Paving the Way for Smooth Transitions: Continuity of Care from Child to Adult Mental Health Systems

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Ethics Statement

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Abstract

There is a significant lack of programs and supports for youth transitioning from the child to adult mental health systems in BC. At the age of 19, youth age out of the child and youth mental health system without the proper supports and resources to smoothly transition into adult services. Though there has been significant discussion about what can be done provincially to address this issue, there has been limited discussion of how to address the issue at the regional level in BC. With this in mind, a series of policy options were developed that can be implemented through the Regional Health Authorities in the Lower Mainland (Vancouver Coastal Health and Fraser Health). Systemic level changes are identified and included in this project; however, the focus of this project is on micro-level programs and policies that can be adopted regardless of the implementation of the systemic level changes. The policy options are based on transition programs developed in other jurisdictions. Background information and evidential support for the policies were provided from the 2015 National Consensus Conference for Emerging Adults, sponsored by the Mental Health Commission of Canada, and from expert interviews. This project recommends a Transition Coordinator Pilot Project, in addition to adoption of systemic changes in the long term.

Keywords: Child Mental Health; Transitions; Emerging Adults; Adult Mental Health; British Columbia; Lower Mainland

Dedication

I dedicate this project to my parents, Mac Nelson and Therese Paradis, who have lovingly supported me throughout my academic career.

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Table of Contents

Approval ii
Ethics Statement iii
Abstract iv
Dedication v
Acknowledgements vi
Table of Contents vii
List of Tables x
List of Figures xi
List of Acronyms xii
Executive Summary xiii

Chapter 1. Introduction 1

Chapter 2. Background 3
2.1. Defining Mental Health Issues 3
2.2. Defining Emerging Adulthood as a Stage of Life 4
2.3. Prevalence and Incidence of Mental Health Issues among Youth in British Columbia and the Lower Mainland 5
2.4. Overview of the Mental Health Systems in British Columbia and the Lower Mainland 6
2.4.1. Ministry of Child and Family Development (MCFD) 6
2.4.2. Ministry of Health (MoH) 7
2.4.3. Regional Health Authorities (RHAs) 7
2.4.4. Hospital Services 9
2.4.5. Specialised Provincial Mental Health Facilities 9
2.4.6. Informal Care 9
2.5. Policy Context 10
2.6. Provincial Mental Health Legislation, Strategies, and Policies 11
2.6.1. The BC Mental Health Act 11
2.6.2. Child and Youth Mental Health Plan 11
2.6.3. Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health 12

Chapter 3. Methodology 13
3.1. Literature Review and Jurisdictional Scan 13
3.2. Consensus Conference on Emerging Adults 14
3.3. Expert Interviews 15
3.4. Limitations 16

Chapter 4. Literature Review 17
4.1. General Barriers Experienced by Transitioning Youth 17

Chapter 5. Jurisdictional Scan 21
5.1. Existing Models of Care for Transition-aged Youth 21
5.1.1. Team/ Shared Management Approach 21
5.1.2. Protocol and Reciprocal Agreement Model 23
5.1.3. Integrated Care Clinic Models 24
5.1.4. Community Care Model 27
5.1.5. Summary 27

Chapter 6. Results 29
6.1. Consensus Conference on Emerging Adults 29
6.1.1. Barriers facing Transition-aged Youth 29
6.1.2. Summary of Best Practice Principles 29
6.1.3. Summary of the Suggestions for Policy Action 33
6.1.4. Summary of the Policy Model Discussion 34
6.2. Expert Interviews 37
6.2.1. Early Intervention 37
6.2.2. More Funding Needed 38
6.2.3. Changes in Management Needed 38
6.2.4. Accountability 39
6.3. Summary of Research Findings 39
6.3.1. Flexibility of Care 39
6.3.2. Consistent Management Structure 40
6.3.3. Financial Management 40
6.3.4. Quality Assurance and Outcome Measures 41
6.3.5. Central Information System 42

Chapter 7. Policy Options 44

Chapter 8. Policy Criteria and Measures 47
8.1. Effectiveness 49
8.2. Budget Impact 50
8.3. Stakeholder Acceptance 50
8.4. Measures and Weights 51

Chapter 9. Policy Analysis 54
9.1. Societal Objective: Determining Effectiveness 54
9.1.1. First Criterion: Proportion of successful transitions from CHMS to AMHS 54
9.1.2. Second Criterion: Increasing Access to Mental Health Services 56
9.1.3. Third Criterion: Reduction in the stigma associated with mental health issues 58
9.2. Government Management Objective: Budget Impact 59
9.3. Government Management Objectives: Stakeholder Acceptability 61
9.3.1. Transition-aged youth and their families 61

9.3.2. Financial Stakeholders 62
9.3.3. Existing Care Providers 62
9.4. Summary of Policy Analysis 64

Chapter 10. Recommendations and Conclusions 66

References 68

Appendix A. Notable Programs in BC 74
British Columbia 74
Lower Mainland Regional Health Authorities 76

Appendix B. Summary of Models and their Application 78

Appendix C. Interview Guides 82

List of Tables

Table 7.1. Policy Options 44
Table 8.1. Criteria and Measures 47
Table 8.2. Measures and Weights 52
Table 9.1. Effectiveness Analysis Summary 54
Table 9.2. Budget Impact Analysis Summary 59
Table 9.3. Stakeholder Acceptability Analysis Summary 61
Table 9.4. Summary of Policy Analysis 64

List of Figures

Figure 2.1. Regional Health Authorities in BC 8

List of Acronyms

AMHS	Adult Mental Health System
BC	British Columbia
BC-IYSI	BC Integrated Youth Services Initiative
CMHS	Child Mental Health System
CYMHSUC	Child and Youth Mental Health and Substance Use Collaborative
MCFD	Ministry of Child and Family Development
MoH	Ministry of Health
PHSA	Provincial Health Services Authority
RHA	Regional Health Authority
SAMHSA	Substance Abuse and Mental Health Services Administration
SSCCY	Standing Senate Committee on Children and Youth
TIP	Transition to Independence Process
VCH	Vancouver Coastal Health

Executive Summary

Policy Problem

In BC, youth lose eligibility to receive child mental health services at the age of 19. At this time, youth are expected to transition into adult services; however, there is a significant lack of services and supports for youth transitioning from the child to adult mental health system (Turpel-Lafond, 2013; SSCCY, 2014). No provincial-wide policy has been fully implemented in BC to address this gap; rather the authority to develop transition policies and programs has been delegated to the individual regional health authorities. The lack of an overall set of provincial requirements and clinical guidelines has led to defaults and inconsistencies in care for this population in transition.

Research Objectives

Several studies have focused on federal and provincial level approaches to the issue of transitions in mental health; however, there are no studies that have examined the specifics of a regional approach to the problem in BC's Lower Mainland. This study focuses on programs and policies that could be implemented through the regional health authorities in the Lower Mainland (Vancouver Coastal Health and Fraser Health) based on a coherent provincial protocol for transitioning youth. The goal of this project is to provide an understanding of the scope of the issue in BC's Lower Mainland and to develop a set of regional level policy options that agencies could implement to assist youth in successfully transitioning to adult services.

Methodology

Three methodologies were used to inform the development of the policy options and their analysis:

1. A substantive literature review and jurisdictional scan was conducted to examine the common barriers facing transition-aged youth and to identify relevant policy models that have been developed in other jurisdictions.

2. Attendance at a conference hosted by the Mental Health Commission of Canada in Ottawa from November 2nd to November 4th. This conference included evidence provided by emerging adults (youth in transition), caregivers, policy makers, researchers, mental health organizations, and clinicians about recommendations for improving the transition of youth from the youth mental health care system to the adult health care system. Qualitative data from the expert speakers and from nine informal interviews with mental health experts at the Conference provided suggestions for a model of youth mental health best practices and potential policy options.

3. In addition, I conducted interviews with four mental health experts, including a Health Systems Consultant, a Professor of Social Work, Child Health Policy Expert, and an MLA. The interviews focused on the barriers facing transition-aged youth, inequalities in accessibility to mental health services for transition-aged youth, and recommendations for policies and programs to improve the transition period for emerging adults. The findings from the interviews supported the need for system-level changes to improve the overall management of BC's mental health system and to increase the use of outcome measures and data collection.

Policy Options

Based on the findings from the literature review, the jurisdictional scan, the Consensus Conference and the expert interviews, three policy options are suggested: a Transition Coordinator Pilot Project, Integrated Care Clinics, and Reciprocal Protocol Agreements. The Transition Coordinator Pilot Project involves the hiring of one to three transition coordinators to support youth within the child mental health system in the Lower Mainland to transition to adult services. The Transition Coordinators ensure that a transition plan has been developed for the youth and that it is being implemented by a child mental health practitioner. The Integrated Care Clinics are "one stop shops," in which youth can access a variety of health and social services, such as physical health, mental health, education, and employment services. The Reciprocal and Protocol Agreement is a provincial-level protocol that would provide clinical guidelines to guide transition programming in the regional health authorities. A series of macro-level changes to improve the mental health system in BC were identified. These options are important to include but were not analysed and are not necessary for the implementation of the three policy options.

Criteria and Measures

The policy options were assessed based on three societal and government management objectives. The first objective was effectiveness, and this included measures to illustrate the policy options ability to promote successful transitions to adult services, access to mental health services, and their ability to reduce the stigma associated with mental health. The policy options were also assessed based on their budget impact and overall stakeholder acceptance.

The scoring of the policy options was meant to demonstrate some of the important trade-offs that exist between the policy options.

Recommendation

The analysis of the policy options resulted in a recommendation for the implementation of the Transition Coordinator Pilot Project in the short term. This policy option would be evaluated over a two-year period to ensure that the program is meeting the needs of transition-aged youth, and would provide an immediate intervention to some of the problems identified.

This immediate response, however, would benefit from some wider and longer-term strategies at the provincial-level. This includes the development of a consistent management structure and a centralised data system. This would facilitate better data collection, increasing the ability of the province to effectively evaluate the mental health system in BC and to implement change on the basis of sound scientific evidence.

Chapter 1.

Introduction

Emerging adulthood can be a difficult time for youth who, during this time, are making decisions about their education and employment that will define their future opportunities. This period can be both challenging and exciting as youth have the chance to have new experiences and develop emotionally and physically. Unfortunately, for many youth with mental health issues, the transition to adulthood is not a time of growth, but instead represents a path riddled with significant barriers to development, leading to sometimes irreparable harm for youths' mental health and general wellbeing.

In BC, youth lose eligibility to receive child mental health services at the age of 19. This transition from child to adult mental health services can be extremely difficult. Many are not provided with appropriate planning or support. Youth lose valuable relationships with care providers and funding for the services they need. In addition, youth face significant institutional barriers to accessing adult mental health services, such as the differing eligibility requirements and cultures of care between child and adult mental health services. Mental Health services are extremely fragmented in BC, making it difficult for youth to access the services they need. Without the proper guidance and planning, youth who "age out" of the child mental health system end up disengaging from the mental health services, which can be extremely detrimental to a youth's progress and treatment.

Despite the mounting evidence that there is a significant gap in services and supports for youth transitioning (Turpel-Lafond, 2013; SSCCY, 2014), no provincial-wide policy has been fully implemented in BC to address these gaps. Instead, the development of policies and programs has been left to the individual regional health authorities. Without any overarching requirements or clinical guidelines, each Regional

Health Authority can develop its own standards, which can lead to inconsistencies in care provided.

Several studies examine the issue of transitions in mental health at the provincial level (Turpel-Lafond, 2013; SSCCY, 2014); however, no studies have examined the issue from a more local perspective. This project aims to provide a more detailed understanding of the gaps in services that exist for transition-aged youth in the Lower Mainland and reveal some of the political and institutional barriers to developing effective transition policies in the Lower Mainland. With a focus on the Regional Health Authorities in the Lower Mainland (Vancouver Coastal Health and Fraser Health), a series of policy options were developed that represent prospective approaches to 'transition' programs and policies. These policy options were developed based on regional approaches in other jurisdictions, which were identified through a substantive literature review and jurisdictional scan. The Consensus Conference on Emerging Adults organized by the Mental Health Commission of Canada and a series of expert interviews provided background information on the issue, as well as informed the policy option development and analysis. Systemic-level changes were identified in this project; however, since the focus of this project is on regional-level approaches, only micro-level policies and programs were analysed. These policy options can be adopted independent of the systemic level changes. Three micro-level policy options were analysed: a Transition Coordinator Pilot Project, the development and expansion of Integrated Care Clinics and Protocol and Reciprocal Agreements. These policy options were analysed using criteria and measures and were subsequently scored based on their relative merit in regards to effectiveness, budget impact, and stakeholder acceptance. The analysis resulted in a recommendation to implement a Transition Coordinator Pilot project, with the adoption of systemic changes in the long-term.

Chapter 2. Background

2.1. Defining Mental Health Issues

The World Health Organisation (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community,” (WHO, 2014). Having good mental health is important for youth to develop properly and fulfill their potential. Having good mental health or a sense of well-being is more than an absence of mental illness. Many youth with mental health issues find they have episodically good and bad moments of mental health (Mental Health Commission of Canada, 2013, p. 4).

The factors associated with variation in mental health are numerous. Individuals’ mental health can vary based on age, experiences, gender, race, culture, sexual identity, level of education, and socio-economic status (Cox et al, 2013, p.15). In summary, what the literature suggests is that “there is no single cause of mental health issues. Whether a mild mental health problem or a severe mental illness, mental health issues are the result of a complex mix of social, economic, psychological, biological, and genetic factors,” (Mental Health Commission of Canada, 2013, p. 4).

Within this project, the term “mental health issues” will be used to describe a variety of mental health conditions from anxiety and depression to schizophrenia. The definition of this term is left deliberately vague given the diversity in mental health issues and range of severity (Mental Health Commission of Canada, 2013). It is also important to recognize that those defined as 'mentally ill' are often the most vulnerable, the poorest, the youngest or oldest, from a minority ethnic group, and are women (Goffman, 1961). They are also often homeless or under the supervision of state agencies (Goffman, 1961). Many others will exhibit the same behavioural problems, but due to

their privileged position, they come to be labelled as eccentric, odd, peculiar, weird, but not mentally ill, and they don't become part of our official statistics (Goffman, 1961). Bouts of severe behavioural dysfunction, however, usually act as common grounds for entry into the 'mental health' system. As the Mental Health Commission of Canada (2013) concludes, mental health is an extremely complex issue.

2.2. Defining Emerging Adulthood as a Stage of Life

Before discussing the barriers and inequalities that youth aged 15 to 24 face in their transition from youth to adult mental health services, it is important to fully understand “emerging adulthood.” Emerging adulthood is a period of the life course, distinct from both adolescence and young adulthood, which ranges roughly from the late teens through to the mid- to late 20s (Arnett, 2000, p.469). Emerging adulthood is not an easily definable age-period since it is experienced differently by every young person, and again, is heavily dependent on social, economic, cultural and racial factors (Arnett, 2000, p. 470).

It is during emerging adulthood that young people make the important education and employment decisions that will be the foundation for their future (Arnett, 2000, p. 474). At the same time, these youth are experiencing major shifts in their social support systems and facing the loss of familiar social structures, such as school supports, which makes this a very difficult period for youth in general (Konstam, 2007, p.1).

Youth who are simultaneously dealing with mental health problems face an even greater challenge. They often experience delayed development, and therefore need greater access to support to face the challenges and decisions of emerging adulthood (Turpel-Lafond, 2013). Furthermore, evidence suggests that late adolescence (17-19 years) is a common time for the onset and/or the aggravation of mental health conditions, making the transition period that much more challenging (SSCCY, 2014). In addition, youth are also more likely to engage in risk-taking behaviour and are at a greater risk for disengaging from mental health services during emerging adulthood (Singh, 2009, p. 386).

