



Canadian response to need for transformation of youth mental health services: ACCESS Open Minds (Esprits ouverts)

Ashok Malla^{1,2,3,4} | Srividya Iyer^{1,2,3,4}  | Jai Shah^{1,2,3,4} | Ridha Joobar^{1,2,3,4} | Patricia Boksa^{1,2,4} | Shalini Lal^{2,4,5,6} | Rebecca Fuhrer^{2,7} | Neil Andersson^{2,8,9} | Amal Abdel-Baki^{2,10,11}  | Daphne Hutt-MacLeod^{2,12} | Ann Beaton^{2,13} | Paula Reaume-Zimmer^{2,14} | Jessica Chisholm-Nelson² | Cécile Rousseau^{1,2,15} | Ranjith Chandrasena^{2,16} | Jimmy Bourque^{2,17} | Diane Aubin^{2,18} | Mary Anne Levasseur^{2,19} | Ina Winkelmann² | Meghan Etter^{2,20} | Jill Kelland^{2,21} | Caroline Tait^{2,22} | Jill Torrie^{2,23} | Helen Vallianatos^{2,24} | the ACCESS Open Minds Youth Mental Health Network

¹Department of Psychiatry, McGill University, Montréal, Québec, Canada

²ACCESS Open Minds (Pan-Canadian Youth Mental Health Services Research Network), Douglas Mental Health University Institute, Montréal, Québec, Canada

³Prevention and Early Intervention Program for Psychosis (PEPP), Douglas Mental Health University Institute, Montréal, Québec, Canada

⁴Douglas Mental Health University Institute, Montréal, Québec, Canada

⁵School of Rehabilitation, Faculty of Medicine, Université de Montréal, Montréal, Québec, Canada

⁶Centre de recherche du Centre hospitalier de l'Université de Montréal (CRCHUM), Montréal, Québec, Canada

⁷Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montréal, Québec, Canada

⁸Department of Family Medicine, Community Information and Epidemiological Technologies (CIET) Institute and Participatory Research at McGill (PRAM), McGill University, Montréal, Québec, Canada

⁹McGill University Institute for Human Development and Well-being, Montréal, Québec, Canada

¹⁰Department of Psychiatry, Université de Montréal, Montréal, Québec, Canada

¹¹Centre hospitalier de l'Université de Montréal (CHUM), CRCHUM, Montréal, Québec, Canada

¹²Eskasoni Mental Health Services, Eskasoni, Nova Scotia, Canada

¹³School of Psychology, Faculty of Health Sciences and Community Services, Université de Moncton, Moncton, New Brunswick, Canada

¹⁴Mental Health and Addictions Services, Bluewater Health and Canadian Mental Health Association, Lambton Kent, Ontario, Canada

¹⁵Centre de recherche SHERPA, Institut Universitaire au regard des communautés culturelles, Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Ouest-de-l'Île-de-Montréal, Montréal, Québec, Canada

¹⁶Schulich School of Medicine, Western University, London, Ontario, Canada

¹⁷Faculty of Education, Université de Moncton, Moncton, New Brunswick, Canada

¹⁸Dans La Rue and Réseau d'intervention de proximité auprès des jeunes de la rue (RIPAJ)-Montréal/Homeless Youth Network, Montréal, Québec, Canada

¹⁹ACCESS Open Minds Family and Carers Council, Douglas Mental Health University Institute, Montréal, Québec, Canada

²⁰Counselling Services, Inuvialuit Regional Corporation, Inuvik, Northwest Territories, Canada

²¹Young Adult and Cross Level Services, Addiction and Mental Health, Edmonton Zone, Alberta Health Services, Edmonton, Alberta, Canada

²²Department of Psychiatry, University of Saskatchewan, Saskatoon, Saskatchewan, Canada

²³Public Health Department, Cree Board of Health and Social Services of James Bay, Mistissini, Québec, Canada

²⁴Department of Anthropology, University of Alberta, Edmonton, Alberta, Canada

Correspondence

Ashok Malla, Department of Psychiatry, McGill University, Montréal, Québec, Canada.
Email: ashok.malla@mcgill.ca

Aim: Youth mental health is of paramount significance to society globally. Given early onset of mental disorders and the inadequate access to appropriate services, a meaningful service transformation, based on globally recognized principles, is necessary. The aim of this paper is to

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describe a national Canadian project designed to achieve transformation of mental health services and to evaluate the impact of such transformation on individual and system related outcomes.

Method: We describe a model for transformation of services for youth with mental health and substance abuse problems across 14 geographically, linguistically and culturally diverse sites, including large and small urban, rural, First Nations and Inuit communities as well as homeless youth and a post-secondary educational setting. The principles guiding service transformation and objectives are identical across all sites but the method to achieve them varies depending on prevailing resources, culture, geography and the population to be served and how each community can best utilize the extra resources for transformation.

