Evolution of Jigsaw - a National Youth Mental Health Service

Aileen O'Reilly1,2 | Gillian O'Brien1 | Jeff Moore1 | Joseph Duffy1 | Paul Longmore1 | Sarah Cullinan1 | Siobhán McGrory1

1Jigsaw–The National Centre for Youth Mental Health, Dublin, Ireland
2School of Psychology, University College Dublin, Ireland

Abstract

Aim: There has been a global movement towards transformation of youth mental health services, but limited information on the core principles and characteristics of these new services is available. Jigsaw is one such service, established in Ireland in 2006, with the intent of creating change in Ireland’s system of mental healthcare for 12–25 year olds. The aim of this paper is to describe the evolution of Jigsaw services, which are now firmly embedded in the Irish system of care for young people, and recognized internationally as an established service network.

Methods: This paper describes provides an up-to-date description of the Jigsaw service model, key areas of evolution that have shaped this model, and identifies future directions in service development.

Results: Key attributes of the Jigsaw service model including therapeutic service, scope of practice, youth mental health promotion, youth participation, and monitoring/evaluation are described in this paper. Information on key enablers (funding and governance/quality) and service providers is also included.

Conclusions: Information on the core principles and characteristics of youth mental health services is important. This paper addresses a gap in the literature by describing the Jigsaw service model, which continues to evolve so that it is responsive to the needs of young people.

KEYWORDS
community mental health services, primary care, service innovation, youth mental health

1 | INTRODUCTION

It is well established that adolescence and early adulthood are peak times for the onset of mental health difficulties. There is also a growing body of evidence indicating that the prevalence of mental health difficulties is increasing amongst 12–25 year olds (Bor et al., 2014; Collishaw, 2015). Paradoxically, mental health difficulties often remain undetected until later in life and many young people do not get adequate support (Patel et al., 2007). In recent years there has been an international movement to transform youth mental health services, so that access to and engagement with services for young people is improved. A global framework for youth mental health was recently developed by Orygen and the World Economic Forum (Killackey et al., 2020), articulating eight principles that underpin an approach to youth mental health. Recent reviews have also described the key attributes of and emerging evidence from existing services, described as integrated youth mental health services (IYMHS) and integrated community-based youth service hubs (Hetrick et al., 2017; Settipani...
et al., 2019). However, both reviews highlighted that there is limited information on the core principles and characteristics of these services. To address this gap, headspace (Rickwood et al., 2019) recently provided an overview of its service model, while descriptions of service innovations in the UK and Canada have also been articulated (Wilson et al., 2018; Vusio et al., 2020, Malla et al., 2019).

Jigsaw—The National Centre for Youth Mental Health (formerly Headstrong) focuses on delivering services, influencing change and strengthening communities to create an Ireland where every young person’s mental health is valued and supported. The Jigsaw service was founded with the aim of creating change in Ireland’s system of mental healthcare for 12–25 year olds, and has grown from five pilot sites in 2010 to 14 services in 2020 (including one digital service), with an additional service opening in 2021. Early papers described the planning and implementation of Jigsaw pilot sites (Illback et al., 2010; Illback & Bates, 2011). However, the Jigsaw service model has evolved significantly such that it is now firmly embedded in the Irish system of care for young people, and recognized internationally as an established service network. In this paper, we aim to add to the knowledge base in youth mental health by describing the Jigsaw service model. In addition, we focus on the evolution of the model to date and identify future directions in service development.

2 | THE JIGSAW ETHOS

Jigsaw recognizes that people live their lives in multiple contexts, which shape their identities and experiences and, in turn, impact on mental health. Jigsaw advocates for a holistic and integrated view of the individual, which is inextricable from the contexts of their lives. At the time it was established, Jigsaw was unique in Ireland in that it was designed to provide a therapeutic service for young people, in addition to supports for adults who occupy important roles in their lives. Aligned to the mental health intervention spectrum (Mrazek & Haggerty, 1994), Jigsaw provides evidence-informed universal prevention efforts aimed at the entire community/population, selective prevention strategies targeting subgroups of young people at risk of developing mental health difficulties, and indicated prevention for young people experiencing mental health difficulties. Central to the ethos of Jigsaw is respecting and valuing the voice of young people. Youth participation is woven into the fabric of the organization, most especially within the person-centred service model, where it is translated into meaningful and tangible action.

