BRITISH COLUMBIA INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

Rationale and Overview

December 2015

ACKNOWLEDGEMENTS

This rationale and overview document is based on the BC-IYSI Proposed Implementation Plan for the Prototype Phase October 2015 - March 2018, and was produced with financial support from the InnerChange and Graham Boeckh Foundations and the Ministry of Health (MOH). The plan was developed through a collaborative process involving a committed working group. Their work was informed by regular consultation with a Governing Council, comprised of senior representatives from the three funding organizations, as well as the BC Ministry of Children and Family Development (MCFD) and the Michael Smith Foundation for Health Research (MSFHR). The working group also received input from the Office of the Chief Medical Officer (CMO) for the First Nations Health Authority (FNHA).

BC-IYSI WORKING GROUP MEMBERS

Steve Mathias (BC-IYSI) – Executive Director

Karen Tee (BC-IYSI) – Director, Operations and Planning

Keli Anderson (FamilySmart™ Network) – Family/Youth Consultant

Skye Barbic (UBC) – Research/Evaluation Consultant

Jane Hood (JH Consulting) – Project Manager

Pamela Liversidge (MOH) – Policy Consultant

Greg Martyn (MSFHR) – Research/Evaluation Consultant

Carolyn Phoenix (Signals) – Production Coordinator

Daniel Presnell (Signals) – Communication Strategy Consultant

Chris Richardson (UBC) – Research/Evaluation Consultant

Mark Tyndall (BCCDC) – Public Health Consultant

Sandy Wiens (MCFD) – Policy Consultant

TABLE OF CONTENTS

1.0 RATIONALE

1.1 TOWARDS INTEGRATED YOUTH SERVICES IN BC

In September 2014, a proposal entitled *Transforming Access to Health and Social Services for Transition-Aged Youth (12-25)* in British Columbia was submitted to the Select Standing Committee (SSC) on Children and Youth. *"Transforming Access"* called for the creation of a branded network of health and social service centres across the province, with an overlay of e-health services and a framework for research and evaluation, with the goal of providing the province's youth and young adults (YYA) with integrated Mental Health and Substance Use (MHSU) services.[1] *"Transforming Access"* identified key characteristics of successful implementation, including: the absence of access barriers; youth-friendly staff; youth-appropriate spaces; and navigational ease, with embedded family supports.

In November 2014, the SSC released their *Interim Report: Youth Mental Health in British Columbia*, documenting best practice examples in BC, such as integrated service delivery, youth-appropriate services, telephone and online counselling, and peer support. The Interim Report noted the reported effectiveness of international models of integrated care, underscoring headspace in Australia as a model for BC to consider, and referenced the *"Transforming Access"* proposal.

In March 2015, InnerChange and Graham Boeckh Foundations each committed funding to initiate the work outlined in *"Transforming Access"*. This funding was matched by the Ministry of Health (MOH), and later increased by commitments from the St Paul's Hospital Foundation and the Michael Smith Foundation for Health Research. This group of funders and the Ministry of Children and Family Development, formed a Governing Council with a promise to establish a prototype phase called the "BC Integrated Youth Services Initiative (BC-IYSI)". The prototype phase, to be completed over 30 months (October 1, 2015 – March 31, 2018), will include the establishment of a provincial Backbone Organization and the physical creation of five health centres (which could entail the augmentation of existing centres), chosen by an independent panel following a formal two step Expression of Interest process from December 2015 to March 2016. Further operational funding has been committed by the MOH to augment and secure clinical services in each of the centres. The intention of the prototype phase is to provide a "proof of concept" to support the potential launch of a broader provincial network of centres for YYA with MHSU problems.

1.0 RATIONALE

1.2 EVIDENCE

Despite compelling evidence that the age of onset for MHSU disorders is between 12 and 24 years, and that nearly 75% of these conditions begin by the age of 24,[2] children and YYA struggle to access MHSU services. In Canada, an estimated 70% of mental health problems in Canada have an onset occurring during childhood or adolescence[3] and 1 in 5 (or 18%) of young people aged 15-24 report experiencing mental illness or substance use problems.[4] However, the literature suggests that less than 25% of youth with MHSU disorders actually receive MHSU services.[5]

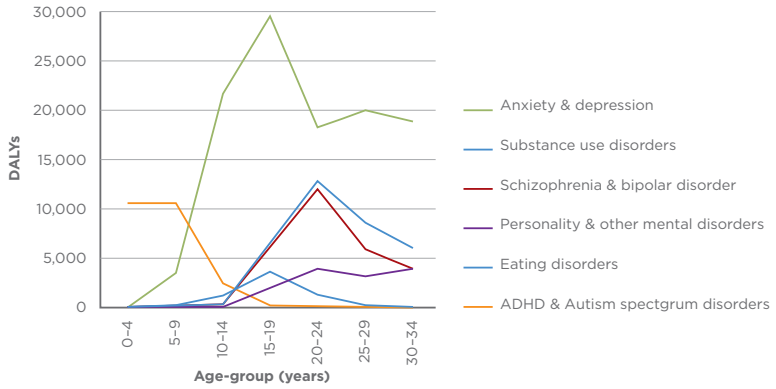

Figure 1. Burden of mental illness by age and disorder (DALYs = disability-adjusted life years, a measure of overall disease burden expressed as the number of years lost due to ill-health, disability or early death).[6]

While youth are susceptible to most types of mental illness, certain conditions, such as anxiety and depression, are most prevalent (see Figure 1, above). While suicide is preventable, it represents the second-leading cause of death for Canadian youth aged 15-24, second only to motor vehicle accidents. Nearly three times more youth will die of suicide than from cancer in 2014.[7] Mental Illness has been identified as a major contributing factor for suicide, with over 90% of suicide victims having a diagnosed mental illness, primarily depression or bipolar disorder.[8] Untreated mental illness in childhood leads to mental illness in adults, which is associated with other public health priorities including obesity, alcohol and substance misuse, smoking, cancer, cardiovascular disease and diabetes.[9]

The lifetime economic burden of childhood onset mental health disorders is compelling. Adjusted for population, the economic cost is roughly $200 billion in Canada and $26 billion in BC. Unassisted mental health problems among adolescents are associated with low educational achievement, unemployment, substance use, risk-taking behaviours, crime, poor sexual and reproductive health, self-harm and inadequate self-care – all of which increase the lifetime risk of morbidity (illness) and premature mortality (death).[10] In addition, early-onset mental disorders that are left untreated are associated with school failure, teenage childbearing, unstable employment, early marriage, and marital instability and violence.[11]

Encouragingly, there are interventions that work to prevent emerging issues from evolving into disabling and expensive-to-manage mental health disorders. Young people whose mental health needs are addressed function better socially, perform better in school and are more likely to develop into well-adjusted and productive adults than those whose needs are unmet. *Access Economics,* Australia's leader in economic modelling and forecasting, identified significant return on investment (ROI) for mental health treatment and best practice intervention in YYA. They reported that for every $1 spent, there is a $3.26 ROI for treatment and a $5.60 ROI for best practice (e.g., early intervention). The report states that preventively-oriented interventions targeted to young people aged 12-25 have the capacity to generate greater personal, social and economic benefits than intervention at any time in the lifespan.[12]

Preventively-oriented interventions targeted to young people aged 12-25 have the capacity to generate greater personal, social and economic benefits than intervention at any time in the lifespan.

1.0 RATIONALE

1.3 A FOCUS ON ACCESS AND INTEGRATION

Rather the challenge in BC, like it is in most national and international jurisdictions, lies in the creation of effective access points that make these treatments available, affordable and acceptable, enabling the majority of YYA with MHSU (well over 100,000 in BC) to engage in evidence-based interventions as they transition from adolescence to adulthood.

The BC Representative for Children and Youth (RCY) report Still Waiting: *First-hand Experiences with Youth Mental Health Services in BC* (April 2013)[13] is based on information collected from surveys, focus groups and interviews with 853 youth, parents, caregivers and/or professionals who work with youth with mental health problems. A recurring theme that emerged from the focus groups involving BC youth, on the issue of youth services, was the lack of accessibility and integration of services. Access to treatment has been defined as consisting of three dimensions: availability, affordability and acceptability.[14] Access, whether physical, timely, continuous, appropriate or collaborative, is lacking in Canada, sparing no type of mental illness, constituency, or geographic setting.

It is important to note that the challenge to meet the health needs of youth and families in BC is not due to the lack of evidence-based treatments for MHSU disorders. In fact, dozens of interventions, both psychosocial and pharmacological, have been described in the child and adolescent psychiatric literature over the past twenty years. Rather the challenge in BC, as in most national and international jurisdictions, lies in the creation of effective access points that make these treatments available, affordable and acceptable, enabling the majority of YYA with MHSU (well over 100,000 in BC) to engage in evidence-based interventions as they transition from adolescence to adulthood. Although there are pockets of innovative services for YYA and clinics that are welcoming for young people, there are examples of "unacceptable" service delivery present in many existing mental health centres that can best be described as "youth unfriendly". These tend to be colourless, rule-bound and demoralizing, stigmatizing the experience of MHSU services and discouraging many vulnerable YYA from engaging in care.

