Foreword: The Real World of Implementing Early Intervention Services for Young People, their Families and their Communities

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The simplicity of the current parlance of ‘scaling up’ or ‘rolling out’ mental health services can unfortunately imply that once a core set of service components, principles and/or values have been devised and articulated, they can be implemented, expanded and increased to meet demand. What these terms neglect, however, is the variability in the needs of the population to be served, and the capacity and the resources of local service providers or communities to deliver on models of care. Context - let alone culture – is often lost in the language of scaling up and service implementation. This supplement provides a rare and invaluable insight into how key principles of early intervention can be honoured, and yet flexibly adapted, to meet the needs of diverse communities in a nationwide service transformation program: in this instance...
via the work of ACCESS Open Minds/Esprits ouverts (Malla et al, 2018; www.accessopenminds.ca) in Canada.

There have been a number of national mental health service transformations, most notably the implementation of early psychosis services in the United Kingdom and the pioneering advance in Australia to establish a new stream of mental health care dedicated to meeting the needs of young people aged 12-15 via the headspace initiative (McGorry et al, 2007). The latter are funded federally as an alternate primary health care platform for young people, and provide services in four core streams: primary care (including sexual health), vocational assistance, drug and alcohol, and mental health. Following the example of Australia, Ireland established a network of services (termed Jigsaw) using similar principles and a model of easily accessible services, akin to headspace (Illback et al, 2010). At headspace, routine data collection (Rickwood et al, 2015) along with an independent evaluation (Hilferty et al, 2015) supports the effectiveness of this new service model, particularly for increasing young people’s access to evidence-based treatment. Such research and evaluation studies are critical for service improvement, but they rarely capture the ‘real world’ complexities and ‘how to’ of service planning, development and implementation. This Supplement provides the most comprehensive account to date on how core components of youth mental health services can be developed and delivered to meet the needs of young people and the local communities in which they live, study and work.

The origins of ACCESS Open Minds (OM) followed a similar path from early intervention in psychosis to the broader arena of youth mental health (Malla et al, 2016) to that in Australia and elsewhere. Following a number of innovative but small scale initiatives undertaken by individual clinicians, service providers and researchers (e.g. Evergreen, Kutcher & McLuckie, 2011), a national effort at transforming youth mental health services in Canada was initiated
through a Strategy of Patient Oriented Research (SPOR), by the Canadian Institutes of Health Research (CIHR). The first SPOR project was developed by CIHR uniquely through collaboration with a philanthropic foundation, resulting eventually in a national network project ACCESS Open Minds/Esprits ouverts. Given the nature of government structure in Canada, with responsibility for all health services resting entirely in provincial and territorial jurisdictions, the ACCESS OM network was deliberately conceived as a network across several provinces and a territory in order to address the geographic, cultural and political realities of a vast country. Several regional youth mental health service initiatives have also emerged since the launch of Access OM in 2014, in line with the regional nature of service delivery.

The establishment of the ACCESS OM network and details regarding the overall structure and process of service transformation across six provinces and one territory has been described previously (Malla et al, 2018). The service transformation is centred around five objectives of (1) increased early detection and intervention, (2) rapid access (including a target of 72 hours), (3) timely appropriate care where needed, (4) continuing care, which removes the artificial transition normally imposed at 18 years between child-adolescent and adult services; and (5) meaningful involvement of youth and family in service planning and delivery. The enormous geo-political and cultural variation across Canada (as in many countries), demands flexibility with regard to how these objectives are met. This is especially important when considering the special needs of indigenous peoples, as well as the needs of vulnerable populations (such as homeless or out-of-home care young people).

The papers in this supplement describe how such service transformation was achieved – based on the five central objectives - in seven of the 14 ACCESS OM sites, representing a diverse range of contexts. These include the Eskasoni First Nation community in Nova Scotia, with a total registered population of 4,556, of whom more than 50% are young people aged 25 years and
younger (Hutt-MacLeod et al, 2019). Service transformation in this context involves the complementary blending of Indigenous and Western methodologies, with the concept of “Two-Eyed Seeing” used to illustrate how to engage youth in the community and attending to their mental health needs and wellness. In Ulukhaktok, however, a tiny hamlet of 396 Inuit indigenous peoples in Canada’s western arctic that is geographically remote and regularly accessible only by air, a different approach was required to adapt the five central objectives (Etter et al, 2019). This was especially the case given the longstanding mistrust of mainstream or Western mental health services, lack of trained indigenous professionals and stigma towards mental health, which required an adaptation of a lay-health worker model and utilization of traditional land based practices to address mental health needs of the youth.