In combination with their mental health issues, emerging adults may be facing a multitude of barriers to positive mental health. This can include stresses associated with personal and familial finances, family or household problems, living in a group home,[1] and/or being away from their support system (Cox et al, 2013, p. 18). To make matters worse, some emerging adults are dealing with substance abuse, a direct result of their mental health issue (Cox et al, 2013, p. 18).

2.3. Prevalence and Incidence of Mental Health Issues among Youth in British Columbia and the Lower Mainland

Waddel et al. (2014, p. 5) conducted a substantive review of mental health surveys from the United States, the United Kingdom, Puerto Rico, Israel, Hong Kong, and British Columbia to determine the prevalence of mental health issues amongst youth aged 4-17 years. In BC, the survey results suggest that 12.6% of youth in BC are experiencing some form of mental health issues at any given time (Waddel et al., 2014, p. 5). This would mean that in 2014, 84,000 youth in BC are suffering from mental health issues that require some form of intervention to prevent further distress (Waddel et al., 2014, p.5). Unfortunately, only 31% (or 26,000) of these youth are estimated to be receiving the services that they need, and thus, given these numbers, it would appear that upwards of 58,000 youth in BC are without access to specialised mental health services (Waddel et al., 2014, p. 5). There is a lack of data surrounding the number of youth eligible to transition into adult services, which makes it very difficult to determine the number needing transitional services, especially within each Regional Health Authority. Better collection of data would assist the development and evaluation of programs for transition-aged youth.

[1]The McCreary Centre Society is a non-profit NGO that aims to improve the health of BC youth through research and through supporting community-based initiatives (MCS, 2015). In a 2013 report by the McCreary Centre Society, emerging adults identified living in a group home as a barrier to positive mental health (Cox et al, p. 18). The youth reported that being away from their family and being surrounded by other youth facing challenges exacerbated their mental health issues. Lack of sleep and feeling unsafe were other reasons why emerging adults reported group homes as a barrier to positive mental health (Cox et al, 2013, p. 18)

In regards to the prevalence of different types of mental health issues, most youth referred to child and youth mental health services exhibit fear and anxiety (56.9%) and depression (40.8%)(MCFD, 2015a, p.32). However, many of these youth have multiple diagnoses, with 78% of youth referred to child and youth mental services presenting with more than one mental health issue (MCFD, 2015a, p.31).

2.4. Overview of the Mental Health Systems in British Columbia and the Lower Mainland

To understand the transition services provided in the Lower Mainland, one has to understand how services are organized and implemented in BC as a whole, as mental health is under provincial jurisdiction. BC's youth and adult mental health system consists of a patchwork of governmental and non-governmental organisations. The two main governing bodies for mental health in BC are the Ministry of Child and Family Development (MCFD) and the Ministry of Health (MoH); most services are delivered through the Provincial Health Services Authority (PHSA) and the Regional Health Authorities (RHAs) (SSCCY, 2014, p.14). Though the PHSA and RHAs work in collaboration with the ministries, communication and cooperation between the MCFD and the MoH is much less commonplace. Instead, as the Representative for Children and Youth concluded, there is a "lack of a comprehensive, well-designed and efficiently delivered suite of mental health services for youth who are transitioning into adulthood," (Turpel-Lafond, 2013, p.72). To illustrate the complexity and diversity of youth and adult mental health service provisions, we need to review the specific youth and adult mental health structures in BC. A list of notable programs in BC and the Lower Mainland is provided in Appendix A.

2.4.1. Ministry of Child and Family Development (MCFD)

The MCFD is primarily responsible for community health services through its Child and Youth Mental Health Services. This program provides assistance and support for youth under the age of 19 with mental health issues and their families (MCFD, 2015b). The Child and Youth Mental Health Services are delivered through specialised mental health teams and child family centres, which employ MCFD mental health staff

(including psychologists, social workers, and nurses), psychiatrists, and contracted-out specialised and community health services (MCFD, 2015b; SSCCY, 2014, p. 14). The MCFD and contracted agencies provide services such as mental health assessments, resource, and support upon referral (SSCCY, 2014, p.14).

Specialised programs in BC for youth are under the jurisdiction of both the MCFD and the Health Authorities, which in turn are under the jurisdiction of the Ministry of Health. The Early Psychosis Intervention program is delivered differently across the province. Generally, youth aged 13-17 are eligible for this program, although the program can serve young adults up to the age of 30. In terms of the transition process of youth, this program is an example of successful collaboration between the Ministry of Health (MoH) and the MCFD. The success of this program may be due to the fact that the youth with severe mental health issues are more likely to be eligible for adult services (SSCCY, 2014, p. 19).

2.4.2. Ministry of Health (MoH)

The MoH is responsible for primary care delivered by family doctors, specialised inpatient mental health care, and acute care in hospitals run by regional health authorities and the Provincial Health Services Authority (SSCCY, 2014, p.14).

Adult services are primarily provided by the Regional Health Authorities (RHA) with funding from the MoH. The focus for adult mental health services is primarily on individuals with severe mental illness. For youth likely to require adult mental health care upon turning 19, transition planning is supposed to start by their 17th birthday or as soon as it becomes apparent that continuing support will be needed (MCFD, 2015; SSCCY, 2014, p. 19).

2.4.3. Regional Health Authorities (RHAs)

BC has one Provincial Health Services Authority (PHSA) and five RHAs. Each is responsible for the development and delivery of its own community- and hospital-based mental health services and programs. RHAs also provide outpatient services to youth aged 16-18 within the community. Even acute hospital-based levels of care can be

provided at home for some patients (SSCCY, 2014, p. 19). The MCFD provides funding to the RHAs to deliver youth addictions services. These services may be more specialised for addicted youth who are also dealing with mental health issues (SSCCY, 2014, p. 19).

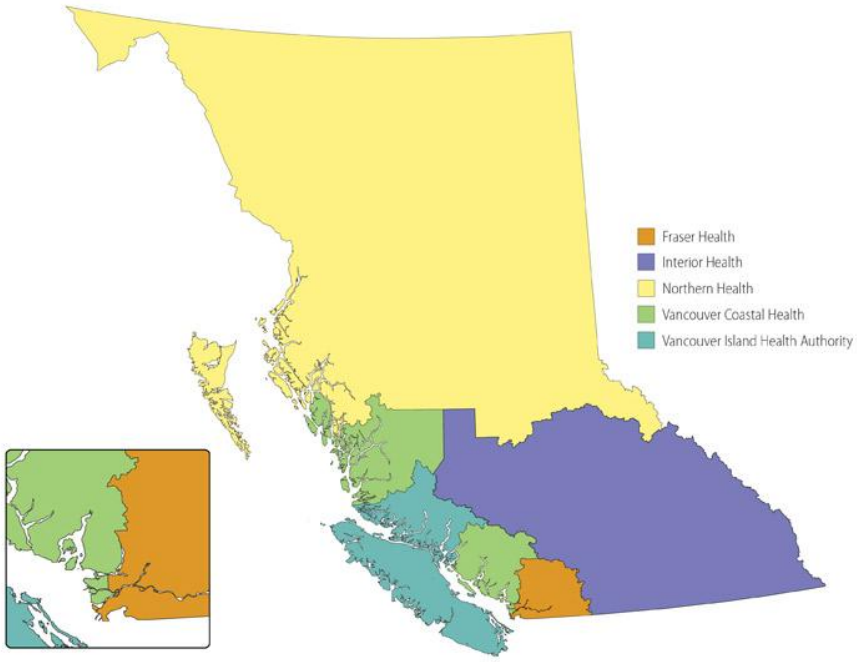

Figure 2.1. Regional Health Authorities in BC
Map used with permission from the BC Government.

Given the diversity of programs in each of these regions, the focus of analysis will be on policies, strategies and services provided within the Lower Mainland, which consists primarily of Vancouver Coastal Health and Fraser Health (as per figure 2.1 above).

Vancouver Coastal Health (VCH) delivers services to over one million individuals in Vancouver, the North Shore, Richmond, the Sea-to-Sky Highway, Sunshine Coast, Bella Bella, Bella Coola, the Central Coast, and the surrounding areas (VCH, 2014). Fraser Health serves approximately 1.6 million people from Burnaby to Hope to Boston Bar (Fraser Health, 2016).

2.4.4. Hospital Services

Hospital in-patient services can also be provided for youth in BC within the general, pediatric, adult psychiatric, or adolescent psychiatric wards depending on the age of the youth and the availability of wards in the hospital (SSCCY, 2014, p. 19). Both assessment and treatment are offered as in-patient services. Hospital psychiatric wards are designated as mental health facilities by the BC Mental Health Act, which allows for the voluntary and involuntary admission of patients to qualified mental health facilities (SSCCY, 2014, p. 20). There are only five specialised adolescent psychiatric wards in BC (SSCCY, 2014, p. 20).

2.4.5. Specialised Provincial Mental Health Facilities

The Lower Mainland has two ultra-specialised mental health treatment facilities: BC Children's Hospital (operated by the Provincial Health Service Agency) and the Maples (operated by MCFD). These facilities are meant for youth who have the most intensive care needs (SSCCY, 2014, p. 21). BC Children's Hospital handles emergency services and short-term care (although longer term care can sometimes be accommodated). The Maples provides longer-term care, and youth tend to be admitted on a planned basis rather than as a response to an acute mental health crisis (SSCCY, 2014, p. 21).

2.4.6. Informal Care

In addition to the above formal forms of care, there are two types of informal care in BC discussed in the literature: self-care and informal community care (Turpel-Lafond, 2013, p. 32). Self-care refers to youth providing care for themselves and/or receiving care from family and/or friends (Turpel-Lafond, 2013, p. 32). Self-care could include managing stress, engaging in treatment planning, and learning to know when to seek help. Informal Community care refers to care provided by community programs and services not officially meant to address mental health (Turpel-Lafond, 2013, p. 32). Schools and their teaching/counselling staff are excellent examples of informal community care.

2.5. Policy Context

BC currently has no provincial-level policy that governs the transition from child to adult mental health services. Instead, policies governing the services and programs available for transition-aged youth depend heavily upon the organisation under which a program is run and its location. Currently, each Regional Health Authority is responsible for creating its transition policies, standards, and protocols consistent with provincial legislation. Each authority determines its own policies and standards without any mechanism to ensure that it is held accountable to the provincial office. This creates disparities in the structure of service delivery, in the types of programs delivered, and in the standards and protocols adopted by each regional authority. This also creates obvious problems for youth in transition who by necessity may be geographically mobile. Curiously, there is a lack of literature or public information available on the specific transition policies and best practices used by the Regional Health Authorities in the Lower Mainland.

In spring 2016, the BC government is implementing a provincial-wide Youth Mental Health Transition Protocol Agreement (YMHTPA). This agreement is a partnership between the Ministry of Child and Family Development, the Ministry of Health and the Regional Health Authorities (RHAs). It is meant to encourage a collaborative approach to assisting youth transition from the child to the adult mental health system (YMHTPA, 2015). The protocol calls for the creation of Joint Management Tables, which consist of management-level officials from both child and adult mental health service providers. The Joint Management Tables are responsible for 1) addressing difficulties in transition planning for youth and 2) collecting data to ensure that protocols are being implemented appropriately (YMHTPA, 2015). The protocol agreement also calls for agencies to provide care based on a “best fit” principle. The “best fit” principle allows youth to continue to receive child mental health services until the age of 21 (YMHTPA, 2015). It would also allow youth to receive adult mental health services between the ages of 17 and 19 if it is deemed that adult mental treatments and services would be more effective for the treatment of the youth. As this protocol has not yet been implemented, it is too early to tell if the protocol will address the issues associated with child to adult mental health transitions. Furthermore, it is unclear what

level of accountability is associated with the adoption of this protocol agreement by local service providers.

2.6. Provincial Mental Health Legislation, Strategies, and Policies

Though not specific to transition-aged youth, several strategic mental health care reports and enabling legislation address transition-aged youths' issues. These are an important backdrop to understanding the current policy positions of the BC government.

2.6.1. The BC Mental Health Act

The Mental Health Act was enacted in 1964. The purpose of the Act was to "provide people with [mental health issues] the treatment and care that they need when they are not willing to accept it" (BC Ministry of Health, 2005, p.1). This Act provides for the voluntary and involuntary confinement of individuals who are defined as a danger to themselves or others and who may be unwilling to seek help for themselves (BC Ministry of Health, 2005, p.1). Youth can be admitted to a hospital psychiatric ward under this Act.

2.6.2. Child and Youth Mental Health Plan

This document was published in 2003 by the Ministry of Child and Family Development (MCFD, 2003). The purpose was to address concerns regarding the fragmentation and the lack of support provided by the current Child and Youth Mental Health system. The plan provided long-term strategies for improvement and resulted in a doubling of annual funding for youth mental health (MCFD, 2003). In regards to transition-age youth, the plan identifies some specific deficiencies and barriers these youth face (MCFD, 2003, p. 18). The plan calls for more formal protocols and more effective communication between the CMHS and the AMHS. The plan also states transition planning should occur well before the age of 19. Despite the fact that the plan ended in 2008, emerging adults continue to face a silo-ed mental health care system today.

2.6.3. Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health

This report was published in 2010 by the Ministries of Child and Family Development and Health. It provides a strategic plan to promote positive mental health for all BC residents, improve the accessibility and quality of mental health services available, and increase the cost-effectiveness of services. There is a brief mention of the need to strategically focus on transition-aged youth to allow for a more supportive and coordinated transition into the adult mental health system, but no mention of long-term substantive strategies on how to remedy the situation (Ministry of Health and the Ministry of Child and Family Development, 2010).

Chapter 3. Methodology

Information for this study has been collected using three main methodologies:

3.1. Literature Review and Jurisdictional Scan

A review of the extant literature was conducted to provide the necessary background information for the study. The focus of the literature review was on 1) the scope of the problem; 2) youth experiences transitioning into the adult health care system (both first-hand reports and second-hand accounts); and 3) the barriers facing emerging adults and 4) identified guidelines and best practices.

In conjunction with the literature review, a jurisdictional scan was conducted to identify transition policies and programs in other Canadian provinces (particularly Ontario) and international jurisdictions (primarily the UK, Australia, and the US). This scan demonstrates how other jurisdictions have attempted to minimize the harms associated with the 'transition period.' The jurisdictional scan involved publicly available secondary data from the various jurisdictions, and as such, all data are in the public domain. Furthermore, all data have been de-identified by the source organization; no participant data were stored or sent outside of the country.

The articles and e-books used in the literature review and jurisdictional scan were accessed via the online search engines available through SFU and through Google. Books from the SFU Library will also be used as sources, but all of the literature review and jurisdictional scan sources are in the public domain and are available to all SFU students.

3.2. Consensus Conference on Emerging Adults

The Consensus Conference on Emerging Adults was hosted by the Mental Health Commission of Canada in Ottawa from November 2nd to 4th, 2015. The purpose was to bring emerging adults, care providers, researchers, and policy analysts together to create a consensus on how the approach to emerging adults in the current mental health system must change and to identify viable policy actions. The conference was separated into four themes: 1) defining emerging adulthood as a stage of life, 2) bridging the gap between child and youth and adult mental health services, 3) transitions across system sectors, and 4) mechanisms for improving mental health system responsiveness. For each theme, there was a series of expert speakers, which included emerging adults, family members of emerging adults, researchers, service providers, and experts. Throughout the speeches, I took in-depth notes of the speakers' ideas and recommendations. The role of the speakers was to provide evidence to the jury panel whose role was to produce a consensus policy statement by the end of the conference. The jury panel was supported by a panel of Emerging Adult Innovators that consisted of youth between the ages of 15-25 who had first-hand experience transitioning from the child to the adult mental health care system. The speeches and discussions by the Emerging Adult Innovators provided an opportunity to gain insight from youth with lived biographical experience.