3 | SERVICES AND INTERVENTIONS

3.1 | Therapeutic service

The Jigsaw model of therapeutic support is brief and evidence-informed. Following initial intake and assessment young people may attend for a therapeutic intervention of up to eight sessions (referred to in Jigsaw as a brief intervention); the average is 5.9. Prior to March 2020, and the official declaration of COVID-19 as a pandemic, a brief intervention was delivered in-person by a clinician in a Jigsaw hub. However, clinicians are now delivering a combination of in-person (57%), video (28%) and phone (15%) support, with phone/video support set to continue beyond the current pandemic. Typically, Jigsaw clinicians draw on a range of therapeutic approaches, such as cognitive behavioural, compassion focused, acceptance and commitment, or solution focused, depending on the needs and developmental level of each young person. Unique in the Irish system, Jigsaw provides a consultation service (which accounts for just under 30% of engagements) advising parents, teachers and other concerned adults about how to support youth mental health and/or how to navigate the complexities of the mental health system. To ensure rapid, easy and affordable access, services are provided at no cost at the point of delivery in youth-friendly service settings, and no professional referral is required. As Table 1 shows, most young people engaging with Jigsaw are female (61%), aged 15–17 years (39%), while self-referrals, parents and General Practitioners (GPs) account for about 87% of referrals. Similar to other services, anxiety, low mood and stress are top presenting issues, a pattern that has been consistent for many years. Other common difficulties reported by young people include sleep changes (10%), anger (8%), family problems (8%), isolation (7%) and thoughts of hurting self (7%); these are reported in detail

| Gender | % |
|--------|---|
| Female | 61 |
| Male   | 39 |

| Age  | % |
|------|---|
| 12–14| 28 |
| 15–17| 39 |
| 18–25| 32 |

| Top referral pathways | % |
|-----------------------|---|
| Parent                | 53 |
| Self                  | 27 |
| Doctor/GP             | 7  |
| School/higher education | 4 |
| Secondary mental health services | 2 |

| Top presenting issues | % |
|-----------------------|---|
| Anxiety               | 21 |
| Low mood              | 16 |
| Stress                | 12 |

| Mode of delivery—brief intervention | % |
|-------------------------------------|---|
| In-person                           | 57 |
| Video                               | 28 |
| Phone                               | 15 |

| Number of sessions—brief intervention | M (SD) |
|---------------------------------------|--------|
| 5.9                                   | (2.5)  |
elsewhere (O’Keeffe, O’Reilly, O’Brien, Buckley, & Illback, 2015; O’Reilly, Illback, Peiper, O’Keeffe, & Clayton, 2015).

The levels of distress amongst young people attending Jigsaw illustrates the high level of need amongst this cohort, with most young people reporting moderate to severe clinical levels of psychological distress pre-intervention (O’Reilly et al., 2015). Encouragingly, the majority of young people report significant reductions in this distress and improvements in wellbeing following a brief intervention (Donnelly et al., 2019; O’Keeffe et al., 2015). Additionally, young people and parents report high levels of satisfaction (O’Reilly et al., 2021). A recent independent evaluation of Jigsaw commissioned by the Irish Health Service Executive (HSE, 2018, p.47) concluded that “the Jigsaw youth mental health service model is focused and robust, delivering evidence-informed approaches.”

Recently, Jigsaw has extended its opening hours to include evening appointments (up to 8 PM) at least one day a week, to accommodate young people with commitments during the day. Although the goal is to offer additional appointments at evening and weekends, staffing services out of traditional working hours is challenging. In counties characterized by a large rural population with poor transport links, services are provided in outreach locations to ease accessibility. Close collaboration with organizations that support vulnerable groups has been essential in helping to ensure accessibility, and Jigsaw intends to improve its method of collecting demographic information so that efforts in this regard can be more accurately captured. In 2020, Jigsaw developed a suite of digital supports for young people, including a synchronous chat service (www.jigsaw.ie). These more recent developments go even further in ensuring that Jigsaw is providing accessible, responsive and youth specific mental health supports.

3.2 Scope of practice

Prior to the establishment of Jigsaw, there were very limited primary care mental health supports for young people in Ireland, leaving little option but to refer to secondary care services. The Jigsaw service model was designed to address this gap by occupying a position “upstream” on the mental health service continuum, providing early access to care for young people with mild to moderate mental health difficulties. Jigsaw has developed a set of referral guidelines to support consistent, good quality decision-making but fundamentally, the critical consideration when faced with every referral is whether a brief intervention of up to eight sessions would be helpful and appropriate given the young person’s needs. Given Jigsaw’s accessibility, some young people with moderate to severe mental health needs present to Jigsaw (e.g., eating disorders, psychosis). In such circumstances, assessment and intervention with multidisciplinary secondary care services is required.