Other contexts for service implementation in this supplement include larger urban areas such as Edmonton, Alberta, where one ACCESS OM program has focused on the high-risk population of entry level (first year) students as they transition from school to tertiary education and early adulthood (Vallianatos et al, 2019), while a separate initiative in downtown Edmonton has focused on delivery of youth mental health services to young people with relatively more complex psychosocial needs via assertive outreach and a multipurpose youth space located in the local YMCA (Abba-Aji et al, 2019). One of the ACCESS OM programs in Montreal (Abdel-Baki et al, 2019) describes how partnerships were created with existing community services and agencies that provide services to homeless young people to promote early identification and care for this highly vulnerable population. The implementation of the five central objectives within a small regional community in Chatham-Kent, Ontario (Reaume-Zimmer et al, 2019) and a rural community in which young people belong to a linguistic and cultural minority in the Acadian Peninsula in New Brunswick (Dubé et al, 2019) further illustrate how timely access to appropriate care can be achieved, when young people, their families and their communities are well-engaged in service design and delivery.
The strengths of this supplement are manifold. Details are provided regarding the step-wise processes utilised at each ACCESS OM site to deliver the mutually agreed upon principles and objectives of the network (such as community mapping and stakeholder consultations). The literature on health service development and implementation is rich with program evaluations or the effectiveness of various interventions, but there is usually scant information available with regard to how service transformation was approached and achieved in different environments, including the unique aspects that were considered and incorporated, and the challenges that were faced and how these were overcome or addressed. This is the critical information that service providers, researchers, policy and decision makers, and funders need if they are to choose to either replicate or implement similar service transformations. And it is this detail that makes this supplement such a rich resource for the field of early intervention and youth mental health.

In the Editorial that follows (Iyer, Boksa & Joober, 2019) some of the principal investigators of the ACCESS OM project comment in greater detail about the differences and similarities across the seven contextual sites and how each site has, or has not, met the challenges posed by their particular context. The Supplement also includes several commentaries from members of the three national councils - Youth, Family-carers and Indigenous – who help form and strengthen the governance structure of ACCESS OM (Malla et al, 2018). Each of these councils represent key stakeholders for service transformation across the pan-Canadian ACCESS OM network, and each site has its own representation of youth and family-carers for service planning and delivery locally. Members of the national councils have provided a commentary on the Supplement from their respective perspectives. These commentaries are of particular interest and note, as they represent a departure from usual academic publications; the latter focus almost exclusively on the perspectives of researchers.
In addition, there are four commentaries from prominent academics who have been directly or indirectly involved in the provision of mental health services for youth. Drs. Schooler and Goldman, both academic clinicians from the United States, present two complementary perspectives: (1) from a system of health care that contrasts to that in Canada, and (2) from their involvement as part of the evaluation framework for the original Transformational Research in Adolescence and young adults in Mental health (TRAM; within the Strategy for Patient-Oriented Research: SPOR) initiative in 2013-2014, which was responsible for evaluating all applications and eventually recommending a funding decision. Their continued interest in the progress of youth mental health service transformation in Canada, initiated by the TRAM process, provides them with an opportunity to comment on what progress has been made thus far. Dr. Goldbloom, a prominent Canadian psychiatrist and previous head of the Mental Health Commission of Canada (MHCC), has contributed in the past through strong structural support in his role in MHCC. His continued involvement as a member of the National Advisory Council for ACCESS OM gives him a unique understanding of the progress made and the challenges faced over the past four years. Dr. Mushquash, as an indigenous academic, provides a commentary and a unique perspective on service transformation in the context of both a first nation (Eskasoni) and a general perspective on indigenous mental health.

Each of the commentators are deeply concerned about the status of youth mental health services in general, and interested in progress that is being made through ACCESS OM and other initiatives. We hope the readers of Early Intervention in Psychiatry will find each of the papers in this supplement not only of interest, but of use, which is the ultimate goal of translational research.
References