In between each series of speakers, participants in the conference were given an opportunity to discuss the various speakers' evidence with members of their assigned audience table. As a participant in the conference, I had the opportunity to be a part of informal discussions with the nine child and adult mental health workers and experts at my table. The participants at the table came from a diverse background in the youth mental health field and included psychiatrists, mental health service managers, individuals with lived experience, youth mental health advocates and ancillary service providers (i.e., housing services). These discussions provided additional information for this study; although much of it is anecdotal, these discussions provide concrete examples useful for consideration of policy alternatives. After the table discussions were concluded, participants were encouraged to summarize the deliberations and recommendations from these discussions, which were submitted to the conference jury.

On the last day of the conference, the conference jury released a draft policy statement that provided best practice principles and recommendations for action. The Emerging Adult Innovators and the participants were then given the chance to provide comments and criticisms of the draft policy statement.

Informed consent was not sought from the expert speakers, the Emerging Adult Innovators, or during the table discussions since all of the participants in the conference consented to provide evidence and are aware that the conference attendees will have access to that information.

3.3. Expert Interviews

To get a better understanding of the scope of the issue and its impact on emerging adults, I conducted semi-structured interviews with various stakeholders to hear their perspectives on the existing services and the transition process in the Lower Mainland. I included four expert interviews in the study: a health systems consultant, a professor of social work, a child mental health policy expert, and a provincial government official.

The purpose of the stakeholder interviews was to get a better understanding of 1) the barriers facing emerging adults, 2) the gaps in services and resources available to emerging adults, 3) the institutional barriers that exist in the BC Lower Mainland, 4) potential inequities in accessibility of mental health services for emerging adults, and 5) recommendations for policies and programs to improve the transition period for emerging adults.

Contact information for participants was, in most cases, found through publicly available sources. Snowball sampling was also used to recruit potential participants. Interview participants were contacted in person, by e-mail, or by telephone. Prospective participants were sent an informed consent form and a brief description of my research prior to the interview to ensure that participation was voluntary. Participants were provided the option to revoke their participation at any point during the study.

3.4. Limitations

There are some limitations to this project. Due to the time constraints and its somewhat critical nature, it was very difficult to organise expert interviewees willing to participate fully in the study. The requirement of research ethics approval for the various ministries (Ministry of Child and Family Development and the Ministry of Health) and the Regional Health Authorities (Vancouver Coastal Health and Fraser Health) prevented further interviewing. That being said, the extensive literature review and the expert interviews that were undertaken provided insight into the perspectives of these various organisations. Another limitation of this project is that no youth with mental health issues were interviewed. This was primarily due to the ethical difficulties of interviewing youth with mental health issues, who may be extremely vulnerable. In lieu, youth input was provided by the Emerging Adult Innovators at the Consensus Conference on Emerging Adults and through the literature review.

Chapter 4. Literature Review

4.1. General Barriers Experienced by Transitioning Youth

In BC, youth become ineligible for child mental health programs and services at the age of 19, after which youth in need of continuing care are expected to move to the adult health care system (Turpel-Lafond, 2013). Unfortunately, this process is not easy. Youth “aging” out of the child mental health system often have difficulty navigating the transition to adult mental health system and in many cases end up unable to access adult services. In some cases, youth are referred to multiple agencies, health authorities and communities between their initial assessment and ultimate treatment (SSCCY, 2013, p. 15). With little to no professional support to help guide them through this difficult and often bureaucratic process, transition-aged youth experience deteriorating mental health (Singh and Tuomainen, 2015, p. 358; SSCCY, 2013, p. 15).

A report by the McCreary Centre Society concluded that few youth under care anticipate what the transition process will mean for their care. This becomes a growing concern as they approach the age of transition (Cox et al, 2013). The report identified that most youth who had already transitioned to the adult mental health care system reported having been discharged from a youth mental health service and/or program at the age of 19 without any transition plan in place. The youth who did report having a transition plan in place felt that they had been excluded from the planning process, and therefore did not feel that the plan necessarily reflected their needs (Cox et al, 2013).

To avoid generalisations, it is important to note that transition experiences can vary greatly based on a number of factors including the type and severity of mental health issue; the extent of familial or peer support; the services available in the community; and the age, gender, sexual orientation, race and socio-economic status of the youth (SSCCY, 2013). Youth with severe mental health issues such as psychosis or

schizophrenia tend to have smoother transitions into the adult mental health system, whereas youth with neuro-developmental, emotional/neurotic and personality disorders tend to have much more difficult transitions because the services they need tend to be unavailable in the adult system (Singh and Tuomainen, 2015, p. 385). For example, only 7% of transition-aged youth labelled with attention deficit hyperactivity disorder in the UK managed to transition to the adult system (Singh and Tuomainen, 2015, p. 385). The adult mental health system is also inclined to treat older patients, with the average patient being aged 40-45. This can make it difficult for transition-aged youth to feel comfortable and socially welcome in an adult mental health service.

Youth under state care are especially vulnerable when transitioning because they are more likely to lack familial supports and are significantly more likely to have serious mental health and social issues (Singh and Tuomainen, 2015, p. 385).

Moreover, youth living in the rural areas of BC have less access to mental health services targeted towards transition-aged youth because of distances from resources, resulting in many of the youth having to travel considerable distances to receive the care they need (SSCCY, 2013, p. 15).

Gender, race, culture, and class can also influence the transition experience. For example, a study by Cauce et al. (2002) identified that culture, ethnicity, gender, and class are important factors in determining if youth will access formal care. Some research has identified that 'ethnic minorities' or newly arrived immigrant groups tend to have higher than average incidence of emotional problems (e.g., anxiety and depression), and substance abuse issues (Kafele, 2004, p.43; Office of the Surgeon General (US) et al., 2001). Despite this, few programs provided for transition-aged youth through the formal health care system are considered culturally sensitive. These youth will be less likely to access or continue with formal care (Kafele, 2004, p.43, Stewart et al, 2012). In BC, First Nation youth are a good example of this issue. They are seriously over-represented in foster care, prisons and other state social-control institutions and are often forced into a culturally hostile mental health system (Kirmayer et al, 2003). Similarly, LGBTQ youth are more likely to experience mental health issues such as depression and substance abuse than their non-LGBTQ peers (Marshal et al, 2011).

The development of programs and services that youth feel are not inclusive may deter them from accessing the care they need.

Mental health service utilisation rates shift once youth reach the age of transition (Pottick et al, 2008, p. 384; Singh and Tuomainen, 2015, p. 385). A study conducted in the US found that when youth reach the age of transition, utilisation rates of outpatient (community mental health services and residential programs) services tend to decrease, whereas utilisation of in-patient services (emergency room visits and hospitalisations) increase drastically (Pottick et al, 2008, p.384). Youth aged 18 to 19 were especially prone to this trend, whereas the utilisation rates of outpatient services tended to slowly increase after youth reached the ages of 20-21 (Pottick et al, 2008, p. 385). The literature suggests that emergency room visits and hospitalisation experiences tend to be more traumatic than outpatient service experiences and can be damaging to recovery (Pottick et al, 2008, p. 384). The US study also found that emerging adults (especially youth aged 18-19) encountered many barriers to recovery, which included "legal realities, developmentally inappropriate programming, community reluctance, or parental or client choice," (Pottick et al, 2008, p. 385). In summary, this study found that transition-aged youth with mental health issues tended to have high hospitalisation and arrest rates and lower levels of employment and enrolment in postsecondary education or training (Pottick et al, 2008, p.385).

There are considerable differences in how child and adult mental health services are delivered, both practically and theoretically. Child and adult mental health professionals tend to have very different professional training, which leads to differing approaches to diagnosis, care, and treatment (Singh, 2009, p. 387; Lamb and Murphy, 2013, p. 41). Likewise, child and adult mental health services tend to have different organisational and structural frameworks, creating cultures of care that are almost incompatible (Singh and Tuomainen, 2015, p. 386). For example, adult psychiatry is influenced by "neurology, phenomenology, psychology, and sociology, and has developed treatment strategies that were once entirely asylum-based but are now increasingly provided in the community," (Singh et al, 2005, p.292). The focus of adult treatment is therefore almost entirely upon the individual's mental health state. Child psychiatry differs in that it has a more recent history and was developed

> Primarily within a sociological context, with the concern about vagrant, traumatised or delinquent youth. It gradually broadened its horizons to include developmental concerns and the role of systems such as the family. The assessment focus is therefore on interactions between developmental and emotional processes, family relations and social experiences, with treatments geared primarily towards psychological and systems interventions," (Singh et al, 2005, p. 242).

Because of this difference, communication and co-operation between the child and adult mental health systems is difficult. The differing structures and cultures of care in these systems in BC result in a "silo-ed" mental health care system, in which access to services is determined by inflexible age-defined boundaries (Singh and Tuomainen, 2015, p. 386). Moreover, "legal, logistic, and clinical differences, combined with time and resources constraints, prevent services working together to provide parallel care, with particular concerns about where the responsibility of clinical care lies," (Singh and Tuomainen, 2015, p. 386). An example of the disagreement occurs in the admission of transition-aged youth to hospital in-patient services. Depending on their age, their mental health issue, and the bed availability in the hospital, a transition-aged youth can be admitted to a pediatric, an adolescent, or an adult ward. Admission to pediatric wards can be neglectful of the age and maturity of transition-aged youth and, in many cases, pediatric wards lack proper mental health supports for adolescents. Admission to an adult psychiatric ward can be very traumatizing for young adults who may not be suffering from the same severity or range of mental health issues that are often exhibited in adult wards (Turpel-Lafond, 2013, p.35; SSCCY, 2014).

Another concern is the loss of youth-defined funding for essentials such as housing, food, education and transportation. Youth may also face the loss of vital patient/care provider relationships developed over the course of their care (SSCCY, 2014). This personal disengagement puts youth mental health patients at significant risk. Being able to maintain key therapeutic relationships while transitioning can help youth feel more prepared and supported throughout the transition process. Overall, youth who were able to gradually transition out of child mental health services tend to report more positive experiences (Hovish et al, 2012, p. 254).

Chapter 5. Jurisdictional Scan

5.1. Existing Models of Care for Transition-aged Youth

Several models of care have been identified in the literature as having the potential to reduce the gaps in services faced by transition-aged youth with mental health issues. A brief description of the models of care is provided below, along with an example of their application in other jurisdictions.

5.1.1. Team/ Shared Management Approach

This model of care is commonly used in the physical health system to provide continuity of care, such as for patients with chronic physical health issues. This model aims to improve transitions for youth by providing a transition team and a transition coordinator (Davidson et al., 2011, p.27). Within the team, mechanisms of accountability and training of other health care providers need to be established to ensure transitions are occurring smoothly (Davidson et al., 2011, p.27). The transition coordinator, usually a nurse or a social worker, is hired by both the child and the adult mental health systems to develop a transition program and provide training evaluation and management (Davidson et al., 2011, p.27). This model requires that co-operation exist among all mental health care providers including primary care physicians (the 'team'), to properly identify the most appropriate adolescent/adult programs and services for transitioning youth (Davidson et al., 2011, p.27). The transition program can function through child or adult mental health clinics or within its own transitional clinic with connections to both services (Davidson et al., 2011, p.27).

Ottawa, Ontario

A good example of this model is the Youth Transition project implemented in 2011. The goal of this pilot project was to determine the effectiveness of shared

management models in increasing the successful transition of youth from child to adult mental health services (Cappelli et al., 2014). The project aimed to improve transitions by collaborating with youth and their families, community service providers, and hospitals. According to Cappelli et al. (2014, p. 3) this shared management model has three key components:

> 1) Collaboration and contributions of partner providers through an advisory committee composed of hospitals and agencies;
>
> (2) A transition coordinator who acts as system navigator to help prepare youth and families for transition, follows through with care plans by coordinating referrals, and ensures that youth are seen in a timely manner and remain engaged in the clinical services that meet their mental health needs; and
>
> (3) A research team to monitor and assess the implementation of the model.

Through collaborations with partner agencies, the transition coordinator would be able to communicate with service providers to determine when transitional planning is necessary (Cappelli et al, 2014). Furthermore, the transition coordinator could communicate with the adult mental health system (AMHS) in preparation for a youth transition from the child mental health system (CMHS). Participation in the Youth Transition project was offered to youth aged 16 to 24 years old who were receiving care from a project-partner agency (Cappelli et al, 2014). Successful transitions were measured solely on the administrative event of accessing the AMHS. In the course of the study a "set of tracking tools, intake procedures and standardised questionnaires [were implemented] to assess (1) the transition process, (2) youth's mental health needs, (3) youth's individual needs, and (4) youth's transition-based needs, strengths and service planning," (Cappelli et al., 2014, p.3). At the end of the 18-month period, 215 youth aged 16 to 20 had participated in the Youth Transitions Project. Of those 215 youth, 59% completed their transition to AMHS, 19.1% remained on a waiting list and 28.1% cancelled services. Of the youth who cancelled services, 16 youth cancelled after seeing the transition coordinator and 31 cancelled after being referred to the AMHS (Cappelli et al., 2014, p.6). The average transition time from the first meeting with the transition coordinator to accessing AMHS was 110 days. The average transition time had significantly declined from measurements from 2011 to 2013 (Cappelli et al., 2014, p. 6). The results also demonstrated some interesting trends in continuation to AMHS,

based on different diagnoses. For example, participants diagnosed with anti-social behaviour and/or anxiety disorder were significantly more likely to cancel services (Cappelli et al., 2014, p.8). Similarly, youth diagnosed with Oppositional Defiant Disorder and Attention-Deficit Hyperactivity Disorder were more likely to be on the wait list for the AMHS (Cappelli et al, 2014, p.8). There was also some discrepancy based on the types of services needed. Youth who needed specialised mental health services tended to have longer wait times for accessing care and longer transition times than youth who did not need specialised services (Cappelli et al., 2014, p.8-9).

Despite the overall success of the project, the study did reveal some important issues. Firstly, this model is heavily reliant on the ability of service providers to provide consistent care. This is mainly because transition services are entrenched within the existing services (Cappelli et al., 2014). This became an issue when adult services were no longer able to meet the demand of the Youth in Transitions program, which led to youth being waitlisted for services. Having a transition team or CMHS services available for youth while they wait for adult services would reduce this issue (Cappelli et al., 2014). Secondly, differing mandates and eligibility requirements of the service providers create significant delays in youth access to services. The study emphasizes the need for strong commitment to the project by all parties involved to ensure the longevity of the program (Cappelli et al., 2014, p.9-10). Increasing funding for specific transition-aged youth programs would also be beneficial.

5.1.2. Protocol and Reciprocal Agreement Model

The protocol and reciprocal agreement model provides local communities with the power to develop their own transition program and services, in the context of over-arching transition guidelines (Davidson et al., 2011, p. 29). This is meant to allow for greater flexibility in community needs while maintaining consistency in service quality (Davidson et al., 2011, p.29).

United Kingdom (UK)

The Protocol and Reciprocal Agreement model is currently used in the United Kingdom to assist transition-aged youth and includes a focus on measuring transition

outcomes for youth (Davidson et al., 2011, p.29). The protocol and reciprocal agreements were meant to be "cost-effective service contracts between health-care settings, to facilitate in the clarification of roles and responsibilities of service providers at both ends of the transition and to provide a foundation for the continuous care of transitioning youth," (Vloet et al., 2011, p.34). The programs using these protocol and reciprocal agreements depend heavily upon the region. Nevertheless, in some cases, the programs and services in a specific region can mirror programs in other regions.