Results: Each site is engaged in community mapping of services followed by training, active stakeholder engagement with youth and families, early case identification initiatives, providing rapid access (within 72 hours) to an assessment of the presenting problems, facilitating connection to an appropriate service within 30 days (if required) with no transition based on age within the 11 to 25 age group and a structured evaluation to track outcomes over the period of the study.

Conclusions: Service transformation that is likely to achieve substantial change involves very detailed and carefully orchestrated processes guided by a set of values, principles, clear objectives, training and evaluation. The evidence gathered from this project can form the basis for scaling up youth mental health services in Canada across a variety of environments.

KEYWORDS

early intervention, community psychiatry, patient oriented research, service transformation, youth mental health

There has been a burgeoning interest recently in youth mental health as part of a greater attention being paid to mental health in general worldwide, exemplified by several editorials (Davidson & Cappelli, 2011; Kutcher, 2011; Kutcher, 2017; McGorry, 2017; Silbernagel & Davidson, 2017; Waddell, Offord, Shepherd, Hua, & McEwan, 2002; Waddell, Shepherd, & McLauchlin, 2008) and interest shown by governments and politicians in Canada (Freeman et al., 2011; Mental Health Commission of Canada, 2015; Trudeau, 2017) and elsewhere. This is indeed long overdue and most welcome considering the social and economic implications of youth mental health.

In a previous report, some of us have argued that transformation of youth mental health services should be the number one priority of mental health care in Canada (Malla et al., 2018). This argument is based above all on the high incidence of mental disorders before the age of 25 and their persistence into adulthood and beyond, resulting in high social and economic costs (Jones, 2013; Merikangas et al., 2010; Statistics Canada, 2013). The high economic cost of untreated mental disorders in young people is accentuated by the shifting demographics of Canadian society with young people forming a relatively small proportion of the population as future drivers of the economy.

Overall response to youth mental problems has been inadequate and, often, inappropriate vis à vis the needs of youth seeking such services. The challenges, apart from high incidence and prevalence (Jones, 2013; Kessler et al., 2007), include extreme delay in access to an assessment and appropriate care (Wang et al., 2005); high rates of disengagement from services (Lal & Malla, 2015; O'Brien, Fahmy, &

Singh, 2009); the largely institutional and bio-medical nature of care available and high rates of hospital emergency service use (Gill et al., 2017); lack of involvement of youth and families; and, not least, the difficulties encountered in transitioning from child-adolescent to adult systems of care (Singh & Tuomainen, 2015). Some of these issues, especially the latter, have been highlighted in reports from several countries including Canada, Australia, Ireland and England (Bailey et al., 2016; Dooley & Fitzgerald, 2012; Mental Health Commission of Canada, 2015; National Health Service, 2015; World Psychiatric Association, 2005).

Therefore, the systemic response demands a major transformation. Neither primary care in its present form nor the specialist care with its silos, based on age and diagnosis, currently have the capacity to meet these challenges. There is, however, indeed an opportunity given the current social and political climate in countries such as Canada, to engineer a bold transformation of youth mental health services that would address most, if not all, of the challenges listed above.

Several countries have embarked on a major systemic response to challenges of youth mental health and, in the case of Australia (McGorry, 2017) and Ireland (Illback & Bates, 2011) created a new system of care designed especially for youth. There is evidence beginning to accumulate that these new systems of youth mental health care are effective (Das et al., 2016; Hetrick et al., 2017). In Canada attempts at improving the system have been initiated by the Mental Health Commission of Canada by putting forward a framework for

such change (Mental Health Commission of Canada, 2015). Several regional initiatives are also being put in place to address the same concerns and challenges (eg, Youth Wellness Hubs, Ontario <https://youthhubs.ca/>; Foundry in British Columbia www.foundrybc.ca).

In this report, we describe a pan-Canadian project involving major transformation of youth mental health services for individuals between the ages of 11 and 25 years that is being tested for its effectiveness in varied jurisdictions. It is highly unlikely that a single model of service delivery will work across the extreme diversity of this country based on geography, politics, culture and level of available mental health resources nor is it feasible to import a model in its entirety that has shown some effectiveness in another country. The principles governing transformation of youth mental health services have, however, been well articulated (Birchwood & Singh, 2013; Hughes, Hebel, Badcock, & Parker, 2018; Malla et al., 2016; McGorry, 2007) and need to be adhered to in any form of service transformation. Briefly, these principles include youth participation at all levels, creation of youth-friendly stigma-free services, optimistic culture of care, early intervention, focus on social and vocational outcomes, services to be based on epidemiological estimates of rates of mental disorders in youth, elimination of discontinuities at times of age transitions and linkages to other relevant services (McGorry, Bates, & Birchwood, 2013).

