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# ACCESS Open Minds

# Transforming Youth Mental Health Services Across Canada

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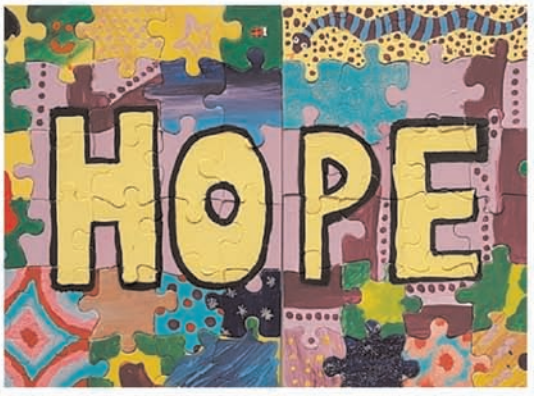



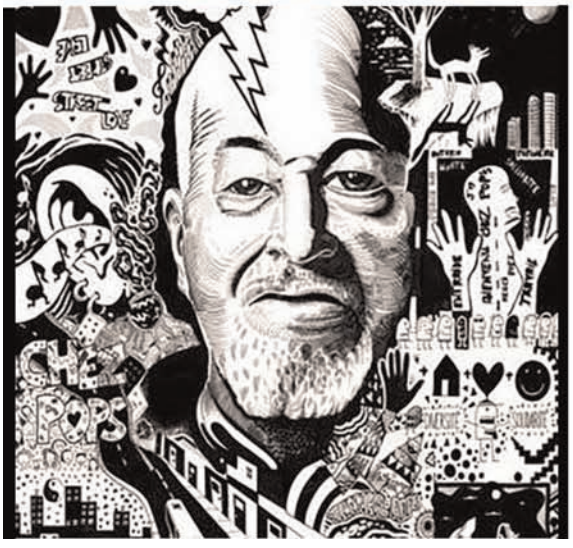


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## Supplement Articles

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SUPPLEMENT ARTICLE

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# Editorial: How youth mental healthcare is being transformed in diverse settings across Canada: Reflections on the experience of the ACCESS Open Minds network

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Having been part of the ACCESS Open Minds (ACCESS OM) project since before its inception, we take pleasure in reflecting on the conception and implementation of the project in its diverse contextual realities.

In 2013, partnering with the Graham Boeckh Foundation, the Canadian Institutes of Health Research, launched a call for grant applications under their new Strategy for Patient-Oriented Research. The 18-month application process brought together various stakeholders from across Canada—youth, families, community organisations, clinicians, researchers, and decision-/policy-makers—around the common recognition that extant systems were not meeting the mental health needs of youth. The resultant ACCESS OM network faced a task that represented both an immense opportunity and a substantial challenge. We were to create a model for youth mental health services transformation that had to be evidence-informed yet anchored in all pertinent stakeholders' perspectives. Our model's core strategies had to have inbuilt flexibility to leverage the strengths and accommodate the realities of diverse sites. Some of the flexibility was necessitated by the nature of Canada's public healthcare system, which is federally mandated but provincially administered (with varying combinations of federal, provincial, and local governance in Indigenous jurisdictions). This has proven to be a strength that makes our model likelier to enjoy local buy-in and ownership and broad applicability in and beyond Canada.

ACCESS OM is being implemented in 14 diverse settings across Canada (Malla et al., 2018). The articles in this supplement describe how the project's core service objectives are being addressed at seven sites that represent distinct contexts. The transformation of youth mental healthcare on such a large scale has been coordinated by a central office in Montreal through common structures and processes that standardise, support, and accelerate implementation.

## 1 | DIRECTING AND DEVOLVING TRANSFORMATION

Working with the project's various governance bodies (Malla et al., 2018), the central office has created a conducive environment for various stakeholders to co-create and influence the project. Consulting actively and regularly with network members and sites, the central office arrived at and has been executing various mechanisms to initiate, support, and monitor the implementation of the ACCESS OM model.

In this regard, the central office elaborated the definitions of and built consensus around five core service objectives and associated benchmarks/indicators (Malla et al., 2018). These objectives are: (a) early identification of youth in need; (b) rapid, engaging access to services; (c) provision of appropriate care; (d) removal of the transition between adolescent and adult services; and (e) youth and family involvement in service planning and care. The central office also listed the activities required to achieve these objectives at all sites, including the creation of a site team comprising, at least, clinicians, youth, and families; the hiring and training of a non-physician clinician (known as the ACCESS Clinician) to serve as a first point of contact and to respond to help-seeking requests within 72 hours; the deployment of

  

a youth-friendly space, designed with inputs from youth, that offers walk-in access and youth-oriented activities; and the implementation of a standardised research/evaluation protocol at all sites. A menu of activities aligned around the five objectives was created to inspire sites in developing their site-specific transformation plans.

Sites and the central office have been collaboratively developing annual work plans that detail activities to be conducted by each site in pursuit of the project's objectives. The human, financial, and material resources required for these activities at any site are identified and supplemented by the central office with additional funds. Thus, transformation at sites has entailed optimising existing resources and transferring additional funds from the project. All work plans include a combination of staff positions and activities common to all sites and some activities that are site-specific (e.g., a gaming night as an outreach exercise in Eskasoni First Nation to promote early identification).

The central office has helped build site-level capacity through training and knowledge translation and by making common resources available (e.g., a website containing site descriptions, a YouTube video promoting ACCESS OM services, etc.). The central office designed and coordinates a regulation-compliant online data collection and management system that enables measurement-based care and research.

An important element of capacity-building was a training program that familiarised core staff at all sites with the project's philosophy and model, including its intake assessment, the integration of evaluations into care, and youth and family engagement. The training included core components that were tailored to each site and was delivered at sites by central office staff. Additionally, site staff were offered specialised training (e.g., on Single-Session Therapy [Campbell, 2012]), expert presentations (e.g., on substance misuse), and booster training.

The central office also offers in-person and phone- or Web-based support and training. Ongoing knowledge translation strategies have included knowledge exchange seminars; guides and tools that have been made freely available, including on the project's website (e.g., on peer support); and interactive webinars (e.g., on informed consent).

Sites are supported by the central office with communications (e.g., creating site narratives and impact statements); with showcasing their work and advocacy (e.g., by informing them about relevant conferences); with data analysis to inform ongoing quality improvement; etc.

Ad hoc, task-specific multi-stakeholder working groups have also been formed. One such group developed a consensus on core values to guide service delivery. These core values are prominently displayed at all sites. There has also been exchange, cross-fertilisation of ideas, and mutual learning across sites, often facilitated by the central office especially through network meetings, and sometimes undertaken by sites on their own initiative. For example, the Ulukhaktok site team visited the Eskasoni First Nation site, where service transformation had begun a year earlier, to learn from their experience. Inter-site exchanges have resulted in more enthusiastic uptake across sites of strategies seen as valuable. For example, the Edmonton site decided to offer skills training to families after learning about it from the Chatham-Kent site.

The network's Indigenous Council has brought Indigenous communities together to develop culturally appropriate approaches and solutions. The network's youth and family/carer councils have supported sites' efforts to involve youth and families in site teams. The youth council passed a motion that mandated involving youth and families in the hiring of staff at all sites, which was accepted by all sites.

## 2 | VICTORIES AND WORKS IN PROGRESS

As is evident in this supplement, youth mental health service transformation is an ongoing, dynamic, and non-linear process. The degree to which sites have been able to attain ACCESS OM objectives has been determined by their ability to implement the project's core components, which in turn has been influenced by certain common facilitators and barriers.

The core components that have enjoyed a high degree of implementation across sites are multi-stakeholder site teams; mapping and reorganisation of diverse extant youth-focused services for co-location or streamlining of connections; the engagement of youth at sites and in the National Youth Council; outreach/publicity; the deployment of an ACCESS Clinician to offer an initial evaluation in a timely fashion (or, in the case of Ulukhaktok, a non-professional community worker); walk-in or direct access; a youth-friendly space; and the hiring/deputation of additional staff to meet project objectives.

At most sites, youth can now access help via technology-enabled portals (e.g., Facebook, text messaging, etc.). Nonetheless, technology-enabled solutions (e.g., telepsychiatry, online interventions) need to be further harnessed by the network to enhance capacity for offering rapid access and appropriate mental healthcare.

Key components that have been more challenging to effectively implement across sites include the involvement of families in site teams; peer support; the integration of or seamless linkages between *all* youth-oriented and youth mental health services; flexibility in terms of location and hours at which services can be accessed; affordable and rapid access to psychotherapy (brief, longer-term, individual, group, etc.); and connection and rapid access to specialised services for those needing them, particularly at more remote sites.

## 3 | WHAT HELPS AND HINDERS

All services at all ACCESS OM sites are provided free of cost, mostly through Canada's public healthcare system and in some instances, by non-profit organisations that receive government and philanthropic funds.

The strength of our model has been its commitment to creating transformational change within existing systems. This has also

sometimes proven to be a hurdle as it has necessitated managing change of significant magnitude within existing bureaucratic organisations, some of which were in the midst of their own reorganisation.

Our experience reiterates the importance of committed local leadership, an often-noted critical factor in implementing systems-level changes. Such leadership can facilitate buy-in at a larger organisational level (e.g., regional health boards, local clinical administrations, Indigenous band councils, etc.). Our experience also highlights that members of different stakeholder groups—youth, families, clinicians, community leaders, etc.—can become effective local champions and ambassadors.

Some unique factors have facilitated and hindered efforts at specific sites at various junctures. For instance, the Chatham-Kent site stands to benefit from being selected for the province of Ontario's youth mental health services initiative for having been an ACCESS OM site for three years. At our *Centre de Bénévolat de la Péninsule Acadienne* site, the implementation of the service transformation was delayed as it could begin only after the site was selected for ACCESS OM by a competition managed by the province of New Brunswick. However, this competition process may bring longer term provincial policy commitment.

Nearly all sites, especially remote ones, have sometimes struggled with recruiting and retaining qualified staff. Many sites face the ongoing challenge of reducing stigma around accessing mental healthcare. In small communities, youth are often reluctant to seek services as they have concerns about their confidentiality being maintained. While most sites were able to engage youth in service design, their retention has sometimes proven difficult because young people tend to have other interests and pursuits to which they move on. A constant pre-occupation for all sites is the sustenance of buy-in from key decision-makers, policy commitment, and funding.

These limitations notwithstanding, the network and individual sites have a collective sense of having engaged in a much-needed endeavour of gargantuan magnitude. The project's service transformation objectives and each site's service transformation plans have been co-developed by multiple stakeholders. This multistakeholder involvement has emerged as a key ingredient for success.

## 4 | THE VIEW FROM THE MIDDLE

Because many ongoing and planned youth mental health reorganisation efforts involve a similar structure of a central coordinating entity managing transformation at multiple sites, it is useful to examine the experience of the ACCESS OM central office. In understanding and addressing diverse stakeholders and sites, the central office had to learn to cope with vast differences in geography, culture, priorities, modes of communication, and types of expertise. Organisational change was also complicated by administrative, structural, and political realities that vary across sites and sometimes change within sites over time. These included differing financial management regimes; labour unions resisting the inclusion of youth and families in hiring panels and varied working hours for ACCESS OM staff; widely varying ethics and institutional/community approval procedures; leaders being replaced; etc.

Exceptionally salient in the Canadian context has been the project's fostering of collaboration between Indigenous and non-Indigenous communities and network members. In this regard, the central office adopted a stance of cultural humility, acknowledging Canada's colonial past. The central office also committed itself to appropriate Indigenous governance precepts and practices such as the OCAP (ownership, control, access, and possession) principles. Service transformation in Indigenous communities often served as inspiration for the network as it was predicated on many of the same values that ACCESS OM was seeking to instil, such as building on community strengths and connections and holistic perspectives on health and wellness.

In collaborating with, supporting, and coordinating 14 diverse communities, the central office has found that building strong relationships and trust has been essential. These same factors have also been important for multiple stakeholders to work effectively together. The commitment to collaboration created a degree of tension because while building trust takes time, the project, being funded for a fixed timeframe, had substantial time constraints of its own.

A striking achievement of the project has been the basing of its transformative efforts in core principles, objectives, and protocols that have been sensitively contextualised to the realities of diverse sites. Because the project's insights regarding the processes underpinning youth mental health services transformation and the factors fostering and hindering such transformation come from its implementation across diverse real-world settings, they can serve as inspiration for other jurisdictions worldwide and generate meaningful directions for continuing research, policy, and service efforts to improve youth mental health outcomes.

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## CONFLICT OF INTEREST

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Invited commentary: ACCESS Open Minds/Esprits ouverts—A seismic shift in Canadian mental healthcare

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This series of reports from seven of the 14 sites of the ACCESS Open Minds (ACCESS OM) initiative provides compelling perspectives on the adaptation of a single vision and research/evaluation design to the local and diverse realities of the Canadian landscape.

ACCESS OM is jointly funded by the Canadian Institutes of Health Research and the Graham Boeckh Foundation, a private family-run foundation that "aims to be a catalyst in bringing about transformational changes that significantly improve the lives of people with or at risk of mental illness" (Graham Boeckh Foundation, n.d.). At just under $25 million in budget, ACCESS OM is the largest clinical research action initiative in Canada and indeed one of the largest funded clinical research projects ever supported by the Canadian Institutes for Health Research.

The last major mental health clinical research initiative of similar scope in Canada was the Mental Health Commission's At Home/Chez Soi programme, funded by the federal government in the amount of $110 million—a randomized clinical trial of a housing-first initiative vs treatment as usual for homeless mentally ill individuals in five Canadian cities—Moncton, Montreal, Toronto, Winnipeg and Vancouver (Goering et al., 2014). That study addressed an urgent social and mental health problem using an experimental design, a commitment to community building as well as to data collection, flexibility and innovation as well as rigour in adapting a single national design to local realities, and an early identification of the importance of sustainability and scaling up in moving Canada beyond the land of pilot projects to a transformed new reality. At Home/Chez Soi had an impact on government policy and funding, and its unprecedented scale as a research initiative on homelessness has led to replication and impact in other countries.

ACCESS OM appears poised to have a similar or greater impact in the arena of youth mental health at a time when awareness is driving demand for help and traditional approaches are overwhelmed, ineffective or simply unavailable. There is broad acknowledgement of both unmet need and significant cost, from social role impairment to suicide, in this population that is vulnerable to the emergence of the majority of adult psychiatric disorders.

The reality of Canada is, despite a national ethos of universal and accessible healthcare, a complex array of local youth mental health services that are difficult to access, challenging to navigate, often unavailable to those over the age of 18, and governed and funded through local and provincial rather than national sources.

Enter ACCESS OM: It is a pan-Canadian study, with a single design that reflects core principles embedded in its acronym: *a*dolescent/young adult *c*onnections to **c**ommunity-driven, *e*arly, *s*trengths-based, *s*tigma-free services). Spread across 14 sites in six provinces and territories, its diverse contexts reported in this issue include: an isolated Indigenous hamlet of 396 people in the far north; homeless youth in a major urban and predominantly francophone setting of 1.7 million people; a rural francophone community with 4000 youth; first-year undergraduates at a large university population of 38 000 students; a mid-size city of 100 000 people and surrounding rural area; a large Indigenous reserve of 4500 people, 50% of whom are under age 25; and a city of over one million people, one-third of them under age 25, that includes a large urban Indigenous population as well as a significant homeless population. The variety inherent in these contexts is both a challenge and an opportunity—how to accommodate the diversity within the context of a study design and how to show the initiative can be successful in communities that reflect the reality of Canada. And with almost 50% of the sites in Indigenous communities, there is a tremendous opportunity for bidirectional sharing of knowledge, identifying similarities and celebrating differences while trying to meet the underserved mental health needs of Indigenous youth.

This series of seven papers from ACCESS OM sites reflects some important themes. First, people were not sitting on their thumbs

  

waiting for ACCESS OM to happen. In most settings, there was awareness that youth mental health needs were not being well met and efforts were underway to achieve change and improvement. However, ACCESS OM brought to them a vision, some organizing principles, and funding—as well as a strong commitment to evidence and measurement. This is reflected in the similar structure of each of these seven reports that allows an understanding of the intersect between common requirements and local realities. The community mapping required at baseline likely catalysed change as well, since any kind of measurement tends to trigger change on its own. Like At Home/Chez Soi, it brings together a disparate array of providers and stakeholders who otherwise might not be at the same table. But the setting of clinical targets—measured in hours and days—for early identification and rapid access to help are still sadly novel in Canadian mental healthcare. The engagement of youth and families, to which lip service is often paid, was established at the outset as a foundational reality—not simply in the role of providing reactive advice and support but rather being involved actively in the design, governance and evaluation.

The commitment to a single data set and to incorporating it into care, in a way that cuts across traditional provincial boundaries for capturing health information, is another important aspect of ACCESS OM that should have repercussions well beyond this initiative. The late statistician W. Edwards Deming is perhaps apocryphally acknowledged as the author of the aphorism "In God we trust; all others bring data". Of note, he also championed quality improvement through the "plan-do-study-act" cycle, and ACCESS OM is very much in this spirit. ACCESS OM's commitment to data collection will have important implications for its sustainability beyond the expiry of its research funding as well as its own evolution; it should allow for learning who the young people are for whom ACCESS OM does and does not work.

One of the remarkable aspects of the ACCESS OM project is the simultaneous evolution of similar integrated youth services initiatives across Canada, including Foundry in British Columbia (https://foundrybc.ca/), with over a dozen established and developing centres, and Youth Wellness Hubs Ontario (https://youthhubs.ca/en/), with 10 planned or running centres. Like ACCESS OM, these initiatives emphasize storefront, "one-stop shopping" programs whose physical space design reflects youth input and a commitment to rapid access to services for mental health, physical health, education and employment support. The ultimate inspiration for ACCESS OM's services emanates from both the nominated principal investigator's two decades of research on early intervention in psychosis and from Australia, where the Headspace initiative (https://headspace.org.au/) has been running since 2006 and now operates over 100 centres across the nation.

What is clear, however, from the reports in this series of ACCESS OM sites, is that adherence to the study design and principles is not the equivalent of opening a fast-food franchise, where the goal of standardization trumps the palate of the taster. Each site has implemented ACCESS OM on a foundation of previous efforts and in acknowledgment of local realities—but now poised to meet the same objectives using the same measures across the network.

ACCESS OM now must insure that its data collection is optimized to generate the evidence that will justify its sustainability; apart from political pressures, governments increasingly need to demonstrate return on investment, especially in the highly competitive context of healthcare which consumes almost 50% of provincial budgets. But the political reality is that the costs and benefits of improving youth mental healthcare extend well beyond health budgets to social services, unemployment and disability support, criminal justice—not to mention hope for recovery, functioning and quality of life for young people and their families.

## CONFLICT OF INTEREST

The author currently sits on the Board of Directors of the Graham Boeckh Foundation, co-funder of this initiative, as well as on the National Advisory Council of ACCESS OM, but joined both well after the funding decision was made and the study initiated. He receives no personal funding in either volunteer role and has no other potential conflicts of interest to declare.

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SUPPLEMENT ARTICLE

WILEY

# Transforming youth mental health services in a large urban centre: ACCESS Open Minds Edmonton

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## Abstract

**Aim:** This paper outlines the transformation of youth mental health services in Edmonton, Alberta, a large city in Western Canada. We describe the processes and challenges involved in restructuring how services and care are delivered to youth (11-25 years old) with mental health needs based on the objectives of the pan-Canadian ACCESS Open Minds network.

**Methods:** We provide a narrative review of how youth mental health services have developed since our engagement with the ACCESS Open Minds initiative, based on its five central objectives of early identification, rapid access, appropriate care, continuity of care, and youth and family engagement.

**Results:** Building on an initial community mapping exercise, a service network has been developed; teams that were previously age-oriented have been integrated together to seamlessly cover the age 11 to 25 range; early identification has thus far focused on high-school populations; and an actual drop-in space facilitates rapid access and linkages to appropriate care within the 30-day benchmark.

**Conclusions:** Initial aspects of the transformation have relied on restructuring and partnerships that have generated early successes. However, further transformation over the longer term will depend on data demonstrating how this has impacted clinical outcomes and service utilization. Ultimately, sustainability in a large urban centre will likely involve scaling up to a network of similar services to cover the entire population of the city.

KEYWORDS

access, case identification, service transformation, youth mental health, Canada

## 1 | INTRODUCTION

The availability of effective services to adolescents and young adults facing mental health and addiction challenges has long been

Adam Abba-Aji and Jai L. Shah are the joint senior authors.

insufficient (Malla et al., 2018). Encouragingly, youth-friendly interventions at early stages of need offer long-term benefits for outcomes (Clark & Unruh, 2009). It is in this context that the ACCESS Open Minds (ACCESS OM) initiative has facilitated service transformation around five common objectives in different contexts across Canada (Malla et al., 2018). Here, we describe how efforts towards these objectives have manifested in service and system transformation in a large urban centre in Edmonton, Alberta. The city has a population of 1.32 million, 31% of which is under the age of 25 along with the second largest urban Indigenous population in Canada and a large homeless population (estimated at 1700), mostly young adults (Statistics Canada, 2016). Edmonton's city centre, where its ACCESS OM program is located, has a population of 17 000 youth aged 10-24 and a relatively high level of unemployment, with one-third of individuals having no income (Statistics Canada, 2016). Thus, the Edmonton ACCESS OM program serves a local population with complex needs, amidst a young, diverse and growing city.

Mental health services in Alberta are primarily provided by Alberta Health Services (AHS) and organized according to geographic zones, one of which is Edmonton and its surrounding regions. Prior to joining ACCESS OM, the Edmonton Zone Addiction and Mental Health program had historically provided a continuum of specialized care options for youth experiencing mental health and/or substance use concerns (Table 1). However, despite initial attempts at integration (e.g., the creation of a young adult portfolio specifically for youth aged 16-25), this age group remained at risk for poor outcomes due to the system's age-bounded service delivery model, the lack of engagement in effective and appropriate care options and a disorganized or poorly supported transition processes (Alberta Health Services, 2017). Rapid access to care was limited except for those who met criteria for early psychosis, services were fragmented with little continuity across teams, and there was no active follow-up for acute patients who did not meet specific Diagnostic and Statistical Manual (DSM) diagnostic criteria. Consequently, service providers were likely to miss opportunities for early identification and intervention.

**TABLE 1** Alberta Health Services Edmonton Zone—developmentally appropriate inpatient and community outpatient programming as of 2014

| | |
|---|---|
| Edmonton early psychosis intervention clinic | For individuals experiencing a first episode of psychosis |
| Transitional youth services | Designed to assist individuals with multi-system needs and co-occurring difficulties graduating from child to adult services |
| Challenge by choice | Providing social and recreational programming options for those under the age of 30 |
| Young adult treatment team | For young adults accessing addiction services, with a 90-day residential program |
| Young Adult Assessment, Treatment, and Reintegration Unit at Alberta Hospital Edmonton | Offering acute care admissions in a youth-friendly environment with a 90-day follow-up post discharge |
| Eating Disorders Program | Operated out of the University of Alberta Hospital with a continuum of inpatient, intensive day treatment and outpatient services |

These service gaps became an important reason for partnership when the Edmonton Zone was approached to join the ACCESS OM initiative. Building on this, the Edmonton Young Adult Addiction and Mental Health Services team organized a multidisciplinary ACCESS OM steering committee with representation across child, youth and family services, young adult and cross level (recovery through employment, education, housing and peer support) services, research and evaluation and decision support and analytics that highlighted areas of the service delivery system that ACCESS OM Edmonton should focus on.

## 2 | COMMUNITY MAPPING

Prior to joining ACCESS OM, community mental health services for youth in Edmonton were sharply divided based on age. Children below the age of 18 attended child and adolescent mental health services (CAMHS), while those between 18 and 65 years of age attended general adult psychiatry. Although transfer of care from CAMHS to general adult services was typically initiated by the time the youth was 18 years old, this model lacked adequate continuity of care: 80% of youth (aged 16-25) discontinued seeing their primary service provider in adult services after three visits and without a planned discharge (Alberta Health Services, 2018). Furthermore, despite utilizing high-intensity services at high rates (with 30% of all psychiatric intensive care admissions being for those under 25 years old), individuals least likely to engage in appropriate care were those who were close to aging out of the service at their first contact (e.g., 17 years old); or who did not have adequate supports in navigating the access point (e.g., homeless youth, individuals who were unable to ask for help from their parents or guardians, or who had parents with mental health and substance use issues) (Alberta Health Services, 2018).

Given this noted gap, a young adult mental health portfolio had been established in 2014 with responsibility for strengthening mental health and addiction services for transition-aged youth, quality improvement to reduce barriers to accessing mental health services, and collaboration in order to better meet the needs of youth and their families. In 2017, the Edmonton Young Adult Addiction and Mental Health Services team formally joined the national ACCESS OM project with the explicit goal of better meeting the needs of youth aged 11-25. This directly led to the alignment of services between CAMHS and general adult psychiatry. The multidisciplinary steering committee then performed community mapping to identify service gaps and resource distribution within the context of socioeconomic demographic and population density needs.

This mapping also led to the development of community mental health services located along public transit routes within Edmonton. In May 2017, Edmonton opened its ACCESS OM site, a centrally

located program to serve all help-seeking youth aged 11-25, but focused on engaging underserved and marginalized youth. Its goal was to provide a continuum of addiction and mental health services that would also act as a more accessible front door to youth seeking mental health services. Based on previous community mapping, the ACCESS OM clinic was established in the downtown Young Men's Christian Association (YMCA) building, easily accessible via public transportation and at no cost to service users, with a staffing model developed to effectively engage and assess those presenting with various addiction and mental health issues.

## 3 | ACCESS CLINICIANS

One of the central transformations funded through ACCESS OM is the creation of ACCESS Clinician positions. As with ACCESS Clinician positions at other ACCESS OM sites, these are full-time individuals (mental health professionals with a related post-secondary degree), who initially engage and then maintain a consistent connection to an otherwise complex system for young people and their families. Through mobile, barrier-free availability in community settings, three ACCESS Clinicians meet young people and their families in their homes, community agencies, schools, coffee shops and work places. This flexibility enables them to build a therapeutic, trusting, and non-judgmental relationship with a youth or young adult and their family and carers, and then (if needed) to leverage that relationship to encourage and support clinical connections to a health care professional.

## 4 | EARLY IDENTIFICATION

Efforts to improve early identification of youth in need of mental health services have focused on relationship-building and simplifying pathways of care for initial presentations. This has been accomplished through direct and indirect public awareness campaigns by ACCESS OM, ranging from formal presentations in venues throughout the city to posting fliers in emergency rooms, suburban community health centres and primary care networks across Edmonton. Both modalities have outlined common presenting problems and available resources for youth experiencing mental health difficulties, as well as information for contacting the ACCESS Clinicians.

A significant investment has also been made in the ACCESS Clinician role and developing skills in motivational interviewing, behavioural activation, harm reduction approaches and strengths-based models of care. To support successful implementation of this role, the AHS clinical informatics team was able to create an “Engagement” visit code to accurately account for the time spent and complex work required by ACCESS Clinicians to engage young people in care: the process of developing a trusting relationship and therapeutic alliance with a young person, even before traditional clinical interventions are provided.

ACCESS Clinicians are also regular attendees at agencies serving youth throughout the Edmonton area, many of which have established drop-in spaces as a means to engage vulnerable groups. Prior to ACCESS OM, these agencies could identify young people who were experiencing mental health difficulties, but had few ways to facilitate access to appropriate mental health evaluations and services. The newfound relationship with ACCESS Clinicians provides agencies with a clear pathway to accessing services—without needing to wait until a threshold for emergency or urgent care is met. Thus, individuals, families and caregivers are now seen based on need rather than whether they meet a minimum threshold or stage of illness.

## 5 | RAPID ACCESS

In addition to the mobile and flexible availability of ACCESS Clinicians, another facilitator of rapid access to care has been the development and opening of a physical ACCESS OM site. Prior to joining ACCESS OM, there was no “walk-in clinic” for young adults with mental health needs in this large urbal centre. The ability to provide services in a drop-in format matches the urgency expressed by youth (age 11-25) to address their needs (Clark & Unruh, 2009). With the help of a youth advisory group, a site at the local Young Men's Christian Association (YMCA) community services building (centrally located and in non-stigmatizing surroundings) was selected to be the location of the walk-in clinic, which is staffed with 2.0 FTE (full-time equivalent) mental health therapists, 1.5 FTE peer support workers and 1.0 FTE reception/administrative support person. Young people participated in the design with special attention to creating a safe, welcoming and comfortable space.