An example of a program using the protocol and reciprocal agreements is the Brandon Centre for Counselling and Psychotherapy for Young People. The Brandon Centre is a charity in London that provides mental health care for youth aged 12-21. Similar to the enhanced primary care model, the Brandon Centre offers a variety of health services such as contraception and sexual health, counselling and psychotherapy, parenting and family education. This program is highly engaged with the community, including legal services and post-secondary institutions. The Brandon Centre has also been successful in attracting vulnerable youth in London who otherwise may not receive the care they need (HM government, 2011, p. 17).

In the UK, the TRACK study (Singh et al., 2008) examined the extent that the protocols were being implemented. It found 13 active protocols in Greater London at the time the study was conducted; however, not all the protocols were consistent with government policy and many differed in respect to the extent of the relationship between child and adult mental health systems. In the UK, less than a quarter of mental health services have specific agreements between child and adult mental health systems. There was also a gap in regards to continuity of care for individuals who did not make it into the adult mental health system (Singh et al, 2008).

5.1.3. Integrated Care Clinic Models

The Integrated Care Clinic model involves the development of free-standing physical clinics in which a spectrum of youth services are provided. This usually includes services such as physical health, mental health, employment, and education. In addition,

the clinics house a variety of professionals who work together in the clinic to promote the overall health and well-being of youth aged 12 to 24 (Davidson et al., 2011).

Australia

The BC government through the BC Integrated Youth Services Initiative has been examining the potential for an integrated care models to address gaps in mental health services for youth (See Appendix A). This initiative is heavily based on one of the best-known integrated care clinic models, Australia's Headspace (Davidson et al., 2011, p.30). Headspace is a National Youth Mental Health Initiative implemented by the Australian government in 2006 to complement the specialised youth mental health clinic services offered through the Orygen program[2] (Davidson et al., 2011, p.29; Purcell et al., 2011, p.77). The purpose of Headspace is to promote early intervention through youth-friendly and easily accessible spaces that provide access to enhanced primary care services for youth aged 12 to 25. The centres have firmly established ties to both community and specialist organisations and services (Purcell et al, 2011, p.77). The focus on ensuring a youth-friendly environment is vital to ensuring that youth feel comfortable accessing the mental health services provided and to reducing the stigma associated with mental health care (Purcell et al, 2011, p.78). By providing a variety of services, youth are less likely to feel stigmatised for accessing services from the Headspace program, since the nature of their visit remains unknown. The four main services are mental health, substance abuse, primary care, and job and post-secondary assistance services (Purcell et al, 2011, p. 78). Each Headspace centre is managed by a key agency that acts on behalf of an array of local organisations that agree to assist in providing these four main services. Currently, there are approximately 100 Headspace centres across Australia. Headspace has clinics in many rural towns that otherwise would have limited access to mental health services, as well as in dense urban areas in which mental health care is especially needed (Purcell et al, 2011, p. 78). A 2009 independent review of Headspace by the National Youth Mental Health Foundation

[2] The Orygen program provides a range of community-based clinical services for young people between the ages of 15 and 25 years old who live ....in northwestern metropolitan Melbourne," (Purcell et al, 2011, p. 79). The program includes services such as initial assessment and triage, mobile intensive care teams and services, and specialised mental health services for youth (Purcell et al., 2011, p.80).

found that most youth surveyed reported improvements in their mental and physical health since accessing Headspace, with notable reductions in psychological stress (Muir et al., 2009, p. xii). A program evaluation conducted by Muir et al. found that Headspace centres providing all of the four main health services and providing access to private practitioners were the most successful in terms of client outcomes. Having leadership with strong clinical and business expertise and having a practitioner-based agency as the main organisation in charge of the Headspace program resulted in greater overall fiscal responsibility (Davidson et al., 2011, p.31). Furthermore, a study by Rickwood et al. (2015a) found 59.9% of Headspace attendees reported improved outcomes in at least one of the client outcome measures after using Headspace services. Thirty-six percent of attendees reported significantly lower levels of psychological distress and 37% reported increases in overall psychosocial functioning.

Despite these successes, Headspace has faced substantial criticism, augmented by the lack of data demonstrating the long-term effectiveness of the Headspace model on youth mental health (Muir et al., 2009). The 2009 evaluation of Headspace by Muir et al. (2009) revealed significant gaps in service delivery in some of the Headspace centres due to difficulties finding qualified staff (e.g., alcohol and substance use specialists, general practitioners, and psychiatrists). This was especially prevalent for Headspace centres in the rural regions (Muir et al., 2009, p.16). The evaluation also revealed that some care providers were concerned about patients' disengaging from care when in service transitions (Muir et, 2009, p. 31). Similarly, the Headspace model has been criticised for creating more transitions as youth enter and exit Headspace services (Tataryn et al., 2011). The implication of this program on youth transitioning has not been effectively discussed. A 2014 report by Australia's National Mental Health Commission identified that Headspace centres need to be better integrated into the regional mental health systems to prevent transitional gaps and further fragmentation of services (p.82-3).

The Headspace model also has some limitations in its ability to provide services for youth. Firstly, Headspace services are primarily meant for youth facing mild to moderate mental health issues and do not have the ability to assist youth who need more specialized acute care (Muir et al., 2009, p. xiii). Secondly, a 2012 study conducted

by Yap et al. (2012) found limited awareness of Headspace as a mental health organisation. The youth surveyed were unlikely to mention Headspace as a place to seek help for themselves or for their friends.

5.1.4. Community Care Model

The community care model is centred on out-patient transition planning for youth with mental health issues (Davidson et al., 2011). Case managers assist youth in developing their own transition plans and provide support as the youth implement their plans. The community care model is highly focused on individual skill building and therefore may be more effective for youth with certain diagnoses.

United States

An example of a community care model is the Transition to Independence Process (TIP), an initiative funded by the United States Substance Abuse and Mental Health Services Administration. TIP has community sites within Washington, Utah, Pennsylvania, Maine and Minnesota (Davidson et al., 2011, p. 32). The goal of the TIP is to provide transitional planning for youth moving into adult mental health services. Youth involved in the program engage with case managers to receive one year of transition planning, in which the youth are heavily involved, and then three years of supported implementation of the plan with a focus on developing individual coping skills (Davidson et al., 2011, p. 31-2). Studies examining this framework have found that youth who partook in the TIP had a greater likelihood of successfully transitioning into post-secondary education and/or the labour force and were less likely to become involved in the criminal justice system (Dresser et al, 2015, p.236).

5.1.5. Summary

These four models and examples offer a selection of the transition policies emphasized in the literature. These policies and programs are useful for informing suggestions in developing a coherent policy for 'transitioning' youth. A summary of the applications of these initiatives is provided within the appendix (B). Given the lack of literature available regarding the policies in the Lower Mainland, this project first must

shed light on the scope of the issue in the Lower Mainland, the current practices and programs that exist in the Lower Mainland, and the extent of the gaps in services and programs.

Chapter 6. Results

6.1. Consensus Conference on Emerging Adults

This conference provided a series of “takeaways” useful in formulating the final policy options. The principles were introduced as part of a national approach to addressing the gaps in services and programs for transition-aged youth. Most importantly, this conference provided an opportunity to hear first-hand accounts from transition-aged youth who are otherwise not participating directly in this project. The names of the experts have not been included within this section to provide some level of confidentiality. This section provides a summary of the ideas and opinions of the expert speakers, the emerging adult innovators, and the nine mental health workers. Much of the information provided within this section is undocumented and therefore sourcing of the data was only provided when possible.

6.1.1. Barriers facing Transition-aged Youth

The presentations by the expert speakers and the table discussions revealed a series of key issues that limit the ability of mental health systems to provide seamless care to transition-aged youth in Canada. These key issues include:

- Lack of funding for mental health services for transition-aged youth
- Fragmentation of services for transition-aged youth
- Lack of involvement of transition-aged youth and their families in treatment planning
- Difficulty accessing services due to increasing wait times for services and navigation issues.
- Lack of data and outcome measurement

6.1.2. Summary of Best Practice Principles

The conference jury offered a broad guideline for emerging adulthood between 14 and 25 years, although they emphasized that this stage could begin as young as 12

and end as old as 30. Services offered need to be based on the need of the youth rather than the youth's chronological age.

Current emerging adults and people with lived experience need to be actively engaged in all aspects of decision making in regards to transition policies.

One of the most important takeaways is the importance of emerging adults and/or individuals with lived experience being actively engaged in all aspects of the policy development and decision-making. Concomitant with this recommendation was that the emerging adults participating should be paid for their involvement, e.g., through an honorarium. Their engagement cannot be superficial. There needs to be substantial, real participation of emerging adults. This is the only way to ensure that the policies, services and programs are meeting the needs of the individuals most affected, rather than the needs or assumptions of the service provider. Furthermore, current and previous emerging adults have first-hand experience with the failures and successes of the resources intended to help them.

Explicitly addressing race, gender, sexual orientation and treatment equity in transition policies is VITAL to improving the experience of youth transitioning from youth to adult mental health services.

This was a very contentious issue throughout the conference. The emerging adult innovators were very firm in their desire for policies to address the significant discrimination that emerging adults experience from youth and adult mental health systems because of their race, religion, gender, and/or sexual orientation. Some examples discussed at the conference:

- An emerging adult innovator testified about her experiences of discrimination by care providers due to her religion. The emerging adult, who identified herself as Arab and Muslim, attempted to access the care she needed for her mental health issues but found that many of the care providers associated her mental health issues with their religion. When she discussed her depression and suicidal thoughts, she was questioned whether she had been thinking of fleeing to Syria or Iraq. Furthermore, the physical abuse by her father was seen as being a part of her family's religion and culture rather than perhaps being the result of their father's post-traumatic stress disorder. The emerging adult innovator found that this treatment was extremely detrimental to her care and made her less willing to seek further care.

- Another emerging adult innovator discussed his experiences seeking mental health care as a result of being sexually assaulted. The emerging adult felt that the intersection of his gender and race meant that he did not receive an adequate level of empathy or care when seeking formal mental health care.

The emerging adult innovators felt that steps needed to be taken to reduce these experiences of discrimination. Explicitly identifying and addressing this discrimination in policies and strategies is important to ensure that all emerging adults receive the care they need regardless of their race, religion, gender, and/or sexual orientation. Some suggestions included encouraging a greater diversity of care providers and ensuring care providers receive cultural and sexual sensitivity training during their education.

Integration of Indigenous knowledge, practices, and traditions into mental health programs as defined by the Indigenous communities.

This principle is important for the BC/Lower Mainland context where Indigenous youth mental health is a major concern (Kirmayer et al, 2003). The conference jury suggested that funding was necessary to ensure that communities, particularly on-reserve communities, can develop culturally appropriate programs for their youth.

Need for an integrated and collaborative approach to emerging adults across sectors.

This principle refers to cooperation within the formal health care system, but also collaboration with other agencies that encounter transition-aged youth with mental health issues. This could refer to the K-12 school system, the criminal justice system, and other organisations whose main purpose is not mental health care.

Better educate caregivers on how to support transition-aged youth.

Ensure that primary caregivers and first points of contact (e.g., police, courts, ambulance) with mental health systems have the training and competencies to support transition-aged youth with mental health and substance abuse issues.

The need for data, evaluations and outcome measurement

There is currently not enough process or outcome data available to properly evaluate the effectiveness of the treatments, programs and resources provided to

emerging adults. The speakers, the jury and the participants in the conference identified the need for a National Clearing House that would collect data on emerging adult outcomes to ensure that current treatments and therapies are producing the appropriate results. An important part of this evaluation process is that emerging adults need to be actively involved in defining the outcome measures used to define their own success and that of the system. The measures used for this evaluation would thus be standardised.

There are some significant obstacles with implementation of this recommendation. Foremost, it is extremely difficult to create a standardised measure for therapy and treatment success, especially one that reflects the perspectives of both patients and care providers. There are issues with using self-reported success. Success can vary depending on the patient. For example, a patient addicted to alcohol may see abstinence as the measure of success while another views a program as a success if alcohol abuse is reduced.

Family and friends should play a role in determining policies

Families and friends often provide a lot of the support for emerging adults; however, the extent of this role remains unclear. There was some debate during the conference about the extent of parental involvement in the care of emerging adults. The family representatives were against the confidentiality policies that prevent them from having any knowledge of their child's treatment after the age of 18. The family representatives stated that this policy endangered their emerging adult son or daughter and prevented them from providing continuing care. On the other hand, some of the emerging adults argued that the confidentiality is important because it allowed them to share things that they otherwise would not have felt comfortable sharing. Either way, one of the conference recommendations was that families and friends of emerging adults should be actively involved in the policy decision-making and policy implementation process.

6.1.3. Summary of the Suggestions for Policy Action

The speakers at the Consensus Conference recommended a variety of actionable items that they felt would provide a more positive transition experience for Canadian youth with mental health issues. Some of the notable themes of policy action recommendations include the following:

Peer Support Workers

Paid peer support workers with lived experience need to be accessible to emerging adults and their families to help youth navigate the mental health care system.

Funding and Accountability

1) *Defining federal transfer payments to ensure greater funding for transition-aged youth mental health services*.

The conference jury recommended that federal transfer payments to the provinces should include strict accountabilities that would ensure a specific amount of health spending was targeted for mental health care for transition-aged youth. This would enable provinces to expand the services available.[3]

2) *Need for adequate and Stable Funding*

To ensure that mental health services for transition-aged youth with mental health issues are sustainable there must be adequate and stable funding for these services.

3) *Tie measurement to funding with clearly defined accountabilities*

The conference jury identified that the funding of programs and services needs to be tied to common outcome measures to ensure that the treatments available for transition-aged youth with mental health issues are appropriate. The accountability to

[3] The provincial governments may not be receptive to this option since this would give the federal government the power to determine provincial spending priorities.

these outcome measures needs to be clear so that each organisation knows its responsibilities.

Post-Secondary Education Institutions and the Provision of Mental Health Services

One of the speakers discussed mental health services in the context of post-secondary institutions. Mental health issues are an increasing concern for universities and colleges in Canada. She argued that there must be a shift in campus culture in regards to mental health for youth to have access to the supports that they need. She recommended the development of post-secondary mental health strategies and the sharing of best practices amongst institutions. She also recommended that requirements for academic accommodation should be standardised and that further supports should be provided for more vulnerable members of the student population (e.g., LGBTQ students, students with diagnosed mental health and substance abuse issues, Aboriginal students, etc.).

Improved Clinical Outcomes

One of the speaker's recommendations included a lengthy discussion of ways in which the goal of improved clinical outcomes could be achieved including

- Increasing provincial support of efforts by regional health authorities to develop interventions to improve outcomes for transition-aged youth.

- Ensuring that the Mental Health Commission of Canada works with Accreditation Canada to develop standards that require health outcomes of transition-aged youth are measured and monitored.

6.1.4. Summary of the Policy Model Discussion

Though some of the conference participants and speakers seemed to be advocating a total system change, the existing policy models and their benefits and limitations continued to be discussed within the conference.

Shared Management

The shared management model was mentioned by one of the expert speakers but only briefly. Nonetheless, amongst the health experts at my table, there seemed to be support for this model. One of the mental health experts at the table was involved in the Transition Coordinator Pilot project in Ontario.

