Community-based Mental Health Service Hubs for Youth

Environmental Scan

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Key Messages

- Integrated Hubs are best understood as the integration of health and social services under one roof in a youth-friendly environment. They typically focus on prevention and early intervention and the provision of resources to help youth manage their concerns and navigate pathways to specialized services as required. Integrated Hubs are an emerging practice based on evidence that the majority of mental health concerns emerge before the age of 24, and that the current system of care is split between child and adult services, resulting in barriers to accessing services that optimally requires systems transformation to meet the needs of youth. While the concept is well documented, different models have emerged based on community needs.

- Integrated Hubs can best meet the needs of youth when they are in an accessible location with a broad range of operating hours, engagement of youth across all stages of the Integrated Hub, and emotional and cultural needs are prioritized to create a safe space.

- The Integrated Hubs that are currently operating are rooted in existing community-based services with established working relationships and led by an agency experienced in building and maintaining partnerships. They also involve youth in their own care and deliver services that are based on a stepped care model which incorporates primary healthcare services and transition plans.

- An optimal practice which sets an Integrated Hub up for success is to conduct a full community readiness assessment as early as possible to determine feasibility. Integrated Hubs remain viable through clear partner arrangements with a long-term horizon for sustainability.

- Ideally, Integrated Hubs operate under the guidance of a lead agency who can unite a team of staff and coordinate across organizations. All Integrated Hub staff should have a shared understanding of youth mental healthcare and incorporate information sharing practices rooted in confidentiality, flexibility, and respect.

- Integrated Hubs are ideally open physical spaces designed in collaboration with youth to incorporate colour and comfort. All current Integrated Hubs consider youth privacy and safety needs in their design. Integrated Hubs allow for youth to self-refer and receive guidance to navigate and transition throughout the system through flexible pathways that encompass how youth enter, use, and exit.

- Integrated Hubs require effective leadership which diversifies decision-making and control structures and incorporates advisory boards to support organizational structures by providing expertise on different subject areas. Integrated Hubs are continually evaluated across all stages, include outcomes identified in collaboration with stakeholders, and measured at multiple levels including the client, program, organization, or systems-levels.

Executive Summary

The Valuing Mental Health: Next Steps (Next Steps) was released June 2017 in response to *Valuing Mental Health: Report of the Alberta Mental Health Review Committee 2015* and called for a transformation of Alberta's addiction and mental health system to better integrate child and adult services in order to better serve the needs of youth. PolicyWise for Children & Families (PolicyWise) has been contracted to create a framework that will support community-led implementation of two to four Community-based Mental Health Service Hubs for Youth (Integrated Hubs) in small to medium population centres in Alberta for youth ages 11-24. The findings from this environmental scan will be used by the sites to guide the development of the framework and implementation of Integrated Hubs.

Project Overview

The environmental scan is the first stage of the Integrated Hubs project. PolicyWise conducted a literature review, site review, and interviews with comparable youth mental health hub practitioners across Canada and internationally to create a robust environmental scan within the project parameters.

Figure 1: Project Timeline

The purpose of this environmental scan is to:

- Identify successful models of Integrated Hubs
- Document what is currently being done within these models to meet the mental health needs of youth ages 11-24
- Identify the systems-level, operational, and practice considerations for Integrated Hubs.

Background

The onset of 70-75% of mental health problems occur by age 24, yet a majority of these youth do not seek professional help or know where to go for help (Provincial Territorial Working Group, 2016; Lee & Murphy, 2013). Youth concerns regarding stigma, embarrassment, and confidentiality (particularly from parents and peers) are barriers to accessing and maintaining access to services. When a youth does seek help it is often through primary healthcare or community services such as educational or vocational supports. These systems are separate and require a youth to navigate between services for care. This challenge is compounded by turning the age of majority and having to suddenly move between separate child and adult services.

Integrated care has been shown to increase service access for all youth as well as populations that are underrepresented at traditional single healthcare settings such as adolescents in their early 20's, homeless youth, low-income youth, or those who identify along the spectrum of sexual orientations (McGorry, Bates, & Birchwood, 2013; Acri et al., 2016; Kutcher, Davidson, & Manion, 2009). Positioning Integrated Hubs as a place where all youth feel that they can turn to for resources and support can help "strengthen a community's capacity to support its young people" (McGorry, Bates, & Birch, 2013, p. S32).

The Canadian Council on Health Services Accreditation (2006) (as referenced in Suter et al., 2009) defines integrated care as services, providers, and organizations from across the continuum working together so that services are complementary and coordinated, in a seamless unified system with continuity for the client. Working with clients who have complex needs requires the following: collaborative working relationships, common goals, effective and frequent communication, an understanding and respect of individual roles and skills within the team setting, and flexibility (Protti, 2009).

Guiding Principles and Critical Elements of Integrated Hubs

Guiding principles serve as the foundation for Integrated Hubs and are universal in their application yet flexible to the needs of each community. When a community is in the early stages of exploring the idea of an Integrated Hub these are the principles which signify alignment with the Integrated Hubs philosophy. The critical elements are the essential components or ingredients that distinguish an Integrated Hub from existing health and social services.

Several overarching principles to guide the implementation and operation of Integrated Hubs were identified. These include accessibility, safety, and youth engagement in the Integrated Hub.

- *Accessibility* refers to the schedule and location, eligibility for services, the lack of waitlists, drop-in vs. referral, and the availability of staff and services within the Integrated Hub
- *Youth engagement* refers to several aspects of mental healthcare, including: getting youth to utilize services, youth engagement in their own care, the involvement of youth and families in the development and ongoing operations of the Integrated Hub, and the role of peer mentorship in service delivery

- *Safety* is an essential principle that entails a youth's psychosocial need to feel secure despite the mental health struggles she/he is enduring. Cultural safety was most frequently referenced in terms of experiences of Indigenous peoples, however any cultural minority can benefit from cultural safety principles. Being mindful of the diversity in which culture, gender, age, sexual orientation, and socioeconomic status all intersect together is important to ensure youth feel that Integrated Hubs are safe spaces (Kirmayer, Whitley, & Fauras, 2009).

Several key elements were described, including care that: is client-centred, is community-based, integrates primary healthcare, involves a stepped care model, and is transition-focused.

Client-centred care (also known as person- or patient-centred care) recognizes the importance of people as co-producers of their care with healthcare professionals through increased engagement and shared decision making (Gask & Coventry, 2012).

Community-based mental healthcare refers to the knitting together of existing services to create a community owned approach to meeting the needs of their youth. A key characteristic is that mental healthcare is provided outside of a hospital and includes supports across the care continuum. These services are brought together to operate out of a single physical location. Potential services provided under the umbrella of community-based mental healthcare include treatment, crisis response, outreach, case management, and ancillary services such as housing, vocational supports, and/or criminal justice programs (CMHA Ontario, 2017).

Both coordination and collaboration were easier to achieve with pre-existing relationships. Lead organizations needed special expertise in building and maintaining partnerships, given that the Integrated Hubs are meant to be integrated and the nature of youth mental health means that multiple services need to come together.

Evidence from the interviews and the academic and grey literature indicates that primary healthcare needs to be integrated into mental healthcare (Boon et al., 2004; Butler et al., 2017; Henderson et al., 2017; Muir et al., 2008). By integrating mental and primary healthcare, multiple needs can be addressed holistically. Primary healthcare is also interconnected with mental healthcare; for example, to provide medications, for screening, and to promote follow-up (Butler et al., 2017). Finally, the integration of primary healthcare into mental healthcare service delivery can help to promote accessibility and reduce stigma (Muir et al., 2008; Kutcher et al., 2009; Acri et al., 2016).

Stepped care is a healthcare delivery model that involves first delivering the least restrictive option (i.e., should have the least financial and time impact on patients, and should have the least treatment intensity (Sobell & Sobell, 2000)) but should still be likely to provide significant health gain (Bower & Gilbody, 2005).

To help address the systems' gaps related to the transition from child to adult mental healthcare, there is a need for the Integrated Hubs to actively work towards transitions for youth with mental health concerns. In this context, transitions refer to several concepts, including: bridging child and adult services ensure a continuum of care, preparing youth for adulthood and being fully responsible for their

own care, and appropriate referrals to additional supports with warm hand offs ensure continuity of care.

Planning, Implementation, and Operations Considerations

In order to ensure that funding is being allocated effectively and usefully, there is a need to conduct community readiness assessments to ensure that communities who are chosen to implement Integrated Hubs are actually able to do so. Community readiness refers to the degree to which a community has capacity to take action on an issue. Community readiness can be defined in several ways and should be issues-specific. For example, being able to adapt to the needs and culture of the community and the target population, and being able to take existing partnerships and services and shifting them towards the vision of the Integrated Hub.

The need to build sustainable funding into the Integrated Hub to ensure that the full range of services could operate over time was often seen as a challenge and an ongoing issue for advocacy and fundraising; however, many of the Integrated Hubs had seen significant support from their funders and the recognition that what they were doing was important. Interviewees indicated that additional funding (e.g., from fundraising or philanthropic donors) allowed them to build more elaborate service programming and space for the youth and to go beyond the basic needs to become more creative and adaptive to the youth's needs.

The space in which the Integrated Hub is delivered is an important consideration for youth-friendly care. The design of the physical space in the Integrated Hub was seen as a very important piece of engagement and service delivery. Designing a youth-friendly environment meant considering their needs in the context of service delivery and engaging them in the development process. Several Integrated Hubs were also initializing eHubs as part of their service delivery, going beyond the physical space to more youth-friendly environments such as apps, websites, or social media. The potential of eHubs to provide services and increased connectivity even for youth in rural or remote settings was a benefit, although the physical space was being developed first.

Governance represents decision making and control within the system (Suter et al., 2007). Strong, focused governance is an integral part of successful integration. Governance should be diversified to include the perspectives and expertise of multiple stakeholders, including physicians and community members (Hawkins, 1998; Shortell et al., 2000), which will help to provide a clear vision and promote collaboration (Friedman et al., 2000; Shortell et al., 2000). At times, governance was provided through a strong 'backbone' lead agency for singular Integrated Hubs or central leadership; however, this role has not been evaluated to date.

Youth mental healthcare delivery requires a specialized approach from all staff working out of an Integrated Hub. Additional training is required for service providers who work in this area to account for

potentially having exclusively worked within either child or adult systems. According to MSAHC (2016), there are several personal characteristics and skills necessary for staff working in Integrated Hubs which include: passion, commitment, and respect for young people; empathy, compassion, patience, and lack of judgment of young people; advocate for youth; willing to learn and adapt to meet the needs of young people; promotion of confidentiality and privacy; ability to communicate effectively with young people; collaborative; expertise in assessing young people; able to establish rapport; and ability to use a developmental-oriented and appropriate approach. Even if the staff members of Integrated Hubs possess these characteristics and skills, if they have a lack of understanding about the role they each play as partners it can limit the potential for collaboration and ultimately the opportunity for youth to receive the best care (England, Lester, & Birchwood, 2009).

Integrated care pathways (ICPs) have been used as a mechanism to formalize operations for integrated care (Currie, 1999 in Rees et al., 2004). ICPs are tools to map out critical clinical and administrative pathways to bring together all of the service providers involved in the patient's care. ICPs can be used to improve multidisciplinary documentation, communication, and planning (Higginson & Johnson, 1997 in Rees et al., 2004). Within mental healthcare, there has been limited research in this area for the application of formalized ICPs, potentially due to concerns about the complexity of mental health issues and the need to be client-centred (Rees et al., 2004). However, ICPs have been used within many settings, resulting in improved outcomes (Hall, 2001; Rees et al., 2004).