1 | WHAT IS ACCESS OPEN MINDS (ESPRITS OUVERTS)?

ACCESS (Adolescent/young adult Connections to Community-driven, Early, Strengths-based and Stigma-free services) Open Minds (Esprits ouverts) is a pan-Canadian project. It aims to transform mental health services for young people aged 11 to 25 years and to evaluate the impact of this transformation on individual and systems outcomes. This project is the result of a competitive process for funding of the first Strategy for Patient Oriented Research (SPOR) network of the Canadian Institutes of Health Research (CIHR) funded jointly by the latter and Graham Boeckh Foundation (GBF).

1.1 | Development of the ACCESS Open Minds network project

The two funding agencies (CIHR, GBF), under the auspices of the SPOR granting process of the CIHR, provided guiding principles for the competitive process, (designated Transformational Research in Adolescent Mental Health, TRAM), that eventually selected ACCESS Open Minds as the successful network project. One of the key principles was that the project should involve a number of key stakeholders: service providers, academics with expertise in mental health services research, youth who are past or current service recipients, youth with lived experience, family members of youth with lived experience, community organizations and policy- and decision-makers. In keeping with the TRAM ethos, ACCESS Open Minds (ACCESS OM) engaged all of these pertinent stakeholder groups, in articulating its service transformation and research values, objectives and strategies. Apart from engagement at this level, a core feature of such engagement

requires eventual translation into active involvement of youth and families at the point of service contact.

The ACCESS OM network is structured and functions as a pan-Canadian project in which youth mental health services are being transformed, along with an evaluation of the impact of the transformation, at 14 sites across five provinces (Alberta, Saskatchewan, Ontario, Québec, New Brunswick, Nova Scotia) and one territory (Northwest Territories). The sites represent diverse geographic, cultural and socio-economic contexts. They include a large urban site in a predominantly English-speaking province (downtown Edmonton, Alberta) and two others in an urban French-speaking setting (Dorval-Lachine-Lasalle and Parc-Extension, Montréal, Québec). Of these, the Parc-Extension site is home to one of Québec's most ethnically diverse populations. Small rural and semi-urban sites include Chatham-Kent, Ontario; and Saint John and the predominantly francophone Acadian Peninsula, New Brunswick. Indigenous sites include First Nations communities in Eskasoni, Nova Scotia; Elsipogtog, New Brunswick; Mistissini, Québec; and Sturgeon Lake, Saskatchewan; and Inuit communities in Ulukhaktok, Northwest Territories and Puvirnituq, Québec. In addition, other youth groups with unique needs are targeted at the RIPAJ (Réseau d'intervention de proximité auprès des jeunes de la rue)-Montréal/Homeless Youth Network site for urban homeless youth; the University of Alberta site for post-secondary students; and the subset of young people (11-18) under state care at the Dorval-Lachine-LaSalle and Parc-Extension sites.

1.2 | Governance and functioning of ACCESS OM

In keeping with the spirit of the SPOR framework and ACCESS OM's consensus vision, the project's governance structure (Figure 1) was designed to meaningfully engage all relevant stakeholder groups in overseeing, administering and evaluating the transformation of youth mental health care. Activities of the network are managed through an Executive Committee with representation from all sites, two representatives from the national Youth Council and one from the Family and Carers' Council. Two key national councils, one each of youth and family and each with its own budget give the key stakeholders a significant role in shaping the project (see www.accessopenminds.ca for details). In addition, an Indigenous Council has been added to the governance structure in the third year of the project following discussions with the Indigenous sites. A Research Advisory Group, which comprises the network's researchers, along with representation from Youth and Family Councils, supports the conceptualization and execution of its evaluation strategy. A National Advisory Council (NAC), comprised of individuals from different regions of the country not directly involved with service transformation or research in ACCESS OM, advises on the overall vision and operations. Members of the NAC were invited to participate based on their expertise in mental health, advocacy, justice, accounting, research, youth perspective (three members), post-secondary education, family, Indigenous issues and communication.