Walk-in appointments are now available with an average wait of less than 30 minutes (Alberta Health Services, 2018) to a skilled counsellor or a peer support worker. An initial visit then opens the door to engaging in a solution-focused counselling session and/or initial intake conversation or a more informal or social visit. Screening tools embedded into the clinic's visit documentation can flag concerns and easily identify areas that may need to be addressed clinically and those that might signal moderate to severe issues, including both mental illness and substance use/misuse.

Beyond the physical space itself, care is readily available at the ACCESS OM clinic by a multidisciplinary team comprised of four psychiatrists, three mental health therapists with background in psychology, two social workers, five addiction counsellors, two peer support workers, two occupational and two recreational therapists and one supported employment specialist, one nurse and one family counsellor. This involves a change in structure and functioning, not just location: most staff have been reoriented from clinic-based appointments (where the young person had to come to them to receive service), to mobile availability in the location of choice (coffee shops, homes, schools, public libraries, etc), and staffing hours are now extended into the early evening (to improve access to services outside of regular business, school and work hours for young people and their families). Furthermore, education, skills training and clinical supervision of staff are based on the principles of recovery-oriented care, harm reduction and self-determination.

## 6 | APPROPRIATE CARE IN 30 DAYS

The transformation of pathways to subsequent appropriate care has been approached in steps, iteratively gathering data and information from young people and their families to inform changes which are then implemented. Although no comparison data are available, within six months of opening the ACCESS OM clinic, young people reported a goal related to mental health 55% of the time, such as "feeling better" or "coping with my anxiety," followed by seeking assistance with employment and career (32%) and community life functioning (31%) (Alberta Health Services, 2018). This prompted further development in the model, including:

1. The role of staff at the ACCESS OM clinic has evolved to include single session counselling; peer support workers have begun to focus more on follow-up and engagement activities.
2. Service providers were required to develop drop-in programming that met goal areas identified by individuals accessing services (and their families): employment and education support, 1:1 addiction counselling, group interventions such as social groups, mindfulness, Cognitive Behavioral Therapy (CBT), distress tolerance, and family psychoeducation programs.
3. In addition to the ACCESS Clinicians, psychiatrists have increased their clinic hours to address the high volume of referrals and offered weekend clinics to address backlogs when there were surges of referrals.
4. Health professionals from the Inpatient Unit (occupational therapy, recreation therapy, addiction counsellor) began to work one day per week at the ACCESS OM clinic to build relationships with community staff, increase their understanding of outpatient services, and facilitate seamless transition for youth who experience an inpatient acute care stay.
5. New resources were allocated to the young adult service in the following months including 2.0 FTE addiction counsellors, 2.0 FTE mental health therapists and a 1.0 FTE Family Peer Support Worker.

Thus, the model of service integration informed by data has allowed multiple needs of youth to be progressively addressed in an iterative manner over time (Hetrick et al., 2017).

## 7 | CONTINUITY OF CARE BEYOND AGE 18

The transformation of continuity of care across the age 18 threshold began prior to ACCESS OM, when two programs spanning these age clusters (under 18 and over 18) together developed a shared vision. Initially, however, individuals accessing services outside of the young adult programs were still required to be referred to an entirely separate adult service when "aging out" of child/adolescent care—creating a jarring and potentially disengaging transition point.

In joining ACCESS OM, the multidisciplinary steering committee recognized that designing a transformation to phase out the notion of "aging out" involved issues such as improved understanding of mature minor status, consent to care for individuals under the age of 18, historical legacies (such as distinctions between child/adolescent and adult psychiatry) that were not designed with youth in mind, and understanding the intricacies of working with families during (eventual) transition periods. Now, due to ACCESS OM, youth aged 16-18 continue to receive continuous services from the same young adult team for as long as is clinically necessary (until the age of 25). While it is relatively rare for individuals under the age of 14 to seek services at the ACCESS OM clinic, clear pathways to well-developed child and adolescent services are in place after an initial assessment has been conducted. Following assessment in the ACCESS OM clinic, some youth are referred to specialized services such as Edmonton Early Psychosis Intervention Center or the Eating Disorders Program.

## 8 | YOUTH AND FAMILY ENGAGEMENT

Prior to ACCESS OM, youth and family engagement was done through a third party such as Youth Empowerment Support Services and Canadian Mental Health Association. Now, the ACCESS OM clinic has itself taken on responsibility for directly engaging with youth and families. Youth and family advisors have been a part of the ACCESS OM Edmonton steering committee. They have been instrumental in developing welcome videos, promotional materials, assisting providers in their approach with young people and reviewing and providing feedback on strategic planning documents. Suggestion boxes and youth advisory meetings have been used to gather feedback and amplify the youth voice in our planning and implementation decisions. As part of the ACCESS OM project, staff have also developed and implemented an inclusive care guideline to formally address working with families and friends of young people (Table 2).

A major catalyst for family engagement was the creation of a Family Peer Support Worker position, an AHS employee who is expected to practice from the viewpoint of lived experience as a parent/carer of a youth with substance misuse and mental illness in three main areas: assistance with system navigation, advocacy for the family voice with service providers, and support and understanding of the experience that youth and their families are going through. Family-oriented groups led by this staff member have covered topics such as

**TABLE 2** Target audiences for the ACCESS OM Edmonton inclusive care guidelines

| | |
|---|---|
| Individuals | To understand the importance of including family and friends in their recovery journey, and creative ways to keep these supports in place |
| Families | Education about the process of recovery and mental health and addiction, increasing understanding and skills to support their loved one and maintaining involvement during this transition phase |
| Staff | Understanding ways to speak to families and include them in care; all staff providing young adult services are now expected to self-evaluate their inclusive care skills in their annual performance appraisal |

education about monitoring symptoms, medication side-effects, learning coping strategies and improving communication.

## 9 | THE UNIQUENESS OF ACCESS OM EDMONTON: COMMUNITY IMPACT

The advent of ACCESS OM has provided a framework, service model and platform for continual evolution of youth mental health services that has been felt throughout the Edmonton Zone. The service has been required to iterate in order to manage expectations of family and youth as we develop and enhance services, listen to individuals and their families, tackle the practicalities of operating a new type of service (e.g., reception hours, technology infrastructure, utilization of finite space), and a new role of advocating for transforming the status quo for vulnerable youth. Initial informal feedback suggests that accessing care is now easier, provided in a more youth-friendly environment, provides relevant options and follows a process that enhances self-determination and a feeling of being in control and collaborating on a youth's health journey.

Because the ACCESS OM site exists in a large urban centre and within a large (province-wide) health systems delivery organization, there was an immediate need to create operational flexibility in order to achieve the objectives of the project. For example, job descriptions were rewritten to ensure clarity about the expectations of working with young people and related competencies in this area, new postings were developed to attract the appropriate type of applicants, and documentation templates were created to standardize data collection and inform service development.

Given the Edmonton Zone team's focus on youth with complex needs, ACCESS OM has facilitated transition of care to the ACCESS OM clinic after an acute episode of illness or entry to services via urgent access points (such as emergency services), and afforded stronger connections between inpatient and community programs for seamless discharge of those youth requiring inpatient stays. These are new relationships and care pathways that did not exist prior to the opening of the ACCESS OM site but now result in negotiation and collaboration around care transitions between hospital- and community-based teams. In addition to the already-integrated services (Table 1), our zone Youth Diversion program is also now embedded within the young adult program, allowing connection between youth identified in the criminal justice system that would benefit from treatment within the addiction and mental health system.

## 10 | RESEARCH AND EVALUATION

In line with the ACCESS OM research protocol, the Edmonton ACCESS OM site is involved in data collection such as tracking symptom severity, levels of distress, suicidality and goal attainment in order to provide information about the effectiveness of the programming offered. With time, this information will be helpful to determine if the model of care is in fact achieving its goals of strengthening access to services, continuity of care and system response.

At the Edmonton site, the research evaluator is being increasingly integrated into the ACCESS OM clinic process and meets with individuals after their clinical visit, during which time the opportunity to participate in research and evaluation is presented. Peer advisors have worked with the evaluators to modify the request to participate in research and the process of ensuring that consent is as youth-friendly as possible. One full-time and two part-time evaluators meet young people and families in locations of their choice across the city to increase ease and reinforce the value that is placed on their continued participation. Monthly reports from clinic walk-in data are completed and used to inform development of services, address operational issues and encourage ongoing data quality.

## 11 | CHALLENGES AND SUSTAINABILITY

Although some early identification programming has been undertaken, the complexity of opening a single clinic with limited resources in a large city has meant that a more thorough, multi-pronged outreach effort is required. In this regard, the Edmonton Zone has an addiction and mental health prevention and promotion team whose mandate is to provide public education, student education and general prevention and promotion materials in our community. In the coming year, ACCESS OM Edmonton plans to liaise with this team to design and plan further outreach activities. An associated challenge is that stronger outreach work will likely draw in more youth in need of care, whereas the current clinic site is already outgrowing its space.

Clinically, many of the connections between a help-seeking youth and an appropriate service provider (e.g., social worker, addiction counsellor, mental health therapist for short-term therapy, recreation therapy) are made within the first 7 to 10 days. For more intensive care options (e.g., specialty care with a psychologist or specialist psychiatric service), there can be challenges to meeting the target timeline due to limited resources, occasional lack of appropriate care options even within this larger system of care, and continuing gaps in service. And although it is uncommon for youth under 14 to present to the ACCESS OM clinic, well-developed clinical programming and specialist services for this age range exist elsewhere in Edmonton: in order to conduct initial assessments and ensure connection to the appropriate service, a dedicated child and adolescent psychiatrist is now located on site.

Additional practical challenges include:

1. Difficulties meeting the required target for both recruitment of research participants and data collection for research/evaluation. A number of factors are responsible for this, including initial lack of alignment between data collection and clinical programming and limited staffing by an evaluator. Despite now having two part-time evaluators, ACCESS OM Edmonton has yet to meet its monthly target for recruitment of participants into research/evaluation.
2. Securing clinic space through a lease and partnership with the YMCA, rather than traditional AHS clinic space
3. Running health informatics infrastructure in a temporary site due to the need for secure connections to transmit health information

4. Changing job descriptions and practice expectations with multiple unions
5. Overall, managing change of such a significant magnitude within a large bureaucratic organization. AHS is transitioning to a new electronic medical record (EMR) provider in late 2019; this may provide opportunities for embedding evaluation tools directly into the new EMR.

Moving forward, the increasing integration of services from a number of sectors/jurisdictions to address the common goal areas of young people and their families accessing services should assist in consistent matching of an individual's needs to available service options. Evaluating this will ensure that services provided can be optimized to meet desired outcomes, and that they are effective and acceptable to young people.

As an outgrowth of ACCESS OM, the AHS-Edmonton Zone team plans to develop, implement and evaluate a growing number of interventions that will provide more options through which services and treatment plans can be individualized. This has converged around the ACCESS OM framework and facilitated by administrative and psychiatry leadership within the Edmonton Zone Addictions and Mental Health portfolio, who are together working to provide a developmentally relevant continuum of services specifically for this transition-age group of individuals. Associated with this, the local Mental Health Foundation has been an impactful convener and advocate for commitment to systems change.

Having now firmly established the ACCESS OM site in Edmonton, the service's sustainability is well-supported by AHS Edmonton Zone, which has allocated operational funds of approximately $1 million/year to increase the capacity of ACCESS OM Edmonton—including case management and psychotherapy interventions, occupational therapy, and partnerships that will further populate the integration of service options.

Finally, a major area of current focus is the scaling up of the single ACCESS OM clinic to a network of integrated youth hubs in the Edmonton Zone. A functional plan has been put forward for a centralized clinical services building and five walk-in clinic sites to be geographically embedded across Edmonton. This work is developing in consultation with the Mental Health Foundation, with the hope that such an approach will expand across the province of Alberta.

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## CONFLICT OF INTEREST

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Improving mental health services for homeless youth in downtown Montreal, Canada: Partnership between a local network and ACCESS Esprits ouverts (Open Minds), a National Services Transformation Research Initiative

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## Abstract

**Aim:** In many parts of the world, there is growing concern about youth homelessness. Homeless youth are particularly vulnerable to psychological distress, substance use and mental disorders, and premature mortality caused by suicide and drug overdose. However, their access to and use of mental health care is very limited.

**Methods:** The *Réseau d'intervention de proximité auprès des jeunes* (RIPAJ), a Montreal network of over 20 community stakeholders providing a wide array of cohesive services, was created to ease homeless youth's access to mental health and psychosocial services. Its philosophy is that there should be no "wrong door" or "wrong timing" for youth seeking help. In 2014, the network partnered with the pan-Canadian transformational research initiative, ACCESS *Esprits ouverts*.

**Results:** Created through this partnership, ACCESS *Esprits ouverts* RIPAJ has been promoting early identification through outreach activities targeting homeless youth and agencies that serve them. An ACCESS Clinician was hired to promote and rapidly respond to help-seeking and referrals. By strengthening connections within RIPAJ and using system navigation, the site is working to facilitate youth's access to timely appropriate care and eliminate age-based transitions between services. A notable feature of our program, that is not usually evident in homelessness services, has been the engagement of the youth in service planning and design and the encouragement of contact with families and/or friends.

**Conclusion:** Challenges remain including eliminating any remaining age-related transitions of care between adolescent and adult services; and the sustainability of services transformation and network coordination. Nonetheless, this program serves as an example of an innovative, much-needed, community-oriented model for improving access to mental health care for homeless youth.

Amal Abdel-Baki and Srividya N. Iyer are joint senior authors.

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community mental health services, early identification, homeless youth, mental illness, service organization, youth mental health, Canada

## 1 | CONTEXT

Montreal, Canada's second most populous city (Statistics Canada, 2017), is in the country's only province whose sole official language is French. Montreal is also home to many English speakers; other linguistic minorities and immigrants. According to the 2016 census, 15.3% of Montreal's population was classified as low-income (Statistics Canada, 2017).

Since 1980, there has been a rapid increase in homelessness in Canada, including among youth (Gaetz, Dej, Richter, & Redman, 2016). Youth homelessness is not an exclusively Canadian concern. In the United States, for instance, a recent report estimated that 3.48 million young adults (aged 18 to 25 years) experienced homelessness or precarious housing over a 12-month period (Morton et al., 2018). In the United Kingdom, it was estimated that 83 000 youth had availed homelessness services for a one-year period (Clark, Burgess, Morris, & Udagawa, 2015).

In Montreal, a 2015 count estimated that 3016 people (19% under 30 years) were homeless (Latimer, McGregor, Méthot, & Smith, 2015). Notably, this estimate did not include youth living in unstable, precarious, or unsafe housing (e.g., short-term homelessness; couch-surfing or squatting in abandoned, unsafe buildings). Further, Indigenous peoples, transgender persons and newcomer immigrants are overrepresented among homeless youth.

Definitions of *youth homelessness* vary across contexts making comparisons difficult. The Canadian Observatory on Homelessness defines the youth homeless as including those "who are living independently of parents and/or caregivers, but do not have the means or ability to acquire a stable, safe or consistent residence" (Gaetz, Gulliver, & Richter, 2014).

Homelessness is both a consequence of and a contributing factor to mental health problems among youth (Folsom et al., 2005; Martijn & Sharpe, 2006). Most mental disorders have their onset in youth and homelessness significantly exacerbates risk (Kessler et al., 2005). Over 85% of homeless youth report high levels of psychological distress (Gaetz, O'Grady, Kidd, & Schwan, 2016). Compared to the general youth population, there is a substantially higher prevalence among homeless youth of mental disorders (Whitbeck, Johnson, Hoyt, & Cauce, 2004) and of specific disorders like psychosis or substance misuse (Martin, Lampinen, & McGhee, 2006; Roy, Haley, & Leclerc, 2004). Self-harm, and suicidal ideation and behaviours are also more frequent, with completed suicide and drug overdose being leading causes of premature death in this population (Roy, Haley, & Leclerc, 2004). Importantly, rates of mental disorders and distress are higher in youth who have been homeless for longer (Solorio, Milburn, Andersen, Trifskin, & Rodriguez, 2006).

Yet, homeless youth have poor access to and utilization of mental healthcare (Kidd, Slesnick, Frederick, Karabanow, & Gaetz, 2018; Kort-Butler & Tyler, 2012; Muir-Cochrane, Fereday, Jureidini, Drummond, & Darbyshire, 2006). In a Canadian national survey, 84% of homeless youth with mental illnesses reported needing services in addition to any they had received (National Learning Community on Youth Homelessness, 2012). There is an urgent need for integrated service models that effectively address the mental health, general health and social support needs of homeless youth; and serve to prevent future homelessness. To this end, a group of community organizations and healthcare institutions that serve homeless youth in downtown Montreal came together in the 2000s.

## 2 | THE CREATION OF *RÉSEAU D'INTERVENTION DE PROXIMITÉ AUPRÈS DES JEUNES*

*Réseau d'intervention de proximité auprès des jeunes* (RIPAJ) was initiated by three psychologists from different organizations who, in 2003, held "proximity meetings" to support each other and exchange ideas about how to best provide care for homeless youth (Aubin et al., 2011). The initial participants then started to invite local stakeholders who joined the meetings, eventually creating a network of partners caring for homeless youth. Over 15 years, the group expanded to include about 20 community organizations and institutional stakeholders (see Table 1) to build a network aimed at improving and accelerating access to and continuity of mental healthcare and related services (Abdel-Baki et al., 2018). Network members include day centres, shelters, housing resources, medical and psychiatric institutions and specialized services such as a supervised injection site. The philosophy behind RIPAJ has been that there is no "wrong door" or "bad timing" for seeking help. A youth can access the services of the network through any RIPAJ partner.

## 3 | MERGING WITH ACCESS ESPRITS OUVERTS: STRONGER STRUCTURE AND SERVICES

To further improve access to and quality of its mental health services, RIPAJ partnered with the national youth mental health services research project, ACCESS *Esprits ouverts* (ACCESS EO), to create ACCESS *Esprits ouverts* RIPAJ (ACCESS EO RIPAJ) in 2014. The five key objectives of ACCESS EO are early identification; rapid access to an initial evaluation; provision of appropriate care within 30 days; continuity of care beyond the age of 18 years and youth and family engagement (Malla et al., 2018).

ACCESS EO RIPAJ has a core team of two leaders, one from an urban academic hospital; and the other from a community

**TABLE 1** Primary partners within ACCESS EO RIPAJ and key services that they offer to homeless youth

| Community organizations | | | Housing services | | | Institutional partners | | |
|---|---|---|---|---|---|---|---|---|
| **Name** | **Target population** | **Services** | **Name** | **Target population** | **Services** | **Name** | **Target population** | **Services** |
| *Dans la rue* | 12-25 y old (transition past 25), homeless youth. | Night shelter, supervised flats and day centre offering psychological services, nursery, social services, Emmett-Johns School, employment programs, veterinarian clinic, clothing, meals and showers. | *Refuge des Jeunes* | 17-25 y old homeless men | Temporary shelter, dormitory, meals and food banks, personal hygiene products and clothing, first aid services, counselling, supervised flats. | *Clinique JAP—ÉQIIP SOL* | 16-30 y old with first psychotic episode. | Social workers, psychiatrists, occupational therapists and nurses. |
| *Diogène* | 18 y old and older with severe mental health issues, SUD, legal issues and/or homelessness. | Outreach, accompaniment and support. | *Passages* | 18-30 y old women in precarious situations | Temporary housing, housing support and social reinsertion. | *Clinique des Jeunes de la Rue* | 14-25 y old, homeless youth. | Nursing, medical and dental care, psychology and social work, psychiatrist, peer helper, accompaniment. |
| *Cactus* | Anyone. | Prevention of STIs, supervised injection site. | *Maison St-Dominique* | 18 y and older with mental health issues. | Supervised apartments and psychosocial support. | *Centre de Réadaptation en Dépendance de Montréal* | <25 y old with addiction problems. | Addiction rehabilitation services, educational and legal support. |
| *Groupe d'intervention alternative par les pairs (GIAP)* | Youth in precarious situations 12-30 y old. | Peer intervention group, STIs prevention, harm reduction interventions. | *Le Tournant* | 18-29 y old homeless men. | Affordable housing, accompaniment and post-housing support. | *Direction de la protection de la jeunesse* | <18 y old with compromised security and development. | Medical care for all needs, mental health care, housing and legal support. |
| *Spectre de Rue* | 18 y and older. | Prevention of STIs, supervised injection site, street messengers. | *La Maison Tangente* | 18-25 y old homeless youth. | Transitory housing, accompaniment and support. | | | |
| *Premier Arrêt—YMCA* | Anyone. | Outreach, psychosocial services. | *Le Foyer des Jeunes Travailleurs et Travailleuses de Montréal* | 17-24 y old youth in precarious situations. | Housing, accompaniment. | | | |
| *Médecins du monde* | 18 y and older. | Psychosocial support, mobile health clinic. | *En Marge 12-17* | Youth 12-17 y old and their parents. | Emergency shelter, short-term housing, supervised | | | |

**TABLE 1** (Continued)

| Community organizations | | | Housing services | | | Institutional partners | | |
|---|---|---|---|---|---|---|---|---|
| Name | Target population | Services | Name | Target population | Services | Name | Target population | Services |
| | | | | | apartments, support for parents. | | | |
| | | | *Diners St-Louis* | 18-30 y old. | Transitional housing, day centre, various social services, clothing and meals. | | | |

Abbreviations: STIs, sexually transmitted infections; SUD, substance use disorder.

organization that runs a day centre, a night shelter and supervised apartments for homeless youth. Three staff members were hired for this project, including a coordinator of all activities and communication within RIPAJ and with outside agencies; an ACCESS Clinician (currently a social worker) to respond to mental health referrals or help-seeking within 72 hours; and a research assistant to conduct evaluations with youth per the ACCESS EO protocol.

Among the organizations visited most by Montreal homeless youth, the *Dans la rue* day centre was the first within the RIPAJ network to offer integrated services—meals, clothing, psychological and psychosocial services, music therapy, employment support, and alternative integrated schooling—in a youth-friendly environment. It is a key node within and a major philosophical influence on ACCESS EO RIPAJ. Annually, RIPAJ serves more than 1000 youth of whom about 300 to 350 are new.

## 4 | COMMUNITY MAPPING

An initial step upon joining ACCESS EO was to engage in community mapping to understand where and how homeless youth access mental healthcare, the factors hindering and facilitating such access, and youth's experiences and perceptions of accessing and receiving mental healthcare. ACCESS EO RIPAJ convened individual meetings with all partner organizations to complete questionnaires describing their targeted clientele, the services they offered, and their opinion on accessibility to their services and others in the network. Simultaneously, youth were involved in community mapping through different activities; for example, a mental health fair at which they pinpointed the organizations that helped them with their mental health on an inner-city map of Montreal. This was done in an accessible manner using "post-it" notes on which they could write and draw. Youth were also invited to comment on the services received within the network. Viewing community mapping as a dynamic exercise that bears repetition, youth are still invited to mark and comment on the same map, which is hanging on a wall of the ACCESS EO RIPAJ youth space at *Dans la rue*. Additional mapping activities have been undertaken in an ongoing graduate project that uses arts-based qualitative methods like PhotoVoice.

## 5 | EARLY IDENTIFICATION

ACCESS EO RIPAJ, with its community and institutional partners spread throughout downtown Montreal, facilitates access to services from several entry points, be they shelters, supervised housing, employment services or general practitioners. The vastness of the network and its broad service scope increase the chances of serving youth with different backgrounds and needs (e.g., acute psychosocial crises, psychiatric disorders, housing-related distress, or employment- or education-related challenges) at different times (day or night). For many homeless youth, regular pathways cannot facilitate access to care (e.g., needing a referral from a family physician but not having one or being denied a service for not having an address or identity card). Homeless youth may be likelier to be identified as needing appropriate

mental healthcare by an integrated service network like ours than when navigating the system alone.

To increase early identification, outreach activities are conducted several times a week in various partner organizations. The ACCESS Clinician is regularly present at the *Dans la rue* day centre to liaise with staff, discuss which youth might need mental healthcare and provide guidance on how to approach youth to discuss their mental health. If needed, the ACCESS Clinician can immediately engage with youth, evaluate their needs and direct or accompany them to appropriate services. Different field workers (e.g., peer support workers, street outreach workers)—and not only healthcare professionals—can provide referrals to promote early identification. Field workers are offered early identification and basic intervention training through planned on-site training, conferences, monthly meetings of ACCESS EO RIPAJ partners, etc.

Youth-friendly early identification activities are regularly offered to youth to enhance their mental health literacy, reduce stigma and promote help-seeking and wellness. Such activities include mental health information sessions, yoga and art sessions, do-it-yourself mental health workshops, drum circles, films/film-making, outdoor activities, adventure therapy and LGBTQ-themed meetings. Traditional (e.g., news) and social media have also been used to reduce stigma and promote help-seeking.

To broaden its offer, ACCESS EO RIPAJ has worked with partners to optimize services (e.g., to offer beds/rooms in a transgender-friendly shelter). Each new partnership/service increases the pool of new potential youth directed to ACCESS EO RIPAJ.

Nonetheless, early identification poses challenges. Some of the most vulnerable youth, often suffering from multiple traumas that hinder trust (Berry, Barrowclough, & Wearden, 2007), may simply not come into contact with RIPAJ organizations. ACCESS EO RIPAJ staff cannot systematically engage with all youth using its services, thus potentially missing some youth in need. In general, many youth can be uncomfortable engaging with personnel because of suspiciousness, active psychiatric symptoms or fears of being misunderstood or stigmatized. Among the homeless, such inhibitors are more pronounced because homeless youth are likelier to have past negative help-seeking experiences and traumas. Such apprehension may be further compounded for those belonging to minority groups. To enhance youth's comfort in engaging with ACCESS EO RIPAJ, several efforts are underway, including reassuring them of confidentiality and respect for autonomy. While important for all clinical practice, these two values have been highlighted as especially salient by homeless youth and have been part of RIPAJ's practice since its inception in 2003.

Some youth with more severe psychiatric symptomatology and/or with difficulty establishing trust may not be voluntarily amenable to assessment, sometimes necessitating legal means like court-ordered psychiatric evaluations. The presence of ACCESS EO RIPAJ members at the partner site hospital and links with other emergency services have helped the early identification of youth with severe mental health and substance use. This will likely reduce traumatic pathways to care such as emergency services, court-ordered psychiatric evaluations and police involvement.

## 6 | RAPID, ENGAGING ACCESS

ACCESS EO RIPAJ provides a mental health evaluation within 72 hours after referral/help-seeking through various ways. The chief strategy has been to hire and train (with support from ACCESS EO central office) a social worker in the ACCESS Clinician role. This clinician can be contacted by telephone, email or in person, and at different sites. Youth can initiate contact by themselves or via a partner organization, for example, through staff at a shelter who often accompany the youth to a first meeting. The first meeting can take place at one of many partner sites, typically one that is already attended by the youth and therefore familiar to them. The ACCESS Clinician frequently visits partner sites, and goes when called, generally ensuring same-day responses to referrals.

Despite a well-planned rapid-access system, some situations make meeting youth within 72 hours challenging. It can be difficult to reach some youth after the initial request if they are inaccessible by phone/e-mail or are preoccupied with basic needs (e.g., food or shelter). Their nomadic circumstances and ambivalence towards mental health professionals, often because of negative past experiences, can impede engagement in the initial evaluation. Many RIPAJ partners make special efforts to facilitate communication, by offering Internet access, taking messages for youth and having a message board. Nevertheless, it remains difficult to keep in touch with youth who have no means of being contacted, especially if they forbid communication about them between partner organizations.

## 7 | APPROPRIATE CARE

ACCESS EO RIPAJ aims to deliver prompt, meaningful medical and psychosocial interventions to youth with mental health problems. Various interventions are available to youth including psychology and psychiatry consultations, psychotherapy, substance use treatment, and legal counselling, typically well within 30 days. These interventions are provided at RIPAJ sites by network professionals or by contracted professionals (e.g., a psychologist from a publicly-funded institute provides substance-related interventions at RIPAJ organizations).

