students may have been unaware of (Mental Health Commission of Canada, 2013).

Despite this, evidence suggests that school-based mental health programs may be underused, likely due to lack of awareness and stigma (Szumilas, Kutcher, LeBlanc & Langille, 2010). A survey of school-based mental health programs in Canada found that costs associated to programming (e.g. funding, buy-in, overheads) were a significant barrier to services (Mental Health Commission of Canada, 2013). The survey also suggested that school-based programs were shaped by the community needs, and thus there is considerable variability of models between schools. The survey recommends partnership with community mental health agencies to alleviate some of these barriers by sharing workload and capacity (Mental Health Commission of Canada, 2013).

4.3 Implementation and models

While the impact of barriers and wait-times is well documented, our search on implementation of mental health access models yielded little evidence. Indeed, the literature highlights access implementation as crucial gap of knowledge (Campo, Bridges, & Fontanella, 2015; McIntye et al., 2009; Davidson et al., 2010). Currently, there are no best practice guidelines on creating or implementing a mental health access system. While there is limited research, the following considerations emerge from the literature:

- The 2010 Annual Report of the Office of the Auditor General of Ontario recommended that to enhance access to services for children and youth in need, agencies should provide (Office of the Auditor General of Ontario, 2010):
  1. A single point of access or collaborative placement process for available residential services and supports.
  2. Fewer access points for non-residential services, or more collaborative efforts to assess and prioritize client needs, and refer them to the most appropriate non-residential service and support available.
  3. Documentation to support the placement.

- Agencies have noted that not everyone involved in a mental health system has the same conceptualization of access (Illback & Bates, 2011). For example, PCPs may conceptualize improved access as seeing more patients on a day to day basis (McIntye et al., 2009) whereas mental health specialists may conceptualize improved access as decreased wait times (Davidson et al., 2010). This can make it difficult to discuss or assess mental health access within an organization and in a system as a whole, and thus may lead to a fragmentation of services (Mental Health Commission of Canada, 2012).

- Research suggests that organizations in a system discuss what access to services looks like in their community before creating policies and strategies to enhance it (Boyle, Appleby, & Harrison, 2010; McIntye, Thiede, & Birch, 2009). Strategies like community mobilization can gather community partners together to discuss gaps and brainstorm solutions.
Community mobilization is defined as a capacity building process where community partners strategize, carry out and evaluate activities on a collaborative basis (Florida Department of Health, 2015). Literature on community mobilization outlines various steps this process can take (The Acquire Project, 2006) such as:

1. A big-picture assessment of the community’s issues, needs and resources
2. Community exploration of issues and priority-setting
3. Community action planning
4. Implementation of community action plans
5. Monitoring and evaluation of community mobilization

Implementing an access strategy works best when agencies have highlighted specific access tiers through the service system, meaning there is a clear understanding of levels of patient needs and the services that respond best to those needs (Mental Health Commission of Canada, 2012).

Sectors should have a common assessment tool to reduce reassessment, wait times and re-entry (Ontario Common Assessment of Need, 2010). Further, it is important to have an established referral relationship among sectors (Hoag & McQillen, 2013).

There is a strong need for collaboration across sectors to properly implement an access system (Aupont, et al., 2012; Davidson et al., 2010).

A triage protocol based upon a service agreement must effectively direct patients to the appropriate services (Mental Health and Drug and Alcohol Office, 2012).

Providers across sectors must hold each other accountable (Teague, Trabin, & Ray, 2006). For example, this may involve following up on patient status and discussing treatment with other service providers.

While implementation literature on access may be limited, there are various examples of access systems that organizations are using. Elements of these various models and examples in the field are explored below.

**Models of access**

Models of access will be shaped by different factors in various communities. For example, the access system in a rural community in Canada will look different from an urban community in the United States. Because of this variation, it is important to describe some critical factors that will shape and influence an access system, specifically scope, coordination and extent to which these systems are centralized.

**Scope**

Scope refers to the range of services captured in an access system. These levels are divided into micro and macro levels.