Street Clinic Entrance

Clinic Waiting Room

Figure 2. Photographs of youth health access points. None of these facilities would be considered "youth friendly".

The lack of accessible services is evidenced by the increasing inability of hospital- and community-based services to avoid severe congestion and/or long wait lists. Furthermore, due to service pressures, programs must intervene in the most serious of cases and often focus services to particular diagnoses or endangering behaviours. In the absence of accessible, low-barrier services, youth utilization of expensive Emergency services has climbed across the health authorities (see Figures 3 and 4, below). For example, there has been an 85% increase in Emergency Department visits over five years (2009 to 2013) for youth aged 15 to 19 in BC, and a comparable increase in the number of youth seeking MHSU inpatient hospital services. For those youth not in crisis, many are unattached to a GP, and therefore left to access walk-in clinics, where no continuity of care exists, and where counselling opportunities are minimal.

1.0 RATIONALE

In the absence of accessible, low-barrier services, youth utilization of expensive and inappropriate ER's has climbed across the health authorities (see Figures 3 and 4).

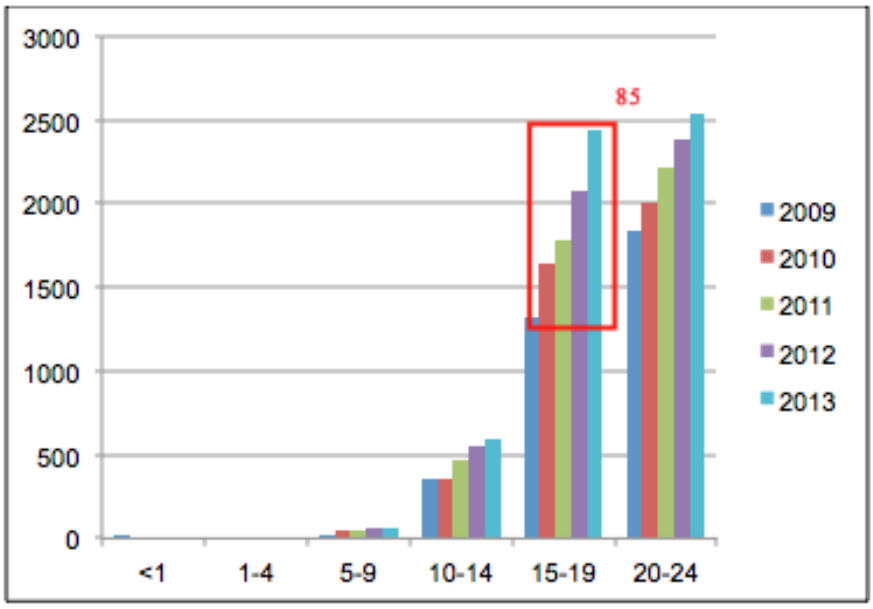

Figure 3. Number of MHSU Emergency Department Visits in BC by Age Group and Year

↑85%

There has been an 85% increase in ER visits over five years (2009 to 2013) for youth aged 15 to 19 in BC, and a comparable increase in the number of youth seeking MHSU inpatient hospital services.

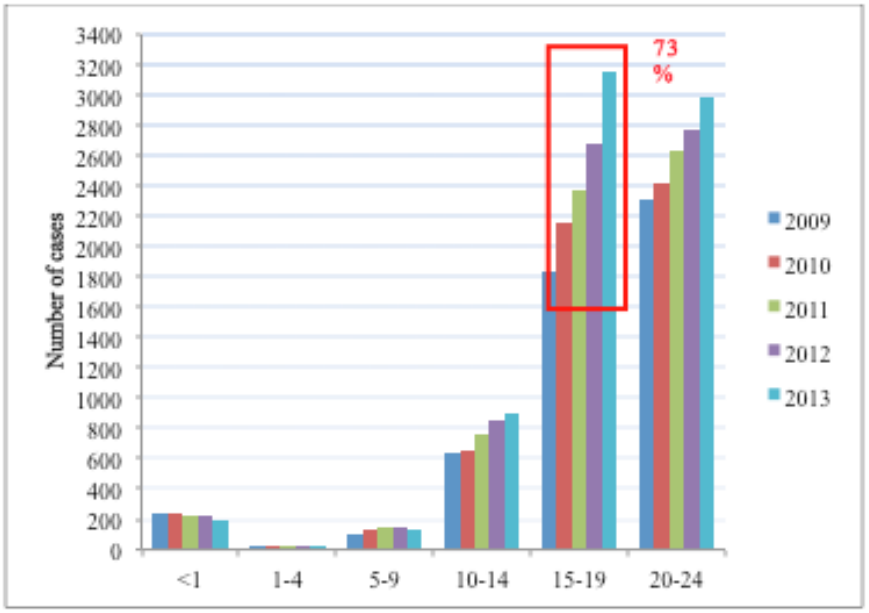

Figure 4. Number of Cases Seeking MHSU Inpatient Hospital Services in BC by Age Group and Year

The lack of integration among existing services for youth and families has led many to conclude that "every door is the wrong door." Existing youth health centres operate as "one off" facilities, often in isolation and without the "economies of scale" required to support the development of rigorous evaluation platforms and participation in broader population initiatives, such as anti-stigma or awareness campaigns.

As outlined in the 2013 RCY report, our province needs services that are inclusive, not exclusive. Areas identified for specific consideration were marginalized youth (including youth in care), justice-involved youth, and Aboriginal youth, whose mental health needs often are neglected since they are not well met through traditional service delivery models. An integrated model of care for YYA, accessed through a youth-friendly environment, represents a critical component in the continuum of services required to respond to the diversity and complexity of needs experienced by BC youth.

In the spring of 2015, MOH released *Primary and Community Care in BC: A Strategic Policy Framework*,[15] outlining the need to establish community-based services that are integrated, comprehensive, and "wrap around" the patient. The aim of this strategic shift is to transform a system focused mainly on acute hospital care to a proactive system of primary and community care built to address changing patient needs early and more effectively, utilizing a collaborative team-based model.

An integrated model of care for YYA, accessed through a youth-friendly environment, represents a critical component in the continuum of services required to respond to the diversity and complexity of needs experienced by BC youth.

1.0 RATIONALE

1.4 CHANGE DRIVERS

Numerous strategic documents highlight the need for integrated, community care. Recently in October 2015, building upon the *Primary and Community Care in BC* paper referenced above, MOH released the draft policy paper, *Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues.*[16] MOH is calling for a system of care that is a responsive and integrated network of services - one that includes patients and families with mild to moderate MHSU issues having their needs addressed through "primary care homes" that are comprised of full service family practice and specific MHSU services (Tiers 2 - 3). This paper also suggests that YYA, who tend to be high hospital users, could benefit from integrated, community-based, youth friendly services.

Another key strategic document has been *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (Healthy Minds, Healthy People).*[17] In summer 2014, the Province facilitated an engagement process with partners and stakeholders to determine key priorities to guide the next three years of *Healthy Minds, Healthy People (2015 – 2018).* Close to 200 individuals participated, with representatives from community-based services, agencies representing people with lived experience, health authorities, all social ministries – including the Ministries of Children and Family Development, Education (MOE), and Social Development and Social Innovation (MSDSI), and the research and academic community. While there was a broad array of ideas and comments shared, certain themes arose consistently throughout discussions across all sessions. Consistent with findings of the focus groups referenced above, the following key priorities were identified:

- **Transition points**: both life and service transitions with a particular emphasis on the importance of youth and young adult transitions;
- **Families**: the critical role that family can play in advocating for and supporting the care of family members, and the importance of providing support to the whole family;

- **Upstream, early focus**: a continued emphasis on the need to focus efforts upstream and early in the lifespan before problems emerge, and to intervene early when problems are identified; and
- **Increased accessibility through service integration**: improved continuity of care (transitions) and accessibility, holistic responses to complexity

Healthy Minds, Healthy People goes so far as to suggest that "the majority of children, youth and adults with MHSU problems experience mild to moderate symptoms that can be effectively supported or treated through low-intensity community-based services. Research has shown that family physicians with access to specialists such as psychiatrists and mental health clinicians, through a shared care model, can significantly enhance their ability to provide ongoing primary mental health and substance use care within their practice" (pp. 26-27).

The majority of children, youth and adults with MHSU problems experience mild to moderate symptoms that can be effectively supported or treated through low-intensity community-based services.

Furthermore, *Healthy Minds, Healthy People* states that:

> It is clear that aligning the existing community capacity to identify and address problems earlier is essential to reduce suffering and avoid more costly hospital or residential specialized services later on. Services must be matched to different levels of need so that the least intrusive interventions with the greatest gain are provided prior to more intensive interventions (p 29).