The success of this service model relies on the functioning of “downstream” services (secondary and tertiary care) as well as good communication and integration between services. Unfortunately, many of the systemic factors in the statutory system, which existed when Jigsaw was established are still present and impact on the feasibility of operating within this scope of practice. These include chronic under-resourcing of statutory mental health services, disjointed services especially at transition points between child and adolescent and adult services, differing inclusion and exclusion criteria, lengthy waiting lists, and limited service provision for those in suicidal crisis. If, following psychosocial assessment using the HEADSS framework (Cohen et al., 1991), Jigsaw identifies that a young person requires input from secondary care, they are supported to access these services, but there can be challenges in facilitating an onward referral as some secondary mental health services only accept GP referrals. Young people who are referred onwards can access a range of online supports whilst awaiting their appointment with secondary care services. Given the potential for these young people to “fall between the cracks” of mental health services, Jigsaw follows up to ensure that they have accessed the appropriate level of care and intervenes, as appropriate, where this has not occurred. It is also the case that following initial screening, comprised of clinical interview supplemented by data from standardized measures of psychological distress, some young people require urgent access to secondary or tertiary care. In these cases, Jigsaw remains actively involved until the young person is picked up by an appropriate service.

In the context of a poorly functioning service system, it was perhaps inevitable that there would be a large and ever-growing demand for accessible, non-stigmatizing services, which do not require a professional referral. Indeed, referrals to Jigsaw services have been increasing each year, with the net result that wait times for Jigsaw services are growing and median wait time is currently 64 days (2018 = 36 days, 2019 = 39 days, 2020 = 63 days). Thus, the early interventionist approach of Jigsaw is coming under pressure, as fewer young people are able to access services early in the course of their distress and a growing number of young people who require more specialized care fall between the gaps of primary and secondary care services (“the missing middle”). The Sláintecare programme of reform for health and social care services in Ireland (Houses of the Oireachtas Committee on the Future of Healthcare, 2017) provides a high-level blueprint for the delivery of Irish mental health services and will require significant change from within existing structures and systems to implement. Jigsaw support implementation of this strategy, as we believe all players in the mental health service system must come together to create a cohesive and seamless range of supports, so that there really is no wrong door for young people when they are seeking help.

3.3 Youth mental health promotion

Central to its vision of a society where every young person’s mental health is valued and supported, youth mental health promotion is a mainstay of the Jigsaw model. In the early years, efforts focused on promoting community awareness, challenging stigma and building the capacity of concerned adults to support young people. Increasingly, Jigsaw’s work in communities is underpinned by the social
of health approach (World Health Organization [WHO], 2008) and an understanding of the various contexts—personal, structural, social and societal—that influence mental health. As the organization has grown, this programme of work has expanded significantly, reaching a much broader audience through collaborations with young people, health and social care agencies, supporting public health initiatives, and partnerships/collaborations with organizations working with high-risk groups. To date, Jigsaw has delivered almost 5000 evidence-informed workshops to 145 000 professionals, volunteers, young people and parents/carers. Typically, workshops are delivered as part of a mental health promotion package that can be adapted to suit local context and culture. Workshops are delivered to adults and young people, both face-to-face and virtually, and are usually 45 min–1 h in duration. Workshops for adults aim to increase mental health literacy and build the capacity of those who work or volunteer with young people to promote and support mental health (e.g., “One Good Adult”™, “One Good Coach” and “Self-care for One Good Adults”). Workshops for young people, delivered in both community and school settings, aim to increase knowledge about mental health, reduce stigma and encourage help-seeking (e.g., “It’s Time to Start Talking”, “My Mental Health—What Helps?”). All workshops are routinely evaluated, and previous studies have indicated they lead to improvements in understanding of mental health, help-seeking intentions and changing negative beliefs about mental health (O’Reilly et al., 2015). As a result of the COVID -19 pandemic much of this work has now moved online.

A major development in recent years has been the creation of the One Good School™ initiative as a coherent, multi-level whole school mental health programme. Jigsaw is currently piloting and evaluating this initiative in 10% (80) of post-primary schools in Ireland. Jigsaw has also developed a new online learning platform to deliver live webinars, eLearning courses and workshops, and is now reaching wider audiences within and beyond Jigsaw service areas. This has been particularly successful with teaching staff, and over 10 000 teachers have registered to date (Jigsaw, 2020).

3.4 | Youth participation

Young people have always been at the very heart of the Jigsaw service model, and from the outset the organization made a commitment to listening and responding to what young people were saying about their mental health needs. Youth partnership and engagement is embedded in the organization in various ways. Each service has a Youth Advisory Panel (YAP) composed of volunteers aged 16–25 years, the purpose of which is to actively engage young people and hear their voice in informing practice at local level. The YAP is not a service user panel as it invites membership from any young person in the community with an interest in mental health.