The Nominated Principal Investigator (NPI) is responsible for all activities, reporting to an Oversight Committee comprised of two representatives each from the two funding bodies. The scientific aspect and service transformation are directed by a PI as the project scientific

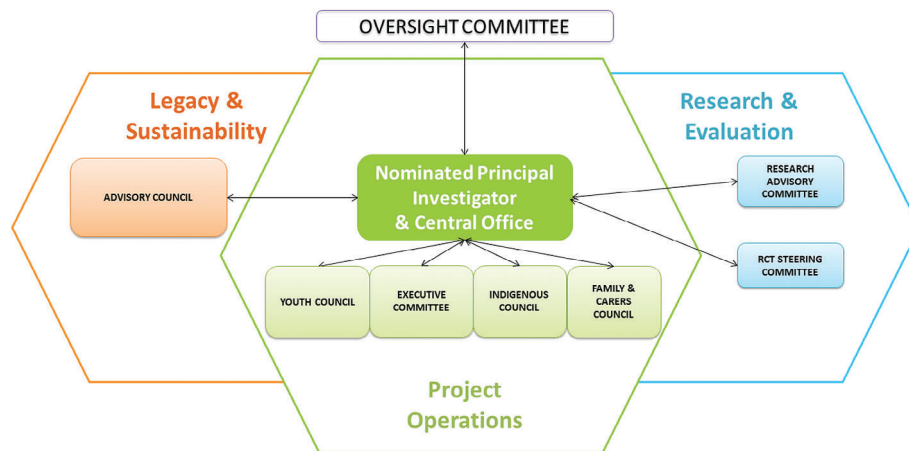


FIGURE 1 ACCESS open minds governance overview

director. The operations of the project are managed by a director each of (1) service transformation, sustainability and site relations; and (2) financial, data management and communications operations. Operations are supported by staff dedicated to site coordination; training and knowledge transfer; youth and family engagement; and research and evaluation.

1.3 | Model of service transformation within ACCESS OM

The funding agencies required the network to lead a fundamental transformation of mental health services and their outcomes for 11 to 25 year old youth through implementation of evidence-based approaches. The stated objectives included a substantial increase in access, quality, timeliness and effectiveness of the care they receive. “Transformative change must involve revolutionary....new ways of thinking” (www.tramcan.ca).

The core of ACCESS OM service transformation is informed by the success of early intervention in psychosis (Iyer et al., 2015; Iyer, Jordan, MacDonald, Joober, & Malla, 2015; Malla et al., 2016; Mental Health Commission of Canada, 2015) especially reduction of delay in treatment through effective early case identification and rapid unencumbered access to care (Iyer, Boksa, et al., 2015; Iyer, Jordan, et al., 2015; Malla, Norman, McLean, Scholten, & Townsend, 2003) as well as success of, and lessons learned from other large initiatives such as Headspace in Australia. In addition, the approach to transformation was shaped through continuous inputs of various stakeholders, the extant body of knowledge on youth mental health and effective interventions, insights of Indigenous communities involved in the network, prior initiatives integrating youth-focused services and delivering mental health care in resource-constrained settings.

1.3.1 | Objectives of service transformation

ACCESS OM has identified five main objectives for service transformation to be achieved at all sites. These objectives include elements outlined in the original funding announcement, and reflect principles agreed upon for an effective youth mental health service (McGorry et al., 2013; Mental Health Commission of Canada, 2015) and accumulated evidence of effective interventions (Dunne, Bishop, Avery, &

Darcy, 2017; Gulliver, Griffiths, & Christensen, 2010; McGorry et al., 2007; Scott et al., 2009; Scott et al., 2013; Wang et al., 2005; Williams, Latta, & Conversano, 2008). These are as follows:

1. *Reducing unmet need* through early case identification interventions designed to increase the number of youth with mental health problems seeking services.
2. Ensuring *rapid access* to youth with mental health problems seeking care by offering an initial assessment within 72 hours.
3. Making *appropriate care* available within 30 days, if such care is required following the initial assessment. This benchmark is based on recommendations of the Canadian Psychiatric Association.
4. Ensuring meaningful *engagement of youth and families* in designing and delivery of service to youth with mental health problems.
5. *Eliminating transitions* based on age (at 18 years) through allowing continuity of services within the same system for the entire age period of 11 to 25 years so that transition within that range is based on need and not age.

Given the geographic, political and cultural diversity in Canada our approach is not prescriptive of a uniform model for all sites. Each site is required to meet these objectives through evidence-based interventions that are contextualized and adapted to local circumstances. Key elements of service transformation within each participating service (site) include a systematic approach to service planning; early case identification; rapid access facilitated through designing and putting in place an integrated *Youth Space*; addition of one or more ACCESS OM clinicians (or ACCESS OM Youth Worker at some sites) to the local team; active youth and family engagement; training of all clinical staff in program values, principles and activities; and addition of research and evaluation capacity.