In an Integrated Hub, it is important to be able to share information between providers; however, to respect youths' right to confidentiality and to decide how their information is used, several practices are suggested (MSAHC, 2016):

- Open communication and informed consent about confidentiality and what information can or cannot be shared
- Familiarity of information and privacy legislation among service providers and the ability to communicate this legislation to youth
- Posting confidentiality legislation within the Integrated Hub
- Providing services (e.g., clinical care, prescriptions, etc.) on-site as much as possible to reduce the number of external providers with whom information sharing is required. Where this is not possible, seamless confidential and youth-friendly referral systems would be necessary.

In order to ensure that interventions and services of the Integrated Hub are achieving their intended outcomes, evaluation metrics need to be built in during the planning phase and consistently monitored throughout implementation and operations (MSAHC, 2016). Butler et al. (2017) note that routine measurement of care is needed to improve healthcare outcomes and lead to systems transformation. Several outcomes were identified for measuring the success of the Integrated Hubs, including: improved functioning for youth, clinical improvement, satisfaction with service models (e.g., goal achievement, engagement, empowerment, and disease burden), and economic evaluations.

Conclusion

The findings from this environmental scan will inform a framework for Integrated Hubs to ensure a level of provincial consistency. As these Integrated Hubs are community-based, the framework will be flexible and adaptable to each community's social, cultural and health needs.

Several considerations emerged from this environmental scan which will directly inform the next steps of this project. The development of an Integrated Hubs Implementation Framework will utilize findings regarding the context, guiding principles, critical elements, and key considerations to ensure that emerging practices are included by communities who seek to develop Integrated Hubs.

Introduction

The *Valuing Mental Health: Next Steps* was released June 2017 in response to *Valuing Mental Health: Report of the Alberta Mental Health Review Committee 2015* and called for a transformation of Alberta's addiction and mental health system to better integrate child and adult services in order to better serve the needs of youth. Following further discussion of the recommendations outlined in the report, a need was identified for integrated youth services focused on prevention and early intervention, as well as evidence-informed tools, guidelines, and standards (i.e., a framework) to support such services across the province, especially outside of the major urban centres of Edmonton and Calgary.

The onset of 70-75% of mental health problems occur by age 24, yet a majority of these youth do not seek professional help or know where to go for help (Provincial Territorial Working Group, 2016; Lee & Murphy, 2013). Youth concerns regarding stigma, embarrassment, and confidentiality (particularly from parents and peers) are barriers to accessing and maintaining access to services. When a youth does seek help it is often through primary healthcare or community services such as educational or vocational supports. These systems are separate and require a youth to navigate between services for care. This challenge is compounded by turning the age of majority and having to suddenly move between separate child and adult services. As a result, emergency department visits and hospitalization for youth with mental health crises is on the rise in Canada which highlights the need for easily identifiable, accessible, and early intervention focused services for youth. For a more in-depth discussion on the landscape of youth mental health in the context of Alberta, please refer to *Valuing Mental Health: Next Steps 2017.*[1]

PolicyWise for Children & Families (PolicyWise) has been contracted to create a framework that will support two to four Community-based Mental Health Service Hubs for Youth (Integrated Hubs[2]) in small to medium population centres in Alberta for youth ages 11-24. To inform the development of the framework, and support the implementation of these Integrated Hubs, PolicyWise has undertaken this environmental scan, consisting of a literature review and interviews with comparable youth mental health hub practitioners across Canada and internationally.

The purpose of this environmental scan is to:

- Identify successful models of Integrated Hubs
- Document what is currently being done within these models to meet the mental health needs of youth ages 11-24
- Identify the systems-level, operational, and practice considerations for Integrated Hubs.

[1] Full report available at: Next Steps

[2] Integrated Hubs knit together relevant community services in a youth-friendly and accessible location to create a 'one-stop-shop' where youth can access mental health supports and holistic care. For a detailed description that emerged from the environmental scan, please see page 15.

This document outlines the results of the environmental scan meant to inform the development and implementation of Integrated Hubs for the prevention and early intervention of youth mental health issues in Alberta. It synthesizes those findings and provides analysis of the key components and considerations for developing a provincial framework.

Methods

To better understand the requirements for addressing gaps in youth mental health services through Integrated Hubs, the environmental scan was comprised of four complementary elements: academic and grey literature review, site review, interviews with Integrated Hub stakeholders, and program document review.

Literature Review

A set of search terms were used for the academic literature review aimed at uncovering articles that met the criteria. Searches were conducted (Table 1 below) in several databases: CINAHL, PsycInfo, PubMed, and SocINDEX.

Table 1: Search Terms

Sample	Mental health terms	Type	Service terms	Purpose	Study terms
Youth	Mental health	Integrated	Service hub	Early intervention	Implementation
OR	***OR***	***OR***	***OR***	***OR***	***OR***
Adolescent*	Mental illness	Community	One stop shop	Prevention	Evaluation
Young adult*		Centralized			Model
Transition age		Inter-agency			Outcome
		Collaborative Interdisciplinary Multidisciplinary Coordinated			Framework Strategy

**denotes multiple word endings including singular and plural*

Searches included the following combinations:

1. (Sample) AND (Mental health terms) AND (Type) AND (Service terms) AND (Purpose) AND (Study terms)
2. (Sample) AND (Mental health terms) AND (Service terms) AND (Purpose) AND (Study terms)
3. (Sample) AND (Mental health terms) AND (Type) AND (Service terms) AND (Purpose)
4. (Sample) AND (Mental health terms) AND (Service terms)
5. (Sample) AND (Mental health terms) AND (Type) AND (Purpose)

Large bodies of evidence exist broadly for the following: the use of Integrated Hubs as a concept to improve access to mental health services, the need for alternate approaches to youth mental healthcare, and the need for supportive transitions between child and adult services. This environmental scan used narrow parameters to ensure findings specifically addressed the current state of practice and evidence related to Integrated Hubs. These parameters were set to inform Alberta's context and implementation of Integrated Hubs and included exploring the state of research on Integrated Hubs that met the criteria for age range as well as prevention and early intervention focused mental health services.

Academic literature was included in this environmental scan if it looked at community-based mental health hubs that served a broad population of transition aged youth through prevention and early intervention, and addressed service integration. Literature was excluded if it was not in English, if it did not describe initiatives taking place in Canada, the United States, the United Kingdom, or Australia/New Zealand, or if it was published prior to 2000. In addition, literature was excluded if the hub or program only served a narrow sub-population of youth or was based on late-stage intervention or intensive treatment. Grey literature was also reviewed with similar search criteria using Google. In total, abstracts or introductions to 64 articles or reports from the grey and academic literature were reviewed with 34 articles and reports reviewed in full.

Site Review

The site review involved documenting information about existing Integrated Hubs as they emerged from the other environmental scan methods and compiling it into a summary chart. Appendix A contains a description of existing Integrated Hubs (national and international) that address youth mental health from an integrated perspective. While not all of the Integrated Hubs included in the site review strictly met the criteria used, they are valuable examples of what is currently happening across Canadian and international communities.

Stakeholder Interviews

Programs that addressed prevention and early intervention strategies for youth mental health through integrated service delivery, such as Integrated Hubs, or similar approaches were identified through a literature search and recommendations from project partners. Potential interviewees from each program were identified and contacted; interviews were set up with those who volunteered to participate. Individuals from both Canadian and international programs were interviewed using a standard interview guide (see Appendix B). Interviews were conducted via telephone and recorded, transcribed, and analyzed using the qualitative data analysis software NVivo 11. More emphasis was given to the voices of programs and interviewees that aligned more closely with the vision for Alberta's Integrated Hubs.

In order to protect the confidentiality of interviewees, themes emerging from the interviews were anonymized as much as possible; however, some aspects of the programming may be familiar to those involved at the various Integrated Hubs. Interviewees included evaluators, executive directors,

researchers, administrators, and service providers in various youth mental health hubs across Canada and internationally. For confidentiality, interviewees are referred to in this environmental scan without mention of their specific roles or organizations.

Document Review

Documents related to program frameworks and core components were shared by a number of the interviewees to assist the project team in more fully understanding the behind the scenes processes of developing an Integrated Hub.

Concepts and examples introduced during interviews and through documents or articles that were not fully explored were further expanded using publicly available information. The information sourced through public domains was upheld to stringent criteria; Google searches were conducted and only materials from recognized academic journals, organizational websites, government websites, and reputable Canadian news websites were used. When secondary sources were found, the content was traced back to its original source to verify that the information was not taken out of context.

Context

All sources of evidence from this environmental scan clearly outlined that youth require specialized services offered in an integrated setting that is supported best when systems transformation occurs.

Youth Specific Integrated Mental Health Services

Key Considerations

- Youth are navigating between dependence and independence
- Youth face multiple barriers to accessing mental health services
- Gaps in eligibility between child and adult services exacerbate these barriers
- Prevention and early intervention is critical to reduce mental health crises later in life
- Integrated care increases service access for all youth.

As identified in the introduction, the onset of a majority of mental health concerns typically begins prior to age 24 (Provincial Territorial Working Group, 2016; Lee & Murphy, 2013). The literature for transition aged youth most commonly referenced Integrated Hubs which served adolescents and young adults between the ages of 15 to 25. Select Integrated Hubs began offering services to adolescents as young as 11 while others offered services to young adults up to age 29. This range was reflective of community need and availability of existing services.

Youth have different needs than young children and older adults. Biological, physiological, and social system changes result in significant periods of development and the emergence of a youth culture

(Ryall, Radovini, Crothers, Schley, Fletcher, Nudds, & Groufsky, 2008; Lee & Murphy, 2013). As a result, youth are at a time in their lives where they are navigating between dependence and independence. Multiple forms of evidence have indicated the need for changes or "transformation" in the way that youth mental health is addressed (Butler et al., 2017; McGorry, 2007; England, Lester, & Birtchwood, 2009). For example, in a cross-provincial mental health assessment, individuals with mental health or addiction issues aged 20-29 years in Alberta had the lowest percentage of access to a stable family physician for continuous care, indicating a need for changes for youth mental health in Alberta (Butler et al., 2017).

> Biological, physiological, and social system changes result in significant periods of development and the emergence of a youth culture.

Youth often face many barriers to accessing mental health services. Both the literature and interviewees revealed that perceived stigma and judgement around mental health, a lack of knowledge of available services, a lack of fit with available services or service providers, lack of eligibility, long waitlists, lack of accessibility to the available services, a lack of trust in the system, and personal barriers were all contributing factors to why a youth did not seek or continue to seek help (Acri, Bornheimer, O'Brien, Sezer, Little, Cleek, & McKay, 2016; BC Ministry of Health, 2012; Ontario Ministry of Children and Youth Services, 2016).

One interviewee mentioned differences in eligibility in different services being a challenge to systems navigation for youth:

> There are a lot of people who do similar things and this is why it's so difficult for youth to navigate the system. Like we do substance use but only for kids in school. And we do substance use but we only do kids who are highly marginalized or out of school or only over 18. So there's been a lot of sending youth there or here and not following up or they get there and they don't qualify or fit with the program. So we were seeing these things at a community-level that needed to shift.

Many interviewees mentioned gaps for youth trying to access mental health services due to issues between 'child & youth services' versus 'adult services' and thus, the need for change and the need to focus on transitions for youth. Allison et al. (2013) found that mental health transitions "were generally poorly planned, poorly executed, and poorly experienced by older adolescents moving on to adult services" (p. 613). In addition to this split, traditional mental health services are often separated from primary healthcare, resulting in silos of practice (Kutcher, Davidson, & Manion, 2009). This limits the number of providers who are trained to deliver mental health services to transition aged youth and forces mental health specialization. It also may contribute to stigma, as individuals have to access mental health services separately from their primary healthcare (Acri et al., 2016; Mount Sinai Adolescent Health Centre, 2016).