Integrated Care Clinics

Three mental health expert speakers addressed integrating primary care and mental health care. The first speaker was an Australian youth mental health expert. His speech focused on discussing the benefits of Australia's Headspace program. He stated that 60% of the attendees of Headspace benefitted from the program. The other 40% did not benefit because these attendees tended to need more specialised care, something Headspace does not currently offer. He also discussed the accessibility and availability of services through Headspace centres, emphasizing that these centres reach a large proportion of the population. He emphasized the potential for this program to bridge the transitional gap; however, he realised that further innovation and funding is necessary to address the limitations of the Headspace program.

The second speaker played a significant role in developing the Granville Youth Health Centre in Vancouver for youth aged 12-24. He provided a detailed outline of services that this centre offers. He discussed ways to integrate services. He then argued that integrated care should be a national focus. More specifically, he wanted a more national, standardised approach to mental health care for transition-aged youth. He recommended creating a branded national youth health and social services network. This network would provide fundamental services such as mental and physical health care, substance use programs and services, social services and support programs for transition-aged youth. Furthermore, the centres would deliver ancillary services such as legal aid, recreation opportunities, and financial learning. With "branded" mental health services, youth would be more likely to recognise where to access mental health care. Furthermore, by developing national mental health services, standardised data could be collected. This would help establish national benchmarks for measures such as wait-times, service satisfaction, and access to services. He estimated that the centres would

cost approximately $900,000 to build and $1.8 million annually to operate. With a goal of 200 centres across the country, this would cost $400 million annually.

The final speaker was a renowned Canadian expert in adolescent mental health. His focus was on promoting integration of primary care and mental health care into the K-12 school system. Integrating mental health and primary care into the school system would provide access to mental health care to the greatest number of youth. In other words, bringing mental health care to the youth rather than making the youth seek out mental health care. He recommended that mental health literacy and self-care should be integrated into school curricula as part of broader life skills development. Furthermore, he recommended the implementation of 1) a national data collection mechanism, 2) targeted transfer payments tied to provincial accountability, 3) a Youth Mental Health Innovations Advisory Committee, and 4) greater investment in mental health research.

Community Care Model

Another speaker focused on the Transition to Independence Process framework. She served as a director for a transition program in Orange County, New York, funded by Substance Abuse and Mental Health Services Administration (SAMHSA). This program targets youth aged 5-21 and brings together youth and their families with community supports in the system. These supports include mental health services, family support services, recreational services, vocational services, the juvenile justice system, and substance abuse services. The Orange County program actually had the various community partners working within the same building. This led to a central intake centre, reducing the redundancies in caseloads. She also identified some of the critical success factors that had made the TIP program in Orange County successful:

- Integrated Pathway to Care
- Cross-system management information system (reducing redundancies in caseloads)
- Care Coordination
- Peer support/ family support
- Enhancement of youth and family voice
- Philosophical shift across systems

- Evidence- based practices and practice- based evidence
- Goal of 51% youth/ family Voice in program planning meetings
- Data driven
- Co-located intake (one plan of care)

She provided a series of recommendations to improve the current mental health system in Canada:

- An Emerging Adult Impact Assessment Tool that would be used by service providers to ensure programs are effective and can be adequately evaluated.
- Sustainable engagement structures that prevent youth from "aging out" of supportive community relationships.
- An individual with lived experience should be a preferred qualification for workers within youth mental health programs and services.
- Systems of care should be integrated and that inter-disciplinary communication and connections should be encouraged.

Evidence-Based Self Care

Some of the speakers discussed the importance of providing transition-aged youth with the tools to care for their own mental health issues. This could include providing knowledge skills to help youth cope with their mental health issues and helping them to learn to identify when they need formal care. This recommendation was offered in the context of less severe mental health patients.

6.2. Expert Interviews

This section will include some of the major themes that were discussed within the four expert interviews undertaken.

6.2.1. Early Intervention

In discussing transitions with the four expert interviewees, it became clear they believe early intervention could prevent, or at least address, the mental health issues

facing transition-aged youth. As one participant noted, “the bedrock for successful development is laid early. As youth age, we spend a lot of time chasing problems that have become entrenched because we allowed them to become entrenched unnecessarily … The robustness of early childhood and middle childhood mental health services has a huge impact on what you can do for adolescents ” (Child Mental Health Policy Expert, 2016). The interviewee noted that preventative policies can be difficult to implement politically since there may be no instantaneous and/or easily measurable benefit.

6.2.2. More Funding Needed

When discussing the political barriers for addressing the issues faced by transition-aged youth, many of the interviewees noted the chronic under-funding for youth-mental health. As one noted, it can be difficult for politicians to push for more mental health funding when the public demand for physical health is ever-growing: “How do you give more money to the children’s ministry when the health ministry is already consuming so much and the public is demanding so much more constantly…very hard to get something else on the agenda when you have such a huge demand,” (Child Health Policy Expert, 2016).

6.2.3. Changes in Management Needed

One prominent theme was the need for substantial systemic changes to how youth mental health services are delivered. One interviewee discussed the difficulty in finding appropriately trained staff to fill positions necessary for providing mental health services. She argued that there was a serious lack of senior supervision for social workers and mental health clinicians, which reduces the quality of care for youth in BC.

Interviewees were concerned over the lack of integration in BC’s child and youth mental health system. One interviewee, a social work professor, argued that “a 19 year old is just as much in need of services as a 15 year old or a 25 year old. As we age and develop there is no point at which you can say ‘all right, now you are finished, you are on your own.’ It is not a good or effective way of providing services to people.”

6.2.4. Accountability

All of the interviewees want more accountability for developing effective programs and services within the provision of services for transition-aged youth. They argued that, despite guidelines, there were no mechanisms through which to hold the service providers accountable. One interviewee, a health systems consultant, noted that the Ministry of Child and Family Development "rel[ies] on [protocols]… but they have no consistent management structure, accountability or reporting to ensure any of these protocols are ever followed." She recommended a single budget, a single information system, and a quality assurance mechanism.

One way to increase accountability is to tie funding to outcome measures. However, one interviewee cautioned that the implementation of this type of accountability can be very difficult, especially when there are multiple governing bodies involved (i.e., the provincial ministries and the regional health authorities). Some of the interviewees also felt that having advocates for the youth, such as the Transition Coordinators, would be a positive way to ensure services meet the needs of transition-aged youth.

6.3. Summary of Research Findings

Based on the review of the extant literature, findings from the Consensus Conference on Mental Health, and interviews conducted in Metro Vancouver, it is clear that there needs to be some macro-level changes to the mental health system in BC, especially with regards to the structure of the Ministry of Child and Family Development (MCFD). The options proposed below are not necessarily specific and exclusive to the needs of youth in transition; they also relate to the improvement in the management and delivery of the overall mental health programs in BC.

6.3.1. Flexibility of Care

The recent Select Standing Committee for Children and Youth final report (2016) recommended that child and youth services be extended to the age of twenty-five. This

recommendation would recognize the difficulties transition-aged youth are facing, and particularly their adjustment to adult mental health services. The extension of the transition age boundaries would delay some of the current issues associated with transitioning to the adult mental health systems; however, it is important to ensure that supports to the adult system remain available for youth once they transition at the later age of twenty-five.

6.3.2. Consistent Management Structure

To realize patient-focused care in Metro Vancouver, there needs to be greater clarity and transparency around the roles and responsibilities of the Ministry of Child and Family Development, the Ministry of Health, the Regional Health Authorities, community providers, and how the various relationships interconnect. One recommendation to improve the clarity of roles and responsibilities offered in the literature and in the interviews is a central management structure, whose main function is to provide coordinated care amongst service providers. For example, the Representative for Children and Youth recommended the development of a new ministry (Ministry of State for Youth Mental Health) whose sole responsibility would be to coordinate youth mental health services with the cooperation of the following ministries: Children and Family Development, Health, Education, Advanced Education, and Social Development (2013, p.71). Furthermore, the Select Standing Committee for Children and Youth recommended in their 2016 final report that care providers with the responsibility for child and youth mental health services should report to a new Cabinet position, a provincial Minister of Mental Health (SSCCY, 2016). The evidence would suggest that having some form of central management structure is necessary to increase accountability in providing mental health services to all British Columbians.

6.3.3. Financial Management

Similarly, there is currently no integrated financial management in the Child and Youth Mental Health Services. In 2014, the Ministry of Children and Family Development reported spending $94 million on child mental health services while the Ministry of Health reported spending $1.38 billion on mental health and substance abuse services

(MCFD, 2015c). Despite this, it remains unclear where exactly this money is being spent and whether these two budget amounts reflect the total mental health funding in BC. Instead, the child and youth mental health budget is as fragmented as the services and programs for transition-aged youth, and it is not clear as to whether other agencies are also funding services for this age group. The lack of an integrated budget means that it is difficult to determine the amount spent on child and youth mental health in BC. By developing an integrated budget, the ministry would have a greater understanding of where funding is currently going, how it is being used, and how it might be most effectively allocated.

6.3.4. Quality Assurance and Outcome Measures

Some of the interviewees raised concerns over the lack of clinical guidelines for MCFD-funded services or programs. A review of the 2015 Ministry of Child and Family Development performance management report revealed that only one performance measures was being used for child mental health: Child and Youth Mental Health Services client satisfaction (p.32). This can be compared to the 30 performance indicators for youth in government care. Without a more comprehensive and robust set of standardized guidelines of care, the possibility of substandard care becomes more likely.

Overall, the interviewee conclusion is that insufficient data are being collected with regards to child and youth mental health in BC, especially with regards to transition-aged youth. They noted that there are currently no figures available regarding the number of youth receiving child and youth mental health services in BC. Furthermore, the Ministry of Children and Family Development and the Ministry of Health have not agreed upon appropriate performance measures to analyze the effectiveness of programs in BC. This makes it very difficult to determine whether the policies and programs in place are effective in caring for youth with mental health issues.

Although measuring mental health outcomes can be difficult, the adoption of both process (ongoing) and outcome evaluation systems is an essential first step in determining whether or not the policies, programs, and treatments are meeting the

needs of the youth. Furthermore, outcome and process measures ensure accountability of mental health care providers to the public. A study by Waddel et al (2013) found that it would only be possible to develop comprehensive program success indicators with the addition of new data and the expansion of current data source and evaluative processes for existing programs (p.9),

6.3.5. Central Information System

Currently there is no central information system for Child/ Youth and Adult Mental Health systems in BC. Instead, information systems vary in form and structure between ministries. Because of this, there is little or no sharing or coordination between agencies and ministries regarding patient information. To illustrate the problem, the literature provides a common example: a youth who is receiving care through a community program ends up in the emergency room after a mental health crisis. The emergency room visit is not reported back to the community program. Without this information, the community program is not fully aware of the patient's current mental health and may not be able to provide the urgent supports that this patient may need at that time. A survey of child and youth mental health practitioners in BC conducted by BC's Representative for Child and Youth (2013, p.91) found that of the child and youth mental health practitioners who responded (n=272):

- 64% reported that they never, seldom or about half the time were told of a youth's visit to a hospital emergency department.
- 66% percent indicated that they never, seldom or about half the time were told of the youth's mental health condition as assessed during their visit to a hospital emergency department.
- 70% indicated that they never, seldom or about half the time were told the outcome of the visit to a hospital emergency department.
- The same trend exists for communication between primary care providers and community service providers and for communication between the child/ youth and adult mental health systems. For example, 50% of Adult Mental Health Clinicians (n=76) surveyed reported that they never, seldom, or about half the time receive the youth's mental health history. Forty-nine percent (n=77) reported never, seldom, or about half the time receiving information about the services and supports that youth is receiving.

Having a Central Information System or at least significant coordination between information systems would help overcome the current separate 'silo' operation of programs. BC's mental health system needs "the support of [a] state-of-the-art, system-wide computerized information system that allow[s] data management and effective tracking of utilization and outcomes" (Suter et al, 2009). The sharing of information through a centralized patient care data bank would also be increased by the adoption of the "one youth, one file" philosophy, which would make it easier for service providers to communicate important information about a youth's needs (SSCCY, 2016, p. 32). There may be some significant privacy issues to overcome.

Chapter 7. Policy Options

All five of the above systemic changes are important to improve the overall mental health system in BC. However, from a more micro focus on BC's Lower Mainland, there are some more specific changes that could be implemented in the Lower Mainland (independent from the systemic changes) to improve the system locally. These policy options are consistent with the broader proposals made above, and they are founded on an extensive jurisdictional scan of existing policy models in Canada and abroad. Table 7.1 provides a brief description of each policy option.

Table 7.1. Policy Options

Policy Options	Description of Policy Options
Transition Coordinator Pilot Project	This policy option is based on the Youth Transition Project in Ottawa (Cappelli et al, 2014) and the "Connected by 25" program in Kelowna **Main purpose:** To address the difficulty of young adults navigating the current mental health system in the Lower Mainland and to increase and facilitate communication and cooperation between relevant ministries and agencies. **Structure**: **Phase 1**: That a three-part pilot project be implemented for a period of two years that would incorporate the following: **1)Transition Coordinators:** • The hiring of one to three[4] transition coordinators who are responsible for assisting and supporting youth aged 16-24 during the transition process to adult mental health services. The transition coordinators would have a broad understanding of the mental health system in BC and would use that knowledge to help youth access the care they need (Cappelli et al., 2014; CMHA-K, 2014). • These positions ideally would be held by nurse practitioners or psychiatric social workers, with strong links with and knowledge of the Lower Mainland Regional Health

[4] The number of Transition Coordinators was based on the Youth Transitions Project and the Connected by 25 project. The Connected by 25 project saw higher demand than expected requiring the hiring of an additional coordinator. It is assumed that demand for the transition coordinators' services would be the same or larger (CMHA-K, 2014).

Transition Coordinator Pilot Project (Cont'd)	Authorities and Community Service providers. • The case load exhibited in the Youth Transitions Project involved approximately 215 youth.[5] Case load in "Connected by 25" was 123[6]. • The transition coordinators would report to an advisory committee. **2)Advisory Committee** • The advisory committee would comprise representatives from hospitals and mental health agencies, and other appropriate partners. • Advisory committee would have clear mandate for improvement of communication and a strong commitment to effective change. • Part of this change mandate involves the development of partnerships between agencies and ministries (MCFD, the MoH and the RHAs). • The advisory committee would be responsible for identifying and addressing systemic issues. • The advisory committee would also act to affirm partnerships between the transition coordinators and service providers. **3) Research Team** • The research team would be responsible for collecting outcomes data and monitoring the effectiveness of the transitions coordinators. • The qualitative and quantitative data collected would be used to inform an evaluator report that would illustrate the strengths and weaknesses of the program. • The research team will provide a representative focus on youths' perspective on program evaluation. **Phase 2: After the Pilot Project Phase, a long term strategy based on the pilot project could add the following dimension:** **Case review committee** • If the pilot project is proven effective, a case review committee could be developed to address difficult cases that may need more specialized focus.
Protocol and Reciprocal Agreements (Status Quo with Provincial Guidelines)	This policy option is based on the UK model and the 2016 BC Youth Transitions Protocol Agreement Transition models might vary by region or communities. For example, there need not be a particular over-arching transition model adopted for the whole of the Lower Mainland. Not necessarily mutually exclusive from the other options. **Main purpose**: to meet the specific needs of youth in accordance with the peculiarities of a community's needs. For example, a program in South Surrey might be different to one in North Vancouver. **Structure**: To facilitate these changes, the following would need to be introduced: **1)Provincial Transitions Protocol Agreement** • The creation of a provincial transition protocol agreement that would outline specific guidelines for youth transitions that care providers in the Lower Mainland would be required to follow. • As long as the program fits within the guidelines, the types of transitional programming

[5] Cappelli et al, 2014

[6] CMHA-K, 2014

	and support might vary based on community needs. **2)The Establishment of Regional Management Tables[7] (RMT)** • The main goals of the regional management tables would be to ensure that the transition protocol is being followed and address any issues that may arise from the implementation of the protocol. • Ideally, the RMTs will involve senior officials from the Ministry of Child and Family Development, the Ministry of Health, the local regional health authority, and community service providers.
Transition services provided through Integrated Care Clinics	A good example of this policy option is provided by the BC Integrated Youth Services Initiative and Australia's Headspace model, which provide transition services through integrated care clinics. **Main purpose**: address issues of access to mental health programs and services and to provide transitioning youth access to auxiliary social services. **Structure:** Integrated Care Clinics would require the following elements: 1)**Development and expansion of Integrated Care Clinics in the Lower Mainland** • Provide physical spaces in which youth (especially youth aged 12-25) can access transition services while accessing other health and well-being services if needed. • Integrated Care Clinics would provide referrals to appropriate local programs and services • The clinics would comprise five core services: Mental Health, Physical Health (including sexual health), Substance Abuse, Employment/ Education Services, and Housing Services. • It would be important to hire multi-disciplinary staff with experience in the core service areas. • The clinic would play a role for youth with more severe mental health issues through referrals to appropriate mental health services. (e.g., the Early Psychosis Intervention program) • These clinics should be located in easily accessible and non-stigmatizing spaces for youth, ideally close to transit. This could include space in schools and community centers. 2)**Management Organization Strategies** • The changes noted above would require organizational change as well. Similar to the BC Integrated Youth Services Initiative, this policy proposal would call for the development of a meta-organization that would provide the management and research support for the individual clinics. • It would also be mandated to collect data and with monitoring and information-sharing.