1.3.2 | Processes and interventions that make up the service transformation

1. *Service planning*: The process for service planning was inspired by the Theory of Change framework that guides the implementation of change by beginning with the desired outcomes and working back to the fulfilment of necessary conditions (Taplin & Clark, 2012). The planning process is designed to create a

transformation plan at each site that would guide the site in meeting the desired objectives (above). The main principle involved is that transformation of service delivery will be achieved from within and not through creating a new parallel system, thus assuring sustainability beyond the project and providing a template for scaling up in other jurisdictions. Facilitated by the central office team, the existing staff at each site undertakes a community mapping exercise in order to identify all existing youth mental health resources including addiction, crisis, social welfare, education, employment, legal and recreational services available within the local community. The service planning, including community mapping, is completed as a first step towards setting up the new consolidated ACCESS OM service for 11 to 25 year olds. While some elements of the services, such as employment, education and social welfare, would continue to be provided by the respective agency, the transformation involves each ACCESS OM site to coordinate all such interactions for the young person seeking and receiving service. The new integrated service team is enhanced through provision of key personnel, such as one or more ACCESS OM clinicians (depending on the size of the site), personnel for evaluation of the impact of service transformation and training in order to increase capacity for both service delivery as well as evaluation. A number of different partners in the community participate in the process, which varies across sites depending on the size of the community, the extent of currently available services and collaboration between them. An essential element of service planning involves merging teams and getting professionals from child-adolescent services and adult services to work together to create a single team that will focus on the 11 to 25 population in order to avoid need for transition at 18, if a young person needs to continue to receive service. In non-Indigenous sites this invariably required working to amalgamate two separate teams one each for child-adolescent and adult populations, while no such division exists in Indigenous sites.

2. *Early Case Identification (ECI)* activities at each site vary by local geographic, population size and cultural context although some general principles apply to all sites as laid out in the ECI guide (www.accessopenminds.ca). For youth age 11 to 18, for example, all sites address school activities with the objective of increasing youth mental health literacy among the teachers, counsellors and students regarding early signs of mental health problems, need for and effectiveness of early intervention, methods to obtain rapid access to service at the site and the importance of and need for assurance regarding confidentiality in accessing services. Other ECI activities address the community directly, especially in small urban-rural and Indigenous communities, using sports and recreation activities and clubs. In the case of Indigenous communities, traditional healers and elders play a significant role in ECI. Finally, ECI activities target all potential sources of referral identified through community mapping, especially in large urban centres where early case identification interventions directly targeting the entire community is often not feasible. Referral sources include relevant social, health, education, employment and legal services, the latter including all aspects of juvenile and adult judicial services. Special efforts are made to ensure that ECI activities target

local organizations that serve particularly vulnerable groups such as, not in education, employment or training (NEET), homeless and those in state care. All of these have relatively high incidence and prevalence of mental disorders although accurate estimates of unmet need (untreated prevalence) are difficult to obtain for populations like that of homeless youth, due to the hidden nature of homelessness in this age group (Boivin, Roy, Haley, & Fort, 2005; Ringwalt, Greene, Robertson, & McPheeters, 1998). Active engagement of youth and families in the site transformation team also promotes contact with other families and youth in the community and gets the ACCESS OM service "known" with its logo and identity.

The central team assists each site to identify targets for reduction of unmet needs based on number of youth currently receiving services as a starting point followed by creating estimates of unmet need for the community. Estimates of the 11 to 25 year-old population are obtained from Statistics Canada, allowing working inferences about the number of youth likely to experience mental health problems that would require intervention, based on the Canadian Community Health Survey-Mental Health (Statistics Canada, 2013) and the assumption that 50% of these youth will need some form of intervention.

3. *Rapid access*: Based on the principle of providing initial access without reliance on physicians or specialists, "rapid access" involves offering an assessment to the help seeking youth and their family within 72 hours and is central to ACCESS OM service transformation. Such access is open to all sources of referral, including self, family and friends and through any means including walk-in, phone, e-mail and social media

This key objective of the ACCESS OM model of service transformation is achieved through one or more "ACCESS OM clinicians," responsible for making contact with the help-seeking youth, conducting the initial assessment and collaboratively guiding the care trajectory. The initial assessment, focusing on the presenting mental health and substance abuse problem, is designed to evaluate the level of distress experienced, overall clinical severity of the presenting problem, and level of functioning in order to make a decision regarding the urgency of the presenting problem and need for specialist or other level of care. In addition, this allows the setting of mutually agreeable short-term goals through collaboration between the ACCESS OM clinician and the young individual and, wherever relevant and feasible, their family and kinship.