> Mental health transitions "were generally poorly planned, poorly executed, and poorly experienced by older adolescents moving on to adult services".
>
> *Allison et al., 2013, p. 613*

As well, there was a consistent need expressed to focus on prevention and early intervention services for youth. The mental health concerns that emerge in youth tend to perpetuate into adulthood and remain long-lasting and chronic (Kutcher, Davidson, & Manion, 2009). One interviewee indicated that individuals requiring but not receiving services as youth were seen within the system again as adults, often with more severe and complex issues coupled with social issues such as poverty and homelessness. The development of mental health services for transition aged youth was seen as effective for service planning, improving outcomes, and as a potential cost-saving measure long-term (Acri et al., 2016).

There is a demonstrated need for integrated care around youth mental health (McGorry, Bates, & Birchwood, 2013; Acri et al., 2016; Protti, 2009). Integrated care has been shown to increase service access for all youth as well as populations that are underrepresented at traditional single healthcare settings such as adolescents in their early 20's, homeless youth, low-income youth, or those who identify along the spectrum of sexual orientations (McGorry, Bates, & Birchwood, 2013; Acri et al., 2016; Kutcher, Davidson, & Manion, 2009). Positioning Integrated Hubs as a place where all youth feel that they can turn to for resources and support can help "strengthen a community's capacity to support its young people" (McGorry, Bates, & Birch, 2013, p. S32).

Integrated Care

Key Considerations

- Integrated care exists along a continuum from parallel practice to integrative
- Integration will look different for each community based on needs and available services.

The Canadian Council on Health Services Accreditation (2006) (as referenced in Suter et al., 2009) defines integrated care as services, providers, and organizations from across the continuum working together so that services are complementary and coordinated, in a seamless unified system with continuity for the client. Working with clients who have complex needs requires the following: collaborative working relationships, common goals, effective and frequent communication, an understanding and respect of individual roles and skills within the team setting, and flexibility (Protti, 2009). As Table 2 below shows, there are a range of care types which can serve as a framework for Integrated Hubs.

Boon et al. (2004) present seven levels of team healthcare practice that denote increasing integration, from parallel practice to integrative. The authors note that as one moves further along the continuum, there is an increasing emphasis on holistic care, a more complex team structure, and increased necessity of communication and consensus decision making. The Provincial Territorial Working Group (2016) identifies multiple collaborative care models that can be found across the continuum of parallel to integrative practice.

Together, the models in Table 2 provide a summary regarding the scope with which service providers can orient their care. One interviewee mentioned that, *"integration looks different for each [Integrated Hub], takes time to build, [and] depends on the community resources".* Therefore, while integration is the goal, the definition of what constitutes an Integrated Hub is reflective of a community's needs.

Table 2: Integrated Care Models

	Community Model of Care (PTWG, 2016)	Continuum of Integrated Practice (Boon et al., 2004)	Setting/Provider/Type of Care
Communication Approach	Communication between practices	Parallel Practice	Separate practices; care/case management; psychiatric consultation.
	Medical-provided Mental Health Substance Use (MHSU)	Consultative	Consultation-liaison; care is provided by a physician with specialized support.
	Co-location	Collaborative Coordinated	Shared space – separate service; collaborative care; provision of education and self-management; independent treatment plans which may include references to the other.
Co-location and Collaboration Approach	Shared care	Multi-disciplinary	Services generally provided at primary healthcare site; care manager provides follow-up care by monitoring individual's responses and adherence to treatment; MHSU service outreach to General Practitioner; provision of education and self-management; treatment plan is primary healthcare of which MHSU is a component.
	Reverse shared care	Multi-disciplinary	Services provided at the MHSU site; shared space where the general/nurse practitioner (full or part time) is in a psychiatric/MHSU setting; treatment plan is primarily MHSU of which primary healthcare is a component.
	Specialized Hub & Spoke Outreach teams	Interdisciplinary	Specialized multi-disciplinary teams provide the General Practitioner, family and other care providers with specialized assessment, consultation, education, and support, and time-limited direct treatment to the individual in the community setting.
Integrated Team Approach	Unified care	Integrated	Full-service primary healthcare and full-service MHSU/psychiatric care in one place; organization-wide integration of clinical services, financing, administration, and integrated medical record/treatment plan.
	Primary Care MHSU team	Integrated	Fully-integrated; MHSU staff part of primary healthcare team and co-manage care; focus on brief interventions for a large number of clients/patients; one-stop concept at intake.
	Fully-integrated system of care	Integrated	Wrap-around teams; seamless continuum of outpatient and supported housing; inter-disciplinary (outpatient and residential); individualized care plans for high-risk individuals across multiple service agencies/disciplines.

Need for Systems Transformation

Key Considerations

- Cross-sectoral resource pooling can support Integrated Hub delivery
- Communication between and among government and service agencies must occur
- Youth and their families are critical voices to include throughout all stages.

Several interviewees discussed their vision for the Integrated Hubs that they were developing or had developed for the provision of youth mental health services. They recognized that there was a need to change the way the system worked and, to do that, a collective or collaborative approach was required. Research consistently demonstrates that the structural systems around finances and institutions can be a barrier for reaching integration (CAMH PSSP, 2016; Acri et al., 2016). Pooling financial resources from multiple agencies and government sources to create new funding streams was seen as a way to support the delivery of Integrated Hubs (McGorry et al., 2007).

One service provider indicated the need for a cross-sectoral response, including other government ministries such as health, child intervention services, social development, justice, and education. These sectors all contribute to youth health and well-being and as such, need to be communicating with each other to help address youth mental health. One interviewee noted that, "*there seems to be a disconnect from policy from the top decision makers down to the front lines... The more that you can talk to the frontline the better decisions get made".*

Another interviewee acknowledged, *"we can't do it all ourselves*", calling for policymakers and practitioners to work together to serve youth. In order to do this effectively, several of the interviewees indicated that frontline providers, families, and youth themselves needed to be consulted to ensure that policies would not have unforeseen or unintended consequences. Youth and their families are part of the frontline as they are the ones navigating the system. Their voices should be included as part of the service planning and implementation processes, and are particularly important at the systems transformation level as this shapes base requirements.

Interviewees identified further considerations for transforming the ways that governments, communities, and those served by systems work together. These included:

- Involve youth in their own care
- Support community advocacy related to youth mental health
- Recognize the need for traditional services to be adapted for youth needs
- Increase understanding of mental health issues at the systems- and community-levels
- Facilitate legal accommodations for confidentiality and information sharing among Integrated Hub service providers.

Advanced stages of systems transformation are achieved when Integrated Hubs are part of a larger provincial or national strategy. These networks of Integrated Hubs demonstrate what is possible when different levels of government, community leaders, practitioners, and youth work together to ensure that there is a minimum standard for youth mental health services and supports regardless of the community they live in. Examples of Integrated Hubs operating multiple sites under a flexible framework adaptable to community needs are provided on page 35.

Findings

An Integrated Hub is best understood as the integration of health and social services under one roof in a youth-friendly environment. They typically focus on prevention and early intervention and the provision of resources to help youth manage their concerns and navigate pathways to specialized services as required. They aim to minimize the service gap between child and adult services by providing a youth-oriented 'one-stop-shop' for youth to access mental healthcare as early as possible. Integrated Hubs typically include the following features:

An Integrated Hub is best understood as the integration of health and social services under one roof in a youth-friendly environment.

- Offers comprehensive services along the care continuum which strives for integration
- Brings together health and social services at one location for a single point of entry
- Has a stepped care approach with transitions to specialized services as required
- Promotes an organizational culture which respects youth

While the idea of Integrated Hubs for addressing prevention and early intervention of youth mental health issues is fairly new and each Integrated Hub is at different stages of implementation, it is clear that a need exists. As described earlier, there is a demonstrated need for a shared understanding of youth-oriented mental health services that strive for integration and accessibility. Moreover, there is acknowledgement that to achieve this, a corresponding focus on systems and policy must occur. This is identified as the context with which Integrated Hubs exist in. The delivery of youth mental health services through Integrated Hubs is an emerging practice[3]. Evaluation of relevant outcomes is in the early stages. Based on preliminary findings from the literature, there is no one single way that works best. Therefore, the definition of what constitutes an Integrated Hub is reflective of a community's needs.

There are, however, certain essential features of the Integrated Hubs that are contributing to positive outcomes. These were reinforced through interviews with Integrated Hub practitioners and stakeholders who shared the successes and challenges of bringing services together in their community

[3] "Emerging practice refers to practices that have been implemented in one setting and there is information obtained from personal accounts, informal observations, and/or ongoing evaluation that suggests that the practice can have a positive impact on outcomes and/or system performance" (Rousell, Scott, Salt, & Rewega, 2016, p. 17).

to form an Integrated Hub. What this means in practice is that Integrated Hubs work best when they are tailored to the specific needs of a community's youth.

Common themes consistently emerged from the different Integrated Hubs and are discussed as guiding principles, critical elements, and considerations for planning, implementation, and operations (Figure 2).

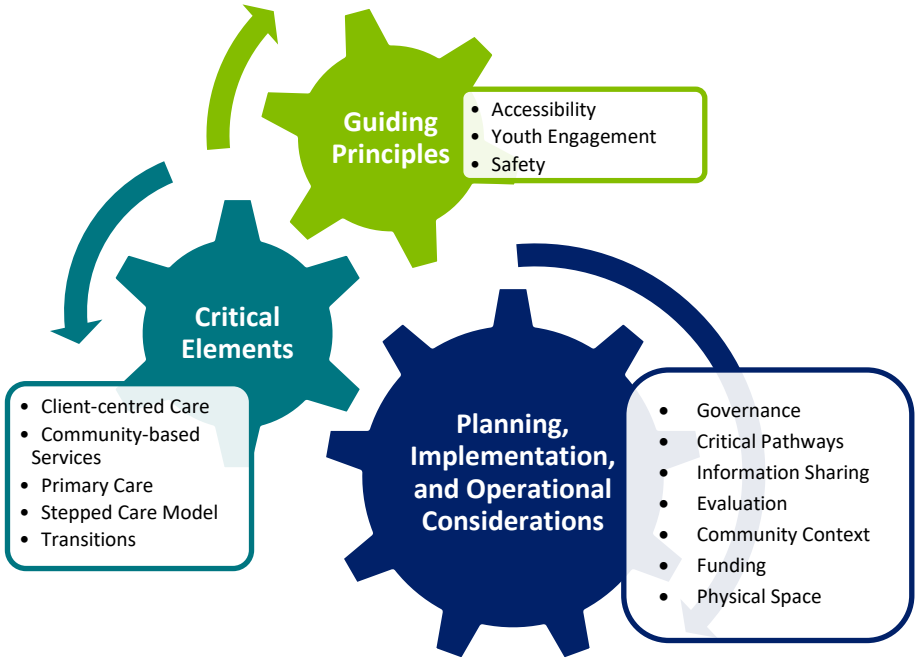

Figure 2: Environmental Scan Findings

The findings have been organized by these topic areas with each sub-theme elaborated on to illustrate a state of practice and potential for Integrated Hubs. Evidence sources varied for each sub-theme but all were brought up to be important factors by interviewees and reflect the current state of practice and desired practice for Integrated Hubs, see Table 3 below.

Table 3: Evidence Review

Topic	Literature[4]	Sites	Interviews
Guiding Principles			
Accessibility	✓	✓	✓
Youth Engagement	✓	✓	✓
Safety	✓	✓	✓
Critical Elements			
Client-centred Care		✓	✓
Community-based Services	✓	✓	✓
Primary Healthcare	✓	✓	✓
Stepped Care Model	✓	✓	✓
Transitions	✓	✓	✓
Planning, Implementation, and Operations Considerations			
Community Readiness		✓	✓
Funding		✓	✓
Space	✓	✓	✓
Governance	✓	✓	✓
Staffing		✓	✓
Critical Pathways	✓	✓	✓
Information Sharing		✓	✓
Evaluation		✓	✓

Guiding Principles of Integrated Hubs

Guiding principles serve as the foundation for Integrated Hubs and are universal in their application yet flexible to the needs of each community. When a community is in the early stages of exploring the idea of an Integrated Hub these are the principles which signify alignment with the Integrated Hubs philosophy. Several overarching principles to guide the implementation and operation of Integrated Hubs were identified. These include accessibility, safety, and youth engagement in the Integrated Hub.