[7] The regional management tables are based on the BC Youth Transitions Protocol (Youth Mental Health Transition Protocol Agreement, 2015)

Chapter 8. Policy Criteria and Measures

The goal of this analysis is to determine whether the policy options provided would be suitable to address the needs of transition-aged youth with mental health issues in the Lower Mainland. Overall, the goals of all the policy options should be to (1) encourage successful transitions from child mental health services to adult mental health services, (2) involve youth and their families in the development and implementation of policies, and (3) remove barriers such as the stigma of having a mental health issue to accessing mental health services, both physical and social. As such, three societal and management objectives have been defined to determine the policy option that best ensure a successful transition. The three societal and management objectives are effectiveness, budgetary impact and stakeholder acceptance. Table 3 elaborates on the criteria and measures that will be used.

Table 8.1. Criteria and Measures

Societal Objectives	Criteria	Measure
Effectiveness	Proportion of successful transitions from CMHS to AMHS	1) Before implementation, the measure will have to be based on experiences in other jurisdictions.

Societal Objectives	Criteria	Measure
	Will the policy increase access to mental health care for youth?	Proportion of transition-youth able to access the policy option. Examine: • Hours of Operation • Eligibility Requirements • Home visits available • Youth friendly design • Wait-times to access services Based on experiences from other jurisdictions
	Will the policy reduce the stigma associated with mental health?	1) Before Implementation, review of academic and policy literature
Government Management Objectives	**Criteria**	**Measure**
Budget Impact	How much will the budget be impacted by the implementation of the policy option? - Number of staff and ability to find staff with appropriate skills - Capital Construction Costs - Operational Costs	Estimated costs of program, based on review of programs inside and outside the Lower Mainland.
Stakeholder Acceptance	Will the policy be positively received by: 1) Transition-aged youth and their parents 2)Financial stakeholders • Finance Ministry, MCFD and MoH Senior Officials 3)The existing service providers • Primary health care providers, social workers, community organizations	Based on reception in other jurisdictions, the Consensus Conference and expert interviews: • Estimated response in focus group meetings

8.1. Effectiveness

The objective of effectiveness is to determine whether or not the policy option is meeting its primary goals. In the case of transition-aged youth with mental health issues, the main goal of the policy options is to ensure that youth are successfully transitioning from the CMHS to the AMHS. Unfortunately, it is extremely difficult to measure whether or not a transition has been successful, and the literature differs on how successful transitions should be measured[8] (Cappelli et al., 2014). Furthermore, specific data on successful transitions were not available for this measure for all of the policy options discussed. It is suggested that before the implementation of the policy options, effectiveness be considered on the basis of the experiences of similar programs in other jurisdictions. After implementation, however, the policy options will need to be measured in the defined geographical and programmatic context based on their perceived success by service providers and their clients.

Specific consideration should be given to policies that increase overall access to the mental health system for transition-aged youth. Policy options in which specific youth gain access to mental health services while other youth do not, need to be identified. The extent that a program increases access may be based on the program's hours of operation, eligibility requirements, or the availability of home visits. Programs should also be analysed based on whether the policy would be considered youth-friendly. Youth-friendly services are more likely to be accessed by youth (and thus more quantitatively successful), in comparison with programs that are not (Turpel-Lafond, 2013, p.35, SSCCY, 2013).

It is important to identify the degree in which policy options reduce the stigma associated with mental health issues. The stigma associated with mental health issues can be a big barrier for youth in seeking access, and subsequently initiating and maintaining attendance, to the necessary mental health services.

[8] Future research on the existing models aimed at addressing transition gaps for mental health should examine the administrative measures of successful transitions (i.e. the youth accesses AMHS services), as well as examining the self-reports of youth who have accessed AMHS (Cappelli et al., 2014)

8.2. Budget Impact

The expert interviews in this study revealed a deep concern over the severe lack of funding available for mental health services for transition-aged youth. Following the release of the 2015 Provincial budget, the Canadian Mental Health Association BC branch estimated that the budget for the Child and Youth Mental Health system would increase by $2.8 million between 2014/15 to 2017/18 (CMHA-BC, 2015). Since 2012, there has been a 1.44% increase in funding for child and youth mental health. The 2016 Provincial budget has no further mention of increased funding for Child and Youth Mental Health services (CMHA-BC, 2016). The MoH received some additional funding ($101 million) in the 2016 BC Budget; however, much of that funding is meant for the new acute mental health facility in Coquitlam[9] (CMHA-BC, 2016) Therefore, it would seem that the relative expenditure would be an important criterion when examining the implications of new policies. The impact of the policy options on the budget will be examined based on an estimate of costs for each program, based on findings from other jurisdictions. The degree of the impact will be based on the limited funding increases available for child and youth mental health. The policy options will be analysed based on both qualitative and quantitative measures of cost. This will include information on the number of staff required, the difficulty of finding adequately trained staff, capital construction costs, and operational costs. Due to the lack of substantive data surrounding the full administrative requirements for each policy options, the assessment of the administrative complexity of the policy options will be based on qualitative data from the Consensus Conference and a literature review.

8.3. Stakeholder Acceptance

This criterion examines whether or not key stakeholders will accept the proposed policy option. The main stakeholders identified are 1) Financial Stakeholders (e.g., Finance Ministry, Senior MCFD and MoH Officials); 2) the existing service providers (e.g., primary health care providers, social workers, community organisations (e.g.,

[9] This new facility will not provide an increase in the number of beds available but rather replace existing beds (CMHA-BC, 2016).

churches), and 3) transition-aged youth and their parents. It is extremely important to include the recipients of transition-aged youth services as a stakeholder group; however, due to the fact that no transition-aged youth or their families were consulted within this project, positive reception will rely on information from the literature review and the Consensus Conference.

8.4. Measures and Weights

The proposed policy options will be assessed using qualitative and quantitative data from the literature review, the Consensus Conference, and the expert interviews. To assess the trade-offs between each policy option, the policy options will be given a rating of high (2), medium (1), or low (0) based on their relative scoring. Though the criteria are not weighted, Effectiveness has three criteria (each worth two points), which makes it worth more than the two government management objectives. This is justified since the Effectiveness criteria are vital to the success of the policy option. Effectiveness is worth a total of 6 points. Budget Impact and Stakeholder acceptance have only one criterion each and are therefore only worth two points each. The maximum score that a policy option can achieve is 10. Table 8.2 illustrates the measures that will be used to assess the policy options and the weighting involved.

Table 8.2. Measures and Weights

Objective	Criterion	Measure	Low	Medium	High
Effectiveness	Proportion of successful transitions from CMHS to AMHS	1) Before implementation, the measure will be assessed on the basis of experiences in other jurisdictions	**(O)** Unlikely that the policy will lead to an increase in the number of youth successfully transitioning from CMHS to AMHS	**(1)** Could lead to an increase in the number of youth successfully transitioning from CMHS to AMHS	**(2)** Very likely to lead to an increase in the number of youth successfully transitioning from CMHS to AMHS
Effectiveness	Will the policy increase access to mental health services for transition-aged youth?	Proportion of transition-youth able to access the policy option. Examine: -Hours of Operation -Eligibility Requirements -Home visits available -Youth friendly design -Wait-times to access services Based on experiences from other jurisdictions.	**(0)** Policy is difficult to access by youth with mental health issues	**(1)** Policy is only accessible to some youth with mental health issues	**(2)** Policy is very accessible to youth with mental health issues

Objective	Criterion	Measure	Low	Medium	High
Effectiveness	Will the policy reduce the stigma associated with mental health?	1) Before Implementation, review of academic and policy literature	**(0)** Policy does not address the stigma associated with mental health issues	**(1)** Policy somewhat addresses the stigma associated with mental health	**(2)** Policy plays a role in significantly reducing the stigma associated with mental health
Budget Impact	How much will the budget be impacted by the implementation of the policy option? - Number of staff and ability to find staff with appropriate skills - Capital Construction Costs - Operational Costs	Estimated costs of program, based on review of programs inside and outside the Lower Mainland.	**High Budget Impact** **(0)** The policy requires a considerable increase in the budget	**Medium Budget Impact** **(1)** This policy requires some additional resources	**Low Budget Impact** **(2)** 2-Policy can be implemented within the existing budget
Stakeholder Acceptance	Will the policy be positively received by: 1) Transition-aged youth and their parents 2)Financial stakeholders - Finance Ministry, MCFD and MoH Senior Officials 3)The existing service providers - Primary health care providers, social workers, community organizations	Scores based on reception in other jurisdictions, the Consensus Conference and expert interviews: - Estimated response in focus group meetings	**(0)** Policy is estimated to have negative responses from stakeholders.	**(1)** Policy is estimated to be somewhat positively received by stakeholders.	**(2)** Policy is estimated to be very positively received by all of the stakeholders
Score (10: maximum score)					

Chapter 9. Policy Analysis

9.1. Societal Objective: Determining Effectiveness

Table 9.1. Effectiveness Analysis Summary

Criteria	Policy Option 1: Transitional Coordinators	Policy Option 2: Protocol and Reciprocal Agreement	Policy Option 3: Integrated Care Clinic
Proportion of successful transitions from CMHS to AMHS	High **(2)**	Low **(0)**	Low **(0)**
Will the policy increase access to mental health care for youth?	Medium **(1)**	Low **(0)**	High **(2)**
Will the policy reduce the stigma associated with mental health?	Low **(0)**	Low **(0)**	Medium **(1)**

As per the above table, each of the social policy options needs to be examined in terms of the three criteria for determining effectiveness in meeting the overall goals of improving the transition for youth into adult mental health services.

9.1.1. First Criterion: Proportion of successful transitions from CHMS to AMHS

For the following reasons it would seem that the Transition Coordinator option rates the highest in regards to successful transitions from the child to adult mental health system. Firstly, the option's specific mandate is to assist and support youth in the transitioning process, and because of its more applied orientation, it has the greatest potential for positive results. Secondly, evidence from both Ottawa's Youth Transition Project and Kelowna's "Connected by 25" (see Appendix A) provides support that this policy option can increase successful transitions, while at the same time providing

supportive relationships for youth (Cappelli et al, 2014; CYMH-K, 2014). Similarly, evidence from the Youth Transitions Project demonstrates that the transition process can be improved by reducing the length of time for transitions (Cappelli et al, 2014). This is not to say that the Youth Transition Project and the "Connected by 25" program are without flaws (Cappelli et al, 2014). For example, 40% youth who were a part of the Youth Transitions Project were either waitlisted for adult mental health services or ended up disengaging from services (Cappelli et al., 2014). The Transition Coordinator option could be implemented in the Lower Mainland to improve performance taking into consideration some of the lessons learned by prior programs in other jurisdictions. The expert interviews revealed that as long as the program has a strong mandate with strong partnerships with community service providers, many of these issues could be resolved. Furthermore, the recent proposals for increasing child and mental health services to the age of twenty-five could help youth continue to access services while they are on the waitlist for adult services.

The Integrated Care Clinics option, on the other hand, does not have a specific applied mandate to assist youth transition from child to adult mental health services; rather the majority of the program's focus is on increasing access to mental health services for youth (which I will discuss later). This program would extend transitions to the age of 25; however, the literature review revealed that, rather than reducing the transitions problems faced by youth, Integrated Care Clinics can actually lead to additional problems because youth must now transition into and out of the Integrated Care Clinics (Cappelli et al, 2014). This could be especially problematic if the youth are not receiving the supports they need to transition out of the Integrated Care Clinics. The expert interviews revealed that this option has the potential for leading to further fragmentation of services if the clinics are not well integrated into existing services. On this note, the expert interviewees expressed concern over whether Integrated Care Clinics were necessary. For example, one of the experts noted "it is not clear to me what [Integrated Care Clinics] would add. Should we put resources to that end, would that take even more resources away from child and youth mental health in the community? Where is that money going to come from?," (Child Mental Health Policy Expert, 2016). In addition, the evaluation of the Australia's Headspace centres, on which this model is based, was not conclusive and revealed many issues with consistency of care between

Headspace centres (Muir et al., 2009, p. 12-16). The 2014 Australian National Mental Health Commission report revealed that Headspace had become too centralised, which reduced the ability of Headspace centres to provide appropriate services based on community need (2014, p. 82). This report also demonstrated that Headspace did not resolve the issue of fragmentation of mental health services in Australia (National Mental Health Commission, 2014, Volume 1, p.32, 82-3; Volume 3 p.37, 131).

In regards to the Reciprocal Protocol Agreement, and the criterion of "Proportion of successful transitions from CMHS to AMHS," the main issue is the lack of accountability associated with this option. The evaluation (Singh et al., 2010) revealed the inconsistency in the implementation and enforcement of these agreements throughout the UK (p. 159). The lack of consistency and accountability associated with the Protocols and Reciprocal Agreements in the UK was the main reason that only 4% (n=90) of referrals "[met] the criteria for optimal transition defined as having continuity of care, at least one transition planning meeting involving the service user and/or carer, a period of joint working between CAMHS and AMHS, and optimal information transfer," (Singh et al., 2010, p.159). Even with the regional management tables, there remains the risk that this protocol will not lead to improvements in transitions for youth. This is evidenced by the concern expressed by the expert interviewees that unless accountability could be successfully tied to funding the protocol would not carry any weight. The expert interviews also revealed the difficulty of ensuring that the regional health authorities fully accept guidelines provided by the province.

9.1.2. Second Criterion: Increasing Access to Mental Health Services

First, the evidence suggests that the Integrated Care Clinics (Policy option 2) have the greatest potential for increasing access to mental health services for youth aged 15-24. Properly structured, Integrated Care Clinics have youth-friendly atmospheres and hours of operation, which increase the likelihood that youth will feel comfortable assessing the clinics' services. The evaluation of Headspace revealed that the program led to a significant increase in the number of youth aged 12-25 accessing mental health services in Australia. Notably, the Headspace program has been

successful in attracting youth such as those who are homeless or at risk who may not otherwise access mental health services (Muir et al., 2009, p.116-7). One of the spin-offs of these centres is that a greater number of youth access physical health, employment, and education services as well (Muir et al., 2009, p.116).

