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Commission de la santé mentale du Canada

Taking the Next Step Forward

Building a Responsive Mental Health and Addictions System for Emerging Adults

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Executive Summary

BACKGROUND

The Mental Health Commission of Canada (MHCC) has identified "youth transitions" as a significant area of mental health policy concern. *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (MHCC, 2012) recommends "remov[ing] barriers to successful transitions between child, youth, adult and seniors mental health services" (Sec. 3.3.5, p. 69). *Taking the Next Step Forward: Building a Responsive Mental Health and Addictions System for Emerging Adults* is a report produced by researchers from the Children's Hospital of Eastern Ontario (CHEO) for the MHCC's Knowledge Exchange Centre (KEC).[1] It considers the current state of Canadian and international policies and programs that support youth with mental health problems and illnesses transitioning into adulthood, argues that our current approaches are substantially limited, and offers a framework for bettering these practices in Canada.

What do we mean in this context when we talk about "transitions?" Emerging adults (EA) who are engaged in child and adolescent mental health services must transition into adult services at a prescribed age. EA are not adequately supported during this transition, despite evidence that interventions at this stage will positively impact an individual's lifetime trajectory of mental health. Additionally, EA requiring services for the first time are often not able to find, access, or recover within the adult mental health and addiction service sector. We therefore envision a seamless continuum of EA services, supported by policy that specifically addresses challenges throughout this time of transition.

Emerging adults transitioning from child/adolescent mental health and addiction services to adult services disengage from service at a higher rate than other age cohorts. Although no longitudinal studies have been carried out in Canada, findings from the United States and the United Kingdom indicate that both treatment retention and successful engagement levels across the child to adult transition are concerning. Untreated mental health issues in early adulthood may indicate increased risk of developing severe and enduring mental health problems and at least 75 per cent of mental health problems and illnesses have an onset in childhood, adolescence, or young adulthood. Issues such as leaving school early, youth unemployment, youth justice involvement, bullying, and traumatic release from care are amplified for young adults with mental illnesses. Unaddressed mental health and substance use issues lead to underemployment and lack of workforce participation and they increase the human and economic burden of mental health problems and illnesses. Most alarmingly, suicide is the second leading cause of death for Canadian youth and one in five of all deaths among young adults age 15–24 are due to suicide.

This stage of emerging adulthood is challenging for all; however, it is a particularly vulnerable stage for EA with mental health issues and addictions problems. Moreover, EA from specific populations have an even greater chance of experiencing poor outcomes during their transition into adulthood. These groups include children born in poverty; First Nations, Inuit, Métis, and newcomer EA; newcomer EA; EA involved with the justice and child welfare systems; EA with disabilities; and lesbian, gay, bisexual, transgender,

WHY USE THE TERM "EMERGING ADULT?"

Currently, the term "emerging adult" is increasingly used to describe youth and young adults (ages 16-25). The term highlights the significance of the growth and development during this part of our lifespan. Using the term "emerging" also acknowledges this phase as a dynamic process, rather than a prescribed span of time driven by chronological age. We use this term throughout the paper, often in its short form – EA.

[1] Throughout the Executive Summary, the pronoun "we" is used to describe the perspectives of the researchers from CHEO. Not all recommendations or actions expressed in this summary necessarily reflect those of the MHCC, although all parties involved in the production of this work appreciate the urgent need for this document and many others across Canada, to advance the conversation around youth transitioning to adult mental health and addiction services.

queer/questioning (LGBTQ) EA. Provincial/territorial policy leads and recent literature also underline significant lack of access and increased risks experienced by marginalized groups living in rural and remote areas. Many rural or remote EAs do not have access to primary care, let alone specialized or EA-responsive programs. EA with acute needs, or those requiring intensive services, must be transported out of rural jurisdictions. In remote locations, few specialized services are available locally beyond community supports, itinerant medical practitioners, and telemedicine.

"There are no intermediate steps between sitting at home alone or going to the hospital in crisis."

– Youth service recipient

WHAT HAVE WE LEARNED?

CURRENTLY IN CANADA:

- Promising models and best practices for EA do exist in various provinces and regions.
- Some youth-specific strategies have been developed, but few provinces or territories have implemented evidence-based approaches to transitions management or EA clinical service delivery approaches.
- No national government leadership, strategy, or pan-Canadian policy guidance exists to support policy makers, planners, and service providers working to support EA in transition.
- No province or territory has fully implemented transitional protocols for EA.
- No policy requiring that health authorities and providers follow protocols currently exists.
- No province or territory is tracking youth across this transition.
- No province or territory has mandated, designated community- or hospital-based specialist clinical services for EA, beyond First Episode Psychosis programs.
- EA are not seen as a distinct population from the policy, planning, funding, and/or service delivery perspective.

In relation to EA and their needs, current research, policy, and programming demonstrate that:

- Up to 52 per cent of young people engaging in the transition process disengage at a time when serious mental health problems or illnesses are most likely to occur.
- Connections with peers and families have been shown to support motivation to engage with services.
- As the brain matures, risk-taking behaviour decreases, and reasoning and capacity to modulate emotions increases. These neurobiological developments peak in the mid-20s.
- A high proportion of EA with mental health issues also use substances.
- Continued engagement with EA is key to improving their mental health outcomes, and for the development of responsive program models.
- Without access to needed assessment and treatment services, health, social, and employment outcomes are compromised, especially for the most vulnerable EA.
- Policy and dedicated funding with a clear priority on EA is important.
- A collaborative, cross-ministry policy approach responding to young people with mental health and addiction issues who are involved, or may need to be involved, with multiple systems and sectors of care is necessary.
- High-profile national champions with political influence and academic and clinical credibility have an impact.
- National research and training initiatives will drive program development.
- There is a need for nationally funded, evidence-based practice and clinical guidelines, based on EA-specific research.
- Collaborations between private and public funders can create change.

GUIDING PRINCIPLES FOR DEVELOPING TRANSITION SERVICES

- Responsive
- Developmentally appropriate and family-connected
- Youth-engaging and peer-driven
- Informed by research, education, and training
- Recovery oriented

An International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model (Cappelli et al., 2012)

WHAT CAN WE DO?

In order to effectively address the needs of EA transitioning to adult mental health and addiction services, an integrated, accessible, and responsive service system needs to be in place. We require a full continuum of services – from universal prevention and health promotion to the most intensive level of services for a small proportion of EA with the most complex needs. Developmentally competent service providers must deliver evidence-based assessment and intervention services and supports across this continuum. We also need to keep track of how EA are faring as far as engagement and outcomes. *Taking the Next Step Forward* makes recommendations for a continuum of services offering seamless movement through and between levels of service intensity, based on individual, changing needs.

Coordinated approaches will need support and leadership from all levels of government and, most importantly, require the input and guidance of EA and their families and communities. In *Taking the Next Step Forward*, we offer a reframing of the problem: where we once asked how to support youth who are transitioning to adult mental health services, we now advance a systemic view that addresses more generally how to support EA and their engagement with the full range of prevention, assessment, treatment, and psychosocial services. We make recommendations around an EA service continuum adapted from, and building on, existing provincial/territorial and national mental health and addiction strategy and planning documents, including the MHCC's *Mental Health Strategy for Canada*. In order to prevent harm, address needs, and ensure access to services at the required level of intensity and specialization, our ultimate goal is to have a full continuum of EA services available in every jurisdiction (see Figure 1 below).

Examples of innovative programs and promising models for serving EA do exist. In Australia, for example, the headspace program will have 90 storefront sites by 2015. These are one-stop centres that are highly visible, non-stigmatizing, timely first contact points for young people experiencing mental health problems or illnesses. There are similar programs in the UK and Ireland. These youth-friendly spaces and service models are designed to engage EA and respond to their unique cultural, social, and developmental needs.

Figure 1:
A Proposed Continuum of Mental Health and Addiction Services for Emerging Adults: A Tier-Based Approach

THIS PROPOSED CONTINUUM:

- includes a full range of required services, from prevention and health promotion for EA in community, health, and education settings (Tier 1), through to an intensive level of specialized mental health services for EA with the most complex needs (Tier 5).
- accounts for primary care response (Tier 2), including early identification and intervention in education and health settings, as well as access to generic social, community, and wellness supports to address the psychosocial aspects of mental health and addictions issues.

While there will never be a one-size-fits-all solution, it is important to reduce fragmentation and achieve better integration of services. In order to identify the areas requiring the most attention, it is helpful to think in terms of different "levels" or "tiers" to the system. Such an approach allows us to focus both on the settings where services are located and on the level of intensity of service. It provides a way of thinking about how to improve the flow and efficiency of mental health-related services, so that people are able to access the most appropriate and least intensive services, treatments or supports required to meet their needs.

– *Changing Directions, Changing Lives* (MHCC, 2012)

- requires access to an EA-responsive mental health and addictions service sector (Tier 3) in order to include more specialized assessment, treatment, and other evidence-based interventions and programatic responses that support recovery.
- offers more intensive levels of specialist services (Tiers 4 and 5), both in the community and in inpatient and residential settings.
- assumes fluid movement across tiers, rather than a lock-step progression, given the shifting needs and episodic nature of mental health and addictions issues.
- requires responsive EA engagement and peer support approaches across all levels of the continuum in order to ensure access to services and capacity to sustain EA in the treatment and recovery processes.

Although access to services is challenging in more rural and/or remote areas of Canada, services from Tiers 1 through 3 should be available locally. Access to more specialized services would likely use cross-regional approaches, including mobile specialized teams, e-Mental health and tele-health services.

These tiered levels of service provision must also ensure that EA can access social and community supports and cross-sectoral services including housing, education, employment, social, and financial services. We must therefore build and sustain relationships with community-based services, more specialized support approaches (e.g., supported education, housing, employment within adult mental health and addiction services), and system navigation or case management. We also propose a more specific core basket of services for regional capacity building.

In any jurisdiction, it will be crucial that EA are involved in service development, design, and evaluation. Developmentally appropriate engagement strategies enhancing access to services are critical with this age group, in part because they have historically had the lowest uptake and highest dropout rates from services. Given the increasing awareness and media discourse about mental health and addictions issues – in particular for this age group – there is an urgent need to develop pathways to services, as well as to service capacity.

Better pathways to services and service capacity will depend on a dedicated effort between national, provincial, and regional stakeholders. The following actions and recommendations may serve as a starting place for advancing the EA agenda in Canada.

> At one point, you know, I was 18 at the time, and was moving to the 19–20 year old range. And they followed me for a certain amount of time. And I was also lucky too, because I was first put in the hospital – right before my 18th birthday. So if I had been even a couple months older before all of this started to come about, you know, who knows what could have happened? Because I know that the adult services are just not quite as good. But, I remember my doctor saying at the time, "Well I know you're supposed to go over to these other programs, I'm just not sure exactly how to do this." And I was thinking, like, "You don't do this?", like "this doesn't come up regularly?" "It's just across the street, I'm sure you know somebody over there… pick up the phone."
>
> – Aaron Goodwin, Youth Participant

PROPOSED NATIONAL ACTIONS

- Identifying EA as a priority population in a national action plan for mental health and addictions
- Establishing a national EA mental health initiative, including funding a longitudinal tracking study, a national centre of excellence, and a knowledge exchange strategy
- Producing a bi-annual national report card, reporting on outcome indicators for EA with mental health and addiction issues
- Establishing a national young adult advisory group
- Funding a Canada Research Chair in emerging adult mental health and addictions

PROPOSED PROVINCIAL/TERRITORIAL ACTIONS

- Including EA as a priority population in provincial/territorial mental health reform and action plans, with specific strategies for the most vulnerable groups
- Establishing a premier-led inter-ministerial cabinet committee to oversee and assert policy implementation and provincial/territorial performance

- Identifying a single ministry accountable for delivering and reporting in a provincial/territorial report card on outcomes for EA with mental health and addictions issues
- Developing and monitoring transition protocols and supports for youth aging out of child and adolescent services
- Confirming the provincial/territorial service continuum, including core services required at each tier (see Figure 1)
- Establishing a provincial/territorial EA advisory council with a clearly articulated and authentic role as a reference and leadership group

PROPOSED REGIONAL ACTIONS

- Including identification of EA as a priority population in any regional health service strategy, as well as an action plan for the most vulnerable EA
- Developing an accountability plan (such as regional report cards) to identify and report on engagement levels and outcomes
- Identifying the most pressing gaps in the full continuum of developmentally appropriate services, and taking action to develop capacity, with particular emphasis on delivering the core basket of services in a timely and accessible manner, including
    - EA inpatient beds/spaces, based on per capita/population requirements per 100,000
    - Specialist EA, community-based, comprehensive day treatment spaces
    - Specialist EA, community-based, mobile, high-intensity community team spaces
    - First episode/early intervention screening, assessment, and treatment services for all diagnoses
    - EA specialized system navigators
    - Peer support and mentoring models that are integrated with clinical and treatment services to enhance engagement
    - Family engagement and education services
    - Transition team coordination resources to ensure engagement and commitment of cross-sectoral providers
- Ensuring the presence of universal prevention and health promotion strategies, as well as strategies across all tiers to minimize impairment, and to build skills, resiliency, and protective factors to support full community, social, and employment participation
- Developing and monitoring the implementation of regional transition protocols and resources, including regional transition coordination functions

Throughout Canada, emerging adults, their family members, service providers, champions in the mental health field, and the national media are profiling the shortcomings of existing services and policies around EA, and the profound impact these shortcomings have on our nation's young people. In our view, the next step forward is ensuring we have a clearly defined continuum of services within a provincial/territorial inter-ministerial policy framework and one that is supported by a national action plan. At the same time, in order to develop innovative and responsive approaches, build evidence, address priority needs, and disseminate learnings about EA, we also need increased collaboration between EA and service providers at the local level.

"Transition – it's kind of a funny word. It means that you're taken from one place, and you're kind of meshed into another. But what happened to me wasn't really a transition. It was really a transfer. I was taken from one side of the system and forced out of it and pushed into another. And in between there, I had about a year of lack of service."

– Emily Beaudoin, Youth Participant (Cappelli et al., 2012)

"There is considerable convergence of evidence from epidemiology, clinical and basic neuroscience, population health and health service evaluation that supports an urgent new investment in development and evaluation of youth mental health initiatives."

– (Hickie, 2011)

Terminology

Addictions: There are many different terms in use today to describe "addictions." Many jurisdictions and groups of people prefer the terms substance use, substance abuse, or substance misuse. For the sake of expediency, we use the phrase "mental health system" often in the paper and intend that it include "addictions."

Business intelligence: The collection and use of raw data to inform quality improvements and service development.

Emerging Adult: Typically defined as the 16–25 year old individual. Emerging adulthood is a distinct period of lifespan development occurring between adolescence and adulthood, experienced by young people in industrialized societies. During this phase, the developmental competencies that began to form in adolescence are continued. In some program models and reference documents, Emerging Adults include individuals up to age 29.

Knowledge transfer (KT) and knowledge exchange (KE): Knowledge transfer is the process of providing decision makers with relevant information throughout the development of policy and practices, which should continue once policies have been set. Knowledge exchange is an exchange of knowledge between those who do research and those who use it. This exchange should be an ongoing dialogue among service providers, government, researchers, EA, families, and communities.

Adult mental health and addictions services (AMHAS) and child and adolescent mental health and addictions services (CAMHAS): We use these terms to describe the current mental health and addiction sector services in place in Canada and in other countries.

Ring-fenced funding: Funding that is specifically earmarked for a certain program, policy initiative, or group of people. We also describe it as a specific or dedicated envelope of funding, distinct from other mental health initiatives.

Transition-aged youth (TAY): There are many different terms to describe youth or young adults. We have chosen to use the term "emerging adults." However, many jurisdictions use the terms "transition-aged youth," "transitional age youth," "young adults," or simply "youth." The age range included in these categories is anywhere from 12–29.

Systems approach: This term describes the core of what we are recommending in this paper. Instead of simply seeing the problem as one of "managing" the transition from one system (CAMHAS) to another (AMHAS), we are proposing to build an integrated system with design elements at multiple levels to respond to the needs of youth with mental health and addictions issues through their emergence as adults.

- Worldwide, up to 20 per cent of children and adolescents suffer from a disabling mental illness. (World Health Organization, 2000)
- Suicide is the third leading cause of death among adolescents, globally. (World Health Organization, 2001)
- Major depressive disorder often has an onset in adolescence, across diverse countries, and is associated with substantial psychosocial impairment and risk of suicide. (Weissman et al., 1999; World Health Organization, 2003)

Section 1
Project Context, Scope, and Statement of the Problem

The Mental Health Commission of Canada (MHCC) has identified "youth transitions" as an area of interest and policy concern, leading to the request for this document. In *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, a recommendation is made to "remove barriers to successful transitions between child, youth, adult and seniors mental health services." (MHCC, 2012, p. 69). This report was commissioned by the MHCC to review the evidence, identify good practices, and provide concrete policy options to guide policy and service development with respect to youth with mental health problems or illnesses transitioning to adulthood.

This section provides the context for discussion of the issues and offers a reframing of the problem from how to support youth who are transitioning to adult mental health services, to a broader systemic view that addresses how to change the system to support youth engagement with services and enhance outcomes. This section will orient the reader to the key concepts of "emerging adult" (EA) and "transitions" that are used throughout the document.

"So what I was told about… transitioning was that there was going to be a wait period. And during that wait period I was not going to be seen by anyone… when anything came up, I didn't really have anyone to go to and I didn't feel supported at all. So when this kind of emerged, I was not well at all."

– Emily Beaudoin, jeune participante

THE CONTEXT FOR THE PROJECT

Youth who are engaged in child and adolescent mental health services and who require continued services are not well supported as they prepare to enter the adult mental health system (Davis & Butler, 2002; Freeland, 2012; Paul et al., 2013; Richards & Vostanis, 2004; Singh et al., 2008; Singh, Paul, Islam, & Weaver, 2010). This occurs despite research evidence clearly demonstrating that the period of transition from youth to adulthood offers an opportunity to impact the lifetime trajectory of mental illness (McGorry, Bates, & Birchwood, 2013; McGorry, 2007). Effective intervention at first onset reduces the risk of increased impairments in day-to-day functioning and significantly increases the probability of recovery (Birchwood, Todd, & Jackson, 1998; Giaconia et al., 1994). Early intervention programs must be a key component of any continuum of services for children, youth, and EA.

In Canada, policy documents and published literature have shown the vulnerability of Canadian young people to mental health problems and illnesses. Despite this, there has been a striking lack of attention directed toward building the capacity of the Child and Adolescent Mental Health and Addictions Services (CAMHAS) and the Adult Mental Health and Addictions Services (AMHAS) to support transitions. As they move into adulthood, transition-aged youth (TAY; aged 16-25 inclusive) with serious mental health conditions often have poor functioning and high rates of homelessness (30 per cent), arrests (up to 60 per cent), school dropout (as high as 50 per cent, twice as high as the general population in this age cohort), and unemployment (50 per cent) (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007; Davis, William, Grudzinskas, & Banks, 2009; Davis & Vander Stoep, 1997; Edlund et al., 2002; Newman, Wagner, Cameto, & Knokey, 2009; Vander Stoep et al., 2000; Vander Stoep, Weiss, Kuo, Cheney, & Cohen, 2003; Wagner & Newman, 2012).

At present, many youth transitioning from CAMHAS to AMHAS disengage from service, reconnecting at a time of crisis that may or may not lead to sustained treatment (Richards & Vostanis, 2004; Singh et al., 2008). Untreated mental health issues in early adulthood may indicate increased risk of developing severe and enduring mental health problems (De Girolamo et al., 2012; Garber & Clarke, 2009; Hetrick et al., 2008; Korczak & Goldsein, 2009; Paus et al., 2008; Perlis et al., 2009). Older adolescents and young adults have the highest rates of disengagement from services, as compared to younger and older age cohorts (Edlund et al., 2002).

Mental health problems experienced by children, youth, and young adults are increasing dramatically, and epidemiologists estimate increases in incidence rates of at least 50 per cent by 2020 (European Commission, 2003; US Department of Health and Human Services, 2000). Seventy-five per cent of mental health problems have an age of onset occurring in childhood, adolescence, or young adulthood (Government of Canada, 2006; Jones, 2013; Kessler, Chiu, Demler, & Walters, 2005).

Recent provincial policy documents have highlighted the importance of effective bridging through transition points over the lifespan (see Appendix 1 for provincial policy documents); however, there have been few initiatives implemented to realize this "ideal" or to integrate practice on the ground. Despite the stated commitment to youth and young adults, federal and provincial policy, funding, and service delivery models do not address access barriers for EA and sometimes unintentionally create them. The silos that have been created around CAMHAS and AMHAS at the policy and institutional levels, and the related chronological-age-based boundaries, are driven by service capacity and system management needs, rather than what is best for young people. The growing knowledge base about neurodevelopmental theory and developmental processes, which are protracted for individuals with emerging mental health and neurocognitive disabilities, strengthens the rationale for the development of continuous service approaches for this group (McGorry et al., 2013; Singh et al., 2010).

"Indeed, transition boundaries drawn strictly by chronological age are driven by service capacity and limitations rather than what is best for young people."

– (Singh et al., 2010)

The traditional division of services between paediatric and adult health streams does not take into account the pattern of onset and the experience of those who live with mental health problems and illnesses. Segregated policy, service standards, research, and siloed, unresponsive service delivery systems lead to discontinuity of care and disengagement from service and from families and peers (Crawford, De Jonge, Freeman, & Weaver, 2004; Harpaz-Rotem, Leslie, & Rosenheck, 2004; Vostanis, 2005). These approaches lead to disruption of the critical developmental milestones and to increasingly tragic personal outcomes. Suicide and self-injury is the second leading cause of death in Canadian youth – over three times as many 16-24 year olds die from suicide than from all forms of cancer combined (Davidson, 2013; Statistics Canada, 2008). As well, research identifies significant rates of leaving school early, unemployment, justice involvement and inappropriate incarceration rates, bullying, and traumatic emancipation of youth from care for young people with mental health concerns (Davis et al., 2009, Davis and Vander Stoep, 1999, Newman et al., 2011, Wagner and Newman, 2012). The experiences of youth have relevance for a number of funding ministries including health, education, colleges and universities, justice, child welfare, and social services. In order to respond effectively, collaborative, cross-ministry approaches to these multidimensional issues are needed. System and organizational structures in many of Canada's provinces are not designed with a view to facilitating the success of young adults with the key tasks of the transition from childhood to independent adulthood and productive, satisfying adult roles.

"Major gaps exist between adolescent and adult services–just at the stage when early intervention could be most effective."

– (International Association of Youth Mental Health, 2013)

This lack of integration and effective collaboration has been noted in Canada, the US, the UK, and Australia (Davidson, Cappelli, & Vloet, 2011; McGorry, 2007; Pottick et al., 2008; Singh, Evans, Sirelin, & Stuart, 2005). In Canada, however, there has been limited tracking of youth "across the divide," so that there is negligible data available.

Recent documentation of the current state of transition policy delineates a number of approaches to addressing the schism and current dysfunction (Davidson et al., 2012;Davidson et al., 2011). These approaches will be discussed in detail in Sections 2 and 3. It is noteworthy that for subpopulations of youth with chronic health issues or other disabilities, transition protocols and/or accountabilities have been developed and implemented in several provinces, some based on shared memoranda of understanding and inter-organizational processes (Alberta Children and Youth

"Optimal transition, defined as adequate transition planning, good information transfer across teams, joint working between teams, and continuity of care following transition, was experienced by less than 5% of those who made a transition."

– (Singh et al., 2010)

Initiative, 2007; British Columbia Government, 2009; Corrigan, 2006; Ministry of Health and Long-term Care & Ministry of Community and Social Services, 2008; The Hospital for Sick Children, 2006).

REFRAMING THE PROBLEM: A SYSTEMIC PERSPECTIVE

The view that CAMHAS and AMHAS can address the issues of young people by developing "transfer" protocols to support their movement from the jurisdiction of a child and adolescent service provider to an adult mental health provider is limiting. It has not been demonstrated that simply "connecting the dots" for youth moving from youth to adult services will lead to them engaging with those services (Cappelli et al., 2013; Harpaz-Rotem et al., 2004; Richards & Vostanis, 2004; Singh et al., 2010; Turpel-Lafond, 2013; Viner & Keane, 1998). Singh and his colleagues, through a comprehensive longitudinal TRACK[2] study, have presented evidence regarding the failure to bridge the sectors in the UK (Singh et al., 2008; Singh et al., 2010).

Instead, a comprehensive systemic and multidimensional response to the issue is required. According to international research and system design experts (Davis, Fortuna, Fisher, & Mistler, 2012; McGorry, 2007), addressing the needs of young people transitioning to adulthood requires a multi-level approach. A system framework to address the problems associated with transition includes (at minimum):

- national and provincial policy frameworks to ensure cross-ministerial accountability, establish priority strategies, and include directives relating to protocols, effective practices, and accountability;
- leadership and coordination of a national policy and system transformation led by high-profile political and expert champions;
- a provincial and regional system design, including access mechanisms and core service elements;
- a service delivery continuum that includes prevention, early intervention, and generic and specialist mental health and addiction services;
- comprehensive, innovative, and engaging service models;
- related transition protocols, tools, and resources to support access to the above; and,
- data collection, research, and knowledge exchange to build, monitor, and ensure performance of effective program, intervention, and transition management models.

"Transition age kids don't need just what the child and youth system has to offer. And the adult system, unless you are in one of the narrow categories, is not including the kinds of things transition aged youth need. We have to make it the mandate, or create more of a family orientation in the adult system. We have to reorient our priorities. It's appalling how little attention we have paid to what makes a difference for young adults. We simply haven't done the research."

– (Hoagwood, personal communication, 2011)

"So the message I think that I really want to communicate is that for us as a family, what we experienced was… we had to find things. There was no system. No systemic approach to any of this."

– Phyllis Grant-Parker, Caregiver Participant (Cappelli et al., 2012)

THE CASE FOR AN EMERGING ADULT FRAMEWORK

In Canada, the number of EA (a population of 4,365,600, representing 13 per cent of Canada's total population) with a diagnosable disorder is conservatively estimated at 873,120 (Government of Canada, 2006). Emerging adulthood is a distinct period of development occurring between adolescence and adulthood, experienced by young people in industrialized and Organization for Economic Co-operation and Development member countries. This is a culturally constructed transitional period in societies that have observed delays in markers of adulthood such as parenthood, financial and living independence, accepting responsibility for oneself, and making independent decisions (Arnett, 2000; Facio & Micocci, 2003; Macek, Bejcek, & Vanickova, 2007; Mayseless & Scharf, 2003; Nelson, Badger, & Wu, 2004).

During emerging adulthood, the developmental competencies that began to form in adolescence are continued (Arnett, 2000). Optimal development in this phase is balanced between autonomy from, and relatedness to, the family of origin, and

A study done for the MHCC "conservatively estimated that the cost of mental illness was $42.3 billion in direct costs and $6.3 billion in indirect costs" in 2011.

(Risk Analytica, 2011, p. 6)

[2] Transition from CAMHS to Adult Mental Health Services (TRACK)

successful transitions are marked by both capacities (Chisholm & Hurrelmann, 1995; O'Connor, Allen, Bell, & Hauser, 1996). As mentioned above, this is also the life stage during which the early symptoms of diagnosable mental disorders and first onset of major mental illnesses are most prevalent (Jones, 2013; Kessler et al., 2005; McGorry et al., 2013; World Health Organization, 2003; World Health Organization, 2007). These findings mean the increased disengagement rates of emerging adults are of special concern (Edlund et al., 2002; Pottick et al., 2008; Singh et al., 2010; O'Brien, Fahmy, & Singh, 2009). Those EA with undiagnosed early onset of mental illness are particularly vulnerable and require special attention since they present with more serious symptoms, experience significant impact on day-to-day functioning and quality of life, and are more likely to disengage from services (Giaconia et al., 1994; Hoehn-Saric, Hazlett, & McLeo, 1993).

Experiences from international jurisdictions suggest that new policies are needed to ensure that the adult system engages with and responds effectively to EA. There is new evidence that specialist mental health services (programs and interventions) uniquely designed for EA are, in fact, required (Brodie, Goldman, & Clapton, 2011; Clark & Unruh, 2009; Davis, 2011; Davis, 2012; McGorry et al., 2013; Vostanis, 2005).