Given the traditional lack of help-seeking behaviours displayed by youth, especially young males,[18] any system of care needs to consider non-traditional health access points – most notably through educational, vocational, income and housing services. In particular, completing school and gaining employment are key developmental milestones for older YYA. For youth with mental illness, challenges at school, home and in the community are compounded by stigma and fragmented resources, resulting in low graduation rates, high unemployment and poor health outcomes.[19] The importance of work and the need for vocational services cannot be underestimated, as employment demonstrates benefits like improved health, social and cognitive abilities, self-esteem, housing stability, and social networks.[20] By providing health services that are either co-located or integrated with social development and education, this system begins to build on the determinants of health, leading to resilience and wellness, which are the ultimate goals of care.

1.0 RATIONALE

Given the traditional lack of help-seeking behaviours displayed by youth, especially males, any system of care needs to consider non-traditional health access points – most notably through educational, vocational, income and housing services.

With an intention to inform the discussion about improving mental health service delivery for YYA in BC, MCFD conducted a research review, *Designing Mental Health Service Delivery to Better Meet the Needs of Youth (October 2015).*[21] The focus of this review was on approaches to YYA health services delivery and promising practices reported in the literature and found in other jurisdictions. Given the concerns about access and integration noted above, the following research findings are key considerations for planning YYA MHSU services:

- Making services more accessible to youth: accessible locations and youth-friendly hours in order to improve accessibility (e.g., located near public transit and other services accessed by youth; services available at times that are convenient to youth, such as after school and on weekends); using the Internet to improve access for youth to information and support about mental health (i.e., with the potential to break down barriers, including geographic barriers; opportunity to engage youth who cannot or do not feel comfortable accessing services in person)
- Creating youth-friendly service delivery environments: to encourage youth to access and remain engaged in services – includes providing an informal, non-clinical, comfortable space where youth can attend appointments and/or hang out with their peers; friendly service providers (of note, several jurisdictions have had youth participate in staff recruitment, including sitting on interview panels)
- Providing a holistic approach to care: services should not be focused exclusively on mental health interventions but also integrate physical health services, educational, vocational and social support; also engage families and caregivers; include mental health promotion, prevention and early intervention
- Encouraging youth participation in service delivery design: when youth are involved at all levels of decision making, barriers to mental health services are reduced and services are better able to meet the needs of youth; this approach can also help enhance protective factors for the youth involved; "youth-friendly" approaches include establishing Youth Advisory Groups.

Figure 5. Word cloud illustrating qualities that youth are looking for in their mental health services. (Adopted from *Designing Mental Health Service Delivery to Better Meet the Needs of Youth* (October 2015), p. 9.

Models such as *headspace* in Australia utilize a network of Community Health Centres, with primary care, mental health, substance use and vocational services all easily accessed through one storefront door.

In addition to strategic documents, a key change driver is the Child and Youth Mental Health and Substance Use Collaborative. Starting in June 2013 and led by the Doctors of BC, the CYMHSU Collaborative has spread across BC, with multiple stakeholders working collectively to improve timely access and coordination of care for children, youth and their families with MHSU challenges. With a vision of system transformation, key stakeholders, service providers, and youth and families, have been working together on common goals and engaging to bring about system improvements and address barriers collectively. An outstanding feature of the Collaborative is the increasing engagement of youth and parents in all levels of the work.

The role of families in the lives of young people is critical. Organizations such as the Institute of Families for Child and Youth Mental Health DBA the FORCE in BC (http://www.familysmart.ca), promote a balance between child and youth-centred and family-centred approaches to MHSU care. This shared model respects and supports the rights of young people, as well as the essential caregiving role that families play in their lives. The Institute has been instrumental in facilitating the inclusion of youth and family perspectives in initiatives such as the CYMHSU Collaborative, and has set the standard for meaningful engagement and participation in service design.

1.0 RATIONALE

1.5 MODELS OF INTEGRATED CARE FOR YOUTH

77

As of 2015, there were 77 *headspace* sites across Australia, with plans to increase to 100 sites by 2016.

As highlighted in the full literature review conducted by MCFD referenced in Section 1.4, there are models of care that exist outside of BC that address, in whole or in part, the issues of accessibility and integration across youth services. Models such as *headspace* (http://headspace.org.au/) in Australia utilize a network of branded Community Health Centres, with primary care, mental health, substance use and vocational services all easily accessed through one storefront door. Services are integrated and staff is engaging and youth-friendly. The spaces housing the services are open, bright and welcoming and youth have been involved in their design. The *headspace* centres are bolstered by the addition of *eheadspace*, an online counselling and referral service, and by a strong communication strategy, leading to national mental health anti-stigma and awareness campaigns.

As of 2015, there were 77 *headspace* sites across Australia, with plans to increase to 100 sites by 2016. *headspace* was designed to complement existing primary care and specialist services, and better integrate and coordinate service responses for young people.[23] Serving YYA aged 12 to 25, headspace clients are 63.7% female, 35.6% male, and 0.7% intersex/transgender/transsexual. The most common age for accessing services is 15 to 17 years.[24] *headspace* is largely achieving its aim to improve service access through early intervention, with over half the young people presenting in the initial stages of developing a mental disorder (mild/moderate to sub-threshold symptoms). About one-fifth have an established disorder, and one-tenth present with serious ongoing disorder.[25] Outcome data indicate that for YYA who accessed headspace centres, over one-third had significant reductions in psychological distress and improved psychosocial functioning.[26]

Jigsaw (https://www.headstrong.ie/jigsaw/), a similar integrated youth service in Ireland serving YYA aged 12 to 25, was developed in 2006 by Headstrong, the National Centre for Youth Mental Health. Beginning with five demonstration sites, and now established in ten communities across Ireland, preliminary evidence indicates that similar proportions of males (43.5%) and females (56.5%)

access their services, and like *headspace*, the most frequent users of the service were between the ages of 15 and 17 years. *Jigsaw* also has reported emerging evidence of the effectiveness of their services, with the majority of young people who self-reported high levels of psychological distress pre-intervention then subsequently reporting healthy (47.2%) or low (28.8%) levels of psychological distress after accessing *Jigsaw*.[27]

The benefits of creating integrated service models with primary care and shared care are supported by a recent systematic meta-analysis showing that integrated "medico-behavioral primary care" improved youth behavioural outcomes.[28] The largest effects were observed for depression, anxiety and behaviour. This timely report, published in JAMA Pediatrics (August 2015), summarized 31 randomized clinical trials (RCTs) examining health outcomes of youth who access health care in primary care settings. The study found a 66% probability that a randomly-selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly-selected youth receiving usual care. The strongest effects were observed for treatment interventions that targeted mental health problems and those that used collaborative care models. The study also showed a significant effect of integrated care for substance use outcomes. The overall conclusion and recommendation from this meta-analysis is that there is preliminary evidence of the benefits of integrated care for improving YYA health outcomes and that more integrated care initiatives for the YYA population are warranted.

Building on these international models and recent evidence, a BC prototype was built in Vancouver. Named the Granville Youth Health Centre (GYHC), this facility was officially opened on March 18th, 2015. The Inner City Youth (ICY) Program at St Paul's Hospital is the lead agency for the GYHC. Services at this youth-friendly centre include primary care and sexual health (provided by a GP and nurse practitioners), mental health (provided by psychiatrists) and substance use counselling (provided by social workers and nurses), as well as psychosocial rehabilitation, housing support (in partnership with Pacific Counselling Resource Services), income assistance (in partnership with the Ministry of Social Development and Social Innovation), and peer support (in partnership with Coast Mental Health). The ICY Program, funded by both philanthropy and MOH to provide Intensive Case Management (ICM) to homeless and marginally housed YYA, leveraged its staffing resources to provide drop-in services available to both homeless and non-homeless youth in order to expand its impact on the local community. The GYHC (see Figure 6, below) was designed with input from a youth advisory committee

66%

The study found a 66% probability that a randomly-selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly-selected youth receiving usual care.

1.0 RATIONALE

and Signals, a communication firm specializing in MHSU services. An early satisfaction survey, completed by over 50 youth who attended the GYHC for various services highlighted a high level of satisfaction with the centre, from its youth friendliness to recognition of the benefit of integrated services. For ongoing evaluation and quality improvement, the GYHC has created a minimal data set. Youth visiting the GYHC now complete a tablet-based health survey on presentation to the centre. These surveys will allow for the collection of a huge baseline dataset to be used at multiple sites across the province.