Accessibility

Key Considerations

- Refers to the ease in which youth can access services
- Location, hours of operation, eligibility, waitlists, and referrals contribute to accessibility
- Co-location of services in a single physical space facilitates accessibility.

[4] Literature in this evidence table refers to both academic and grey that met the search criteria. At times, additional literature is referenced within sub-theme sections to expand and define concepts that were introduced through the site review or interviews. These are not considered part of the evidence sources for Integrated Hubs.

There is a need for Integrated Hubs to focus on increasing accessibility for youth mental healthcare. In order for the Integrated Hub to be appropriate for youth, it needs to be "able to be used" (Mount Sinai Adolescent Health Centre [MSAHC], 2016), as one interviewee noted that, "*fundamentally, there is poor accessibility to mental healthcare [which is] particularly prevalent and problematic amongst young people*". In the context of Integrated Hubs, accessibility refers to the schedule and location, eligibility for services, the lack of waitlists, drop-in vs. referral, and the availability of staff and services within the Integrated Hub.

The potential for prevention or early intervention for general mental health issues can be limited as waitlists preclude youth from accessing timely care and from receiving support before mental health issues became more complex.

Transportation and the placement of the building within the community are important considerations as youth need to be able to get to the Integrated Hub. Further, operating at times that are convenient for youth (e.g., after school or on weekends) was also found to be essential. For some Integrated Hubs, this meant that they were open every day (e.g., for Integrated Hubs that served homeless youth who had nowhere else to go). Other Integrated Hubs had drop-in hours where youth could come for whatever they needed (e.g., from 12:00 – 3:00 PM every day) such as a meal or a safe place, but at all other hours they needed to be coming to access the targeted services provided. One interviewee noted, "*if you are open for example from 5:00 AM to noon and half the teenagers aren't awake at that time, that wouldn't work. But it might be very logical to have them open till 11:00 PM when everyone is awake and needing some care*".

While interviewees emphasized youth-oriented hours, these did not always line up with what they were able to offer in practice due to staffing availability. Striking a balance between hours convenient for youth and hours convenient for staff was identified as an ongoing challenge. Many Integrated Hubs compromised by offering a consistent schedule that balanced typical office hours of 9:00 AM – 5:00 PM with hours that were more accommodating of a youth's potential school or work schedule. One interviewee mentioned the potential difficulties with accessibility for remote or rural communities and the need to broaden the concept of 'accessibility' with options such as mobile outreach instead of solely a walk-in physical space.

Youth trying to access mental health services often face issues regarding eligibility. Several interviewees discussed stories of youth who tried to access supports but were turned away because they did not fit the eligibility criteria of the services. Existing child or adult services are often specialized, dealing with one specific issue (e.g., substance use or borderline personality disorder). If youth do not fit into a single category, it may be difficult for them to obtain services.

Long waitlists for mental healthcare services (whether focused on prevention or intervention) often exist, particularly for assessment and scheduled treatment (Kowalewski, McLennan, & McGrath, 2011). Wait times for mental healthcare are generally shorter for those with increasing clinical priority (Ibid). This indicates that the potential for prevention or early intervention for general mental health issues can be limited as waitlists preclude youth from accessing timely care and from receiving support before mental health issues became more complex. A 2016 report on wait times for healthcare in Canada

indicated that patients seeking mental healthcare treatment (specifically psychiatric) face long wait times. On average, there is a 20.8 week period from general practitioner referral to elective treatment.

Wait times from first meeting with a specialist to receiving elective treatment are 183% longer than specialists deem appropriate (Barua & Ren, 2016). Furthermore, according to Children's Mental Health Ontario (2016), more than 6500 children and adolescents are waiting over a year to access mental health treatment. Wait times such as this are detrimental to youth and reduce accessibility to services.

To address the barriers of eligibility and wait times, youth need to be able to access the Integrated Hub on a drop-in basis, without a referral. All of the interviewees indicated that their Integrated Hubs involved drop-in services for youth. As well, the drop-in nature of the Integrated Hub recognized that youth should be able to self-refer rather than waiting for a referral from another service provider which may prevent them from coming to access services.

Finally, the co-location of multiple staff and services help to ensure that youth can access the services they need without having to wait or to travel to a second location. A single-point of entry means that, in a single visit, a youth can have access to all of the services that they need (England et al., 2009; Lee & Murphy, 2013). The model of Integrated Hubs was seen by interviewees to increase accessibility by "*embedding [the services] in communities and pooling relevant services to offer them in one place*". Another interviewee mentioned that even the co-location of services on one floor helped with youth engagement and retention in services.

Youth Engagement

Key Considerations

- Youth participate in planning, implementing, and evaluating Integrated Hubs
- Relationships are fostered between youth and Integrated Hub staff
- Youth are engaged in their own care
- Peer support is a valuable engagement tool.

Engagement was seen as an integral part of the success of Integrated Hubs. The World Health Organization defines participation and engagement as:

> The process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, and delivering services and in taking action for active change (as cited in Fraser Health, 2009, p. 3).

Engagement refers to several aspects of mental healthcare, including: getting youth to come to services, youth engagement in their own care, the involvement of youth and families in the development and ongoing operations of the Integrated Hub, and the role of peer mentorship in service delivery. The

Canadian Association of Mental Health indicates that effective programming requires youth participation in governance, planning, and implementation of services (O'Reilly et al., 2015; Howe et al., 2014; McGorry et al., 2013).

Engaging youth in services was described as not always being an easy task. Several interviewees indicated that just because the service was available and accessible did not mean that youth would come to use the services. One interviewee said, "*You have to do all kinds of engagement work before you get to your real purpose"* and another indicated that, "*if you don't do the engagement work, just because you showed up and offered services, young people don't necessarily come banging on your door"*. In order to engage with youth, there was a need to reduce the logistical and administrative barriers to accessing programming. Some Integrated Hubs used social media as a way to communicate with youth, all with a focus of "*reaching the youth where they are at*". One of the main ways that youth were retained in services was through a focus on building relationships between service providers and the youth.

Involving youth helped to create better programming and to ensure that services were youth-friendly.

All of the interviewees mentioned the need to build relationships with the youth as part of the service delivery. Building trust with all young people can take time but particular care and focus should be given to youth with complex needs who may have been let down by the system before and who do not trust it to have their best interests in mind. One interviewee said that, for those youth, it was important to "*give them time to trust and… some time to decide that they want help and be there when they're ready*". Trust, love, and respect were all seen to be part of building relationships and connections to the Integrated Hub. One interviewee indicated that, *"the purpose of the first visit is to get a second visit"*, therefore the relationship building process had to start as soon as the youth came in the door.

Relationship building techniques did not have to be complicated, as one interviewee revealed: *"you learn their name, you remember their name, you offer them food, you offer them help, you offer them this and when they screw up you don't give up on them".*

Evidence from both the interviews and the literature indicated the need to highlight the voice of youth and their families as part of the planning, operations, and implementation of the Integrated Hubs. Literature from multiple Integrated Hubs indicated that involving youth helped to create better programming and to ensure that services were youth-friendly (McGorry et al., 2013; Langdon et al., 2016). Most Integrated Hubs deliberately engaged youth and their families as part of their advisory boards to help co-create services that would work for youth, to identify gaps, and to help make them more youth-friendly. By recognizing the youth voice, Integrated Hubs improved their understanding of the needs of the youth population and the best way to work with them. One interviewee noted that:

> *By including youth and families as co-creators and co-decision makers in a project like this you are going to get a product that is going to be more acceptable and appealing and more likely to be accessed by your target group and that's going to be an important part of sustainability.*

In addition, another interviewee observed that by adding the youth voice, youth could become more engaged in their own care, unlike more traditional health and mental health services. They said that *"[youth] are steering the ship. Goals are up to them. We respect their path".* Taking a client-centred approach (as discussed further in the Critical Elements section below) helps to ensure that youth can establish their own needs and goals and can access the services that they view as most appropriate.

Finally, peer outreach could be used to help with the engagement of other youth in services. Repper and Carter (2011) note that using peer mentorship and support in mental health service delivery increased youth's sense of hope, empowerment, and social functioning while also reducing stigma. Many interviewees indicated that the youth who they served might have trust issues with the system or may be hesitant to access mental health services. Peer outreach is seen as one potential solution for increasing youth engagement in services as well as increasing the services' acceptability among youth.

Safety

Key Considerations

- Integrated Hubs are safe spaces where youth will not be turned away
- Youths' personal information will remain confidential
- Safety considers the needs of cultural, socioeconomic, and LGBTQ2 diverse youth.

Safety is an essential principle that entails a youth's psychosocial need to feel secure despite the mental health struggles she/he is enduring. One of the principles of safety is for youth to know that adults, as service providers, will be there for them without judgement. There should be no fear of being turned away for presenting concerns that may be considered petty or too severe which makes the space safe (MSAHC, 2016; McGorry et al., 2007). As one interviewee stated:

> *We're there. Every. Single. Day. So [youth] show up and we're there. And we don't care what their story is, we don't care what they've done, we're just there. And that's the only thing you can do for them until they know, until they actually understand that you are going to be there and that's when you can start working on the trauma… We're providing consistent stability, boundaries, guidelines, and care.*

As part of building trust and relationships with the youth, confidentiality of the services provided and the information shared is necessary. Thus, youth must consent to having their information shared between the multiple partners of the Integrated Hubs with the knowledge that it will remain protected. The Integrated Hubs must also be cognizant of the potential for harm with insurance billing as a means for parents to find out about the youth's participation in services (MSAHC, 2016). One interviewee mentioned funding streams that allowed them to bill for services only if it was anonymous.

Strides have been made to normalize accessing mental health supports but the reality is that stigma and discrimination still exist and may compromise a youth's sense of safety in being able to access services. While part of fostering safety is achieved through youth engagement and outreach as described earlier,

Integrated Hubs must consider the principle of safety in ways that include cultural safety and additional supports for vulnerable populations.

Cultural safety was most frequently referenced in terms of experiences of Indigenous peoples but any cultural minority can benefit from cultural safety principles. The National Aboriginal Health Organization (NAHO) (2008) offers the following definition:

> Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs (p. 19).

Furthermore, the foundations of cultural safety are based upon three dimensions that are inter-related with power distribution: 1) equal partnership, which allows for mutual respect and dialogue; 2) active participation, which encourages both groups to be involved on all levels (cognitive, affective, and behavioral) in each phase of interaction; and 3) protection of cultural identity and well-being, to reduce any possibility of discrimination or stereotyping and ensure ethical foundations of the relationships (Blanchett Garneau, & Pepin, 2012).

Being mindful of the diversity in which culture, gender, age, sexual orientation, and socioeconomic status all intersect together is important to ensure youth feel that Integrated Hubs are safe spaces (Kirmayer, Whitley, & Fauras, 2009). For youth who identify as lesbian, gay, bisexual, transgender, queer/questioning, or two-spirited (LGBTQ2), one way this can be done is by framing questions in an open manner as to not assume heteronormative bias (Medeiros, Seehaus, Elliot, & Melaney, 2004). Youth who are homeless or low-income face additional safety concerns as they may not have their basic needs of food, safety, and shelter continually met. The ability to offer services free of charge can alleviate concerns that homeless youth may have about accessing services and ensure they have access to Integrated Hub resources that can assist with their basic needs and mental health needs (MSAHC, 2016; Acri et al., 2016).