The common sense of early financial investment in this cohort is clear. A recent study done for the MHCC states that "If we just reduced the number of people experiencing a new mental illness in a given year by 10 per cent – something that is very feasible in many illnesses among young people – after 10 years we could be saving the economy at least $4 billion a year" (MHCC, 2013).

THE MANY FACES OF "TRANSITION"

Transition in the EA context is the "purposeful planned movement of adolescents with chronic physical and mental conditions from child-centered to adult-oriented healthcare systems" the goal of which "is to provide healthcare that is uninterrupted, coordinated, developmentally appropriate, psychosocially sound, and comprehensive" (Blum et al., 1993). A number of transitions directly influence the EA: institutional (service system components), developmental (individual variables), sectoral (age-based components), and the complex interface between these sector, system, community, and individual factors (Davidson et al., 2011). Descriptions are included in Table 1 below.

Table 1: Transitions Impacting Emerging Adults

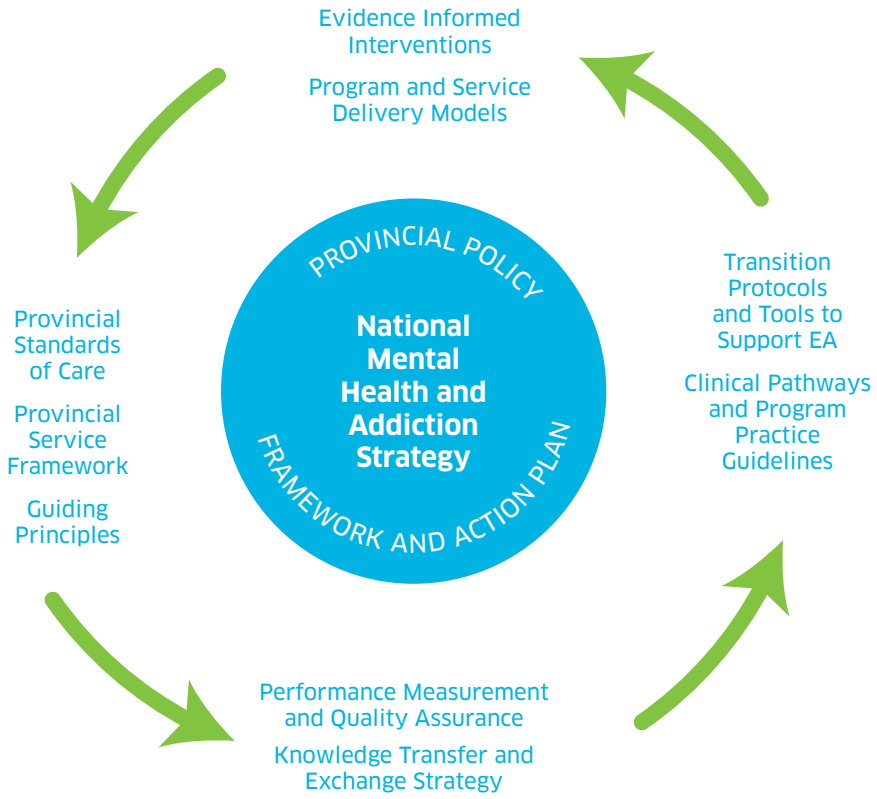
Institutional Transition	Transition is regarded as an administrative event where responsibility for care of an individual is transferred from one organization to another (Vostanis, 2005). Following traditionally established healthcare infrastructure (developed for physical illnesses), transitional boundaries and services are often determined by bureaucratic and legal variables (Mallory, 1995; Singh et al., 2010). The institutional transition from CAMHAS to AMHAS assumes a change in autonomy (changing from a family-oriented system to a patient-oriented system); however, not all youth may be at a point, developmentally, where they can effectively manage their own care.
Developmental Transition	Transition at the individual level, whereby youth are undergoing maturational processes occurring biologically, socially, and cognitively and are adapting to new abilities and social roles as autonomy increases. Developmental transition becomes an underpinning to the legal definition of adult and the associated shift in rights (Paul, 2007).
Sectoral Transition	A systemically defined transition when a youth reaches the age of 16 or 18 and their care is no longer administered and funded through a Child and Youth focused Ministry (generally accountable for social, health, mental health, child welfare, and youth justice), but through a Ministry of Health (may be combined with social services, long-term care, and/or well-being, but with a focus on individuals 16 or 18 years and older). Similarly, youth move out of a provincially administered and funded education system that focuses on school-aged persons (generally up to 18 and at most up to 21). They do not have access to educational and vocational support as well as special needs and clinical services offered through the educational system and the mandated "transition planning" for young people with special needs.

REFRAMING THE SCOPE

The mismatch between institutional and developmental transitions is a central barrier to the uninterrupted provision of services to EA. This lack of fit is characteristic of a provider-led system, where care is determined by institutional factors rather than client needs (Singh et al., 2010). Viner writes, "to achieve effective transition, it must be recognized that transition in healthcare is but one part of a wider transition from dependent child to independent adult"(Viner, 1999). The MHCC's vision states, "the mental health system must respond to the diverse needs that arise from evolution across the lifespan"(MHCC, 2009a). For EA, this means providing care in a system that is informed by knowledge about multiple transitions. The MHCC framework specifies that this will require coordination of resources, not simply from the health sector, but from broader primary healthcare services, schools, workplaces, justice, and housing services (MHCC, 2009a). All of these systems have a role to play in promoting the mental health of children, youth, and EA.

Taking the Next Step Forward applies a systemic perspective by viewing EA with capacity, knowledge exchange, service delivery, system design, and policy lenses in order to develop a conceptual framework for forward motion. Figure 2 shows that effective transition models and supports for EA are generated by and fed back into provincial and national policy frameworks for mental health and addiction, forming a dynamic relationship.

Figure 2: A Responsive Mental Health and Addictions System for Emerging Adults



Responding to the needs of EA, either those transitioning from the CAMHAS system or those requiring access to AMHAS for the first time, requires aligned strategies and related actions. However, system change rarely happens in a linear process. Changes will occur at different rates, on different levels, with the final aim being alignment between all levels. Figure 2 shows all the elements that will have to be in play to encourage effective transitions for, and responses to, emerging adults. They include:

- a national mental health and addictions strategy with specific attention to EA;
- provincial policy frameworks and action plans with target outcome measures with respect to EA;
- an integrated provincial adult mental health and addictions continuum of services, including services at all levels of intensity to address EA needs effectively;
- provincial standards of care and related guidelines for services to EA;
- program and service delivery models for EA or that are EA-inclusive and competent;
- evidence-informed interventions, tried and true within the EA cohort;
- clinical and program practice guidelines for implementation of evidence-informed interventions;
- protocols and tools to support young people through transitions;
- knowledge transfer and exchange strategy and related actions to continue development of practice and enhance capacity to implement evidence-based practices; and,
- performance measurement and quality assurance including data management and reporting and a business intelligence strategy (at the provincial level, rolled down through all funded authorities to organizations).

KEY POINTS FROM SECTION 1 TO TAKE FORWARD:

- Emerging adulthood (between ages 16–25) is a developmental period in its own right.
- It is during this period that 75 per cent of adult mental disorders emerge.
- This period includes multiple transitions and developmental tasks for the individual.
- Adult services are not designed to respond effectively to the needs of this group.
- Responding to needs through enhancing management of the transitions process is a limited approach that will lead to limited solutions.
- Investment in the mental wellness of EA will save governments money.
- A systemic response is needed, including a policy framework, system design, and a service delivery framework that includes the full continuum of services for EA as well as innovative program models and evaluation and monitoring of outcomes for youth.

Section 2
Strengthening the Case for Action

In building a framework for transitions and emerging adults (EA), it is important to consider critical foundations. This section offers a high-level overview of the evidence, the program responses on the ground, youth and family perspectives, vulnerable populations, and the degree of alignment between what EA need and what the adult system has to offer them.

THE CASE FOR RESEARCH AND KNOWLEDGE EXCHANGE

Given the multiple levels within the transitions framework, the term "evidence" needs to be understood to reach beyond intervention efficacy to include documentation of relevant policies and practices and implementation status of transition protocols. This is particularly important in considering the current state of policy and practice in each of Canada's provinces and territories, which is core to this review (see Section 3). There has been no outcome research in the Canadian context that demonstrates how transition management and support practices impact engagement and tenure in Adult Mental Health and Addictions Services (AMHAS), except for one pilot study completed in 2013 (Cappelli et al., 2013). There are no randomly controlled trials to evaluate the impact of transition processes and protocols where they are being utilized. In Canada, there have been no longitudinal studies completed, nor consistent data collected to identify how EA are engaging in, and using, adult mental health services and how they are faring as they transition to adulthood.

There is considerable grey literature available related to practice, facilitators and barriers to transition, and the developmental literature for this age group. Davidson et al. (2011) recently completed a comprehensive review of the literature as part of a report commissioned by the Ontario Centre of Excellence for Child and Youth Mental Health. Practices and protocols to support transitions have been in place in other sectors, generally for children and youth with "complex" or "special" needs and are beginning to be adapted and implemented to address the needs of EA with mental health concerns (Grant & Pan, 2011; Van Staa, Jedeloo, van Meeteren, & Latour, 2011); however, not in the Canadian context.

It is important to note that the evidence is at the "accumulation" phase. In particular, in Canada, neither the unique needs and engagement of this cohort, nor the outcomes achieved through engagement with service models and interventions, have been the focus of research. The data available from all sources is indeed limited. With a few exceptions in the UK, US, and Australia, EA are not conceptualized as a defined population from the policy, planning, funding, and/or service delivery perspectives.

Review of documentation regarding specialized service approaches and system designs has also been included in our methodology and findings, as available and reported in Section 3. Evaluation outcome documentation and research rigour are not robust. In recent interviews with key research leaders (e.g. MaryAnn Davis & Marsha Ellison, University of Massachusetts; Kimberley Hoagwood, Columbia University; Hewitt Clark, National Center on Youth Transition for Behavioral Health, University of Florida; Patrick McGorry, University of Melbourne and Director of Orygen Youth Health Research Centre; John Lyons, University of Ottawa), acknowledgement of the significant lag in research within this demographic was consistent and impassioned.

> There remain two large gaps in mental health services research related to interventions for young adults with serious mental health needs: research on interventions specifically for this age group and evidence of efficacy in this age group from evidence-based practices developed for other age groups. There are few rehabilitation interventions developed specifically for this population and all are in early stages of development. Evidence of the efficacy of evidence-based adult or child interventions with a young adult population is limited.
>
> Researchers also need to look at federal, state and program policies that surround service delivery to young adults.
>
> (Davis, Koroloff, & Ellison, 2012)

THE CASE FOR ENHANCED SYSTEM DESIGN, PROGRAMS, AND SERVICES

Effective and evidence-based service responses to address the mental health needs of EA are not evident in the Canadian context, except in the case of first episode or early psychosis programs. The first episode program model has been rolled out in many jurisdictions across Canada, generally commissioned through an adult mental health services funding stream. These programs have been evaluated in many provinces, and in some provinces, standards of delivery are clearly stated and require adherence (Government of Nova Scotia, 2009; Government of Ontario, 2011).

This commitment was made following robust evidence from Australia (McGorry et al., 2013) and the UK (Birchwood et al., 1998). Early intervention impacts the trajectory of psychotic disorders and the probability of full recovery if treated at first onset and is correlated with a shortened duration of the untreated period. The first episode/early psychosis program model is an evidence-based approach, which has helped to build the capacity to respond to young adults experiencing first onset psychotic disorders. In some provinces, this program model is included in provincial policy standards as a required element of the service design (e.g. New Brunswick, Ontario). This program model has not broadened beyond the original diagnostic group, so that young adults with the higher frequency diagnoses (e.g. mood and anxiety disorders) are not able to access the same level of service at early onset, although there are evidence-based interventions and clinical guidelines (e.g. National Institute for Health and Care Excellence, NICE), which are beginning to demonstrate positive outcomes with these diagnostic cohorts. Orygen Youth Health Research Centre in Australia have seen such good results from their early onset psychosis program that they have expanded it to include all mental health disorders and addictions issues (McGorry et al., 2013).

International experts have emphasized the need to build developmentally appropriate services to engage emerging adults specifically (Clark & Unruh, 2010; Davidson, Lamb and Murphy, 2013; McGorry et al., 2013; Richards & Vostanis, 2004). Admittedly, there have been a number of innovative program models and interventions that have been developed almost organically in several Canadian jurisdictions, without policy or prioritized funding envelopes. These programs and interventions, however, have not been evaluated, so there is minimal evidence related to their impact and efficacy. Several of these programs are presented within the framework of transition program models and interventions in Section 3 (e.g. Inner City Youth Mental Health Program, Vancouver, BC; Laing House, Halifax, NS; Y-Connect, Toronto, ON). The limitation of these approaches is that they are "one offs," not embedded in a system design or supported by a broader, funded policy framework. These programs generally deliver the ancillary psychosocial and recovery support services, and do not include early diagnosis and intervention, comprehensive clinical assessment, or evidence-based treatment services.

THE CASE FOR TRANSITION SUPPORTS

Although evidence on how youth are faring in Canada in making the transition into adult mental health services has not been collected, there is certainly significant concern, with early data and anecdotal evidence demonstrating that access to the required services is far from adequate. The impact of intervening early in the course of illness is well documented (Birchwood, Fowler, & Jackson, 2000; McGorry et al., 2013; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996). As well, youth who don't have proper transitional care are at increased risk of developing severe and enduring mental health problems (Davis, 2004; O'Brien et al., 2009; Richards

> The problem of how to improve the experiences of young people with transition trajectories that do not meet current eligibility criteria for AMHS is challenging for our current service structures. Tackling these problems requires action on the part of those commissioning and planning services as well as those providing services. The key issue for young people who do not meet eligibility criteria for AMHS is that no service currently exists to meet their needs. The improvement of mental health services for these young people requires extension of adult services to offer interventions for young adults with developmental problems, high-risk behaviours associated with emerging personality disorders and those with severe anxiety and affective disorders. This requires new resources whatever the service design.
>
> (Lamb & Murphy, 2013)

& Vostanis, 2004; Youth Advisory Committee of the Mental Health Commission of Canada, 2010).

Failure to provide adequate transitional care for youth with mental health concerns, especially when developmental transitions are ignored, often results in disengagement from services (Crawford et al., 2004; Richards & Vostanis, 2004; Singh et al., 2008). Estimates from the UK suggest that up to 52 per cent of young people identified as needing and referred to continued service in the AMHAS disengage (Singh et al., 2008; Paul et al., 2013). Adolescents and young adults have higher drop-out rates from service compared to younger and older cohorts (Edlund et al., 2002; Harpaz-Rotem et al., 2004). Similar drop-out rates are reported in a recent census-based US study examining the patterns of mental health service use by persons of transition age (16–25 years), confirming a concerning decline (a 48 per cent drop) in service use at a time when serious mental health issues are most likely to occur (Pottick et al., 2008). Further, it is the most vulnerable youth who are also the most likely to disengage (Crawford et al., 2004; Edlund et al., 2002; Guigliano, 2004; Vostanis, 2005).

Recent research from the UK indicates that optimal transition was experienced by less than five per cent of youth who made a transition (Singh, 2012). These youth were more likely to have a history of severe mental illness, requiring medication or admission to an inpatient unit, as opposed to a neurodevelopmental disorder, emotional/neurotic disorder, or emerging personality disorder. Some high needs populations, like those with autism spectrum disorder, experience difficulty with transition due to their high rates of comorbidity and the resultant complex coordination of services (McConachie, Hoole, & Le Couteur, 2011). To date, poor access to adult mental health and community care services is an ongoing problem for emerging adults on the autism spectrum (McConachie et al., 2011), a growing cohort of whom will be needing adult sector services in the next decade across the country.

In addition, behavioural characteristics associated with specific mental health diagnoses may have important implications for service delivery over the transition period. For example, issues with impulse control, which are characteristic of psychotic and externalizing behaviour conditions, have a detrimental impact on school completion, on developing a close personal connection to vocational specialists, as well as on obtaining and maintaining employment (Vorhies, Davis, Frounfelker, & Kaiser, 2012). Individuals with these disorders who do not make the transition successfully will be at greater risk of leaving school early, unemployment, and youth justice involvement as they are the population most highly represented in the cohort of persons with mental health issues in the youth and adult justice system (Davis et al., 2007; Schufelt & Cocozza, 2006). In addition, the high proportion of individuals in this cohort who use substances requires skill and knowledge in integrated evidence-based practices. EA-engaging transition supports that focus on vocational goals and address concurrent substance use are required to enhance positive outcomes.

THE CASE FOR YOUTH ENGAGEMENT AND FAMILY AND PEER SUPPORT

In examining the issue of transitions, it is important to acknowledge the perspectives of the key stakeholders – EA and their families need to be front and centre. Families are key to an effective transition process. The study of the experiences of EA in the system (or out of it, as the case may be) will give researchers essential information to help build new strategies. Without new strategies, engagement and retention levels and outcomes are not likely to be promising.

> And I thought, transition – it's kind of a funny word. It means that you're taken from one place, and you're kind of meshed into another. But what happened to me wasn't really a transition. It was really a transfer. I was taken from one side of the system and forced out of it and pushed into another. And in between there, I had about a year of lack of service.
>
> – Emily Beaudoin, Youth Participant (Cappelli et al., 2012)

Youth Engagement and Peer Support

Young adults in the UK and the US have "voted with their feet" on how current transition supports and adult services have responded to their needs. Although no systematic data collection has taken place in Canada, there is evidence from a recent study in Ontario, as well as from a comprehensive longitudinal study in the UK, that confirms significant shortcomings in both transition practices and the capacity of the AMHAS to engage, accept, and serve young adults (Cappelli et al., 2013; Singh et al., 2010).

Not to be underestimated is the significance of EA engagement in the discussion of transition planning and service delivery. Several of the system change models described later were designed with input from young people in order to ensure development of EA-centred engagement and service models (Jigsaw, Ireland; youthspace, UK; Reachout, UK; Youngminds, UK). Motivational issues and stages of change are significant factors in service discontinuance with this population, which can be addressed through thoughtful and evidence-based engagement practices (Davis, Lidz, Haddad, & Fisher, 2012). An EA engagement framework would include customized approaches to attracting youth to the door, as well as support for the development of peer connections, including mentors, peer support groups, and peer support worker roles at and behind the door (Delgado & Staples, 2008; Ontario Public Health Association, 2011).

One of the limitations of the simplistic, linear, "connecting the dots" model of transitioning youth to the adult service system is the minimizing of peer connections. Typically, adult services are focused on a traditional referral, intake, and service initiation process. Peer connections complement the role of parents to offer motivation to begin, continue, or discontinue an activity. The presence of peers has been shown to support successful transitions and maximizes the probability of continued engagement or first-time connection with AMHAS (Youth Advisory Committee of the Mental Health Commission of Canada, 2010). This would be a distinguishing factor for services that are truly responsive and designed with EA in mind.

The Mental Health Commission of Canada (MHCC) has developed three significant and relevant documents, *Evergreen: A Child and Youth Mental Health Framework for Canada* (Youth Advisory Committee of the Mental Health Commission of Canada, 2010), *Making the Case for Peer Support* (Hagan, Cyr, Mckee, & Priest, 2010), and the *Guidelines for the Practice and Training of Peer Support* (Sunderland, Mishkin, Peer Leadership Group, MHCC, 2013), all of which offer a foundation for the ongoing role of peers. Particularly relevant to EA, the MHCC created the Child and Youth Advisory Committee in 2008 to listen to the needs, experiences, and advice of a group of young people with mental health problems or illnesses. This was the group that produced the *Evergreen* report. Clear preferences and priorities related to engagement and service delivery approaches are included in this document.

With regard to prevention, the Committee's strategic directions include developing "targeted initiatives for transitional-age young people (i.e. 16–25 years of age) including funded community-based, social, vocational and educational programs designed to mitigate the effects of mental disorders and enhance secondary prevention" (Youth Advisory Committee of the Mental Health Commission of Canada, 2010, Direction #18, p. 27). The document includes directions regarding the need for the development of EA-specific services. With regard to "Intervention and Ongoing Care," the committee offers a number of specific directions including:

- establish a full range of mental health services that meet the specific needs of young people ages 16–25;

"For me too, thinking about the successes that I've had, they really stem from the supports that I've had. Not just from the hospital or from outpatient services, but also from families and friends."

– Aaron Goodwin, Youth Participant (Cappelli et al., 2012)

Transition personnel who used informal strength-based assessments (rather than traditional formal assessments that tend to be deficit-based) and person-centered future planning were more likely to engage young people. Engagement and enrollment need to be different. Policies and funding need to respect that difference.

(Deschenes, 2010)

- create appropriately staffed facilities in communities designed to be one stop shopping that meet the mental health and physical health needs of young people and families in one location and widely promote the availability of such resources; and,
- enhance the development and delivery of early onset programs in the major mental disorders (e.g. psychosis, anxiety disorders, substance use disorders, and mood disorders). (Directions 3,5,6; p. 31-32)

In addition to preferences for a youth engagement approach to services, a body of evidence is developing around the impact of peer support approaches. Peer support, defined as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful," will play a key role in the recovery of EA with mental health problems or illnesses (Mead, 2003, p.6). Indeed, peer support alleviates barriers to treatment and fosters correlates of mental health in adults, including:

- reduced stigma (Hagan et al., 2010; Mowbray, Moxley, & Collins, 1998);
- strengthened social support networks (Forchuk, Martin, Chan, & Jensen, 2005);
- increased self-confidence and empowerment (Davidson et al., 1999; Repper & Carter, 2011; Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002);
- improved rates of employment (Repper & Carter, 2011);
- increased community integration (Nelson, Ochocka, Janzen, & Trainor, 2006);
- increased healthy coping strategies (Hagan et al., 2010); and,
- increased hope for the future (Mowbray et al., 1998).

A recent study on the effect of peer support on crisis stabilization found that peer support was associated with an increased likelihood of crisis stabilization; for those without a crisis stabilization episode, peer support was associated with a decreased likelihood of psychiatric hospitalization (Landers & Zhou, 2011). Further, some peer support programs have demonstrated reductions in hospital readmission rates, and longer community tenure (Lawn, Smith, & Hunter, 2008; Min, Whitecraft, Rothband, & Salzer, 1998).

Development of peer support training and delivery models tailored to the needs of EA will be a crucial element of future EA services. There are few models for this cohort and none have been evaluated.

One of the most commonly raised concerns was that of the problems of accessing youth friendly/transitional age services – for young people. In the words of one parent, "There are no good services for people between 17 and 25!" This gap between needs and availability was noted by one youth service recipient who stated, "There are no intermediate steps between sitting at home alone, or going to the hospital in crisis." The need to provide mental health services that are designed to specifically meet the needs of young people in this age group, often referred to as the transitional age group, was one of the most consistent themes appearing in the consultation.

- (Youth Advisory Committee of the Mental Health Commission of Canada, 2010)

Family and Caregiver Support

Another critical factor in supporting successful transitions is the inclusion of families in the care and transition plan. Families have a substantial impact on the lives of emerging adults and accordingly, are "an invaluable resource in promoting recovery from mental health problems and illnesses" (MHCC, 2009, p. 58). Indeed, family cohesion and connectedness have been demonstrated to be correlated with positive mental health outcomes
(Singh et al., 2010).

Despite this, the philosophical shift away from family-centred care to autonomous client-centred care, and the altered legal status and confidentiality requirements as youth turn 18, decreases family involvement from the moment of institutional transition, sometimes alienating this support entirely (Davidson et al., 2011). This practice is in stark contrast to research demonstrating that treatment compliance

"One of the other things that was really, extremely helpful, was his psychiatrist was extremely family engaged. Which meant that she was able to acknowledge (son)'s need for privacy, and respect that while still very cleverly always engaging the family, which means that we were always there helping in his transitions, to be there and be supportive."

– Phyllis Grant-Parker, Caregiver Participant (Cappelli et al., 2012)

is increased when family involvement is maintained through the transitional period (Dixon, Adams, & Lucksted, 2000; Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001). While it is also important to recognize nascent autonomy and decision-making rights in EA, competency to make independent decisions varies greatly in this population and treatment outcomes improve with family involvement (Patel, Flisher, Hetrick, & McGorry, 2007).

Notwithstanding the generally positive impact that family involvement has on EA mental health, "specific individual families vary in their ability to act as a source of strength or resiliency in the life of a young person affected by mental illness" (Davidson et al., 2011). While implicit family tensions are often exacerbated by transition, the desire of youth for autonomy and increased rights to confidentiality must still be balanced with the desires and continued role of family members (many of whom have advocated for their children when they were younger and continue to care for them through transition) on a case-by-case basis. Parents and other caregivers are often the core support for a young person and need to be involved, informed, and supported. Issues of confidentiality need to be addressed head on, rather than used as a powerful barrier to communication. This will need to include respecting caregiver contributions, working through the resistance of practitioners to enter into family negotiations, and engaging the young person who is seeking increased autonomy, while still requiring continued support and resources (e.g. housing, finances) from family. Professionals need specific competencies, as well as a willingness to address and mediate and support all parties through the autonomy-dependency struggle.

THE CASE FOR SPECIAL ATTENTION TO VULNERABLE POPULATIONS

Recent research on EA has identified specific populations who experience poor outcomes during and after transition into adulthood. Poor transition outcomes have been linked to vulnerability factors such as racial and language minority status, intellectual disability, involvement in the child-welfare system, and youth-in-care status (Aratani & Cooper, 2011; Fowler, Toro, & Miles, 2011; Larkin, Jahoda, MacMahon, & Pert, 2012; Shook et al., 2011; While et al., 2004).

First Nation, Inuit, and Métis EA continue to experience a disproportionately high rate of mental illness and suicide (Khan, 2008). A number of factors impact the mental health of Aboriginal EA, specifically the legacies of colonialization and the Residential School System (Loppie Reading & Wien, 2009; O'Connor, 2000). The emergency status of First Nation youth with regard to their mental health, addictions, and suicide rates warrants urgent response.

Significant challenges are reported by EA experiencing mental health and substance use issues who are coming out of the criminal justice system (Osgood, Foster, Flanagan, & Ruth, 2005). Justice-involved young adults have high rates of diagnosable mental illnesses, with rates suggested as high as 70 per cent (Shufelt & Cocozza, 2006). Additionally, the justice system is often an end point for those who require mental health services due to externalizing and behavioural issues, but who have been unable to access traditional mental health services (Rosenblatt, Rosenblatt, & Biggs, 2000; UK Department of Health, 2009).

Poverty associated with the immigration process to Canada can affect mental health outcomes for new immigrants and their children (Beiser, Hou, Hyman, & Tousignant, 2002). Additionally, cultural factors, such as doctors' perceived overreliance on pharmaceutical treatments, dismissive physician attitudes, and beliefs in non-traditional forms of medicine, have been cited as primary reasons for the reluctance of new Canadians to access mental health resources (Whitley, Kirmayer, & Groleau, 2006). Cultural and linguistic barriers to service access, as well as differences in help-seeking behaviours, are associated with lower access to mental health services, despite access to universal healthcare among new Canadians (Kirmayer et al., 2007). Understanding the realities faced by new Canadians and the differential stigma in ethnoculturally diverse communities will be crucial to the development of culturally relevant transition services and engagement practices. More vulnerable EA (from diverse and lower socioeconomic backgrounds) are generally less likely to access services (Lalongo et al., 2004).

LGBTQ EAs experience a unique set of factors that contribute to elevated levels of suicidal and risk-taking behaviour, mental illness, and addictions. These can include homophobic persecution in schools (including both physical and verbal attacks), family rejection, and the stigma associated with being LGBTQ (Bagley & Tremblay, 2000; D'augelli, 2002; Ryan, Huebner, Diaz, & Sanchez, 2009). Special attention needs to be paid to the special needs, safety concerns, and circumstances of LGBTQ youth.

Even this brief overview of the increased risk for EA from marginalized and/or vulnerable communities should be cause for great concern in a developed country with a longstanding commitment to health equity practices and policy development based on the social determinants of health. The impact of these vulnerabilities places these EA at

particularly high risk, thus requiring thoughtful, assertive, and culturally relevant national and provincial policy responses and engagement and delivery practices at the regional and local levels.