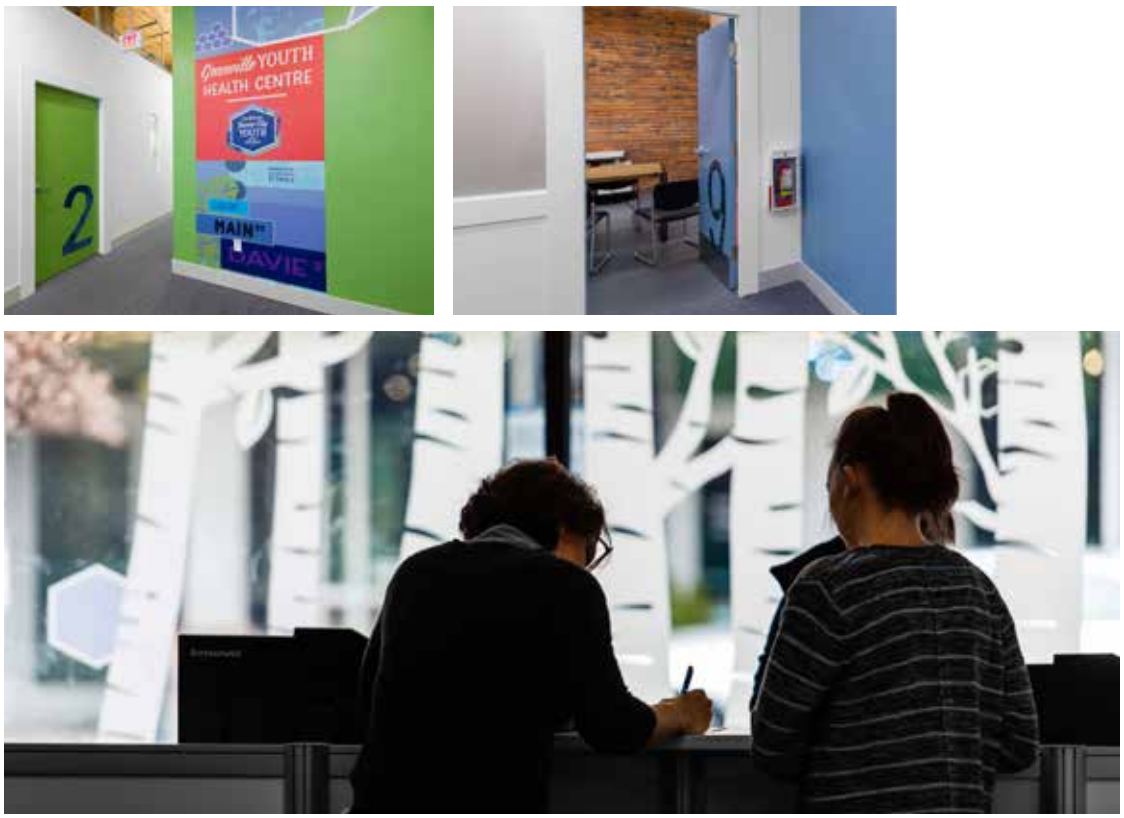

Figure 6. Granville Youth Health Centre

In September 2015, the ICY Program, in partnership with the Urban Native Youth Association, opened the Urban Native Youth Wellness Centre on East Hastings Street in Vancouver. This youth-friendly clinic houses three offices, and offers services including primary care, MHSU counselling, and midwifery.

1.6 EVIDENCE FOR A STEPPED CARE MODEL FOR YOUTH MENTAL HEALTH SERVICES

The purpose of this section is to briefly introduce the stepped care model (SCM) and summarize the evidence supporting its implementation. In an SCM of healthcare delivery, treatment options are organized hierarchically according to their level of intensity[29]. In this model, patients are initially provided with a treatment as indicated by current evidence for their level of disease severity, that is also the least disruptive, extensive, intensive and expensive option.[30,31] The model is self-correcting in that treatment effects are regularly monitored so that intervention intensity can be stepped up or down according to a patients' needs.[30,32] More expensive and complex interventions are only implemented after simpler, less costly interventions have been unsuccessful. This approach allows for the utilization of available resources in an efficient and effective manner.[33]

1.0 RATIONALE

In addition to supporting the cost-effective use of traditional resources, recent technological advances in e-mental health have dramatically increased our ability to provide a wide range of mental health services. For example, clients with mild to moderate disorders, who would traditionally be waitlisted to receive face-to-face psychiatric assessment and treatment, can now be directed to online resources tailored to their individual needs and illness severity.[29] Online tools can also be used to support regular monitoring during watchful waiting, provide self-help training modules to support self-management and provide online coaching for clients with mild to moderate disorders.[32] YYA's high level of comfort with technology also provides strong support for the embedding of e-health resources into an SCM of MHSU care for YYA.

Among adult populations, SCMs have been outlined for the treatment of depression,[34-44] anxiety[45-48]and mood and anxiety disorders.[49-52] In a systematic review and meta-analysis of randomized trials on stepped care for depression[53], researchers found a moderate effect for stepped care treatment. However, they also reported substantial variation across studies in the number and duration of treatment steps, treatments offered, professionals involved, and criteria to "step up", and recommended that future studies examine the economic benefit of implementing a stepped care approach[53]. A separate systematic review of SCMs for working-age adults experiencing depression found that studies comparing usual care with stepped care yielded mixed results in terms of their effects on depression outcomes. SCMs have also been proposed for adults presenting with alcohol use disorders.[55,56] Additionally, a systematic review of SCMs of psychosocial interventions for treating nicotine and alcohol use disorders found little evidence to conclude that increasing intervention intensity for non-responders (i.e., stepping up) improved their outcomes;[57] however there was evidence of improved outcomes attributed to greater differentiation in level of intensity between interventions offered in each step.[57]

Compared to adult populations, much less research on SCMs for the provision of mental health services for youth has been carried out. Several scientific reports have been published that describe the development and implementation of stepped care mental health programs for youth,[58-61] as well as specifically for youth with anxiety[62,63] and depression[64]. Most of these stepped care interventions were implemented in headspace centres, Australia's nationwide youth mental health service, within the framework of a clinical staging model.[65] Of note, the Transitions Study recently recruited a cohort of 802 youth (12-15 years) who were seeking mental health care at headspace centres.[66] The goal of this study is to "longitudinally explore and refine a clinical staging model of the development and progression of mental disorders".[67] Of the few studies of SCMs for youth that have reported clinical outcomes, one randomized controlled trial found that a stepped care treatment significantly reduced the proportion of children meeting the criteria for any anxiety disorder.[68] Another study found that a stepped care intervention successfully reduced risky behavior, such as weapon carrying, among randomly sampled hospitalized adolescents with and without traumatic brain injury.[69]

The Canadian mental health system has been described as "a fragmented patchwork of programs and services, many of which face a constant struggle to find adequate resources to meet ongoing demands."[70] While some researchers have not found a significant improvement in outcomes among clients treated in a stepped care versus usual or matched care approach,[54] it is important to note that these conclusions are often derived from comparisons with well-developed systems of mental healthcare delivery. In contrast, services in BC suffer from the same fragmentation and lack of resources experienced by provinces and territories across the country.[70] Although different models of care, such as matched care, have sometimes been shown to yield superior outcomes in well-established systems of mental health care, implementation of a system of stepped care can be considered a first step in the refinement of a comprehensive system of mental healthcare delivery, while ensuring access to effective and low-intensity treatment for clients with mild to moderate disorders.[71] This view is supported by recent guidelines for treatment of depression among children and adolescents in the UK[72] and the Netherlands[73] which explicitly identify the implementation of stepped care models within the child and youth mental health care system.

1.0 RATIONALE

The use of stepped care models for mental health service delivery can also be viewed as being closely aligned with the *Triple Aim Strategy*[74] in that they are:

a) **Patient centered**, by offering patients relatively quick access to the least intrusive treatment based on their current needs combined with regular monitoring of progress. They can also be empowering, by incorporating patients' preferences among a range of options when making treatment decisions;[29,33]

b) **Cost-effective**, by providing costly high-intensity treatments only when appropriate, and by offering a range of less expensive and less intensive interventions for patients with less severe disorders[29,33]; and

c) **Aim to improve population health** by enabling early intervention to prevent progression to more severe disorders. Additionally, scaling up the delivery of cost-effective interventions (especially those delivered with an e-health platform) can significantly reduce the overall burden of mental illness in the population[33].

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

The British Columbia Integrated Youth Services Initiative (BC-IYSI) seeks to improve access to mental health, substance use and primary care services for youth and young adults (YYA) across BC. The BC-IYSI will support communities to establish youth-friendly, integrated, health and social service storefronts, and work alongside provincial online and phone line resources, and link to specialized mental health and substance use services and community agencies, to strengthen a network of care for young British Columbians and their families.