> Strides have been made to normalize accessing mental health supports but the reality is that stigma and discrimination still exist and may compromise a youth's sense of safety in being able to access services.

Critical Elements of Integrated Hubs

Critical elements are the essential components or ingredients that distinguish an Integrated Hub from existing health and social services. The following critical elements of youth-friendly care were consistently highlighted by service providers, executive directors, and program and policy makers. Interviewees recognized that there were issues with the current system that were preventing youth from being able to access services. Both the literature and the interviews indicated a need to focus the Integrated Hubs on what youth need and to make them youth-friendly. Several key elements were described, including

care that: is client-centred, is community-based, integrates primary healthcare, involves a stepped care model, and is transition-focused.

Client-centred Care

Key Considerations

- Youth are co-producers of their care
- Youth are given choices
- Power is shared between youth and service providers.

The critical element of client-centred care may be best captured by the phrase shared by an interviewee, "*nothing for us, without us*". Client-centred care (also known as person- or patient-centred care) recognizes the importance of people as co-producers of their care with healthcare professionals through increased engagement and shared decision making (Gask & Coventry, 2012). Mead and Bower (2000) outline five key dimensions of client-centred care:

- One that recognizes the impact of psychosocial dimensions (personal, emotional, family, and community) as well as biological agents on health and diseases (Engel, 1980)
- An acknowledgement of the patient as a person and thus, an understanding of the personal meaning of the illness
- The sharing power and responsibility around shared decision making
- The development of a therapeutic alliance
- The doctor as a person (i.e., recognition of the personal qualities and subjectivity of the doctor).

With consideration of these dimensions, client-centred care requires a shift from more "paternalistic" healthcare to shared decision making and patient empowerment (Gask & Coventry, 2012, p. 140). Many interviewees indicated that the youth could decide which services they wanted to access and when they were ready to access services. One interviewee cautioned that, although involving youth may be important, youth in crisis may not know exactly what they need and may need guidance from other parts of the care team. Another interviewee noted:

> *Some of what [youth] appreciate is the level of clinical care and that there are different forms of it. So not only is there traditional psychologist type teams, but there's also peer support workers available who they define as someone who's actually been through a mental illness themselves and now can kind of come back and work with someone who's still trying to actively manage or get through it. And so I think that is also appreciated because that's away from the hyper clinical model and more towards the community care. Those options are helpful because different things are going to work for different people. I think that kind of flexibility is appreciated, and as well there is a real feeling of patients being at the centre of care.*

Therefore, youth could decide—with the guidance of Integrated Hub practitioners, what they are ready for, what they need in the moment and long-term, and who they want to work with to meet their needs. This means that youth need to have options within Integrated Hubs.

Community-based Services

Key Considerations

- Community-based services knit together existing services in a single physical location
- They thrive when built upon existing partnerships and relationships
- Management from a lead agency supports ongoing operation and service delivery.

Community-based mental healthcare refers to the knitting together of existing services to create a community owned approach to meeting the needs of their youth. A key characteristic is that mental healthcare is provided outside of a hospital and includes supports across the care continuum. These services are brought together to operate out of a single physical location. Potential services provided under the umbrella of community-based mental healthcare include treatment, crisis response, outreach, case management, and ancillary services such as housing, vocational supports, and/or criminal justice programs (CMHA Ontario, 2017).

The specifics regarding what is offered at an Integrated Hub beyond mental healthcare is dependent on community identified needs. Interviewees described the development of the Integrated Hubs as an organic process. Many had no desire to "*recreate the wheel*" and utilized existing resources in terms of knowledge, services, and structures. The Integrated Hubs often evolved based on community capacity, available resources, and the needs of youth. This drove what services were to be offered, in what location, and by whom.

As interviewees noted, this can vary based on what is culturally appropriate and reflective of community diversity. Organizations already located in the community have the experience and expertise to work within the local cultural context and ensure services meet cultural safety needs, which has been identified as a significant factor in the success of youth mental health initiatives (Langdon et al., 2016; Kirmayer et al., 2009; MSAHC, 2016).

Existing partnerships meant that the Integrated Hub could be built on what was already there without a lot of additional resources.

Several interviewees mentioned the existing partnerships and established relationships between community organizations as an important contributing factor to the success of the Integrated Hub's development and implementation. One interviewee indicated that existing partnerships meant that the Integrated Hub could be built on what was already there without a lot of additional resources: *"When you start to realize existing resources/impacts in community and connect the dots, things can happen. You don't always need a lot of money. But as an organization, you need to have finger on the pulse"*. Another interviewee noted that the success of their Integrated Hub was due to *"the fact that it was set up, owned, and operated by a community-based agency who was in the lead"*. Having a lead or core organization at the helm of the

Integrated Hub also helped foster partnership sustainability through buy-in and by being clear up front that eventually, the partner organizations' services would have to be *"folded into the organization".*

Both coordination and collaboration were easier to achieve with pre-existing relationships; Integrated Hubs without these relationships faced challenges developing strong collaborative partnerships within funding timelines of one to two years (Muir et al., 2009). Lead organizations needed special expertise in building and maintaining partnerships, given that the Integrated Hubs are meant to be integrated and the nature of youth mental health means that multiple services need to come together. In order to fully engage communities, there was a need for buy-in into the vision and goals of the Integrated Hub, which could be difficult, as it might require a shift from a single agency's mission and/or goals. Several interviewees indicated the *"need to have the right people at the table"* – in reference to those focused on building solutions, not merely on discussing what was not working. Community-based services shift the mentality from programming being brought in to fix the community, to the community and their youth taking the reins and guiding service direction with the support of government.

Primary Healthcare

Key Considerations

- Primary healthcare integration looks different for each community
- Primary healthcare contributes to holistic health
- Primary healthcare can provide a stigma-free reason to access an Integrated Hub.

Evidence from the interviews and the academic and grey literature indicates that primary healthcare needs to be integrated into mental healthcare (Boon et al., 2004; Butler et al., 2017; Henderson et al., 2017; Muir et al., 2008). Individuals with mental health or substance use issues often have difficulty accessing high-quality primary healthcare (Butler et al., 2017). By integrating mental and primary healthcare, multiple needs can be addressed holistically. Primary healthcare is also interconnected with mental healthcare; for example, to provide medications, for screening, and to promote follow-up (Butler et al., 2017). Finally, the integration of primary healthcare into mental healthcare service delivery can help to promote accessibility and reduce stigma (Muir et al., 2008; Kutcher et al., 2009; Acri et al., 2016). Kutcher et al. (2009) note that one barrier to accessing mental healthcare is the silos existing in mental versus primary healthcare, resulting in parallel, not integrated, practices. The authors also note that separating mental and physical healthcare prevents the development of competencies of primary healthcare physicians around mental health assessment and diagnosis and limits the potential for collaboration.

The interviewees indicated that primary healthcare was differentially integrated into their service delivery. Some had built their Integrated Hub with a primary healthcare partner; others had healthcare professionals, such as nurse practitioners, on staff. Some of the Integrated Hub models that were more focused on service navigation provided necessary referrals to primary or mental healthcare resources,

as required by the youth. All acknowledged the importance of working towards integrated practice to ensure youth receive the best combination of health services.

Stepped Care Model

Key Considerations

- Stepped care offers the greatest impact for the least resources
- Stepped care reaches more people using lower-intensity interventions
- Stepped care involves monitoring to determine when care needs to be 'stepped up' to a higher-intensity.

In order to ensure that the finite financial and human resources available for addressing mental health issues are used effectively, there is a need to use a stepped care model (Bower & Gilbody, 2005; McGorry et al., 2013; Rickwood et al., 2015), as it has potential to get the greatest benefit from available therapeutic resources. Several interviewees from the Integrated Hubs indicated that they were using stepped care models to guide their service delivery. Stepped care is a healthcare delivery model that involves first delivering the most effective, yet least resource-intensive treatment, to patients (Richards et al., 2012). Stepped care is a model of healthcare delivery that has two main features:

- The recommended treatment should be the least restrictive option (i.e., should have the least financial and time impact on patients and should have the least treatment intensity (Sobell & Sobell, 2000)) but should still be likely to provide significant health gain (Bower & Gilbody, 2005).
- Stepped care healthcare delivery is self-correcting, meaning that the results of treatments and decisions about treatment types are monitored and changes are made if current interventions are not achieving positive change. This provides the opportunity for individuals to 'step up' to more intensive treatments as needed (Richards et al., 2012).

Stepped care involves different options of treatment intensity and is based on the assumption that lower intensity interventions can provide significant health gain (as compared to more intensive interventions) for at least a proportion of the population and are acceptable to patients and professionals. Thus, by using these lower-intensity interventions, healthcare resources can be used more effectively (Bower & Gilbody, 2005). This is demonstrated below in Figure 3.

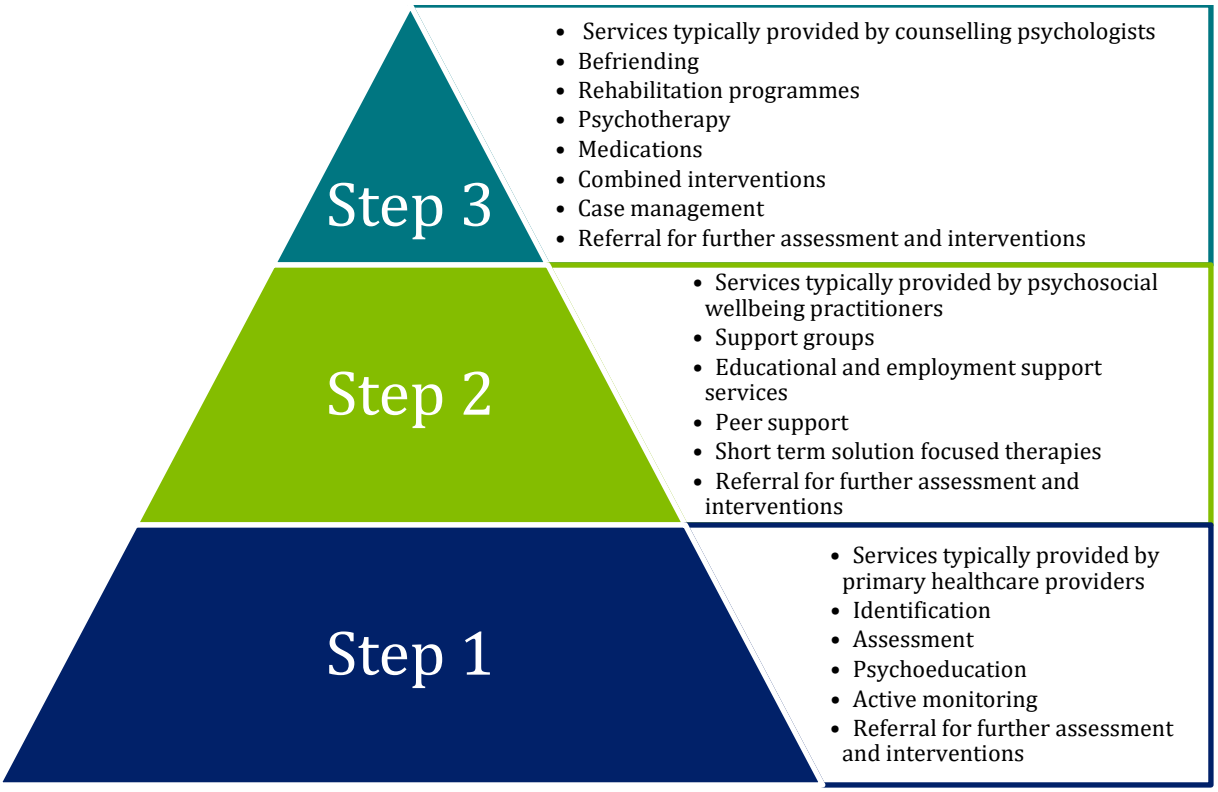

Figure 3: Stepped Care Model. Adapted from the National Institute for Health and Care Excellence (2011).