A major strength of ACCESS EO RIPAJ is its ability to integrate under one umbrella services that address a range of homeless youth's needs (see Table 1). These include medical, psychological, psychiatric, education, employment, legal, housing, and financial services. For instance, la *Clinique des jeunes de la rue*, created within the province's public primary healthcare system, provides general health services. These include access to general practitioners, dentists, social workers, a psychologist, a psychiatrist and primary care nurses (for mental healthcare and other problems such as sexually transmitted infections, etc.). Psychotherapy and other mental health services are provided at multiple locations like *Dans la rue* and *Clinique des jeunes de la rue* for as long as needed until 25 years old. Additionally, the *ÉQIIP SOL* clinic provides three to five years of specialized services for homeless youth with psychosis, including psychiatry, intensive case management,

occupational therapy, housing support, employment and education support and substance use treatment. Multiple psychosocial and educational services are also offered at *Dans la rue*. Depending on their needs, youth can be referred to partner organizations, including housing service providers like *Passages* that offers temporary housing to young homeless women.

All services are free and can often be obtained within 30 days. The ACCESS Clinician works with RIPAJ partners to ensure seamless transitions and exchange of information, and to adapt interventions to the changing needs of youth.

Nonetheless, obstacles remain that impede timely service provision, including difficulty reaching youth or maintaining contact. One way this is being addressed is by the ACCESS Clinician regularly spending time at partner sites, especially *Dans la rue*, to establish direct contact with current service recipients. Within ACCESS EO RIPAJ, doctors volunteer their time to serve those youth who do not have public or private health insurance. The lack of health insurance (whether because of ineligibility or lack of proof) occasionally delays access to services outside the network.

Youth are referred outside RIPAJ for certain specialist services (e.g., for autism, serious eating or personality disorders). In such instances, the referral process may not be as seamless as it is within RIPAJ. External services often require traditional written consultations, have long waiting lists, are poorly integrated and may tend to marginalize and stigmatize homeless youth. For example, some specialized services outside RIPAJ exclude those with comorbid substance use and severe mental illness, compromising access for some of the most vulnerable youth.

## 8 | YOUTH AND FAMILY ENGAGEMENT

The most salient change to RIPAJ since joining ACCESS EO has been the involvement of youth and families in the planning and administration processes of partner organizations. Earlier, youth had a limited role in most partner organizations. Some organizations had peer support workers who accompanied youth to care, but few engaged youth in additional ways. In ACCESS EO RIPAJ, youth and family members/carers are invited to join committees, provide input in planning services and activities, and help tailor clinical programs and research to their needs. Youth also act as “ambassadors” and help engage other youth in services, research and stigma-reduction activities through testimonials, artistic performances, etc. Following an ACCESS EO national youth council recommendation, youth have helped interview potential ACCESS EO RIPAJ staff to evaluate their congruence with the network's values and signalling to them the primacy accorded to the youth voice. A RIPAJ youth sits on ACCESS EO's national youth council, to which she brings the under-represented perspectives of Francophone and homeless youth. At RIPAJ's partner hospital, youth have prompted significant changes in an inpatient ward's rules to make it more youth-friendly. These have included extending visiting hours; providing access to Wi-Fi, electronic devices and art materials; permitting the wearing of youth's own clothes upon admission; allowing direct inpatient admission without having to pass through the emergency room; etc. Overall, youth who have been variously engaged have reported feeling empowered and more satisfied with services.

Although often isolated and often despite negative past traumatic experiences involving family members (Winland, Gaetz, & Patton, 2011), homeless youth can create and preserve positive links with family members and other attachment figures. As family and social support positively impacts service use (Kozloff et al., 2013), RIPAJ personnel help youth resolve difficulties with their relatives and re-establish family links, *when appropriate*. These links may have been lost because of their mental illness and substance misuse or difficult past experiences. Furthermore, adopting a broad definition of social support, staff also support youth in creating and maintaining other meaningful relationships such as with friends or other significant attachment figures (e.g., peer mentor).

Nevertheless, engaging youth and especially families/carers and sustaining their involvement can be challenging. This is attributable to the marginalized status of homeless youth, their often-complicated relations with family, and their families' own challenges. Moreover, youth living in precarious situations spend a lot of time addressing basic needs, and find it difficult to stay involved over longer periods of time.

There is wide variation in the spectrum of youth engagement across RIPAJ organizations with some actively partnering with youth in service planning and delivery, and others engaging youth only as collaborative service recipients. Also, not all RIPAJ organizations have the requisite training to engage families/carers. While some services have been adapted in response to youth and family recommendations, this has proven harder in institutional partner settings. Sustained, creative efforts are still needed to ensure the meaningful involvement of marginalized youth and families.

## 9 | ELIMINATING AGE-BASED TRANSITIONS

Like in many parts of the world, those receiving care in Quebec's children's mental health services are moved to the adult healthcare system at the age of 18 years. Also, children in the youth protection system (in other jurisdictions, referred to as looked-after children or children in care) are transitioned out at the age of 18. When these transitions are not well organized, which is often the case for homeless youth, it can result in delays or interruptions in care provision as some services are neither available in the adult system nor developmentally suitable. The situation is even worse for youth who received little or no mental healthcare before adulthood.

To ensure the continuity of care into adulthood (if needed), various RIPAJ partners have eliminated age-based transitions, instead articulating inclusion criteria around needs and offering services from early or mid-adolescence up to 25 to 30 years. When age-based transitions become unavoidable, RIPAJ workers plan transfers well in

advance and accompany youth as they connect to appropriate adult services.

Over a 10-year course of collaboration, RIPAJ encouraged youth protection services to establish two single-sex group homes for 16- to 21-year-olds with severe mental illness. Staff at these supervised homes work with treating teams and are being trained to be more familiar with severe mental illnesses and youth needs.

Despite these efforts, easing youth's transitions into adulthood remains arduous. ACCESS EO RIPAJ has limited influence on the organization of care in external services. Consequently, some youth continue experiencing abrupt, age-based discontinuities of care. By demonstrating the effectiveness of its approach, ACCESS EO RIPAJ hopes to positively influence policy in this regard.

## 10 | VIGNETTE

To illustrate the functioning of ACCESS EO RIPAJ, we present an anonymized vignette of a youth's journey through services. Originally from the countryside, "C" had been placed in youth protection as a preadolescent after his mother died of cancer. When he turned 18 and left foster care, he dropped out of school and moved in with acquaintances. His drug intake increased and he became increasingly disorganized. When conflicts erupted, C was evicted from the apartment. He was repeatedly brought by the police to emergency rooms in states of acute intoxication and despite multiple assessments ending in referrals to mental health services, C faced a long waiting list to see a psychologist and did not engage in the proposed psychiatric follow-up. Eventually, he moved to Montreal and began frequenting shelters to eat and sleep. C confided to a RIPAJ shelter worker whom he had known for a few weeks and come to trust, that he had begun experiencing psychotic symptoms. With his permission, the shelter worker contacted the ACCESS Clinician. C was met the same day at the shelter for an evaluation and the ACCESS Clinician arranged an appointment with a psychiatrist a few days later.

The shelter worker in whom he had initially confided was present for this appointment, helping C develop trust in his mental healthcare team. C's psychiatric symptoms were stabilized with the help of the early intervention for psychosis team, while he lived in a RIPAJ group home until he developed more autonomy. With his health and housing thus stabilized, C expressed interest in returning to school, and registered at the *Dans la rue* school. Within a year, he moved into a supervised apartment run by a partner organization and started working. Before RIPAJ became an ACCESS EO site, a youth like C would not have received an evaluation on the same day and would not have been supported until and nor accompanied to his appointment with the psychiatrist, by the RIPAJ network workers. While the various organizations involved in C's care prior to ACCESS EO RIPAJ were linked, their ability to work collaboratively has been greatly enhanced because of the ACCESS Clinician's role, the regular inter-organization meetings that now occur and the coordination provided by a dedicated staff member hired for the project.

## 11 | DISCUSSION AND CONCLUSION

RIPAJ joined the ACCESS EO network with strong links between various community and institutional stakeholders who were aligned around the common aim of simplifying and expediting access to mental healthcare for homeless youth. Since joining ACCESS EO, RIPAJ has been further strengthened by hiring a coordinator and an ACCESS Clinician who help youth navigate the existing system; by increased youth, community and families' involvement and by enhanced data collection to help measure the impact of the ACCESS EO RIPAJ intervention on youth outcomes and experiences. Through ACCESS EO RIPAJ, network partners have strengthened their commitment to better meeting the mental health needs of homeless youth in Montreal including the aim of eliminating strictly age-based transitions. The involvement in RIPAJ of some organizations (and, thereby, the continued serving of related needs) remains dependent on clinicians volunteering time. Sustaining the efforts, initiatives and philosophies of ACCESS EO RIPAJ will require service administrators and policymakers to embrace the ACCESS EO RIPAJ transformation and their roles therein.

Efforts are underway to ensure the sustenance of the RIPAJ partnerships beyond the duration of the ACCESS EO project. We are documenting the transformation process and key factors contributing to improved access and outcomes by involving youth in data collection. Regular stakeholder meetings are being held to help integrate ACCESS EO values into all RIPAJ youth services. The diversity of our partners, though a core strength, makes the harmonization of practices difficult. A sustainability-related priority that we have identified is ensuring the retention of the positions of the project coordinator and the ACCESS Clinician. The coordinator will ensure the maintenance of smooth links between network partners and the continuation of common training and early identification activities. The ACCESS Clinician will ensure continued early identification, rapid access and navigation supports. We will also strive to sustain the elimination of age-based transitions. For unavoidable transitions, we will continue easing the process by accompanying youth.

Our model serves as an example for other initiatives that seek to address the mental health needs of homeless youth. As our experience has shown, homeless youth are well-served by an integrated services approach in which mental healthcare is part of a broad-spectrum compendium of services and supports. Facilitating service access for hard-to-reach youth also requires mobile clinicians who are flexible enough to meet youth where and when they desire. The structure of ACCESS EO RIPAJ itself represents an innovative approach to cross-sectoral and inter-services integration whereby diverse services align around a common objective without losing their individual identities and strengths or requiring co-location or extensive restructuring.

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## CONFLICT OF INTEREST

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Transforming child and youth mental health care: ACCESS Open Minds New Brunswick in the rural Francophone region of the Acadian Peninsula

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## Abstract

**Aim:** This paper describes how the transformation of youth mental health services in the rural Francophone region of the Acadian Peninsula in New Brunswick, Canada, is meeting the five objectives of ACCESS Open Minds.

**Methods:** Implementation of the ACCESS Open Minds framework of care in the Acadian Peninsula of New Brunswick began in 2016 at a well-established volunteer centre and community-based mental health organization. Through focus groups with youth aged 14 to 22 (n = 13), community mapping was used to describe the youth-related mental health service transformation, followed by thematic analysis, validation by member checking and triangulation.

**Results:** Preliminary results show a generally successful implementation of the ACCESS Open Minds model, as evidenced by the transformation of mental health service provision, the enhancement of capacity in human resources and the participation of youth. Transformation was evidenced across the five objectives of mental healthcare of ACCESS Open Minds, albeit to variable extents. Several facilitating factors and challenges are identified based on youths' accounts.

**Conclusions:** It is possible to successfully implement the ACCESS Open Minds model among francophones living in a minority setting and despite the constraints of a rural area. Most key components of the framework were implemented with high program fidelity. The rural context presents unique challenges that require creative and effective use of resources, while offering opportunities that arise from a culture of resourcefulness and collaboration.

**KEYWORDS**

access, francophone linguistic minority, mental health care, transformation, youth, youth mental health, Canada

Ann M. Beaton is the Senior author.

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## 1 | INTRODUCTION

Access to appropriate services is important for anyone grappling with mental health (MH) challenges. However, for youth who belong to a linguistic and cultural minority group such as the Acadians in New Brunswick, access to appropriate interventions during the early onset of mental illness may be particularly challenging (Dezetter, Beaton, & Bourque, 2016).

Language is a determinant of MH and a low proficiency in the dominant language can create health disparities (Puchala, Leis, Lim, & Tempier, 2013). For many years, MH program coordinators in the Acadian Peninsula have advocated for the importance of community-based and innovative MH care for youth. Mahmoud, Sers, and Tuite (2016) have noted the scarcity of MH research in this Francophone region. They also called for better quality and greater accessibility of culturally sensitive MH programs.

The pan-Canadian ACCESS Open Minds (ACCESS OM) project responded to the needs of the youth population. The project aims to transform the way mainstream MH services are delivered to youth aged 11 to 25 years. This transformation model is based on five main objectives of care: (i) early identification of youth in need; (ii) rapid access to mental healthcare; (iii) appropriate care; (iv) continuity of care beyond the age of 18; and (v) youth and family engagement (Malla et al., 2018). This paper aims to describe how the transformation of youth MH services in the Acadian Peninsula is meeting the five objectives of ACCESS OM.

## 2 | CONTEXT

New Brunswick reflects Canada's diversity: it is rural and urban, officially bilingual and includes different cultures. Many of its population (48%) live in rural areas. In northern New Brunswick, French is predominantly spoken, with fewer than 33% of English speakers (Figure 1).

One of the three sites of ACCESS Open Minds New Brunswick (ACCESS OM NB) is located in the main Francophone Acadian Peninsula (*la Péninsule acadienne*) in northern New Brunswick (Figure 1). It is a rural setting with fishing and agriculture as the dominant industry. The proportion of households with low income (21.4%) is higher than the provincial average (17.2%) (New Brunswick Health Council, 2016a). Its current population is estimated at 50 000 (6.6% of New Brunswick total population), with about 4000 youth aged 10 to 24 years (Statistics Canada, 2016). The average family income in the Peninsula is $31 301CAD after tax for a two persons household (Statistics Canada, 2017).

More children and youth are hospitalized for mental illness over time in the Acadian Peninsula at a rate of 90 to 126 per 10 000 compared to 28 to 51 per 10 000 in other parts of the province. Depressive episodes, stress reactive disorders, behavioural and learning disorders are the leading causes of mental illness admissions in the region (NBHC, 2016b). Among Acadian youth aged 12 to 17 years, 20% report symptoms of depression, while 25% report symptoms of anxiety (NBHC, 2017). Caron and Liu (2010) argue that the proportion of youth in need of MH services is much greater than estimated. In fact, only 8% of total youth received adequate MH treatment in the Acadian Peninsula (Morrison & Peterson, 2017).

## 3 | MENTAL HEALTH SERVICES IN NEW BRUNSWICK PRIOR TO ACCESS OM

Comorbidity in youth with mental illness is prevalent in New Brunswick (Caron & Liu, 2010). Further, early onset psychosis is associated with a variety of other MH conditions such as anxiety and addictions, which can disrupt life trajectories and future prospects (Kutcher & McDougall, 2009). Since 2015, New Brunswick has made youth mental healthcare one of its four health priorities (NBHC, 2016a). As a result, new provincial MH policies have focused on integrated service delivery to better coordinate responses to multiple youth-related problems based on a recovery model of care (Government of New Brunswick, 2018). This provincial momentum provided a leverage for innovative programming such as ACCESS OM (Malla et al., 2018).

Implementation of the ACCESS OM framework in the Acadian Peninsula began in 2017 at the *Centre de bénévolat de la Péninsule acadienne* (CBPA) in Caraquet, a well-established volunteer centre and

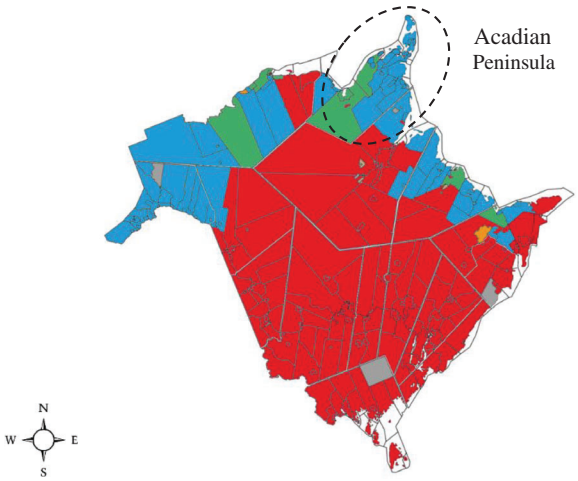


**FIGURE 1** Linguistic map of New Brunswick, Eastern Canada (Statistics Canada, 2006). Red ■: majority English-speaking, less than 33% French-speaking. Blue ■: majority French-speaking, less than 33% English-speaking. Orange ■: majority English-speaking, more than 33% French-speaking. Green ■: majority French-speaking, more than 33% English-speaking. Brown ■: majority allophone (Indigenous languages). Grey ■: no data available

community-based MH organization. Prior to ACCESS OM, youth 13 to 16 years of age had access to a program called Intersection. Although the program touched on some aspects of MH, the purpose of Intersection was the prevention of criminality among youth in the region by engaging them in activities meant to build life-skills. Staff soon realized that through the Intersection program, youth were often dealing with MH problems. In fact, the majority of youth who participated in the Intersection program lived with undiagnosed and untreated MH issues. At the CBPA, two ACCESS social work Clinicians who hold Bachelor degrees and four youth workers who completed a community integration course provide services designed to meet the five objectives of care. Most clinicians and youth workers that presently work for ACCESS OM NB at the CBPA were also part of the Intersection program, which enabled a natural flow and abundance of admissions at the initial opening.

## 4 | COMMUNITY MAPPING

Following the approval of ethics committees, a community mapping of the MH access points in the Acadian Peninsula was conducted. Two separate focus groups were held with youth 14 to 22 years (n = 13), followed by thematic analysis, validation by member checking and triangulation (Braun & Clarke, 2006; Creswell & Poth, 2018). Key informants and youth representatives from different areas of the province provided information to ensure that the research protocol was youth-appropriate. The purpose of the focus groups was to explore youth perceptions of the different MH access points (people and places). Youth were encouraged to draw or map the different points of access (hospitals, schools, community centres, clinics) and to share their stories. The preliminary findings suggest many of these participants experienced challenges with the standard, heavily regulated and often-inflexible mental healthcare system in New Brunswick. Some youth also described the formal MH system as disconnected and insufficiently integrated. More importantly, youth explained that they avoided what they described as a dehumanizing formal system that left them feeling traumatized. The following is a description of the ACCESS OM NB transformation in the Acadian Peninsula. Some preliminary findings from the community mapping focus groups has been added to gain a better understanding of the MH transformation.

## 5 | MEETING THE OBJECTIVES OF ACCESS OM

### 5.1 | Early Identification of youth in need

With respect to early identification of youth in need of MH services, ACCESS OM NB welcomes youth as young as 11 years old and remains flexible with the eligibility criteria for MH assessments and services. Any issue causing distress for youth is a criterion for assessment. Unlike other mental healthcare programs in the region, such as schools and hospitals, youth do not require a predefined MH problem or diagnosis for eligibility. In fact, the ACCESS OM program in the Acadian Peninsula presents fewer barriers for youth to receive faster MH support as compared to other regional services (ie, flexible hours, mobile services). This allows the program to quickly identify and meet with youth experiencing psychological distress before it devolves into a full-blown mental illness or becomes a crisis.

Collective regional effort, such as inviting other youth-related programs and MH sectors to the ACCESS OM NB promotional activities (ie, social events, community kitchens or collective cooking classes), has been key to the enhancement of early identification. The program planners make a collective effort not to duplicate or compete with other regional services and programs. They often work in close collaboration with other community sectors (ie, integrated service delivery for children and youth in school, education and early childhood development, social development) to identify the early onset of youth-related MH problems and identify youth in need.

In our experience, youth who participate in ACCESS OM NB are proud of their program and openly talk about their positive experiences. This creates a sense of ownership, which in turn reduces stigma and labelling associated with the initial willingness to access services. Teachers have shared that youth openly talk about the program at school, which often leads to self-referrals and early identification.

### 5.2 | Rapid access to MH services

Rapid access means that an ACCESS Clinician or a youth worker provides an initial contact and crisis assessment within 72 hours of reaching out for help. The young person will determine the preferred setting for rapid access. In some cases, youth will opt for a meeting in an office space. In other cases outreach is provided and will include virtual contact (eg, text) or a community setting (eg, car). Considering the vastness of the Acadian Peninsula region, outreach represents an important initiative provided by the ACCESS OM team to ensure rapid access to youth-based care. When the program was launched in the Acadian Peninsula, the flow of youth seeking services increased dramatically. The team quickly realized that the program needed to adapt to meet the target for rapid access. It was decided that when the clinician could not physically meet the youth within 72 hours, the program would ensure that an initial crisis assessment be made by a youth worker by phone or in person. Therefore, the clinician could spend more time with the youth to complete the MH assessments and the admission process (eg, bio-psycho-social and research assessments).

Due to a shared youth-centred approach, the ACCESS OM NB site and other community and government services (ie, Child and Youth MH services) in the region developed an informal partnership to meet the 72 hour requirement. The ACCESS OM approach is flexible, allowing the on-call clinician or youth worker who receives a call from a youth in crisis, to assess the situation and respond accordingly. For instance, this may require the clinician or youth worker to advocate on behalf of the youth to receive an initial assessment from a government-based MH service and accompany the youth at every stage of this process. Furthermore, if other community organizations

or government services recognize the need for a 72 hour assessment, and feel that the ACCESS OM team is better suited to rapidly meet the needs of the youth, the youth will be referred to the ACCESS Clinician. Such close collaboration between the ACCESS OM team with government and community sectors represents a major change to MH care for youth.

The importance of rapid access was mentioned by many youth who participated in the community mapping focus groups. They explained that flexibility was one of the most influential features of rapid access. Youth added that when a crisis occurs, the clinician or youth worker will come to them, which is very beneficial for a youth who lives in a more remote area.

### 5.3 | Appropriate care

Access to evidence-informed intervention through an integrated mental healthcare approach is a priority. The ACCESS OM staff offer youth-related MH counselling services in an informal and comfortable setting, oftentimes outside the conventional "office space." Youth are offered different options for access to mental healthcare: (i) counselling with a clinician; (ii) counselling with a clinician and follow-up care with a youth worker; (iii) counselling with a clinician, follow-up care with a youth worker and program of activities; (iv) program of activities if youth already has adequate mental healthcare (eg, school, clinic) in place but still wants to participate in activities to enhance life skills.

To adequately meet the needs of youth, the team developed an evidence-informed individual counselling therapy and skill building program in a mobile "safe space" setting (ie, text, phone, coffee shop), where clinicians and youth workers will go to the youth in need for assessments, counselling and follow-up care. At first glance, the program of activities might appear to focus on leisure. However, they are all framed to build upon specific skills, such as anxiety/depression awareness, counselling, relaxation strategies, healthy relationships, self-esteem building, social skills, job readiness, youth mentorship skills, assertiveness skill building, crisis and suicide prevention strategies.

The ACCESS OM NB site does not employ a clinical psychologist, sexologist or psychiatrist to offer more complex psychotherapy and behavioural interventions. Therefore, a member of the site team (clinician or youth worker) will initially meet the youth to assess the crisis level and refer to a more specialized program (eg, emergency department, psychiatrist) for further complex mental healthcare, such as an untreated episode of psychosis. Long wait time for MH specialized care is a major challenge for many youth and unfortunately creates further MH complications that often can be prevented with rapid access to care. What has been key to the success of ACCESS OM is its ability to remain with the youth during their MH crisis continuum, from the initial contact to the assessment of MH, the management of immediate care if needed (emergency department) and the coordination of long-term services with appropriate specialist.

### 5.4 | Continuity of care

Youth transitioning to the adult MH program was problematic in the region, as the waiting list was long and young adults would go several months to a year without adequate care. The continuity of care objective is particularly important at the CBPA, as it responds to a critical need for adequate care in the region and allows for a better transition of MH services for young adults up to 25 years old. At the inception of ACCESS OM NB, the program coordination and service providers informed youth-related sectors (youth protection services, clinical psychologists and psychiatrists) about the availability of MH services for young adults transitioning from the youth program to the adult program, which has a significant waitlist and long wait time for admission. There was a natural transition with ACCESS, as the older youth had previously built a trusting relationship with the intersection program clinicians and youth workers.

For youth living with a MH issue, the transition to adulthood can be a challenge. The ACCESS Clinician and youth workers at the CBPA recognize the importance of continuity of care beyond 18 years of age. They offer counselling and care that is required by the young person and designed to help them gain different life skills (eg, planning budget, searching for employment). Along with appropriate MH services, ACCESS Clinician and youth workers collaborate with other community services to ensure that all youths who reach 18 continue to have access to the care they need.

### 5.5 | Youth and family engagement

The Youth Advisory Committee offers youth a voice in the governance structure of ACCESS OM NB at the CBPA. They are directly part of the decision-making process related to programming and intervention. Peer support is also an important component of ACCESS OM. Yet, at the onset, the community clinicians and youth workers were reluctant to assign youth mentors to incoming youth without providing them with any support or training. Therefore, the ACCESS Clinicians and the youth workers specifically choose the youth mentors according to their life trajectories, their MH outcome, and their capacity to mentor new youth in search of mental healthcare. Furthermore, clinicians and youth workers aid youth in building their mentorship skills to help welcome new and younger youth to the program and facilitate engagement activities. The ACCESS OM NB Family-Caregivers Advisory Committee has been more challenging to establish. The scarcity of parent participation is noteworthy but not entirely surprising. Most families and youth have complex issues, histories and present challenges affecting their ability to connect. Indeed, the ACCESS OM project is relatively new to the community and mainstream mental healthcare services generally do not emphasize family engagement. According to the ACCESS OM team, young people search for a meaningful and secure relationship with youth workers. This is a priority for the ACCESS OM team at the CBPA and the key to keeping youth engaged.

During the community mapping focus groups, preliminary findings suggest that some youth do not want their family members involved in their mental healthcare, as some parents may also be affected by mental illnesses or other issues or might contribute to some of the difficulties experienced by youth. Although many youth shared that they did not have close relationships with their family, they still expressed a hope to become closer one day. Youth also identified people or groups that represented a "family substitute" in their lives because they played an influential and beneficial role regarding their mental healthcare. The fact that families were not mentioned by participating youth in the focus groups as an important support for mental healthcare does not mean that families are disengaged. Further research is underway to better understand the parent's perception and needs regarding youth MH in the region.

## 6 | WHAT IS SPECIAL ABOUT THIS SITE?

A unique feature of the ACCESS OM NB site at the CBPA is its ability to combine the Intersection and the ACCESS OM programming to meet the MH needs of youth. The ACCESS OM objectives also build on an existing MH platform of integrated service delivery recently established by the province to improve access to MH related services.

Despite the challenges of remoteness and limited resources, this site heavily draws on a culture of resourcefulness, capacity building and collaboration, both within the community and with outside service providers. Important bottlenecks such as limited number of clinicians, lack of integration in service delivery, and restrictive eligibility criteria have been identified and rapidly addressed in order to reach out to more youth in need. Likewise, the site developed a mobile "safe space" venue for assessment and counselling, enabling rapid access and early identification, thus minimizing some important gaps of MH services such as difficult access, stigma and long wait times for young adults. The program also actively invites youth to participate and be part of the decision-making mental healthcare processes as well as promotional activities that do not focus solely on MH. Finally, yet importantly, the service providers at this site consider establishing trust in ways that are meaningful to youth. The ACCESS Clinician and youth worker will adapt and meet youth at a local coffee shop if needed to complete assessment or offer counselling.

A number of facilitators (eg, key champions, building of trust) identified by youth may contribute to the development of protective factors that help build resilience in youth, which in turn contributes to improved MH (NBHC, 2016c). These protective factors include an ability to solve problems without harming oneself or others, knowledge of where to go in the community to get help, people to look up to, caregivers who are well-informed about the youth, the support of friends during difficult times, as well as opportunities to develop useful skills. The development of these protective factors is essential to sustain the beneficial impacts of programs such as ACCESS OM on youth MH and well-being.

## 7 | SUSTAINABILITY

A dialogue is underway between the government of New Brunswick decision-makers, ACCESS OM NB site leads, and stakeholders, such as family members and First Nations community representatives, to negotiate the terms of integration of ACCESS OM NB within the provincial Network of Excellence. The Network of Excellence is a government strategy whereby a collaboration between Social Development, Education and Early Childhood Development, Health, Justice and Public Safety, and Regional Health Authorities allows for the planning and implementation of a coherent approach to service delivery designed to support children and youth who experience addictions and MH challenges. Some of the key issues under discussion include governance (eg, collaborative leadership), programming and intervention (eg, definition of respective roles in continuum of service), communication and training (eg, sharing of information).

## 8 | COMMUNITY IMPACT

A fundamental transformation of youth MH services in the Acadian Peninsula has been underway since 2016, due to the launch of ACCESS OM. As a result, the five objectives of the ACCESS OM framework of care have been reached, albeit to variable extents. Several facilitating factors and challenges were identified based on youth accounts. Challenges such as stigma related to MH and limited family engagement will require further consideration by the ACCESS OM NB team.