2.1 AGE RANGE OF POPULATION SERVED

Defining the age range for "youth" is a topic of debate these days in Canada. In November 2015, the Mental Health Commission of Canada (MHCC) held a consensus conference to specify what age range constitutes youth. As we await the results of this exercise, it is helpful to turn to previous work in this area. For example, the International Association for Youth Mental Health[75] (IAYMH) has identified a need to provide services to youth aged 12-24. Based on the research evidence of age of onset, and rates of mental ill-health and problematic substance use among young people, the BC-IYSI has identified a need to provide services to YYA aged 12 to 24. The lower end of this age range represents the period when youth typically enter high school, placing them at risk for recreational substance use and early sexual encounters. This age span has been adopted by programs in other countries, such as *headspace* in Australia and *Jigsaw* in Ireland, which have reported that the most common age group to use integrated health services is 15 to 17 years.[76]

> Early, effective intervention, targeting young people aged 12-25 years... is required if we wish to reduce the burden of disease created by these disorders. A strong focus on young peoples' mental health has the capacity

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

> to generate greater person, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the 'best buys' for future reforms.[77, p.S6]

Given that the age range of existing services varies from organization to organization across the province, the BC-IYSI will apply flexible consideration with respect to how services define their program age-based inclusion criteria. Wherever possible, agencies will be requested to shift service provision to the 12-24 age range, although in Indigenous communities where some youth services commonly run up to age 29, this may not be possible.

2.2 OBJECTIVES FOR THE PROTOTYPE PHASE

The intention of the prototype phase is to provide a "proof of concept" to support the potential launch of a broader provincial initiative for YYA with mild to moderate mental health and substance use (MHSU) problems. An environmental scan of existing and potentially nascent integrated youth service centres indicates that there are nearly one dozen potential sites across BC. Through a Request for Expression of Interest process, one centre in each region of the province will be selected to participate in the prototype phase of BC-IYSI. The BC-IYSI has adopted a framework for action known as collective impact, an approach which includes a centralized infrastructure and structured processes to coordinate ongoing collaboration. The BC-IYSI entered a 30-month roll out of the prototype phase in October 2015. The main objectives for this phase are to:

1. Create and establish the BC-IYSI Backbone Organization, with the following functions: standards development, knowledge translation and mobilization, research, evaluation and common communication strategy;
2. In partnership with five BC communities, establish integrated health service centres, one located in each regional health authority. These centres will offer standard health services (physical and sexual health, MHSU), as well as services addressing determinants of health (e.g., vocational support, income assistance, housing, education, family and youth peer support, etc.);

3. Partner in the expansion of online, web-based and telephone resources for youth in urban, rural and remote sites, all integrated within a stepped care model and with a common communication strategy including branding;
4. Facilitate evaluation, quality improvement and research that will be integrated into all services, providing real-time performance feedback in order to support scaling and expansion of the system of care; and
5. Develop a youth public health strategy for the province of BC, in partnership with the BC Centre of Disease Control (BCCDC).

2.3 GUIDING PRINCIPLES

The *Youth and Young Adult Working Group* of the CYMHSU Collaborative established a set of guiding principles for service delivery in this sector. The principles were reached through consensus by members of the working group, who represent services from the health authorities, social services, not-for-profit organizations, as well as youth and families. These principles have guided the development of the BC-IYSI implementation plan and its rollout.

- A comprehensive system of care ensures that health promotion, prevention and early intervention are core components of its services;
- Services need to be timely, accessible, developmentally appropriate, socially inclusive and equitable, and culturally sensitive, congruent, and safe;
- Services are youth- and family-centred, collaborative and empowering to both;
- Integration of services should occur through intentional partnerships and collaborative inter-sectorial working relationships, with special attention on the actual process of integration; and
- All services should be evidence- and trauma-informed and effective.

2.4 GOVERNANCE STRUCTURE

This initiative is a partnership between the Ministry of Health (MOH), Ministry of Children and Family Development (MCFD), Graham Boeckh Foundation (GBF), InnerChange Foundation (ICF), Michael Smith Foundation for Health Research (MSFHR), and the St Paul's Hospital Foundation (SPHF). These organizations form the Governing Council.

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

The Governing Council (GC) provides strategic, policy and financial oversight to the Backbone Organization, which is tasked with planning, implementation and administration of the BC-IYSI. The Backbone Organization plays a critical role in facilitating and supporting collective impact. It reports to the Governing Council, and receives input from a Provincial Advisory Committee and a regional Operations Network, both comprised of key stakeholders. The Backbone Organization operates as an independent body with a dedicated staff, and provides ongoing support, planning, and management across the regional centres. The Backbone Organization is based at a host organization - Providence Health Care (PHC), and has a host foundation to manage its funds - St. Paul's Hospital Foundation (SPHF). As depicted in Figure 7, below, the BC-IYSI consists of a Governing Council, Backbone Organization, host organization and foundation, Provincial Advisory Committee and Operations Network (supporting operations), all linked to the five sites.

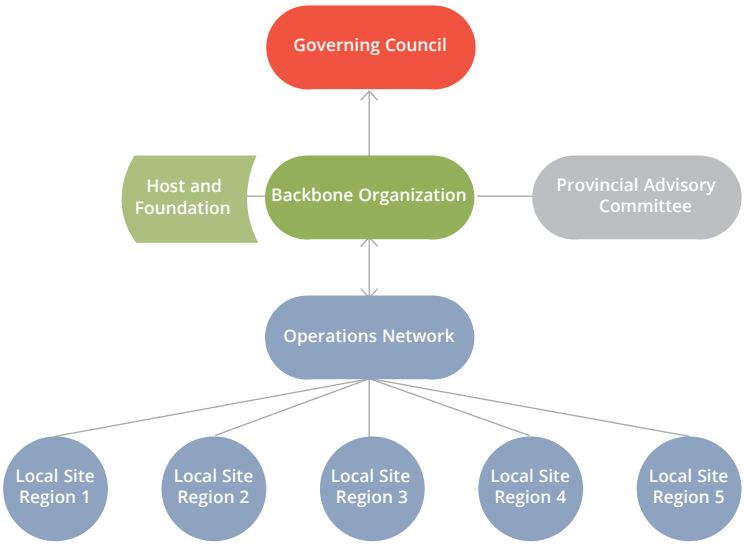

Figure 7. Governance Structure of the BC-IYSI

2.5 YOUTH HEALTH CENTRES

Five centres across BC will be selected by the Backbone Organization to receive augmented capital and operational funding. These centres will provide standardized services based on core principles with core service components and care pathways, while adhering to standards of practice. The BC-IYSI will implement a stepped care model at the centres in partnership with other mental health and substance use service providers, an approach which allows for the utilization of available resources in an efficient and effective manner. The centres will be non-stigmatizing and youth-friendly, with accessible hours and preferable locations.

The intention of the BC-IYSI is to offer YYA access to integrated health and social services in all regions of the province, either by access to youth-friendly storefronts or through a robust e-service gateway. The goal is to enhance service integration and continuity thereby easing the transitions points for youth and families. The centres will be linked through a branded network that is marketed to inclusively target YYA aged 12 to 24, in combination with province-wide anti-stigma and awareness campaigns. Funding will be contractual with an identified, local lead agency and subject to review by the Backbone Organization. In order to provide continuous performance feedback for practice development, the centres will include an embedded evaluation strategy, drawing on high-quality standardized quantitative measures, combined with qualitative methods to address outcomes on multiple levels and from diverse stakeholder perspectives.

CORE PRINCIPLES

The BC-IYSI core principles for youth health centres reflect the combined efforts of the *Youth and Young Adult Working Group* of the CYMHSU Collaborative and the *Youth Health Centres Network*, cross-referenced with the principles outlined in *Primary and Community Care in BC: A Strategic Policy Framework (2015)*. These core principles are dynamic and as such will be further refined collaboratively by the Backbone Organization and the network of centres.

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

- **Patient/client-centered** – Driven by regular input from youth with lived experience, services are youth-friendly and welcoming. Services are culturally sensitive and reflect the diversity of youth. There is a strength-based approach that is optimistic and delivered using a wellness and resiliency lens. Offered services are free. There is a youth defined "family" (natural supports) engagement.
- **Integrated and comprehensive** – Youth experience seamless and responsive care with shared information and particular attention to the determinants of health and health equity. Services have a focus on community engagement and social inclusion, are collaborative, and recognize the importance of prevention and early intervention.
- **High quality** – Services have low barrier access and importantly are innovative, creative, effective and evidence-informed while being sustainable, safe and individualized, and supported by developmental evaluation with lean principles applied to flow and evaluation.
- **Responsible operations** – Management and leadership are accountable and transparent.

CORE SERVICE COMPONENTS

The core services outlined below are based on the feedback of the *Youth and Young Adult Working Group* and the *Youth Health Centres Network*. The first four fundamental components are consistent with integrated youth service models such as Australia's *headspace* and Ireland's *Jigsaw*.