THE CASE FOR SUPPORTING EDUCATION AND TRAINING

A key aspect of life during emerging adulthood is involvement in education and training. This is the period during which EA are developing the roles they will have as adults. Education outcomes for EA with mental health problems or illnesses suffer when compared with students without mental health issues (Ellison, Rogers, & Costa, 2013; Kessler, Foster, Saunders, & Stang, 1995; Newman et al., 2011; Vander Stoep et al., 2000; Vander Stoep et al., 2003; Wagner & Newman, 2012). Access to counselling, suicide prevention programs, and peer advocacy and support can help EA in high school and college attain their education goals (Ellison et al., 2013). The *Healthy Minds, Healthy Campuses* project in British Columbia is an example of how to provide supports for students with mental health and/or substance use issues. They have a community focus and state: "Our initiative is driven by Community of Practice members and a strong focus on meaningful connections and knowledge exchange. We value local wisdom in combination with evidence-based practices and encourage innovation spanning the full continuum of action and research – from promotion and prevention to treatment and recovery" (Healthy Minds/Healthy Campuses Initiative website, 2012). Mental health awareness and support programs are also being run in universities and colleges in other provinces (e.g. the Jack Project in Ontario, the MHCC's Mental Health First Aid Canada initiative) and in some elementary and secondary schools ("Friends For Life" in Alberta and British Columbia, and in Nova Scotia and Ontario where the "Strengthening Families for the Future"[3] program is being implemented in school communities). Although there is still not enough research in this area, studies being done in the US aim to provide more rigorous data and determination of evidence-based practices to support vocational success for the EA cohort (Davis, 2013).

That EA have had challenges with completion of secondary and post-secondary education (Newman et al., 2011) and diminished access to employment is demonstrated by the higher unemployment rates of EA with mental health issues in relation to their peers (Wagner & Newman, 2012). Although there has been limited data collection in the Canadian context, the international evidence clearly confirms significant educational and economic marginalization of young adults (YA) with significant mental health and addictions issues (Davis & Vander Stoep, 1997). Identifying evidence-based approaches specifically for this cohort will be crucial, as research regarding supported education and employment approaches, for example, demonstrates that programs developed for the general adult population with mental health needs will need adaptation for the YA cohort (Davis, 2013). There is currently no systematic body of evidence demonstrating the effectiveness of interventions and models with this age group specifically.

THE CASE FOR SPECIALIST SERVICE RESPONSES

The chronological determination of transition point (generally between 16 and 18 years of age), does not have a basis in developmental theory and is described as being the most vulnerable point with respect to emerging mental health and addictions issues.

The onset of mental health problems or illnesses most often falls during emerging adulthood (Government of Canada, 2006; Kessler et al, 2005; Jones, 2013). It is

Strong educational attainment supports better employment, and opportunities for careers that sustain employment, over time in all young adults.

- (Ellison et al., 2013)

"He did a couple section 23 programs. He tried to go back to the adult high school because again, 18 was the cut off. He couldn't go back to a regular school; they did not have anything for him. The adult high school did not have the supports in place that would really support him. And he did try to go back even with the supports at the college, and he ended up back in hospital because of the stress."

– Phyllis Grant-Parker, Caregiver Participant (Cappelli et al., 2012)

[3] http://www.camh.net/Publications/CAMH_Publications/strengthen_families.html

not clear that either the child and youth sector or the adult sector mental health services are appropriate or responsive. Some experts would posit that neither sector is equipped (McGorry et al., 2013; Richards & Vostanis, 2004). It is in the late teens and early 20s that distinctions can be made between episodic or acute symptoms and potentially more functionally debilitating chronic illnesses, such as schizophrenia and severe personality and bipolar disorders, which will require different treatment and psychosocial responses.

Generally, the focus of AMHAS in Canada and the UK has been on individuals with severe mental illness, with persons with mild and moderate mental health needs expected to seek assistance through primary care practitioners. Specialist Child and Adolescent Mental Health and Addictions Services (CAMHAS) in most parts of Canada provide services for children and adolescents with a wide range of disorders, including depression, anxiety, eating disorders, obsessive-compulsive disorder, and psychosis, as well as autism spectrum disorders, intellectual disabilities, and attention-deficit hyperactivity disorder. Many CAMHAS providers also provide interventions for children with high levels of impairment and emotional, behavioural, and conduct issues related to mental health difficulties, who might not reach the diagnostic criteria for a mental health disorder and therefore entry into AMHAS. This client user profile may not fit the admission criteria for AMHAS, which would generally be focused on serious mental health disorders, specific diagnostic categories, and evidence of prolonged disability. Simply the age and stage of young people and their childhood diagnoses may exclude them from specialist mental health services in the adult system. The AMHAS, for example, is ill equipped to respond to the needs of the growing number of young people on the autism spectrum who have comorbid mental health issues, and will, in many cases, exclude them from service.

A review of state practices in the US underlined variance in access criteria between the child and adult systems and showed a striking lack of referral and transition planning activity (Davis & Sondheimer, 2005). The misalignment between the exit and entry criteria of the two sectors doesn't facilitate continuity of service for youth.

Developmental characteristics can, in themselves, disrupt the journey. It is now understood that the maturation of the cognitive control system (evidence from both structural and functional changes in the prefrontal cortex) and increased connections between the cortical and subcortical areas of the brain result in decreased risk-taking behaviour and increased capacity to modulate socially and emotionally arousing thoughts with deliberate reasoning (Steinberg, 2008). These neurobiological developments, and their behavioural consequences, may not be concluded until an individual's mid-20s. It is highly probable that youth may not have the skills required to effectively negotiate the CAMHAS/AMHAS transition without significant supports. At the same time, adult mental health service providers may not have the skills or willingness to engage with this potentially high-risk and energetic cohort whose developing organizational, planning, and follow-through skills can create challenges to engagement in services and continuity of care. In addition, concurrent addictions have historically led to denial of service to many young adults. A knowledge transfer strategy is required that includes a consolidated curriculum across all professional training programs in the CAMHAS and AMHAS. This would need to include competencies related to response to behavioural, developmental, and concurrent disorders.

Other disconnects also create challenges over the transition and will need to be addressed at the policy level. Professional training in the two sectors is different and services in CAMHAS and AMHAS are generally provided by different organizations with different cultures and philosophies of care, are funded through different ministries, and are accountable for delivery on different outcomes.

> Public specialist mental health services have followed a paediatric-adult split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest.
>
> - (McGorry, 2007)

Again, looking to the UK TRACK study (as such data are not available from Canadian work), Singh et al. (2010) reported that over 80 per cent of cases were considered suitable for transfer by CAMHAS, but a third of these were not referred. The adult services accepted 93 per cent of all referrals, but 25 per cent of cases accepted by AMHAS were discharged without being seen. Even among those who crossed the gap, only five per cent experienced "optimal transition."

> The consequence of these service differences is that young people in receipt of a service from CAMHS may find that on reaching adulthood their condition and presentation has not changed but secondary care AMHS are not configured to provide for them. If there is no alternative service available in primary care or the voluntary sector, young people and their families are left to cope alone.
>
> - (Lamb & Murphy, 2013)

KEY POINTS FROM SECTION 2 TO TAKE FORWARD:

- Little evidence is available regarding effective transition-related and EA-responsive service delivery designs. Evidence-based research with EA is minimal.
- There are no comprehensive or integrated service responses for EA in the Canadian context.
- Youth and family perspectives and engagement requirements have not been addressed by AMHAS, so uptake is impacted.
- Vigilance is required for a number of high-risk, vulnerable populations who require priority attention (e.g. First Nation, Métis, and Inuit EA; those leaving care of the child welfare system; marginalized members of ethnoracially diverse communities; justice-involved EA; LGBTQ).
- There is a serious disconnect between what EA need and what the adult system has to offer them.
- EA and family engagement is key to developing relevant programs.

Section 3
Current Approaches—Processes, Models, and Policies

In this section, we describe the methodology for our scan of the research, policy, and practice landscape specific to emerging adults (EA) and present models for transition programs and responses. In addition, we summarize findings related to the current state of international, national, and provincial/territorial policy and showcase strong practices and learnings that offer direction and potential strategies for better EA services in the Canadian context.

METHODOLOGY/SOURCES OF INFORMATION

To build the foundation for our policy, systems, and practice review, our method included several components. First, proceedings were consolidated from a "summit" meeting of international experts held in October 2012, *An International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model* (Cappelli et al., 2012). The international meeting included Canadian and international system design and policy champions, researchers, and clinical experts (see Appendix 2 for a list of participants). Participants were charged with building a conceptual framework for transitional care and EA mental health responses that could be a foundation for policy, research, and practice. Content experts and stakeholders shared information in order to develop a common set of principles, align methodologies, and create a network of researchers and a shared foundation from which to move forward.

Next, a review of the literature explored promising practices and approaches to transitional mental healthcare and, more broadly, responses to the needs of EA with mental health and addictions issues at the policy, system, service delivery, program, and intervention levels. Four sources of data were explored: scientific publications, published guidelines and protocols, mental health service program websites, and international, national, and provincial policy documents.

Scientific publications were gathered in a literature review (Medline, EMBASE, CINAHL, PsychINFO, the Cochrane Library, IBSS, and NRR for English- and French-language articles). Searches were date-restricted to cover the period from January 1, 2011 until May 2013, to update the literature search conducted by Davidson et al., (2011). National and provincial policy documents (child and youth mental health as well as broad/population mental health and addiction strategies and documented transition-related policies and protocols) were collected from the MHCC and each of the provincial and territorial governments. Key informant interviews were conducted with mental health policy leaders from across the country. Additional policy documents were requested during interviews with provincial/territorial personnel.

Published guidelines and protocols, recent conference proceedings, and mental health service program websites were reviewed, as well as guideline clearinghouses and agencies (including NICE, SIGN50, Ontario GAC, as well as professional organizations and mental health websites). Additionally, local regions (Local Health Integration Networks) were contacted in Ontario for a more detailed account of whether and how policies, protocols, and practices are being developed and implemented to support transitions and the needs of EA more generally. Interviews were recorded and transcribed to facilitate the identification of key themes.

FACILITATORS AND BARRIERS TO EFFECTIVE TRANSITIONS

Youth in transition, families, and service providers must overcome many barriers when negotiating the gap between mental healthcare systems. While emerging adults may be more interested in receiving services than their younger counterparts (Silver, Unger, & Friedman, 1995), the largest declines in service use are found in this age cohort (Government of Alberta, 2006; Edlund et al, 2002).

The literature demonstrates a high level of agreement regarding facilitators for successful transitions (McDonagh, 2007; and see Appendix 3). Best practice guidelines are currently in use internationally by providers who offer transition support services (Clark & Unruh, 2009; Coughlan et al., 2013). Davidson (2011) summarizes the most common barriers and provides strategies to improve transitional pathways (see Appendix 4 for full descriptions).

CURRENT MODELS FOR TRANSITION PROGRAMS AND RESPONSES TO EMERGING ADULTS

From the analysis of current international practices in transitional mental healthcare, and based on presentations and in-depth collaborative work at the October 2012 Summit (Cappelli et al., 2012), two major models were identified.

The transition management model focuses on transition processes and practices with the goal of successful engagement

of a youth with AMHAS. The system design model focuses on impacting the broader mental health system and its service responses to address the needs of EA. In addition, a number of transition interventions at the clinical level are beginning to demonstrate positive outcomes for EA and so deserve inclusion in this discussion.

The intention is not to suggest that one approach should be used in isolation, rather that these approaches will be complementary to each other. For example, in tandem with implementation of the system design or transition management model, transition interventions relevant to individual need will need to be offered to ensure positive treatment outcomes. Exemplars are offered as typical and strong examples, many of which were presented at the October 2012 Summit meeting. The exemplar lists are not exhaustive and are drawn from the October Summit, from interview data, and from the practice and research literature.

System Design Models

The first, and most dramatic departure from current Canadian practices, are the system design models. They are typically a system-level approach, generally replicable across a number of jurisdictions, sometimes functioning within a separately defined service sector dedicated to the EA response. They are usually supported by a national or state/provincial policy framework with mechanisms in place for designated funding.

Rather than solely achieving individual outcomes, the goal of system design models is to enhance the continuum of services and/or relevant and prevention-focused, multidimensional service responses. The aim is to increase access and engagement, to achieve recovery and mental health, and ultimately to reduce the need for transition into, and dependence on, adult mental health services (McGorry et al., 2013).

The goal of these models is to assist youth and EA with developmental, psychological, institutional, and system transitions. The institutional transition is from children- and youth-serving organizations to adult service organizations and the system transition is from the sector that funds and manages child and youth mental health services to the sector funding adult mental health and addiction services. These system design models ensure service availability to those transitioning from youth services, but also for EA who have not previously been engaged in mental health services. They may include program responses to address a variety of mental health needs or they may be more limited in scope. Universally, system design models seek to modify, and sometimes transform, existing healthcare systems, enhancing responses to EA through designated and separate service arrangements.

Proponents of system design approaches argue that lack of engagement and access is almost entirely related to the current design of our adult mental healthcare system, which is inadequate to address the unique developmental and cultural needs of the EA.

Guiding strategies for the redesign of services generally include:

- youth participation at all levels of development, essential to the creation of youth-engaging, stigma-free cultures of care;
- a holistic, preventive, and optimistic service philosophy with sequential/stepwise care governed by risk/benefit and shared decision-making principles;
- early intervention, social inclusion, and vocational outcomes as core targets;
- care reflecting both the epidemiology of mental ill health in young people and the new developmental culture of emerging adulthood in the early 21st century;
- eliminating barriers to service continuity at peak periods of need for care and developmental transition; and,
- positive and seamless linkages with services for younger children and older adults (McGorry et al., 2013).

System change is often initiated in the context of a national mental health policy framework that has a developmental and lifespan perspective with recovery as its aim. System design includes service models specific to EA, and as success is demonstrated and the service models are scaled up within the system, the entire system begins to shift, as does the utilization of services over the lifespan.

Features of this model typically include:

- a system design framework within a defined jurisdiction (may be national, state/provincial, or regional), which includes service delivery elements specifically tailored to the needs of youth/young adults;
- programming for a variety of service needs beyond those specific to a particular diagnosed mental illness and

consistent with a robust prevention, youth engagement, and recovery framework;

- a strong and enveloped funding base;
- multidisciplinary teams as part of an aligned continuum of services from early intervention to access to the most intensive specialized services; and,
- stand-alone centres for EA (generally independent physical space or integrated with other core youth-engaging services such as primary care, employment, and recreation).

Exemplars (see Appendix 5 for details):

- Headspace and Orygen Youth Health, Australia[4]
- Youth One Stop Shops (YOSS), NZ[5]
- Right Here, Youthspace, UK[6]
- Headstrong and Jigsaw, Ireland[7]
- Transition to Independence (TIP) Funding Model/Research & Training Centres; Partnerships for Youth Transition(PYT)[8]
- Nation- and province-wide installation of integrated school-based approaches, including universal and targeted prevention (e.g. Mindmatters[9], Australia; Integrated Service Delivery, New Brunswick) and access to the full continuum of tiered services.
- BeyondBlue,[10] a national web, phone-based, and computer-assisted information and clinical resource initiative for individuals, families, schools, and professionals to address depression and anxiety
- Youth Health, an initiative of the Australian Medical Association[11]

Transition Management Models

- Transition management models focus on processes and services that facilitate
  the movement of a young person from the child to the adult mental healthcare system. These models target youth who have been receiving and continue to
  need services. The goal is effective bridging between Child and Adolescent
  Mental Health and Addictions Services (CAMHAS) and Adult Mental Health and Addictions Services (AMHAS) to ensure mental health needs are met, the individual and their family are prepared to change service providers and systems, and they
  are supported throughout the transition. This is in contrast to the system design model that aims to build responsiveness in, or add to, a new constellation of EA-specific services. Principles and effective processes have been defined elsewhere (Davidson et al., 2011; McDonagh, 2007; Singh et al., 2010). Core elements of effective transitions processes have been synthesized from the findings of a significant longitudinal study conducted in the UK (O'Brien et al., 2009; Singh et al., 2008), as well as practices with special or complex needs youth in the healthcare system more broadly. In the UK, transition management models have been documented and evaluated: (the TRACK study (UK),[12] a multisite study of transitions of care from CAMHAS to adult services; and the Bridge Project (UK),[13] a comparison of two models of transitional care).

Features of this model typically include:

- entry/access starting between age 16 and 17 to begin preparations for transition by age 18 or 19, depending on jurisdictional age criteria;

[4] www.oyh.org.au
[5] www.yoss.org.nz
[6] www.youthspace.me; www.right-here.org.uk
[7] www.headstrong.ie
[8] www.tipstars.org
[9] www.mindmatters.edu.au
[10] www.beyondblue.org.au
[11] https://ama.com.au/youthhealth
[12] The TRACK study and the BRIDGE project are research studies, rather than Transition Management Models, per se. They are included here for context and reference, as they have contributed to building practice, are the most comprehensive tracking of models and transition approaches, and offer a significant contribution. The BRIDGE study is a comparison of two models, and includes specific approaches.
[13] http://www.bridgesproject.org.uk

- support to the individual and family during the transition period;
- a transition coordinator or facilitator managing small caseloads;
- a transition team of child, youth, and adult providers in the relevant sectors;
- a transition-relevant tracking tool for youth to record their important local healthcare information (which may include readiness checklists, health passports, as well as information transfer/documentation tools);
- a reciprocal agreement or shared care protocol between the child and adult mental health providers to meet and plan transitions at specific age-based points in time; and,
- adult and child mental health system advisory boards or management groups.

Exemplars (see Appendix 5 for details):

- Ottawa Mental Health Transition Project, Champlain LHIN
- The Bridging Program, Ottawa
- Good2Go Transition Program, Hospital for Sick Children, Toronto
- LIFEspan, Holland Bloorview Kids Rehabilitation Hospital
- Growing Up Ready, Toronto Rehabilitation Institute
- IWK Health Centre Halifax
- National Health Service (NHS) Lothian, UK

Transition Interventions

Transition interventions have also demonstrated some success in facilitating mental health transitions and responding to the specific needs of EA. They are characterized by the provision of specific, time-limited interventions that seek to either build skills that are critical to the successful transition, to remove a specific known barrier to successful transition, or to deliver a clinical intervention specifically for EA. Transition interventions may address several key skills and use a range of healthcare professionals.

Intervention goals might include:

- skill development;
- increased engagement in service;
- measurable mental health outcomes;
- completion of developmental tasks;
- educational and vocational outcomes;
- reduced hospitalization and/or a shift in illness trajectory;
- self-management/regulation of symptoms;
- autonomy development;
- positive identity development;
- decision-making skills;
- adult role development;
- development of supportive relationships with family and friends;
- attainment of stable housing; and,
- attainment of youth-determined health goals.

Features of these interventions typically include:

- targeting young adults from 16–28 (or as broad as 12–30 as in First Episode Psychosis Programs where criteria are based on stage of onset, rather than age);
- using a manualized approach for a specific intervention based on specific and documented practice standards and/or fidelity requirements for the intervention; and,
- identifying outcomes based on EA goals or developmental milestones/outcomes (e.g. employment, education), and/or decreased intrusive service use (e.g. inpatient and emergency hospital services) and/or symptomatology/ health indicators.

In order to be considered as an evidence-based intervention, the usual criteria would apply (such as manualized practice with specific fidelity criteria, a defined cohort, ample efficacy evidence with the specific population, replicability, use of appropriate evaluation methodology). These interventions can be key inclusions in a system design.

Exemplars (see Appendix 5 for details):

- First episode/early intervention programs for psychosis (although these may include individuals as young as 14 and as old as 35, depending on age of onset, so these are not EA-specific interventions, but are diagnosis based)
- Multi-systemic therapy for EA (MST-EA)[14]
- A number of EA-specific programs that operate using the Transition to Independence (TIP) Model, a framework implemented and identified as promising/EB practices (Clark & Unruh, 2010)

THE INTERNATIONAL SCENE

From the international perspective, data have been gathered from policy documents, published materials, interviews, and the proceedings of the October 2012 meeting, *An International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model* (Cappelli et al., 2012). The international scan includes a review of selected English speaking OECD countries only.

Notwithstanding recent initiatives in Canada by the Mental Health Commission of Canada (MHCC) and mental health policies that are in place in many of Canada's provinces and territories, policy change and evidence-informed service responses in other OECD countries have far exceeded advances in Canada.

Australia

Australia and its Department of Health and Ageing have led the way in developing policy and practice that alter the service use trajectory for youth with early signs of mental health problems and diagnosable mental illnesses. Australia's robust prevention and early intervention policies and related programs have been in place for more than 15 years, a longer term commitment than any other country (McGorry et al., 1996). Australia initiated early onset psychosis practices and programs and the ensuing international movement and implementation. A recent wave of mental health reform, within which transformational change in youth mental health is key, is occurring at both the primary and specialist care levels. Australia's whole-of-government approach to mental health has aligned federal and state initiatives to support a youth mental health strategy as well as a national suicide prevention strategy (Child Commission for Children and Young People and Queensland, 2011).

As in Canada, there are jurisdictional complexities because of the federal and state governmental system and policy base. However, the national government has responded with significant "ring-fenced" or dedicated resource allocation for 14–25 year olds in 2013, investing $491.7 million over five years. This will fund the expansion of youth- and young adult-focused early intervention models and includes the expansion of *headspace* to 90 sites nationally by 2015. The *headspace* "prototype," which has now been funded across Australia as an all-Commonwealth initiative, is the high-visibility, low-stigma, first contact point for young people experiencing mental health concerns. Nationally, *headspace* serves 40,000 young people annually (see Appendix 5). *Headspace* is the strongest example of an EA-specific service model, albeit with a primary care approach, responding to the needs of youth and young adults (aged 12–25) with mild to moderate mental health disorders. The availability of health insurance coverage for non-medical counselling services, a high level of collaboration, and annual operational funding are the cornerstones of the *headspace* model. An online

[14] http://academicdepartments.musc.edu/psychiatry/research/fsrc/subsites/mstforea.htm

eheadspace program is also in place and the MindMatters mental health promotion, prevention, and early intervention initiative for Australian secondary schools has been in operation for over a decade,[15] as well as a national anxiety and depression prevention program (BeyondBlue).[16]

Following Australia's Fourth National Mental Health Strategy (Commonwealth of Australia, 2009), National Standards for Mental Health Services were developed, which include benchmarks for performance related to prevention and access to treatment of mental disorders (Australian Government, 2010). As well, the Australian Suicide Prevention Advisory Council is in place to address the morbidity issues related to mental health, with a particular focus on youth and aboriginal suicide rates. They released the high-profile report noted above with a strong call to action (Standing Committee on Health and Ageing, 2011). The National Suicide Prevention Strategy outlines Australia's national commitment to suicide prevention with an emphasis on promotion, prevention, and early intervention and, recently, they released the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Australian Government, 2013). They have recommended a priority research agenda for youth suicide, with a view to supporting a coordinated and targeted program of research with National Health and Medical Research Councils and the Australian Research Council. EA outcomes are monitored at a national level.

In several jurisdictions, notably urban centres, a range of specialist services for young people are in place that focus entirely on the needs of the 14–25 year old youth with more intensive needs. Through Orygen Youth Health (OYH) in Melbourne, a specialist tertiary mental health service continuum has been developed that includes outreach, peer and family support, as well as five community-based Continuing Care Teams to respond to young people with specific diagnoses (see Appendix 5). These programs are connected with a Youth Access Team for triage, assessment, and support, as well as with crisis intervention and inpatient specialist services. An enhanced headspace funding stream is being rolled out currently, which will integrate headspace with deeper specialist services for young adults (YA) with more intensive needs and, in particular, with early psychosis.

What we can learn from the Australian experience:

- The Third (2003 – 2008) and Fourth (2009 – 2014) National Mental Health Plans (Commonwealth of Australia, 2003, 2009), including a priority strategy for youth and early intervention, have been the foundation for effective program development and system design (specifically the headspace National Youth Mental Health Foundation) and includes specific performance indicators.
- Envelopes of "ring-fenced" funding for specialized responses for EA mental health are critical.
- Leading edge program development can be catalyzed through the power of philanthropy (headspace and ORYGEN roots).
- Youth engagement in policy, system design, and evaluation processes creates responsive services.
- National champions with political influence, research and academic affiliation, and international profile drive transformation.
- Change processes require leadership, research, and advocacy over decades.
- Despite significant lead on policy, system design, and models, collection of evidence through robust research efforts needs to be developed to demonstrate impact.

- Young people need youth-friendly services that recognise and respond to their special cultural and developmental needs. At the primary and community level, headspace: the National Youth Mental Health Foundation, is a national response to this and aims to provide better access, engagement, and enhanced multi-disciplinary care for young people across Australia.
- The specialist mental health service level should be complemented by youth-specific specialist mental health services for young people, aged 12–25 years, which would strengthen the existing system with a better targeted stream of care, providing access to integrated mental health, substance use, and vocational-recovery services. Alternative approaches to creating this capacity should be urgently developed and evaluated, and sustained reform informed by evidence as well as values.

  - (McGorry, 2007)

[15] http://www.mindmatters.edu.au
[16] http://www.beyondblue.org.au

- Development of a specialized young adult sector requires addressing the transition into and out of this sector.

New Zealand

New Zealand has kept pace with Australia in developing national mental health policy initiatives in the child, youth, and adult mental health system. The *Blueprint for Mental Health Services* (New Zealand Mental Health Commission, 1998) has provided guidance for the development of publicly funded mental healthcare in New Zealand since 1998 with a focus on addressing the multidimensional needs of persons with the most severe disorders across the lifespan.

More recently, there has been concern with the significant and rising national prevalence of depression (considerably higher than in other OECD partner countries) and with youth suicide. This concern has driven policy reform and service response to specifically address youth and adolescents, who are most at risk as a demographic (Ministry of Health, 2006). The launch of the National Depression Initiative in 2006 included the establishment of Regional Suicide Prevention Coordinators within five District Health Boards and specific "on the ground" initiatives. This initiative aimed to reach the 13 per cent of secondary school students who are depressed at any one time, and who, in the past, would never have found specialist mental health services (Ministry of Health, 2006, 2008, 2009).

As there was limited focus on the high-risk group of young adults (over 18) with diagnosable mental illness, the reach of implementation to this demographic fell short and further mental health reform was initiated. In October 2009, the Prime Minister requested that the Office of the Chief Science Advisor review the scientific basis of the high rate of social morbidity associated with being an adolescent in New Zealand. In 2011, a report was released (Prime Minister's Chief Science Advisor, 2011), raising a number of concerns regarding the period when young people move from childhood to adulthood and the concurrent onset of depression and other mental health problems or illnesses, increased harmful addictions, and risk of suicide. Recommendations underlined the lack of a preventative, developmental, and lifespan approach to addressing adolescent mental health. This included increasing capacity to provide screening and treatment for the substantial group of young people whose lives are impacted by mental health issues and a long-term commitment to appropriate policies and programs nationally.

The Prime Minister's Youth Mental Health Project (Key, 2012) outlines policy for early intervention and an expanded youth mental health agenda. The initiative is aimed at improving the mental health and well-being of young people aged 12–19 years and will be implemented over a four-year period from 2012–2016. Enhancements include significant in-school, in-community, online, and mental health and health provider capacity building, to address the needs of young people. These initiatives have generally targeted youth, rather than reaching EA over 18. Specific initiatives include:

- Follow-up for those discharged from CAMHAS and youth Alcohol and Other Drug (AOD) services;
- a national wellness screening program in schools and primary care settings (home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety);
- enhancement for Youth One Stop Shops (YOSS); and,
- a clear recommendation for a strategic national approach to reducing depression in adolescence.

What we can learn from the New Zealand experience:

- Issue-based, policy-development-focused investment in urgent needs can impact the broader system for EA (the identification of elevated depression and suicide rates significantly impacted change).
- High-level political leadership creates an agenda for action that drives transformation (in the NZ case, the Prime Minister's Office taking the lead).
- Moving ahead with an urgent timeline and singular focus can drive system transformation (e.g. the National Depression Initiative) and creates ripple effects/advances across multiple sectors (in the NZ case, families, communities, schools, primary care, specialist mental healthcare, research and education sector), but targets need to ensure a broader inclusion with respect to age ceilings.
- A focus on child and adolescent mental health delivery does not necessarily shift response to this group as they age into the adult mental health and addiction system.