Youth participation is also embedded in Jigsaw’s therapeutic services, which are developmentally appropriate and fundamentally person-centred in their orientation; for example, young people are centrally involved in their assessment and intervention plans, and satisfaction data are routinely gathered from young people to inform service delivery. An online service user forum is planned to ensure that the views of young people who have used Jigsaw services are informing future developments. A youth research council, which involves young people actively contributing to Jigsaw’s research programme, has also recently been established to ensure that this work is relevant, meaningful and impactful.

Ongoing quality reviews and research show high levels of youth involvement in the development of new initiatives, staff recruitment and governance (Barry, 2014). However, a recent mapping of youth participation practice has highlighted that participation does not always equate to youth voice in decision-making. Therefore, in collaboration with the Irish Department of Children, Equality, Disability, Integration and Youth (DCEDIY), Jigsaw is working towards implementation of a new national framework for youth participation in decision-making. This framework will be firmly embedded in the 1989 United Nations Convention on the Rights of the Child (UNCRC) and adopt the revised Lundy (2007) model of participation, emphasizing the role of space, voice, audience and influence in decision-making.

4 | INFRASTRUCTURE AND ENABLERS

4.1 | Monitoring and evaluation

From the beginning, Jigsaw has placed a strong emphasis on contributing evidence to the emerging area of youth mental health and evaluating the support it provides. Information about young people engaging with Jigsaw services is captured on electronic case management and evaluation systems, including demographic and psychosocial characteristics, goals and outcomes. Routine outcome measures include the CORE-10 (Connell & Barkham, 2007), YP-CORE (Twigg et al., 2009), Goal Based Outcome Measure (GBO; Law, 2011), the headspace youth satisfaction survey (Simmons et al., 2014) and an author-designed parent satisfaction survey (O’Reilly et al., 2021). Key performance indicators (KPIs), based on evidence and international best practice, were introduced for services in 2014, measuring performance across clinical, operational, mental health promotion, and youth participation domains. A regular system of reporting on progress towards targets, agreed in partnership with service staff and funders, then facilitates continuous improvement. Jigsaw also has a research partnership with the School of Psychology, University College Dublin (UCD) and services are regularly involved in research and evaluation projects. While evidence is a cornerstone of the service model, investing in an infrastructure to facilitate effective and efficient data collection, facilitating compliance with data entry and monitoring, and interrogating the wealth of information and evidence gathered are priorities for further evolution in this area.

4.2 | Funding

Jigsaw was founded as a philanthropically funded charitable organization in 2006. From the outset, a key ambition of the organization was to secure mainstream funding from the HSE. Until 2014, Jigsaw relied
on philanthropic funds and innovation funding from the department of health. In 2015, Jigsaw was written into the HSE annual service plan for the first time and received significant mainstream funding. This funding has grown year-on-year to support the expansion of services, and the HSE now funds the majority of costs associated with service delivery. The transition to mainstream, recurrent funding was significant for Jigsaw and meant, for the first time, the organization could plan for continuing service delivery including the employment of professional staff on permanent contracts. However, the need for the organization to balance its independence whilst in receipt of significant government funding is an ongoing consideration. Alongside mainstream funding, Jigsaw also engages in fundraising with individuals, communities and corporate partners to support organizational innovations.

4.3 Governance and quality

The governance model for Jigsaw services initially comprised partnerships between the organization and local community agencies, who played a number of roles from fiscal agent to employer. This model had many strengths, primarily in terms of the local commitment to and investment in the success of each service. A strong sense of community ownership developed which helped to fully embed a service in the local community. Importantly for service providers in other jurisdictions, Jigsaw experienced significant challenge implementing a national service model with multiple stakeholders with differing priorities and expectations. This resulted in critical differences between services; for example, in age range, scope of practice, staffing profile and funding. Furthermore, clinical governance arrangements were unnecessarily complex, which impacted on management of clinical risk, and the variation in employment arrangements created challenges in delivering a consistent model.