Fundamental

1. Primary Care – i.e., physical health, sexual health
2. Mental Health Services
3. Substance Use Services
4. Social Services – i.e., vocational, educational, financial, housing/shelter
5. Youth and Family Peer Support and Navigation

Ancillary *(not an exhaustive list - based on local needs and can be a service component or partnership link)*

- Financial literacy and skill development
- Recreation
- Food security
- Child care and transportation
- Legal aid
- Clinical navigator

Potential Partners for Co-location

Fundamental components may be augmented by the co-location and elemental integration of more specialized services such as:

- Adolescent outreach team
- Early Psychosis Intervention Program (EPI)
- Crisis response services
- Youth Concurrent Disorders Program
- Specialty treatment services (e.g. DBT, trauma counselling)

2.6 OPPORTUNITIES FOR COLLABORATION AND INTEGRATION

The purpose of the initiative is to support YYA with easy to access core services including primary care, mental health, and substance use, as well as with youth and family navigation supports. Opportunities to involve other services such as housing, vocational, employment, income assistance and education exist. The BC- IYSI centres will work with community and inter-ministerial partners to develop a continuum of care for youth who may struggle to access services through more traditional entry points. The centres will link into schools, community and social service organizations as well as both Child and Youth Mental Health and Adult Mental Health, easing transitions and integration for youth from child to adult services. Collaborative dialogue among all key partners will ensure strong linkages and referral pathways, with support services provided through community agencies and specialized MHSU services, and facilitate clarity regarding roles and responsibilities across the continuum of care. The centres main aim will be to address mild to moderate disorders while

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

referring more complex and severely ill youth to specialized services. Specialized services such Early Psychosis Intervention or Dialectical Behavioural Therapy, may also be co-located or integrated within these centres. In all likelihood, the initial sites will serve as hubs of services for their respective health authorities.

Of great interest to the BC-IYSI are the possibilities of e-health, particularly given that the online environment has become a critical setting for mental health service delivery for youth and has the potential to break down barriers.[7,8] In serving the range of YYA with MHSU presentations, interventions must maintain all elements of accessibility, i.e., affordability, acceptability and availability. Partnerships with Kids Help Phone and the Provincial Health Services Authority (PHSA) will lead to integrated services that will eventually include supports by phone, chat/email/text supports and online therapies, as well as virtual clinics (guided online therapy, web-delivered psychological and counselling services, and telemedicine). See Figure 8 below.

Figure 8. The *eheadspace* website's primary focus is on youth and family interaction, and integrates a youth help line (phone), online help via chat/instant messaging, as well as an easy-to-use search function. Clear calls to action guide the user experience.

e-health has the potential not only to complement face-to-face services by providing lower intensity and after-hours care, but to become the mainstay of services for YYA faced with issues of affordability and availability. YYA's high level of comfort with technology also provides strong support for the embedding of e-health resources into a stepped care model of MHSU care for YYA. Figure 9 further below provides an example of integrated e-health services in the stepped care model that could be implemented in BC-IYSI (adapted from the work of Dr. Peter Cornish at Memorial University[32]). In the near future, e-health services will be a cornerstone in supporting rural, remote and Indigenous communities. Emerging evidence for integrated e-health shows that when YYA use these services, the vast majority experience immediate support and relief of symptoms[79].

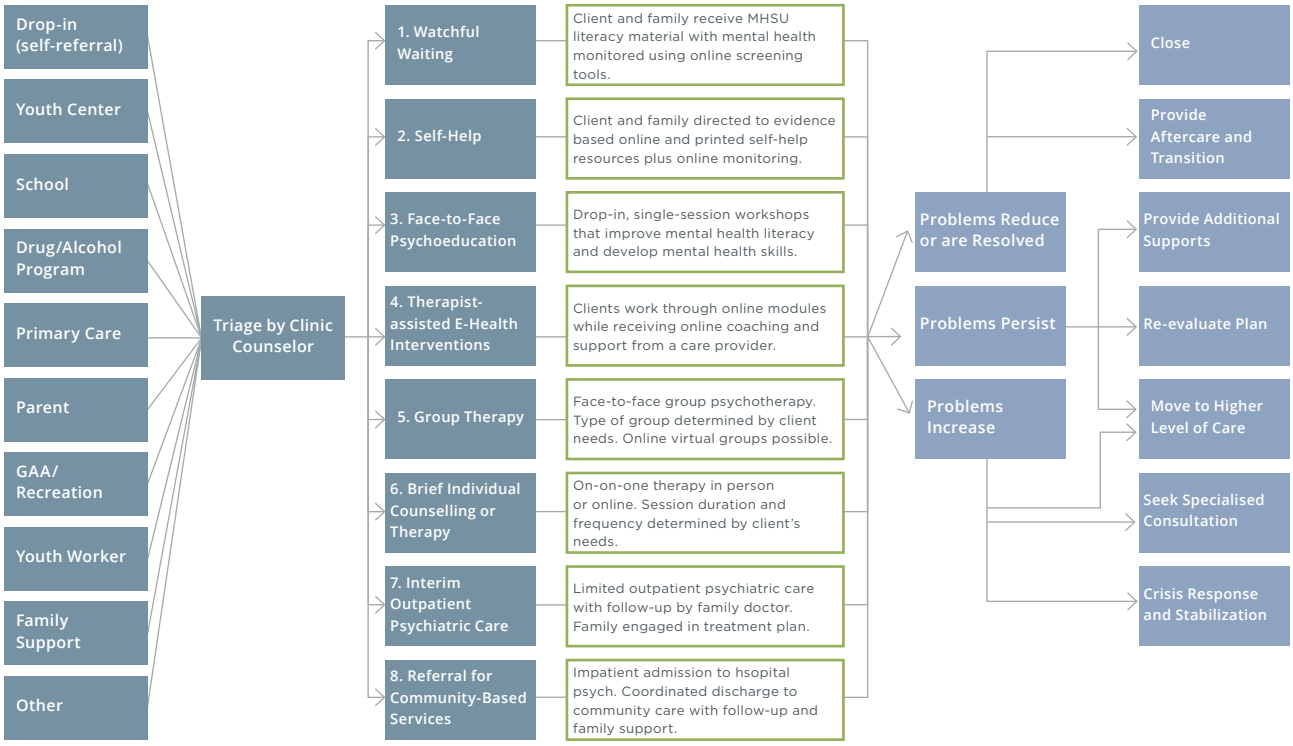

Figure 9. Example of a Stepped Care Model for a Youth Health Centre, adapted from Cornish 2014 [32]

2.0 THE BC INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)

The BC-IYSI is committed to collaboration with other health and community organizations and alignment on public and population-based health strategies. The planned collaboration between the BC-IYSI and the BC Centre for Disease Control will provide a unique opportunity to work on novel frameworks that address effective public health approaches to YYA. This will include: 1) a public health framework specifically addressing youth issues, including identifying priority areas and addressing the potential impact of existing public health programs and policies on youth; 2) development of a prospective provincial cohort of youth; 3) evaluation planning with the BC-IYSI through expertise available at the BCCDC in data collection, analysis and linkages; and 4) data access arrangements for STIs, HIV and HCV and other measures that would be used in the BC-IYSI evaluation process.

Similarly, preliminary discussions with the office of the First Nations Health Authority Chief Medical Officer (CMO) have identified multiple opportunities for the FNHA and BC-IYSI to work together to support the health and wellness of Aboriginal youth in our province. Collaborative activities between the FNHA and BC-IYSI may include: 1) developing a comprehensive Urban Youth Health Strategy; 2) enhancing a wellness focus in health centre programming; 3) developing cultural safety programming; and 4) leveraging the FNHA's telehealth infrastructure. The CMO's office looks forward to exploring these areas further with the BC-IYSI and building upon this important work as it progresses, with a view to ensuring effective delivery of services that are culturally relevant, safe, and meaningful to Aboriginal youth, wherever they may live.

2.7 RESEARCH AND EVALUATION

Research and evaluation is foundational in the BC-IYSI, and will be built-in from the start. Furthermore, expanded implementation of the BC-IYSI will be linked to outcomes and evaluation results. The prototype phase is for "proof of concept" and evidence will be required. Consequently, the Backbone Organization will conduct evaluation as a priority and partner in research opportunities. One of the main objectives of the prototype phase is to facilitate evaluation, quality improvement and research that will be integrated into all services, evaluating

performance of the BC-IYSI in real time. An early focus will be on the use of technology, such as data capture systems, to facilitate and support service integration across numerous partners and pre-existing data platforms. This work will be linked to academic centres and to the ACCESS Canada network, a patient-centred initiative in youth and adolescent mental health and wellbeing.

The Centre for Health Evaluation and Outcome Sciences (CHEOS) will lead projects in partnership with the BC-IYSI, including developmental evaluation, data integration, and stakeholder engagement. Given the importance of the BC-IYSI, developmental evaluation will support the innovation and enable early data collection, as well as contribute to assessing the early impacts of the initiative. Furthermore, BC-IYSI presents a unique opportunity to pilot an appropriate integrated data solution that will support clinical care, research and evaluation. Finally, CHEOS will plan and conduct a multi-stakeholder workshop to define the scope of the research and evaluation opportunity presented by the BC-IYSI. Researchers, decision-makers, clinicians, clients and their families have different needs from a research system and unique capacities to contribute. The BC-IYSI will benefit from a common understanding of the range of stakeholders' research/evidence needs. With a shared vision of the scope of research and evaluation opportunity, it may be possible to: a) identify a minimal data set for collection; b) develop specific research questions; and c) enable the Governing Council and the Backbone Organization to set research priorities for investment of available funds. Engaging with stakeholders across BC, including academic institutions, and national and international partners, may lead to a national and international understanding of what is required to effectively support the YYA population and their specific needs.