Transitions

Key Considerations

- Transitions bridging child and adult services ensure a continuum of care
- Preparing youth for adulthood is an important part of this transition of being fully responsible for their own care
- Appropriate referrals to additional supports with warm hand offs ensure continuity of care.

McGorry et al. (2013) note that the transition from childhood to adulthood overlaps a prolonged and unstable developmental age. The Mental Health Commission of Canada (2015) report that youth experiencing mental health concerns during the transition to adulthood may experience poor functioning, systems involvement (e.g., homelessness, justice involvement), and challenges with education and employment. Thus, the transition to adulthood requires "diverse, integrated, and comprehensive supports that promote mental wellness and early identification of [mental health] concerns" (CAMH, 2016, p. 2).

To help address the systems' gaps related to the transition from child to adult mental healthcare, there is a need for the Integrated Hubs to actively work towards transitions for youth with mental health concerns. In this context, transitions refer to several concepts.

> The transition to adulthood requires "diverse, integrated, and comprehensive supports that promote mental wellness and early identification of [mental health] concerns"
>
> (CAMH, 2016, p. 2).

Several interviewees indicated that there was a need to establish partnerships and pathways with child and adult mental health services. Many interviewees recalled anecdotes of youth trying to access child mental health services but, with long waitlists, were not seen. If the youth tried to access adult mental health services, they would be turned away as ineligible. Thus, it is important for the Integrated Hubs to fill the gap in the care continuum from child to adult mental health services and to ensure that transitions between these services are well-established.

In addition, Integrated Hubs should help youth transition to independence. Most of the Integrated Hubs indicated a target population of up to 25 years (with some going up to 29 years). However, after this eligibility period is over, the youth who are aging out of the Integrated Hub need to be familiar with and know how to access services available to them as adults. One interviewee mentioned the need to build in independence training while still providing support for the youth so that they would be ready for the transition when necessary.

Even within the youth-focused service delivery, many of the interviewees mentioned the need to be able to refer youth to other services or supports within the community and beyond. For example, if the youth needed more complex mental healthcare or a support that was not provided within the Integrated Hub, there was a need for systems navigation support. In these cases, building in a warm hand-off to other services was described as important so that the youth would still feel engaged in the service delivery even when they have been referred or transferred to other services. Many of the interviewees also stated that part of this hand-off included gently encouraging youth to find ways to expand their social support system, whether this was from parents or friends, and worked with them to reach out if they were unsure of how to do so. Connecting youth with supportive people, whether with formal service providers or informal supports such as family and friends, is an essential aspect to Integrated Hubs.

Finally, because the Integrated Hubs are meant to focus on prevention and early intervention, not to replace the more intensive treatment programs for complex mental health needs, there is a need for therapies to be transition-focused and short-term. Examples of evidence-based therapeutic resources delivered as part of prevention and/or early intervention mental healthcare for youth include:

- *Solution-Focused Brief Therapy*: an approach to psychotherapy based on solution-building rather than problem-solving. Thus, solution-focus brief therapy focuses specifically on developing a solution or goal and the resources necessary to achieve it (de Shazer et al., 1986; Iveson, 2002).

- *Motivational Interviewing*: a counselling style based on respectful collaboration between counsellor and client where specific strategies are used to explore the person's values and goals in relation to the issue of interest (it is often used for addressing substance use issues) and to build motivation for change in the client (Rollnick & Miller, 2004).
- *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*: is a treatment used to help children and adolescents recover from trauma. TF-CBT is a structured, short-term treatment model that effectively improves trauma-related outcomes and the developing nature of the child or adolescent's cognitive and emotional regulation abilities (Ramirez de Arellano et al., 2014).
- *Mindfulness*: a particular way of paying attention to the experience, on purpose, in the present moment, without judgment (Kabat-Zinn, 2003). This can be used in mindfulness-based cognitive therapy, dialectic behavior therapy, and acceptance and commitment therapy. Shapiro et al. (2006) note three primary elements in the process of mindfulness: attitude, attention, and intention.

Planning, Implementation, and Operations Considerations

Content included in this section was primarily identified by interviewees and in the site review. Themes are described briefly and will be discussed in further detail in an accompanying implementation guide.

Community Readiness

Key Considerations

- Community readiness assessments determine a community's preparedness and capacity for taking action
- Existing relationships enhance a community's readiness for an Integrated Hub.

In order to ensure that funding is being allocated effectively and usefully, there is a need to conduct community readiness assessments to ensure that communities who are chosen to implement Integrated Hubs are actually able to do so. Community readiness refers to the degree to which a community has capacity to take action on an issue. Community readiness can be defined in several ways and should be issue-specific. For example, being able to adapt to the needs and culture of the community and the target population and being able to take existing partnerships and services and shifting them towards the vision of the Integrated Hub.

The Tri-Ethnic Centre for Prevention Research developed a model for understanding the dimensions of community readiness (see Figure 4). This model includes key factors about the community's preparedness for taking action: existing community efforts, community awareness about these efforts, leadership, community climate (e.g., attitude towards action), community knowledge about the issues, and resources available for addressing the issue.

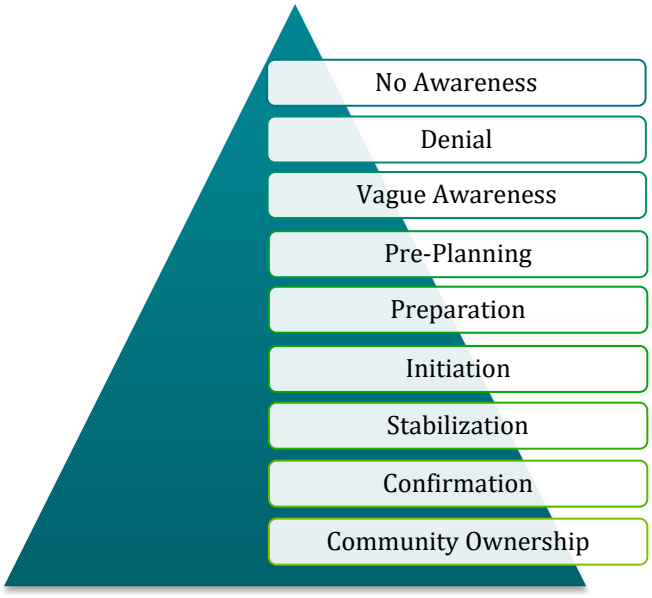

Figure 4: Stages of Community Readiness. Adapted from the Tri-Ethnic Centre for Prevention Research (2014).

These factors are further reflected in interviewee's perceptions of community readiness. For an Integrated Hub to be set up for success, communities must critically examine their stage of readiness and what steps need to be taken to obtain full community ownership of the project. One interviewee mentioned the importance of existing partnerships and capacity in place, as relationship capital was an important resource for moving the Integrated Hub forward. The inclusion of youth and family voice as a proponent of relational capital was noted by one interviewee to be astrength because "*we are building a better model than if we were working on it on our own*".

Funding

Key Considerations

- Funding should be sustainable so that the Integrated Hub remains viable
- Strong examples of sustainable Integrated Hubs are community led and knit together existing services to maximize resources
- Formal agreements, such as memorandums of understanding, can help to leverage existing resources and ensure that funds move fluidly for Integrated Hub needs
- Fundraising initiatives provide a boost to deliver additional services.

Many Integrated Hubs had successfully started up by shifting their available resources and practices to do things differently with what they already had. While money was consistently seen by interviewees as a barrier to providing services as they envisioned them, there was recognition that the fiscal climate often requires that they "*do more with less*" and this was only possible through coming together. Whether the Integrated Hub is an independent operation or part of a larger multi-site network, several interviewees indicated that there was a strong need for sustainability in funding, whether public or

private, to ensure that services remained viable over time and that staff could be retained. For example, with potential physician shortages and the reality of individuals being seconded from positions, it was important to ensure that staff had long-term, renewable contracts that would help to retain them within the Integrated Hub rather than short-term, casual contracts. This was connected to the need for reliable, long-term staff to build relationships with youth. Several interviewees also noted the need for a formalized agreement (such as a memorandums of understanding) between partners to ensure that funding flowed as necessary for ensuring staff from each agency was properly paid from the pooled resources.

Interviewees also mentioned the need for continued advocacy and fundraising to ensure sustained implementation and operation of the Integrated Hub. Much of the initial start-up and implementation funding for the Integrated Hubs came from the government; within Canada, several interviewees mentioned that the shift in provincial governments could affect their funding. This was seen as a sustainability risk therefore the emphasis from interviewees was that Integrated Hubs required a mindset shift regarding the use of existing operational funds rather than temporary Integrated Hub specific funding. The reliance on short term funding was especially concerning given the need for quality and long-term evaluation metrics to show the success of the Integrated Hub. One interviewee indicated that, "*It takes a long time to build relationships and then initiatives like this have to demonstrate impact quickly*". As such, there is a need for communities and systems to recognize the intricacies and the importance of integrated service delivery for youth mental health when considering allocation of resources and provide protection for existing operating budgets.

The need to build sustainable funding into the Integrated Hub to ensure that the full range of services could operate over time was often seen as a challenge and an ongoing issue for advocacy and fundraising; however, many of the Integrated Hubs had seen significant support from their funders and the recognition that what they were doing was important. Interviewees indicated that additional funding (e.g., from fundraising or philanthropic donors) allowed them to build more elaborate service programming and space for the youth, and to go beyond the basic needs to become more creative and adaptive to the youth's needs.

Space

Key Considerations

- Physical space should be youth-friendly, incorporating colour and comfort into its design
- Physical space uses an open concept while considering privacy and safety needs
- eHubs are often part of service delivery, going beyond the physical space to more youth-friendly environments such as apps, websites, or social media.

The space in which the Integrated Hub is delivered is an important consideration for youth-friendly care. This consideration incorporates the recognition of both physical space as well as virtual space.

Designing a youth-friendly environment meant considering their needs in the context of service delivery and engaging them in the development process.

The design of the physical space in the Integrated Hub was seen as a very important piece of engagement and service delivery. Designing a youth-friendly environment meant considering their needs in the context of service delivery and engaging them in the development process. In an evaluation of the headspace™ Integrated Hubs, youth indicated that a youth-friendly environment required (Rickwood et al., 2014):

- a comfortable space (e.g., comfortable couches and chairs)
- colourful walls, artwork, and a shift away from the clinical atmosphere of a doctor's office
- an open waiting area as well as open centre spaces (e.g., high ceilings) so that youth did not feel closed in.

The interviewees concurred with many of these design elements, using terms such as "*open concept*" and spaces that facilitated conversation. Another stated that:

> *At the very least, having a youth-friendly space where they aren't walking into a waiting room with a bunch of 55 year old men, you know? Or a group of preschoolers who are playing with toys. I think those pieces are important.*

Interviewees also noted the need to balance the youths' needs for trust with the needs of safety for the whole community. One interviewee stated that by concentrating youth services at one location, there is the reality that some of the most at-risk youth will bring street life into the facility. They stated, "*If you're inviting all of these people, it becomes a bit of a powder keg on a bit of a daily basis".* This meant negotiating the use of barriers between staff and clients such as plexi glass, particularly at entry points.