- **Micro** level models are used to enhance or support access for a specific sector.
  - Example: In the adult sector, some collaborative care models focus on enhancing the PCP’s capacity to support a patient and help them access the appropriate service. It also allows the PCP and patient to access psychiatric resources to better assess patients and make more informed decision on treatment and referrals (Shiner, et al., 2009; Steel, et al., 2006).
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- **Macro** level models enhance or establish access at a systems level, with multiple sectors involved.
  - Example: The Improved Access to Psychological Therapies (IAPT) model was developed in response to unmet needs for mental health care identified in a 2006 report (Peachey, Hicks & Adams, 2013). The program is a large-scale initiative that aims to greatly increase the availability of evidence-based psychological therapies for depression and anxiety disorders in England for children, youth and adults. The program sets a clear model of what access through this system looks like, which is provided below.

(Peachey, Hicks, & Adams, 2013)

**Figure 1: Recommended stepped care pathway for IAPT services**

**Coordination**

As described in MCYS’ service framework, coordination of access is an important consideration in implementing a community mental health system. The type of coordination and intensity varies between every partnership and community, but some level of coordination must exist to properly handle demand of client needs. The British Columbia Ministry of Health’s report (2012) on integrated models of primary and mental health care in the community highlights three approaches to coordination for both the child and adult sector:

1) **Communication approach**: This approach is geared towards those with a mild to moderate severity of need, where services operate separately from each other. Coordination in this context usually means consultation between services when client needs are out of the scope of one service, and are typically informal partnerships. An example would be a family doctor calling a psychiatrist to consult about a patient diagnosis.
2) **Co-location and collaboration approach:** This approach is geared towards addressing moderate to severe needs. In this approach, agencies and service providers collaborate by sharing space and/or sharing treatment responsibilities. Consultations between service providers are a regular occurrence, and typically mental health and physical health are treated together. For example, the Australian program Headspace has a PCP and mental health specialist share the same location, easing referrals and collaboration between the two sectors.

3) **Integrated approach:** This approach is aimed at addressing severe, persistent and complex needs. Here, health teams consist of experts from multiple fields and care for patients is unified. Since all members are equally accountable for the outcome of patients, care must be intensive and collaborative to effectively treat patients. This is usually seen in hospital settings.

**Decentralization vs. Centralization**

A decentralized model uses multiple coordinated locations (physical, virtual or both) throughout the community that offer assessments and referrals (Building Changes, 2015). Sites can be led by one agency or by different agencies. All sites are coordinated because they use the same assessment form, targeting tools and referral process (Building Changes, 2015). In this system, there is not one hub that is promoted as the central point of access. In adult offender literature, research has indicated that taking a decentralized intake approach provides service providers with more control over the assessment (Correctional Services Canada, 2001). When demand exceeds capacity, agencies may be forced to redirect clients to other services, possibly adding to wait times and frustration experienced by families. Because of this, centralized intake is the favored model, especially in communities with a large service area and with many different services.

A centralized model uses one entry point where people are assessed to determine the best resources for their specific needs (Building Changes, 2015). This entry point typically employs those with expertise in triage, assessment and referrals, and typically does not offer counselling or treatment services. The entry point can be virtual (telephone or Web) or might be a physical location; in either case, the entry point is promoted as the place of first contact for mental health concerns (Building Changes, 2015). The key to central intake is creating a central hub for young people and families and the need for a central location in order to access services. In their best practices guided on centralized intake, Early Childhood Iowa highlighted benefits of centralized intake (2011):

- Allows maximum usage of services.
- Focuses on a single point of entry.
- Assures that children, youth and families will be linked to the most appropriate services available for them based on their needs.
- Allows for a uniform screening process and a uniform mechanism for referral follow-up.
- Promotes collaboration between programs.
- Eliminates duplication by creating a single point of entry for families.

Duncombe (2008) concluded that the model of the intake system is not as important as its ability to deliver good intake practice. Since good intake practices will differ depending on context, a showcase of different models should provide better insight. Below are access and intake models in the field that have been highlighted by the requesting agency and/or highlighted in literature.