The ACCESS OM clinician is a professional with background in nursing, social work, psychology or occupational therapy trained specifically (see below under training) to provide a thorough assessment of the presenting problems at the time of the first contact with the youth seeking help. The assessment follows a semi-structured protocol and uses some key clinical instruments including a self-rating of distress (K-10) (Kessler et al., 2002); Clinical Global Impression (CGI) scale (Busner & Targum, 2007), modified for the purpose of assessing mental health problems of all levels of severity, and the Social and Occupational Functioning Assessment Scale (SOFAS; Goldman, Skodol, & Lave, 1992). A cut-off of a score of 30 for K-10, CGI of >4 and a SOFAS score of <60 are regarded as indicative of a moderate to serious mental

health problem. If the cut-off on two of the three measures is met, the young person is regarded as presenting with a moderate to severe mental health problem. This method avoids premature use of diagnosis at the first assessment and has the merit of putting equal emphasis on self-perceived distress, symptoms judged by a clinician and level of functioning, aspects of mental health that are of more immediate concern to youth and their families. This was also preferred by youth during consultation with the national Youth Council.

The ACCESS OM clinician, in collaboration with the young client and their family and in consultation with a senior clinician, decides on the course of action. A young person presenting with a moderate to severe problem is referred, depending on their needs and availability of the level of service needed, to care within the ACCESS OM service or to a specialist. If the problem is deemed to be of low-grade distress with no indication of an identifiable mental disorder, the ACCESS OM clinician is equipped to offer brief counselling (eg, a single session intervention) and connected to ancillary services (eg, for employment, education or physical health), based on need. Such decisions are supported by information obtained through the three measures mentioned above. In all cases family is invited to be involved, when available, and if the presenting young person is in agreement.

4. *Appropriate care*: Need for and type of appropriate care is determined collaboratively between the service user and the ACCESS OM clinician and the ACCESS OM team, guided by the nature and severity of the presenting problems (see above) and often by published guidelines for specific disorders. Depending on the presenting problem, appropriate care may involve transfer to a specialist service (eg, an early psychosis service, eating disorder program) or for specific therapies (eg, Dialectical Behaviour Therapy for emotional dysregulation; addiction treatment in cases of severe substance abuse) or even admission to a hospital in case of problems such as high risk of suicide, aggression or presentation of acute psychosis. Such transfers, when needed, are managed by the ACCESS OM clinician in order to avoid any gap in services, especially if the specialist service is not part of the same clinical structure as the ACCESS OM service.

While it is desirable to make specialist care available within the ACCESS OM service at each site, this is likely to be more difficult in remote and Indigenous sites. Alternate methods of providing specialist care will be explored at these sites, including use of telemedicine and access to fly-in services. Although a benchmark of 30 days has been set for this objective, the local availability of specialist care or addiction treatment is likely to determine the length of the waiting period subsequent to the initial assessment. In order to ensure continued engagement of the young person, the ACCESS OM clinician continues to provide support during the waiting period. Most sites are encouraged to create peer support programs both for the young service user as well as for their families. Peer support interventions are expected to improve youth and family engagement in the service as well as act to provide support during the waiting period.

5. *Youth and Family Engagement* is a major objective of ACCESS OM achieved at the national level through the Youth Council and the

Family and Carers' Council. At the site level, mandatory involvement of at least one youth and one family representative on the site transformation team (also includes a clinician, a decision maker such as a service manager and a research representative) is expected to improve youth and family engagement. This team guides the service transformation in collaboration with direction from the ACCESS OM central office in order to meet the above stated five objectives. The national Youth and Family Councils assist sites in youth and family engagement. A core feature of engagement is the inclusion of the young person and families in the assessment, goal-setting and treatment planning. Sites are also encouraged to establish youth and family peer support programs guided by the current best practices in the field and assisted by the two national councils and the ACCESS OM central office. Training for the latter interventions is facilitated whenever available.

6. *Integrated Youth Space*: The most visible aspect of youth engagement and of improved unencumbered access to youth-focused service is the establishment of youth friendly space at each site. Such spaces ensure that young people can come not only to receive the mental health and addiction services of ACCESS OM but also be able to engage in social and recreational activities as well as have access to a range of other services such as employment counselling, addiction services and physical health at some sites. These youth spaces are situated in the community but directly connected to a community health care facility, which is organizationally associated with either primary (Montréal) or specialist (Edmonton) care or a combination of a specialist and a community mental health service (Chatham-Kent). In Indigenous sites the ACCESS OM service is often situated in purpose built youth spaces that are embedded within the community's main health services system. Youth spaces at all sites are developed with leadership primarily from local youth in collaboration with professionals and local family representatives; most of the youth are either present or past service users and/or part of local youth or the national Youth Council. This approach ensures greater buy-in from and ownership of the service by young people.
7. *Eliminating transitions at 18*: Within the prevailing system of care mental health services are configured around child-adolescent and adult needs and young people have to undergo a transition at 18 if they continue to require services. In order to reduce the trauma of an abrupt transition and to reduce the high risk of disengagement during transition (Paul, Street, Wheeler, & Singh, 2015; Singh & Tuomainen, 2015), ACCESS OM ensures that young people continue receiving the services they need at the same site and from the same service providers throughout the years of 11 to 25 years of age. While entry into and exit from an ACCESS OM service is determined by the specified age group to be served as defined by the TRAM grant process, care is taken to ensure that transition is based on need and not age within the age range of 11 to 25.
8. *Training and building service capacity*: For systemic reforms to have a significant impact on outcomes requires particular attention to building capacity in the form of appropriately trained personnel for putting the service reform in practice. Among the key