It was further noted that many facilitators in the ACCESS OM transformation enhance the deployment of key principles of mental healthcare, and contribute to the development of protective factors. In turn, these protective factors promote resilience in youth and improve MH outcomes and health trajectory. Overall, the preliminary results obtained at this site show that it is possible to implement the ACCESS OM framework in a rural area among francophones living in a minority context. The rural context presents unique challenges that require a strategic use of community assets and socio-cultural strengths.

## 9 | CHALLENGES

Youths' accounts in the Acadian Peninsula suggest that stigma, confidentiality and the delay of some referrals are important factors hindering the early identification of MH issues. This supports previous perspectives on youth MH (Kutcher & McDougall, 2009). It is also noteworthy that youth in this region did not identify family members as sources of support in times of crisis or for help with other matters regarding MH. Youth also identified gaps in the current traditional MH system, such as administrative constraints, delays, lack of integration and inflexible hours, which seem to be major hurdles in meeting their needs. These findings helped the ACCESS OM NB team to reflect critically on innovative approaches to reach all youth in need and find ways

to better connect with the traditional MH services. The perspectives of other stakeholders, including family members, carers and other community members will be considered in the near future to gain a comprehensive understanding of the ongoing transformation of youth mental healthcare in the Acadian Peninsula and its impact in the community.

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## CONFLICT OF INTEREST

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Improving youth mental wellness services in an Indigenous context in Ulukhaktok, Northwest Territories: ACCESS Open Minds Project

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## Abstract

**Aim:** To describe a community-specific and culturally coherent approach to youth mental health services in a small and remote northern Indigenous community in Canada's Northwest Territories, under the framework of ACCESS Open Minds (ACCESS OM), a pan-Canadian youth mental health research and evaluation network.

**Methods:** As 1 of the 14 Canadian communities participating in a 5-year, federally funded service transformation and evaluation project, the arctic Inuit community of Ulukhaktok has undertaken culturally relevant adjustments in their delivery of youth mental wellness services and related community wellness initiatives. These enhancement activities highlight connections to culture and traditional skills, honour youth- and community-expressed desires to incorporate Inuvialuit-specific approaches to wellness, and strengthen the support systems to improve access to mainstream mental healthcare, when needed. The adaptation of a Lay Health Worker model from Global Mental Health to the local circumstances resulting in creation of lay community health workers is central to this approach in meeting contextual needs.

**Results:** Community leaders identified key activities for sustainable change, including human capital development, authentic collaboration and diversified engagement strategies. Building around five ACCESS OM objectives, the local site team in Ulukhaktok has identified its youth programming and mental wellness service gaps through an ongoing process of community mapping.

**Conclusions:** Information from service providers, youth and other community members demonstrates attuning of the ACCESS OM framework to Inuit paradigms in Ulukhaktok. It could prove to be a sustainable prototype for delivering youth mental health services in other communities in the Inuvialuit Settlement Region and possibly across the entire Inuit Nunangat. It needs, however, to be further supported by easier access to specialized mental health services when needed.

Meghan Etter and Ashok Malla are joint senior authors.

**KEYWORDS**
culture, Indigenous, Inuit, lay health worker, youth mental health, Canada

## 1 | INTRODUCTION

Addressing mental health needs of young people should be a priority for healthcare in Canada (Malla, Shah, et al., 2018). Frequently reported high rates of adverse mental health and suicide in Indigenous communities are of particularly grave concern (Boothroyd, Kirmayer, Spreng, Malus, & Hodgins, 2001; Health Canada, 2013). The urgency of this is accentuated by the fact that Indigenous communities have relatively high proportions of population under the age of 25 (40%-50%) (Turner, Crompton, & Langlois, 2011). Risk factors, related to the worst consequences of colonialism and the large-scale intergenerational trauma, are associated with high rates of mental health problems and addiction while also negatively influencing acceptance of non-Indigenous services (Nelson & Wilson, 2017).

In response to growing concerns about grossly inadequate mental health services available to youth living in very diverse geographic, cultural and historical circumstances in Canada, a pan-Canadian service transformation project, ACCESS Open Minds (ACCESS OM) was launched in 2014. ACCESS OM, initiated under the auspices of the Strategies for Patient-Oriented Research (SPOR), comprises 14 very diverse sites, including four First Nations and two Inuit communities, as outlined in a recent report on ACCESS OM (Malla, Srividya et al., 2018).

Here, we describe how this service is being transformed in the remotely situated Inuit community of Ulukhaktok. The preparatory phase of the ACCESS OM project, launched in Ulukhaktok in September 2016, involved a feast attended by approximately one-quarter of the community. The site team was fully staffed by early 2017 and activities have been underway since. An official launch of the ACCESS OM Youth Space is anticipated for 2019.

## 2 | BACKGROUND

Based on the key principles and objectives of the national project (Malla, Srividya et al., 2018), the ACCESS OM implementation in Ulukhaktok is built by local community members within the context of unique characteristics of the community, the people, and their lived reality as 21st century Ulukhaktokmuit, or people of Ulukhaktok.

### 2.1 | Geographical context

Inuit have thrived in the high arctic for more than a millennium, harvesting food from the land and the icy waters, and passing on tradition and culture through spoken word, art and practice. Connection to the land, culture and history is woven into the fabric of an Inuvialuit understanding of wellness, and by extension to the understanding of mental health.

Ulukhaktok is a small hamlet of 396 people (Statistics Canada, 2017) in Canada's western arctic, part of the Inuvialuit Settlement Region (ISR) on the western coast of Victoria Island. Almost all community residents have knowledge of English. While the traditional language, Inuinnaqtun, is the mother tongue for 130, an additional 85 have knowledge of it. Until "settlements" in the 1930s were established under colonial rule, Inuit were traditionally nomadic, having set up communities throughout the region following the seasons for their traditional practices of hunting, fishing and gathering food from the land.

Regularly accessible only by air, Ulukhaktok is geographically remote; the tundra landscape, above the tree-line, is rocky and for much of the year covered in snow and ice. Apart from access by air, an annual barge from the south makes larger deliveries (building supplies, dry goods, or vehicles). The community hosts the world's northernmost golf tournament and has also hosted international cruise ships navigating the Arctic Ocean's Northwest Passage.

### 2.2 | Socio-historical context

The history of Inuvialuit and their experience of colonization is directly relevant for any discussion of the provision of services, especially mental health services in Ulukhaktok. Among the principal sources of intergenerational trauma is the effect of residential schools. Indigenous children from this community, as elsewhere in Canada, were forcibly removed from their families as early as five years old and transported to residential schools, under the Indian Act (Truth and Reconciliation Commission of Canada, 2015). The latter enforced compulsory attendance for all children in order to assimilate Indigenous children into "mainstream" Canada and to ultimately "kill the Indian in the child" (De Leeuw, 2009). Punished for speaking their language, prohibited from practising their culture, and made to believe that being Indigenous was "sinful," these children suffered high rates of malnutrition and emotional, physical and sexual abuse (Truth and Reconciliation Commission of Canada, 2015). In the Inuvialuit Settlement Region, the last school was closed as late as 1996.

## 3 | STATUS OF MENTAL HEALTH SERVICE PROVISION

As a first step towards service transformation contextualized to local realities, within ACCESS OM each site engaged in an exercise of "community mapping" in order to understand the current status of service delivery within each community.

### 3.1 | Community mapping results

Established in 1984, the Inuvialuit Regional Corporation (IRC) represents the collective Inuvialuit interests in dealings with governments. IRC is responsible for "continually improving the economic, social and cultural well-being of all Inuvialuit," (Inuvialuit Regional Corporation, 2018) including ACCESS OM.

Initiated by an external consultant, IRC took charge of the ACCESS OM project, its strategies, management and site-level activities in partnership with Ulukhaktok Community Corporation. Mental health services are incorporated within general health services in that the counsellor is located in the community health centre. Non-Indigenous nurses from the south provided general health services to youth, travelling in and out of the community for 8 weeks at a time. One staff member lived in the community for part of the year job-sharing with another nurse. Other staff (social worker, childcare worker) also visited the community from time to time. Members of the community often hold the positions of Community Health Representative, Home Support Worker and Student and Family Support Worker.

The small geographical hamlet promotes a central location for the provision of multiple services. These are located in the School, Health Centre, Kayutak Centre and the Hamlet Office. A Youth Centre, situated adjacent to the Community Centre and the school, serves youth from all elementary and secondary grades and hosts an after-school recreation program, including, sports, games and computer access. The Community Centre provides culturally coherent activities such as drum dancing, cooking programs and community feasts. Older youth (18-25 years), however, often do not engage in the pre-existing activities. In addition to healthcare providers, other service providers such as teachers, the school principal and the Royal Canadian Mounted Police (RCMP; the federal police agency serving Ulukhaktok) are often preferred points of contact for youth with mental health problems, presumably, due to reluctance to reveal such concerns to those who are known to them as fellow community members.

### 3.2 | Service deficiencies

During planning stages of the ACCESS OM project, the community team identified a lack of mental health knowledge or local skills in this community to provide support to young community members. They wanted their own knowledge and skills to deal with young people when they have mental health difficulties, and to use their traditional land- and sea-based activities to support them. There are no psychiatric services available locally, and youth in severe crises (e.g., psychosis, severe substance abuse, suicidal attempt or overdose) are referred to hospitals further south, minimum of one-and-a-half-hour flight away from the community. The ACCESS OM local community team wanted the skills to provide aftercare to young people on their return from these hospital stays, to identify young people with mental health and addiction problems, and to be able to support them locally.

Apart from difficulties envisaged in hiring a full-time ACCESS Clinician (Malla, Srividya et al., 2018), it was highly unlikely that such a staff position would necessarily be in the best interest of youth. Professional staff would ordinarily deliver "standardized" mental health services. In this setting, however, the local community team felt that service providers needed better understanding of local youth and a trusting relationship and, therefore, considerable investment in and connection to the community. The team expressed that there may be lingering mistrust of "mainstream" mental health services and general stigma towards mental health. As an alternative, they proposed that a local resident—someone with in-depth understanding of the community and its unique needs—would be better able to fill the gap, their exact role redefined for the context.

### 3.3 | Creating a mental health service based on local needs and resources

Based on deficiencies identified by the local Inuit community, especially a lack of culturally appropriate and relevant professional resources, and the remote location of the community, an innovative alternate model of care seemed appropriate. Such a model of care must be feasible, based on some degree of prior evidence and the community's highest priorities. The national ACCESS OM leadership team had previous experience of providing training to local lay health workers (LHWs) in shifting key tasks from professionals to the trained LHWs in a low-resource rural setting (Malla et al., 2019). Tasks safely shifted to trained LHWs include identifying individuals with emerging or persistent mental health problems and substance abuse, support in seeking additional professional help and to those who received professional interventions elsewhere.

In Ulukhaktok, community mapping clarified these issues. One impact of multigenerational trauma is the active struggle in this community to keep a strong connection with culture while increasing ownership of resources, including healthcare. In some other parts of the world where there has been widespread trauma and violence, communities have introduced alternate models of providing mental health services (Chan, Parish, & Yellowlees, 2015; Humayun, Azad, Khan, Ahmad, & Farooq, 2016; Malla et al., In press; Mendenhall et al., 2014; Rathod et al., 2017; Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2019).

### 3.4 | Adapting and applying a LHW model of care to Ulukhaktok

The success of implementing a LHW model depends on: careful local adaptation to prevailing geographic, cultural and economic conditions; adequate training focused on the specific role LHWs take on and tasks they will perform; cultural and linguistic congruity with those in need of the services; external professional back-up and resources to deal with mental health problems that are beyond the capacity of LHWs; and adequate availability and appropriate use of technology (Chan et al., 2015; Hilty et al., 2013; Hubley, Lynch, Schneck, Thomas, & Shore, 2016; Moirangthem et al., 2017).

The Ulukhaktok team decided that this approach could be adapted adequately to the local circumstances, as a non-threatening, culturally

relevant option for youth seeking mental health supports and services. The team adapted LHW role and training for an *ACCESS OM Youth Worker* (AYW). Two AYWs recruited from the local community (initially one young person and one elder) received training which was a combination of training derived from World Health Organization (WHO) training material and Indigenous-focused modules. The latter included Mental Health First Aid-Inuit, Applied Suicide Intervention Skills Training (ASIST), CPR/First Aid, bullying education through the Red Cross and an adaptation of the WHO mhGAP intervention guide was provided by ACCESS OM central office.

Given the unique cultural context, the training was conducted through a series of conversations between the AYWs in the community and the training staff at the ACCESS OM central office, wherein the material from the WHO Lay Health Worker model (document) was presented. Subsequent discussions that ensued involved how such an concept might fit into the Inuvialuit way of thinking and how the AYWs might see this concept being applicable to them in their community. In particular, we used the wisdom and experience of one of the two initial AYWs, an Elder from the community. The latter has significant experience being a support person/helper and working in her community's school and as a teacher of traditional ways. As such, the discussions were generally facilitated to amplify her voice in learning how such concepts around community mental health work (as written from a more global perspective) might apply to the incorporation of the ACCESS OM framework in Ulukhaktok.

Now integral to the community site team, these workers focus on outreach activities, provide education about mental health issues, guide youth to appropriate services, and work collaboratively with youth, service providers, and other community members to provide better mental health care for youth. The Ulukhaktok team considered the best way to connect with all youth is to build strong connections with the AYWs and with other supportive adults in the community. AYWs facilitate youth events and activities, including fishing trips, cooking workshops, arts and crafts projects, and other on-the-land programming (e.g., hunting, igloo building, collaborations with other initiatives such as Project Jewel, an on-the-land wellness program through IRC).

## 4 | MEETING THE FIVE OBJECTIVES OF THE ACCESS OM FRAMEWORK IN ULUKHAKTOK

The ACCESS OM framework is built around five foundational objectives to be addressed at service sites in diverse ways due to the vast differences in cultural context, geography and population (Malla, Srividya et al., 2018). This framework allows for a community's contextual differences to be the strength of their service delivery. How the ACCESS OM objectives are being achieved in Ulukhaktok is detailed below.

### 4.1 | Early identification

The first objective of the ACCESS OM project is to identify more youth who are experiencing a mental health problem sooner in order to reduce untreated prevalence of mental health problems. The approach of estimating untreated prevalence based on census data from Statistics Canada and the Canadian Community Health Survey (CCHS) is used for non-Indigenous sites but is inappropriate for most Indigenous communities due to the lack of their inclusion in the CCHS. Further, Inuit might not share the same cultural concept of mental disorders as non-Inuit or non-Indigenous peoples of Canada. The community team recognizes, however, an urgent need to improve general mental health literacy and to identify young people with emerging mental health concerns. Working closely with schools and other agencies (through community mapping), the AYWs are able to discuss issues related to mental health and substance abuse. Recently, collaboration between the local Royal Canadian Mounted Police and youth leaders resulted in an information session within the school on common mental health issues, online resources and telephone help lines. Engagement and identification of school-aged youth has been one of the site team's strengths; the school administration often shares their concerns regarding individual students with the AYWs. The engagement activities, initiated by the AYWs, bring youth together and facilitate the learning of cultural practices. This allows them to connect with the youth in their community in a way that no outside-sourced professional could.

### 4.2 | Rapid access

The second objective of ACCESS OM is that youth in need (or those acting on their behalf) are offered an initial evaluation of their presenting problem within 72 hours of seeking help. In Ulukhaktok, this objective is modified since the AYWs do not provide mental health assessments, especially if the problem appears to be severe. The AYWs connect with help-seeking young people quickly and guide them and their families towards the most appropriate services. In general, rapid access to *someone* in the regular services is rarely a concern in Ulukhaktok due to the small size of the community. Rapid access to specialized mental health interventions, such as addictions treatment or psychiatric care, however, requires leaving the community. This can take significant time to arrange and, at the same time, may not be adequate or appropriate. The AYWs' role includes helping navigate these pathways towards care and supporting youth and their family members in the journey, in the quickest way possible. The AYWs are now in the process of obtaining training to be able to offer support to youth as they return to the community after seeking care elsewhere.

### 4.3 | Appropriate care

The ACCESS OM framework intends to connect youth to high quality, needs based, evidence-informed, culturally appropriate and youth-friendly care within 30 days (Malla, Srividya et al., 2018). For the ACCESS OM Ulukhaktok team, “appropriate care” means several

things including that interventions are aligned with the cultural context. AYWs can provide general mental health and personal support, including land-based and culturally appropriate programming. But specific treatment for more severe mental disorders like psychosis, suicidal crisis and severe addiction is not currently available locally. Use of technology (eg, tele-psychiatry) to facilitate access to care will be explored in future.

### 4.4 | Continuity of care

Within the ACCESS OM framework, any transition in care should be based on clinical need and not chronological age (Malla, Srividya et al., 2018; Osgood, Foster, & Courtney, 2010; Singh et al., 2010; Singh & Tuomainen, 2015). In the case of Ulukhaktok, as in many other Indigenous communities, there is no real division between these two age-based systems of care. The division of child-adolescent and young adult services remains problematic when youth require psychiatric care outside the community in non-Indigenous settings. By building relationships with the mental healthcare system outside the community, the AYWs hope to better support young people (and their families) who have left the community for care, and to better manage the transition once they return.

### 4.5 | Youth and family engagement

As a project funded under the Canadian Institutes of Health Research (CIHR)'s Strategy for Patient-Oriented Research, engagement of youth and families is fundamental to service transformation under the ACCESS OM project. In Ulukhaktok, engaging family members and carers in ACCESS OM initiatives has been challenging despite sharing information through both formal (e.g., presentations) and informal social networks (e.g., word-of-mouth, online presence). Many community members, young and old alike, describe a marked generational divide between youth and Elders, but also a desire for increased intergenerational connectivity in the community. As well, over the course of the first two years of ACCESS OM activities, parents and young families have been identified as in need of further exposure to learning about mental health. There is also some hesitation expressed by youth in Ulukhaktok to share their mental health concerns, such as suicidal thoughts, with their own families. The AYWs have started hosting “family nights” at the community hall and are planning other activities, such as support groups for parents to engage older adults in discussions of mental health.

### 4.6 | Research and evaluation

A fundamental component of the ACCESS OM project is to evaluate each objective of the service transformation through collection of individual, as well as program level data, using an evaluation protocol (Iyer, Jordan, MacDonald, Joober, & Malla, 2015). As the transformation proceeded (described above), it also became obvious that the standard measures used at other sites were not possible to apply with the same precision and expectations in this small Inuvialuit community of less than 400 people. Apart from the small numbers expected to meet criteria for a mental health disorder, the lack of tradition of recording responses in written format (as per the originally stated protocol) was an important facet of the site. Therefore, in consultation with community leadership, data will be collected mostly in the form of stories and personal narratives using a qualitative research strategy, as well as some preliminary interviews conducted by a trained graduate nursing student who met with the youth informally. The details of the qualitative strategy to be applied to all sites will be discussed in a separate report. Follow-up community mapping activities comparing the pre- and post-implementation overview of services and activities in the community and reports of skill-building, on-the-land wellness programs, both in the community and beyond, will form part of the evaluation.

## 5 | DISCUSSION

In this report, we have described how the ACCESS OM service transformation was adapted to the very special circumstances of a small arctic (Inuit) community, with particular attention to the unique cultural context, effects of intergenerational trauma related to colonialism, the deliberate suppression of their nomadic culture, variable and largely inadequate mental health resources for provision of appropriate care and absence of local ownership of mental health resources. This cultural attuning of the ACCESS OM framework includes training two local Inuvialuit AYWs to support youth in the community in social, cultural and land-based activities. We expect this will assist early identification of emerging and existing mental health problems. Their role also involves connecting youth in need to professional services available in the community from the non-Indigenous, territorial-funded system, supporting more satisfactory transitions to seeking services outside the community, and supporting youth when they return from episodes of care outside of the community.

### 5.1 | Challenges

The community reports that older youth (18-25) are less likely to engage in basic support services and participate in culturally appropriate activities compared to the younger youth. Some of the former are working, starting families and leaving the community to pursue post-secondary education. In response to the recurrent request by youth to create more opportunities to connect to their culture and learn about mental wellness, the transmission of traditional knowledge became central to ACCESS OM activities in Ulukhaktok. Older youth have requested advanced Inuinnaqtun instructions, sewing and beading classes, and lengthier on-the-land camps. Facilities are currently being built to create a separate youth centre, attached to the sports arena, where they will have access to activities and supportive resources in collaboration with the AYWs.

Being central to the service transformation locally, AYWs must manage a dual identity. Being members of the small remote community, they have their own identities as parents, siblings, community

members and, in the case of an Elder AYW, grandparent and respected Elder. Seen as trusted confidants by the youth, the AYWs also have to identify youth with mental health problems who may need additional professional help while such access is often not easy. They have to live up to expectations of being trusted community members and at the same time navigate issues of confidentiality between the youth, their families, and those in positions of perceived authority (e.g., school administrators, child and family workers and police).

Given the small size and close-knit nature of the community, difficulty in maintaining privacy when seeking help was seen by youth as a challenge and by AYWs as a barrier to early identification of mental health problems. Youth viewed receiving help for mental health as a threat to social acceptance by both peers and family. Youth also state that parents and carers do not generally ask in-depth questions about mental wellness. They feel they are expected to rely on themselves to cope with threats to their mental health. The most common alternatives to reaching out for clinical support included disclosing to a trusted friend or engaging in cultural practices such as being on the land (Ulukhaktok youth, personal communication, July 6 & 19, 2018).

The challenge of meeting the ACCESS OM benchmarks for rapid access is grounded in the fact that no specialized care, such as addiction or psychiatric interventions, are available within Ulukhaktok; this care requires travel outside the community, which also has an impact upon continuity of care.

## 6 | CONCLUSION

Much of the care being provided by the local ACCESS OM team is not directed at specific mental health interventions that would treat individual problems, but rather the team is helping to build supportive and integrated community responses to improve overall mental health literacy and wellness. Future efforts should also support the development of structures and use of technology that can help youth presenting with identifiable mental health and addictions crises, or who might require specialized mental healthcare. Collaborative work with the site team and their regional partners is not only a solution for amplifying their voices in this research project, but also in how this community response to improving mental health services could shape youth mental healthcare in other remote, arctic locations across Canada's north. Stigma and confidentiality remain challenges that the local team continues to work on to find creative solutions, such as increasing activity-based interventions for older youth to be started in the new venue.

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## CONFLICT OF INTEREST STATEMENT

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Eskasoni First Nation's transformation of youth mental healthcare: Partnership between a Mi'kmaq community and the ACCESS Open Minds research project in implementing innovative practice and service evaluation

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## Abstract

**Aim:** ACCESS Open Minds (ACCESS OM) is a pan-Canadian project aimed at improving youth mental healthcare. This paper describes implementation of the ACCESS OM objectives for youth mental health service transformation within a pre-existing Fish Net Model of transformative youth mental healthcare service in the First Nation community of Eskasoni, on Canada's east coast.

**Methods:** We describe an adaptation of the ACCESS OM service transformation objectives through the complementary blending of Indigenous and Western methodologies. This concept of "Two-Eyed Seeing" is illustrated as central to engaging youth in the community and attending to their mental health needs and wellness.

**Results:** The ACCESS OM Eskasoni First Nation Youth Space acts as a central location for the site team and its activities, which expand into the rest of the community to facilitate early identification of youth in need. Rapid access to care is promoted via barrier-free availability through a central intake crisis and referral centre, and ease of contact through social media and other modalities. Youth are given the choice between standard Western mental health services, or Indigenous methods of improving well-being, or a combination of the two.

**Conclusions:** The ACCESS OM framework has shown early results of being a positive addition to the Eskasoni community. Local leadership and community buy-in are identified as key factors to success. Further exploration, research, and evaluation of this transformation is ongoing. Successful implementation of this model in Eskasoni could act as a model for youth mental health programmes in other First Nations across Canada.

Daphne Hutt-MacLeod and Patricia Boksa are joint senior authors.

**KEYWORDS**
community participation, health promotion, Indigenous community mental health services, suicide, youth mental health, Canada

## 1 | INTRODUCTION

Eskasoni First Nation is a rural Mi'kmaq community located on Cape Breton Island, Nova Scotia, on Canada's east coast, with a total registered population of 4556 (Indigenous and Northern Affairs Canada, 2018). More than 50% of the population is under the age of 25. Thus, provision of health and wellness care to the community's youth is integral to the future of the community. This paper describes the transformation of youth mental health service delivery in Eskasoni in alignment with ACCESS Open Minds (OM), a pan-Canadian project in which youth mental health services are being transformed to achieve five main objectives: early case identification, rapid access to initial assessment, availability of appropriate services, engagement of youth and families, and elimination of transitions in service based on age (Malla et al., 2018).

In implementing a pan-Canadian project in our First Nations community, it is of critical importance that the service transformation responds appropriately to the needs of the youth in the community, respecting Mi'kmaq traditions, values, learnings, language, and historical contexts, while integrating the elements of Western knowledge that can support young people in their pathway towards wellness. The "Two-Eyed Seeing" approach, created by honoured Mi'kmaq Elders Albert and Murdena Marshall, has been a guiding principle for the Eskasoni team and has been integrated into all aspects of service delivery with community youth. This approach is based on the idea that one can learn to take the perspective of seeing from one eye the strengths of Indigenous ways of knowing, and from the other eye, the strengths of Western ways of knowing, and to use both of these perspectives for the benefit of those being served (Bartlett, Marshall, & Marshall, 2007).

At the outset of the ACCESS OM project in 2014, existing initiatives that had been put in place to address youth mental health needs in Eskasoni First Nation lent themselves well to integration with the five ACCESS OM objectives (Malla et al., 2018). ACCESS OM has served to emphasize and accelerate transformational components of youth mental health services in the community, and importantly, allows for systematic evaluation of the effectiveness of these services.

## 2 | IMPETUS FOR TRANSFORMATION

During the fall of 2008 and the winter of 2009, the community of Eskasoni First Nation suffered the loss of a number of youth by suicide and accidental drug overdose. The resulting negative news headlines caused emotional, mental and economic suffering to the population. This experience and challenges within the community, such as an increase in prescription and intravenous drug misuse and high rates of poverty (Frank & Saulnier, 2017), mortality and unemployment, exacerbated other systemic and underlying issues such as the intergenerational traumatic effects of the residential school system and other catastrophic impacts of decades of colonial policy promoting cultural discontinuity (Bombay et al., 2019; Kirmayer, Brass, & Tait, 2000; Kirmayer, Gone, & Moses, 2014; Truth and Reconciliation Commission of Canada, 2015; Wilk, Maltby, & Cooke, 2017). A regional health survey at the time reported that between the current issues and persisting community loss, "nearly every young person in the [Eskasoni] community has been impacted negatively," with 16.5% of youth surveyed expressing that they had contemplated suicide (First Nations Regional Health Survey, 2010).

## 3 | PRE-ACCESS OPEN MINDS TRANSFORMATION

Beginning in 2010, following the 2008 to 2009 suicides and untimely youth deaths, Eskasoni Mental Health Services responded with a process of major transformation of mental health and addictions service delivery in the community. One of the first steps was to amalgamate and co-locate formerly siloed community mental health services, crisis services and case management into a united and integrated team under one director. This newly reformulated team was given a mandate to provide coordinated, streamlined, barrier-free and user-friendly mental health and addiction services. A community-wide mental healthcare service model—the Fish Net Model—was developed and adopted, which emphasized community development and ownership of programs, and aimed at building upon community-identified priorities. This model of care is uniquely tailored to the needs, objectives and conceptualizations of health of the community. The approach involves casting a wide net across the community in a variety of ways and for an assortment of interventions. These interventions include standard Western mental healthcare services (e.g., psychology and clinical therapy services, social work, case management, therapy groups); cultural support (e.g., residential school survivor and descendant services, connecting youth with Elder support, providing youth and families opportunities to engage in Mi'kmaq traditions and practices); programming and activities for youth, families and community members of all ages; peer support; and crisis services (see Liebenberg & Hutt-MacLeod, 2017).

A number of components were woven into the existing Fish Net Community Mental Health model of service delivery in Eskasoni that align well with ACCESS OM objectives, including youth programming to promote early case identification, implementation of barrier-free and user-friendly services, and the involvement of youth, families and community members at all levels of care. The Fish Net model also attempted, with no additional funding or support, to fulfil and implement the components of the First Nations Mental Wellness Continuum Framework (2015), jointly developed by the First Nations and Inuit Health Branch of Health Canada, the Assembly of First Nations, and

Indigenous mental health leaders from various First Nations. This framework highlights the importance of focusing on all areas of health, including emotional, spiritual, physical and mental wellbeing, and correspondingly hope, belonging, meaning and purpose.