United States

In the United States, over the past 15 years, and following the release of the *Surgeon General's Report on Mental Health* (Office of the Surgeon General, 1999), the New Freedom Commission on Mental Health (2003), and the *National Strategy for Suicide Prevention* (U.S. Department of Health and Human Services, 2001), there has been limited sustained advancement at the national policy level or in the publicly funded system to support children, transitioning youth, or EA.

There have been several initiatives to infuse funds at the service delivery level including the "Healthy Transitions Initiative" in 2009 (through SAMHSA grants)[17] and the U.S. Social Security Administration's "Youth Transition Demonstration" project (United States Government Accountability Office, 2008). Time-limited funding was received in several states to develop comprehensive service delivery programs, including a strategic plan, policies, financial mechanisms, and other reforms.

There have been repeated calls for increased investment, particularly in early identification and intervention for mental illness in children, adolescents, and teenagers from numerous academic and commissioned public tables (American Academy of Pediatrics, 2004; The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; US Preventive Services Task Force, 2009), and from President Bush's New Freedom Commission on Mental Health (New Freedom Commission on Mental Health, 2003). There has been limited response to these calls for action at a policy or service level. In fact, there has been a reduction in funding at a state level totalling nearly $1.6 billion dollars between 2009 and 2011 (National Alliance on Mental Illness, 2011).

The United States has had a unique journey in their development of approaches to address transitions, some of which have gained traction and have been replicated internationally (e.g. the TIP program developed by Rusty Clarke). Rather than being driven by policy initiatives, as in Australia and New Zealand, advances in the US have been driven by national initiatives to develop capacity through specific federally funded transitions initiatives and through research and training grants. For example, the National Institute of Disability and Rehabilitation Research, together with SAMHSA, have cofunded two Rehabilitation Research and Training Centers (Portland State University[18] and Transitions Research and Training Center at UMass[19]) to conduct research and knowledge exchange activities to improve role functioning for this age group. Following the acknowledgement of a concerning lack of connection of young adults (14–25 age group) to adult services, five sites were given four-year funding in 2002 to develop and implement transition programs for youth with mental and emotional difficulties.

Concurrently, a review of state policy and funded programs to address the needs of young people moving from adolescent to adult service sectors demonstrated that only 37 per cent of states have actually mandated transition planning for adolescents, usually at six to 12 months before child services will end (Davis, Geller, & Hunt, 2006; Davis, 2001). A follow-up state survey of transition supports and services for EA demonstrated that 75 per cent of state child mental health systems had developed some specific services to support preparation for adulthood, but only 50 per cent of state adult mental health systems actually offered any specialized services for young adults (Davis et al., 2006).

Similarly, a study of patterns of mental health service use for transition-aged youth and young adults demonstrated a drastic decline based on admissions to inpatient, outpatient, and residential services (Pottick et al., 2008). Findings underline the need for targeted resources for transition planning as well as for those who experience their first episodes of mental illness in early adulthood. A national longitudinal transition study supported outcome tracking for a significant cohort of EA around issues of employment, education and arrest rates (Wagner & Newman, 2012).

Perhaps the most embedded young adult-related approach is the Transition to Independence (TIP) process, which received Partnerships for Youth Transition Initiative demonstration project funding (SAMHSA). The TIP system prepares youth and young adults for future adult roles through an individualized goal-driven approach, engaging EA in the process of planning for their own futures, as well as providing developmentally appropriate services and supports (see Appendix 5). The TIP process has been implemented through a knowledge translation strategy in other countries including the UK, and more recently in Canada in Ontario, and offers a set of principles and specialized tools to frame practice with EA.

There have been a number of studies on the experiences and outcomes of transition-aged youth in community programs (including the TIP programs). One study noted transition-aged youth in community programs "showed increased rates of progress and decreased rates of challenges over four quarters of enrolment" (Haber, Karpur, Deschenes, & Clark, 2008, p.1).

[17] http://www.samhsa.gov/grants/2009/sm_09_008.aspx

What we can learn from the US experience:

- National research and training initiatives, even with multiyear, federal, multiple source funding, may have minimal system impact.
- In the absence of a national policy, funding-specific initiatives with a strong research and evaluation framework to build knowledge, replicable programs, effective practices, and interventions contribute to positive outcomes for EA.
- Building capacity and competency by increasing funding helps, but there is no evidence that this generalizes across the service continuum.
- Hosting a national registry of evidence-based practices and programs to inform system and practice development and enhance evidence-based planning and program delivery supports effective practice.
- Nationally supported longitudinal tracking provides hard data for monitoring outcomes and provides evidence of the need for capacity building and practice change.

United Kingdom

The needs of EA in the UK have been strongly impacted by initiatives over the last two decades at the clinical, program, research, system design, and policy levels. This includes, but is not limited to:

- Development of the first Early Intervention in Psychosis service in the UK in 1994, following the Australian lead championed by Patrick McGorry (Birchwood et al., 2000). Eventually, conceptual innovations translated into the mental health policy framework for the Department of Health as part of the NHS *National Plan* (Department of Health, 2000). The service attracted "Beacon" status and has been replicated with over 125 teams across the country, as well as internationally, including many provinces in Canada.
- Development of a Mental Health National Continuum of Services (Department of Health, 1999) and an accompanying NHS Plan (Department of Health, 2000), which highlights opportunities for cooperative planning and provision to take place between CAMHAS and services for adults, especially in the provision of early intervention services for people with psychosis.
- Development of a National Continuum of Services for Children and Young People (Department of Health, 2004).
- New Horizons consultation and action strategy development (Department of Health, 2009), which includes commitments from 11 government departments, specific actions around transition planning processes, and the development of models of mental healthcare for adolescents and young adults. The strategy articulates the need to identify, disseminate information on, and evaluate models of good practice.
- A burgeoning on and offline youth empowerment advocacy initiative in the UK (YoungMinds, 2005).
- An extensive longitudinal tracking study analyzing the protocols, process, and engagement outcomes of youth transitioning to the adult mental health system (O'Brien et al., 2009; Singh et al., 2005; Singh et al., 2008; Singh et al., 2010).
- A refreshed transformation agenda, based on development of the 2011 mental health strategy (Department of Health, 2011) and 2012 implementation plan (Department of Health, 2012). This includes an article on commissioning for effective transitions that outlines specific outcomes to be achieved within a lifespan, developmental framework.
- Establishment of a Directorate Children and Young People.
- Development of a Children and Young People's Health Outcomes Strategy (Department of Health et al., 2013; Lewis & Lenehan, 2012), the first of its kind in the new health system brought in through the Health and Social Care Act 2012.
- A policy-driven shift within mental health reform to improve access to psychological therapies for young people based on NICE (National Institute for Health and Care Excellence).

Recently, there has been significant focus on the development of youth-engaging, visible, street-front programs that are built with youth and based on the clear and identified needs of each community. The Youth Access Initiative[20] supports 165 Young People's Information, Advice, Counselling and Support Services (YIACS) nationwide. YIACS provide services to thousands of young people who might not otherwise access support and are a first contact point for youth with mental

[18] Lead by Nancy Koroloff www.rtc.pdx.edu
[19] Lead by MaryAnn Davis http://labs.umassmed.edu/transitionsRTC/index.htm#sthash.yXNOa1qg.dpbs

health and addictions needs. In addition, a system of youth Connexions programs, which are publicly funded across the UK, provide impartial careers advice and confidential support for all young people between ages 13 and 19, but up to 25 for persons with any disability (e.g. youthspace and Connexions Centres in Birmingham[21], and Northhamptonshire[22]). Other approaches are funded through NHS local trusts such as "Icebreak" in Plymouth,[23] "Bridging the Gap" in Sussex,[24] and the Right Here project[25], which is funded by the Paul Hamlyn Foundation and the Mental Health Fund and aims to change the way in which the mental health of young people aged 16–25 is addressed in the UK.

What we can learn from the UK experience:

- Longitudinal tracking studies of youth transitions (such as the TRACK study, Singh et al., 2008; Singh et al., 2010) offer critical evidence regarding overall system performance and the requirement for practice shift.
- The BRIDGE Program and related randomized controlled trials evaluate outcomes of transition models and offer evidence of a need for system design and practice shift.
- Implementation planning requires standards, as well as vision and policy documents, to support on-the-ground response.
- National leadership from clinician researchers is a foundation for system change (for example, Max Birchwood's leadership in Birmingham has moved international practice in responding to First Episode Psychosis). It is noteworthy that Birmingham has become an incubator and lead jurisdiction for the next wave of youth-engaging, highly accessible storefront program models in the UK.
- Youth and community engagement is critical to the development of responsive program models.
- Private foundations and Prince's Trust seeded significant youth engagement, which demonstrates the effectiveness of politically influential champions as well as the power of private-public funding partnerships.
- Establishment of National Institute for Health and Care Excellence supports building an evidence-based culture, clinical care pathways, and resources that are ready for uptake as policy and funding are aligned.

Ireland

Headstrong and the Jigsaw Communities

The Headstrong initiative in Ireland (based on the work of McGorry and the development of Headspace in Australia and carried forward through significant philanthropic contribution and leadership by Dr. Tony Bates and Matthew Hamilton) has refocused mental health policy and services in the community and on young people. In 2006, thousands of young people in Ireland were asked what they needed to better support their mental health on their journey into adulthood. Based on the findings, Headstrong went in search of best-practice models from all over the world. They developed an initiative called Jigsaw, which engages young people, service providers, and all other relevant organizations as equal partners to develop an effective response to the mental health needs of young people at the local level (see Appendix 5). Headstrong will now be receiving government funding and will need to move from the mental health promotion agenda to a greater focus on clinical service delivery.

What we can learn from the Irish experience:

- Philanthropy can be a significant catalyst to system change.
- National umbrella initiatives with rollout to regional areas support community ownership, youth engagement, and, therefore, uptake.
- Community and young adult participation in model development ensures relevance to local communities and builds responsive services and supports.
- Use international champions to inspire change and support innovation and program design.

[20] www.youthaccess.org.uk
[21] www.connexions-bs.co.uks
[22] www.4you2.org.uk
[23] www.thezoneplymouth.co.uk
[24] http://youngpeopleinfocus.fastnet.co.uk/madetomeasure/casestudies/bridging-the-gap
[25] www.right-here.org.uk

NATIONAL STRATEGY: THE CANADIAN PERSPECTIVE

Changing Directions, Changing Lives: The Mental Health Strategy for Canada (MHCC, 2012) is our country's first roadmap for responsive mental health services nationwide. Development followed a comprehensive stakeholder consultation process. This is a significant initiative as it is the first mental health strategy for Canada, offered up as a framework for provincial and territorial policy development. Until its release, Canada was the only advanced industrial country without a national strategy on mental health and addictions.

Prior to release of this document, the MHCC released a foundational framework document, *Toward Recovery and Well-Being, A Framework for a Mental Health Strategy for Canada* (MHCC, 2009b). In the addictions sub-sector, a National Treatment Strategy was prepared in 2008 (*A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy* [National Treatment Strategy Working Group, 2008]), and, more recently, an integrating strategy was developed
(*A Systems Approach: Integrating Substance Use and Mental Health Systems in Canada-Recommendations for a National Treatment Strategy* [Canadian Centre on Substance Abuse, 2013]). These are sector-developed documents rather than national policy frameworks.

Several inclusions and recommendations for action in the *Strategy* make reference to "transitions" (see sidebar). These actions are high level and will require "drilling down" to specific implementation plans and related performance indicators (as will be recommended in Section 4).

The challenge will be to ensure a collaborative, interprovincial, and interministerial "whole government" approach to fund the *Strategy's* implementation action plan and truly make a difference for young adults who desperately require supports and services. The current jurisdictional division and lack of national approach to evaluating delivery on mental health and addiction policy and related metrics will
not help meet this challenge.

PROVINCIAL/TERRITORIAL POLICIES AND PROGRAMS

Relevant policy documents were gathered for each Canadian province and territory, where available, and interviews were done with key policy personnel from the relevant ministries in all of the 10 provinces and one of the three territories. Any lines of inquiry garnered from these interviews related to provincial policies, practices, protocols, and challenges were followed. These discussions explored and confirmed the current state of relevant provincial policy frameworks for mental health, with particular focus on transitions and EA. In general, there was great concern expressed by interviewees about this issue. Although there may not be many formal policies regarding services for EA, there is movement on many different levels. Given the volume of content from interviews, key themes and catalysts have been extracted that are relevant to, or provide a foundation for, moving forward in addressing the needs of EA.

The Jurisdiction and Age Criteria

Overall, there are commonalities and variance regarding jurisdictional scope. It is a complex landscape. The findings include the following:

- The majority of provinces have separate ministries with jurisdiction for child and youth mental health and for adult mental health, sometimes, but not always, inclusive of addictions.
- Some provinces have a single accountable ministry for mental health across the lifespan (Nova Scotia, Manitoba, and Alberta); however, in most cases, separate departments within the ministry still exist for funding and managing child and youth mental health services and adult mental health and addictions services.
- There is significant variance in the degree of integration between mental health and addiction service sectors from a policy and system management perspective.
- In Ontario, high-intensity, acute paediatric beds are funded by the Ministry of Health and Long Term Care, which does not fund community-based clinical treatment.
- Even in provinces where child, youth, and adult mental health are funded through a single ministry (British Columbia, Prince Edward Island, and Nova Scotia), separate funding envelopes still exist. Different health service providers, reporting within separate accountability and funding agreements, separately administer the paediatric and adult secondary and tertiary services.

- Almost every province now has Regional Health Authorities (RHA) that are the local administrators, funders, and system managers for health services in particular geographical areas (e.g. 12 in Saskatchewan, 14 in Ontario, and 18 in Québec). In some provinces, the RHAs manage child, youth, and adult services (e.g. New Brunswick, Québec, and Prince Edward Island). In others, the RHA is only accountable for adult mental health and addictions and primary health services across the lifespan, but not mental health and/or addiction services for children and youth. These are often under a separate ministry with their own distinct regional service areas (as in British Columbia's Ministry of Child and Family Development; New Brunswick's Department of Social Development; Ontario's Ministry of Child and Youth Services, although most hospital-based services are funded by Ontario's Ministry of Health and Long Term Care). Some of these divisions of services separate child and youth mental health and addiction services from core health system funding, arguably marginalizing the CAMHAS sector and creating barriers to lifelong health planning and system design.
- At this time, Alberta has reconstituted to a central management structure to create one super-regional health authority, Alberta Health Services, with five geographic subdivisions funded centrally for health service delivery.
- For most provinces, the cut-off age or criteria for the end of CAMHAS and starting age or criteria for take up into adult mental health services is at the 18–19 year mark, with some exceptions. There is some cross-ministry variation. For example, youth who are accessing mental health services and were charged as young offenders can continue to access youth justice mental health and addiction support services until their probation/sentence is complete (which may be beyond their 19th birthday). There may be circumstances (particularly mentioned in British Columbia, Manitoba, Québec, and New Brunswick) where a youth would continue to be served by CAMHAS past the 18-year point, where specific clinical issues and comorbidities exist that place the youth at increased risk or increased vulnerability. This is not supported in policy. Generally, any youth approaching the CAMHAS after their 19th birthday would not be accepted, unless a particular transitional program for this cohort is in place (which are few and far between, currently).
- Manitoba is an exception as the transition age to adult services can extend to 21/22 years old, to allow greater fluidity in treatment/service access.
- In some regional health authorities (i.e. in Québec, notably, Laval), there is significant work being done to adapt services at a clinical level for young adults so that a transition is not forced at age 18, but this is not currently supported in policy. In New Brunswick, the health authorities hold accountability for all mental health services across the lifespan and have a robust community-based delivery model since reform following implementation of the McKee Report (2006).
- A priority concern in many provinces (New Brunswick, Nova Scotia, Ontario) is the "chasm" for youth between 16 and 18. Child- and youth-serving providers are not appropriate. For youth who have been in the care of child welfare, services may be continued. In some jurisdictions, access to medical services after one's 16th birthday would be in the adult system, while mental health services would still be available at some paediatric hospitals. This creates confusion and a complex journey for youth with mental health issues who have comorbid physical health issues and cannot receive treatment from the same facility. Symbolic of the full rift in services, it is unclear whether child and youth or adult services are responsible for mental health services during the transition out of the care and support delivered through child welfare services, which happens at different

RECOMMENDATIONS FOR ACTION

Improve coordination and collaboration between and across mental health, health, addictions, and other service systems for people of all ages, and provide tools and supports for navigating the system. (p. 63)

Youth with severe and complex mental health problems and illnesses face additional barriers in access to intensive services, treatments and supports. Many fall through the cracks when they get too old to be served by the child and youth mental health system. They can lose access to youth services that are not always available in the adult system and can also experience gaps in service because their move to adult services has not been properly organized. (p.# 67)

Remove barriers to successful transitions between child, youth, adult, and seniors' mental health services. (p.# 69) (Recommendation 3.3.5.)

Up to 70 per cent of mental health problems and illnesses begin in childhood or adolescence and as many as three in four children and youth with mental health problems and illnesses do not access services and treatments. Children who experience mental health problems or illnesses are at much higher risk of experiencing them as adults *(Continued...)*

ages in different provinces, with uneven resources available after the age of 16. Northwest Territories is in the process of extending service agreements and delivery to youth in care to age 24, with the required legislative amendments.

Policy Context for Transitions and Emerging Adults

Most provinces and territories have developed, or are in the process of developing, a compelling mental health and addiction strategy. In many cases, a provincial plan or strategy has been developed for reform and forward movement, followed by an "Action Plan" or "Implementation Strategy" identifying more specific targets and outcome indicators, and often with expectation for subsequent annual reporting.

In some cases, there is specific mention of lifespan transitions, including youth to adult and adult to senior (see Appendix 1). In some provinces, the child and youth and adult strategies are separate, rather than integrated (i.e. Ontario and British Columbia). Many provinces have prioritized youth mental health, not generally including addiction/substance use, despite mention of the prevalence of concurrent disorders. Policy initiatives by province have been included in Appendix 1. Overall:

- Child and youth mental health, including approaches to prevention, resiliency building, and early intervention is included as a general priority area in all provincial policy documents, but may not be included in related action plans. Based on jurisdictional definitions, "child and youth" policies would pertain to those up to the age of 18.
- Specific reference to "emerging adults" or "transition-aged youth" is not made in any of the policy documents, although age of onset of major mental disorders is generally identified as being during this critical developmental phase. The importance of "barrier-free" transitions over the lifespan is mentioned in several documents, but with limited follow-through in implementation or action plans.
- Interview data and provincial strategy documents indicate that many provinces are "on the cusp" of giving priority to the EA population, driven by the concern about youth suicide, increased prevalence of mental illness, age of onset, and heightened awareness of the issues for youth as they become adults. Often "youth" are mentioned, but it is not clear what demographic this refers to as the age range is not defined, but generally assumed to mean up to the age of 18, so exclusive of a significant cohort of EA.

There appears to be no province/territory currently calculating investment across the full continuum or attempting to understand the economic cost or long-term benefit of enhancing the system to respond to EA needs. Similarly, current data regarding access, waitlists, use, and disengagement are not collected or available as a baseline for performance monitoring, system change, quality improvement, or outcome evaluation.

Policy frameworks and actions plans are "under construction," so rollout in local areas is inconsistent. Local area health authorities may or may not have prioritized EA. Outcome metrics for those policies that specifically refer to youth and lifespan transitions are not included in most cases (except New Brunswick and Standards in Nova Scotia). In some cases, the development of transitions protocols was a starting place, while in other provinces, other catalysts have mobilized action.

Most provincial representatives interviewed identify significant concern with the EA cohort and there is heightened awareness of the complexities of the transition between CAMHAS and AMHAS. Interviewees understood that multiple ministries are required to collaborate in transition-planning processes and saw this as "challenging" and "daunting" given the size of the population in any jurisdiction (up to 20 per cent of EA).

and are also more likely to have other complicating health and social problems.

A recent report in the U.S. estimated that the lifetime economic cost of childhood mental health disorders was enormous–$2.1 trillion, which with our smaller population would roughly translate to $200 billion in Canada. (p. 125)

- (Excerpted from *Changing Directions, Changing Lives* [MHCC, 2012)

New evidence continues to emerge regarding the increasing prevalence of depression and anxiety in the 16–25 year old demographic (CAMH, 2014) and deep concern about chronic youth unemployment, increased suicidal thoughts, the prevalence of harmful addiction use, and the lack of resiliency of young people in Canada. However, the walk hasn't caught up with the talk in terms of policy directives to mobilize change on the ground.

Provincially Mandated Transition Protocols and Guidelines

Many provinces have developed transition policy frameworks and related protocols for children and youth with "special needs" moving into adulthood, which often pertain to the transition from school to post-secondary community involvement. The focus is generally on youth with developmental disabilities, complex physical disabilities and chronic health needs. In several of these protocols, mention is made of the involvement of adult mental health services "as relevant or appropriate," with minimal specific directives regarding roles or tools. Most provinces do not have specific policies or procedural guidelines relating to roles, responsibilities, or protocols for the transition process from child and adolescent to adult mental health services. No specific resources to support transitions were reported, except for some new initiatives to support transitions of youth out of care (e.g. Connected by 25 in British Columbia, Youth in Transition initiative in Ontario).

Manitoba has led the way by developing transition protocols for youth with complex or special needs that have been built on by other provinces (Alberta and British Columbia). Manitoba has had transitional protocols in place for longer than any other province (Healthy Child Manitoba, 2008). Protocols exist to encourage and ensure collaboration and have funding tied to them. Youth providers and adult providers are required to begin meeting when a youth is 15 years old. The protocol loosely outlines how child and adolescent sector workers are to connect with adult workers, how housing and employment are to be addressed, and when transition committees need to be established in particular cases. There is no protocol specifically for transition of the general CAMHAS population, rather they are included in the broad policy scope, and adult mental health services are to be involved "to conduct eligibility assessment" and to "provide services as appropriate."

In British Columbia, a *Cross-Ministry Transition Planning Protocol for Youth with Special Needs* (British Columbia Government, 2009) was developed, including agreement between nine government departments regarding roles and supports for the transition to adulthood of youth with special needs.

Overall, across Canada, policy personnel indicated that although these protocols are in place, there is much work to be done with regard to implementation at the regional level. Some regional health authorities have taken a particular interest in developing protocols to ensure transition processes are in place, but they have tended to be limited to the institutional transfer from a regional paediatric centre to the adult mental health facility in that region (e.g. Capital District Health Authority in Halifax, HS; Hospital for Sick Children in Toronto has developed the G2G [Good to Go] Transition Program with associated tools and protocols). The Champlain LHIN in Ontario, which has been noted earlier in this document as an exemplar, is a protocol as well as a collaboratively based transition management process that has increased engagement (The Ottawa Transitions Project); however, the lack of capacity in the adult system is of deep concern and is having an impact on uptake.

Many provincial transition planning guidelines are focused on the transition of special needs youth out of the education system (Manitoba Children and Youth Secretariat, 1999; Nova Scotia Department of Education, 2005; Saskatchewan Ministry of Education, 2001). In Alberta, the Report of the Advisory Committee on Transitions for Youth With Disabilities (*Transition Framework for Youth With Disabilities*) was published in 2003 and has also led to the development of the *Transition Planning Protocol for Youth with Disabilities* (2007). Alberta Health Services (the delivery arm of Alberta's Health and Wellness ministry, which holds the policy pen) has established a working group that is currently developing protocols and standards around mental health and transitions.

What is clear is that, despite provincial cross-ministerial protocols being developed, implementation is inconsistent.

In British Columbia, for example, the roll out in 2002 led to protocol development between regional health authorities and the regions of the Ministry of Children and Family Development. Although these are generally consistent, there are some differences. In addition, a review of the effectiveness of the Mental Health Transition Protocol Agreements (2002) was completed in 2012 with a commitment to development of future protocols.

New Brunswick has a regional transition team in place for children and youth with complex mental health and other needs. They have a defined process for elevating the cases of youth with complex mental health needs that cannot be addressed;

they go to a regional table of senior clinicians and decision makers and then to a provincial table, if service organizations are unable to find collaborative local solutions.

The recent New Brunswick Action Plan (2011–2018) includes an action item to create an interdepartmental case management process to ensure continuity of service to all persons living with mental illness (1.1.3). The service model was intended to target 400 hard-to-serve youth by 2013 across the transition to adulthood (Government of New Brunswick, 2011). This Integrated Service Delivery approach is being implemented and evaluated in New Brunswick schools with multi-ministry support and a range of services delivered within schools.

Nova Scotia is the only province with specific provincial standards around mental healthcare delivery and it recently developed indicators for performance and accountability for the transitions process (Government of Nova Scotia, 2009). In Halifax, which is the provincial centre for specialist services, the IWK Pediatric Hospital and the Capital Health Centre have developed specific guidelines, protocols, and tools for the transition of youth to adult services. The guidelines include a Transfer of Care Process flow chart (see Appendix 6), Complex Case protocols, and "key principles" (Hennen et al., 2012).

Despite the clearly identified need for transitioning processes, protocols, care, and supports, no province has accepted transitional care as a core service component for young people. Certainly the barriers have been well documented. It is a complex process to implement transition protocols. The focus continues to be on gathering evidence of need and not gathering evidence of effective implementation and outcomes for youth.

Strong provincial transition protocols and processes, as well as learnings from the UK with respect to transition protocols, are integrated into recommendations at the provincial and regional levels (see Section 4).

The Catalysts of Policy Reform

In reviewing provincial/territorial policies relating to transitions across Canada, there are initiatives and/or actions that have been taken by some provinces, which are highlighted as effective drivers of policy change to respond to the needs of EA. Some of these strategies, in particular where they align with learnings from the international scan, are included below.

Policy and Implementation Champions: Several provinces have appointed a lead or commissioner for mental health, either for children and youth (as in Prince Edward Island's Chief Mental Health and Addictions Officer), as an advisor for mental health (Nova Scotia's Special Advisor on Mental Health), or to "lead the mental health strategy to action" (e.g. Saskatchewan has appointed a Commissioner to advise the Minister, and work with a committee to oversee the development and implementation of the interministerial plan).

Call to Action Driven by an Urgent Priority: In several provinces, a high profile, urgent mental health issue has driven policy response. As was observed in the New Zealand experience, concern with suicide rates of youth, and aboriginal youth in particular, has driven some provinces to develop a suicide prevention strategy. In British Columbia, for example, *Strengthening the Safety Net: a report on the suicide prevention, intervention and postvention initiative for BC* (Joshi, Damstrom-albach, & Ross, 2009) put the issue on the public agenda. Northwest Territories and Alberta also developed specific provincial suicide prevention strategies (Alberta Mental Health Board, 2009; Government of Nunavut, 2011). In Saskatchewan, suicide prevention was identified as a significant concern and is now monitored as part of the Annual Ministry of Health Plan (Ministry of Health and Healthcare System, 2014). In Alberta, the 2006 Suicide Prevention Strategy (updated in 2009) has led to policy development as well as the creation of the Pathways for Depression project in the province.[26] Ontario's Youth Suicide Prevention Plan was to be launched in the fall of 2013, but was not released, as suicide prevention and early intervention initiatives have been included in Ontario's Comprehensive Mental Health and Addictions Strategy (2011), which has focused on children, youth, and, more recently, on youth in transition to adult services (Ministry of Health, 2014 expanded strategy).

In New Brunswick, pressure and concern from the New Brunswick Child and Youth Advocate on the situation of children with complex needs (see their report, *Connecting the Dots*, Child and Youth Advocate, 2008), as well as response to the *Ashley Smith Report* (Ombudsman and Child and Youth Advocate, 2008), drew attention from policy makers. Subsequently, the provincial government issued *Reducing the risk, addressing the need: Being responsive to at-risk and highly complex children and youth* (Government of New Brunswick, 2009), setting out possibilities for integrated service models for children and youth.

[26] http://www.albertahealthservices.ca/7538.asp

In Québec, the *Plan d'action en santé mentale* (Ministère de la Santé et des Services Sociaux, 2005) focused on ensuring equitable access to primary care and other ancillary services, including mental health services, for all Québecois. The plan specified the number of full-time primary care and complementary mental health services for children and youth to be funded per 100,000 population. At the time of this policy release, the inequity of access to primary care was highlighted as an urgent priority. The 2013–2020 plan will highlight directives related to access to evidence-based clinical services for children and youth and required supports as well as mandated protocols to be followed during transition.