5. **Examples of access models**

**Headspace**
<table>
<thead>
<tr>
<th>Location</th>
<th>Australia</th>
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<tbody>
<tr>
<td>Target client</td>
<td>Children and youth</td>
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**Description**

(Headspace, 2008) Created in 2006, Headspace aims to promote and support early intervention for youth with mental and substance abuse disorders. Designed to complement and integrate primary care and specialist services, the Australian government supported the initiative with an investment of more than $54 million. Thirty Headspace youth service platforms have been established in metropolitan, regional, rural and remote locations across Australia to build local capacity and improve visibility. Developed and guided by a consortium of researchers and practice experts, Headspace aims to build local and national awareness, create youth- and family-friendly services environments, promote evidenced-based interventions and improve access through co-location, outreach and collaboration.

**Goals**

(Headspace, 2008)

- Increase community capacity for early identification and intervention of young people at risk of mental health related issues.
- Create better access to specialist assistance for health, education and vocational related issues.
- Create more concise pathways for young people.
- Provide evidence-based interventions provided through an integrated model of care.
- Ensure that young people play an active role in shaping the delivery of services.

**Type of model**

Centralized and collaboration approach

The Headspace model focuses on providing centralized mental health services, where physical health is a component (Patulny, Muir, Powell, Flaxman, & Oprea, 2013). This is a reversal of the typical shared cared strategy where primary care is the central focus and mental health services act as additional support (British Columbia Ministry of Health, 2012). Their locations offer a variety of mental health and social services, while also offering physical health programs like a check up with a PCP. In this model, assessment and treatment plans are primarily handled by the mental health specialist. PCPs provide additional support where their skills are needed (British Columbia Ministry of Health, 2012).

**Core components**

- **Co-location:** Primary care services and specialist mental health services share the same space to facilitate referrals, decrease unnecessary pathways to services and decrease wait times (Patulny, Muir, Powell, Flaxman, & Oprea, 2013).
- **Multiple delivery sites:** With over 30 locations around Australia and an online website with group chat options, Headspace aims to capture as many young people as possible across the country. These sites are placed in specific areas to respond to different needs for services have (Muir, Powell, & McDermott, 2012). The head office in Melbourne oversees the marketing for Headspace, manages the needs of other Headspace locations, establishes a youth advisory and engages.
<table>
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<tr>
<th>Implementation considerations and evaluation</th>
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| Headspace’s access strategy has focused on building capacity across the service network (Headspace, 2008). From its conception, this has required Headspace centres to act as lead organizations in their service area (Muir et al., 2009). This in turn required not only the delivery of shared care services, but also strengthening the capacity of the community through building capacity strategies, evidence-based information, appropriate training and strategic and operational support. The activities of each of the components are framed around the following four priority areas (Headspace, 2012):

- **Setting direction**: promoting reformed policy at all levels of government to achieve better access, care and outcomes for young people
- **Community support**: strengthening community understanding and support for young people with mental health issues
- **Stronger services**: establishing integrated multidisciplinary service sites in local communities that provide more effective systems of mental health and other care
- **Youth and family engagement**: working with young people and care givers at all levels of Headspace to inform service development

There has been strong interest in Headspace’s impact on young people. In 2013, researchers found it had generally improved access across the population and also improved access among males and socially and economically disadvantaged youth (Patulny, Muir, Powell, Flaxman & Oprea, 2013). Interviews with young people reported that Headspace locations were easy for youth to identify and access, that services were youth-friendly and that staff played crucial roles in establishing positive relationships (Patulny, Muir, Powell, Flaxman, & Oprea 2013).|
Evaluation on the implementation of Headspace found interesting results for service providers. An extensive, longitudinal evaluation of the program found that (Muir et al., 2009):