elements of ACCESS OM is a well-defined strategy for building capacity at the service (site) level and increasing competencies of frontline clinical staff. All clinicians in the integrated service team and evaluation staff at each site receive face to face training focused around the values, ethos and principles of ACCESS OM. Training of ACCESS OM clinicians for their pivotal role involves imparting or improving skills necessary to conduct thorough assessments of mental health problems presented by youth, to engage youth and their families, and to make decisions for appropriate care. The objective of the training is to empower the ACCESS OM clinician to function independently as the first point of contact capable of making decisions based not on diagnosis but distress, symptoms and functioning. At some Indigenous (Inuit) sites, the role of the ACCESS OM clinician is assumed by a community youth worker, a concept adapted from the Lay Health Worker model. The latter has been shown to be effective in poorly resourced environments (Mutamba, van Ginneken, Pain- tain, Wandiembe, & Schellenberg, 2013; Van Ginneken et al., 2013). This particular training focuses initially on teaching basic mental health assessment skills using the WHO Mental Health Action program (mh-GAP), modified to suit local cultural context. Building service capacity is also enhanced through youth and family representatives being able to provide valuable insights from lived experience to other team members, thus building capacity in competency and service delivery. Moreover, the capacity of youth and family representatives in service is also developed and enhanced, thereby increasing the opportunities for more youth and families to be involved.

9. Building research and evaluation capacity: A probable source of lack of success of service reform and decay over time is the absence of evaluation of such service transformation. To prevent this and to facilitate future scale-up ACCESS OM includes a strong, integrated research and evaluation component, which will be described in greater detail in a separate report. Here we limit ourselves to providing a brief overview

The evaluation strategy entails a continuous assessment of each site's fidelity to the original principles and objectives of the model (eg, extent of adherence to the 72-hour access); barriers to and facilitators of transformation at the level of sites (eg, location of the youth space) and the system (eg, availability of specialists) and outcomes for individuals (eg, change in level of functioning or level of satisfaction) and for sites and systems (number of young people served, proportion of unmet needs met). Each ACCESS OM site is equipped with a research staff preferably with prior experience in clinical services and research. This staff member conducts and-or coordinates all evaluations including those completed by the young client and the clinician as per the evaluation protocol.

To equip clinical and research personnel to conduct and document these evaluations at the site level and thereby facilitate research at the project level, training is provided on administering relevant evaluation instruments. Case vignettes covering a variation of severity of mental health problems are used to provide training in clinical and research evaluations. All aspects of training are provided initially in person with a semi-standard format at

each site supplemented by booster sessions through subsequent face to face sessions and webinars. In addition, research and evaluation capacity are enhanced through the deployment of a custom-built web-based data collection platform (developed in collaboration with Dacima Software, www.dacimasoftware.com).

1.3.3 | Funding and implementation timelines

ACCESS OM was announced in 2014, with the initial 2015 year spent planning and establishing the overall project and at the site level. The first ACCESS OM site opened in May 2016 and the last one in June 2017. With implementation timelines across sites varying depending on site readiness and local circumstances, the project will end in 2020, with the expectation that sustainability would have been achieved in most sites. Sites receive limited funding to facilitate transformation of the core service elements related to the research and evaluation project. This includes funding for one or more ACCESS OM clinician(s) and one or two research staff, depending on the size of the site; youth space (for cost to renovate and upgrade, not operational expenses); youth and family engagement; stipends and costs for local activities; information technology (IT) infrastructure required to collect data. The site funding model is based on up to 3 years of full funding, followed by 2 years of "sustainability" (reduced) funding, as enhanced services (eg, clinicians) move to more sustainable funding streams. The funding provided to each site averaged between \$290 000 and \$320 000 (Canadian dollars) per year depending on the current level of services already funded, size of the population served and special needs (eg, high prevalence rates such as, among homeless youth and Indigenous communities).