Families Matter: a Framework for Family Mental Health in British Columbia (British Columbia Ministry of Health, 2012) is a core policy document that reflects the foundation for health promotion and prevention from a family perspective and was developed following significant pressure by a provincial family advocacy group, the F.O.R.C.E.[27] Society for Kids' Mental Health.

Much attention is currently being paid to young adults in post-secondary institutions and their vulnerability to suicide and the onset of mental health problems or illnesses. In British Columbia, the Healthy Minds, Healthy Campuses Initiative[28] has been implemented. In Ontario, the Jack Project[29] has increased awareness and a two-phased initiative has been announced recently to address the needs of post-secondary students experiencing mental health issues. This initiative is funded by Ontario's Ministry of Health and rolled out through the Ministry of Training, Colleges and Universities (MTCU), which also supports projects on 11 university and college campuses, generally to connect students to existing resources, which, as indicated, have limited capacity to address the needs of EA. These investments are related to provincial initiatives and specific funding envelopes (e.g. in Ontario, MTCU investments associated with the province's Comprehensive Mental Health and Addictions Strategy Child and Youth Mental Health Strategy).

Mandated Service Models: Some provinces have included directives at the policy level so that service responses have been implemented at a province-wide level. Essentially, such policy directives indicate that certain program offerings must be delivered in every health region.

For example, policy has directed the standard development and implementation of early intervention in psychosis programs in several provinces. Although the timing has varied across Canada, currently Nova Scotia, New Brunswick, Québec, Ontario, and British Columbia have province-wide directives, as well as service standards and fidelity requirements for operation of these programs.

Based on clear provincial policy directives, school-based universal prevention programs have been implemented, building resiliency and addressing the needs of EA as early as possible. Examples include:

- British Columbia's implementation of Friends for Life[30] is available in every school district and in First Nations' schools).
- Alberta's roll out of Mindmatters throughout the education sector.
- Manitoba's implementation of Roots of Empathy,[31] Seeds of Empathy,[32] Paths to Pax,[33] and currently a randomized controlled trial on implementation of Triple P Parenting,[34] focused on building protective factors against anxiety, depression, and suicide.

In several provinces, there are policy directives and related funding for community-based clinic approaches, which often have less concern for age criteria and focus on equitable access to primary care and mental health services (generally targeting mild and moderate severity). The clinic model has been established for youth in British Columbia (mostly in marginalized, high-need urban areas), for mental health across the age span in New Brunswick, and for primary care and mental health in Québec (Centre de santé et de services sociaux) for persons with mild and moderate mental health needs. Recently the Family Care Clinic initiative has been funded in Alberta, including nurse practitioner led primary care centres with mental health components. These are currently being piloted in three different communities with vulnerable populations.

The designated system design for access to health and associated services in Manitoba also includes a one-stop, one-

[27] Families Organized for Recognition and Care Equality
[28] http://healthycampuses.ca
[29] www.thejackproject.org
[30] www.mcf.gov.bc.ca/mental_health/friends.htm
[31] www.rootsofempathy.org
[32] www.seedsofempathy.org
[33] www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-prevention-and-early-intervention/Paths/index
[34] www.triplep.net

door access centre at regional and sub-regional health services centres, which include teen clinics as well as referral access to mental health services across the lifespan.

Provincial Reform Agenda: A significant reform process was initiated following the release of *Together into the Future: A Transformed Mental Health System in New Brunswick* (McKee, 2009),which directed a significant shift to recovery-oriented community-based care. This resulted in ground breaking policy directives in both child and youth and adult sectors. Some of the components of this initiative are:

- a clear "action plan" identifying specific goals and timelines;
- residential treatment services for children and youth with the most serious disorders;
- a new multidisciplinary service delivery model for at-risk youth;
- expansion of early psychosis intervention services to provincial reach;
- Integrated Service Delivery in schools; and,
- youth concurrent disorder teams.

Public/private collaborations: The Graham Boeckh Foundation (GBF) in Montréal has spearheaded the Transformational Research in Adolescent Mental Health (TRAM) initiative.[35] This is a joint initiative funded by Canadian Institutes of Health Research and GBF (each contributing $12.5 million over five years). The initiative will identify proven practices and establish a pan-Canadian network to better serve the mental health needs of adolescents and young adults through the development of innovative, transformative program models.

Laing House in Halifax is another organization seeded by private citizens and now funded by public and private funds. They are a peer and psychosocial support organization for youth from 16–30 with mental health problems or illnesses. In Toronto, Stella's Place has just started fundraising to open a storefront centre with robust clinical services for EA with mental health and addiction issues. Notably, EA with mental health issues and their family members initiated all of these initiatives and programs.

Provincial/Territorial Initiatives

Based on policy and research review, as well as interviews with provincial/territorial leads, a number of initiatives were identified that are worthy of inclusion and which contribute to the recommendations in Section 4 of this document.

Priority Population Designation: In some provinces, and across health authorities, attention is being paid to young adults in response to community need and priority identification in some provincial policy documents. In Ontario, for example, each of the 14 Local Health Integration Networks (LHINs) is responsible for identifying priority areas to respond to in an Integrated Health Service Plan. Currently, three LHINs have specific initiatives underway to address the mental health needs of transition-aged youth, based on designation of this demographic as a priority population. These initiatives are described in Appendix 7.

Program Model Development: A number of provincial leads confirm a disconnection between what children are able to access in the CAMHAS sector and what programs and services are actually available in AMHAS. This contributes to the disengagement of youth as they are either not referred for service or there is no appropriate service that will accept them or engage them on their terms in the adult sector.

Several programs and collaborative initiatives are worthy of mention. The very few Canadian program models that have been developed to address the needs of EA are included earlier in this section (e.g. Inner City Youth Mental Health Team, Vancouver, BC; First Episode Mood and Anxiety Program, London, ON). Others are under development in single jurisdictions, often as a result of family advocacy and private fundraising (e.g. Stella's Place and the Slaight Centre for Youth in Transition out of CAMH, under development in Toronto, ON). Others offer psychosocial or community support but may not address more comprehensive clinical assessment and treatment needs (e.g. Laing House in Halifax, NS; Staying Connected Mental Health Project, Halifax, NS; Youth in Transition Workers, ON; Youth Wellness Clinic, Hamilton, ON; LOFT, Toronto, ON; Y Connect, North York, ON; Connect by 25, BC; Land-based Healing Program, Kwanlun Dun First Nation, Whitehorse, YK; Choices for Youth – Bridging the Gap program, St John's, NL; La Maison Dauphine, Québec City, QC).

[35] www.tramcan.ca

With respect to core service responses that are dedicated to EA, and which are intentionally building youth-engaging and developmentally appropriate clinical and psychosocial supports, there are only isolated examples of program approaches. There is no operational program model in Canada that addresses the multidimensional needs of EA.

Cross-sector and Collaborative Work: Several interministerial initiatives have been undertaken to build collaborative, cross-sector policies and protocols and support the development of collaborative local responses to transitions and addressing the mental health needs of EA.

Several provinces have developed high-level interministerial tables and advisors to ensure the required horizontal responses. Some relevant initiatives are:

- British Columbia has developed a provincial mental health and substance use planning committee, made up of mental health and substance use leads, medical directors of the health authorities, and representatives from the Ministry of Health and the Ministry of Child and Development.
- Saskatchewan has developed a high-level, integrated, horizontal approach to addressing identified mental health priority issues through a Special Committee of Cabinet.
- Manitoba has a Healthy Child Secretariat and a Healthy Child Committee of Cabinet that includes 10 ministers responding to issues collaboratively. In both instances, leadership from these influential tables has had significant impact.
- New Brunswick's Integrated Service Delivery Model for youth with complex needs, led by the Department of Education and Early Childhood Development, in partnership with the Departments of Education, Health, and Public Safety, will close service gaps, including residential services for youths 16–18, by developing a new multidisciplinary service delivery model for youth at risk.
- In Prince Edward Island the government will be establishing a mental health and addictions advisory council, comprised of both government and community members. This came out of the recent Review of Mental Health and Addictions Services and Supports.

In other provincial jurisdictions, collaborative initiatives at the provider level have been initiated, sometimes through direct single or cross-ministry funding and sometimes through funding to a provincially mandated mental health service provider. Examples include:

- Alberta's Regional Collaborative Service Delivery Model that provides mental health services in the school environment, ages 0–20.[36]
- British Columbia's health authority-level collaborations that have evolved organically and are based on locally identified needs.
- Ontario's 18 Service Collaboratives, which have been funded to manage transitions between inpatient/outpatient, health and justice, and CAMHAS and AMHAS sectors. Focused activity of four of the collaboratives relates to transition-aged youth, specifically:
    - Simcoe-Muskoka Collaborative: implementation of the Transition to Independence Process model in order to develop and enhance local services for transition-aged youth

"Everybody is aware that we should be working harder at developing services for that group"

"There are barriers with the adult system not always feeling comfortable with dealing with young people. I would say that some clinicians are more comfortable than others with adolescents and older adolescents. And certainly with things like some of the neurodevelopmental disorders, like autism, the adult system really tends to shy away from that."

– (Provincial Government Interviewee, personal communication, 2013)

[36] http://education.alberta.ca/teachers/resources/connection/archive/october-2012/other/regional.aspx

- Waterloo-Wellington Collaborative: transitions from youth to adult services within addiction and mental health services, and postsecondary transitions
- Hamilton Collaborative: age-related transitions, access/connectivity to service for youth with the most complex needs, and system navigation for multi-service and system-involved youth
- Kingston Frontenac, Lennox and Addington (KFL&A) Collaborative: development of a clear pathway and protocol for youth aged 16–24 with mental health and/or addictions issues

PRIORITIES TO ADDRESS GOING FORWARD

Provincial representatives who were key informants during the policy review phase, were asked to identify priority areas for policy development and action, which may or may not represent the view of their home ministry. These have been aggregated and themed across provinces and contribute to the identification of recommendations in Section 4. The key priorities to address include:

Interministerial Collaboration to Embed Protocols and Address the Chasm

- Continue movement towards greater cross-ministry service integration and response to the needs of EA (specifically Health, Education, Human Services, Social Services, and Health, Solicitor General).
- Enhance interministerial communication, given that youth with mental health problems or illnesses require services in multiple domains and multiple ministries provide the funding for these services.
- Integrate mental health and addictions across ministries and throughout the lifespan and increase the prominence of integrated concurrent disorder responses in youth and adult systems.
- Develop standards of care for youth with concurrent disorders who are excluded from child, youth, and adult services.
- Embed transition protocols for youth with serious mental disorders in policy and legislation.
- Implement transition protocols (and develop them where they don't exist) through developing agreements on who is accountable for delivery at the health authority level and between authorities, funding ministries, and providers.

Developmentally Based Service Criteria

- Build service criteria, transition practices, and services that take brain plasticity and development into account; expand adolescent age criteria so that person, not system, criteria drive transition timing.
- Eliminate the service split at age 18, working through the separate financing and systems to adapt services and build in policy support for that momentum towards a life span approach.

Cultural and Administrative Differences

- Address the misalignment between criteria for services for those up to 18 (based on a variety of presenting emotional and behavioural issues) and the criteria for access to the adult mental health and addiction sector (i.e. diagnosable mental disorder or hazardous addiction).
- Address the cultural differences between sectors. For instance, the child system is often family-centred and offers a range of services for a wide variety of mental health problems or illnesses; the adult system is client-centred, often not family-inclusive, and generally offers services to a more restricted and higher acuity and severity population.
- Address confidentiality and consent practices that unnecessarily inhibit data sharing and interministerial collaboration (this is not to suggest changes to PHIPA requirements, but increased attention to achieving consent to collaboration with families and between services in support of a young adult).
- Encourage partnerships and cross-lifespan delivery because agencies often do not "speak the same language" and operate independently, resulting in disorganization across the transition boundary.
- Develop and support regional service collaboratives related to transitions in order to build locally relevant service responses for EA.
- Educate mental health professionals to develop particular skills to work with EA and to recognize and respond to developmental needs and concurrent disorders.

- Develop effective engagement strategies to increase access and retention by EA.

Data Collection and Accountability

- Identify and begin reporting on common data elements to track and evaluate progress across the transition threshold. This could include electronic medical records to track individuals across services, and/or use of software platforms such as the Level of Care Utilization System for Psychiatric and Addiction Services[37] to assess clinical need and level of care required across transitions and across the lifespan.

Service to Priority and Vulnerable Populations

- Enhance service to First Nations, Inuit, and Métis (FNIM) communities where there are particular challenges due to jurisdictional issues. Sort out the federal/provincial accountabilities so that services being deployed to communities with large FNIM populations break through these access issues. Incorporate cultural diversity into service principles, design, and delivery.
- Ensure attention to local and provincial priority populations who are identified as significantly at risk and vulnerable, and design policy and service responses to address their needs urgently.

Service Capacity

- Address service capacity issues for EA cohort: "You can have a person who can help to navigate, but if there's no services to navigate to—you still have a transitions problem." (Mental Health Policy Lead, Provincial Ministry of Health)
- Increase the number of EA competent professionals providing mental health and addictions services.
- Identify the core services required in each community and ensure clear and visible access pathways to these services, including seamless access and specific transition protocols.
- Build resources for youth and families to navigate transition and address the concerning dropout rate after 18th birthday.
- Build policy frameworks for universal access to evidence-based interventions and to specialized first-episode interventions for psychosis and other major disorders.
- Address the lack of technologically current and age-appropriate outreach, engagement, and service approaches, including access and service delivery in EA-appropriate locations (i.e. schools, shelters, employment, and community centres).
- Address the inequities in capacity and practices outside urban areas, in particular for specialist mental health services.
- Identify who needs the most intensive levels of specialist care and build a protocol for access to residential, partial hospitalization, and inpatient care for EA.

"Families need to understand what's available and who provides it. We need to have really good working protocols and documented pathways between and among all of those things, and then we need people to know what they can expect – we have some expectations and standards and data to track how well we're doing. And when you put it all together, then you have a more seamless service system."

– Director, Provincial Children and Youth Ministry

[37] http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/locus.aspx

KEY POINTS FROM SECTION 3 TO TAKE FORWARD:

- Models for responding to transitions and EA include:
  - *system design models*, which aim to ensure a continuum of multidimensional service responses is available and
  - *transition management models*, which focus on facilitating effective bridging between CAMHAS and AMHAS to ensure continuity of care through the transition and engagement with adult providers and systems.
- Transition interventions include evidence-based and specific clinical treatment and/or skill-building approaches that impact on individual level outcomes (e.g. skills development, mental health improvement, engagement in service, reduced hospitalization, educational, and vocational).

KEY LEARNINGS FROM INTERNATIONAL SCAN INCLUDE:

- robust policy with clear priority on youth and young adults and ring-fenced funding supports development of specialist EA services;
- high-profile, national champions with political influence, academic and clinical credibility, and international scope impact policy and practice;
- identification of urgent poor health outcomes mobilizes policy development and accelerates funding;
- national research and training initiatives drive program development, but need to go beyond time-limited "demonstration" funding;
- nationally funded, knowledge exchange hubs help to mobilize evaluation, research, and performance improvement; and,
- shortcomings in data collection and outcome evaluation limit opportunity for monitoring system performance.

IN CANADA:

- There are no specific policy initiatives directed at EA as a priority group, although all provinces prioritize "children and youth," which is generally understood as the up-to-18 demographic.
- Catalysts of policy reform and investment in youth-related initiatives are documented, as well as effective collaborative practices that enhance multi-sector responses.
- Policy directives and protocols for transition are not yet implemented for youth with mental health problems or illnesses in most provinces, although they may have been developed for "special needs" youth in transition.
- Beyond first-episode psychosis programs and school-based universal prevention programs, which have been mandated and implemented in several provinces, no other service delivery models or required core services for EA, are specifically identified in any provincial policy in Canada.
- Current initiatives and priority areas identified by provincial/territorial policy leads are summarized and will be incorporated in recommendations in Section 4.

Section 4
A Responsive Mental Health System for Emerging Adults

We have confirmed the need for a multi-level systems approach to emerging adults (EA) through an extensive review of research, policy and program documents, and interviews with key provincial policy personnel and EA. Our recommendations in this section are very detailed, offering a vision for an integrated and effective policy response. Some of these recommendations are being implemented in some jurisdictions. The subtitle of this report is "building a responsive mental health system for emerging adults," and the key word is "building." It will take time, leadership, and care to build more effective and responsive service delivery systems. This section will elaborate on the many different parts of the plan that needs to be built (also see *Figure 2*).

Essentially, the current state, requiring a full response, is:

- No Canadian province has fully implemented transitional protocols for EA.
- There is no policy requiring that health authorities and providers follow the protocols that do exist.
- No Canadian province is tracking youth across the transition or reporting on engagement of this age cohort post transition or following first contact with adult mental health and addiction services.
- No Canadian province or territory has designated community- or hospital-based specialist clinical services for EA.
- Few provinces have implemented evidence-based approaches to transitions management or EA clinical service delivery approaches.

Based on inputs from the research, policy, and practice scan, this section proposes a framework to build a responsive system. Taking the systemic perspective, the alignment requirements are articulated in some detail below. Some key foundations to effectively address the needs of EA in transition include:

- a national mental health and addictions strategy and action plan identifying EA as a priority population;
- a provincial policy framework and action plan identifying EA as a priority population to guide mental health and addiction system planners, policy makers, and service providers;
- an integrated, provincial, tier-based mental health and addictions continuum of services for all adults, including EA;
- core EA service principles as a starting place for the development of service standards and practice guidelines (see Section 2); and,
- an articulation of system supports to ensure accountability and performance, including a transitions strategy; guidelines and protocols supported by national, provincial, and regional policy; strategy and action plans; a dedicated funding envelope; performance measurement and quality assurance (including minimum data set); and a research and knowledge transfer and exchange strategy.

"I just needed to talk to somebody about everything that was going on. And there just isn't appropriate access to psychologists, in my opinion, here. But, yeah, and like I said, I was talking to a psych nurse, and I said, 'Is my doctor just going to shove pills down my throat?' and she said, 'Yes,' and I said, 'Well, thank you for your services' and then I walked out and never went back."

– Aaron Goodwin, Youth Participant (Cappelli et al., 2012)

THE INTEGRATED MENTAL HEALTH AND ADDICTION SYSTEM

In order to effectively address the needs of EA transitioning to, or requiring access to, adult mental health and addiction services, a principle-based, integrated, accessible, and responsive system needs to be in place, embedded in provincial policy.

Guiding Principles

Despite the lack of explicit empirical support, promising transitional programs, like the *headspace* program in Australia and the US's Transition to Independence approach (TIP) being implemented across North America, ascribe to a well-articulated set of principles that are the foundation for effective practice (Clark, Pschorr, Wells, Curtis, & Tighe, 2004; Haber et al., 2008; Hagner, Cheney, & Malloy, 1999; Koroloff, Pullmann, & Gordon, 2008; Muir et al., 2009). These principles underline the requirement for working differently with this cohort.

At the October 2012 Summit, *An International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model* (Cappelli et al., 2012), a collective vision statement was developed by participants that increased the scope of the project beyond "effective transitioning across the chasm." It was at this think tank session that the systemic framework and the need for a broadened view was articulated and received consensus support from a group of close to 50 international experts (see Appendix 2 for List of Participants).

In addition, key principles were developed that should be reflected in any transitional services policy and service model. Grounding any service planning and implementation in collaboratively developed guiding principles is a starting place, especially in the absence of service guidelines, standards, and performance metrics. These key principles fall under five distinct themes and are "cohort specific":

"Our goal is to foster confidence and self-determination throughout transitions to help young people and emerging adults move toward their visions of success. Mental health and addictions care will be resiliency focused and propelled by the needs AND strengths of young people, families, and communities."

– (Cappelli et al., 2012)

1. Responsive

Services are responsive to the needs of youth and EA, and;

- are built around individual needs and strengths;
- honour and promote self-determined goals;
- acknowledge the importance of cultural and individual variables in peoples' lives;
- cross transitional domains;
- reflect the ability of systems (e.g. child and adolescent mental health and addictions services /adult mental health and addictions services , hospital/community), researchers, and care providers to work collaboratively to deliver services;
- are proactive;
- are fluid, coordinated, seamless, and invested; and,
- help people flourish.

2. Developmentally Appropriate and Family Connected

The transition between adolescence and adulthood is a complicated developmental period and happens at different rates for different people. As a result, responsive services are:

- flexible;
- appropriate to an individual's developmental age;
- based on a youth's readiness to progress;
- made in the context of the broader understanding of the individual, their relationship with themselves, their peers, and their level of family/ community involvement;
- focused on education and skill development, titrated to developmental milestone; and,
- informed by a collaborative spirit that encourages family engagement when possible and appropriate.

3. Youth Engaging and Peer Driven

All transitional services, EA specialist services, and CAMHAS/AMHAS that treat, serve, and/or support EA:

- reflect the voices of EA;
- provide EA with choices and help empower them in their decision-making processes;
- mobilize supportive networks present in the lives of young people (e.g. friends, teachers, parents, peer ambassadors, and mentors) when it is in the best interest of the young person (health professionals can facilitate this process);
- are communicated in youth friendly ways using youth preferred communication modes; and,
- include opportunities for EA to offer and receive support to and from their peers.

Research and innovation should be driven with the help of youth voices. Professionals should develop appropriate knowledge exchange strategies that are accessible to young people and that use available and developing technologies to support engagement, learning, and continuity of service.

4. Informed

All transition protocols, services, EA specialist services, and CAMHAS/AMHAS that treat, serve, and/or support EA:

- include enhanced education, training, and research capacities to support effective transitional care;
- improve training and education for professionals regarding the developmental needs of EA and factors that promote readiness for transition;
- promote educational and training needs of peer ambassadors, mentors, and coaches;
- include a dimension of accountability on the part of researchers and administrators;
- strive to identify critical research questions and appropriate outcome variables, encourage collegial interactions and collaborations between research groups, evaluate our programs, and identify best practices;
- allow for the participation in knowledge exchange activities that identify both the strengths and weaknesses of our practices; and,
- are anchored in best practice guidelines and oriented around identifying evidence-based practices.

5. Recovery-oriented

All transitional services, EA specialist services, and CAMHAS/AMHAS that treat, serve, and/or support EA:

- are resiliency-building, recovery-based, and peer-inclusive;
- consider wellness, health, and meaningful role outcomes, rather than being limited to service engagement and symptom management/relief;
- commit to and demonstrate EA-driven individual and program practices;
- offer opportunities for youth to be involved in community building with their peers; and,
- advocate for and support EA in self-advocacy to ensure their needs are understood, and self-identified outcomes are achieved, within a framework of hope, meaningful roles, and recovery.

> The concept of recovery refers to living a satisfying, hopeful and contributing life, even when there are on-going limitations caused by mental health problems and illnesses.
>
> (MHCC, 2012)

The Continuum Concept

The World Health Organization (WHO) articulates the need for continuum of care as a response to fragmented service delivery across the lifespan (WHO, 2003). A continuum framework, however, will also require "an investment of financial resources and the training of professionals to utilize the spectrum of services included in a continuum" as well as system capacity enhancements, based on epidemiological data (WHO, 2003). WHO also identifies the importance of incorporating practice guidelines or practice parameters within a full continuum of services.

The Mental Health Commission of Canada's (MHCC) former Child and Youth Advisory Committee and international experts on youth mental health align in the unequivocal message that specific services that are responsive to the emerging adult age cohort are a key requirement of an effective system.

The MHCC recommends a tiered approach to the continuum of services (referred to in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, 2012). This tiered approach is also clearly articulated in *A Systems Approach to Substance Use in Canada – Recommendations for a National Treatment Strategy* (National Treatment Strategy Working Group, 2008), Saskatchewan's *Mental Health and Alcohol and Drug Misuse Services: Framework for Service Delivery* (Saskatchewan Ministry of Health, 2012), *Creating Connections: Alberta's Addiction and Mental Health Strategy* (Alberta Health Services, 2011), and *The Action Plan for Mental Health in New Brunswick 2011-18* (Government of New Brunswick, 2011).

The concept of a tiered framework has been included in many provincial mental health and addiction service strategy documents (Saskatchewan Ministry of Health [2012]; Alberta Health Services [2011]; Government of New Brunswick [2011, 2013]; National Treatment Strategy Working Group [2008]; British Columbia Ministry of Health Services [2004]). These frameworks are built to accommodate the needs of any individual age 16 or older when accessing services for the first time. As those 16 and over are often dealing with the emergence of major adult disorders, it is appropriate that these EA should be served by organizations funded within the AMHAS envelope, as they will need access to the full spectrum of services. These organizations, however, need to be EA competent and, as indicated, EA-specific services need to be included at each tier of the continuum.

> While there will never be a "one-size-fits-all" solution, it is important to reduce fragmentation and achieve better integration of services. In order to identify the areas requiring the most attention, it is helpful to think in terms of different "levels" or "tiers" to the system. Such an approach allows us to focus both on the settings where services are located and on the level of intensity of service. It provides a way of thinking about how to improve the flow and efficiency of mental health-related services, so that people are able to access the most appropriate and least intensive services, treatments or supports required to meet their needs.
>
> *- Changing Directions, Changing Lives* (MHCC, 2012)

THE FULL CONTINUUM TO SUPPORT A SYSTEM APPROACH TO EMERGING ADULT MENTAL HEALTH

The following continuum of services will support a system approach to EA. The continuum identifies specialist service responses and requirements of each of the tiers in order to meet the needs of the EA (see Figure 3), and is adapted from continuum-based models from a number of provincial strategy documents.

It is crucial to understand that a tiered continuum assumes seamless movement through levels of intensity or service, based on needs, rather than individual assignment to a tier. A flexible system is able to ensure access to a required tier at any given time, based on individual needs, complexity of situation, and service intensity requirements.

The following sub-sections give a fuller explanation of the tiers of the continuum.

Tiers

Universal and primary or first-contact responses (Tiers 1 and 2 respectively) are to be delivered by primary care, education, and community partners; specialist responses (Tiers 3, 4, and 5) are to be delivered by mental health and addictions

sector services designed to address EA specifically. In all tiers, system navigation and peer support and mentoring for the EA cohort need to be available, as well as prevention and wellness promotion initiatives to maximize resiliency and skill development. To facilitate access to, and engagement with, more intensive specialist services, youth-engaging "front doors" with embedded services are needed. Figure 4 gives more detail for the kind of EA-engaging, highly visible, community-based hubs that will be entry points to the mental health system, like Australia's headspace, the UK's Youthspace and Headstrong/Jigsaw in Ireland.