## 4 | COMMUNITY MAPPING AND RESEARCH AS A TOOL FOR CREATING TRANSFORMATION

The ACCESS OM project began in Eskasoni in 2014 with numerous community mapping exercises. These exercises were facilitated by Eskasoni's relatively small geographical size allowing for convenient communication among its community services. Community mapping included creating a physical map of services and potential gaps, outlining and dissemination of community events, partnering with Kids Help Phone Interactive map, creating an online portal to accessing services, showcasing initiatives through artistic products and performances, conducting numerous focus groups, creation of videos and staff evolutionary meetings. Community mapping continues on an ongoing basis to ensure that services remains relevant, timely and responsive to the community by continuously identifying and remediating service gaps.

Mi'kmaq culture, tradition and language is deeply rooted within all aspects of Eskasoni's community life. Moreover, cultural connectedness has been reported to be strongly associated with indicators of mental wellness among First Nations youth (Liebenberg & Reich, 2016; Snowshoe, Crooks, Tremblay, & Hinson, 2017). Previous resilience research within the Eskasoni community (Liebenberg, Sanders, & Munford, 2016; Liebenberg, Ungar, & Vijver, 2012) has provided foundational information regarding core elements of youth resilience. These findings are in alignment with the Spaces and Places participatory action research initiative carried out in Eskasoni First Nation (Liebenberg & Reich, 2016; Liebenberg, Wood, & Wall, 2018), which outlined the following themes as pertinent to Eskasoni youth resilience: relational supports (family, Elders, friends and the broader community); engagement with culture, including language and nature; strong personal attributes like self-esteem; and holistic education. These themes have guided Eskasoni Mental Health Services in adjusting their services with the aim of fostering resiliency among youth accessing these programmes. The idea of centring services around an individual and their family, and their individual and collective needs, has been viewed as central to providing integrated holistic youth mental health services in Eskasoni. Moreover, in a community where youth make up a larger proportion of the population than in the previous generation, the strength of resiliency—and its connection to ancestral knowledge and ways of being and living—are of utmost importance.

## 5 | EARLY IDENTIFICATION

The Eskasoni mental healthcare service model contains a wide variety of approaches expressly designed to meet the first ACCESS OM objective, namely to increase the number of youth with mental health problems seeking services through early identification. In Eskasoni, the mental health staff members provide counselling support, facilitate mental health and well-being groups in the community and organize and facilitate sport, recreation, community and cultural activities. They meet youth and other clients (family members, carers) in the location of their choice—in the family home, in the community, on the land—and are outgoing, approachable and visible individuals within the community and to other community services (e.g., other health and school staff). Their outreach and visibility in the community are essential tools for reducing stigma, breaking down barriers to care and identifying those struggling as early as possible to connect them with appropriate services. The goal is to engage in activities that bring staff and youth together, establish relationships and build trust with the youth, whether they require mental health support or not. Should those youth require more specific mental health services in the future, they will have already forged a trusting bond with the mental health staff.

A wide variety of activities take place at the ACCESS OM Youth Space, renovated through funding from the ACCESS OM project. This acts to reduce stigmatization in a small community where stigma around mental healthcare, though improving, is still present. The community's youth have identified that it is important for them to be viewed in a holistic way, taking into account the balance between emotional, mental, spiritual and physical well-being outlined in the Medicine Wheel (Bell, 2014), and not to be seen only for their mental health concerns. The Eskasoni service model aims to attract all youth from the community, whether or not they require mental health support. Eskasoni youth see the ACCESS OM Youth Space as a safe and welcoming environment where activities are constantly occurring, and there is no differentiation between mental health programming and regular youth programming. Youth identified activities and programmes that interest them, including movie nights, youth dances, expressive art therapy, song writing circles, piano and guitar lessons, gamer nights, mixed martial arts sessions, exercise classes, traditional Native crafts, regalia making, sweats and language classes. Staff members also share their own Passion Projects (which began as an employee wellness initiative) with youth at the ACCESS OM Youth Space, including gardening, fishing, Wild Child nature programme and baking, to name but a few. Engaging youth in such programmes increases resilience among community youth and the chances of identifying youth in need earlier. Family members and carers often bring their youth to the ACCESS OM space to participate in activities, and then subsequently learn about other available services, or speak with mental health service providers about strategies to best support their young family members. Staff members (Trained Trainers) regularly provide training workshops to community members, especially youth, such as the Mental Health Commission of Canada's Mental Health First Aid for First Nations, Applied Suicide Intervention Skills Training (ASIST) and the Red Cross Healthy Youth Relationships to increase the community's awareness of mental health issues.

## 6 | RAPID ACCESS

The ability to access services when needed, and rapidly, is the second objective of the ACCESS OM framework. The underlying principle is

that youth in need, or those acting on their behalf, should be able to access someone for a first assessment within 72 hours of first contact, and such access should take place in an engaging environment that does not stigmatize the help-seeker. In Eskasoni, the methods through which rapid access is promoted include: availability of the ACCESS Clinician, other clinicians and youth peer support workers, use of the youth space and crisis centre, and ease of contact through social media and other modalities. To complement the benefits of the Youth Space, key staff members were added to the team in order to meet the objective of rapid access. As a result, a clinical psychologist, a behaviour interventionist, a youth worker, an intake worker and a research assistant were hired as a crucial part of the ACCESS OM transformation at Eskasoni. The ACCESS OM Research Assistant/Intake worker facilitates rapid access in two different ways: first, the intake and assessment process is accelerated as the worker obtains demographics and administers scales (e.g., Kessler Psychological Distress Scale, K10) to obtain initial clinical information from the youth; second, evaluation data is made available on a regular basis, providing timely information on emerging needs of community youth. For example, when data indicated trends of increased self-harm among youth seeking services, Eskasoni Mental Health Services responded with increased visibility of services through social media, public service announcements on local cable television, and school presentations, and held a staff consultation with a leading Nova Scotia self-harm care provider at the regional children's hospital.

Additionally, access to Eskasoni's services were largely barrier-free prior to ACCESS OM implementation; numerous modalities exist to contact support workers and service providers within the community, such as a toll-free telephone number and various social media platforms (including Messenger, Twitter, Facebook). Youth in Eskasoni also have rapid access to support through the Crisis/Distress/Central Intake and Referral Centre, which is open 24 hours a day, 7 days a week, year-round. Crisis staff are trained to identify individuals who may benefit from additional services and offer connection to those services. Although the Crisis Centre is funded through Eskasoni Band Own Source Fishing Revenue, and is not an ACCESS OM initiative, these staff work directly with ACCESS OM staff to facilitate connecting youth to support services, central intake and crisis intervention.

## 7 | APPROPRIATE CARE

Appropriate care is provided in accordance with the "Two-Eyed Seeing" approach (see above). In consultation with the clinician, youth are given the choice to have a standard Western mental health service, or an Indigenous method of improving well-being, or any combination of the two that they prefer. The Eskasoni team's Ladder of Care, which includes peer supporters with lived experience, paraprofessionals, baccalaureate, graduate and post-graduates, will often connect youth with multiple services, programs and providers. This approach allows youth seeking support to have access to a wide range of helping professionals (psychologists, social workers, family physicians), paraprofessionals (with certificates and diplomas in mental health and addictions), youth peer support, well-being activities and groups and supportive community members. Family physicians work collaboratively with the mental health practitioners in instances where youth require psychiatric medication. Indigenous traditions of improving mental wellness that may be offered include working with Elders in the traditional medicine garden, participating in land-based nature programmes and summer culture camps, taking part in traditional pipe ceremonies, sweat lodge ceremonies, naming ceremonies, Grandmother Moon ceremonies, blanket ceremonies and Letting Go ceremonies, and practicing traditional crafts such as drum making, beadwork and basket-making. This team approach, wherein youth have access to a range of supports, more effectively addresses the appropriate care of youth in need; not every young person experiencing distress necessarily requires extensive psychological services. Depending on circumstances, the care that a young person needs comes in different forms, whether it is reducing isolation, connecting to the land and one's culture, or a discussion with a counsellor in times of grief. For example, a young person may meet with a psychologist for in-office therapeutic services, as well as a youth peer supporter who is available between appointments for added support, or to help connect them with community programmes or services. Dedicated on-going communication between the support team and the youth is a key component to providing this approach to care.

A challenge is posed in providing appropriate care when youth require referrals for more specialized services, such as those of a psychiatrist, not available within the community. This remains difficult due to limited resources in the provincial healthcare system. The local health authority is experiencing a significant shortage of psychiatrists that has led to long wait times and difficulty connecting youth to these specialized services. Any local youth requiring specialized mental health service is required to travel four and a half hours to the hospital in Halifax to obtain services. This can impose a major stressor on an already vulnerable youth who may have to travel and remain in Halifax without an accompanying family member due to financial or other constraints. Use of tele-health services for accessing psychiatry and other specialized mental health services is an option that is being explored.

## 8 | CONTINUITY OF CARE

Another important objective within the ACCESS OM framework is the elimination of disruptions in service based on age when youth transition from youth to adult services. Instead, transitions are based on needs and seek to encourage prompt, seamless and continuous access to care. In Eskasoni, this objective of elimination of age-based disruptions in service was already met prior to the ACCESS OM project. The aforementioned amalgamation drew multiple services under one team umbrella and mental health services are offered from "womb to tomb," meaning that the whole community is served across the lifespan. A client who has built a relationship with a clinician or service provider over time does not need to worry about having to "start over" with a new clinician or being discharged from services because they have "aged

out." Transitions to a new service or another provider are based on the client's need and desire rather than age restrictions.

## 9 | YOUTH AND FAMILY ENGAGEMENT

Meaningful engagement of youth and their families and carers has been a key principle and objective of ACCESS OM nationally, and is readily embodied in Eskasoni, assuring that the services created are inviting, effective and cater to the needs and preferences of youth in the community. Such engagement is likely to increase participation in services, decrease drop-out rates and maximize benefits for service users. Several methods have been used to engage youth locally. A local youth council was created to design the ACCESS OM Youth Space, and continues to contribute to the creation of programming, activities and services. ACCESS OM team members regularly visit the local schools, seeking feedback on current services and programs, and gathering suggestions for future activities. The ACCESS OM Youth Space also provides programmes meant to engage entire families. For example, the ACCESS OM Youth Space hosts parenting programmes and "special needs" support groups facilitated by ACCESS OM and Eskasoni Mental Health Services team members.

One transformation that occurred in service provision in response to youth feedback was broadening means of communication and removing barriers to accessing services. Youth expressed that they would like to be able to self-refer online, and reach out through social media to begin the process of engaging in services. As a result, the site team uses social media such as Facebook to advertise events at the Youth Space, online messaging to communicate with youth, Instagram and Twitter to share photos and news, and maintains a website to reach a wider audience. Eskasoni is also currently working to launch an online self-referral platform.

## 10 | RESEARCH AND EVALUATION

Since July 2016, the Eskasoni First Nation team has been carrying out the ACCESS OM Evaluation Protocol, recruiting youth receiving services and engaging them in providing feedback on outcomes and satisfaction with services, both on the clinical/individual level, as well as at a site-level. To promote integration of the ACCESS OM evaluation into the entire mental health service, the entire site team participated in the initial knowledge sharing and training sessions facilitated by the ACCESS OM central office team. As well, many of the site team members perform data collection and entry using Dacima software, the online electronic database system that the network is using to manage data. Evaluation data provides information on emerging needs and will allow our site to evaluate the quality of mental health care offered, identifying interventions effective at improving youth mental health. Participation in the ACCESS OM evaluation may also provide a powerful tool for lobbying for sustainable funding and policy change related to youth mental health in First Nations communities.

## 11 | DISCUSSION

One of the advantages of being a part of the pan-Canadian ACCESS OM initiative is that while all sites aim to achieve the same objectives, each site is also encouraged to customize the implementation to unique site populations. The ACCESS OM Eskasoni First Nation team takes a "human first" mentality; foundational to everything is to meet people where they are (physically, geographically, socially, spiritually and emotionally), engage them in what interests them, and teach and learn about wellness from a holistic perspective. Culture is embraced as the underpinning of mental wellness programmes, addressing the need for cultural competency and humility embedded within service delivery (Kirmayer et al., 2000; Kirmayer, Tait, & Simpson, 2009). Through an integrated Two-Eyed Seeing approach, both Indigenous- and Western-influenced methods of wellness and treatment are implemented and honoured, providing youth access to culturally appropriate and engaging mental health services. An emphasis on promotion, prevention, education and community involvement in these culturally competent and client-centred services aims to strengthen youth resilience and to promote early identification and engagement of young people at risk of progressing to development of a mental disorder. Within a First Nations framework, helping those with even complex mental health needs is inextricably linked with the holistic promotion of mental wellness. As stated in the First Nations Mental Wellness Continuum Framework (2015): "Mental wellness is supported by culture, language, Elders, families and creation and is necessary for healthy individual, community and family life."

As with any time-limited funded research project, an ongoing challenge to the ACCESS OM team in Eskasoni is finding long-term funding for the transformations taking place. Sustainability is a constant pressure. Many mental health initiatives encountered in First Nations communities in Canada are obtained via demonstration sites, pilot projects or proposal driven initiatives. Limited by staff who also provide frontline services, the Eskasoni team is in a constant state of writing and submitting proposals to granting agencies and charitable organizations, to supplement staff salaries and funding of programming. This is a systemic problem with the way in which Indigenous communities are funded for mental health services in Canada (mainly from a combination of federal, provincial and local Band funding). Additional challenges are caused by the fact that with increased visibility in the community comes an increase in youth seeking mental health services, which can challenge the capacity of the service. Lastly, an outstanding challenge is around family/carer engagement. Although youth present more readily for services, and it would seem that stigma has been reduced in general, many youth are still hesitant to involve family members in their care journey. The site team aims to address ways to support families and carers while still honouring the wishes of youth and maintaining confidentiality. The ACCESS OM team in Eskasoni regularly seeks feedback from youth service users, youth council members, their support systems and the community on ways to improve services.

While issues of sustainability, program funding, scale-up and capacity of service providers to meet service demands remain a constant challenge, a major strength has been the ability of the Eskasoni youth mental

health team to attract staff who are enthusiastic, competent, dedicated, passionate, and who really want to work in Eskasoni. The Eskasoni First Nation team aims to support other Indigenous communities undertaking similar transformations, and hopes to act as a model for future communities who seek to improve mental healthcare services for their youth.

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## CONFLICT OF INTEREST

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Transforming youth mental health care in a semi-urban and rural region of Canada: A service description of ACCESS Open Minds Chatham-Kent

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## Abstract

**Aim:** This study describes how mental health services for youth are being transformed within the context of a semi-urban and rural region of Canada (Chatham-Kent, Ontario), based on the framework of ACCESS Open Minds (ACCESS OM), a pan-Canadian youth mental health research and evaluation network.

**Methods:** Transformation has focused on the five key objectives of ACCESS OM, namely early identification, rapid access, appropriate care, continuity of care, and youth and family engagement. A community mapping process was conducted at the beginning of the transformation to help develop a comprehensive inventory of services, identify challenges and optimize partnerships to address the five key objectives.

**Results:** The following strategies represent key elements in the transformation: coordination and partnerships between hospital, community and voluntary organizations, as well as different sectors of the community (e.g., Child and Youth Services, Education, Community Safety and Correctional Services, CSCS); working with local champions (e.g., Youth Diversion Officer and the Mental Health and Addictions Nurse in the school sectors); establishing a youth-friendly space in a central part of the community, where services are co-located and operate within an open-concept design; training of ACCESS Clinicians to conduct an initial assessment; engaging youth and family in service-level recruitment, planning, daily operations, and evaluation, including hiring of youth and family peer navigators; and, engaging the community through awareness and educational events.

**Conclusions:** The success of this transformation needs to be measured on various outcome parameters, but it is notable that neighbouring communities are already beginning to implement a similar model.

KEYWORDS

access, community participation, health care quality, mental health services, youth mental health, Canada

Paula Reaume-Zimmer and Shalini Lal are joint senior authors.

## 1 | INTRODUCTION

Young people in Canada experience significant challenges in accessing mental health services, including delayed identification of mental health issues, long wait lists and abrupt transitions in care (Malla et al., 2018). These barriers are compounded in rural, remote, and Indigenous communities where geographic, economic and cultural factors also influence access to services (Boydell et al., 2006). To respond to these challenges, ACCESS Open Minds (ACCESS OM), a pan-Canadian project aiming to transform and evaluate the way mental health services are delivered to youth between the ages of 11 and 25 in 14 diverse communities, was initiated in 2014 (Malla et al., 2018). In this study, we describe how service transformation occurred during the initial implementation phase in the semi-urban and rural region of Chatham-Kent.

## 2 | COMMUNITY CONTEXT

Chatham-Kent is mostly a rural municipality, located in the south-western region of Ontario, Canada with a population of 101 647, including 11 595 residents between the ages of 15 and 24. The vast majority of residents speak only English (97 790) with a minority speaking only French (2245); 5270 persons indicate being of Indigenous origin (Statistics Canada, 2017). Homelessness has become an issue in this municipality and there have been recent efforts to address this, for example, through the implementation of a Housing First Homes 4 Youth (Homes for Good) Intensive Case Management Supportive Housing program (Chatham-Kent Housing & Homelessness, 2017).

### 2.1 | Status of youth mental health services prior to ACCESS Open Minds transformation

Historically, mental health services in Chatham-Kent have been delivered through a collaborative structure between a public hospital and a community organization. This structure includes: (a) the Chatham-Kent Health Alliance (CKHA), a publicly funded hospital providing inpatient and outpatient mental health and addiction services and (b) the Canadian Mental Health Association Lambton-Kent (CMHA-LK), a national not-for-profit organization promoting mental health and providing recovery-oriented mental health services. An integrated leadership approach, wherein both organizations are led by the same Director of Operations and the Chief of Psychiatry, facilitates continuity of care, efficient use of human resources, and sharing of data through an electronic health record system. Within this context, six psychiatrists provide specialized mental health services (e.g., eating disorders, addictions and first episode psychosis), general psychiatric services for long-term care, and telepsychiatry services for individuals in rural communities. Moreover, children and adolescents with mental health issues were referred to CKHA or to Chatham-Kent Children's Services.

### 2.2 | Challenges pertaining to youth mental healthcare

Despite the unique collaborative structure between the hospital (CKHA) and community organization (CMHA-LK), youth visits to hospital emergency departments and demand for services were increasing each year. Navigating the system was complicated for youth and their families with several factors contributing to these challenges, including: (a) services operating in a siloed manner with significant overlap; for example, Chatham-Kent Children's Services provided mental health services to individuals under 18, while the CMHA-LK offered services to individuals 16 and over, resulting in uncertainty regarding where individuals between 16 and 18 should access care; (b) lack of coordination among mental health education and awareness initiatives; (c) limited access to a child psychiatrist with paediatricians often filling this void and referring youth to a local psychiatrist for shared care or consultation; (d) no inpatient child and youth mental health services; and (e) minimal awareness of existing protocols, frameworks or structures to coordinate operations among community organizations providing services to youth.

## 3 | TRANSFORMING YOUTH MENTAL HEALTH SERVICES IN CHATHAM-KENT

### 3.1 | Community mapping

In January 2015, a community stakeholder meeting was facilitated by an international leader in innovation and change management who had been involved in many of the region's discussions related to youth mental health services. The purpose of the meeting was to introduce agencies delivering youth-focused services to the opportunity of establishing a youth hub in Chatham-Kent. Stakeholders attending this meeting included mental health and addictions services; social services, such as housing and employment; partners in the education sector; youth police diversion services and community organizations.

At the beginning of the meeting, each agency identified gaps in youth mental health services; however, as this process unfolded, the list of gaps reduced significantly as each agency became aware of the services that existed in the community. Next, an operational planning working group was formed to develop a comprehensive list of existing mental health and related community resources and to identify gaps in services. Two ACCESS OM ambassadors (a family peer navigator (PN) and a community volunteer) then took the lead in establishing a more detailed inventory of services and gaps. They approached each agency, inquiring about resources and services, compiling a list of stakeholders, their program type, and their type of contribution to the service transformation, as illustrated in Table 1.

## 4 | MEETING ACCESS OM OBJECTIVES

Building on the insights gained through community mapping, ACCESS OM Chatham-Kent created capacity by bringing together existing

**TABLE 1** Description of stakeholder organizations (listed alphabetically) and their involvement in the transformed service

| Agency | Program type | Frequency | Description |
|---|---|---|---|
| ACCESS Open Minds (ACCESS OM) Youth Advisory Council | Core/Peer Support | As needed | Chatham-Kent youth who contribute to ACCESS OM by providing expertise to ensure that the ACCESS OM Chatham-Kent site is youth friendly |
| Canadian Mental Health Association (CMHA)<br>• MH First Responder<br>• Case Manager | Core/Adjunct | Two permanent offices; and on an as needed "walk-in" basis | Youth Transitional Case Management: Provides case management services with a strength-based, goal-oriented approach that empowers and provides clients with the tools to independent recovery<br>First Response Team: Initial first assessment and triage into mental health and related community services |
| Chatham-Kent Children's Service | Core | Daily | Provides counselling sessions (non-crisis and crisis) and brief services (single sessions for non-crisis situations and walk-in clinic). Provides mental health assessments or inpatient care |
| Chatham-Kent Police Services | Adjunct | As needed | Provides an alternative for youth to receive counselling and education while providing restitution to the victim instead of the youth being charged with the offence involved and attending court resulting in a possible criminal record |
| Chatham-Kent Public Health Unit | Core/Adjunct | As needed | Provides smoking cessation, counselling and support (group or individual). Also offers mental health/well-being programs (friends programming and teaching cognitive and emotional skills) |
| Chatham-Kent Recreation | Adjunct | As needed; provides offsite opportunity | Provides recreation opportunities such as swimming, arenas, fit parks multi-trails, parks and open spaces. Goal is to get "more people, more active, more often" in a positive, safe environment |
| Community Care Access Centre-Erie St. Clair (CCAC) | Adjunct | | Provides school support, assessments, interventions and support to students with mental health and or addictions issues. Provides consultation and education services to district school board staff in relation to mental health and/or addictions |
| Family Service Kent (FSK) | Adjunct | Daily | KIDS Team coordinates access to various services and supports for children/adolescents (0-18) with complex needs that may require a response from more than one service provider |
| Lambton Kent District School Board (LKDSB) | Core/Section 23/ Adjunct | As needed | Connecting to school mental health supports including psychoeducational clinicians, social workers, and child and youth workers |
| Make Children Better Now | Adjunct | As needed | Offers one-on-one counselling to victims, bystanders and family for the betterment of a "child's life" through active listening in a non-judgmental and empathetic way |
| Mental Health and Addictions Program (MHAP) | Core | Daily | Provides early intervention, assessment and treatment for individuals experiencing early signs and symptoms of psychosis. In addition, provides Mental Health and Addictions counselling services inclusive of eating disorders therapy |
| Mental Health Network (MHN) | Core | As needed | Peer support and daily health and wellness programming for individuals with mental illness |
| Rain & Shine Behavioural Counselling | Core/Adjunct | As needed | Counselling and programs utilizing Applied Behavioural Analysis and Cognitive Behavioural Therapy to address behavioural issues |
| St. Clair Catholic School Board (SCCSB) | Adjunct | As needed | Connecting to school mental health supports including psychoeducational clinicians, social workers, and child and youth workers |
| Restorative Justice | Adjunct | As needed | Alternative pathways for youth 7-17 who are at risk for delinquent, negative behaviours, and may be struggling in school, at home, and/or within their social environments |

**TABLE 1** (Continued)

| Agency | Program type | Frequency | Description |
|---|---|---|---|
| Today Not Tomorrow (TNT)—Parent Group (Early Intervention for Psychosis) | Core/Adjunct/Peer Support | Daily/as needed | Provides recovery-based program offering support, information and tools to families whose loved ones have had a first-time psychosis |
| Western Area Youth Services (WAYS) | Core/Adjunct | As needed | Goal-focused counselling and mental health support, including telephone crisis support |

resources to ensure that youth in need were connected to the appropriate providers. The aim was to reduce duplication of resources and address the disjointed experience of youth and their families in going from agency to agency, sometimes receiving overlapping or even contradictory services. Various youth services were integrated to optimize continuity of care and increase capacity through efficient sharing of resources and responsibilities. Next, we describe the specific strategies used in addressing the five primary objectives of the ACCESS OM model of service transformation.

## 4.1 | Early identification

ACCESS OM Chatham-Kent has implemented several strategies to improve early identification of youth in need of services. For example, the site has conducted community-wide education to increase mental health awareness and promote the service as a central point for youth referrals, targeting stakeholders at the frontline and leadership level including: two Chatham-Kent School Boards, Home and Community Care, Mental Health and Addiction Nurses, Chatham-Kent Police Services Youth Officer, Primary and Specialized Practitioners, the CKHA Mental Health and Addictions Program, and the CMHA-LK. A mental health promotion specialist, employed by CMHA-LK, has delivered presentations at work, school, and public education events on early identification, basic coping strategies, information on where youth could seek mental health services, and what to expect from ACCESS OM Chatham-Kent. This specialist also collaborated with the Youth Diversion Officer in giving presentations to service clubs including Cogeco programs, May Court Club, the Lions Club and the Rotary Club.

All community organizations providing youth-focused services were invited to the site's initial launch in May 2016 and the grand opening of its permanent physical space in May 2017. Organizations set up booths in the new physical space to promote their work, which also provided an opportunity for strengthening mutual awareness and inter-organizational connections. In addition, ACCESS OM Chatham-Kent, through a partnership agreement, engaged with the Municipality of Chatham-Kent's income and housing program ("Homes 4 Youth—Home for Good") to identify youth at risk of becoming homeless (e.g., those who have dropped out of high school) and provide them with safe and affordable housing.

As part of the community education initiatives, youth have been involved in creating visually appealing marketing materials (e.g., pins, posters, business cards) using the slogan "What's your emoji?" (see Figure 1). These materials are disseminated during community awareness events with the aim of engaging audiences in a fun and interactive way in discussing how to recognize, relate to, and help youth connect to mental healthcare. ACCESS OM Chatham-Kent has also participated in radio interviews, has been featured in local news articles, and has disseminated agency-specific communications for broader community exposure. In addition, the site manages a website and a Twitter account, and it has hosted a well-publicized Twitter live-chat targeting youth.

In the first year of ACCESS OM Chatham-Kent operation (May 2016-March 2017) there was an increase in the numbers of youth seeking mental healthcare by approximately 25% in comparison to the previous 12 months, including adolescents aged 15 and under. This increase could be attributed to the prominent location of the new physical space (ie, downtown centre), coordinated approach between partnering organizations, and awareness activities. Figure 2 illustrates how youth have learned about ACCESS OM Chatham-Kent and the key role community partners have had in this process.

## 4.2 | Rapid access

To facilitate rapid access to an assessment within 72 hours (an ACCESS OM objective), a "youth space" was developed as the "go-to" place for youth, families, and friends seeking mental health-related support and services. Many core services (e.g., counselling, housing, case management and psychiatry) have been co-located in this youth space using an open-concept design. This co-location has removed barriers to care through removing walls, transforming the

**FIGURE 1** Illustration of "What's your emoji?" marketing materials, co-designed by young people, used at community events

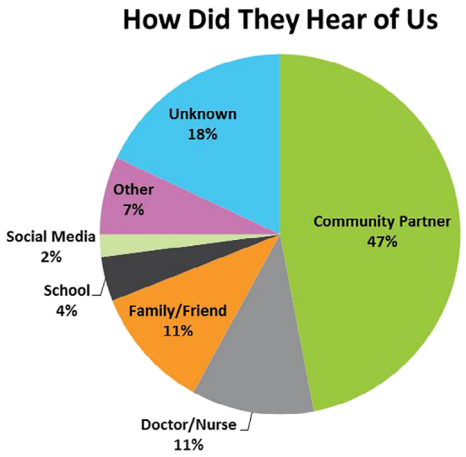


**FIGURE 2** Summary of how youth learned about ACCESS Open Minds Chatham-Kent

way service providers conduct their daily work. This approach prevents individuals from being unnecessarily referred out to multiple locations and aims to improve continuity of care through a coordinated, unified approach to treatment planning.