2.8 NEXT STEPS

In December 2015, a Request for Expressions of Interest will be posted on the BC-IYSI website. This will be an invitation for communities from all reaches of the province to apply for capital and operational funding for a youth integrated health centre. An Expression of Interest submission form will be available for download and organizations will be asked to outline the partnerships that would lead to providing a breadth of health and social services in a "one stop" storefront.

The BC-ISYI looks forward to working with British Columbian communities as we strive to build better, more accessible services for our youth and young adults.

APPENDIX: REFERENCES

1. Mathias SM. Transforming Access to Health and Social Services for Transition-Aged Youth (12-25) in British Columbia, September 2014.
2. Kessler RC, Berglund P, Demler O et al. (2005). Lifetime Prevalence and Age-of-Onset Distributions Of Dsm-Iv Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62: 593-768.
3. Statistics Canada (2006). Population and Dwelling Counts, for Canada, Provinces and Territories, 2006 Ad 2001 Censuses – 100% Data. Retrieved from www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-550/Index.cfm?TPL=P1C&Page=RETR&LANG=Eng&T=101
4. Kirby, M. & Keon, W. (2004). Report 1, Mental Health, Mental Illness and Addiction: Overview Of Policies and Programs in Canada. Interim Report of the Standing Senate Committee on Social Affairs, Science And Technology.
5. Access and Wait Times in Child and Youth Mental Health: A Background Paper. Canadian Association of Paediatric Health Centres, National Infant, Child and Youth Mental Health Consortium Advisory, and Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. Canadian Institutes of Health Research Institute of Human Development, Child and Youth Health (CIHR – IHDCYH), 2010.
6. Begg S, Vos T, Barker B et al. (2007). The burden of disease and injury in Australia 2003. PHE 82. Canberra: Australian Institute of Health and Welfare (AIHW).
7. Leading Causes Of Death, Total Population, By Age Group and Sex, Canada, Annual 2014. Statistics Canada. CANSIM Table 102-0561.
8. Mann J, Apter A, Bertolote J et al. (2005). Suicide Prevention Strategies: A Systematic Review. JAMA, 294(16): 2064-2074.
9. Royal College of Psychiatrists (2010). No health Without Public Mental Health: The Case For Action. Position Statement PS4/2010, London, UK.
10. The State of the World's Children 2011: Adolescence-An Age of Opportunity. UNICEF: New York, 2011.

11. National Comorbidity Survey Replication (NCS-R) (2005).
12. The Economic Impact of Youth Mental Illness and the Cost Effectiveness of Early Intervention (2009). Access Economics Limited, Australia.
13. Still Waiting: First-hand Experiences with Youth Mental Health Services in BC. Representative for Children and Youth, 2013.
14. Davidson S & Manion IG (1996). Facing the challenge: Mental health and Illness in Canadian Youth. Psychology, Health and Medicine, 1:41-56.
15. Primary and Community Care in BC: A Strategic Policy Framework. Ministry of Health, 2015.
16. Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues. Ministry of Health, October 2015.
17. Healthy Minds, Healthy People: A Ten-Year Plan To Address Mental Health And Substance Use In British Columbia. Ministry Of Health, 2010.
18. Dooley B & Fitzgerald A (2013). Methodology on the My World Survey (MWS): A Unique Window into the World Of Adolescents in Ireland. Early Intervention in Psychiatry, 7:12-22.
19. Bond GR, Drake RE & Campbell K (2014). Effectiveness of individual placement and supported employment for young adults. Early Intervention in Psychiatry. doi: 10.1111/eip.12175 [Epub ahead of print].
20. http://www.mcs.bc.ca/literature_reviews
21. Designing Mental Health Service Delivery to Better Meet the Needs of Youth. Ministry of Children and Family Development, July 2015.
22. Institute of Families for Child and Youth Mental Health and FORCE Society for Kids' Mental Health (2015). BC FamilySmart™ Network Implementation Framework. Confidential Draft.
23. McGorry PD, Tanti C, Stokes R et al. (2007). headspace: Australia's National Youth Mental Health Foundation — Where Young Minds Come First. Medical Journal of Australia, 187:S68–S70.
24. Rickwood D, Van Dyke N & Telford N (2015). Innovation in Youth Mental Health Services in Australia: Common Characteristics Across The First Headspace Centres. Early Intervention in Psychiatry, 9: 27-37.
25. Rickwood DJ, Telford NR, Parker AG et al. (2014). headspace – Australian Innovation in Youth Mental Health Care: Who are the Clients and Why are they Presenting to Headspace Centres? Medical Journal of Australia, 200(2): 108-111.

APPENDIX: REFERENCES

26. Rickwood DJ, Mazzer KR, Telford NR et al. (2015). Changes in Psychological Distress And Psychosocial Functioning in Young People Accessing Headspace Centres for Mental Health Problems. Medical Journal of Australia, 202(10): 537-543.
27. O'Keefe L, O'Reilly A, O'Brien G et al. (2015). Description and Outcome Evaluation of Jigsaw: An Emergent Irish Mental Health Early Intervention Programme for Young People. Irish Journal of Psychological Medicine, 32: 71-77.
28. Asarnow, JR, Rozenman, M, Wiblin, J, Zeltzer, L. (2015), Integrated Medical-Behavioral Care Compared with Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. JAMA Pediatr. 2015 Aug 10. doi: 10.1001/jamapediatrics.2015.1141. [Epub ahead of print].
29. O'Donohue WT, Draper C. The Case For Evidence-Based Stepped Care As Part Of A Reformed Delivery System. In: Stepped Care and e-Health [Internet]. Springer; 2011 [cited 2015 Jul 14]. p. 1–16.
30. Bower P, Gilbody S. Stepped Care In Psychological Therapies: Access, Effectiveness and Efficiency Narrative Literature Review. Br J Psychiatry. 2005;186(1):11–7.
31. Strosahl K. Training Behavioral Health And Primary Care Providers For Integrated Care: A core competencies approach. Behav Integr Care Treat Work Prim Care Setting. 2005;15–52.
32. Cornish P. Innovating Online with Stepped Care: A Research-Based Stepped Care Mental Health Community of Practice Proposal. Communiqué. 2014;14(3):9–12.
33. Snipes C, Maragakis A, O'Donohue W. Team-based Stepped Care in Integrated Delivery Settings. Fam Med Community Health. 2015;3(1):39–46.
34. Simon GE, Katon WJ, VonKorff M, Unützer J, Lin EH, Walker EA, et al. Cost-Effectiveness of a Collaborative Care Program for Primary Care Patients with Persistent Depression. Am J Psychiatry. 2001 Oct;158(10):1638–44.
35. Scogin FR, Hanson A, Welsh D. Self-administered Treatment in Stepped-Care Models Of Depression Treatment. J Clin Psychol. 2003 Mar 1;59(3):341–9.

36. Meeuwissen JAC, van der Feltz-Cornelis CM, van Marwijk HWJ, Rijnders PBM, Donker MCH. A Stepped Care Programme for Depression Management: an Uncontrolled Pre-Post Study in Primary And Secondary Care in the Netherlands. Int J Integr Care [Internet]. 2008 Feb 21 [cited 2015 Jul 14];8.

37. Katon W, Von Korff M, Lin E, Simon G, Walker E, Unützer J, et al. Stepped Collaborative Care for Primary Care Patients with Persistent Symptoms of Depression: A Randomized Trial. Arch Gen Psychiatry. 1999;56(12):1109–15.

38. Gjerdingen D, Katon W, Rich DE. Stepped care treatment of postpartum depression: a primary care-based management model. Womens Health Issues. 2008;18(1):44–52.

39. Hermens MLM, Muntingh A, Franx G, van Splunteren PT, Nuyen J. Stepped Care For Depression Is Easy To Recommend, But Harder To Implement: Results Of An Explorative Study Within Primary Care In The Netherlands. BMC Fam Pract. 2014;15:5.

40. Franx G, Oud M, de Lange J, Wensing M, Grol R. Implementing a Stepped-Care Approach in Primary Care: Results of a Qualitative Study. Implement Sci. 2012;7(1):8.

41. Gureje O, Oladeji BD, Araya R, Montgomery AA. A Cluster Randomized Clinical Trial Of A Stepped Care Intervention For Depression In Primary Care (STEPCARE)- study protocol. BMC Psychiatry. 2015;15:148.

42. Gidding LG, Spigt MG, Dinant G-J. Stepped Collaborative Depression Care: Primary Care Results Before And After Implementation Of A Stepped Collaborative Depression Programme. Fam Pract. 2014 Apr;31(2):180–92.