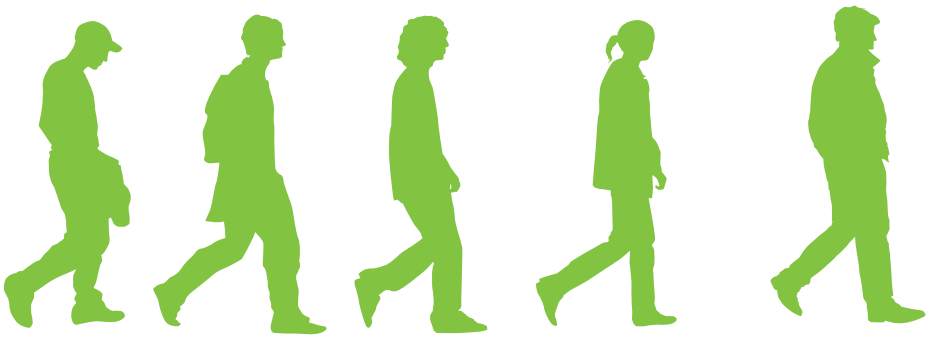
Figure 3: The Full Continuum of Mental Health and Addiction Services for EA – A Tier-Based Approach

Specialist services for EA with the most intensive mental health needs include, but are not limited to:

- Tiers 4 and 5: Specialized, dedicated inpatient acute assessment/treatment and residential treatment beds for those with the most complex needs at any time, requiring intensive treatment and safe management. The requirement per 100,000 population would be determined based on population base/prevalence, capacity benchmarks, and availability of intensive community-based options, which are the preference, as in Australia and New Zealand (Andrews & Tolkien II Team, 2006; New Zealand Mental Health Commission, 1998). Services may be cross-regional.
- Tier 4: Specialist, dedicated community-based day treatment. This includes comprehensive assessment, treatment, skill development, and clinical interventions delivered within a youth-engaging, peer-driven, recovery-oriented program approach and based on evidence-informed practices for EA (e.g. Orygen Youth Health in Australia).
- Tiers 3 and 4: Community-based, high-intensity clinical teams, as in the Assertive Community Treatment approach, Ontario Ministry of Health and Long Term Care (Ministry of Health and Long-term Care, 2005); PACT, Wisconsin, US (Mendota Mental Health Institute, 2014); Antenna model, UK (McKenzie et al., 2001); Inner City Youth Mental Health Team, British Columbia; First Episode Teams, Canada, UK, Australia).
- Tiers 2, 3, 4, and 5: System navigators who offer Intensive Case Management services and who have been referred to as transition coaches/facilitators for youth transitions navigators (Clark & Unruh, 2009; Singh, 2012). System navigators ensure that EA and their families are engaged in supports and services and have access to assessment and treatment, peer and family networks, housing, education, employment, and financial services.
- Tiers 2, 3, 4, and 5: Peer support and mentoring capacity integrated with specialized EA services and at access points to the service continuum (Davidson et al., 1999; Hagan et al., 2010; Lawn et al., 2008; Repper & Carter, 2011).
- Tier 1: Prevention and health promotion initiatives to enhance protective factors and build resiliency need to target and be highly visible to EA through the school system, post-secondary education environments, employment centres,

workplaces, public locations, and in a range of online platforms frequented by this demographic. Prevention and health promotion strategies are not limited to Tier 1, as minimizing negative health impacts and more serious mental health problems or illnesses, as well as building wellness-enhancing skills, is required at all tiers of the continuum, in line with the recovery approach.

Figure 4: Community-Based Hubs for EA – Core Elements



Engagement

- EA designed and led storefront drop-in
- informal groups
- workshops
- social media
- peer connectionand support

Services

- counselling
- assessment and referrals
- clinical help
- education and training

Recovery supports

- health and wellness support employment counselling
- career support
- peer support and mentoring

Access

In addition to service elements, the system would address access by different cohorts of EA (based on needs and history of service use), be informed by an understanding of severity, and consider the most appropriate delivery context. An effective system will need to be inclusive of individuals who may be entering at any point along their engagement in services, regardless of the severity of their mental health problem or illness and be responded to in a context which is the least restrictive and most appropriate for their level of need.

1. In any jurisdiction, the system will need to be accessed by and respond to EA who:
    - Have been served in the child and youth mental health and addiction system and who continue to require mental health and/or addictions-related services when they are no longer eligible for adolescent services. These are young adults who:
        - have had significant and sometimes highly complex childhood behavioural, attention deficit problems, psychological, neurocognitive and mental health issues; child welfare involvement and/or behavioural/conduct disorders, sometimes leading them into contact with the youth justice system or the developmental services sector; or,
        - have less severe mental health and addictions issues and may not meet current eligibility requirements of the adult mental health and addictions system.

    These EA will require access through a coordinated, planned transition to AMHAS prior to age 18, but also will require appropriate service destinations, either in the AMHAS or in primary care settings (those with mild and moderate severity or those who have achieved stability).
2. Are age 16 or more and are experiencing their first episode of an emerging mental health and/or addiction issue, including mood and anxiety disorders and psychosis (75 per cent of these adult disorders will emerge before age 25). These EA may or may not have had contact with the formal mental health system, although they may have been in contact with a primary care practitioner or school-based service provider.

3. Have severe disorders but are currently stable and may be supported by primary care teams with consultation and backup from specialist EA providers. These young adults may need access to specialized services episodically.

The key features of the coordination and access mechanisms within any region include, but are not limited to:

- regionally coordinated transition team, based on transition management approach for youth with the most complex needs who require continued support and treatment on leaving the CAMHAS sector and who are not able to access these services in the adult system;
- visible youth and family-engaging "front door" access point to specialized EA services and to adult mental health and addictions service system, which may be a single door for EA and adults, or even children and youth, EA, and adults, but needs to ensure that it conforms with service principles for EA (e.g. point/person/place and online visibility, accessibility, youth-engaging, including peer roles); and,
- access to system navigators with specific competency in engagement of EA and their families, both at "front door" and at time of transition from CAMHAS to AMHAS.

Severity

An effective EA continuum will respond to the needs of all EA, although many can be addressed through the supports offered in school, community, and primary care settings (Tiers 1 and 2, Figure 3). The tiered approach presumes seamless movement and access as required between tiers, is based on individual need, and considers that:

- EA may have mild, moderate, or severe disorders and their related impacts on day to day functioning.
- EA with mild and moderate disorders may need access to intensive (higher-tier) services from time to time during the trajectory of their illness, although needs are best met in community-based settings and by primary care practitioners, with specialist mental health consultation as required.
- EA with severe disorders will need access to hospital and/or community-based intensive services for assessment, stabilization, and treatment (Tiers 3, 4, and 5, and access to lower-tier services once stabilized).

The MHCC underlines the importance of responding promptly to the needs of individuals with the most severe and complex mental health problems and that this is a measure of performance. Building the capacity of the AMHAS to respond to EA with the most intensive needs and the greatest severity of illness may be an appropriate starting place for system development and investment (i.e. Tiers 4 and 5).

Context of Care

Based on the evidence outlined so far, a number of contextual variables are worthy of inclusion in the discussion of the integrated continuum of services for EA:

- EA need to be engaged, supported, and treated in contexts where they are assured safety.
- EA must be engaged in and offered developmentally relevant assessment, intervention, and support in the least restrictive setting (i.e. in community contexts). The deeper their needs, the more intensive the required service response or level of care will need to be.
- Although community-based intensive treatment will be the preferred option (whether in the home, community, or in a community-based treatment environment), EA may require an acute inpatient hospital or specialized residential treatment that can address their needs when most intense/acute.
- Within the service continuum, level of care needs assessment and supported, seamless transition to lower-tier, lower-intensity services is needed.

Capacity Building

The capacity of our current system is not adequate to address the needs of EA in most, if not all, jurisdictions (Cappelli et al., 2013; Coughlan et al., 2013; Davidson et al., 2012; McGorry, 2007; Turpel-Lafond, 2013). In addition to specialist EA resources at Tiers 3, 4, and 5, other tiers need to strengthen their capacity to respond effectively to EA needs (see research and knowledge exchange included in this section). In Tier 1, prevention and health promotion initiatives

are already increasing awareness about mental health and wellness. Tier 2 and 3 providers will need to increase their skills and knowledge and engage in program development to ensure that appropriate services and supports are available in:

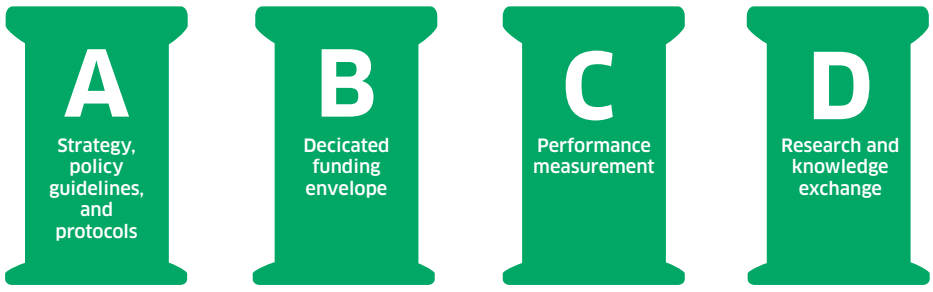
- community health settings such as primary care, community clinics, community health centres, family health teams, access centres, walk-in clinics, etc.;
- education contexts including secondary schools, colleges and universities, and student guidance, accessibility, and health services;
- peer support and recovery support programs, which are currently focused on consumers with serious mental illness, many of whom have been in the system for a long time, in environments that may not be engaging or feel safe for EA; and,
- services that offer supports to attain and sustain housing, education, employment, and finances (housing and education access programs are not often focused on the needs of EA specifically).

> An important measure of how well a transformed mental health system is working is the way in which it responds to the needs of people with the most severe or complex mental health problems and illnesses—in particular, whether it enables timely access to intensive or specialized services and makes sure that people are able to obtain all needed treatments.
>
> - *Changing Directions, Changing Lives* (MHCC, 2012)

RECOMMENDATIONS FOR A RESPONSIVE SYSTEM DESIGN

In the next sections, we present detailed recommendations from our review of national and international policy and practice review, which are the building blocks for a responsive system design. We present relevant elements, beginning in each case with the designation of EA as a priority and make policy recommendations by level of jurisdiction (i.e. national, provincial, regional).

Figure 5: Foundations of a Responsive System



A. Strategy, Policy, Guidelines, Protocols

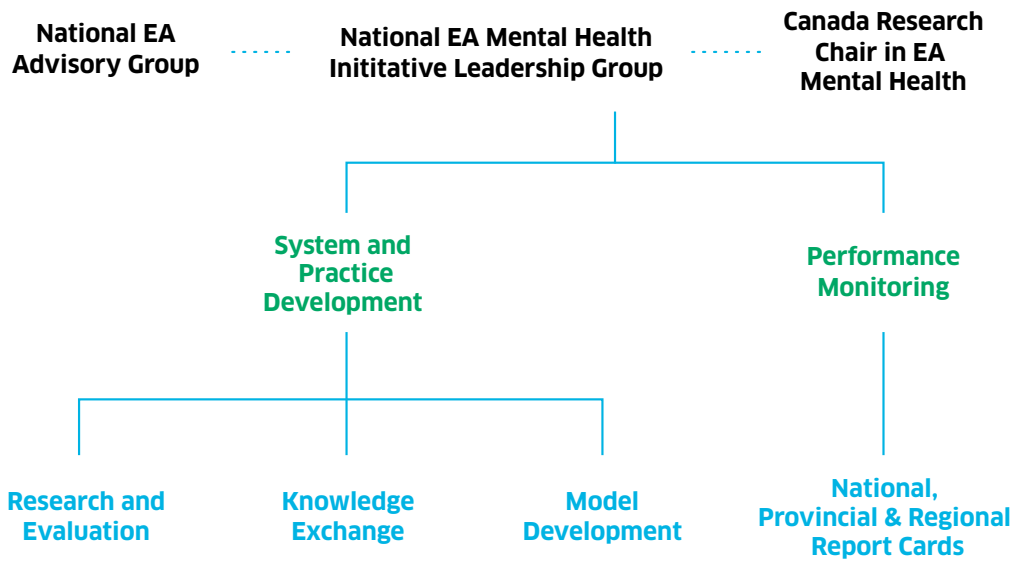
National Strategy

Identification of EA as a priority, including:

- development of a government-supported national action plan for mental health and addictions, containing:
  - evidence related to the vulnerability of EA (e.g. suicide, rising prevalence of mental disorders, neurocognitive evidence, engagement levels) and the impact of early intervention (e.g. untreated youth become increasingly vulnerable and less resilient over time);
  - priority strategy regarding the most vulnerable EA populations and action steps/indicators for access and inclusion;
  - the appointment of a funded Canada research chair in EA mental health; and,
  - the establishment of a national EA advisory group (as in hY NRG Headspace Australia).

- establishment of a national EA mental health initiative (see Figure 6), focused on funding and implementing specific mental health and/or addictions programs. This should complement but not duplicate the activities of the TRAM initiative[38] and include funding for:
  - a longitudinal tracking study to include youth from age 16 involved in the CAMHAS system and transitioning into the AMHAS sector with key indicators and measures; and,
  - a national and provincial knowledge exchange entity.
- production of a bi-annual "national report card" on action, service utilization, and outcomes in EA mental health from provincial and regional reporting on identified national indicators, including data from the Canadian Community Health Survey – Mental Health (CCHS).

Figure 6: National EA Mental Health Initiative



Provincial and Territorial Strategy

Identification of EA as a priority, including:

- gathering evidence related to the size of the provincial/territorial EA population and the indices of their vulnerability and capacity;
- identification of effective transitions and addressing EA mental health and addiction needs as a provincial and territorial priority;
- a strategy making the most vulnerable EA populations a priority (with action steps, indicators for access, inclusion, and outcomes);
- a Premier-led interministerial cabinet committee to oversee policy implementation, contribute to a provincial action plan, and address the findings of a bi-annual provincial report card on EA mental health;
- a provincial/territorial EA advisory council with an authentic role as an advisory and leadership group; and,
- identification of a single ministry accountable to deliver and report on outcomes for EA.

[38] A collaboration between The Graham Boeckh Foundation and the Canadian Institutes of Health Research to support highly-innovative approaches to improving mental health outcomes for 11-25 year-olds in Canada within five years.

Service Delivery Standard

The first phase of standard development is the collection of evidence regarding outcomes and efficacy of protocols and interventions for EA, based on consistent data collection, indicators, model development, and evaluation. From these outputs, standards can be developed and adherence can be monitored. Elements to be included at the policy level in the shorter term would be:

- service delivery principles for specialist services to EA (as opposed to standards yet to be developed related to service arrangements/facilities, staff skills, knowledge and therapeutic approach, evidence-informed practices, philosophy of care);
- a provincial and territorial knowledge exchange strategy for human resources and delivery of evidence-based interventions with EA; and,
- a requirement for demonstrated capacity to respond to EA in developmentally appropriate ways for adult hospital and community-based mental health and addiction service providers.

Core Basket of Services

The following core basket of mental health and addiction services for EA should be available as separate and distinct from current services for "children and youth" and "adults," based on findings from an environmental scan and literature/practice review (Clark & Unruh, 2009; Davis, 2003; Leavy, Goering, Macfalane, Bradley, & Cochrane, 2000; McGorry, 2007, 2012; Singh et al., 2010). Given variable population demographics, some specialist services may not be available in more rural and remote areas; however, access to this level of intensity would need to be available cross-regionally, or through a combination of community supports and telehealth services. The basket would be included in each provincial/territorial mental health and addictions strategy, have the capacity to respond to EA with mental health and addiction issues, and would include:

- acute inpatient mental health beds;
- community-based, comprehensive day treatment services;
- community-based, mobile, high-intensity clinical teams;
- first episode/early intervention for all diagnoses including screening, assessment, treatment service;
- system navigators;
- peer support/mentoring, accessible within support environments;
- family engagement, education, and support; and,
- transition team coordination.

In addition, other requirements would include:

- engaging service access pathways for EA, based on evidence-informed approaches and user preferences;
- provincial capacity requirement to be met regionally regarding allocation/reallocation of adult inpatient beds to address the acute assessment and treatment needs of EA;
- identification of a selected transition management model and related indicators to support planning, implementation, and follow-up of data collection;
- transition protocols outlining roles, requirements, and accountabilities of CAMHAS and AMHAS providers in all relevant ministries (including child welfare agencies, developmental service agencies, income supports) and sign offs by each ministry – these have already been developed and implemented in British Columbia, Manitoba, and Alberta for "complex needs" youth, but not implemented for youth with serious mental disorders; and
- resources for the development of electronic tools to support transition planning processes and practice (through an E-transitions project to include a "buffet" of tools for regional implementation, but developed at provincial level).

Regional Strategy (Regional/Local Health Authorities, Integration Networks)

Identification of EA as a priority, including:

- development of a strategic plan/priorities strategy, with related actions and indicators, regarding enhancing transitions out of CAMHAS and into AMHAS (referral, wait time, engagement);
- development of a regional plan with specific actions and related indicators regarding transitions planning and implementation, as well as resource investment, and the development and monitoring of specialist EA core services;
- documentation of the scope of the problem/need for the region, including demand prevalence and the most vulnerable EA; and,
- regional report card.

Core Basket of Services:

The regional mental health and addictions strategy and action plan includes a development plan and funding envelope through the allocation/reallocation of resources for, at minimum, **the core 8**, including:

1. Specialist EA inpatient beds/spaces, based on per capita/population requirements per 100,000.
2. Specialist EA community-based comprehensive day treatment spaces.
3. Specialist EA community-based, mobile, high-intensity community team spaces based on per capita/population requirements per 100,000.
4. First episode/early intervention screening, assessment, and treatment services for all diagnoses.
5. EA-specialized system navigators.
6. Peer support and mentoring models to enhance engagement, integrated with clinical and treatment services (rather than marginalized), and based on identified competencies, training, and role definition.
7. Family engagement and education services.
8. Transition team coordination resource to ensure engagement and commitment of cross-sectoral providers in the regional transition model.

In addition to the core basket of 8, prevention and health promotion initiatives should be included within each of the core services as well as across tiers of the continuum.

Regional Lead for Transitions:

A regional lead for transitions and EA mental health and addictions would to be responsible for:

- translation of relevant strategic priorities into operational requirements;
- achieving cross-sectoral inputs to build transition protocols for the region;
- convening regional interministerial players and key service providers in the CAMHAS and AMHAS to determine regionally appropriate implementation planning for selected transition protocols and accountabilities;
- development and sustained operation of regional transition team for shared management of most complex youth in transition (with support of transition team coordination resource);
- documentation of, and Knowledge Translation for, implementation of evidence-informed, effective transition practices across the full range of health and service subsectors, and ensuring collaboration with these subsectors;

Clients and their families should have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities). Those with continuing, complex needs should be supported by a plan that will lead them through their journey to recovery and wellness, particularly on discharge from institutional or residential treatment.

Final Report: Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians (Committee on Mental Health and Addictions, 2010)

- development and oversight of business intelligence processes (collection and use of raw data to inform quality improvements and service development) for reporting, and performance monitoring at the regional level to be included in a provincial report card;
- ensuring the designated EA core basket of services is available and delivered according to provincial guidelines and standards (as available).

Regional Transition Protocols and Shared Management:

Regionally approved and implemented electronic transition planning guidelines, protocols, and tools, will include, at minimum:

- online educational materials for client, family, and providers;
- individual transition plan;
- transition tracking tool;
- standardized/common assessment tool completion and regular follow-up (currently in place in Saskatchewan, Ontario);
- other assessment and tracking tools as determined by province/region (e.g. Global Appraisal of Individual Needs Short Screener, Consumer Satisfaction Questionnaire/Perception of Care Tool);
- materials for EA and families related to AMHAS at the local level and issues of relevance related to consent and confidentiality barriers and how to address them;
- regional strategy and resources to address information transfer issues through e-solutions (with appropriate Personal Health Information requirements identified and met); and,
- core data reporting mechanisms to ensure reporting regarding transition, engagement, and health outcomes to local health authority for inclusion in regional, provincial, and national report cards.

The essential requirements for coordination and shared responsibility/accountability through and across the bridge from CAMHAS to AMHAS for EA include:

- a sign-off/Memorandum of Understanding, based on the provincial interministerial guideline, to ensure shared responsibility across ministries, age-based systems, and provincially funded sectors within the region;
- an articulated transition management model in place regionally and aligned with provincial standards and guidelines, which includes:
  - access, referral, tracking, assessment, follow along, data collection protocols, and tools;
  - specific and signed off requirements for CAMHAS and AMHAS providers prior to, across, and following the transfer;
  - designation of senior representatives from cross-sector partners (e.g. primary health, vocational/educational service providers) for inclusion in transition management model development and implementation as required;
  - effective electronic information sharing processes to ensure access to assessment, treatment, diagnostic, and service/treatment planning documentation related to the EA;
  - a transition team and/or advisory committee function made up of organizations accountable to deliver CAMHAS and AMHAS within the region or sub-region;
  - a transition coordination function/resource to facilitate and ensure engagement and support of the young person and their family during and following the transition period, in particular those with most complex needs; and,
  - regional availability of system navigators to support and connect with the individual and their family through the transition.

B. Dedicated Funding Envelope

At the national level, ring-fenced funding to support the national EA mental health initiative, including:

- Canada research chair in EA mental health;
- longitudinal tracking study;
- national centre for excellence and evidence-based practices;

- knowledge exchange strategy (including competency analysis, tools, materials, shared learning platforms);
- research and model development for EA (effective transition support and EA service models in the core 8); and,
- development of the national strategy, action plan, and subsequent bi-annual national report cards.

At the provincial and territorial level, ring-fenced funding to support:

- transitions and EA mental health regional lead;
- transition coordination resource;
- EA-engaging, integrated, visible access point and processes (including online/virtual and place-based);
- Core 8 basket of services (see previous);
- development and implementation of EA knowledge exchange/human resource development strategy at regional level; and,
- implementation of business intelligence strategy and client information management systems with the capacity to support data entry, integration, and reporting on established indicators.

C. Performance Measurement and Quality Assurance

At the national level, a tracking study would include data for reporting on key indicators related to EA in the bi-annual national report card including:

- increase in the percentage of EA (16–25 years)[39] who report positive mental health (*in Canadian Community Health Survey – Mental Health [CCHS]*);
- increase in the proportion of EA with mood or anxiety disorders in the past year who consulted a professional for mental health needs (CCHS Annual Survey);
- increased proportion of EA with any mental health diagnosis who seek services, access and engage with AMHAS (both specialist and generic mental health services), and/or seek help from any professional for mental health reasons (CCHS Annual Survey);
- increase in the percentage of EA living with severe mental illnesses (Vital Statistics/Statistics Canada and linked physician data) who live to their 25th birthday; or specifically, a reduction in the suicide rate of 16–25 year olds;
- increased specialist service models and capacity to respond to needs of EA (as per core 8, and particularly for EA with the most complex and intensive needs), including acute inpatient beds/spaces and intensive community-based services; and,
- decreased wait times for assessment and treatment services for EA (with common definition).

At the provincial and territorial level, in addition to the above, specific EA-related indicators reported in a bi-annual provincial report card (and in a national report card), to include, but not be limited to:

- increase in the number/percentage of youth/EA who are referred to AMHAS from the CAMHAS and who are engaged in service after one and two years;
- decrease in the number of unmet needs of EA who are referred to AMHAS from the CAMHAS and who are engaged in service after one and two years (based on documented results from the administration of a provincially selected, standard needs assessment tool at regional level, prior to transition and/or on entry to AMHAS);
- increased provincial uptake on mandated use of a standardized/common assessment tool to be utilized across provinces and administered at defined intervals;
- reporting on a standardized minimum data set across all EA related to key national and provincial indicators (to include, but not be limited to: access, engagement, outcome, and user experience) for reporting in provincial report card—this will create an opportunity for measurement and comparison between provinces and territories; and,
- demonstrated equity of access by most vulnerable populations defined in provincial policy statement.

Implementation accountabilities related to transition planning would include:

[39] In the National Strategy document, the term "people" is used, so in these excerpts this has been replaced by EA (16-25).

- documentation of shared responsibility and specifically articulated roles and accountabilities of all relevant provincial funding ministries, including interministerial guidelines and sign-offs with respect to transitions planning from CAMHAS to AMHAS;
- clear accountability for implementation of transition planning within national guidelines and related performance indicators, downloaded to local/regional health authority and relevant regional system managers for other ministries; and,
- documentation of interministerial collaboration at the local/regional level.

At the regional level, specific EA-related indicators reported in a bi-annual regional report card (and rolled up to provincial and national report cards), to include, but not be limited to:

- collected core data regarding youth transitioning to AMHAS and entering directly to AMHAS, including:
  - a standardized package of epidemiological and clinical information to be obtained by the professional initiating service. Data will include age, gender, ethnocultural identity, presenting issues, diagnosis, and community of residence admitted to adult mental health and addictions who initiated service;
  - service use: tracking of requests for service/first contact/inquiry, assessment, acceptance for service, service initiation, treatment/intervention planning, visit/hours of service provided, length of service; wait time from admission to service initiation; waitlist volumes from admission to service initiation;
  - evidence-based interventions delivered, including direct service hours;
  - client outcomes: individual assessment of met and unmet needs (at regular intervals as defined by provincial guideline); and,
  - individual and family perception of care.
- data sources, client/system information management systems, repository, and reporting mechanisms are in place for all funded regional providers.

Implementation indicators related to the presence and enhancement of service system features in each of the following areas (**the 6 Ps**) include:

1. **Process:** a "transitioning and shared management protocol" is in place for EA with the most severe mental disorders and complex issues who require ongoing clinical treatment and specialist support and who are aging out of child and adolescent services. Health, education, justice, developmental services, and child welfare service providers from CAMHAS and AMHAS sign onto protocol.
2. **Place:** visible community-based access/entry point is available in every local community where information, resources, connections, wellness promotion, and linkage to formal services are available.
3. **Presence:** online or physical sites, including service and referral information, mental health and addictions information materials; check-ins on wellness/screening tools; and drop-in EA resource centres with public promotion regarding mental health, addictions, and local responses.
4. **People:** professional staff and peer mentors are available at access points, first response points, service locations, and online, and are trained in required competencies to support and engage with EA.
5. **Programs:** specialized service responses are in place to address the needs of EA as in the core basket of 8.
6. **Proven Practice:** Evidence-based practices are utilized where possible and/or evaluation frameworks are used to determine the efficacy of approaches implemented at the program and intervention levels for the EA population.

D. Research and Knowledge Exchange

There have been significant advances in the promotion, education, and awareness of mental health problems and illnesses and prevention strategies (including the MHCC's roll out of Mental Health First Aid, as well as the school-based mental health and addictions services projects in British Columbia, Alberta, New Brunswick, and Ontario). There has not been focused attention on knowledge exchange (KE) or the implementation of evidence-informed intervention practices and program models with the EA population and/or in relation to effective transition practices. The risk is that increasing volumes of EA will recognize their mental health and addictions needs and will reach out for services but that the adult mental health and addictions service system will not have the capacity and will be under equipped to address the distinct needs of these young people effectively.

It will be important to ensure data is collected and integrated for continuous learning and practice improvement, as well as evaluation of outcomes and research related to effective practices. Obtaining these data, and promoting active knowledge exchange will inform policy refinement, program development and practice improvement in the EA field.

Research about effective transition practices, as well as evidence-informed approaches to specialist EA mental health services is in its infancy in Canada. Elements of a comprehensive KE strategy will need to include:

- collaboration between the scientific community and policy makers (including politicians), so that principles of evidence-based program selection, implementation, and evaluation science have greater prominence in the policy development process; investment in training research and policy staff regarding the principles of evaluation and the implementation of evidence-based programs;
- a KE research and practice development network on EA to be part of the national EA mental health initiative's KE strategy, integrated with the MHCC's Knowledge Exchange Centre (e.g. SPARK[40]), and based on emerging evidence from the TRAM initiative;[41]
- funding for a national institute for clinical excellence and a high-profile Canada research chair to champion policy, research, and service design implementation. This would include a Canadian registry of evidence-based practices and the establishment and documentation of clinical guidelines with this population cohort and by DSM-V Disorders/ICD Codes (to integrate and build on SAMHSA's National Registry of Evidence-based Programs and Practices, NREPP and NICE guidelines, and pathways for the Canadian context and with this cohort);
- investment in a longitudinal transitions and EA tracking study;
- determination of core competencies for staff, as well as peer support workers to address the needs of this population;
- broad knowledge exchange initiative based on the core competencies for working with EA, to be determined by specific disciplines and clinical areas as well as by program context and core basket element;
- service model development, confirmation, and replication for each of the core 8;
- determination of a "common minimum data set" (including definitions, indicators, measures, sources – see previous C. Performance Measurement and Quality Assurance);
- research initiative specifically related to transition model development, including funding within a national EA mental health initiative;
- provincially authorized/required needs assessment tool implemented in each province and territory;
- provincially authorized tools for assessment of severity of illness/mental health and addiction-related needs, related intensity of support requirements, and services required;
- transition tools development and implementation, and shared education, information, and practice support tools available online, including process and outcome evaluation mechanisms; and,
- increased funding through the national EA mental health initiative for research and evaluation at the program/service delivery "ground" level.

TAKING THE NEXT STEP: WALKING THE TALK TO ACTION

It is not the intention of this document to prescribe an implementation plan for moving ahead to address the needs of emerging adults. As has been shown earlier in this paper, there have been many catalysts to system change. Based on experiences from jurisdictions that are further along the road to truly addressing the needs of EA, several starting points are offered for consideration. Sequencing and timelines will need to be addressed by the relevant jurisdictions.