- On average, it took headspace locations seven months to establish an effective network of care
- Engagement of psychiatrists to the headspace program was initially very limited
- Effective implementation relied heavily on headspace centres to provide strategic direction
- Improved access to services relied on both local and national community awareness of activities and programs
- Young people accessed and remained engaged with headspace because of its youth friendly nature. Aspects of youth friendliness include the non-clinical environment, the good location of most sites, non-judgmental and trusting relationships between young people and their practitioners, a sense of control over service experiences, low or no cost services and appointment reminders

Website  
http://headspace.org.au/

**Choice and Partnership Approach (CAPA)**

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<thead>
<tr>
<th>Location</th>
<th>United Kingdom, New Zealand and parts of Australia and Halifax, Canada</th>
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<tbody>
<tr>
<td>Target client</td>
<td>Children and youth</td>
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<tr>
<td>Description (The Choice and Partnership Approach, 2015)</td>
<td>The Choice and Partnership Approach (CAPA) is a service transformation system that originates in the United Kingdom. The aim of CAPA is to engage young people and their families while enhancing access to services in the community. CAPA focuses on providing many access and treatment choices to clients while creating and sustaining partnership between clients and service providers. In this system, young people and their families are invited to an initial ‘Choice appointment’ where they are offered a choice of day, time, venue, clinician and intervention. After this appointment, families and youth are invited to book ‘Partnership appointments’. The aim here is work in partnership with a mental health professional on mutually agreed goals.</td>
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### Goals

The goals of this system are separated into two categories: Choice and Partnership.

**Choice**

The aim of the Choice component in CAPA is to gather as much information about the client as possible while providing various options to empower them. As we have seen above in the conceptualization and barriers of access, many factors can influence a person’s ability use services (McIntye et al., 2009). Giving clients a choice between referral times, treatment modality and location allows the client to have more deciding power throughout the treatment and referral process (Robotham & James, 2009). Other aims of the Choice appointment include (Choice and Partnership Approach, 2015):

- Assessment
- Motivational enhancement
- Psycho-education
- Goal setting
- Maintenance until partnership appointment

**Partnership**

Partnership aims to foster a positive therapeutic alliance between clients and service providers. Young people and families work in partnership with the mental health professional on mutually agreed goals flexibility on treatment type, frequency and intensity (The Choice and Partnership Approach, 2015). Clients have most of the decision-making power in this partnership.

### Type of model

**Centralized intake and shared care**

At its core, CAPA takes a centralized intake approach to its system (The Choice and Partnership Approach, 2015). When a client is referred to a CAPA organization or team, they are offered a choice appointment that acts similarly to an assessment found in most centralized intake programs. The Choice appointment aims to assess the client’s severity of symptoms, risk and history while aiming to ease access, standardize assessment and reduce wait-times. These goals align very closely with a typical centralized intake model (Duncombe, 2008).

Where CAPA differs from most centralized programs is in its client-centered approach (The Choice and Partnership Approach, 2015). Once referred, clients choose from a range of appointment times that best fit with their schedule, where they see a clinician or service provider who knows the service area well. Here, clients and the choice clinician will devise a plan on what services are needed, the intensity of service and any other consideration for treatment. At the end of the appointment, a partnership appointment with either the organization’s services or outside services is made to connect clients with the most appropriate programs.
CAPA focuses on 11 key components to implement their model effectively, divided into major categories.

### Foundational component

1. **Leadership and management:** Three members of staff take the lead on administrative, clinical and management work. These three staff should collaborate and meet regularly. This component is **essential** to the implementation of CAPA.

### Choice component

2. **Language:** Terms such as assessment and treatment are replaced with alternative, locally developed terms to create a less stigmatizing environment.

3. **Handle demand:** Referrals are screened as soon as they become known to clear wait lists on the initial choice appointment.

4. **Choice Framework:** Children, families and clinicians must develop strategies for help. This includes self-help resources, outside specialist services or help accessing relevant services.

### Transfer to partnership components

5. **Full booking to partnership:** A ‘full booking’ appointment system should be used for follow-up appointments. If after the choice appointment a client and choice clinician decide that follow-up is needed, then the client is immediately booked a partnership appointment with a specific clinician. Importantly, clinicians have a certain number of free slots specifically for partnership appointments. All other unused time is focused on seeing other patients.