1.3.4 | Discussion and conclusions

ACCESS Open Minds is a national project designed to produce and to evaluate a transformation of youth mental health services in different geographic, cultural and population contexts across Canada, with a view to provide an empirical basis for scaling up variations of a model of transformed services. Such transformation includes an emphasis on high-risk populations, such as Indigenous communities, homeless youth and youth in care. This network of youth mental health transformation and its evaluation has been presented here in the context of needs of young people with mental health problems that are too often not met by the current system. The focus is to reduce the well-documented unmet mental health and addiction needs of youth across Canada through providing early intervention (early case identification and rapid access) and to provide or to arrange appropriate care targeting the entire variation of severity of mental disorders in youth without any transition across different services based on age during the 11 to 25 year period. The transformation is driven by strong engagement of two key stakeholders, youth and family, as well as service providers, researchers and policy makers. The evaluation of this transformation is being carried out using multilevel outcome measures that will be described within the framework of the evaluation protocol in a separate report.

We carefully examined the two major transformational system interventions in place internationally, namely, Headspace (Australia) and Headstrong-Jigsaw (Ireland). While these initiatives have had

some success in their respective environments, any duplication of such initiatives would need to rely on some key assumptions. One relates to the jurisdiction of a central organization over services across the country and the availability of an envelope of a relatively substantial new public funding. Both of these requirements for a national initiative are not feasible in Canada, a confederation of provinces and territories since 1867. One of the unique challenges in service organization, and hence of service transformation in Canada is the federal-provincial structure within which provincial governments have total non-negotiable control over the provision of, or any changes to, the system of health care although the funding formula is a mixture of provincial and federal contributions. Headspace has been built as a national response to youth mental health needs and functions as an enhanced primary care systems and an addition to the existing primary and specialist systems of care. Jigsaw, a community based youth mental health service launched as a national program with sites across the country, followed research and advocacy in youth mental health by Headstrong, a dedicated youth mental health organization in Ireland (Malla et al., 2016; O'keeffe, O'Reilly, O'Brien, Buckley, & Illback, 2015). While based on a logical sequence of identifying need and designing a system of care based on such need as well as on successes of early intervention in psychosis, neither was designed at the outset as a research initiative to produce evidence to justify the proposed models, although an evaluation framework was integral to each initiative. Recently published evaluation of these programs now provides evidence to support their utility with respect to significantly improved functional and/or symptomatic outcomes for youth with mental health problems (Iorfino et al., 2018; Schley et al., 2018; reviewed by Hetrick et al., 2017).

At ACCESS OM we chose to take advantage of an opportunity offered through TRAM to test a transformation of the current service systems based on need and principles similar to those of the above initiatives and on local evidence of the effectiveness of early intervention services for psychosis. This required very early engagement of multiple stakeholders, both centrally and at individual sites, especially engagement of multiple service providers across sectors, service users and families. One of the strengths of ACCESS OM is the flexibility in meeting the target objectives described earlier depending on local context and environment, as long as all the fundamental principles and values are adhered to in reaching these objectives. The sites have been deliberately chosen to represent the widest possible range of geographic (eg, large urban vs small urban and rural), social, cultural and economic conditions (remote communities, Indigenous, homeless) while youth populations with highly specific needs (post-secondary educational institutions, youth under state care) are also targeted. Despite the variation across sites, at all sites, all types of mental health and addiction problems of all levels of severity are included. Initial assessments are provided within 72 hours and further care decisions are made based not on an initial diagnosis but on subjective distress, global symptoms and level of functional impairment. In future publications we will address how the variation across sites in implementing ACCESS OM is being addressed.

This is the first ever pan-Canadian effort to engage in a major transformation of the way mental health services are provided while the outcomes from it are being evaluated. This report summarizes the

general framework, which will hopefully be scaled up following completion of the study and analyses of data on each objective. The project should generate results on outcome of this transformation across the sites and it should capture unique aspects of different contexts represented by different sites. Following the service transformation example from research on early intervention for psychosis, our results should inform future development of youth mental health services in Canada and possibly elsewhere. The variety of contexts will also allow us to examine what aspects of transformation work well in which settings and what processes of transformation are appropriate for each context. The processes involved in creating the evaluation protocol and a unique custom-designed data management system may set the stage in future for a common set of measures that will be required to measure the outcomes for young people and their families seeking mental health services while also evaluating the functioning of the system of care at the same time, using benchmarks identified through ACCESS OM. The nature and methods for such evaluation will be published separately.

As the transformation process proceeds at different sites, a number of facilitators and obstacles are likely to emerge as part of the learning from this project. Such challenges are connected to the scale and complexity of the problem and the transformation attempted. It is important to address such complexities given the variation across the country alluded to earlier. In future, we will describe the specific processes and activities involved in the transformation within each of the contexts described above, identify challenges and how they vary across sites and what can be done to mitigate any obstacles in future.

ORCID

Srividya Iyer  <https://orcid.org/0000-0001-5367-9086>

Amal Abdel-Baki  <https://orcid.org/0000-0003-3333-9652>

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