Similarly, the Inner City Granville Youth Clinic has achieved contact with a significant number of youth at risk since its inception in 2007. The Inner City Youth Granville clinic has low eligibility requirements, with many on-site services that allow youth aged 12-24 to simply walk in and/or at the very most, to book an appointment in order to access services[10]. Some of this group's more specialized professional services do require a referral, but the Inner City Youth Clinic has a low wait-time for these services, the average being a week (Steve Mathias, National Conference on Homelessness, Nov.2, 2015).

Nevertheless there are some access issues to the Integrated Care Clinics that need to be identified. Firstly, the mental health services provided within Integrated Care Clinics tend to be focussed on youth with less severe mental health issues. Youth with more severe health issues need to be referred to other services. Secondly, the jurisdictional scan revealed that it is unclear whether youth in Australia are aware of the availability of Headspace centres in their neighbourhood. For example, the study by Yap et al. (2012), identified that only 2.3% (n=302) of youth surveyed in Australia had spontaneous awareness of Headspace as a mental health organisation. Knowledge of and access to the integrated care clinics could be increased if the clinics are built within youth-accessible spaces (e.g., schools and community centres) and are easily accessible by transit.

In terms of access, the Transition Coordinator policy option was given a lower scoring than the Integrated Care Clinics due to its higher eligibility for help requirement and the fact that the hours of operation may not necessarily be the best for youth (assuming 9am to 5pm working hours). For a youth to access the services provided by the transitions coordinator they would need to be referred by a child and youth mental

[10] Consensus Conference on Emerging Adults Presentation

health provider. This means that youth who are not currently a part of the child and youth mental health system would not be able to access this program directly. The Transition Coordinator policy is also heavily reliant on partnered service providers to provide the mental health treatment for youth, which means that eligibility requirements may not necessarily be consistent between services and hence hamper the provision of appropriate care (Cappelli et al., 2014). In addition, the Transition Coordinator option does not necessarily remove the issue of waitlists for adult services. Approximately 19.1% of youth participants in the Youth Transitions Project remained on waitlists (Cappelli et al., 2014).

Nonetheless, the results from the Youth Transition Project and the "Connected by 25" Program demonstrates that the Transition Coordinators option would increase access to child and adult services for youth within the child and youth mental health system. In addition, Transition Coordinators could provide home visits for youth who feel more comfortable accessing services at home.

I would argue that the Protocol and Reciprocal Agreement option is the least likely to increase access for youth within or outside the child and youth mental health system. This is a result of the differing thresholds and eligibility requirements, which may make it difficult for youth to access the services that they need.

9.1.3. Third Criterion: Reduction in the stigma associated with mental health issues

The literature would suggest that both the Transitions Coordinator and the Protocol and Reciprocal Agreement options are not expected to reduce the general stigma associated with mental health issues. There is no evidence available that suggests that these programs would lead to a reduction in the stigma associated with mental health issues. This could be because the youth who would benefit from these programs would already be within the child and youth mental health system. In other words, these initiatives would be less focused on reducing stigma in the general population, and more focused on increasing awareness of the programs amongst youth in the child mental health system and amongst service providers.

The Integrated Care Clinics, on the other hand, have been known to reduce the stigma associated with accessing mental health services. This is because the clinics provide a multiplicity of services including employment, housing and education advice that diffuse perceptions of the facility as solely a 'mental health' clinic. This is an important feature for youth fearful of being labelled mentally ill and worried that someone might find out. The Australian Headspace centres have also been effective in producing mental health awareness campaigns that reduce the stigma associated with mental health issues within the general public (Muir et al., 2009, p.117). Nonetheless, it remains unclear to what extent the implementation of Integrated Care Clinics has resulted in a decrease in stigma amongst the general population; it has not been proven to "increase[e] young people's awareness of mental health issues, or chang[e] [their] help-seeking behaviours" (Muir et al. 2009, p. 107). This is why it was not deemed appropriate to give the Integrated Care Clinics a "High" rating for reducing stigma.

9.2. Government Management Objective: Budget Impact

Table 9.2. Budget Impact Analysis Summary

Criteria	Policy Option 1: Transitional Coordinators	Policy Option 2: Protocol and Reciprocal Agreement	Policy Option 3: Integrated Care Clinic
How much will the budget be impacted by the implementation of the policy option?	Medium Budget impact **(1)**	Low Budget impact **(2)**	High Budget impact **(0)**

As the table above suggests, the Protocol and Reciprocal Agreement is estimated to have the smallest budget impact of the three policy options suggested. The Protocol Agreement can be implemented using the existing service providers and will not involve the hiring of new staff or increasing capital and operational costs.

The Transition Coordinator option will require some additional resources since it involves the hiring of new staff. Based on the "Connected by 25" program, it was determined that the Transition Coordinator Pilot Project would initially involve 1-3 transition coordinators per regional health authority. The number of transition

coordinators would increase as demand requires (and if additional funding is available). The “Connected by 25” program was initially funded through a Community Action Initiative Service Innovation Grant, which has a maximum value of $200,000 for a project running for 18-24 months (Community Action Initiative, 2016). To meet client demand, an additional $350,000 was received by outside funders to hire the two transition coordinators, as well as provide some extra programming (CMHA-K, 2013, p.3). This is a total expenditure of $550,000 for staff and operations over a two-year period or $225,000 per year. Even if the Lower Mainland’s expenditure requirements are triple that of Kelowna’s, this is a relatively small funding requirement, especially since there is also limited capital costs associated with the project. This option is well within the $2.8 million budget increase available between 2014 and 2018.

The Integrated Care Clinics are the most resource-intensive policy option. Based on the projections from the BC Integrated Youth Services Initiative, the five Integrated Care Clinics would receive $600,000 each to build the clinics or to renovate existing buildings (BC-ISYSI, 2016). This is in addition to the $500,000 that the centres will receive annually over a three-year period (BC-ISYSI, 2016). This is a total of $10,500,000 for capital and operation costs for the five centres over three years or $3,500,000 per year. As part of this funding, there is the need to hire a substantial number of multi-disciplinary staff (see appendix). This may not be the case in BC's current employment situation, but evidence from the Headspace project in Australia noted a significant difficulty finding appropriately trained staff to fill positions within their program (Muir et al., 2009, p.16). This is well above the $2.8 million increase available estimated between 2014 and 2018.

9.3. Government Management Objectives: Stakeholder Acceptability

Table 9.3. Stakeholder Acceptability Analysis Summary

Criteria	Policy Option 1: Transitional Coordinators	Policy Option 2: Protocol and Reciprocal Agreement	Policy Option 3: Integrated Care Clinic
Will the policy be positively received by: 1) Transition-aged youth and their parents 2)Financial stakeholders - Finance Ministry, MCFD and MoH Senior Officials 3)The existing service providers - Primary health care providers, social workers, community organizations	High **(2)**	Low **(0)**	Medium **(1)**

9.3.1. Transition-aged youth and their families

The Headspace Model is likely to be positively received by the youth and their families. In the 2009 Evaluation of Headspace, 97.8% of youth reported feeling respected by Headspace workers (Muir et al. p. 56). Youth also reported that they valued the information that they received from care (Muir et al, p.57). Most importantly, 79.4% of youth that attended Headspace clinics felt they had definitely been involved in planning their care or treatment (Muir et al, p. 57). Similarly, the Granville Inner City Youth Centre found that 83% of youth (n=286) reported describing the Granville Inner City Youth Centre as youth-friendly (Steve Mathias, National Conference on Homelessness, Nov.2, 2015).

The Transition Coordinator model is also expected to be positively received by youth and their families. This is based on experiences within the Connected by 25 program in which “young people who were served by the project also spoke highly about

the impact and the role that the [transition] navigators played in their lives, including flexibility and willingness to support them in navigating systems, as well as helping to build life skills and social connections," (CMHA-K, 2014, p.4).

The Reciprocal and Protocol Agreement will not be positively received by youth and their families. This is primarily because of the expected lack of impact – unless it includes a strong accountability framework.

9.3.2. Financial Stakeholders

In regards to the financial stakeholders, the major issue would be the level of funding required for the project, as well as the length of time that funding for this project will be necessary. The Protocol and Reciprocal Agreement would be well received by financial stakeholders since there are limited funding requirements associated with this project.

The Transition Coordinators are also expected to be positively received by the financial stakeholder since the project does not require extensive capital expenditures and the operating costs are relatively low.

Since the BC Integrated Youth Services Initiatives has received funding through the MCFD and the MoH, presumably the cabinet and Finance Ministry are somewhat sympathetic. However, this option is far more expensive than the two others, and the willingness of government to sustain funding past the initial three-year implementation period remains uncertain (BCIYSI, 2016).

9.3.3. Existing Care Providers

Based on the experiences in Australia, it is possible that the implementation of Integrated Care Clinics will not be positively received by existing care providers. The experience of the Headspace Model was that it received criticism from mental health academics, service providers, and practitioners in Australia (National Mental Health Commission, 2014; Muir et al., 2009). Similarly, three of this study's expert interviewees were very critical of this model in the Lower Mainland, arguing that the model had yet to

be proven successful in Australia. It is expected that there will be a mix of positive and negative responses if the Lower Mainland adopts this model. In particular, existing service providers who lose funding because of this program would likely be unsupportive. On the other hand, primary care doctors and social workers who would be included in this model may receive it positively.

In contrast, the Transition Coordinator option was well received by all but one of the BC expert interviewees. It was seen as a supportive way to assist youth transition from the child to adult mental health system. One can conjecture that, because no current service providers would lose funding, the Transition Coordinator option would be received positively by other service providers. Furthermore, experiences from the Connected by 25 Program in Kelowna demonstrated an overall community acceptance of the program as a means of assisting transition-aged youth (CMHA-K, 2014, p.4). The program was also nominated for the BC Representative of Children and Youth Award of Excellence in Service Innovation, demonstrating the positive impression of this model within BC (CYMH-K, 2014, p.4).

Based on the experiences in the UK, it is unlikely that mental health service providers will receive the Protocol and Reciprocal Agreement positively, especially if there is no accountability associated with the implementation of this option. For example, the UK Track Study found that the Protocols tended to have a limited impact on clinical practice (Singh, 2010, p.163). The UK study found that with this model, care providers did not feel like they were adequately prepared to help youth transition (Singh, 2010, p.163). Unless existing services in BC could be assured of the overall efficacy of this model, it would be difficult to implement.

9.4. Summary of Policy Analysis

Table 9.4 provides a summary of the policy analysis.

Table 9.4. Summary of Policy Analysis

Objectives	Criteria	Policy Option 1: Transition Coordinator	Policy Option 2: Protocol and Reciprocal Agreement	Policy Option 3: Integrated Care Clinics
Effective-ness	Proportion of successful transitions from CMHS to AMHS	**High (2)** - This policy will increase the proportion of youth that successfully transition -Specifically targets child to adult transitions -proven successful in the Youth Transitions Project and the Connected by 25 program -e.g., approx. 60% of youth who participated in the Youth Transitions Project transitioned successfully to adult mental health services -provides supportive relationship during the transition	**Low (0)** -The policy will not lead to an increase in the proportion of successful transitions -Lack of accountability -Uncertain whether will lead to an increase in successful transitions -UK- only 4% of youth had optimal transitions.	**Low (0)** -This policy will not lead to an increase in the proportion of successful transitions from child to adult mental health services -Not specifically targeting transitions from child to adult mental health services; more focused on access. -Could lead to more transitions and the further fragmentation of services. - could take funding away from current programs that are fully functional.
	Will the policy increase access to mental health care for youth?	**Medium (1)** -This policy could lead to an increase in access to mental health care for youth -High Eligibility Requirements -Sub-optimal operation hours -Home visits possible - Increase access for youth already in the system	**Low (0)** -This policy will not increase access to mental health care for youth -Differing eligibility requirements will make it difficult for youth to access the care they need.	**High (2)** -This policy will lead to an increase in access to mental health care -Headspace: increase in the number of youth accessing care -Inner City Youth Program: Youth friendly location and hours of operation. -Low eligibility requirements -Only meant for youth with mild to moderate mental health issues; youth with serious mental health issues referred elsewhere. -Headspace: youth not aware of centers

Objective	Criterion	Policy Option 1: Transition Coordinators	Policy Option 2: Protocol and Reciprocal Agreement	Policy Option 3: Integrated Care Clinics
Effective-ness	Will the policy reduce the stigma associated with mental health?	**Low (0)** -This policy will not reduce the stigma associated with mental health care - Meant for youth already in the system.	**Low (0)** - This policy will not reduce the stigma associated with mental health care -Meant for youth already in the system.	**Medium (1)** - This policy could potentially reduce the stigma associated with mental health care - non-stigmatizing centers (multiple services provided) -Awareness Campaigns -Not sure of the extent of success of the awareness campaigns on youth.
Budget Impact	How much will the budget be impacted by the implementation of the policy option?	**Medium budget impact (1)** -This policy will require some additional resources -In BC, $550,000 total operational and staffing costs	**Low budget impact (2)** -This policy can be implemented without additional resources	**High budget impact (0)** -Resource intensive -In BC, $$3,500,000 annual capital and operational costs -Difficulty finding appropriately trained staff.
Stakeholder Acceptance	Will the policy be positively received by: 1) The existing service providers primary health care providers, social workers, community organizations (e.g. churches) 2)Transition-aged youth and their parents	**High (2)** -Assumed to be positively received by existing service providers and youth and their families.	**Low (0)** -Assumed to not be positively received by service providers or youth and their families based on the UK experience.	**Medium (1)** -Assumed to be somewhat positively received by service providers based on Headspace experiences - Expected to be positively received by youth and their families based on the headspace model.
	SCORE	6	2	4

Chapter 10. Recommendations and Conclusions

Based on the analysis provided, it is recommended that the Regional Health Authorities implement the Transition Coordinator Pilot Project (Policy Option 1). To begin with, the Regional Health Authorities should work to accumulate partnerships with the Ministry of Child and Family Development, the Ministry of Health, community service providers, and other mental health organisations to form an advisory committee. This is important in developing links with service providers in which the Transition Coordinators will work and to commence the important work of facilitating organizational change. Through the advisory committee, a project proposal should be developed that outlines the implementation process as a Pilot Project. This could be based on the examples of both the Youth Transitions Project and the Connected by 25 programs.

Efforts should be made on the part of the Regional Health Authorities to include youth with lived experience from various backgrounds in the development of the pilot project and its implementation. Consultations should also be conducted to determine the appropriate number of Transition Coordinators per Regional Health Authority. The Regional Health authorities should also develop an awareness campaign for service providers to ensure that as many care providers can be involved in the project as possible and necessary.

Regional Health Authorities should then seek funding to implement the program by 2018 at the latest. Once funding had been achieved, the research team and the Transitions Coordinators should be hired. Essential in the Pilot Project planning and design will be the development of research segment that can provide on-going evaluation (so that the program can adjust) and a two year longitudinal study of pre- and post-youth in transition access rates. After the two-year pilot project phase, the Regional Health Authorities should review the outcome data to ensure that the program is meeting the needs of transition-aged youth. Based on the success of the program, the Regional

Health Authorities can make an informed decision on continuing the program and provide hard data to support any further funding decisions.