Youth and family peer workers are the initial points of contact helping to engage individuals seeking help and identifying their needs. Including peer workers at the initial point of care aims to reduce the demand for specialized services (e.g., psychiatric consultation) and avoid unnecessary services as in our experience, sometimes all that is needed is to be heard and supported from someone with live experience. Youth have access to an inter-professional team, including ACCESS Clinicians (social workers, nurses and occupational therapist), trained to conduct an informative and engaging initial evaluation. A clinical coordinator/social worker assists with triaging individuals who need case management support vs counselling vs psychiatric consultations. When an initial evaluation indicates that a youth may be in acute crisis, a mental health nurse from the CKHA is invited to the youth space, and accompanies the youth to emergency or inpatient services, whenever possible. This procedure aims to facilitate a less traumatic experience for youth who may need inpatient care. Another key strategy deployed to facilitate rapid access is that no referral or clinical diagnosis is required to receive ACCESS OM services.

### 4.3 | Appropriate care in 30 days

The majority of services provided by the site are located within shared office space, facilitating access to appropriate care within 30 days. These services include: (a) youth and family support, including a dialectical behaviour therapy skill-based group for family members called "Family Connections" providing education and skills (e.g., emotion regulation, problem management, effective communication) to effectively engage with youth; (b) psychological therapy for up to 14 sessions as per provincial guidelines; (c) Housing First Homes 4 Youth program; (d) single-session walk-in therapy two days a week for individuals who are not in crisis, not judged to have serious mental health problems such as psychosis, bipolar disorder or major depression, and are seeking an immediate response. Single-session therapy with a professional counsellor is based on the ideas that most clients can benefit from a single session; in many cases one session may be all that individuals attend; and for many, a single session is sufficient to reduce distress (Hymmen, Stalker, & Cait, 2013; Slive, McElheran, & Lawson, 2008; Stalker et al., 2016). Single-session therapy is a point of entry into care, providing an opportunity to engage youth, offer immediate services, and proceed to an ACCESS OM assessment. This immediate access is designed to make services available to individuals who are ready to access therapy and reduce the issue of no-shows; (e) consultation and treatment provided by .3 FTE (1.5 days) psychiatrists; (f) life skills training and focused specialized services, including the Today Not Tomorrow early intervention for psychosis service and (g) social networking groups.

Youth requiring interventions not offered in the ACCESS OM space (e.g., long-term follow-up for bipolar disorder) are referred to appropriate services, with support provided to youth and families until the appropriate intervention commences. Such referrals and navigation support are facilitated by strong links between ACCESS OM and other mental health services in the community, and staff from these other services who spend time in the ACCESS OM space.

### 4.4 | Continuity of care

ACCESS OM Chatham-Kent was built on pre-existing work towards integration to improve youth experiences of mental health services. This preliminary effort has resulted in a fundamental partnership between children's mental health services, hospital, and the adult mental health sector, and has produced strategies for improving continuity of care. For example, the emergency department diversion program was established two years prior to ACCESS OM, where children's services were on-call to complete an assessment for any youth arriving in the emergency department. This practice is helping to raise awareness in terms of what community services can offer as an alternative to hospital admission. Furthermore, with Chatham-Kent Children's Services offering services within the ACCESS OM physical space, youth no longer experience the abrupt change at age 18 in terms of where they receive services. Youth can continue to receive services in the same location and maintain proximity to a former counsellor. Counsellors facilitate seamless transitions through introducing and accompanying youth in their first interactions with new counsellors, and even continuing to provide services using a shared care approach, while the client establishes a therapeutic relationship with the new counsellor. Youth and family have expressed appreciation for being able to receive services in a familiar setting, including being greeting by the same receptionist who has received them in the past.

### 4.5 | Youth and family engagement

Youth and families have been actively involved in the establishment and operation of the site, raising awareness in the community, and

providing leadership on youth and family engagement at the national level of the network.

*Establishing the site and contributing to its daily operations.* Members of the site's youth advisory committee have contributed to choosing the location of the space, meeting with realtors, touring potential facilities, and designing the space. The latter included selecting themes for individual rooms and contributing ideas on the "look and feel" of the common space, which has been decorated with youth-made art. This process contributed to youths' decision-making skills, as they often needed to make choices in relation to feasibility and priorities.

Youth and families participate in the site's daily operations. The program employs two Youth PNs and a Family Navigator; they are often the first individuals whom visitors meet upon entering the centre and are part of the clinical team. They are trained in Mental Health First Aid (Kitchener & Jorm, 2002) and active listening, and aim to provide empathic support, helping visitors feel like they are not alone. This can also be a fulfilling employment opportunity for those who have experienced the mental healthcare system and subsequently want to help their peers. Youth and families also contribute to decisions regarding staff hiring by participating in interviews and sharing feedback on candidates' ability to engage, level of passion, shared vision, and understanding of ACCESS OM. In terms of program planning and evaluation, the Family Navigator participates in the Quality Committee, challenging existing practices and providing feedback on new initiatives, and the Youth Navigators are trained to support data collection activities for research and evaluation.

*Promoting ACCESS OM.* Youth and family representatives have become site ambassadors, attending all promotional events, participating in radio interviews, hosting the launch events and giving public presentations. Some of the youth and family representatives have employed positions within the site (e.g., PNs) whereas others are volunteers who are often compensated through gift cards, meals and reimbursement for travel. Leaders in the community, healthcare and social services, private funders, and policy-makers have been eager to hear directly from youth, seeking their approval on every issue and event.

*Providing leadership and support at the national level.* Youth and family leaders from the site are members of the ACCESS OM National Youth and Family and Carers Councils and have served as role models to other ACCESS OM sites in youth and family engagement practices (e.g., supporting ACCESS OM Edmonton in their creation of a family peer support position to offer Family Connections groups). This modelling role has further empowered Chatham-Kent's youth and family leaders.

## 5 | ACTIVE INVOLVEMENT OF VOLUNTARY ORGANIZATIONS AND COMMUNITY MEMBERS

Community engagement has been instrumental to the establishment of the physical space and the services offered. For example, a local contractor who contributed to the street-scape design of the space volunteered services for additional projects, stating, "If this service existed when I was younger, I would have looked for help." Moreover, the Chatham-Kent community has supported ACCESS OM in various ways, including unsolicited donations from local high schools, philanthropic organizations, private industry and family members. The Rotary Club has played a consistent cornerstone role by providing seed funding for programs, and donations for furnishings and numerous public events.

## 6 | RESEARCH AND EVALUATION

Service evaluation is conducted through the implementation of the ACCESS OM Evaluation Protocol. To facilitate engaging youth in both clinical and research activities, we created a joint position integrating PN and Research Assistant (RA) functions. The PN/RAs received training from the ACCESS OM central office and contribute to ongoing data collection at the site. Having two PN/RAs share roles ensures that they do not duplicate work and are able to support each other. Integrating peer navigation with research/evaluation aims to ensure continuity, team communication and youth understanding of the importance of research/evaluation in youth mental healthcare.

## 7 | SUSTAINABILITY

Several strategies are being implemented towards achieving sustainability. For example, participating organizations are identifying opportunities to maximize the use of existing resources and funds that have been invested in the ACCESS OM model. To illustrate, the early psychosis program has expanded its scope to providing services for individuals experiencing anxiety and mood disorders. In addition, the site has participated in numerous local, regional, provincial, and national presentations to further promote ACCESS OM as a core component of the community. Community champions such as the Youth Diversion Officer and the Mental Health and Addictions Nurse in the school sectors continue to introduce ACCESS OM as a key resource for youth seeking help. Although the donations received from the community are one-time gifts, and sources of sustainable base funding continue to be explored, donors have expressed the value that ACCESS OM brings to the community and recognize the critical need for it to remain a core service.

Inter-ministerial and private sector collaborations have also contributed to sustainability of ACCESS OM Chatham-Kent. Involvement of other provincial ministries, including Health, Child and Youth Services, Education, Police Services and the local municipality, are indicators of the community coming together to transform youth mental health services. Furthermore, the Ontario Ministry of Health is now committing to an initial investment of 10 hubs to promote youth wellness in Ontario (Youth Wellness Hubs Ontario, YWHO), one of them being in Chatham-Kent.

## 8 | COMMUNITY IMPACT

The site team was the proud host for the launch of the provincial YWHO initiative, where leaders, front-line staff, youth, and peers from outside the community visited the site to witness what can be achieved in a modest-sized community. The site team has also been overwhelmed with meeting requests, site tours, and formal conference presentations, and has taken time to accommodate each one, recognizing the importance of building awareness about such an innovative youth mental health endeavour. There are current efforts to expand similar services to a neighbouring city (ie, Sarnia, Ontario); this new project is already garnering similar attention and coalescing local passion as in Chatham-Kent.

## 9 | DISCUSSION

We have described how the five objectives of ACCESS OM have been implemented in a mostly rural and semi-urban Canadian community to improve mental health services for youth. A key element of the transformation has been to establish a youth-friendly space in a central part of the community, where services are co-located and operate within an open-concept design. Within this shared-space, youth and family engagement is integral to the planning, operations, evaluation and promotion of services. ACCESS Clinicians are critical to ensuring youth receive informative and engaging initial assessments and care. Coordination and partnerships between hospital, community and voluntary organizations; engagement of different service sectors (e.g., Child and Youth Services, Education, Police Services); and working with local champions (e.g., Youth Diversion Officer), have been core strategies for facilitating early identification of youth in need and supporting sustainability.

## 10 | CHALLENGES

Several challenges have been experienced in transforming the services; these pertain to shared-decision-making between stakeholders, recruitment and retention of qualified staff in a semi-urban and rural setting, staff going on temporary leave, acquiring sustainable funding, providing services to individuals living in rural settings (including Indigenous communities) located at a distance from the ACCESS OM Chatham-Kent physical site, and maintaining capacity to deliver services with increasing numbers of youth being referred. To address these challenges, ACCESS OM Chatham-Kent has made progress towards improving access to remote communities through embracing technology and creating community partnerships in various rural locations in an effort to improve awareness, early detection of mental illness, and strengthen linkages with AOM services. The next stage of transformation will be focussed on developing and implementing strategies to address the needs of youth living in Indigenous communities.

Working in a model of shared-decision-making between stakeholder groups has also been a learning process. For example, during the renovations of the youth space, contractors created a graffiti wall without the knowledge of the youth advisory committee. This initially invoked a sense of panic among the leadership team since the decision had been made without youth involvement. Although it was an uncomfortable unveiling, the youth advisory council was pleasantly surprised. This incident reinforced the value of transparency and the practice of "nothing for youth, without youth."

Establishing a human resource base with a clear understanding of ACCESS OM's objectives has also been a key challenge. There is a need for therapists, community social workers, and psychiatrists who can engage youth and appreciate the challenges that transitional age youth experience. Sustainable funding is also a challenge. Grant proposals and business case submissions have helped to maintain funding for ACCESS OM. The Chatham-Kent site is optimistic that this model is now on the radar of their provincial Ministry of Health, as evidenced through the investment towards the YWHO initiative. While helpful in building awareness and promoting buy-in for sustainability, engagement and education events take resources away from direct services. This responsibility has now mostly shifted to a mental health promotion specialist, thus reducing demand on direct service providers.

## 11 | CONCLUSION

ACCESS OM Chatham-Kent has the privilege of being the only site in Ontario to participate in the pan-Canadian ACCESS OM project. A sense of commitment among various community stakeholders has been instrumental in driving youth mental health services transformation in Chatham-Kent. The transformation has entailed partnership between mental health and addiction services, youth and families, community organizations and volunteer organizations. The lessons learned from establishing this youth-oriented model serve as inspiration for similar projects, particularly in similar geographic and organizational contexts.

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## CONFLICT OF INTEREST

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# ACCESS Open Minds at the University of Alberta: Transforming student mental health services in a large Canadian post-secondary educational institution

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## Abstract

**Aim:** Demands for mental health services in post-secondary institutions are increasing. This paper describes key features of a response to these needs: ACCESS Open Minds University of Alberta (ACCESS OM UA) is focused on improving mental health services for first-year students, as youth transition to university and adulthood.

**Methods:** The core transformation activities at ACCESS OM UA are described, including early case identification, rapid access, appropriate and timely connections to follow-up care and engagement of students and families/carers. In addition, we depict local experiences of transforming existing services around these objectives.

**Results:** The ACCESS OM UA Network has brought together staff with diverse backgrounds in order to address the unique needs of students. Together with the addition of ACCESS Clinicians these elements represent a systematic effort to support not just mental health, but the student as a whole. Key learnings include the importance of community mapping to developing networks and partnerships, and engaging stakeholders from design through to implementation for transformation to be sustainable.

**Conclusions:** Service transformation grounded in principles of community-based research allows for incorporation of local knowledge, expertise and opportunities. This approach requires ample time to consult, develop rapport between staff and stakeholders across diverse units and develop processes in keeping with local opportunities and constraints. Ongoing efforts will continue to monitor changing student needs and to evaluate and adapt the transformations outlined in this paper to reflect those needs.

KEYWORDS

accessibility, intake, post-secondary campus health services, service transformation, student mental health, youth mental health, Canada

Helen Vallianatos and Jai L. Shah are joint senior authors.

## 1 | INTRODUCTION

While a growing body of research speaks to the urgency and complexities of youth mental health, more work is needed to define and understand effective approaches for youth in Canada (Malla, Iyer, Shah, et al., 2018; Malla, Shah, Iyer, et al., 2018). ACCESS Open Minds (ACCESS OM) is committed to developing and evaluating the impact of a framework of care that can be implemented across diverse sociocultural contexts in Canada.

One of 14 such sites, the University of Alberta (UA) is the only setting within the ACCESS OM network centred in a post-secondary educational institution. The mental health of post-secondary students requires further investigation, as concern over a "crisis" in mental health for this segment of the population has escalated in popular discourse (CMAJ, 2017; Kadison & DiGeronimo, 2004; Lunau, 2012; Payne, 2017; Purdon, 2017). Studies have shown that the growth of mental health problems affecting post-secondary students spans the globe (Eisenberg, Hunt, & Speer, 2013; Liu et al., 2017; Macaskill, 2013; Stallman, 2010; Storrie, Ahern, & Tuckett, 2010). The stressors of post-secondary student life, especially for first-year students, can exacerbate mental health difficulties, as students navigate financial constraints, academic and volunteer commitments, and new social networks—often for the first time. These concerns are mirrored in Canada, where post-secondary students face similar stressors that affect their mental health alongside financial, academic, and physical wellness (Kirsh et al., 2016).

While the rate of help-seeking among students is relatively low (Reavley, McCann, & Jorm, 2012b), more students are self-disclosing mental illness and there is increasing use of campus mental health services both in Canada and internationally (Beiter et al., 2015; Gunnell, Kidger, & Elvidge, 2018; Hunt & Eisenberg, 2010; Lipson, Lattie, & Eisenberg, 2018; Mowbray et al., 2006). The post-secondary context therefore provides a unique opportunity to both transform existing mental health services and foster adaptive and coping strategies that students will carry with them for life. The implementation of the ACCESS OM framework at UA is focused on first-year students attending this large university, a group between the ages of 18-25.

An important element for investigating the post-secondary mental health landscape is to recognize the diversity between and within institutions. UA is a large research-intensive university, with 18 faculties. Approximately 38 000 students attend UA, with most (81%) being undergraduates—although there are 500 graduate programmes offered as well. The student body is broad, with many students coming from rural and remote areas, including a growing number of First Nations, Métis and Inuit students, and a large contingent of international students (~21% of the total student population). In addition, there is an increasing diversity in ages of undergraduate students and a growing number of students who are themselves parents. Each of these student communities may have different levels of vulnerability to mental health problems and different coping and help-seeking capacities (Currie, Wild, Schopflocher, Laing, & Veugelers, 2012; Jaworska, De Somma, Fonseka, Heck, & MacQueen, 2016; Popadiuk & Arthur, 2004; Reavley, McCann, & Jorm, 2012a). Together, this diverse and changing student body should impact upon how student services are designed, advertised and delivered (Reavley & Jorm, 2010).

### 1.1 | Historical context

In December 2012, the then-Interim Dean of Students was commissioned by the university's Provost to lead a reorganization of campus mental health services to address rising demand (Figure 1). This reorganization was based on best practices in post-secondary mental health services at that time (Cornell Mental Health Framework, n.d.; Eisenberg, Golberstein, & Hunt, 2009; Silverman, Underhile, & Keeling, 2008); a revised report was completed in 2015 (Everall, 2015). One outcome was the addition of community social workers (CSWs) as central figures in the service landscape. Rather than traditional one-on-one clinical social work, the work of CSWs aims to destigmatize mental illness, build mental health literacy and community capacity, educate students on coping and life skills, and ultimately to create opportunities that foster a culture of support and resiliency (along with destigmatizing access to formal services, if needed) while students learn to navigate the stressors that accompany university life.

A further outcome of the reorganization was a shift in the intake model at the university's Counselling and Clinical Services (CCS). Prior to the reorganization, intakes for counselling services functioned essentially on a first-come, first-serve basis. Given the increasing demand, a weeks-long wait list quickly formed; those who did not have the capacity to call daily would not receive an appointment. In 2013, an intake model was implemented where students could book an intake consultation with a clinician (Mental Health Consultant, psychiatric nurse, etc.) within 72 hours of first contact, followed by referral to appropriate care or suggestions for other campus or community resources. This initial consultation essentially functioned as a triage point, allowing the team to identify and prioritize the most serious cases requiring immediate care. Typically, during peak stress times (e.g., final exams), staff were only able to see critical or urgent cases, leaving those with mild-moderate concerns waiting.

While the mental health service landscape had significantly improved with the triage model in CCS and the community work of CSWs, demand continued to increase and students with mild-moderate concerns were increasingly unable to access service. This was a lost opportunity for early intervention, as students typically could not access CCS services until their mental health problem had escalated. Furthermore, when students were referred to resources elsewhere (campus or community), there was no means of follow-up. It is in the midst of these increasing demands on mental health services that ACCESS OM entered the scene, specifically in providing a framework to improve early intervention and enhance rapid access to appropriate care.

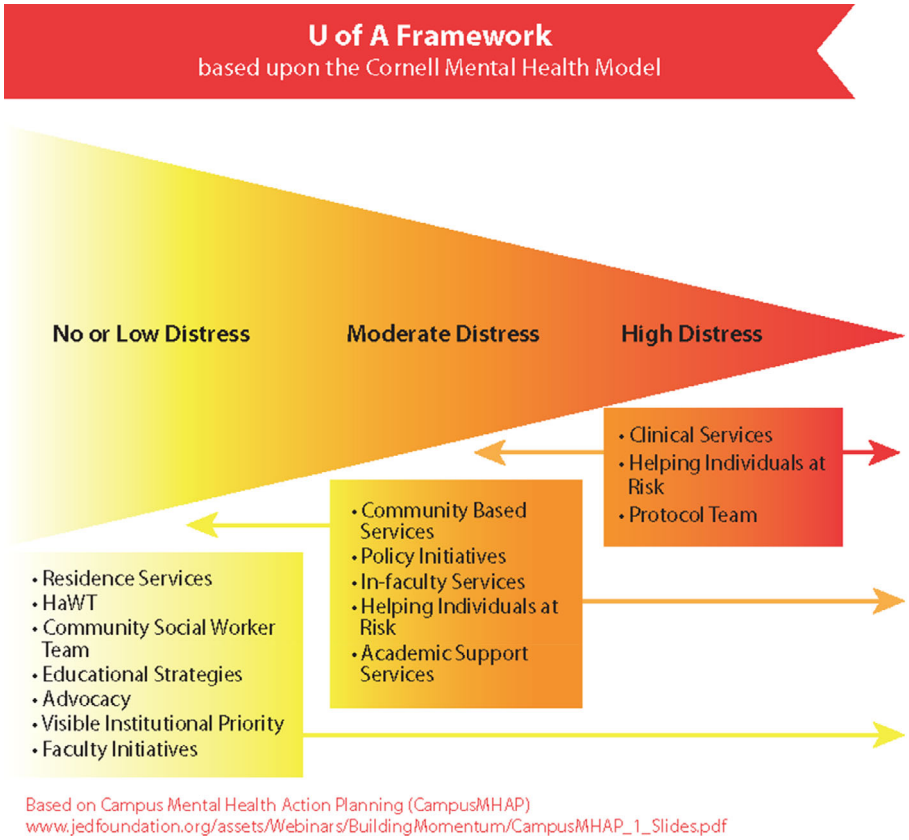


**FIGURE 1** Visual of the University of Alberta reorganization prior to ACCESS Open Minds University of Alberta, based on the Cornell Mental Health Framework. *Source:* Everall, 2015 (p. 18)

## 2 | COMMUNITY MAPPING

Figure 2 illustrates the range of on and off campus resources that were already known through environmental scanning activities prior to ACCESS OM (Everall, 2015). The main mental health service was CCS, consisting of psychologists and psychiatrists who specialized in psychotherapy and/or medication management, including specialists in attention deficit hyperactivity disorder, borderline personality disorder, and bipolar disorder. This service was located in the same space as most student services, but additional psychologists were embedded in faculties (Figure 2). The CCS team worked closely with, and received referrals from, the University Health Centre, Sexual Assault Centre and the CSW team, in addition to non-health services and staff across campuses. Students could also self-refer and schedule an initial consultation.

As part of the implementation of the ACCESS OM project, from January to July 2017 a series of focus groups were undertaken across the university in order to assess students' beliefs and practices regarding their mental health, their current needs and their suggestions on how those identified needs were being or could be better met. Based on this, the first of the ACCESS Clinicians (both social workers) began outreach work with staff and other stakeholders within the university community in May 2017, ultimately forming the ACCESS OM UA Network. This network is led by the aforementioned Clinicians, and consists of delegates from various health, academic and non-academic services distributed across campus, who in various ways encounter students experiencing mental health difficulties (see Figure 3 for a depiction of the range of services that comprise the Network). The network meets monthly to discuss referral processes, barriers to accessing all types of services and how to reduce these barriers, and trends in student concerns, and other issues. At a large institution, connecting diverse and disparate service providers across campus silos is a structural shift that would not have come about without ACCESS OM's tripartite focus on supporting students regardless of where they first seek help, then following this through to early identification and referral to mental health services when needed.

## 3 | EARLY CASE IDENTIFICATION

Although students can self-refer, the majority of students needing help are in fact, referred to the ACCESS Clinicians through the Network. A student in distress may be identified by any Network member; the aim is to ensure that no matter where a student turns for help, provision of appropriate services is facilitated. At an initial session, the student may meet with one of the two ACCESS Clinicians the ACCESS Evaluator, who is also a social worker, or CCS nursing staff. The initial session is held within 72 hours of referral, aiming to identify needs and to refer the student to appropriate services, which may include psychologists or psychiatrists working in CCS, other types of on-campus supports (e.g., academic supports, campus food bank, etc.), and/or off-campus resources (e.g., through Alberta Health Services [AHS]). The ACCESS Clinicians conduct any referral follow-up and case management work.

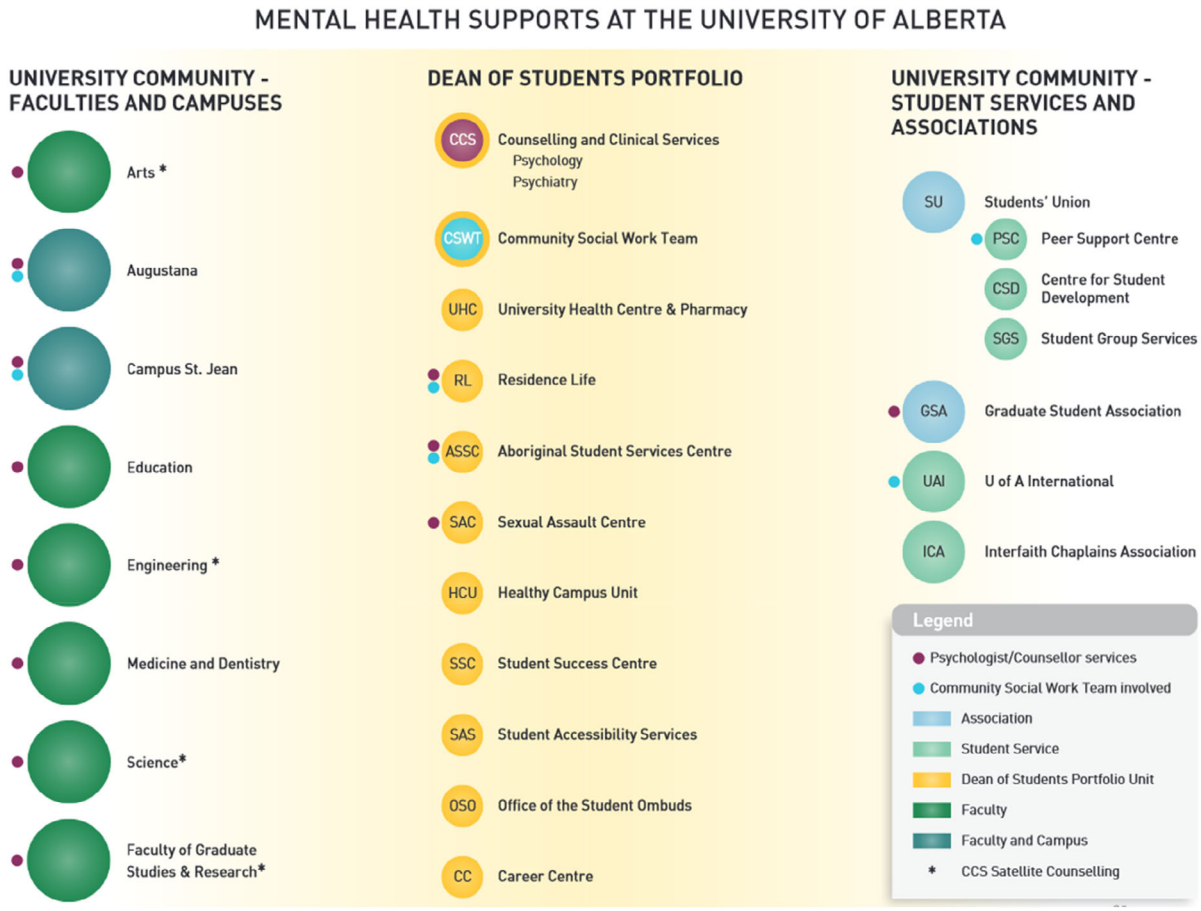


**FIGURE 2** Illustration of campus and community resources that were previously identified. *Source:* Everall, 2015 (p. 23)

Additional early case identification activities include: working with the ACCESS OM UA Network to improve referral processes and directly connect struggling or distressed students to ACCESS Clinicians consulting with non-health service providers, faculty and staff; attending and/or supporting "student of concern" meetings that are held by the Dean of Students to ensure that appropriate referrals to mental health and other services are made; providing yoga classes to students and staff (e.g., Yoga for Mental Health classes); advertising to students through multiple modes of communication (e.g., emails, posters, slides on TVs located in public areas within UA buildings, attending events, etc.); and connecting with each FreshStart UA student (first-year students who are struggling academically) to provide an initial assessment and then regular mental health check-ins throughout the academic year.

## 4 | RAPID ACCESS

Because of the ACCESS OM UA Network, students in distress can seek help not just at CCS but through multiple portals of entry on campus (Figure 3), where they will be directly referred to the ACCESS Clinicians. If the student accesses CCS first, an assessment of past or current mental health issues would be undertaken and available to the ACCESS Clinician. If the student was referred by a non-health service Network partner, then the Clinicians themselves conduct a mental health assessment that includes screening for past or current conditions (and would be available to the CCS staff as needed). The ACCESS Clinicians strive to offer an initial session within 72 hours of referral, a goal that has been met except in situations where the student's schedule does not allow for a booking to occur within this timeframe (and the clinician is comfortable that the severity does not require immediate contact). Students may also refer themselves directly to ACCESS OM UA, via email, phone, or in-person without a referral. The ACCESS Clinicians are mobile, have flexible hours, and meet students at a variety of locations based on students' preferences. All services are at no cost to the student.

ACCESS OM UA has established clear and flexible referral procedures with Network partners. With the goal of streamlining referrals, workflow, and reducing barriers to care, a review and coordination of intake processes and practices across different services took place in 2018 and continues to be evaluated. For example, in summer 2018, ACCESS Clinicians worked closely with CCS to create a shared intake process, ensuring appropriate information is available to all clinicians while reducing transitions between services.

## 5 | APPROPRIATE CARE (IN 30 DAYS)

ACCESS OM sites aim to offer a direct entry point to services and to initiate follow-up or specialized services within 30 days, if required.