6. **Selecting partnership clinician by skill:** Clients are matched with the most relevant clinician based on needs, personality and skills.

### Partnership components

7. **Separating core partnership work and specific partnership work**

   Treatment work is separated by intensity and different clinicians work in these categories:
   - **Core work:** low-medium intensity treatment. High volume, low duration
   - **Specific work:** medium-high intensity treatment. Low volume, high duration.

8. **Job planning:** All members of the CAPA team have clearly stated tasks. For example, clinicians will work specifically on choice appointments, follow-up to partnership appointments and develop training. All staff have the capacity to work efficiently and effectively.

### Letting go

9. **Goal setting and care planning:** care plans are written down with families, focusing on goals and outcomes to facilitate their engagement after professional treatment ends. Clients and clinician review overall progress. Letting go helps the CAPA teams take on new patients.

10. **Peer group supervision:** members of the team meet to discuss individual cases,
**Access to child and youth mental health services**

<table>
<thead>
<tr>
<th>Implementation considerations and evaluation</th>
<th>An evaluation lead by Robotham and James (2009) looked into how CAPA was being implemented and which key component influenced the service flow the most. Authors found the following:</th>
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<tbody>
<tr>
<td><strong>Benefits:</strong></td>
<td></td>
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<tr>
<td>- The model improved access and reduces wait times for families and youth entering services.</td>
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<td>- CAPA significantly reduced demand on services.</td>
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<td>- Service providers and clients reported greater transparency within services.</td>
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<tr>
<td>- Service providers reported less demand on specialist services.</td>
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<tr>
<td><strong>Challenges:</strong></td>
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<tr>
<td>- Workers outside of the core CAPA team (such as PCPs or social workers) find this model difficult since their roles are not clearly defined.</td>
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<td>- Families may wait long periods of time between choice appointment and partnership appointment.</td>
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<td>- Of the 6 teams evaluated, no team was fully implementing all 11 key components of CAPA. At most, 8 key components were fully implemented.</td>
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<tr>
<td>- The most implemented component was separating core partnership work and specific partnership work, while the least implemented was handling demand.</td>
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</table>

**Website**

http://www.capa.co.uk/

**Youth Wellness Centre (YWC)**

<table>
<thead>
<tr>
<th>Location</th>
<th>Hamilton, Ontario, Canada</th>
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</thead>
<tbody>
<tr>
<td>Target client</td>
<td>Youth ages 12-25</td>
</tr>
</tbody>
</table>

**Description** (St. Joseph Healthcare Hamilton, 2014)

St. Joseph’s Healthcare Hamilton’s Youth Wellness Centre is a mental health service that aims to provide expert mental health care by appointment. Services include counselling, support and service area navigation. Youth and families can self-refer or be referred by a care provider. There are two streams of clinical mental health care at YWC:

- **Early intervention**: Young people suffering from emerging mental health and addictions concerns.
- **Transition support**: Young people looking for support in moving from the child and youth mental health sector to the adult mental health sector.