Some Integrated Hubs had formalized the design of the physical space to create consistent branding throughout a region while allowing flexibility within communities. This was meant to create fidelity to a specific brand that represented a level of experiences and services from the physical space to the design of the business cards. One interviewee indicated that such decisions could be difficult to manage because:

> *We have a brand [and] specifications that people need to adopt [so we are] constantly trying to find balance between consistency in brand, experience, and fidelity to a model [while still] allowing for community flexibility and uniqueness [and the] rich histories and competencies [of the lead agencies].*

An eHub or online space was also seen to be important for integrated mental health delivery for youth. eMental Health can be defined as mental health services and information delivered or enhanced through the internet and related technologies (Christensen, Griffiths, & Evans, 2002). Online mental health service delivery can facilitate peer-to-peer support, self-help, improved awareness, and recovery (Bennett, Reynolds, Christensen, & Griffiths, 2010). Bennett and colleagues (2010) identify two main forms of services for eHubs: those that delivered online interventions or those that facilitated support groups.

Several Integrated Hubs were also initializing eHubs as part of their service delivery, going beyond the physical space to more youth-friendly environments such as apps, websites, or social media. The potential of eHubs to provide services and increased connectivity even for youth in rural or remote settings was a benefit, although the physical space was being developed first.

EHubs or online platforms can also help to ensure that information sharing is integrated across the service providers and partner organizations involved in the Integrated Hub. One interviewee mentioned their Integrated Hub used a mobile platform to help youth make appointments, review lab results, and find health-related information.

Governance

Key Considerations

- Decision-making and control structures within the Integrated Hub should be diversified
- Strong governance requires mechanisms that promote coordination and accountability
- Advisory boards support organizational structures by providing expertise on different subject areas.

As with the funding models and the service models, different Integrated Hubs had different governance structures. Governance represents decision making and control within the system (Suter et al., 2007). Strong, focused governance is an integral part of successful integration. Governance should be diversified to include the perspectives and expertise of multiple stakeholders, including physicians and community members (Hawkins, 1998; Shortell et al., 2000), which will help to provide a clear vision and promote collaboration (Friedman et al., 2000; Shortell et al., 2000).

> Governance should be diversified to include the perspectives and expertise of multiple stakeholders, including physicians and community members.

Integration of multiple services requires the development of organizational structures that promote coordination (Suter et al., 2007). Integrated service delivery requires responsive organizational structures that fully utilize: the skills and talents of the employees; strong connections with external stakeholders, the government, and the community; and financial incentives (Suter et al., 2007). Strong

governance also requires mechanisms for case management, accountability, and decision making (Friedman et al., 2001; Wilson et al., 2003).

The site review and interviews revealed both similarities and differences in the governance and organizational structures of Integrated Hubs. Similarities included:

- The involvement of advisory boards to bring together expertise on subject matters to guide the development and ongoing operations of the Integrated Hub and its strategic direction. Advisory boards were made up of experts and community members. Interviewees mentioned having advisory boards (as a whole or with sub-committees) to oversee clinical practice, governance, youth and family needs, education, fundraising, communications, and evaluation.
- All of the Integrated Hubs had an agency which served as the lead among the service providers and acted to bring together the partners around a central purpose. The lead or core agency was responsible for developing central leadership among existing agencies to be accountable for the administration of the Integrated Hub and reporting to the funders.

Several differences in organizational structure and governance also emerged from the site review and interviews. Some of the Integrated Hubs operated as a single site whereas others operated as multiple sites across a region. In the latter case, several Integrated Hubs had a centralized office which managed the funding, planning, and implementation of the sites.

To illustrate these structures and the differences between them, three Integrated Hubs are highlighted as examples:

1. Mount Sinai Adolescent Health Center (MSAHC) aims to improve health outcomes for young people aged 10 to 24 years in the greater New York City area through an integrated, holistic, and empowering approach. MSAHC is led by a senior administrative team (consisting of the Director, Medical Director, Chief Operations Officer, and Assistant Director) that is responsible for: hiring, supervising, and mentoring staff; the operations of MSAHC (including the clinical, research, and funding aspects); managing the provision of direct patient care; fundraising; and supporting strategic planning. In addition, an advisory board (consisting of 35 stakeholders from diverse areas including finance, juvenile justice, management, fundraising, and communications) represents and advocates for MSAHC as well as carries out fundraising. MSAHC also is affiliated with the Mount Sinai Hospital and Icahn School of Medicine, three New York City public high schools, and provides training in adolescent medicine (e.g., medical student rotations).

2. Foundry is a provincial initiative in British Columbia, Canada, that currently operates five sites (phase I) with plans to open two additional sites (phase II). Foundry has a central office that oversees the cross-provincial sites. This office receives guidance from several advisory committees and reports to the government and other funders. They also provide guidance to the sites, each of which have their own advisory boards and governance structures (within agency and hub-specific). The individual sites report to the Foundry central office that

administrates their funding and design, as well as helps to develop common tools to be used by the sites (e.g., MOU templates, staffing models, etc.).

3. headspace™ is a federal initiative in Australia aiming to promote and facilitate improvements in mental health, social well-being, and economic participation of young people (age 12-25 years) by providing holistic services, increasing community capacity, encouraging help-seeking, and providing quality evidence-based services (Muir et al., 2009). headspace™ has 30 Communities of Youth Services (CYSs) providing direct service delivery, supported by the headspace™ National Office (central administrative branch), the headspace™ Centre of Excellence (the evaluative branch), the Service Provider Education and Training Program, and the Community Awareness Program. These sites receive funding from the Department of Health and Ageing (DoHA). The governance of headspace™ involves several levels:
    - The ORYGEN Research Centre and the University of Melbourne who report to the DoHA
    - The Foundation Executive Committee provides strategic direction for headspace™ and is made up of five consortium members: the ORYGEN Research Centre, the University of Melbourne, the Brain and Mind Research Institute, the Australian Psychological Society, and the Australian General Practice Network
    - The advisory board provides recommendations for the strategic direction of headspace™ and reports to the DoHA
    - The CEO who provides oversight for the CYS sites.

Staffing

Key Considerations

- Mental health clinicians are trained to work in child or adult systems and will need additional training for youth mental health service delivery
- Youth mental healthcare should be confidential, respectful, and flexible.

Youth mental healthcare delivery requires a specialized approach from all staff working out of an Integrated Hub. Additional training is required for service providers who work in this area to account for potentially having exclusively worked within either child or adult systems. Delivering youth-friendly care requires staff to adapt to a stepped care model which may be counter-intuitive to the way they were trained to provide service. As one interviewee stressed:

> *I think really working with the workforce, the clinicians, and service providers to change what they think about what's required. So it's hard for clinicians who have done, perhaps a year to three of individual sessions of counseling or psychotherapy to actually believe that they can have a significant impact on a young person in one 60 minute session or three 60 minute sessions. It takes a shift. I think paying attention to the workforce development piece, the capacity building*

> *piece. Don't short shift that because those ultimately, it doesn't matter what I say to policy makers, ultimately the young person goes in the door and gets services from that provider.*

According to MSAHC (2017), there are several personal characteristics and skills necessary for staff working in Integrated Hubs which include: passion, commitment, and respect for young people; empathy, compassion, patience, and lack of judgment of young people; advocate for youth; willing to learn and adapt to meet the needs of young people; promotion of confidentiality and privacy; ability to communicate effectively with young people; collaborative; expertise in assessing young people; able to establish rapport; and ability to use a developmental-oriented and appropriate approach.

Even if the staff members of Integrated Hubs possess these characteristics and skills, if they have a lack of understanding about the role they each play as partners it can limit the potential for collaboration and ultimately the opportunity for youth to receive the best care (England, Lester, & Birchwood, 2009). Potential barriers to successful integrated stepped care can be overcome by ensuring that staff brought together to work within the Integrated Hub are focused on delivering youth-specific mental healthcare and share a vision of what youth mental healthcare should look like. Ongoing joint training and educational initiatives provide opportunities for all staff to become better informed of the importance of routine mental health monitoring through Integrated Hubs (Kutcher et al., 2009; Williams et al., 2004).

Even if the staff members of Integrated Hubs possess these characteristics and skills, if they have a lack of understanding about the role they each play as partners it can limit the potential for collaboration and ultimately the opportunity for youth to receive the best care.

Critical Pathways

Key Considerations

- Flexible pathways encompass how youth enter, use, and exit Integrated Hubs
- Youth should be able to access the Integrated Hubs through self-referral and receive guidance to navigate and transition throughout the system.

Integrated care pathways (ICPs) have been used as a mechanism to formalize operations for integrated care (Currie, 1999 in Rees et al., 2004). ICPs are tools to map out critical clinical and administrative pathways to bring together all of the service providers involved in the patient's care. ICPs can be used to improve multidisciplinary documentation, communication, and planning (Higginson & Johnson, 1997 in Rees et al., 2004). Within mental healthcare, there has been limited evidence for the application of formalized ICPs, potentially due to concerns about the complexity of mental health issues and the need to be client-centred (Rees et al., 2004). However, ICPs have been used within many settings, resulting in improved outcomes (Hall, 2001; Rees et al., 2004).

There was a focus on critical care pathways to allow for youth-friendly care. Within integrated mental healthcare systems, critical care pathways show the progression of youth into, through, and out of services. Pathways were seen to be flexible to allow for client-centred care along with the complexities that some youth may be experiencing.

> ICPs are tools to map out critical clinical and administrative pathways to bring together all of the service providers involved in the patient's care. ICPs can be used to improve multidisciplinary documentation, communication, and planning.

Youth may face many barriers to accessing mental health services. Some may have had previous poor experiences with service providers or have had to approach several service providers before receiving care. Thus, youth should be able to access the Integrated Hub through self-referrals or multiple referral sources, including schools, primary healthcare, hospitals, mental health facilities, addictions treatment, child welfare, and/or juvenile justice (Ontario Centre of Excellence for Child and Youth Mental Health, 2014). Interviewees indicated that youth could drop-in to access services at any time, without an appointment or a referral. One interviewee mentioned that "*the minimum requirement to becoming a client is being able to ring the doorbell".* Once clients access services, most agencies described an intake process to assess the youth's needs and to gather basic information about the client to aid in service delivery. This often involved a receptionist or system navigator as the first point of contact to assist the youth with the intake process.

Once the youth have been engaged in the services, service providers offer client-centred care along a stepped care continuum, promoting integrated service delivery with all of the agencies connected within the Integrated Hub. For some Integrated Hubs, this involved case management of the youth as they moved through the services; for others, service navigators were used to direct youth to appropriate services beyond the Integrated Hub. These strategies were dependent on the services available within the Integrated Hub and within the community.

To ensure a continuum of care between child, youth, and adult mental health services and between the Integrated Hub and other services, the Integrated Hubs need to have mechanisms in place for transitions to other services. One interviewee mentioned the importance of maintaining connections to clients even when they were no longer in the community or no longer accessing services in the Integrated Hub. Another interviewee described the importance of maintaining relationships with community partners to help smooth transitions for youth, noting that, "*you need local relationships and provincial relationships – you are only as strong as your weakest link".*

Information Sharing

Key Considerations

- Integration involves the coordination of services to patients as well as the coordination of clinical activities across providers
- Co-location and frequent team meetings are important for information sharing
- Technology facilitates confidential information sharing through electronic health records.

Suter et al. (2007) address multiple forms of integration within the health field, with two types in particular being important considerations for Integrated Hubs: functional and clinical (see Figure 5 below). Functional integration involves the coordination of operational considerations among co-located practitioners to maximize shared resources, whereas clinical integration refers to the coordination of specialized clinical activities across providers and services (Ibid). At the core of these two integration types is information sharing.

Functional Integration Coordination of activities such as:	Clinical Integration Coordination of activities such as:
• Finances • Management • Human resources • Strategic planning • Information management	• Central system of client records • Communication among caregivers • Continuity of care • Smooth transitions • Best practice protocols

Figure 5: Functional and Clinical Integration Activities. Adapted from Suter et al., 2007, p. 17.