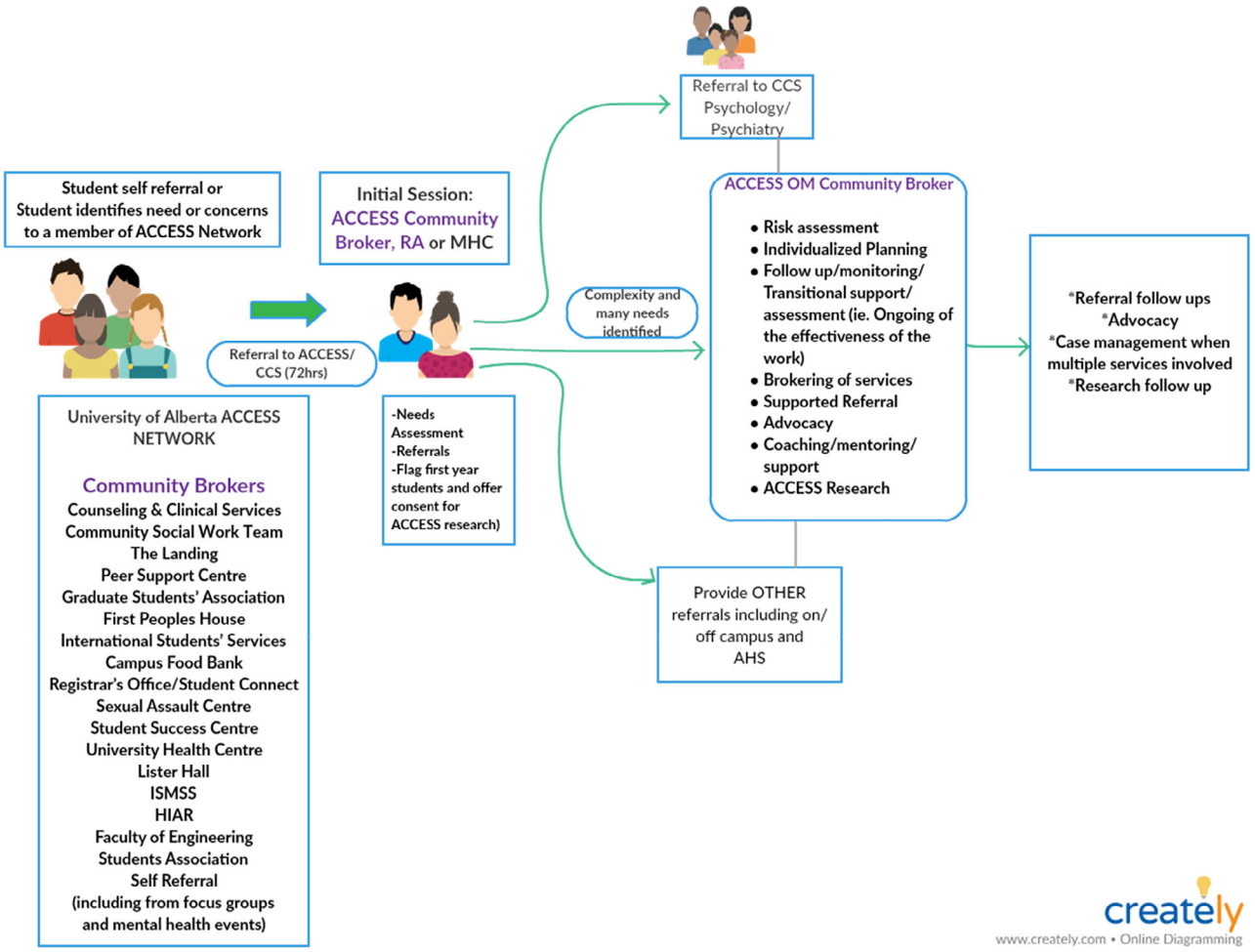


**FIGURE 3** The ACCESS Open Minds University of Alberta (ACCESS OM UA) Network, highlighting the pathways and connections between all types of supports and services across campus, and the primary role of the ACCESS Clinicians in fostering these connections (called community brokers in this diagram)

Based on the ACCESS OM assessment, the ACCESS Clinician will collaborate with the student to develop an appropriate care plan that may include connection to social supports, address basic necessities (food security, housing, etc.) and/or provide a warm hand-off to clinical services in the case of crisis and imminent harm. The ACCESS Clinician will, if needed, directly connect a client to a psychologist or psychiatrist in CCS or other appropriate campus service(s) (e.g., sometimes via a priority appointment). They have also connected students to appropriate services in the community when specialist care is required (e.g., for eating disorders), including working with colleagues in the ACCESS OM Edmonton site.

Where the student is already connected to mental health services and was then connected to ACCESS OM UA, the problem is often that mental health services alone were not sufficient. In those cases, the ACCESS Clinician also offers assistance with connecting to non-health services—also aiming for the 30-day benchmark. Thus, other services such as academic supports, peer support, campus food bank, the international centre, Indigenous students' centre, Accessibility Resources and so on, are engaged. In other words, in order to support the mental health of students, we have learned that campuses need to offer clinical mental health services alongside addressing social factors impacting mental health.

## 6 | CONTINUITY OF CARE BEYOND AGE 18

Since the vast majority of students are 18 or older when they begin their studies at UA, the ACCESS OM objective of eliminating age-based transitions at this age does not apply to the UA context.

## 7 | YOUTH AND FAMILY ENGAGEMENT

As part of ensuring that services are designed with students, a new ACCESS OM UA Youth Council was formed. Composed of UA students committed to supporting students' mental health and collaborating with the ACCESS OM UA team, they promote the ACCESS OM project and other wellness initiatives to the campus community. Since the beginning of the project, the Council has acted as a consulting body for the development of the site, initiatives that derive from the project or other UA wellness initiatives that require students'

perspective. For instance, they provided feedback during the development of the protocol (e.g., testing length of time assessment tools took to complete, flow of online versions of the protocol, etc.). And in early 2018, one of the Youth Council co-chairs initiated a conversation on a partnership with the Canadian Mental Health Association and the UA on improving the supports they offer to students through a 24/7 information and crisis phone service known as "211"; this project is currently underway.

ACCESS OM UA maintains a youth-friendly physical space where the ACCESS Clinicians practice. The space is located across the hall from CCS, and in the same building as most other student services. The ACCESS OM UA team is located behind a glass storefront window, where students see an open space with couches, snacks, and ambient lighting and surrounding offices.

Youth and families/carers are considered equal partners in all aspects of the ACCESS OM project. The ACCESS OM UA service team is student-centred in that clinicians work with students as partners in their own care, to identify a plan of care that is appropriate for the student. This may include family members, friends or other key people in the student's life, if desired. The notion of "carers" expands the concept of family to include supporters such as students' peers, friends or roommates.

## 8 | WHAT IS SPECIAL ABOUT THE NATURE/PROCESS OF SERVICE TRANSFORMATION AT UA

Any transformation that involves a major shift in service delivery must identify barriers and facilitators that inhibit or promote that transformation. From a student's perspective, prior to ACCESS OM UA one would have first faced multiple, disconnected portals of entry when seeking help (CCS, CSW, academic advising, etc.) with potentially long wait lists. It was difficult for students to know which door to approach first; and because services were disconnected from one another, there was little continuity of care or support for students between services or (once accepted to a service) between appointments.

Since the initiation of ACCESS OM, students have a clear portal of entry to contact if they need help for mental health issues, and the opportunity to meet with someone to assess their needs within 72 hours of reaching out. Through the new Network, students are also able to access the mobile ACCESS OM UA team via multiple routes, or in situations where a rapid response (such as a student in crisis presenting at a service where no professionals can immediately see them) is needed. Referrals between services are also now managed as "warm hand-offs" with the service providers managing and supporting transitions; the onus is no longer on the students to know where to go. Between appointments, students can always reach out to the ACCESS OM UA team for support; conversely, the team actively follows up with students in situations of missed appointments or potential disengagement.

From the perspective of service providers (who vary in their desire and capacity to shift practice), in order for substantive change to be embraced and sustained, staff must support and believe in the new model of delivery. The initial years of the ACCESS OM UA project were spent attempting to enhance relationships between diverse service providers using a participatory approach, in order to learn from their local experiences and to incorporate their ideas and address their concerns regarding implementation of ACCESS OM at UA. Arguably, it was when existing services began working together and saw the benefit of the ACCESS OM UA team in their daily work supporting individual students that this systems change took root.

Another contributor to success has been the type and characteristics of staff hired for the ACCESS OM UA team. The ACCESS Clinicians have played a critical role in not only providing exceptional services to students, but also in engaging and then working collaboratively with existing services to improve relationships and pathways to care. Given the very short timeframe of the project, retaining these Clinicians has ensured that the transformation has been led on the ground by a cohesive group, provided continuity in driving the on-campus transformation and facilitated on-going positive and trusting relationships between service providers.

## 9 | RESEARCH AND EVALUATION

Routine evaluation is a critical part of the ACCESS OM project, in order to inform care for individual youth as well as to better understand the evolution and overall quality of service that is being provided. The hiring of the first ACCESS Clinician was instrumental in determining a streamlined protocol that integrated the ACCESS OM tools into provision of care that was not overly burdensome for the student or the service provider. Since then, a number of options have been identified to ease the burden of data gathering on clinicians, such as adding a dedicated Evaluator to the ACCESS OM UA team who could collect data in conjunction with follow-up/check-in calls with clients. Additional strategies involve the Evaluator conducting outreach activities in residences where first-year students live, and/or other places where students congregate.

Data collection for local evaluation and national research purposes has been incorporated into the intake process. The ACCESS UA Evaluator has increased the capacity to conduct follow-up interviews, critical to measuring effectiveness of supports and services over time. Qualitative data also continues to be gathered through participatory methods; feedback from diverse student voices is critical so that we can continue to best serve student needs into the future. There are limits to our evaluation activities; for example, while it is clear that there is a relationship between mental health and student academic success (Eisenberg et al., 2009), our institution or ACCESS OM UA does not conduct exit interviews to determine if mental health problems were a causal factor in a student's withdrawal or failure to complete a course of study. Discussions with campus administrators may result in future shifts on if, and how, such data could be gathered.

## 10 | SUSTAINABILITY

The ACCESS OM UA service transformation utilizes a participatory, community-based approach that is grounded in local knowledge. We have adopted a mixed methods data collection approach that incorporates metrics on local service use as well as qualitative data that captures multiple stakeholders' ideas, experiences and knowledge (e.g., through focus groups), in order to lay the foundations for a sustainable transformation. Such an approach requires time to allow for ideas to be tried and iterated, and for beliefs and practices to concurrently shift. Arguably, when service transformation follows this approach, stakeholders are more invested in the process and outcome of the transformation, and the transformation has meaning and value to all.

The service transformation shepherded by ACCESS OM includes multiple components that are now highly valued by university administration and integrated within the UA mental health service landscape, including the ACCESS Clinicians (particularly their model of care that incorporates follow-up) and the Network. ACCESS OM UA leadership have been actively working with university, philanthropy and government decision-makers to advocate for the sustainability of the ACCESS OM UA model.

## 11 | COMMUNITY IMPACT

Since its inception, ACCESS OM UA has contributed to significant changes across the UA campus mental health service landscape. Over roughly one year, the ACCESS OM UA team has become the primary source for responding to, and supporting students in need. Referrals come from across the university, illustrating the importance of creating the ACCESS OM UA Network. For example, staff providing financial services now connect students directly to the ACCESS Clinicians when financial health conversations reveal potential underlying mental health issues.

It appears that the ACCESS Clinicians increasingly play a critical role in the community, as a safe, welcoming and mobile option to receive help on a variety of issues. For students who are struggling with mental health issues, this is often accompanied by a variety of other needs. Having a single service where one can receive assistance on all of these needs is valued by students.

## 12 | CHALLENGES

The ACCESS OM UA Network and open referral system has reduced the barriers to accessing care on campus; however, as knowledge about the service and early identification of those in need increases (at the same time as stigma around mental health issues improves), the numbers of students dropping in for services has increased significantly. An iterative—and at times creative—process of problem solving and service transformation will be required to ensure that students can consistently access care within 72 hours. For example, ACCESS Clinicians may increasingly work with other student services to ensure that some needs are met in the short term (e.g., partnering with Peer Support Services or CSWs).

The local political-economic context is also critical for understanding the process of change in service transformation. With post-secondary institutions being guided towards a health promotion and illness prevention focus, long-term specialist care is to be provided off-campus, in surrounding communities. While this approach complements aspects of the ACCESS OM model, it requires ACCESS OM UA to continue to support students on-campus—while also finding timely community resources that can support longer-term needs for UA students. Informal supports (such as peer support) and bridging supports (such as interim counselling) are avenues through which to ensure that individuals do not fall through the cracks during such transitions, or the wait times that are sometimes associated with them.

Other challenges encountered include: (a) supporting sustainable and meaningful youth engagement, given students' many commitments including academic, volunteer and employment duties—the ACCESS OM UA team meets with the Youth Council leaders and the group as a whole to foster discussions on the importance of self-care; (b) change management across multidisciplinary teams requires extensive consultations to ensure engagement and buy-in; (c) finding innovative ways to educate and inform students' family members on issues and available supports in the post-secondary context while also respecting confidentiality requirements—sharing information on students' health problems with parents is not possible unless consent has been provided by the student. One potential means of conversing with parents is to generically share what typical processes and supports are provided to students who are experiencing mental health problems; (d) managing expectations on the role of ACCESS OM UA, especially as demand for the service increases—this is particularly important in a context where funders' priorities can shift; and (e) navigating issues of confidentiality and disclosure—individual services or providers may not be able to share information within the ACCESS OM UA Network (Figure 3), which can contribute to delays in obtaining an assessment by the ACCESS Clinicians. As a result, the Network is working towards development of a shared form/process that would enable such disclosure across services (with the student's consent).

## 13 | CONCLUSIONS

Research undertaken in diverse settings has reported on the range of stressors that combine to impact student mental health, and post-secondary institutions across North America and elsewhere are grappling with how to address students' needs when resources are limited. In this paper, we have described the process and key features of mental health service transformation in a large post-secondary institution—and in particular how the addition of the ACCESS Clinician and (through them) the Network of services has changed the mental health service landscape through a holistic and engagement-focused model of care. Service transformation that is grounded in the principles of community-based research is recommended as a means of incorporating local knowledge, expertise, and opportunities given the particular needs and features of a post-secondary educational environment: the diverse

nature of the student body, the breadth of locations across campus(es) where early identification is required, the coordination required with specialist mental health providers (e.g., CCS), and the transition to independence and decreased involvement of family members around this period. In sum, the ACCESS OM UA case study is an example of how to holistically approach mental health services, where the complicated intersections of a variety of issues—academic, social, financial, familial, etc.—that influence student mental health can be simultaneously supported in a more seamless manner. Future efforts will continue to evaluate the effectiveness of the transformations outlined in this paper and to monitor changing student needs.

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## CONFLICT OF INTEREST STATEMENT

Dr. Malla reports having received honoraria for conference presentations and advisory board participation from Lundbeck and Otsuka, Canada and International in the past three years. None of these have any relation to manuscripts in this supplement.

Dr. Joober reports having received honoraria for conference presentations and advisory board participation from Janssen, Lundbeck, Myelin, Otsuka, Perdue, Pfizer, Shire, and Sunovian; he also received grants from Astra Zeneca, BMS, HLS, Janssen, Lundbeck, and Otsuka; and has royalties from Henry Stewart talks. None of these have any relation to manuscripts in this supplement.

Other authors report no conflicts of interest.

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SUPPLEMENT ARTICLE

WILEY

# Invited Commentary: ACCESS Open Minds National Youth Council

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## 1 | INTRODUCTION

As members of the ACCESS Open Minds National Youth Council, we are pleased to comment and summarize our reactions to site level transformations as described in this supplement. We express excitement at the change that the ACCESS Open Minds (ACCESS OM) network is making across Canada. Many members, however, still share some scepticism in regards to the healthcare system, based on their lived experiences with existing services: long wait times, bed shortages, burnt out clinicians, ageism and lack of flexibility or adaptability.

The ACCESS OM objectives, as core components to service transformation towards *better* quality care to *more* youth in need, *sooner*, were based on needs expressed by youth themselves in addition to gaps identified by researchers, service providers and decision makers. Overall, the increase in youth seeking care as well as the statistics surrounding wait times and access to services are inspiring. ACCESS OM has brought a whole new level of care to a country that is in need of a youth mental healthcare transformation.

## 2 | DIVERSITY

Despite a central framework and a set of agreed-upon core objectives, each site can implement the five objectives detailed in the supplement in ways deemed appropriate by the community. Communities have considerable autonomy and agency over the transformation process. While accommodating diversity may create some difficulties for a research project, it also recognizes local knowledge. It is exciting to learn about this contextual expertise and how it can translate to individual sites. The efforts of the ACCESS OM network are inherently scalable in this respect—between the sites across the network, there is undoubtedly something that can be applied to another context.

Sites serve unique communities varying from remote Northern communities to large urban sites. The youth population in many sites is large and is growing rapidly. The needs of the community also vary. This flux requires strong leadership and significant operational flexibility to achieve the objectives outlined by the ACCESS OM

  

model. Youth workers must respond to youth in ways that are culturally safe, respecting and honouring their identity and their culture.

## 3 | YOUTH ENGAGEMENT

Descriptions of youth-friendly clinical models illustrate the strategies that site teams have implemented to meet youth in environments that are conducive to therapeutic alliances. Council members view these strategies as innovations in youth mental health service delivery.

Specific examples of innovation include Eskasoni First Nation's Fish Net model, the use of Facebook and texting services, the Réseau d'intervention de proximité auprès des jeunes de la rue (RIPAJ)'s "there is no wrong door" care pathway, mobile services, meeting youth in a location of their choice and the integration of mental health programming into other types of programming. These innovations improve services by rendering them more accessible, more approachable and less intimidating.

Sites have adopted various strategies to involve youth in early identification activities and strategic planning: social media campaigns (news, radio, community agencies, local television, school presentations, hosting weekly "family nights"), peer navigators creating safe spaces for youth engagement in daily operations (steering committee, developing welcome videos, strategic planning, youth as peer advisors), designing physical space of the ACCESS OM site (including residential spaces, access to Wi-Fi, art materials, etc.), community mapping, inclusion of youth in hiring panels. Council members, however, remain critical of youth engagement strategies and question whether different communities are offering youth an authentic way to actively collaborate with service providers, researchers and decision makers.

The creation of youth advisors and councils is paramount as they facilitate a structural relationship between care providers, service providers, administrators and youth. This may, however, be insufficient to achieve sustained, authentic youth engagement. All stakeholders must make significant efforts towards meaningful collaboration and not merely assign advisory roles to youth. While youth may need to be guided to become aware of their limitations, other stakeholders may miss the opportunity of gaining valuable insight through an enhanced agency of the youth. At the same time, structures may also need to be managed cautiously to avoid an unwieldy bureaucracy and to maintain empathetic human connections among all stakeholders.

## 4 | FAMILY ENGAGEMENT

While the ACCESS OM Family and Carers Council has commented in greater detail, we are encouraged by examples of innovations such as, University of Alberta's work to integrate "chosen family" (roommates, coaches, friends, etc.) and the Acadian Peninsula's work to integrate family substitutes in healthcare planning.

## 5 | CHATHAM KENT, ONTARIO

Prior to the initiation of ACCESS OM, there had been no mental health services specifically designated to this population of 11 to 25 year old. Various youth services are now working in collaboration with ACCESS OM to provide youth with the most adequate support and care possible. Drop in programming, walk-in appointments and single session interventions are seen as an innovative way to offer youth the care and support when they need it.

## 6 | EDMONTON, ALBERTA

This article provides in depth and insightful information about this large urban ACCESS OM site, including the challenges they faced and the positive outcomes of the ACCESS OM transformation. The steps that were taken prior to Edmonton officially joining the ACCESS OM network is an illustration of this community's investment in the lives of youth. Smart investments were made based on community mapping which identified the most significant gaps in youth mental healthcare. Changes to the clinical team are very detailed; however, more information is needed on how professionals work together to illustrate the community impact of these transformed services. Innovations include breaking the silo between mental health and addictions, implementing peer support in formal service delivery, visit codes and the creation of a youth council. We believe, the location of the AOM site within a YMCA is an excellent way of integrating formal mental health services with other less stigmatizing environments that also offer opportunities such as fitness.

## 7 | ESKASONI FIRST NATION, NOVA SCOTIA

ACCESS OM seems to be a significant resource to this First Nation community given its large youth population and its history. The wide variety of services and programs offered to youth is impressive. Many communities can learn from Eskasoni's way of integrating mental health programming into cultural Mi'kmaq traditions. More information on suicide prevention and any service gaps would deepen our understanding of this community's reality. The outcomes of community mapping may lead to additional strategic partnerships for sustained funding, casting a larger "fish net." We want to learn whether language barriers exist and how services were adapted for First Nation youth and their families.

## 8 | PÉNINSULE ACADIENNE, NEW BRUNSWICK

This article brought attention to the struggles of a minority culture/language group. It provides information on challenges and the impact ACCESS OM is having on youth in the community. Community mapping seemed to be a specific event with a small focus group, which may have limited outcomes. The early identification and youth engagement efforts to meet youth in local coffee shops are intriguing. We wonder how youth feel about completing an assessment in a public space. We would also like to emphasize the link between

addictions and mental illness (eg, addictions can trigger or intensify mental health issues).

## 9 | RIPAJ MONTREAL-YOUTH HOMELESS NETWORK, QUEBEC

Homelessness and mental health, two very stigmatizing concepts, are being addressed together and supports the most marginalized group of youth by offering multiple pathways to care (no wrong door/no bad timing). Youth want and need access to all services under one roof. Examples of how the media are being used effectively to promote help-seeking and a description of the types of family engagement training would have been helpful. The authors admitted to not being able to "reach all youth effectively", which illustrates the site's profound commitment and ongoing effort to come to the assistance of all youth in need. The Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) specific themed meetings give youth the opportunity to discuss how mental health varies from group to group.

## 10 | ULUKHAKTOK, NORTHWEST TERRITORIES

This paper is an illustration of the adaptability of the ACCESS OM framework, though there is still much more that needs to be done to provide specialized services to youth in their local community. The article provides the historical context to understand the impact of residential schools and intergenerational trauma. It is alarming to learn that emergency services and crisis intervention resources are not readily available in the community. Stigma appears to be an influential deterrent to help seeking. Investments need to be made for suicide prevention and health prevention in general. If the Royal Canadian Mounted Police (RCMP) is seen as presumably trustworthy ally for youth, perhaps they can allocate time to prevention and outreach to begin to address stigma from multiple fronts. It is interesting to read about the lay health workers. More information is needed to learn about how peers can support one another in such a small community where identity and sense of self is linked to reconnecting with cultural practices and the land.

## 11 | UNIVERSITY OF ALBERTA, ALBERTA

A university is an important location for an ACCESS OM site; the transitions that university students encounter can have a massive impact on their mental health and emotional well-being. It is an age where many mental health conditions begin to emerge. The dedication to understand stressful lives of university students is evident through their accessible services and diverse clinical teams. Offering aid in redirecting students to other services in the community demonstrates a co-operative attitude for meeting students where they are at and supporting mental health needs in a safe environment however transitions and continuity of care between campus and community services remain a gap in service provision. More information is needed about the socio-economic status of students and their origins (eg, rural, international), which can impact student life on campus.

## 12 | CONCLUSION

We are optimistic that the innovations described by ACCESS OM sites will change the way young people feel about mental health services. These innovations are breaking many structural barriers and are better responding to the needs of young people. These changes have begun to make services more readily available to youth in need. While much work has been done to engage youth in site level transformation, the ACCESS OM network must further its efforts and partner with youth (defining it as "youth partnership") rather than engaging youth ("youth engagement"). Youth voices should be emphasized in all areas of ACCESS OM work and documentation: youth are not simply research subjects but partners. As such, the perceived barriers of working collaboratively with youth need to be understood and addressed. Young people want to change mental health services. ACCESS OM is facilitating the process by beginning to offer meaningful opportunities for youth to shape service planning, delivery and evaluation. These efforts will build a better system.

### ACKNOWLEDGEMENTS

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SUPPLEMENT ARTICLE

WILEY

# Invited Commentary: ACCESS Open Minds Family and Carers Council

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## 1 | INTRODUCTION

ACCESS Open Minds Family and Carers (AFC) Council represents families and carers, one of the key stakeholder groups participating in ACCESS Open Minds (ACCESS OM) (Malla et al., 2018). Families and carers are often part of a young person's life before that young person even reaches the first point of contact with mental health services, and are an important resource in the treatment and recovery of youth affected by mental health problems. Involving families and carers in their youth's care as early as possible increases the chance of better recovery.

Within the context of the ACCESS OM core objectives AFC Council works to ensure that families and carers at all 14 ACCESS OM sites are able to participate fully in the transformation of youth mental health services as proposed by ACCESS OM.

## 2 | AFC COUNCIL COMMENTARY ON FAMILY/CARER INVOLVEMENT AT SPECIFIC ACCESS OM SITES

### 2.1 | Eskasoni First Nation, Nova Scotia

This site has engaged youth and their families and carers early on in the ACCESS OM initiative, as part of the community's integrated and holistic youth mental healthcare philosophy, as well as in the context of the ACCESS OM core objectives. The site has also contributed to maintaining family/carer representation on the national level in the AFC Council, adding much in terms of community knowledge and cultural tradition to the AFC Council. The site states that families are being engaged while maintaining confidentiality of youth. The AFC Council would like to learn more about how families are being engaged in site activities, including cultural activities.

### 2.2 | Chatham-Kent, Ontario

This site has embedded the overarching principles and core objectives of ACCESS OM from the outset of the project, including youth and family engagement. Youth and family/carer representatives are involved in their respective councils at the site and national levels. The AFC Council is fortunate to have had active family/carer representatives from this site, who have shared much information on family engagement tools, resources, expertise and insights with the AFC Council. The AFC Council continues to build capacity by learning more about the impact of the family navigator who offers peer support and connects families to services in the community which best suit the family/carer's desires and needs. The family navigator encourages families to participate in the ACCESS OM research in addition to co-facilitating various groups for families and carers (eg, : Family Connections, EPI family group, Parents for Children's Mental Health chapter). AFC Council would also like to learn more about the activities led by site team members to get families involved.

  

### 2.3 | Ulukhaktok, Northwest Territories

This site is committed to transforming youth mental health and engaging families/carers within its own Inuit traditions and cultural context. The AFC Council has collaborated with site leads to support family engagement initiatives as the site builds capacity. The article describes lack of intergenerational connectivity and hesitation of youth to talk about mental health issues with their families as barriers to involving family members in care. Maintaining confidentiality in such a small community was also identified as a challenge. Despite these challenges, the site team continues their efforts to support the community by building capacity in community leaders, through their adaptation of a lay health worker model.

### 2.4 | Péninsule acadienne, New Brunswick

This site has made great inroads in the transformation of youth mental healthcare. Site team members have engaged youth in creative and inclusive ways through their community mapping exercise, which has led to youth owning their participation in ACCESS OM NB. The article describes youth's impressions of ACCESS OM NB as a place they can trust, which is critical for youth seeking help. Despite challenges to establish the ACCESS OM NB Family-Caregivers Advisory Committee, this site has reached out to AFC Council members with the goal of helping families and carers to continue to build a provincial AFC advisory committee, with the possibility of family-carer representation on the AFC National Council.

The site has also come to a mutual understanding on how youth define "family." The fact that families were not mentioned by youth as an important support for mental healthcare does not necessarily mean that families are disengaged. Youth may say that family members are not involved, yet there may be someone who is supporting the young person in a healthy way. Youth may express a desire to meet clinicians alone as an expression of independence, which is an important transition from youth to adulthood. As youth embrace their independence, the system shifts away from parental/family/carer involvement towards parental/family/carer support when youth need it. Families and carers remain engaged but in a different way. It is vital that clinicians include families and carers in care while respecting youths' need for independence. This balance can be achieved by creating space for this vital conversation with youth about healthy support systems and their impact on well-being. These conversations must be ongoing and sustained throughout the care pathway through deep and continued conversations about healthy forms of familial support with the aim of including the significant adult in care planning. AFC Council is optimistic that the site team's mindset will strengthen future efforts to engage families.

### 2.5 | Edmonton, Alberta

Early days in the ACCESS OM project saw this site work diligently to reorganize and update aspects of its healthcare model to adapt to the core objectives of the ACCESS OM model, including youth and family/carer engagement. AFC Council has been grateful for family/carer representation from this site on the national level. While the learning curve sometimes has been steep for all stakeholders, AFC Council is thrilled that the current family representative on the AFC Council is also this site's new Family Peer Support worker. The AFC Council would like to learn if educating families is leading to demonstrably better outcomes for both youth and their families.