The service also includes a mobile team that provides outreach support to college and university students in the area that may face significant barriers as well as services for
| Marginalized and street involved youth. The YWC is composed of a multidisciplinary team including an intake coordinator, youth mentor, registered nurse care coordinator, transition coach, social worker, psychiatrist, family educator and psychologist. |
|---|---|
| **Goals** (St. Joseph Healthcare Hamilton, 2014) | The Youth Wellness Centre’s vision is to create “a service that is system and community linked; focused on youth experiencing emerging mental health difficulties with the goal of rapid assessment, treatment and recovery.” |
| **Type of model** (Gillett, 2014) | **Centralized and shared care** |
| YWC takes a centralized approach to their system. To enhance youth empowerment to access services YWC promotes self and community referrals. Once referred to the service, youth and/or families meet with an initial assessment clinician. This clinician screens and assesses the youth, connects with referrals, follows-up with clients on treatment and collaboratively decides on next steps with the youth and families. |
| **Core components** (St. Joseph Healthcare Hamilton, 2014) | - **System navigation:** As mentioned above, each client is connected with a clinical staff who acts as a client point person to navigate the service system. This component also focuses on the collaboration and partnership within the service area; mental health organizations should work and engage the community to promote shared-care models that make transitions between services as seamless as possible. 
- **Youth and family friendly identity:** Having an approachable location helps youth and families to refer themselves to the program. Youth and families were also engaged throughout the planning of this service so that programs would be as representative and helpful as possible. 
- **Multimodal treatment:** After screening and assessment, YWC offers traditional treatment options such as CBT or didactic skills training, as well as some alternatives like peer lead workshops or skills based groups. 
- **Medium to long care:** Once clients are referred and a treatment plan is in place, YWC follows youth for 2-5 years, with varying intensity or treatment depending on needs. 
- **Pilot site:** YWC is a testing site for a new access model. Data is currently being gathered on the effectiveness of this system. |
<p>| <strong>Implementation considerations and evaluation</strong> | At the moment, there is no publicly available evaluation of YWC. |
| <strong>Website</strong> | <a href="http://www.stjoes.ca/hospital-services/mental-health-addiction-services/mental-health-services/youth-wellness-centre">www.stjoes.ca/hospital-services/mental-health-addiction-services/mental-health-services/youth-wellness-centre</a> |</p>
<table>
<thead>
<tr>
<th>Contact Brant</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
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<tr>
<td><strong>Target client</strong></td>
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<tr>
<td><strong>Description</strong> (Contact Brant, 2014)</td>
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<tr>
<td><strong>Goals</strong> (Contact Brant, 2014)</td>
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<tr>
<td><strong>Type of model</strong></td>
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<tr>
<td><strong>Core components</strong> (Shaw, Chmiel, Ruman, &amp; Angus, 2013)</td>
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<tr>
<td><strong>Implementation considerations and evaluation</strong> (Shaw, Chmiel, Ruman, &amp; Angus, 2013)</td>
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</tbody>
</table>
### Mood Disorders Association of BC (MDABC)

<table>
<thead>
<tr>
<th>Location</th>
<th>British Columbia, Canada</th>
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<tbody>
<tr>
<td>Target Client</td>
<td>Youth and adults</td>
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<tr>
<td><strong>Description</strong></td>
<td>The Mood Disorders Association of BC (MDABC) is a nonprofit mental health organization that provides treatment, support, education and hope for people living with a mood disorders and other mental health concerns. The organization has many different services, such as counselling, workshops, educational videos and group therapy. A unique service they provide is Rapid Access to Psychiatric Services. This aims to create new treatment options that family physicians can offer to patients who are suffering from mental health issues. Patients referred to the program receive a one-on-one consultation by a psychiatrist, who then provides them and the referring family physician with a written consultation that includes a diagnosis and treatment recommendation. Patients can then choose to either have their family doctor initiate psychiatric treatment or to attend the drop-in group medical visits and have program psychiatrists manage their treatment. They can also choose to receive follow-up treatment through future drop-in group medical visits or e-mail communication with program psychiatrists.</td>
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</table>
| **Goals**        | - Provide treatment, support and education.  
- Reduce the stigma.  
- Engage the community in mental health well-being.  
- Provide rapid access to psychiatric services.  
- Encourage the development of effective self-help models.  
- Encourage research into mood disorders and self-help models. |
| **Type of model**| Decentralized and shared care |
| **Core components** | While providing limited resources on their core components and goals, MDABC states five key elements to their services:  
- MDABC provides innovative ways to increase access to services, such as group appointments and client motivating techniques.  
- MDABC reports offering research and teaching opportunities for clients and |

**Website**
http://www.contactbrant.net/
Service providers.
- MDABC strives to provide clinical excellence.
- MDABC builds community capacity by helping patients engage with their community and by partnering with organizations.