The ultimate goal is to have a full continuum of services to address the needs of EA in place and accessible in every region of Canada. While there will be differences in capacity between large urban areas and rural and remote parts of the nation, there must be a responsive set of services in place, and ensured, inclusive access and engagement strategies. Each EA needs to be supported along their recovery path in order to transition to contributing adult roles and positive health outcomes, accessing treatment and support as needed along their developmental journey. Outcomes

[40] Supporting the Promotion of Activated Research and Knowledge (SPARK) Training Workshop helps participants learn how to move evidence-informed research from the fields of mental health, substance use, and addictions more quickly into practice.

[41] CIHR and Graham Boeckh Foundation's Transformational Research in Adolescent Mental Health (TRAM).

of engagement and service participation need to be measured and quality improvements need to be initiated. It is time to take action through the development of a national policy framework and leadership in its implementation and performance monitoring. Definition of the required continuum of services within a provincial, interministerial policy framework, and clear priority setting for capacity building in at least the core 8 services at the regional level, are the suggested starting places.

Nationally:

1. Build an influential table of champions including political leadership and appointees at the national and/or provincial level (to include at least one provincial Premier) to craft a national strategy and action plan with key indicators and timelines to be reported on in a national report card. Do the research. Collect the data. Demonstrate effectiveness (access, engagement, outcomes). Replicate the effective models.
2. Following up from the July 2013 Premiers Meeting where bullying was one of the five agenda items, build a compelling case to seek a federal call to action regarding mental health and addictions issues for EA for whom mental health is the most prevalent and significant health issue.
3. Identify the most urgent issue for EA and strike a high-powered inter- or intra-provincial, cross-ministerial group to act on the issue (see New Brunswick focus on suicide and youth justice; consider transitions issues for most vulnerable population, concurrent substance use, suicidality).
4. Launch a national EA mental health initiative, including a longitudinal national tracking study and model development components.

Provincially and territorially:

1. Convene a Premier-led interministerial initiative regarding EA mental health and addiction issues.
2. Develop an action plan including priority on EA and transitions (see New Brunswick).
3. Identify a provincial/territorial champion for youth and EA action plan (see Saskatchewan).
4. Report on how 16–25 year olds are engaging in the system and what their outcomes are.
5. Define expectations regarding a streamlined access pathway to mental health and addiction services for EA.
6. Identify benchmarks and timelines for core basket of services in each community.
7. Implement evidence-based prevention and integrated early intervention programs in schools and post-secondary institutions, targeting the most vulnerable/high-risk populations.
8. Launch a provincial/territorial service development initiative selecting from the core 8 and ensure a consistent data collection and research/evaluation framework.

Regionally:

1. Develop and implement transition protocols for the most complex EA with mental health and/or addictions issues and report on it.
2. Track and report on service use and outcomes (engagement and outcomes over two years) of complex EA transitioning to AMHAS (as part of a national EA mental health initiative).
3. Identify and fund a regional transitions lead and strike an EA engagement group to act as a reference, quality assurance, and leadership team.
4. Identify current capacity of primary care system to address the needs of this age cohort.
5. Fund a visible front door to services for EA.
6. Identify and fund priority specialist service needs for EA in each region and community (from core 8), including proposed evidence-based approaches to address needs and develop implementation plan.
7. Identify a specific strategy for providing acute inpatient services safely, effectively, and developmentally appropriate to this population.
8. Build access pathways for EA to specialist adult and primary care services (as per provincial guidelines).

TAKE THE NEXT STEP FORWARD. WALK THE TALK.

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Appendices

Appendix 1: Provincial Policy Documents by Type and Inclusions of Transitions/EA

Appendix 2: October 2012 Summit Meeting Participants

Appendix 3: Facilitators of Effective Transitions

Appendix 4: Barriers to Effective Transitions from Child and Youth to Adult Mental Health Systems

Appendix 5: Transition Management and EA System Design Models—Exemplars

Appendix 6: Youth Receiving IWK Mental Health and Addictions Services Transfer of Care Process

Appendix 7: Ontario LHIN Selected Initiatives to Support Youth in Transition

Appendix 1
Provincial Policy Documents by Type and Inclusions of Transitions/EA

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
BRITISH COLUMBIA: Progress on British Columbia's child and youth mental health plan (2003) was recently critiqued by the Representative for Children and Youth in their report *Still Waiting: First Hand Experiences with Youth Mental Health Services in BC* (Turpel-Lafond, 2013); in the adult system, *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (British Columbia Ministry of Health Services & British Columbia Ministry of Children and Family Development, 2010), was followed up by monitoring reports in 2011 and 2012.				
Healthy minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (2010)	Strategy	Yes	• Reduce cannabis use before age 15 • Reduce proportion of children and youth who are vulnerable in terms of social-emotional development • Reduce hazardous drinking for 15+ • Promoting mental health in schools • Focus on children and youth with developmental disabilities • Transition planning protocol for children and youth with special needs	Supports for families where parents have mental health and addiction problems Increased in evidence-based community-level interventions
Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia. Monitoring Progress: First Annual Report (2011)	Report	Yes	• Outlines selected successes or actions undertaken during the year based on 2010 report • Many actions were undertaken or are underway	
Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia. Monitoring Progress: 2012 Annual Report	Report	See above	• Full section on transformation of many systems (child and family development, health, justice, housing, etc.) to provide better coordinated services	
A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Abuse – 10 Year Plan (2012)	Strategy	No	• Some mention of supports for children and youth, but no explicit focus	• Focus on incorporating traditional healing • Mindful of the impact of colonization and residential schools
Strong, Safe and Supported: A Commitment to BC's Children and Youth	Strategy	Yes	• Focused on reducing vulnerability. Not specifically related to mental health	• Focus on Aboriginals added
Cross Ministry Transition Planning Protocol for Youth with Special Needs (2009)	Protocol	Yes	• Document is specific to children and youth only	• Special attention to Aboriginal issues • Not specific to mental health, but does encompass broad range of special needs

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
ALBERTA: Alberta's 2006 Child Youth Strategy, Positive Futures (Government of Alberta, 2006) was tabled and followed up with an Action Plan (Government of Alberta, 2011). Similarly in the adult sector, Alberta Health and Wellness and Alberta Health Services jointly sponsored the development of Creating Connections: Alberta's Addiction and Mental Health Strategy (Alberta Health Services, 2011) with a subsequent Action Plan 2011-2016 identifying an interministerial Mental Health Secretariat responsible for its implementation. Youth and emerging adults one of three "priority areas" identified for the 2013-2014 Action Plan.				
Children's Mental Health Plan for Alberta: Three Year Action Plan (2008-2011)	Strategy	Yes	• Transition service in Edmonton and Calgary for 16–24 year olds with difficult to severe conditions • Access standards for children and youth: 24 hours for emergent/acute needs, two weeks for urgent needs, and 30 days for scheduled appointments • Increased access for rural and remote children and youth • Transition from inpatient to community care • School-based programs • Risk-factor prevention • Early interventions for at-risk youth and families	
Creating Connections: Alberta's Addictions and Mental Health Strategy, September, 2011	Strategy	Yes	• Child, youth, and maternal mental health programs • School-based programs • Access standards for children and youth: 24 hours for acute/ emergent needs, two weeks for urgent needs, and 30 days for scheduled appointments • Service coordination, especially for transition-aged youth	• Stigma reduction • Formalizing integrated case-management approaches • Increased support for families and caregivers • Culturally appropriate interventions • Tertiary Care Framework • Housing supports
Positive Futures: Optimizing Mental Health for Alberta's Children & Youth – A Framework for Action (2006-2016)	Strategy	Yes	• Increased capacity in the mental health system • Prevention and early intervention capacity • Increased access to and awareness of mental health services • Enhanced range of services available	• Determinants of health

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
SASKATCHEWAN: In Saskatchewan, a provincial Child & Youth Mental Health Plan was completed in 2007 (Saskatchewan Health, 2006), with the integration of mental health and addictions across the lifespan identified as a priority. In 2012, a Framework for Service Delivery was released, integrating sectors, as well as mental health and addiction services (Saskatchewan Ministry of Health, 2012). In May 2013, an interministerial action strategy was developed to address mental health and addiction and a Commissioner of Mental Health has been appointed to advise the Minister on development of this plan. An Executive Steering Committee will provide strategic oversight to the plan's development, will be chaired by the Minister of Health and will be made up of leaders from the Ministries of Education, Social Services, Corrections, Policing, and Justice; regional health authorities; Aboriginal representatives; the education and policing sectors; and service users. A Child and Youth Standing Committee (Cabinet Committee) was established December 2010, co-chaired by regional directors of mental health and addiction services. This committee enhances horizontal, issue-based problem solving, leading to policy development and legislative scaffolding to support on the ground initiatives (e.g. use of cross-province mental health screening tools, individual support plans mandated in policy, implementation of LOCUS to establish required levels of care).				
A Better Future for Youth: Saskatchewan's Plan for Child & Youth Mental Health Services	Strategy	No	• Increased outreach programs • Introduction of early psychosis program in Regina • Inclusion of youth in planning process of mental health services	• Hire additional staff in more remote locations
Mental Health and Drug and Alcohol Misuse Services: Integration Framework (2012)	Framework	No	• No	• Provides for the integration of addictions and mental health services in a client-focused fashion to better serve those with concurrent disorders
Mental Health and Drug and Alcohol Misuse Services: Framework for Service Delivery (2012)	Framework	Yes	• Identifies transition from childhood to adulthood as key intervention point	

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
MANITOBA: Manitoba has the most aligned and integrated policy and transitional protocols in place with a single initiative, Healthy Child Manitoba, forming the framework for delivery, with enabling legislation: The Healthy Child Manitoba Act (Government of Manitoba, 2007). In addition, a cabinet committee is in place, so that rather than one "super-ministry," there are 10 voices around the cabinet table. The legislation provides the mandate to collect identifying data to report on follow-through across the life course for effective performance/outcome monitoring. Manitoba has established a Child and Youth Secretariat as well as a Healthy Child Committee of Cabinet that bridges between the political realm and the community and includes a parallel structure in the community comprised of residents and professionals. The Manitoba Centre for Health Policy is a repository for identifying data so that report cards on system-wide performance can be achieved.				
Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community (2008)	Protocol	Yes	• Specifically for special-needs kids transitioning out of care back into the community	• Supports interdepartmental collaboration on this subject
Transition to Adulthood (Not Dated)	Fact Sheet	Yes	• Fact sheet of information for emerging adults with disabilities transitioning into adulthood	• N/A
Mental Health Framework for Students: A Position Statement (2011) (Manitoba Association of School Superintendents)	Position Statement	No	• Examines the mental health needs of school-aged children in Manitoba	• Includes a call to action for integrated services • Recommendations for other actions, such as universal/easier access to psychiatry, etc.
Rising to the Challenge: A Strategic Plan for the Mental Health and Well-being of Manitobans	Strategic Plan	Yes	• Strengthen the capacity of the mental health system with one area of focus on children and youth • Strengthen coordination between child and adolescent service systems and adult service systems	• Broad strategic directions include an emphasis on the inclusion of peer and family support in mental healthcare • Strengthen cross-departmental and cross-sectorial province-wide planning
Health and the Human Spirit: Shaping the Direction of Spiritual Health Care in Manitoba	Strategic Plan	No	• None	• Promotes the inclusion of spiritual support in mental healthcare

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
ONTARIO: Ontario's *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (Government of Ontario, 2011) and the recent report released by the Select Committee on Mental Health and Addictions provide the policy framework. Child and youth mental health is clearly recognized as a priority and starting place for implementation. Currently a strategic "transformation is underway in the Ministry of Children and Youth Services" (MCYS) Child and Youth Mental Health system, with the most recent policy document (Ministry of Children and Youth Services, 2006) now out of date. Within MCYS, a strategic transformation process is currently underway to build a framework to enhance access, pathways to care, and working protocols for a more seamless service system, while embedding a set of core services. A noted limitation is that this may not be a "whole-system" approach, as it is not a joint initiative between health, education, and the MCYS. In November 2012, *Moving on Mental Health – A system that makes sense for children and youth* was released, which sets the stage for transformation, focusing on ensuring information regarding services and access to services province-wide.				
Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (2011)	Strategy	Yes	• Early intervention and stigma reduction programs for children and youth • Increase school-based capacity • Improve access to child and youth mental health services • Early identification and intervention • 18 service collaboratives to manage transitions between inpatient/outpatient, health and justice, and child and youth mental health services and adult mental health services	• Improving housing and employment supports • First responder training • Integration of mental health and addiction services • Integrate and support transitions between services
A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health	Strategy	Yes	• Support enhanced integration of children and youth-serving ministries, services, etc. • Facilitate transitions between services at key transition periods • Improve child and youth mental health service responsiveness	• Stigma-reduction efforts • Increase evidence to support effective interventions and prevention • Enhance formal system of accountability between child and youth mental health services and government • Develop service standards
Moving on Mental Health – A System That Makes Sense for Children and Youth (2012)	Action Plan	No	Three-year action plan aimed to: • Help parents find services • Match funding to community-based service needs • Increase province-wide reporting • Increase access for youth and their families (mentioned specifically)	• Plan to define core services to be available in all areas in Ontario • New funding model based on local demands • Plan developed in collaboration with parents, young people, service providers, and system experts

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
QUÉBEC: Québec's *Mental Health Action Plan 2005-2010 Plan d'Action Santé Mentale (2005-2010)* (Ministère de la Santé et des Services sociaux, 2005) was refreshed with an action plan in the fall of 2013, which will be the policy directive to guide implementation until 2020. Consultations held during the process of building the new framework confirmed significant concern with youth transitions and the impact of the rigid age cut off. The Health Commissioner's Report on Mental Health included five core recommendations, one of which was to enhance transitions and access to appropriate services for youth and young adults. In the upcoming strategy, broadened provincial capacity, access to first-episode programs, universal access to psychological therapies, and the embedding of transition protocols in legislation are likely to be included.				
Plan d'action en santé mentale: la force des liens (2005-2010)	Strategy	Yes	• Social marketing campaigns targeted at children and youth and their carers • Greater integration of services between health and other human services • Encouraged integration among primary and secondary mental health services for children and youth • Assess and treat mental health conditions in secondary services	• 24/7 crisis intervention services available to all residents
État de situation sur la santé mentale au Québec et réponse du système de santé et de services sociaux (2012)	Report	Yes	• Recognizes the difficulty with classifying services as "child/ youth," "adult," and "geriatric"	• Provides recommendations on enhanced resourcing of the mental health system and performance of the mental health system

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
NEW BRUNSWICK: New Brunswick has launched an innovative seven-year provincial mental health plan, which outlines priorities for mental health promotion, service delivery changes for all sectors, early identification and intervention, and changes in residents' attitudes and values on mental health. Specific targets for province-wide service development are included (e.g. youth concurrent disorders teams; first-episode teams; integrated service delivery in schools), which are currently in the early stages of operation and evaluation.				
Action Plan for Mental Health in New Brunswick (2011-2018)	Strategy	No	• State wards. • Housing for 16-18 year olds • General mental health needs	
Together into the Future: A Transformed Mental Health system for New Brunswick (2009) AKA: McKee Report	Report	Yes (p.# 22)	• School staff training • Early interventions (i.e. for early psychosis, youth concurrent disorder teams, children and youth mental health courts) • In-province assessment and treatment • Social service access for 16-19 year olds	• Need for interdepartmental collaboration • Ensure linkage to community resources • Importance of family in mental health system and care
Change Vision: Helping People in Their Recovery Journey – Addiction and Mental Health Program Guidelines (2013)	Guidelines	No		• Provides for transition of services to a recovery approach
PRINCE EDWARD ISLAND: Health PEI is the corporation responsible for mental health service delivery and is funded by a single Department of Health. Prince Edward Island is in the process of implementing a Mental Health Services Strategy that includes several projects in various stages of completion. They include service and system review, system accountability, legislation review to support information sharing, interministerial and cross-sector collaboration and service integration, integrated access and a number of mandated provincial program initiatives.				

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
NOVA SCOTIA: Nova Scotia's *Together We Can* plan (Government of Nova Scotia, 2011) and subsequent *First Year Report Card* (Government of Nova Scotia, 2013) are based on service delivery standards as well as a significant shift to an accountable system. They include specific strategies to support prevention, as well as youth and adults with concurrent disorders, and to ensure regional equity of access through a number of action items and reporting on adherence to standards (Government of Nova Scotia, 2009) and are based on a consistent provincial minimum data set.				
Standards for Mental Health Services In Nova Scotia (2009)	Standards	Yes (p.# 6, 40, 48)	• Sexually aggressive children and youth • Forensic mental health assessments for youth • Early psychosis for children and youth and adults • Children and youth with neurodevelopmental disorders	
Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians	Strategy	Yes	• Children and youth identified as a priority • Wait times for children and youth waiting for services • Early intervention for prevention	• Focus on First Nations and Aboriginals • Peer and family support • SchoolPlus program
Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians Our First Year (2013)	Report	No	• School-based interventions • 18-month developmental screening	• Peer support • Skills training for family • Concurrent disorders training • Collaborative treatment support for Aboriginals • Gay/straight alliances

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
NEWFOUNDLAND AND LABRADOR: Newfoundland's "Working together for Mental Health" (2005) is the current policy framework; however, a new policy framework with a focus on children and youth (up to 18) is under construction. A Provincial Mental Health and Addictions Advisory Council Activity Plan (2011-2014) is in place as the framework for mental health and addiction service development with significant budget increases focusing on prevention and promotion as well as a tele-mental health infrastructure for youth (targeting depression and based on the New Zealand model).				
Working Together for Mental Health: A Provincial Policy Framework for Mental Health and Addictions Services in Newfoundland and Labrador (2005)	Strategy	No	• Primary prevention • Consultation and case management • Community and home support • Crisis services • Inpatient/residential treatment • Day treatment	• Need for greater coordination between agencies in general, but no specific mention of transitions
Provincial Mental Health and Addictions Advisory Council Activity Plan (2011-2014)	Report	No	• Accessibility for rural youth	• Aboriginal mental health noted as a concern

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
NORTHWEST TERRITORIES: The Northwest Territories' (NWT) Department of Health and Social Services released *A Shared Path Towards Wellness: Mental Health and Addictions Action Plan 2012-2015* in June 2012, which was followed up in April 2013 by *Healing Voices: The Minister's Forum on Addictions and Community Wellness*. These documents and initiatives will be integrated into a "New Directions" strategy, currently under development, but which had its foundations in a 2011 review, *Transformational Process for Mental Health and Addictions: Future Directions and Promising Practices in the NWT.* Previous policy and health status review documents have declared NWT's issues with poverty, addictions, mental health problems and illnesses, and inflated suicide rates "a state of emergency" (NWT Suicide Prevention Program; Chalmers et al., 2002). The plan recommends transformational change aligned with increased emphasis on community wellness and the integration of spiritual and cultural elements in the planning, delivery, and evaluation of mental health and addiction services (particularly for youth, given the current population bulge in the 12–15 year demographic, coupled with disproportional substance misuse). It is of note that there is no formal children and youth mental health system in NWT and those with intensive needs are served outside the territories, although there is an overflowing Child and Family Services (Child Welfare) sector, which will shortly extend services from the current age 19 ceiling to age 24 through legislative amendment.				
A Shared Path Towards Wellness: Mental Health and Addictions Action Plan (2012-2015)	Strategy	No (mention of continuum of care, but uses example of community to residential treatment program within system)	• Increased programming targeting children in mental health and addictions • Need for early health promotion and intervention programs for children • Deliver "My voice, My choice" program • Implement early detection and intervention tools for specific professionals (i.e. nurses, teachers), for use with youth • Include mental wellness initiatives in the development of the Early Childhood Framework	• Integrated continuum of care • Integration among departments and services • Offer on-the-land and traditional healing • Better integration between health, justice, and social departments

Document Name	Document Type	Explicit Mentions of Transitions	Specific Children and Youth Foci	Other Notable Mentions
NUNAVUT: Nunavut's mental health strategy is embedded in a territorial Public Health Strategy. In addition, a Suicide Prevention Strategy was developed for implementation from September 2011 to March 2014.				
Developing Healthy Communities	Strategy	No	• Decrease mental, physical, emotional, and sexual abuse, particularly in children • Decrease the incidence of youth engaged in risky behaviours	• Increase resources for families to strengthen resiliency and wellbeing
Nunavut Suicide Prevention Strategy Action Plan	Action Plan	No	• Increase service collaboration between government, schools, and RCMP to serve children and youth in distress better • Increase access to early childhood development and family programs, and programs for at-risk youth and adults • Increase resilience-focused education in schools • Increase youth-specific mental health knowledge (with an emphasis on sexual abuse) through programming for front-line workers, education professionals, and parents	

Appendix 2
October 2012 Summit Meeting Participants[42]

Name	Affiliation	Location
Jean Addington	University of Calgary	Calgary, AB
Suzanne Archie	McMaster University	Hamilton, ON
Emily Beaudoin	Youth Participant	Ottawa, ON
Max Birchwood	Youthspace	Ottawa, ON
Gary Blau	Center for Mental Health Services	Washington, US
Pamela Brown	Ministry of Children and Youth Services	Toronto, ON
Heather Bullock	Centre for Addiction and Mental Health	Toronto, ON
Mario Cappelli	CHEO; University of Ottawa	Ottawa, ON
Sarah Cannon	Parent Participant	Niagara, ON
Jenny Carver	Mental Health and Substance Use Service System; Jenny Carver and Associates Planner	Toronto, ON
Giles Charron	Ottawa Transitional Program	Ottawa, ON
Amy Cheung	Sunnybrook Research Institute; University of Toronto	Toronto, ON
Simon Davidson	Ontario Centre of Excellence for Child and Youth Mental Health	Ottawa, ON
Mary Ann Davis	University of Massachusetts	Boston, MA
Sheree Davis	Ministry of Health & Long-term Care	Toronto, ON
Shaimaa Abo-El Ella	Queens University	Kingston, ON
Maureen Fedorus	The Royal Ottawa Health Care Group; University of Ottawa	Ottawa, ON
Allison Freeland	The Ottawa Transitional Program	Ottawa, ON
Asha Gajaria	CHEO; University of Ottawa	Ottawa, ON
Kathy Gillis	University of Ottawa; Ottawa Hospital	Ottawa, ON
Aaron Goodwin	Youth Participant	Halifax, NS
Phyllis Grant-Parker	Parent Participant	Ottawa, ON
Louise Grenier	Champlain Local Health Integration Network	Ottawa, ON

[42] "The International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model" was funded through a grant from CIHR (143375).

Name	Affiliation	Location
Alexia Jaouich	Centre for Addiction and Mental Health	Toronto, ON
Miriam Kaufman	The Hospital for Sick Children	Toronto, ON
Sean Kidd	Centre for Addiction and Mental Health; University of Toronto; McMaster University	Toronto, ON; Hamilton, ON
Ashok Malla	McGill University/Douglas Hospital	Montréal, QC
Steve Mathias	University of British Columbia	Vancouver, BC
Patrick McGorry	Orygen/Headspace	Melbourne, Australia
Joanne Lowe	Youth Services Bureau of Ottawa	Ottawa, ON
Ian Manion	Ottawa Centre of Excellence for Children and Youth Mental Health	Ottawa, ON
Kwame McKenzie	University of Toronto; Centre for Addiction and Mental Health	Toronto, ON
Moli Paul	University of Warwick	Warwick, UK
David Pilon	Capital District Mental Health Program	Halifax, NS
Cathy Richards	National Health Service Lothian	Edinburgh, Scotland
Paul Roy	The Ottawa Hospital	Ottawa, ON
Megan Schellenberg	Youth Participant	Vancouver, BC
Kyleigh Schrader	University of Western Ontario	London, ON
Swaran Singh	University of Warwick	Warwick, UK
Amanda Slaunwhite	Mental Health Commission of Canada	Ottawa, ON
Marg Synyshyn	Manitoba Adolescent Treatment Centre	Winnipeg, MB
Karen Tataryn	CHEO	Ottawa, ON
Melissa Vloet	University of Ottawa	Ottawa, ON
Janet Walker	Portland State University	Portland, OR
Trevor Wereley	Centre for Addiction and Mental Health	Toronto, ON

Appendix 3
Facilitators of Effective Transitions

In addition to identifying facilitators to successful transitions, McDonagh (2007) also articulates key requirements for transition support, presented as the **4 P's** of transitional care, including:

- **people** (the young person, parents or caregivers, a transition coordinator and keyworker, interested adult services, primary care, multidisciplinary/multi-agency networks and professional training),
- **process** (written transition policy, transition programs, and evaluation and audit),
- **paper** (informational resources and administrative support); and
- **place** (youth-friendly spaces).

Facilitators to successful transitions for youth with mental health concerns[43]

- An active, future-focused process
- Young-person centred
- Inclusive of parents/caregivers
- Starts early
- Resilience framework
- Multidisciplinary, interagency
- Involves paediatric and adult services in addition to primary care
- Provision of coordinated, uninterrupted healthcare that is
  - Age and developmentally appropriate
  - Culturally appropriate
  - Comprehensive, flexible, responsive
  - Holistic – includes medical, psychosocial, and educational/vocational aspects
- Skills training for the young person in communication, decision making, assertiveness, self-care, and self-management
- Enhance sense of control and interdependence in healthcare to maximize life-long functioning and potential
- McDonagh, 2007

[43] Permission was obtained from Dr. Janet McDonagh and the Department of Health in England for use of this table.

Appendix 4
Barriers to Effective Transitions from Child and Youth to Adult Mental Health Systems

Barrier	Strategy
Time	Clinic appointments for adults are often shorter than paediatric/youth appointments and are not always tailored to the complex needs of youth in transition. Some flexibility is needed when scheduling appointments for youth and developing realistic treatment plans for their developmental stage.
Different Care Philosophies	Youth in transition often feel displaced between the paediatric model of service delivery (where responsibilities are limited and family is considered a central part of delivery of care) and adult-oriented systems (that privilege autonomy and often disregard family concerns). This lack of fit between the model of care and the service can result in disengagement and poor transition in young people with mental health problems or illnesses (Davis, 2003). The most significant limitation of a mental health system that follows a paediatric/adult split in service provision is that it ignores emerging adulthood as an important period of development. This inevitably leads to service environments that are not youth-centred by child and adolescent mental health and addictions services (CAMHAS) and not family-oriented by adult mental health and addictions services (AMHAS).
Training	Training programs and professional education programs in the health disciplines exacerbate the paediatric/adult split in the mental health system. The result is that most service providers, upon graduating from programs, lack the necessary competency to work with youth in transition. Many mental health professionals may lack an understanding of the approaches of professionals on the opposite side of the split. A complicating factor in this process is a documented lack of communication between paediatric and adult health service environments. The combined effect of these variables is often that 1) service providers feel unprepared or unable to provide adequate mental health services for youth in transition; and 2) a culture of mistrust between paediatric and adult-based providers is likely to develop (Blum et al., 1993; Davidson et al., 2011; Por et al., 2004; Sawyer, Drew, Yeo, & Britto, 2007; Singh, 2012).
Financial – Insurance, resources for service provision	Health professionals require training regarding evidence-based practices for transitions. It is necessary to disseminate information about the developmental period of emerging adulthood and how we can best service this population.
Different perceptions of young person, parents, providers, and attitudinal factors	One of the biggest challenges faced by the mental health system is bridging the financial split between paediatric and adult mental health services. Funding is a critical issue; just as the responsibility for transitions needs to be shared, so too does the funding envelope.
Discomfort of professionals involved	People involved in care often have different goals for treatment and outcomes. Developing a transition plan represents a necessary step in identifying shared goals and in providing education about the rights and responsibilities of stakeholders engaged in the transition.
Difficulty accessing resources	Fostering a dialogue about the importance of mental health transitions within the healthcare system is necessary and will lay the foundation for mutually shared goals across the paediatric/adult split.
Poor intra-agency coordination	To promote successful transitions, an elastic approach, whereby the changing needs and perspectives of youth are privileged over institutional factors, is preferred.
Poor interagency communication	Developing common goals will facilitate streamlined communication within, and between, service environments (Por et al., 2004).