Interviewees noted that while co-location of services can promote information sharing, establishing information sharing protocols and systems was a challenge when developing Integrated Hubs. Suter et al. (2009) similarly describe that developing and implementing integrated information sharing systems and/or electronic records is time consuming, complex, and costly. Many of the interviewees saw the development of memorandums of understanding (MOU) to allow for information sharing among partner agencies as difficult due to the need to consider balancing confidentiality for youth, privacy laws, and different methods of collecting and storing information. None of the interviewees had completely integrated information sharing; this was occasionally dependent on provincial legislation which restricted sharing patient records or the stage of development of the Integrated Hub. However, all of the interviewees had found ways to allow for some level of information sharing between providers.

Several interviewees mentioned the importance of confidentiality in youth mental healthcare. In an Integrated Hub, it is important to be able to share information between providers; however, to respect youths' right to confidentiality and to decide how their information is used, several practices are suggested (MSAHC, 2016):

- Open communication and informed consent about confidentiality and what information can or cannot be shared
- Familiarity of information and privacy legislation among service providers and the ability to communicate this legislation to youth
- Posting confidentiality legislation within the Integrated Hub
- Providing services (e.g., clinical care, prescriptions, etc.) on-site as much as possible to reduce the number of external providers with whom information sharing is required. Where this is not possible, seamless confidential and youth-friendly referral systems would be necessary.

Evaluation

Key Considerations

- Evaluation needs to be built in throughout the design, development, and implementation
- Outcomes should be identified in collaboration with stakeholders (including youth and their families)
- Outcomes can be measured at multiple levels, including the client-, program-, organization-, or system-levels
- Effective evaluation takes time and resources. Lead agencies need to consider how they will resource evaluation efforts and build buy-in among partners.

In order to ensure that interventions and services of the Integrated Hub are achieving their intended outcomes, evaluation metrics need to be built in during the planning phase and consistently monitored throughout implementation and operations (MSAHC, 2016). Butler et al. (2017) note that routine measurement of care is needed to improve healthcare outcomes and lead to systems transformation; however, measurement of outcomes around mental health has been limited in Canada.

Several interviewees mentioned the importance of being able to demonstrate the success of their Integrated Hub through the improvement of youth mental health services; however, many found it difficult to demonstrate impacts given the short time frame of their operating funding or the reporting requirements of their funder. One interviewee indicated, *"We've struggled with the evaluation piece…. Initiatives like this have to demonstrate impact quickly and I think that is almost impossible in some ways [due to systems-level barriers]".*

Another interviewee who worked within an Integrated Hub with a more formalized evaluation strategy shared they struggled with needing to balance the use of resources for evaluation and achieving targets with engagement of the service providers at each site. They also found it difficult to develop measures that were both informative for funders but also for clinicians. One site used a developmental evaluation process to help them develop their outcome evaluation and service delivery plan, such as:

> *… how [the Integrated Hub] works and what the steps are, what are the criteria and scoring, clinician judgement, client preference, the determination of stepped care and services. The developmental evaluation helped us to understand what would drive the decision making and how does it work in reality.*

Two key considerations for evaluation include: the time required for conducting evaluation and achieving results as compared to the reporting or funding timelines that the Integrated Hubs need to meet; and, the cost and resources of conducting an evaluation, requiring specific budget items and potentially a staff member to ensure that the evaluation metrics are developed and routinely collected (MSAHC, 2016). The need for evaluation also must be balanced with the data collection burden on frontline service providers and the privacy of the youth involved in the Integrated Hub.

Of the Integrated Hubs analyzed for this review, different outcomes were used to measure the success of the Integrated Hub overall, accessibility of the mental health supports, and the progression of youth within and beyond the Integrated Hub. Some outcomes were based specifically on client satisfaction, functioning, and success (e.g., whether they feel like they have improved or declined). Other outcomes focused on evaluating the impact of the service delivery model (e.g., services provided, referrals made, follow-up, and retention of clients). Some Integrated Hubs focused on organizational or health systems-level outcomes, such as healthcare utilization. Some used validated clinical measures and others used measures such as youth empowerment and engagement in care. Many of the Integrated Hubs looked at service delivery and access internally but others looked beyond to see the impact of the Integrated Hubs' services on issues such as housing, employment, family relationships, justice system involvement, and education (e.g., drop-out rates).

Many of the sites had yet to implement their full evaluation plans, but anecdotal and self-report evidence from the youth involved in the Integrated Hubs that was shared by the interviewees was generally positive. One interviewee indicated that, *"[youth] really appreciated the drop-in ability and the convenience".* Another explained that youth also liked the flexibility of care and having options, while still being at the centre of care.

Similarly, in the literature, several outcomes were identified for measuring the success of the Integrated Hubs, including: improved functioning for youth; clinical improvement; satisfaction with service models (e.g., goal achievement, engagement, empowerment, and disease burden); and economic evaluations. In a cross-provincial performance assessment of mental health outcomes identified through administrative data, Butler et al. (2017) found several common measures that could be used to assess mental health service delivery:

- Consistent access to the same family physician across time
- First treatment contact for individuals with mental health or addictions issue is in an emergency department
- Physician follow-up after hospital discharge for a mental health disorder or addiction
- Rate of suicide attempts among people diagnosed with a mental health disorder or addiction
- Suicide rates among people diagnosed with a mental disorder or addiction
- Mortality of people diagnosed with a mental disorder or addiction.

Conclusion

An Integrated Hub is best understood as the integration of health and social services under one roof in a youth-friendly environment. They typically focus on prevention and early intervention and the provision of resources to help youth manage their concerns and navigate pathways to specialized services as required. They aim to minimize the service gap between child and adult services by providing a youth-oriented 'one-stop-shop' for youth to access mental healthcare as early as possible.

While implementation and service delivery may vary, critical elements of an Integrated Hub emerged from this environmental scan. Integrated Hubs are most effective when:

- They are responsive to community needs, are community-led, and are supported by pre-existing relationships among services providers
- Youth are co-producers in the development, engagement, and implementation
- Primary healthcare is integrated into mental healthcare
- Stepped mental healthcare is a core service provided
- They are focused on supporting transitions for youth.

Several considerations emerged from this environmental scan which will directly inform the next steps of this project. The development of an Integrated Hubs Implementation Framework will utilize findings regarding the context, guiding principles, critical elements, and key considerations to ensure that emerging practices are included by communities who seek to develop Integrated Hubs.

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Appendix A: Site Review

Comparative Model	Type	Target Population	Core Services Offered	Website
Integrative				
Foundry *BC*	▪ Drop-in services ▪ Stepped care ▪ Framework of practice ▪ E-hub in development	12 to 24	*Varies by location. Core services include:* ▪ Mental health clinicians ▪ Primary healthcare clinicians ▪ Social services ▪ Substance use services	http://foundrybc.ca/
Mount Sinai Adolescent Health Center *New York, USA*	▪ Drop-in services ▪ Stepped care ▪ Framework of practice ▪ Training facility	10 to 24	▪ Primary healthcare clinicians ▪ Mental health clinicians ▪ Counsellors ▪ Sexual and reproductive health ▪ Dental care ▪ Nutrition, fitness and wellness ▪ Peer support workers	http://www.mountsinai.org/patient-care/service-areas/adolescent-health-center/
Headspace *Australia*	▪ Appointment based ▪ National framework of practice ▪ E-hub ▪ 90+ locations	12 to 25	*Varies by location. Core services include:* ▪ Mental health clinicians ▪ Primary healthcare physicians ▪ Substance use services ▪ Vocational services ▪ Peer support workers	https://www.headspace.org.au/
Jigsaw *Ireland*	▪ Drop-in services ▪ National framework of practice ▪ 13+ locations	12 to 25	*Varies by location. Core services include:* ▪ Support workers	https://www.jigsaw.ie
Multi-Disciplinary & Interdisciplinary				
YouthCan IMPACT *Ontario*	▪ Drop-in services ▪ Framework of practice	Under 29	▪ Mental health clinicians ▪ Primary healthcare clinicians ▪ Social services ▪ Substance use services ▪ Peer support workers	http://www.youthcanimpact.com/

Access Open Minds	▪ Drop-in services ▪ Framework of practice	11 to 25	▪ Mental health clinicians ▪ Social services ▪ Child welfare	http://accessopenminds.ca/
Victoria Youth Clinic *Victoria, BC*	▪ Drop-in services	12 to 24	▪ Primary healthcare clinicians ▪ Mental health clinicians ▪ Counsellors ▪ Outreach workers	https://www.victoriayouthclinic.ca
Collaborative & Coordinated				
CHOICES for Youth *St. John's, NL*	▪ Drop-in services ▪ Emergency youth shelter based	16 to 24	▪ Outreach workers ▪ Counsellors ▪ Nurse practitioners ▪ Targeted supports	http://www.choicesforyouth.ca/home/
Futures Forward *Winnipeg, MB*	▪ Appointment based ▪ For youth in Manitoba currently or formerly involved with Child and Family Services	15 to 29	▪ Service navigators ▪ Mental health counselling ▪ Vocational support ▪ Financial services	https://www.futuresforward.ca/
E-hub				
NHS choices	▪ Website	Youth	▪ Information on mental health ▪ Links to finding services ▪ Self-assessment questionnaire	http://www.nhs.uk/Livewell/youth-mental-health/Pages/Youth-mental-health-help.aspx
Young Minds	▪ Website	14 to 25	▪ Information on mental health ▪ Links to finding services	https://youngminds.org.uk/find-help/
The Mix	▪ Website	Under 25	▪ Information on mental health ▪ Links to finding services ▪ Discussion boards	http://www.themix.org.uk/

Appendix B: Interview Guide

Introduction and Consent

Thank you for agreeing to participate in the "Valuing Mental Health—Implementing a Community-based Service Hub Model for Youth" project. We greatly value your time and feedback.

The purpose of the project is to understand and build on 'what works' in community-based youth mental health services with a prevention and early intervention focus. Additionally, knowledge gained will be used to initiate a community-engagement and capacity-building process that will inform the establishment of integrated youth service hubs in small urban centres in Alberta.

This interview will take approximately one hour. Participation in this interview is voluntary and you can end the conversation at any time or choose not to answer certain questions. Your answers are confidential and will only be used for project purposes.

We would also like to record the interview and have it transcribed. The recording of our conversation will be kept on a secured, locked and protected site, and nobody outside the project will have access to it. Are you comfortable with this interview being recorded?

Hub Development and Operations

1. Why did your organization go with a community-based service hub model?
    a. **Follow-up:** Can you tell us about the development process? How was community readiness determined?

2. What services do you bring together in the hub?
    a. **Follow-up:** Did these services already exist in the community?

3. How are services coordinated or integrated between practitioners or partners?
    a. **Follow-up:** How is information sharing and records handled? How do all stakeholders communicate with each other?

4. Can you walk us through what happens when a youth first comes to the hub?
    a. **Follow-up:** What are the pathways to access services?

Hub Governance and Funding

5. What is the governance structure of the hub?
    a. **Follow-up:** Who is the hub accountable to?

6. How is the hub funded?
    a. **Follow-up:** What is your plan for sustainability?

Evaluation

7. What are your intended outcomes and how do you measure success?

8. Are there common goals among those working out of the hub?
    a. **Follow-up:** Who helped to develop these goals? How are the goals reviewed? How do you know you achieved them?

9. What type of feedback have you received from the youth served by the hub?

10. What do you think are the most significant strengths of your service hub and what directly contributes to those?

Lessons Learned

11. What are the barriers or challenges to the success of your service hub?
    a. **Follow-up:** How do you (or could you) overcome them?

12. How has the landscape of youth mental health in your community changed since starting the hub?
    a. **Follow-up:** What kind of shifts have you made? Why? Are there any contextual factors that have influenced your hub?

13. What is your most important piece of advice?

14. Is there anything else you feel is relevant to the implementation of service hubs that we have not discussed already?