**Implementation considerations and evaluation**
(Hoag & McQuillen, 2013)

While there is no publicly available evaluation of MDABC as a whole or their implementation of services, Hoag and McQuillen studied the agency’s Rapid Access to Psychiatry program with the following results:

- MDABC’s rapid access model helped psychiatrists assess 6.7 times as many new patients and conduct 553 more follow-up visits per year than psychiatrists providing traditional outpatient psychiatric care.
- Rapid access to psychiatry was three times less costly per annum for moderate cases and more than four times less costly for severe cases than traditional psychiatric outpatient care.
- PCPs surveyed reported a high level of satisfaction with timely patient access to care. Patients surveyed reported a high level of satisfaction with wait times, quality of care and quality of information, and were satisfied with the wait time for referrals.

**Website**
http://www.mdabc.net/

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**The Community Outreach in Paediatrics/Psychiatry and Education program (COPE)**

<table>
<thead>
<tr>
<th>Location</th>
<th>Calgary, Alberta, Canada</th>
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<tbody>
<tr>
<td><strong>Target Client</strong></td>
<td>Children in elementary school</td>
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<tr>
<td><strong>Description</strong></td>
<td>The Community Outreach in Pediatrics/Psychiatry and Education (COPE) seeks to link children, families, schools and mental health professionals. Participating schools refer students with developmental, behavioural, or emotional difficulties and, following a multidisciplinary screening, physicians conduct assessments within the school setting. An action plan is then developed with the team and the family, in order to link children with needed services.</td>
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<tr>
<td><strong>Goals</strong></td>
<td>To provide early identification of children with emotional and behavioural problems.</td>
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<td></td>
<td>To provide early medical consultation and provision of comprehensive assessment of psychosocial and health status to better match needs and interventions.</td>
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<td></td>
<td>To improve access to existing health and mental health services.</td>
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<tr>
<td></td>
<td>To aim for more effective utilization of health and education resources to identify and direct children to more appropriate interventions.</td>
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<tr>
<td></td>
<td>To improve psychosocial outcomes of children served by the program.</td>
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</table>
### Type of model
(McLennan, Reckord, & Clarke, 2008)

**Centralized intake and collaboration**
COPE acts as a centralized intake hub within a school context. All schools within the area refer children to the same program, where assessments and treatment recommendation are determined. COPE does not provide treatment, but rather provides specialized assessment, consultation treatment recommendations and referrals. Treatment strategy involves physicians, school personnel, and a behavior specialist or psychiatrist to provide a collaborative care approach. After consultation and recommendation, treatment is for the most part handled by the referring physician or school personnel.

### Core components
(McLennan et al., 2008)

- **Screening**: multidisciplinary team to enhance validity of assessment and provide more than one opinion on treatment and diagnosis does assessments.
- **Multidisciplinary teams** consisting of a physician, family therapist and school personnel.

### Implementation considerations and evaluation
(McLennan et al., 2008)

Researchers found that while the COPE program helped families access services such as assessments, referrals, specialist consultations and treatment recommendations, there were three major limitation to the program:

- This approach did not reduce the demand on the service system, but acted more as a redirect. Since the program did not provide treatment itself, only recommendation and consultation, families often need to contact community agencies to maintain treatment.
- Psychiatrist or pediatricians that focus on child mental health are in shortage in Calgary, and often the COPE program itself suffered from significant wait-times.
- Since referrals came primarily from school personnel, most children seen were referred due to externalizing behaviors. There is likely a population of children who are not referred since their behaviors were not evident to the school personnel.

### Website
http://www.hullservices.ca/service/hull-family-and-education-service
6. Next steps and other resources

Access to services is a complex and important topic for health care providers. There are many different factors influencing agencies’ capabilities to increase access to services. Literature on access systems, however, is limited and requires further exploration. The most common recommendations in the available literature include community organizations partnering together to increase overall capacity, taking a coordinated access approach and creating opportunities to empower clients to access services.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.

For general mental health information, including links to resources for families:

http://www.ementalhealth.ca
Access to child and youth mental health services

References