43. Watzke B, Heddaeus D, Steinmann M, König H-H, Wegscheider K, Schulz H, et al. Effectiveness and Cost-Effectiveness of a Guideline-Based Stepped Care Model for Patients with Depression: Study Protocol of a Cluster-Randomized Controlled Trial in Routine Care. BMC Psychiatry. 2014;14(1):230.

44. van Straten A, Seekles W, van 't Veer-Tazelaar NJ, Beekman ATF, Cuijpers P. Stepped Care for Depression in Primary Care: What Should Be Offered and How? Med J Aust. 2010 Jun 7;192(11 Suppl):S36–9.

45. Muntingh A, van der Feltz-Cornelis C, van Marwijk H, Spinhoven P, Assendelft W, de Waal M, et al. Effectiveness of Collaborative Stepped Care for Anxiety Disorders in Primary Care: A Pragmatic Cluster Randomised Controlled Trial. Psychother Psychosom. 2014;83(1):37–44.

APPENDIX: REFERENCES

46. Newman MG. Recommendations For A Cost-Offset Model Of Psychotherapy Allocation Using Generalized Anxiety Disorder as an Example. J Consult Clin Psychol. 2000 Aug;68(4):549–55.
47. Goorden M, Muntingh A, van Marwijk H, Spinhoven P, Adèr H, van Balkom A, et al. Cost Utility Analysis Of A Collaborative Stepped Care Intervention for Panic and Generalized Anxiety Disorders in Primary care. J Psychosom Res. 2014 Jul;77(1):57–63.
48. Sinnema H, Oosterbaan D, Terluin B, van Wetten H, Franx G, van Balkom A. How to Improve Recognition, Diagnosis and Treatment of Anxiety Disorders in Primary Care: Results of the Dutch Breakthrough Collaborative. Methodol Rev Appl Res. 2015;2(1):7–26.
49. van Straten A, Tiemens B, Hakkaart L, Nolen WA, Donker MCH. Stepped Care Vs. Matched Care For Mood And Anxiety Disorders: A Randomized Trial In Routine Practice. Acta Psychiatr Scand. 2006;113(6):468–76.
50. Richards DA, Suckling R. Improving Access To Psychological Therapies: Phase Iv Prospective Cohort Study. Br J Clin Psychol. 2009 Nov 1;48(4):377–96.
51. Seekles W, van Straten A, Beekman A, van Marwijk H, Cuijpers P. Stepped Care Treatment For Depression and Anxiety in Primary Care. A Randomized Controlled Trial. Trials. 2011;12(1):171.
52. Richards DA, Bower P, Pagel C, Weaver A, Utley M, Cape J, et al. Delivering Stepped Care: An Analysis of Implementation in Routine Practice. Implement Sci. 2012;7(3):5908–7.
53. van Straten A, Hill J, Richards DA, Cuijpers P. Stepped Care Treatment Delivery for Depression: A Systematic Review and Meta-analysis. Psychol Med. 2015 Jan;45(02):231-46.
54. Firth N, Barkham M, Kellett S. The Clinical Effectiveness of Stepped Care Systems for Depression in Working Age Adults: A Systematic Review. J Affect Disord. 2015 Jan 1;170:119–30.

55. Sobell MB, Sobell LC. Stepped Care as a Heuristic Approach to the Treatment of Alcohol Problems. J Consult Clin Psychol. 2000 Aug;68(4):573–9.

56. Breslin FC, Sobell MB, Sobell LC, Buchan G, Cunningham JA. Toward a stepped care approach to treating problem drinkers: the predictive utility of within-treatment variables and therapist prognostic ratings. Addict Abingdon Engl. 1997 Nov;92(11):1479–89.

57. Jaehne A, Loessl B, Frick K, Berner M, Hulse G, Balmford J. The Efficacy of Stepped Care Models Involving Psychosocial Treatment of Alcohol Use Disorders and Nicotine Dependence: A Systematic Review of the Literature. Curr Drug Abuse Rev. 2012 Mar 1;5(1):41–51.

58. Magor-Blatch LE, Ingham L. Youth with Mental Illness: Attitudes Towards and Therapeutic Benefits of Residential Stepped Care. Community Ment Health J. 2015 Apr;51(3):338–46.

59. Hickie IB, Scott EM, Hermens DF, Naismith SL, Guastella AJ, Kaur M, et al. Applying Clinical Staging to Young People who Present for Mental Health Care. Early Interv Psychiatry. 2013 Feb 1;7(1):31–43.

60. Campo JV, Shafer S, Strohm J, Lucas A, Cassesse CG, Shaeffer D, et al. Pediatric Behavioral Health in Primary Care: A Collaborative Approach. J Am Psychiatr Nurses Assoc. 2005 Oct 1;11(5):276–82.

61. Cross SPM, Hermens DF, Hickie IB. Treatment Patterns and Short-Term Outcomes in an Early Intervention Youth Mental Health Service. Early Interv Psychiatry. 2014;65(7):939–43.

62. Kanuri N, Taylor CB, Cohen JM, Newman MG. Classification Models for Subthreshold Generalized Anxiety Disorder in a College Population: Implications for Prevention. J Anxiety Disord. 2015;34:43–52.

63. Clarke PJF, Hickie IB, Scott E, Guastella AJ. Clinical Staging Model Applied to Young People Presenting with Social Anxiety. Early Interv Psychiatry. 2012 Aug;6(3):256–64.

64. Hermens MLM, Oud M, Sinnema H, Nauta MH, Stikkelbroek Y, van Duin D, et al. The Multidisciplinary Depression Guideline for Children and Adolescents: An Implementation Study. Eur Child Adolesc Psychiatry. 2015 Jan 15;1–12.

65. McGorry PD, Goldstone SD, Parker AG, Rickwood DJ, Hickie IB. Cultures for Mental Health Care Of Young People: An Australian Blueprint for Reform. Lancet Psychiatry. 2014;1(7):559–68.

APPENDIX: REFERENCES

66. Purcell R, Jorm AF, Hickie IB, Yung AR, Pantelis C, Amminger GP, et al. Transitions Study of Predictors of Illness Progression in Young People with Mental Ill Health: Study Methodology. Early Interv Psychiatry. 2015 Feb;9(1):38–47.
67. Purcell R, Jorm AF, Hickie IB, Yung AR, Pantelis C, Amminger GP, et al. Demographic and Clinical Characteristics Of Young People Seeking Help at Youth Mental Health Services: Baseline Findings of the Transitions Study. Early Interv Psychiatry. 2015 Dec;9(6):487-97.
68. van der Leeden AJ, van Widenfelt BM, van der Leeden R, Liber JM, Utens EM, Treffers PD. Stepped Care Cognitive Behavioural Therapy for Children with Anxiety Disorders: A New Treatment Approach. Behav Cogn Psychother. 2011;39(01):55–75.
69. Zatzick D, Russo J, Lord SP, Varley C, Wang J, Berliner L, et al. Collaborative Care Intervention Targeting Violence Risk Behaviors, Substance Use, and Posttraumatic Stress and Depressive Symptoms in Injured Adolescents: A Randomized Clinical Trial. JAMA Pediatr. 2014 Jun;168(6):532–9.
70. Mental Health Commission of Canada. Toward Recovery & Well-Being. A Framework for a Mental Health Strategy for Canada. 2009.
71. Patten SB, Goldner E. The Evolving Understanding of Major Depression Epidemiology: Implications for Practice and Policy. Can J Psychiatry. 2008;53(10):689.
72. National Collaborating Centre for Mental Health (UK). Depression in Children and Young People: Identification and Management in Primary, Community and Secondary Care [Internet]. Leicester (UK): British Psychological Society; 2005 [cited 2015 Aug 4]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK56425/
73. Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling, in de GGZ. Richtlijn voor depressie bij jeugd, addendum. Trimbos-instituut. Utrecht; 2009.
74. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, and Cost. Health Aff (Millwood). 2008 May 1;27(3):759–69.

75. International Association for Youth Mental Health (2013). Towards a New Paradigm of Care: The International Declaration on Youth Mental Health. Early Intervention in Psychiatry, 7:103-108.

76. McGorry PD (2007). The Specialist Youth Mental Health Model: Strengthening the Weakest Link in the Public Mental Health System. Medical Journal of Australia, 187(7):S53-S56.

77. McGorry, PD, Purcell, R, Hickie, IB & Jorm, AF (2007). Editorial: Investing in Youth Mental Health is a Best Buy: The Logic and Plan for Achieving Early Intervention in Youth Mental Health in Australia Medical Journal of Australia, 187 (7):S5-S7.

78. Burns, J., & Birrell, E. (2014). Enhancing Early Engagement with Mental Health Services by Young People. Psychology Research and Behaviour Management, 7, p. 303-312.

79. Headspace National Youth Mental Health Foundation. eheadspace Evaluation Final Report, June 2014.

BRITISH COLUMBIA INTEGRATED YOUTH SERVICES INITIATIVE (BC-IYSI)