The Transition Coordinator program will not solve all the issues associated with the child mental health system and the transition for youth to the adult mental health system in BC. It is a recommendation that can be implemented in the short term to improve transitions from child to adult mental health services. However, in the long-term, the efforts of the Transition Coordinators could be strengthened by the adoption of significant system-level changes. With this in mind, in the long term, the provincial government should develop a management structure[11] with the capability to properly monitor and assess the mental health system in BC to ensure that the needs of people with mental health issues are being met (SSCCY, 2016). This will make it easier for the provincial government to implement a centralised information system and mental health budget that enables the gathering of hard data necessary for ongoing evaluation and improvement of the system.

[11] This could the creation of A Minister of Health position in the cabinet as recommended in the Final Report of the Senate Standing Committee on Children and Youth (SSCCY, 2016).

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Appendix A. Notable Programs in BC

British Columbia

Though no province-wide “transition” policy exists in BC, a few notable programs have been developed in BC that illustrate the variety of approaches to transition-aged youth that could be implemented and/or expanded in the Lower Mainland.

The BC government and other stakeholders in youth mental health have developed a Child and Youth Mental Health and Substance Use Collaborative (CYMHSUC). This Collaborative is meant to bring “community partners together to educate one another and make the system work better locally and provincially” (CYMHSUC, 2013). It is supported by Ministry of Health, the Ministry of Child and Family Development, and the Regional Health Authorities. The Collaborative is funded through the Shared Care Committee, which is a project of the Ministry of Health and Doctors of BC. The goal of the Collaborative is to increase access to integrated mental health care and increase child/youth and family involvement in program and policy design (CYMHSU, 2013). Most importantly, the Collaborative has led to the development of local action teams responsible for developing local improvements in mental health service delivery (CYMHSU, 2013). Though a relatively new organisation, the Collaborative has had some success in increasing communication amongst the BC ministries and the community service providers (CYMHSU, 2013)

The BC government has also been in the process of introducing integrated care clinics as a means of addressing the gaps in services for vulnerable youth aged 12-24. This is part of the BC Integrated Youth Services Initiative (BC-ISYI), which proposes the development of “one stop” integrated care clinics that provide a variety of health and social services within one physical space (BC-IYSI, 2016). The BC-ISYI proposes that the individual clinics will be connected and supported by a backbone organisation responsible for “the development of standards, knowledge translation and mobilisation,

research, evaluation, and a common communication strategy," (BC-IYSI, 2016). This organisation will be responsible to the program's funders: the Ministries of Health and Children and Family Development, and the InnerChange, Graham Boeckh and St Paul's Hospital Foundations and the Michael Smith Foundation for Health Research (BC-IYSI, 2016). Established examples of these clinics exist in the Lower Mainland, including Raven Song, which is operated by VCH and the Granville Inner City Youth Program. The Granville Inner City Youth program was implemented in 2007 at St. Paul's Hospital in Vancouver. Since its implementation in 2007, over 700 youth have accessed the clinic (Steve Mathias, National Conference on Homelessness Nov 2nd, 2015). The program has also provided approximately 3000 psychiatric appointments per year (Steve Mathias, National Conference on Homelessness Nov 2nd, 2015). The majority of youth (67%, n=286) who visited the clinic had an excellent experience at the Granville Youth Health Centre. Youth also felt that the centre was youth-friendly (Steve Mathias, National Conference on Homelessness Nov 2nd, 2015). Despite initial positive results, there has yet to be a formal review of the program.

Another program developed in BC to assist transition-aged youth is Kelowna's "Connected by 25" program offered in partnership with the Canadian Mental Health Association Kelowna, Interior Health, the Bridge Youth and Family Services, Inn from the Cold-Kelowna, the Ministry of Children and Family Development, BC Housing, and University of British Columbia-Okanagan. This pilot project targets youth aged 16 to 24 in the Central Okanagan identified as needing assistance navigating the transition to adult services (CMHA-K, 2014). Youth are given access to a "youth transitions navigator" who is responsible for "assist[ing] youth in navigating complex and multiple systems of care, providing the relational, emotional, and material support they required to be successful, and to develop the relationships with natural supports necessary to sustain them into adulthood" (CMHA-K, 2014, p.3). Overall the project involved 123 youth. An evaluation of the program found that overall it was well received by the community and led to improvements in both individual and community capacity (CMHA-K, 2014). In recognition of its success, Connected by 25 was nominated for the BC Representative of Children and Youth Award in Service Innovation (CMHA-K, 2014, p. 4).

Lower Mainland Regional Health Authorities

There are also some programs developed by the Regional Health Authorities in the Lower Mainland that are useful in assisting youth in their transition.

Vancouver Coastal Health (VCH)

One such program is the Richmond Central Intake Program, which was developed by VCH and Richmond Mental Health and Addiction Services in 2011. This program is intended to provide an easy access point for receiving mental health services. Potential clients are connected to appropriate mental health services within or outside the community after receiving a phone-based assessment (VCH, 2012). In terms of the number of referrals, this program has been quite successful. By 2012, the program had enabled 2,500 Richmond residents to access mental health services, receiving at the time approximately 200 referrals per month (VCH, 2012). In addition, the Central Intake Centre contributed significantly to reducing the wait times for mental health and addiction services (VCH, 2012). Though not providing an overall solution for youth transitioning, it may provide contact assistance for youth who are having difficulty accessing adult services.

VCH also has a Community Transition Team, which assists youth discharged from in-patient hospital service transition back into the community. Assistance provided by the Community Transition Team includes finding appropriate housing, crisis response, client health management, and referrals to community health services (VCH, 2014b).

Fraser Health

Fraser Health has some programs available for children and adolescent youth but only limited services specifically targeted toward youth aged 18-25. For example, Fraser Health offers an Adolescent Psychiatry Unit and an Adolescent Day Treatment Program that serves youth up to the age of 18 (Fraser Health, 2016b; Fraser Health, 2016c). Fraser Health is also heavily involved in the Child and Youth Mental Health and Substance Use Collaborative with local action teams in Abbotsford, Ridge Meadows, Delta, Surrey-Delta, Langley, White Rock-South Surrey, Burnaby, New Westminster,

and the Fraser Cascades (CYMHSUC, 2013). Through the collaborative, Fraser Health has developed a regional management table. Regional management tables consist of officials from the Ministry of Education, the Ministry of Child and Family Development and the Fraser Health Authority. The mandate of the regional management tables is broader than the Collaborative (CYMHSUC, 2013). In a 2014 report on Fraser Health's Strategic and Operation Policies, Fraser Health identified the need for more mental health services for youth. The report recommended a program similar to Australia's Headspace. This program in Australia promotes early intervention through the establishment of youth-friendly and easily accessible spaces for youth aged 12 to 25 (Fraser Health, 2014, p.19).

Appendix B. Summary of Models and their Application

	Transition Team/Coordinator Model	Protocol and Reciprocal Agreement Model	Integrated Care Clinic Model	Transition to Independence Model
Aim	The goal of the transition coordinator, in partnership with CHMS and AMHS and other community providers, is to develop transition plans for youth planning on transitioning to AMHS. -works WITHIN the existing CMHS and AMHS services.	The goal of the Protocol and Reciprocal Agreements is to provide clinical guidelines to guide the development and implementation of transition policies. The Regional Health Authorities and the local service providers have the flexibility to develop transition programming that fits the needs of the youth in their community.	This model is meant to provide a youth-friendly physical space in which youth are able to access a variety of services including mental health, physical health (including sexual health), employment and education services, and housing supports.	This model is meant to provide out-patient based, individualised transition planning for youth aged 15-24. The focus is on building individual patients' ability to manage their own mental health issues.
Application of the Model	Ottawa- Youth Transitions Project[1]	UK- Brandon Centre for Counselling and Psychotherapy for Young People	Australia- Headspace	US- Transition to Independence Process (TIP)
Structure	Example: Youth Transition Project 1)Transition Coordinator 2)Transitions Advisory Group -Service Delivery Partners and Project Sponsor	Highly dependent on the types of services adopted. For example, in the UK Track Study[2], 12 protocols were examined: -Protocols differed based on: 1) The agencies involved in protocol	1)Community of Youth Services (Integrated Care clinics)[3] -Staffed by psychologists, social workers, mental health nurses, occupational therapists, and Drug and Substance abuse specialists -Private Practitioners (billed	Transition Facilitator[6] - assists in planning transition and implementation -small caseloads

1 Cappelli et al., 2014

2 Singh et al, 2010

3 Muir et al, 2009

	3)Research Team -monitor the effectiveness of the model FOR COMPLEX CASES: 4)Case Review Committee The Case Review Committee is responsible for: -reviewing difficult referrals -Advocate for specific program planning/youth service - Chair (manager), 3 Clinicians (CMHS, AMHS, Community) -Transition Coordinators	development, 2) Age at which CMHS ended and AMHS begun, 3)The flexibility of the boundary age, referral criteria for AMHS 4) The guidelines for transitions (i.e., amount of time for planning and whether formal transition plans were required) -Cooperation between CMHS and AMHS varied depending on the protocol. Some required	through MSB) Supported by: 2)Headspace National Office -Manage and support the implementation of the clinics[4] -Oversee the operation of the clinics[5] -Hold other bodies accountable - Marketing and Communications 3)Centre of Excellence -Research and Outcome Measurement 4)Community Awareness Program 5)Service Provider Education and Training -Increasing community capacity for identifying mental health issues. -Evidence-Based Treatment Governance by: Chief Executive Officer, Orygen Research Centre, Foundation Executive Committee, Advisory Committee (Government appointed)	

6 Davidson et al., 2011

4 Muir et al., 2009, p. 3

5 Ibid

Positive Outcomes	-Example Youth Transition Project[7] -Majority of youth in the Youth Transitions project successfully transitioned to AMHS services (59.1%) -Average length of transition time (in days) declined from 2011-2013 - youth were heavily involved in individualized transition planning - Feasible model within the Canadians (and BC context)[8].	-Flexibility based on geography -Sets clinical guidelines	-Increases access to Care -Reduces stigma associated with Mental Health issues Study by Rickwood et al. (2015a) found 59.9% of headspace attendees reported improved outcomes in at least one of the client outcome measures. - Significantly lower levels of psychological distress (36%) - Increases in overall psychosocial functioning (37%). Another study by Rickwood et al. (2015b) found that 80.1% of clients waited less than two weeks for an appointment at headspace (increased access to care)	- Individual's heavily involved in their own transition planning -Flexible care based on the individual -Case Managers have low number of cases, meaning more focused care - Provides general life skills -Greater likelihood of transitioning into post-secondary, employment. - less likely to be involved in the Criminal Justice System
Limitations	-19.1% of youth remain wait-listed for AMHS[9] -21.8% cancelled services Requires a high level of stakeholder investment [10] -Difficult to recruit personnel, and difficult to manage schedules.	-Dependent on location and funding -In UK, only a ¼ of programs and services have agreements between CMHS and the AMHS[11].	-Does not specifically focus on assisting youth transition. -Provides referrals and assistance to youth transitioning. -less ability to assist youth with specialized mental health needs Costly and Contingent upon	- Limited evaluation of the TIP framework - May be difficult to access if case managers only accepting limited caseloads

[7] Cappelli et al., 2014

[8] Vloet, Davidson, and Cappelli, 2011

[9] Capelli et al., 2014

[10] Vloet, Davidson, and Cappelli, 2011

[11] Singh et al., 2010.

			stakeholder buy-in at multiple government and community levels.[12] Youth encounter two transitions Further fragmentation of services Not well integrated into regional service providers	
Funding	Funding provided through the Champlain LHIN (Ontario equivalent of a regional health authority)[13]	- Funded primarily by the UK government but delivered through local Health Auth. Depends on type of agreement and region.	- e.g., Headspace -Funded primarily by the Australian National government with Headspace received approximately 14.9 million government funding from 2006-2009 with 30 centers est.[14] In combination with Mixed funding sources	Funded through Substance Abuse and Mental Health Services Association[15]

[12] Cappelli et al., 2014
[13] ibid
[14] Muir, 2009
[15] Davidson et al., 2011

Appendix C. Interview Guides

Interview Guide: Expert Interview #1

Date: Jan 8th
Time 10:00 am

Questions:

1) ***To begin with, I would love to hear more about your review of the Child and Youth Mental Health system?***

- What were some of the significant findings from the review?

2) ***What role do you think the ministry of education and the education system should have in addressing mental health issues in transition aged youth?***

- Do you think that the school system should play a larger role in the early prevention and detection of mental health issue in youth?

3) ***What do you think are the major barriers facing transition-aged youth in BCs mental health care system?***

- More specifically, what do you think are the main institutional barriers affecting youth in BC

4) ***What are some possible solutions to address some of the barriers faced by transition-aged youth?***

- This can also refer to potential best practices.

5) ***How do you feel about integrated primary care clinics, similar to the RavenSong clinic as a potential policy option to address the needs of transition-aged youth?***

6) ***From the articles that you recommended and from my own readings, it has become clear that there is a significant problem, which is well known to many health experts and government officials. Nonetheless, nothing substantive seems to have been done. What do you think are some of barriers that exist that prevent a solution from being developed?***

- Are there political barriers?
- Why do you think these barriers are so difficult to overcome?

Interview Guide: Expert Interview #2

Date: January 21, 2016
Time: 11:00am

Questions:

1) ***To begin with I am wondering in what capacity you have engaged with transition age youth with mental health issues in your social work, and while working as an educator within a post-secondary institution?***

- What do you think are the major barriers facing transition-aged youth?

2) ***What role do you think social workers should have in assisting youth transition from the youth to adult mental health system***

- What role should clinicians play in determining policies and guidelines?

3) ***The Ministry of Child and Family development has been facing criticism recently regarding transitions of care based on chronological age? Based on your many years in the field and as an educator, do you any recommendations for how the system can be improved?***

4) ***Based on your many years in the field and as an educator in this field, what do you feel about these policy option***

- Do you think that a having an inter-professional transition team would be a good option?
- Integrated models of Care
- Reciprocal and Protocol Agreement

Interview Guide: Expert Interview #3

Date: Feb 4th
Time: 4:00pm

Questions- Barriers and Solutions

1) ***To begin with I am wondering if you could tell me a bit about your experience with transition-aged youth in your professional life?***

2) ***What are the significant barriers facing youth transitioning from the child to adult mental health system?***

- What are some of the political and institutional barriers?
- What do you think are some of the solutions to address these barriers?

3) **What needs to be done to improve transitions for youth in the Lower Mainland?**

Questions: Policy Options

1) ***Do you think that Integrated Care Clinics will address the gaps and services that exist for transition-aged youth?***

- What are some of the issues surrounding integrated care clinics?
- What gaps will still remain?
- Is this option politically feasible?

2) ***In Ontario, they have adopted the use of a transitions coordinator that works with the child and adult mental health systems to monitor the transitions of youth.***

- How would this address the gaps?
- What do you think are some of the potential issues with this approach?
- What gaps still remain?
- Is this option politically feasible?

3) ***How would the development of provincial protocols address the issues associated with youth transitions?***

- What do you think are some of the potential issues with this approach?
- What gaps still remain?

Interview Guide: Expert Interview #4

Date: February 10th
Time 11:30am

Questions

1) ***To begin with I am wondering if you could tell me a bit about your experience with transition-aged youth in your professional life?***
2) ***What were some of the best practices that you feel are the most important for addressing transitions for youth specifically?***
3) ***Notably, I was wondering Integrated Care Clinics would assist youth transitioning from the child to adult mental health care system?***
    - Once youth are no longer eligible for this clinic at age 25 what supports would be available for these youth in transitioning to adult services?
4) ***Based on your experience, how do you think accountability can be improved within youth mental health programs and services?***
5) ***What do you think are the most important takeaways for someone creating policy for youth mental health?***