### 2.6 | University of Alberta, Alberta

This site represents a university student population; therefore, the emphasis is on engaging youth in their own care, including welcoming who the student chooses to be part of their care team. The AFC Council acknowledges and respects the focus of this site's team to accommodate and ensure youth at this university site receive appropriate services. The AFC Council also recognizes the necessity of an ongoing commitment by the site to engage families and carers supporting students with mental health concerns. The AFC Council would like to learn more about the strategies that are employed to empower students to identify family and carers who are part of their support system, in the hopes that this is an ongoing invitation and conversation.

### 2.7 | Réseau d'intervention de proximité auprés des jeunes de la rue (RIPAJ) Montréal Youth Homeless Network, Quebec

Youth engagement at this site is especially challenging as the ACCESS OM site team works with homeless young people from both local and distant communities who are often in precarious situations. Yet this site has not neglected family engagement by reaching out to families and carers when possible. Site leads invite family and carer representatives to attend local events and to present on family engagement at site meetings, as well as sharing information and updates with various AFC Council members on the national level. Homelessness often includes disenfranchisement from family, yet the site acknowledges and works towards family-orientated discussion points. ACCESS OM RIPAJ recognizes that even though youth appear to be alone, and homeless, it remains critical and highly relevant, to have deep dialogue with youth about positive forms of family or carer support. This conversation must continue throughout the care pathway. This site's approach may provide insight to other communities who are struggling to engage family and carers.

## 3 | CONCLUSION

The site articles acknowledge commitment at all sites to family/carer engagement. AFC Council endeavours to document all activities intended to promote family/carer engagement vision, needs, barriers and successes, particularly when efforts are made to connect families with families. Such activities include family navigator and peer support positions as well as family advisors and family members participating in the hiring process of service providers and staff. AFC Council looks forward to continuing its work with the network on such initiatives. AFC

Council members have stated that connecting with each other has validated individual experiences, which has equipped members with practical tools to cope, a caring community and hope. Data and insights, both quantitative and qualitative, need to be documented and disseminated with the aim of demonstrating the impact of family/carer engagement. AFC Council is eager to learn more about specific strategies, whether successful or not, that seek to involve families/carers in order to promote cross learnings. Ongoing communication about barriers and insights into family/carer engagement may promote the uptake of promising practices.

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SUPPLEMENT ARTICLE

WILEY

# Invited Commentary: ACCESS Open Minds National Indigenous Council

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The ACCESS Open Minds (ACCESS OM) Indigenous Council was created in September 2017, connecting Indigenous leaders from within the ACCESS OM network. Elders, youth and site leads from Elsipogtog First Nation (New Brunswick), Eskasoni First Nation (Nova Scotia), Aschiikuwaadaauch (Mistissini, Quebec), Sturgeon Lake First Nation (Saskatchewan), Puvirnituq (Nunavik, Quebec) and Ulukhaktok (Inuvialuit Settlement Region, Northwest Territories) initiated the creation of this council, which meets to share knowledge and provide leadership on matters affecting or pertaining to Indigenous communities within the context of ACCESS OM.

The council discusses ways to implement the ACCESS OM research and evaluation protocol with and for Indigenous communities, ensuring that OCAP principles on data ownership are respected (https://fnigc.ca/ocapr.html). The council strives to create more opportunities for Indigenous researchers. Local youth and family engagement strategies are shared in order to empower and support the next generation through intergenerational teachings. The council is excited to be contributing to the supplement by providing our thoughts on the transformations happening at the seven ACCESS OM sites across Canada, that are included in the supplement.

In reading the summaries about the Indigenous ACCESS OM sites, it becomes clear that the best way to support the needs of Indigenous clientele is to use models that prize the integration of Indigenous voices, values and cultural perspectives into the healing and wellness journey. Often these are models that have been created by Indigenous people for Indigenous people.

It would be interesting to learn how non-Indigenous ACCESS OM sites, such as Réseau d'intervention de proximité auprès des jeunes de la rue (RIPAJ) located in a large city such as Montreal, or sites in Edmonton, another large city (that have significant proportions of Indigenous clientele in the mental health system), address the cultural diversity of their clientele. More specifically, what model(s) are being used to best support this clientele from an Indigenous perspective. Is there a concerted effort to hire Elders, Healers or other staff that have Indigenous knowledge or are able to speak an Indigenous language?

It appears that what has been omitted so far from many of the ACCESS OM non-Indigenous sites, is a description of the diversity of the youth and families that are being served and how their cultures, languages and values are addressed within the mental health context. How are sites addressing the existence of these cultural differences or are they simply not being addressed at all? It would have been interesting to hear if sites experience challenges in interweaving Western and Indigenous practices, values and ways of offering mental health care.

What is missing from many summaries is the Indigenous voice and reflections on diversity in general. However, this is of primary importance if the health care system, especially in the area of mental health, is to engage in best practices. Without a fundamental understanding of the clientele being served and without an ability to serve clients in their language, this raises questions about the efficacy of the system and the quality of the support being provided.

  

We would strongly suggest that any non-Indigenous site that has not yet contemplated how to incorporate Indigenous voices and cultural perspectives into their system of health care do so in a systematic way. We would also encourage non-Indigenous sites to collaborate with Indigenous communities and engage in knowledge sharing because much of the foundational work has already been done, many models already exist and it is just a matter of each site selecting the model that will best meet their clients' needs. And the best way of knowing what clients' wants and needs are, is to ask them and make them an integral part of their health care process. There seems much to be gained by adding the Indigenous perspective on health that are being used by Indigenous communities, but can these models be easily transferred and implemented into urban settings? If not, what adaptations are needed in order for clients, especially youth and their families, to be well supported?

We recommend that sites incorporate an overall history of their community, which would help deepen our understanding of positive and negative issues that each site is currently facing.

## 1 | CHATHAM-KENT, ONTARIO

Chatham-Kent site is well beyond the curve when it comes to transformation. Although the described challenges are legitimate and concerning, they are manageable and not extraordinary. Overall, ACCESS OM has enabled a conversation to take place to improve capacity among an existing network of service providers along with powerful voices of youth, family and friends and good community support.

Chatham-Kent does a lot for their site and community. This can be seen from reading about all of the different organizations that they collaborate/work with, educating them about mental health awareness, ACCESS OM and youth referrals. This includes school boards, home and community care, mental health and addictions nurses, addictions programs, and the list goes on.

## 2 | EDMONTON, ALBERTA

At this ACCESS OM site, the community mapping exercise helped in the identification of gaps in the mental health care system. This led to the opportunity to build partnerships and create multidisciplinary teams. ACCESS OM clinicians were hired and were allowed mobility to travel to see youth where they choose to be seen. The paper does not highlight very much youth and family engagement, which one could then assume to be low and of less influence, though this is hard to determine.

Edmonton is an example of a systems approach to change. This required working with and around union rules. Working within such a highly bureaucratic healthcare system which suggests that the chances of sustainability are excellent. This article gave the best in depth examples of the ACCESS OM five central pillar objectives.

## 3 | PÉNINSULE ACADIENNE, NEW BRUNSWICK

In this very rural community with many low income families, there is high need for mental health care among youth and demand for services for youth with unmet needs is high.

Community mapping was done with a focus on youth consultation. This had not been done before, and most services in this community are not youth friendly. Existing services often left youth more traumatized with high barriers accessing institutional, regulated and inflexible, disconnected services. A primary concern in the past with youth seemed to revolve around criminality. Could this be related to intergenerational poverty, diminished life prospects, family breakdown/instability and negative social behaviour?

ACCESS OM has helped to identify issues youth are concerned about. ACCESS OM staff now meets the individuals where they are at; for example, meeting a youth at the local coffee shop to complete an assessment or offering counselling sessions. It is amazing that they are able to provide that for the youth.

Questions remain about how youth access ACCESS OM services. How is ACCESS OM linked with existing provincial Integrated Service Delivery services for children and youth with mental health issues?

## 4 | RIPAJ YOUTH HOMELESS NETWORK, QUEBEC

This paper highlights the strong pre-existing 15 year relationship among service agencies with a common goal to improve services for street involved youth. RIPAJ is already a one door service and can deal with a wide range of needs for youth with some service centres able to provide similar services, that is, psychotherapy. This article allowed the reader to gain insight into what Montreal is doing to support homeless youth in regards to mental health and well-being; and provides ideas for other sites who want to help the homeless population within their community.

The most salient change occurred in youth and family engagement. Youth were primarily the consumers of services and played little role in planning them. This paper highlights that youth are more satisfied and feel empowered through their involvement with ACCESS OM. Including these youth voices in the paper rather than just second hand anecdotes would have been more powerful. ACCESS OM has provided an opportunity for agencies to enhance their current service model, increase service capacity and work towards greater youth and family inclusion—the ACCESS OM model seems to be most effective in agencies where there is already an existing service in place that is average to good.

## 5 | UNIVERSITY OF ALBERTA, ALBERTA

This ACCESS OM site features a high-density youth environment and specific cohort of youth, most under the age of 25 and academically

successful. However, this cohort experiences high levels of mental health struggles, anxiety, stress, depression and psychosis. The consultations and community mapping led to better communication between intra-university services as well as recognition of the need to work with off-campus services. Referral and service barriers were also identified.

Overall our impression is that ACCESS OM has been highly successful at this site as it seems to have transformed services. That said, this also corresponds to our view that similar ACCESS OM sites that are further along the youth mental health services continuum and a pre-existing movement towards a better service model, ensured the additional funding would be highly beneficial and transformative.

## 6 | ULUKHAKTOK, NORTHWEST TERRITORIES

In Ulukhaktok, local health services are primarily made up of non-Indigenous nurses flown up from the south which is common practice in Northern communities. Hiring an ACCESS OM clinician was not feasible for the hamlet and not in the best interests of local youth due to issues of trust and stigma. The community felt it was better to have a local person act in this role. As a result, they hired local lay health workers (LHW), renamed as ACCESS OM Youth Workers (AYW), who were trained by ACCESS OM as well as locally.

A LHW and AYW approach makes sense and was a logical decision. Mistissini, a First Nations community, that is another ACCESS OM site, implemented a similar approach many years before becoming an ACCESS OM site. Although this approach has worked quite well for a time and still used to some degree, it has gradually become less reliable over time. Employing local community members can burden individuals who may have their own domestic burdens to bear. Who helps them with vicarious trauma? Also, some locals may prefer to discuss their family and personal issues with trained professionals who are not community members due to gossip concerns; a localized approach can be fraught with issues of confidentiality and quality assurance and may drop adherence to professional ethics. That said, we should not throw the baby out with the bath water; on-going and regular training, support and professional guidance on adhering to ethical guidelines about confidentiality and disclosure can strengthen this local approach.

The need for qualitative research is very well highlighted in this paper. Many standardized questionnaires are not validated for Northern and Indigenous populations, and are problematic at best. This is an important opportunity for the ACCESS OM research advisory committee to step up its game on qualitative research efforts and come up with a sound approach. We wholeheartedly agree!

It was great to read about all the different programs that Ulukhaktok has to offer, but we wish there was more in depth descriptions of the cultural programs or cultural aspects of the community.

## 7 | ESKASONI FIRST NATION, NOVA SCOTIA

Community suicide tragedies were an early impetus for transformation of services in this community and laid the groundwork long before the implementation of ACCESS OM. Eskasoni developed a 'Fish Net Model' to serve the community, developed by the community for the community which consisted of "casting a wide net across the community in a variety of ways and for an assortment of interventions" (Hutt-MacLeod et al., 2019). Eskasoni's model of care was already in line with the ACCESS OM objectives before they became a site. ACCESS OM was able to enhance existing services. Current services include respect for the Indigenous culture within the community.

When implementing the pan-Canadian ACCESS OM project within the community of Eskasoni, it is great to see that they adapted the project with regards to Mi'kmaq traditions, values, learnings, language and historical contexts. Because of cultural and language barriers, the community of Eskasoni was/is respectful in adapting changes that would be suitable when working with First Nation's youth and their families.

It is unclear if Eskasoni will actually be able to sustain the ACCESS OM model. They appear to be caught within the same bureaucratic funding trap that faces most First Nations across Canada: limited funding from federal agencies responsible for funding First Nations and Inuit communities for mental health services (i.e., Indigenous Services Canada [formerly Indigenous and Northern Affairs Canada] and the Non-Insured Health Benefits Program for First Nations and Inuit).

## 8 | ACKNOWLEDGEMENTS

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SUPPLEMENT ARTICLE

WILEY

# Invited commentary: 49° north

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There is more than an arc of latitude at 49° north, separating Canada from the United States.

The view from your neighbour to the south is one of admiration for your developing national services for early intervention in mental health disorders, as reflected in the interesting papers in this timely Supplement to *Early Intervention in Psychiatry*. The ACCESS Open Minds (OM) initiative, a Strategy for Patient-Oriented Research (SPOR) network, supported by a partnership between the Canadian Institutes for Health Research (CIHR) and the Graham Boeckh Foundation, is a model of concerted community action to promote health and social welfare. The focus of ACCESS OM is on youth with significant mental health problems.

Our friendly border demarcates two different approaches to health and social welfare services. It is instructive to examine the differences between our two countries in those policy domains to appreciate the differences in our approaches to early intervention services. The papers in this Supplement focus primarily on service transformation directed at all levels and types of mental health problems and conditions. This brief commentary addresses the policy issues that characterize the Canadian initiative in early intervention services and contrast them with our activities in the United States, which are primarily directed at early intervention in psychosis. It also offers encouragement for a focus on implementing evidence-based clinical services within a SPOR network of services guided collaboratively by clinicians and their community partners.

The papers in the Supplement present the initial stories of transformation in ACCESS OM sites across Canada. The observations are hopeful, reflecting early successes in building a network of collaborative partnerships, following the design of the SPOR demonstration project. Sites as varied as the networks in Ontario and Alberta or with the Eskasoni First Nation in rural Nova Scotia and with the Ulukhaktok in the Northwest Territories each implemented the required elements of the network. Each project developed procedures to identify youth in need of treatment early in the course of their illness, to provide them rapid access to appropriate services with continuity of care and to engage them and their families in services and supports. Local adaptation has been encouraged to account for local cultural patterns and preferences. First Nations networks are tailored to different local needs in Nova Scotia and the Northwest Territories. SPOR network services also are locally adapted in Francophone New Brunswick, in a network for homeless youth in Quebec, and in post-secondary school student services in Edmonton. Local variations are encouraged at the same time that each of the networks is required to implement the five central elements of the ACCESS OM service model. Getting the right balance between standardization and local adaptation may hold the key to the ultimate success of the demonstration.

What structural elements of health and social welfare policy support this successful implementation? First and foremost, Canada has universal health insurance as a critical starting point to provide funding to implement and sustain early intervention services. Health insurance is necessary, but not sufficient, however, for successful implementation. Other resources additionally have been made available to pay for services that are not covered by health insurance. Of equal importance is Canada's strong communitarian spirit, at least as reflected in the experience with ACCESS OM. There is also a commitment to inclusive values, seen in culturally sensitive and youth-involved programming and in shared decision making. Of course, if Canada's mental health systems were perfect and had sufficient resources for early intervention services, there would have been no need for the Boeckh Foundation and CIHR to develop the ACCESS OM SPOR initiative. They are to be praised for their commitment to overcoming these limitations and to transforming services for youth. All-the-same, whatever the deficiencies, Canada is much further ahead in all of those areas of policy and programming in early intervention services. But the United States is trying to catch up.

In the United States between the late 1970s and the year 2000, various government and foundation initiatives in mental health focused on improving the organization and financing of mental health services, particularly on individuals with the most severe mental

  

disorders. Emphasis was placed on rehabilitation and social support services more than on early intervention. And the emphasis on systems issues took the focus off the content and quality of the services and treatments themselves. The results of many of these initiatives (including one called ACCESS! (Goldman et al., 2002)) suggested that mental health and social welfare systems could be integrated and services implemented, but that the expected improvements in clinical status and quality of life could not be attributed directly to the systems changes. Systems change may have been feasible, but it was not adequate to achieve good outcomes. Effective treatments and social interventions were essential to improve functioning and quality of life. Mental health initiatives in the United States refocused on the implementation of evidence-based practices as essential to improved health and social welfare outcomes.

In the past decade the shift in focus to implementing evidence-based practices has included a renewed interest in early intervention services. The United States has been slow to enter this field compared to Australia, Europe and Canada, for a number of reasons, not least of which is a series of policies favouring services for individuals with already disabling mental disorders. Local and State governments set funding priorities for rehabilitation and services for individuals with longstanding mental health problems. Private health insurance often was denied to individuals whose mental illness represented a pre-existing condition, and eligibility for federal health insurance often was based on an individual's meeting criteria for disability benefits. Early intervention services, designed to prevent disability, particularly due to psychosis, were a low priority for mental health service delivery in the United States until several states broke into the field, and the National Institute of Mental Health began the RAISE (Recovery After an Initial Schizophrenia Episode) initiative. Positive results from the studies within RAISE led the federal government to make available some added resources for early intervention services, and the Affordable Care Act (ACA) made insurance coverage more available as well (Dixon, Goldman, Srihari, & Kane, 2018). That said, threats to the ACA and failure of some states to adopt all of its provisions, coupled with the limited nature of other federal supports, have restricted early intervention service development and implementation. There is no universal structural and financial support to sustain early intervention services in the United States.

These papers provide an encouraging view of early implementation of ACCESS OM. Canadian mental health and social welfare policies support those programmes. That is something to be appreciated, especially when one considers other countries, where conditions are not so favourable for mental health services innovation and implementation, including the United States. It remains to be seen if these early intervention programmes will produce good results. Based on our experience with services integration demonstrations in the United States, it is imperative to focus on the quality and content of clinical services. No matter how well services are organized and financed, good outcomes depend on implementing evidence-based practices as intended, faithful to effective models of services and treatment. I look forward to observing the next phase of ACCESS OM from down here, below the 49th parallel.

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SUPPLEMENT ARTICLE

WILEY

# Invited commentary: "Everybody has won, and all must have prizes" (Carroll, 1865)

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Many of us are familiar with the verdict of the Dodo bird in Alice's Adventures in Wonderland after a "race" (Carroll, 1865). In this commentary on the implementation of ACCESS Open Minds (ACCESS OM) I will show how aptly "everybody has won, and all must have prizes" fits the pan-Canadian reach of the programme. I will offer further comment on issues that face ACCESS OM as the initial funding provided by the Strategy for Patient-Oriented Research Network funded by the Canadian Institutes of Health Research (CIHR) and the Graham Boeckh Foundation (GBF) winds down. And finally, I will consider the research potential for implementation science that ACCESS OM represents.

Seven of the 14 sites that are part of ACCESS OM are represented with descriptions that aim to fit a template of the components of the transformation of care for youth mental health. These are community mapping, early identification, rapid access, appropriate care, continuity of care, youth and family engagement and research and evaluation (Malla et al., 2018). Critical to all of these is the definition of youth as age 11-25 and the elimination of the traditional silos that divide youth between child and adolescent services and those for adults. Each of the sites represented in this supplement provides a different slant on the model and the adaptations required. Sites joined ACCESS OM with different levels of services and care already in place and therefore needed to adapt to those conditions forging relationships and integrating with ongoing services while at the same time registering the novel vision represented by the model.

One of the most striking differences among the sites is the degree to which "professional" mental health providers are available at point of first contact and how access is managed; the small Inuit community of Ulukhaktok in the Northwest Territories (Etter et al., 2019) and at the University of Alberta in Edmonton (Vallianotos et al., 2019), highlight this. Language also presents challenges in Canada, a nation with two official (English and French) and many Indigenous languages. ACCESS OM becomes ACCESS Esprits ouverts in the programme for homeless youth in Montreal (Abdel-Baki et al., 2019). Although "ouvert" translates cleanly and only to "open" in English, "esprits" can also be translated as "spirit" which may be more empowering. Dubé et al. (2019) describe provision of services for a rural francophone community located in New Brunswick, which is majority English speaking. Sometimes ACCESS OM is housed in dedicated physical space providing access outside of traditional service settings that may have negative associations and be stigmatizing for youth. Reaume-Zimmer et al. (2019) describe a centrally located youth space in Chatham-Kent as the point of access rather than the traditional hospital and community organizations that serve the community. Although there is no requirement for referral, almost 50% of the youth seen at the Chatham-Kent youth space are referred by traditional community agencies.

Services provided also vary greatly. Hutt-McLeod et al. (2019) describe the Eskasoni First Nation "two-eyed-seeing" approach to mental health care; seeing from one eye the strengths of Indigenous ways of knowing, and from the other eye, the strengths of Western (or mainstream) ways of knowing, and using both perspectives to benefit those being served. Eskasoni ACCESS OM built on integrated services in a small geographic community to renovate their Youth Space, the dedicated centre for activities that go beyond mental health care to youth and families. In contrast, ACCESS OM in Edmonton, Alberta, a sprawling city with a population of 1.3 million faced a very different problem: where and who to focus services initially (Abba-Aji et al., 2019). The decision was to focus narrowly initially on high-school youth in leased space at a YMCA in centre city—a neutral and accessible location, with scaling to include all of Edmonton a future goal.

These are just some examples of the variability and innovation shown by sites within the unifying ACCESS OM framework. Clearly, all have won and all must have prizes!

  

All of the groups point to challenges faced; some met and some still await. The ACCESS OM model has demonstrated flexibility and adaptability in a wide range of settings. The next critical question is whether it makes a difference in mental health and other outcomes for the youth who are being served. That will represent the next challenge. The research mandate of ACCESS OM includes collection of uniform data across sites both to characterize the youth being served and to develop longitudinal data that can address outcomes. We will await the answers that will emerge from these data.

Last, but not least, are the questions of sustainability for the sites, where ACCESS OM has been initiated, and scalability. ACCESS OM was funded in 2014 and the central team formally opened its door in 2015. Support will end in 2021, following an extension. Several of the articles speak to the challenge and efforts underway to ensure that the programmes continue after funding ends. Money is always problematic and in the same way that community mapping served to inform the initiation and implementation of the model at sites, it will be valuable to document the processes, more and less successful, that come into play in the effort to sustain the model after funding ends.

Malla et al. (2018) have clearly demonstrated that ACCESS OM can be implemented in five Canadian provinces and a territory that span the continent and the complex linguistic environment that characterizes Canada. The final remaining question is whether the model can be scaled so that all youth in need have access to services that are timely, sustained and are not artificially constrained by whether one is under or over 18.

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SUPPLEMENT ARTICLE

WILEY

# Invited Commentary: Community adaptations to ACCESS Open Minds—Lessons from Eskasoni and Ulukhaktok

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Developing a high-quality system of youth mental health services in Canada is of tremendous importance, not only for improving the lives and prognoses for those youth experiencing mental health difficulties and their families who support them (which should be motivation enough!) but also from a broader social perspective. As noted by Malla et al. (2018), there are a great many reasons why youth mental health should be a priority. However, system transformation is an endeavour that necessarily requires the engagement of the general population at large, as well as specific groups with differential access to care for reasons related to culture and context. For example, Indigenous people comprise 4.9% of the total population of Canada and are the fastest growing segment-growing at a rate four times that of the general Canadian population (Statistics Canada, 2016). At the same time, when compared to youth from the general Canadian population, Indigenous youth experience disparity in proximal, intermediate and distal determinants of health (Reading & Wien, 2009). As a consequence, Indigenous youth have high rates of mental health difficulties. At the same time, Indigenous communities often experience limited access to mental health resources and specialist care.

Hutt-MacLeod et al. (2019) describe the adaptation and implementation of the ACCESS Open Minds (ACCESS OM) service transformation objectives for youth in the culture and context of Eskasoni First Nation on Unama'ki. Utilizing the Mi'kmaq concept of *Two-Eyed Seeing* as described by Elder Albert Marshall (2004), Eskasoni Mental Health Services, in partnership with ACCESS OM, developed a local approach aimed at improving local services to local youth experiencing mental health difficulties and their families. Similarly, Etter et al. (2019) show that lay community health workers are central to meeting contextual needs in Ulukhaktok, as is a continued process of community mapping. For Indigenous people, there has been a long history of imposition of external structures and approaches that fail to take into consideration the unique histories, languages, cultures and contexts inherent in our communities. This has resulted in less than adequate care as well as frustration and hesitance in engaging with such systems. And, justifiably so. Indeed, what has always been needed is a system of service that includes objectives such as those of the ACCESS OM Project: early identification, rapid access, appropriate care, continuity of care and youth and family engagement, but which is implemented within the culture and context of the community served in a manner that incorporates the great wisdom inherent in culture-based approaches to wellness. Indeed, these five objectives are what Eskasoni Mental Health Services and ACCESS OM pursued and what community leaders of Ulukhaktok used as a framework for identifying key activities for sustainable change. The results are as follows: In Eskasoni, mental health services where youth are given the choice between mental health services as usual, Mi'kmaq methods of improving well-being, or a combination; and In Ulukhaktok, attunement of the ACCESS OM framework to Inuit paradigms and a potentially sustainable working model for others to consider in the Inuvialuit Settlement Region and Inuit Nunangat. These collaborative examples of the *gift of multiple perspectives* have the potential to inform the transformation of systems of service in other Indigenous communities.

  

But, there remain a few considerations for further development. Which age demographic to prioritize and the timing of such prioritization depends upon level of analysis. For example, if considering attachment mediated neurodevelopment in the context of adverse childhood experiences (ie, ACEs), ages 0 to 6 years are relevant. Epidemiological ACEs data suggest the window should include ages 0 to 18 years. If considering developmental onset of mental health difficulties, as ACCESS OM does, youth ages 11 to 25 are the focus. Indigenous community-based initiatives can also include programming aimed at pre-natal neurodevelopment in the context of exposure to substances such as alcohol or opioids, which suggests the focus might be ages −40 weeks to birth. And new developments in epigenetic research and maternal stress might expand the developmental window of interest from ages −two years to birth. Executive function, as an overarching conceptual framework which could encapsulate each of these developmental periods (and may also be relatively culturally neutral as a construct), would suggest the importance of consideration from ages −two years to 25 when prefrontal cortical development has completed (eg, particularly in the case of marijuana exposure). And, since our youth will someday have families of their own, we can expand these windows further in directions both backward and forward in time. What emerges is the need for an integrated conceptual model that can organize all of what is known into an accessible framework for developing and implementing what is needed for an individual, family and community to be well. Seven generations in both directions. Indigenous cultural knowledge holds this as true.

What will be important in addition to improvement of systems and services in Indigenous communities is the ability of systems of service aimed at specific developmental age groups to be able to communicate and collaborate with adjacent systems. That is, infants become children who become youth who become adults who have infants. And, depending upon prevention and/or treatment effectiveness, it can be the case that an individual requires supports throughout her or his lifetime. Currently, it seems to be the case that in many jurisdictions these adjacent systems do not communicate as well as they ought to, and that our decision- and policy makers focus on their mandated developmental windows, sometimes at the exclusion of other developmental windows. This can result in gaps in service and care for those transitioning between demographics. Indigenous communities are working to improve their community systems of care. Eskasoni, for example, has developed a "womb to tomb" model of mental health which serves the whole community across the lifespan, thus improving continuity of care and ensuring issues related to re-referral, relationship building and aging-out of service are mitigated. The geographic context for Ulukhaktok reminds us additional challenges remain, such as the continued need for improved access to specialized mental health services.

While system and service transformation is essential, at the same time, community-based initiatives aimed at stemming the effects of differential access to proximal, intermediate and distal determinants of mental health are required. Youth aged 11-25 years are to mental health treatment as children aged 0 to 6 years are to prevention. Indeed, in many Indigenous communities, ACEs are common and have significant developmental sequelae as demonstrated in the multitude of epidemiological studies published since the 1990s. For example, Dube et al. (2001) showed that an ACE score of at least 7 increased the likelihood of childhood/adolescent suicide attempts 51-fold (and adult suicide attempts 30-fold). With such massive effect sizes, the importance of system and service improvements cannot be overstated but neither can the importance of prevention. Perhaps nowhere is this so important as in Indigenous communities. Ambitious and necessary collaborations such as those between Eskasoni Mental Health Services, Ulukhaktok and ACCESS OM provide clear examples of how Indigenous communities and leaders in system transformation are working together to improve the lives of our youth.

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## CONFLICT OF INTEREST

Dr. Mushquash currently sits on the Board of the Ontario Psychological Association. He receives no personal funding in this role and has no other potential conflicts of interest to declare.

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