Barrier	Strategy
Difficulties addressing parental issues	There is a great deal of diagnostic uncertainty for youth in transition since the developmental period is marked by an overlap of normative turmoil, prodromal symptoms, and, in many cases, addictions (Singh et al., 2005). Even when the diagnosis is clear and recognized by CAMHAS, there are no guarantees that it will result in service provision in AMHAS. Often, the nomenclature fails to translate across the split, meaning the threshold for severity is not reached or the mandate of the AMHAS does not recognize a diagnosis. In these cases, the most common outcome is a loss of service. In most instances, this inspires a crisis-driven reconnection with the mental health system that proves costly for the individual as well as for the system. For the CAMHAS/AMHAS transition to be successful, the system-level responsibility has to be shared by paediatric and adult service environments.
Adolescent resistance	Families are often one of the best resources, but their involvement must be tempered with considerations of dynamics and youth competency. Research has demonstrated that families of youth in transition feel ignored and disrespected (Davis & Vander Stoep, 1996).
Family resistance	Young people commonly endorse feelings of being misled and misunderstood by care providers during their transitions (Hatter, Williford, & Dickens, 2000). Patients and families must be educated in the self-advocacy skills required to make mental health decisions.
Lack of institutional support/lack of local protocols and procedures to guide transition	It is essential to provide education to youth in transition, as well as to their families, about the changing legal status and factors that should be considered (guardianship, competency) in preparing for the transition.
Lack of planning	All stakeholders (youth, parents, care providers) need to be made aware of the transition and be informed about roles and responsibilities in this process. For youth identified with childhood diagnoses, care should be taken to make sure that they receive the proper assessment in advance of the transition so that their eligibility for service provision is maintained. In addition to the need for flexibility, there has to be a period of preparation. This should target the needs of youth in transition, families, and professionals at both ends of the CAMHAS/AMHAS transition. This preparation period should be characterized by 1) didactic counselling for youth and families; 2) anticipation of assessments and changes in nomenclature to help ease the transition; and 3) a formal transition plan that is agreed upon by all parties involved.
Lack of appropriate adult specialists	Limited training opportunities in adolescent mental health are available in Canada and there are shortages of health professionals who are knowledgeable about transitions (Kirby, 2006). In order to create a pathway for effective transitions, training opportunities must be created that emphasize the important goal of having adult providers who can meet youth at the transition.
Arbitrary age restrictions	Flexibility is required for age cut-offs to ensure that the system is not driving the needs of the client. This approach respects the developmental period of emerging adulthood rather than serving to pathologize it, particularly in cases when diagnoses are not straightforward. Maintaining this elastic approach demonstrates a more youth-driven focus, whereby the changing needs and perspectives of youth are given priority over institutional factors. Although consideration of developmental age is certainly important, there remains a lack of understanding about how to assess readiness for the CAMHAS/AMHAS transition. Some groups have suggested that asking young people to describe specifically what adulthood means for them, and then using those individual definitions and indicators to determine readiness to transition, is a viable option (Government of Alberta, 2006).

Appendix 5
Transition Management and EA System Design Models– Exemplars

Model	Brief Description	Aims	Resources	Challenges	Leadership
System Design Model - Exemplars					

Headspace, Australia	Based on national mental health policy prioritizing early intervention and access, 70 nationally funded "one-stop shops" provide an enhanced primary care model with four central elements: youth-friendly general practitioners, allied mental health professionals, educational/vocational services, and drug and alcohol expertise.	1. Increase the community's capacity to assist in the early identification of young people with mental health and related problems
		2. Encourage help-seeking by young people and their caregivers
		3. Provide quality services that are evidence-based and delivered by well-trained and appropriate professionals
		4. Enhance coordination and integration within communities as well as at the state/territory government policy level
			• Youth-friendly centres,
			• Multidisciplinary teams including:
			  • general practitioners (in some centres)
			  • sessional psychiatrists
			  • psychologists
			  • mental health nurses
			  • social workers
			  • occupational therapists
			  • youth workers
			  • alcohol and drug workers
			• Extensive website that assists youth with finding a centre, finding evidence-based interventions, and reading about, and connecting with, other youth and families that have used the headspace program
				Not stated	Chris Tanti, CEO

Model	Brief Description	Aims	Resources	Challenges	Leadership
Orygen, Melbourne, Australia Oyh.org.au	The Orygen Youth Health (OYH) model has grown from the need for evidence-based mental health services focusing on the unique needs of youth. They work from an integrated model incorporating clinical, research and training, and communications expertise within their organizational structure. They work with young people and their families to ensure optimal mental health outcomes for people age 15–25 in the western and north-western areas of Melbourne. The OYH model has been emulated in many countries around the world, including the US, UK, Canada, Switzerland, Norway, Denmark, The Netherlands, Hong Kong, and Singapore.	1. Focus on youth 2. Early intervention 3. Clinical staging (interventions are selected in terms of their ability to prevent the progression of a disorder) 4. Evidence-based practice 5. Youth participation 6. Family participation 7. Case management 8. Family and peer support 9. Functional recovery 10. Mental health promotion	• Specialized youth mental health clinical service • Research centre • Integrated training and communications program • Inpatient care • Acute care • Outreach • Case management • Psychosocial programs • Peer and family integration	Not stated	Patrick McGorry

Model	Brief Description	Aims	Resources	Challenges	Leadership
Youthspace, UK Youthspace.me	Birmingham and Solihull Mental Health Foundation Trust created a youth services program, Youthspace, to develop a youth-sensitive service provision to improve youth access and health outcomes.	1. Encourage personal responsibility for mental health by understanding "how it works" 2. Encourage people to support and motivate each other 3. Promote a wider awareness and understanding of mental health and mental illness 4. Offer up-to-date information about maintaining emotional well-being and self-confidence 5. Provide useful help and advice to anyone in distress 6. Provide general links and resources for people wanting more information 7. Reduce negativity, prejudice, and stigma through increased understanding	• Centralized access • Youth assessment services • Reporting to primary care • Brief CBT intervention (six weeks max) • Referral to time-limited early intervention streams	Most GPs would like direct access to YouthSpace 16–25 rather than through single access point as required	Max Birchwood
FRIENDS for Life www.friendsrt.com	FRIENDS for Life is an evidence-based prevention program proven to be effective in building emotional resilience and teaching strategies that are practical and useful for coping with times of worry and change.	1. Normalize the emotional state of anxiety 2. Promote self-confidence in dealing with difficult or anxiety-provoking situations	• Training workshops for school professionals • Website	Not stated	Paula Barrett

Model	Brief Description	Aims	Resources	Challenges	Leadership
Youth One Stop Shops (YOSS) www.yoss.org.nz	YOSS is an approved social service provider, supported by the Department of Child, Youth and Family, the Ministry of Health and Central PHO. They use multidisciplinary staff to provide services from a youth development framework, focusing on preparing youth for adult life rather than primarily focusing on their problems. They serve ages 10–24.	1. Preparing youth for adulthood 2. Provide free information, support, advocacy, counseling, health services, preparation or life skills programs, and holiday programs for young people	• Youth workers • Counselling services • Health services • Alcohol and drug support • Clinical psychology • Social work	Not stated	Trissel Mayor
Headstrong & Jigsaw www.headstrong.ie	Headstrong works with communities and statutory services to empower young people to develop the skills, self-confidence, and resilience to cope with mental health challenges.	1. Give every young person in Ireland somewhere to turn and someone to talk to 2. Change the way Ireland thinks about youth mental health	• Service Development (Jigsaw) brings community services together around youth issues in each community • Advocates at local and national levels for young people to have access to better mental health supports • Research is ongoing for the project "My World," which seeks to uncover factors affecting the mental health and well-being of young people	Not stated	Tony Bates Bob Illbach
Transition to Independence (TIP) www.tipstars.org	Provided by the National Network on Youth Transition for Behavioral Health, the TIP model seeks to improve outcomes for transition-aged youth with emotional and/or behavioural difficulties through system development, program implementation, and research.	Improved: • Employment outcomes • Educational outcomes • Housing • Community-life functioning	• Transition facilitators/life-coaches • Core practice principles (rationales, social problem solving, *in vivo* teaching, and high-risk behaviour prevention planning) • Evidence-supported interventions (e.g. CBT, DBT)	None stated	Hewitt B. "Rusty" Clark

Model	Brief Description	Aims	Resources	Challenges	Leadership
The Partnerships for Youth Transition (PYT), US, 2002 www.nami.org/Content/ContentGroups/CAAC/Final_PYT_5-23.pdf	Substance Abuse and Mental Health Services Administration (SAMHSA) funded transition initiatives involving five community sites in Washington, Utah, Pennsylvania, Maine, and Minnesota. Also funded Research and Training Centers to support evidence building and knowledge exchange.	To develop, implement, stabilize, and document models of comprehensive programs to help support ages 14–21 with serious mental health conditions as they enter the period of emerging adulthood. This was achieved using the TIP model framework and principles.	• Awards for $2.5million/year for four years in five US community sites	N/A	Federal Center for Mental Health Services SAMHSA
MindMatters www.mindmatters.edu.au	The MindMatters program is a national mental health initiative for secondary schools funded by the Australian Government, Department of Health and Ageing, and implemented by Principals Australia Institute. They use a whole-school approach to mental health promotion.	1. Embed promotion, prevention, and early intervention activities for mental health and well-being in Australian secondary schools 2. Enhance the development of school environments where young people feel safe, valued, engaged, and purposeful 3. Develop the social and emotional skills required to meet life's challenges 4. Help school communities create a climate of positive mental health and well-being 5. Develop strategies to enable a continuum of support for students with additional needs in relation to mental health and well-being 6. Enable schools to better collaborate with families and the health sector	• Resource kit for secondary schools • Professional development calendar • Website • Evaluation reports	Not stated	Jill Pearman

Model	Brief Description	Aims	Resources	Challenges	Leadership
Australian Medical Association – Youth Health ama.com.au/youthhealth	The Australian Medical Association (AMA) is the peak membership organization representing the registered medical practitioners and medical students of Australia. They provide advocacy and support for practitioners, as well as facilitating the formation of special interest committees – including one for Youth Health.	To inform young people about issues that affect their health and wellbeing.	• Comprehensive website • Online information pamphlets about mental health issues with a youth focus • Advocacy for youth mental health	Not stated	Not stated
Transition Management Model – Exemplars					
Ottawa Mental Health Transition Project, Champlain LHIN, ON, Canada	The Ottawa Mental Health Transition Project is a research project funded in part by the Ontario Centre of Excellence and the Champlain LHIN to develop and test a shared management model for transitional care.	To navigate the in-kind contributions agreed to by child and adult providers for each transition patient.	• Transition coordinator • Service managers from both the child and adult systems to form advisory committee	Sustainability of in-kind contributions has been difficult to achieve and permanent funding must still be attained	Simon Davidson Mario Cappelli
Good 2 Go Transition Program, Toronto, ON, Canada www.sickkids.ca/good2go/	A program at the Hospital for Sick Children to assist youth with chronic health conditions transitioning to adult services.	Promote a gradual shift in care to prepare all youth with chronic health conditions to leave Sick Kids by the age of 18 years with the necessary skills, responsibility, and knowledge to advocate for themselves (or through others); maintain health-promoting behaviours; and utilize adult healthcare services appropriately and successfully.	The program has created a number of tools to aid in this process, including: • transition readiness checklists • transfer tools for healthcare providers • websites and an internet-based program that allows a young person to easily create a wallet-sized health summary (www.sickkids.ca/myhealthpassport)	• Lack of robust evidence for inter-ventions • Enticing adult care partners to provide services for young adults • The in-equality of services offered in the child and adult systems • Ties to mental health service providers for mental illness with paediatric onset • The transfer of children with multiple mor-bidities	Miriam Kaufman

Model	Brief Description	Aims	Resources	Challenges	Leadership
NHS Lothian, UK www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Documents/SenseOfBelonging.pdf (4.9)	This guideline outlines seven principles that are currently being adapted into the Lothian Model of Transition of Care.	1. Recognize and respect different cultures 2. Be flexible, considering personal, clinical, and social stage rather than age 3. Early preparation and forward planning is the responsibility of both child and adult services 4. Care planning should involve both child and adult systems and include a period of overlap 5. Both adult and child systems must develop a shared values base to respond to the needs of young people 6. Systems and protocols should be developed and put in place to transition youth smoothly 7. Ensure that services received by the patient before and after transition are equitable	Memorandum of understanding between the child and adult mental healthcare providers	More precise agreements must be drafted for local areas as variation in adult mental health services exist by location	Cathy Richards

Model	Brief Description	Aims	Resources	Challenges	Leadership
IWK/CHC, Halifax, NS, Canada	Their current transfer strategy uses a shared management model.	Successful transition between child and adult mental healthcare systems that is gradual and guided by youth readiness, stages of development, and needs.	Primary care Child mental health representative Adult mental health representative Memorandum of understanding between facilities	• Service gaps exist in adult context (e.g. develop-mental clinic) • Involve-ment of primary care physician • Ongoing collabor-ation with com-munity partners • Financial support for peer and family mentors • Emer-gency entry referrals to tran-sition services • Co-ordination with Complex Case Co-ordinators • Lack of elec-tronic health record across fac-ilities	David Pilon

Model	Brief Description	Aims	Resources	Challenges	Leadership
Growing Up Ready www.hollandbloorview.ca/resourcecentre/transitions/familiesyouth.php	Growing Up Ready is a multifaceted program at Bloorview Kids Rehab to help families understand the everyday experiences and skills their children need to become mature, confident adults, and how to access them. It is primarily a timetable and a series of checklists to make parents aware of the activities their child needs to be involved in at different ages and stages. The documentation is supported by opportunities to attend education sessions (through Bloorview's Life Skills and Wellness Institute), and a demonstration clinic (through Bloorview and Toronto Rehab) that aims to smooth the transition from children to adult rehab services.	To prepare and support children with disabilities and their families for the transition to adulthood and independence.	• Timetable and checklists to make parents aware of different activities for life-stage progression • Education sessions led by caregiver peers • Access to Bloorview's Life Skills and Wellness Institute, including recreation, creative, mentorship, and skill-building activities • Demonstration clinic to address issues related to institutional transition	None stated	
LIFEspan Service www.hollandbloorview.ca/programsandservices/childdevelopment/lifespan.php	The LIFEspan service was developed jointly by Holland Bloorview Kids Rehabilitation Hospital and Toronto Rehab to offer an interdisciplinary approach to support transitions to adult services in the rehabilitation and health services sector (from intensive services for children/youth).	Designed to help youth and young adults with childhood-onset disabilities to successfully transfer from the paediatric rehabilitation system to the adult healthcare system.	• Assessment • Consultation Intervention from various disciplines including: • psychiatry • nurse practitioners • occupational therapy • physiotherapy • social work • speech-language pathology • youth facilitation • life skills coaching	Not stated	Andrea Lauzon

Model	Brief Description	Aims	Resources	Challenges	Leadership
Learning and Working During the Transition to Adulthood Rehabilitation Research & Training Center, and Multi-systemic therapy for emerging adults (MST-EA), US labs.umassmed.edu/transitionsRTC/	Conducts research for youth ages 14–30 with a serious mental illness. Provides MST-EA in a home-based intervention designed to target the major problem behaviours with the transition-age population (e.g. antisocial with peers, too much unstructured time, substance use, irrational choices/ distorted cognition)	This research focuses on programs that support education, training, and working during the transition phase and into adulthood. The program delivers evidence-based practices in an in-home setting, at a high degree of intensity, with a multidisciplinary team to provide individualized "youth driven" care.	• Three therapists • On-site supervisor • Off-site consultant • Part-time psychiatrist • Four life-coaches – all of whom work on a full caseload of 12 individuals	Not stated	Maryanne Davis
Inner City Youth Mental Health Program, BC, Canada. www.heretohelp.bc.ca/visions/housing-vol8/the-inner-city-youth-mental-health-program	A psychiatrist-led program intended to serve inner city youth with mental health problems or illnesses in Vancouver, British Columbia. They collaborate with other agencies in the area like Covenant House, the Broadway Youth Resource Centre, and Coast Mental Health to provide mental healthcare with an assertive outreach philosophy (trying to follow up with youth wherever possible), and an "attachment informed" therapeutic framework. They provide a wide range of services, including dialectical behaviour therapy, contingency management, photovoice, and mindfulness-based cognitive therapy. They also act as a central hub, in a network of related services. The program serves all youth age 24 or younger, with or without a fixed address, that are currently living with a mental health or substance misuse disorder.	Priority is given to fostering attachment with the youth, supporting and stabilizing housing, and achieving youth-determined mental health goals.	• Five offices in buildings, in addition to the spaces held by collaborators and many other scattered sites • Eight psychiatrists • Two social workers • Occupational therapist • Nurse • Funding through Providence Healthcare • Highly integrated community network • Access to mental health clinicians and case managers (through Covenant House), youth workers (through Broadway Youth Resource Centre), housing case managers (through Coast Mental Health), and income assistance workers	• Secure funding to continue providing their full comp-lement of services • Lack of physical pres-ence in key areas of the city • Transition out of the program (especially for develop-mental delays and fetal alcohol) • Minimal resources to conduct research	Steve Mathias

Model	Brief Description	Aims	Resources	Challenges	Leadership
Early Intervention for Psychosis (PEPP), Canada www.douglas.qc.ca/pages/view?section_id=165&locale=en	PEPP is a program for first episode psychosis. The program serves individuals ages 14–35. They use an intensive case management model. Their services include regular evaluations by case managers and psychiatrists, clinical evaluation protocols and research, neuropsychological evaluation, group interventions, individual placement and support, CBT (group and individual), psychoeducation for patients and families, metabolic monitoring and intervention, medical management, and psychosocial follow-up in multiple settings.	1. Prompt assessment 2. Phase-specific medical and psychosocial intervention	• Psychiatrists • Neuropsychologists • Psychologists • Social workers • Case managers	• Housing needs • Assist-ing employ-ment and edu-cational opport-unities • Nego-tiating the complex and some-times inflex-ible sys-tem bet-ween the hospital and re-search centre	Ashok Malla
First Episode/ Early Intervention Programs for Psychosis, UK &Australia eppic.org.au/eppic-clinical-guidelines	The Early Psychosis Prevention and Intervention Centre (EPPIC) is an integrated and comprehensive mental health service aimed at addressing the needs of people aged 15–24 with a first episode of psychosis in the western and northwestern regions of Melbourne. EPPIC is a specialist clinical program of Orygen Youth Health, which is itself a component service of NorthWestern Mental Health and Melbourne Health.	1. Detection and assessment 2. Immediate management/ treatment 3. Early and late recovery 4. Continuing care	• Case managers • Primary care physicians • Psychiatrists	Not Stated	Patrick McGorry Max Birchwood

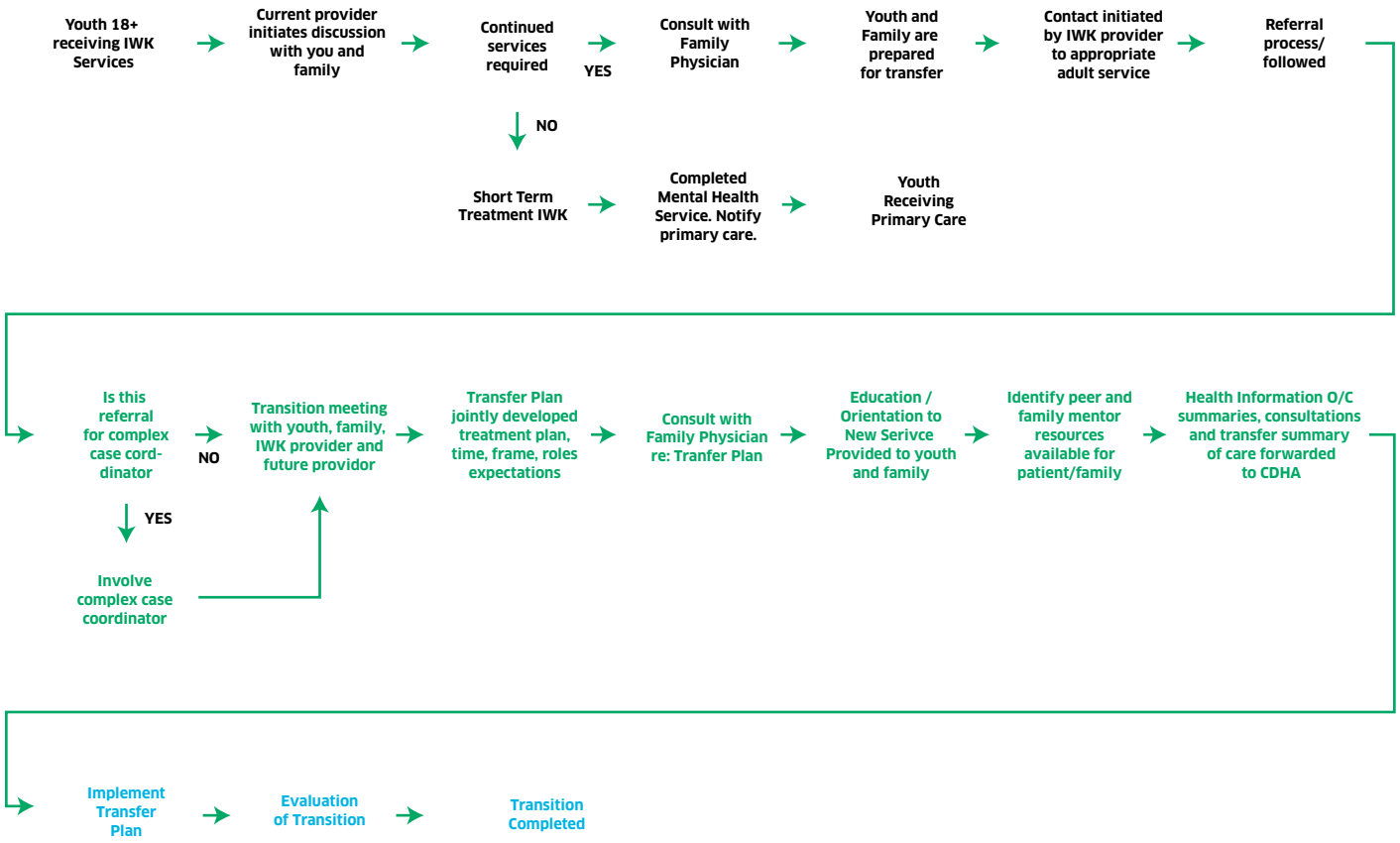
Model	Brief Description	Aims	Resources	Challenges	Leadership
Cleghorn Alumni Program www.stjoes.ca/default.asp?action=article&ID=365	An early intervention in psychosis program that works with individuals between the ages of 14–35 years who could benefit from treatment for a first episode of psychosis. The alumni program is a shared care program involving Cleghorn program staff and the family physician and is designed to transition patients from specialized care to primary care.	1. Client choice 2. Flexibility in services 3. Individualized supports 4. Highlighting the importance of families, significant others, and communities 5. Considering the negative impacts of mental illness such as poverty, stigma, and poor housing 6. Incorporating wellness promotion, rights advice, and the attainment of basic support such as income	• Family educator • Nurse • Occupational therapist • Psychiatrist • Psychologist • Recovery support workers • Recreation therapist	Not stated	Suzanne Archie
beyondblue www.beyondblue.org.au	beyondblue is an independent, not-for-profit organization working to increase awareness and understanding of anxiety and depression in Australia and to reduce the associated stigma. They serve many stakeholders, and offer specific programming for youth age 16–24.	To provide national leadership to reduce the impact of depression and anxiety in the Australian community. They seek to: 1. Increase awareness of depression and anxiety 2. Reduce stigma and discrimination 3. Improve help seeking 4. Reduce impact, disability, and mortality 5. Facilitate learning, collaboration, innovation, and research	• Comprehensive website with information on youth mental health and treatment options • 24-hour support hotline • Chatroom and email mental health support	Not stated	Not stated
Research/Tracking Models					
Collaborative for Academic, Social, and Emotional Learning (CASEL) www.casel.org	CASEL seeks to establish social and emotional learning as an essential part of education.	1. Advance the science of social and emotional learning 2. Expand integrated, evidence-based social and emotional learning practice 3. Strengthen the field and impact of social and emotional learning	• Comprehensive website • Strong organizational capacity to bring together researchers and practitioners	Not stated	Roger Weissberg

Model	Brief Description	Aims	Resources	Challenges	Leadership
TRACK & BRIDGES, UK www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1613-117_V01.pdf www2.warwick.ac.uk/fac/med/staff/singhs/	At present, transitional care in the UK aims to shift individuals from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) by their 17th birthday. All individuals with a neurodevelopmental disorder are exempt, except if they have a comorbid mental illness. Transition planning begins at 16.5 years of age, when a transition worker becomes involved at the request of either a CAMHS or AMHS clinician. The transition worker facilitates the transfer and transition between mental health systems, manages a small number of young people at a time, provides training to both CAMHS and AMHS staff, facilitates CAMHS service users with non-AMHS services when appropriate/necessary, and evaluates transition policy application within the National Health Trust. An investigation to evaluate how the addition of a transition worker facilitates this shift, over and above a protocol-driven strategy, is being conducted at present (BRIDGES Project).	Follow transition-aged youth through the transition period in the UK.	• Transition workers	• Service reorg-anization • Staffing changes • Funding cutbacks • Widely varying responsib-ilities of individual transition workers	Swaran Singh

Appendix 6

Youth Receiving IWK Mental Health and Addictions Services Transfer of Care Process

YOUTH RECEIVING IWK MENTAL HEALTH AND ADDICTION SERVICES TRANSFER OF CARE PROCESS



(Joint IWK-CDHA Steering Committee on Transition Needs of Youth and Families, 2012)

Appendix 7
Ontario LHIN Selected Initiatives to Support Youth in Transition

LHIN	Strategy
Central West: System Transition and Coordination Model (CW LHIN, 2012)	• System Transition Coordinator: facilitates access to adult mental health and psychosocial supports • Service Integration Advisory Committee: a multisector committee that facilitates the development of shared protocols and guidelines between agencies, including formal service agreements
Mississauga Halton: Transitional Aged Youth Coordinating Committee (Systems Integration Group for Mental Health and Addictions, Mississauga Halton, 2010)	• Coordinating Committee: a table of service providers from both youth and adult services that comes together for the purpose of ensuring seamless, client-centred services for youth ages 16–24 • Transition protocol: includes a referral process, a comprehensive referral form to invite the appropriate agencies to the committee meeting, and feedback loops to youth, supporters, and service providers
Simcoe/Muskoka: Telepsychiatry Consultation Service	• One-time telepsychiatry consultation for youth ages 16–24 with the goal of providing effective early intervention. • This initiative is currently a pilot project in the Midland and Penetanguishene region
South East (SE): Transition Facilitator (Lee, 2012)	• The SE LHIN conducted an extensive scan and consultation process to understand the problems and scope of youth transitioning through the identification of key barriers and missing services • Transition Facilitator: promotes access to supports and services, data collection re: youth, services sought, and minimum data set of demographics • Youth Habilitation Quinte has been funded to conduct research regarding existing services for youth aged 15–24, to identify perceptions, service gaps, and barriers for children and youth in the mental health and addiction system
Champlain LHIN: Shared Management Framework (Davidson & Cappelli, 2011)	• 2010 funding for a 15-month Transitional Youth Pilot Project • Transitions Coordinator: receives referrals and conducts intake assessment interviews, develops a transition plan with youth and their families, coordinates and facilitates movement from the child and adolescent system to the adult system, supports youth during transition, and tracks youth throughout the transition process • Supporting structures include a Transitional Youth Advisory Committee (partners from local community-based agencies, hospitals, and other mental health organizations) and a Clinical Case Review Committee (responsible for the review and identification of services for complex cases) • A robust evaluation framework: Global Appraisal of Individual Needs Short Screener, Ontario Common Assessment of Need, Adult Needs and Strength Assessment, and client satisfaction questionnaire
Toronto Central LHIN	• The LHIN is currently supporting a Transition Age Youth Steering Committee and environmental scan and has identified this as a priority • Priority population of youth at risk in the one per cent of the population with the most serious/complex mental health problems or illnesses
Hamilton Niagara Haldimand Brant LHIN	• Based on the LHIN's Strategic Directions, St Joseph's Healthcare Hamilton will spearhead the development of a Youth Wellness Clinic, an outreach and multi-service centre in downtown Hamilton

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