Subsequently, a single governance model developed in which Jigsaw became the sole employer responsible for corporate and clinical governance. Over time, it became clear that a single governance model was the preferred way forward, and, by 2018, all services under a partnership governance model were transitioned to a single model. This more streamlined structure eliminated many of the challenges of the dispersed model, facilitated more efficient and effective use of resources, and allowed Jigsaw to demonstrate more impact and greater return on investment to funders. However, it also resulted in a reduced sense of local ownership in each service, which had to be nurtured over time. To account for this, each year Jigsaw services engage in a planning process, where strategies for delivery of standardized KPIs and localized initiatives are documented. These plans are agreed via regional and national structures and, through this process, localized initiatives often evolve into standardized ways of working. Conversely, local staff are regularly involved in the development of national initiatives, which fosters

![Jigsaw's organizational structure and operational and clinical governance model for Jigsaw services](image-url)
collective responsibility across the organization. There also are differences in services in terms of their team size and catchment areas, with some offering therapeutic support on an outreach basis, and local variation exists in some outward facing campaigns and health promotion activities.

To support the transition to a single governance model, Jigsaw invested in the development of centralized functions including finance, human resources, and IT/facilities. Figure 1 outlines Jigsaw’s organizational structure and details the operational and clinical governance model for services. Under the terms of service level agreements with the HSE, Jigsaw is responsible for delivering safe, high quality services in line with agreed targets and KPIs. Jigsaw has adopted a quality assurance system and has a Quality and Safety Board subcommittee to oversee this.

4.4 Service providers

Early experimentation in the Jigsaw model meant that each service looked very different, comprised of mental health professionals with a range of skills. Over time, as the critical components of the model emerged, the skillset and competency mix required became apparent. Today, each service is jointly managed by a clinical manager and service manager who are responsible for clinical and operational elements of the service respectively (see Figure 1). Members of the clinical team are drawn from a range of disciplines including psychologists, social workers, occupational therapists, mental health nurses and psychotherapists. The clinical team is transdisciplinary in that each member draws on their experience and training, whilst working in a brief therapeutic model. There is a strong emphasis on shared competencies and cross-disciplinary learning, and the discipline-based hierarchies that exist in traditional mental health services in Ireland are absent. In addition to clinical work, clinicians have protected time to engage in mental health promotion. Teams have youth and community roles focused on health promotion and youth participation, and support is provided by service administrators. The public health model in Ireland, in which Jigsaw is a contracted provider, does not allow for incentive or individual fee payments. Jigsaw staff are paid on salary ranges, which take due regard to public sector pay scales. Whilst mainstream funding provided staff with the security that comes with permanent contracts, Jigsaw is a relatively small organization in competition for staff with the HSE, which is the largest employer of healthcare professionals in Ireland. Developing innovative ways to attract and retain staff has impacted on service provision, so this is a priority for Jigsaw alongside influencing training of the future workforce and further enhancing organizational culture.

5 CONCLUSION

This paper provides an up-to-date description of the Jigsaw service model, and describes historical and ongoing challenges that have shaped the evolution of this model. This addresses a key recommendation from systematic reviews of youth mental health services, and we hope that our contribution will be useful to those interested in creating similar service models. However, it is important to note that while Jigsaw’s service model aligns too many of the principles set out in the recently launched global framework for youth mental health, local contextual factors heavily influence implementation of youth mental health services (Killackey et al., 2020). Further evolution of the model is also required to ensure Jigsaw continues to be responsive to the needs of young people, and particularly in light of the current COVID-19 pandemic.

ACKNOWLEDGEMENTS

Open access funding provided by IReL.

CONFLICT OF INTEREST

No conflict of interest to declare.

AUTHOR CONTRIBUTIONS

All authors contributed to this manuscript, and provided final approval of the version of this paper submitted for review.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

Aileen O’Reilly https://orcid.org/0000-0001-9965-575X

REFERENCES

Barry, J. (2014). An investigation of youth participation in an Irish youth mental health service: Staff and young people’s perspectives [Unpublished Master’s thesis]. Dublin Institute of Technology.

Bor, W., Dean, A. J., Najman, J., & Hayatbakhsh, R. (2014). Are child and adolescent mental health problems increasing in the 21st century? A systematic review. *Australian & New Zealand Journal of Psychiatry*, 48(7), 606–616. https://doi.org/10.1177/004867414533834

Cohen, E., Mackenzie, R. G., & Yates, G. L. (1991). HEADSS, a psychosocial risk assessment instrument: Implications for designing effective intervention programs for runaway youth. *Journal of Adolescent Health*, 12(7), 539–544. https://doi.org/10.1016/0197-0070(91)90084-Y

Collishaw, S. (2015). Annual research review: Secular trends in child and adolescent mental health. *Journal of Child Psychology & Psychiatry*, 56(3), 370–393. https://doi.org/10.1111/jcpp.12372

Connell, J., & Barkham, M. (2007). CORE-10 user manual, version 1.1. CORE System Trust & CORE Information Management Systems Ltd.

Donnelly, A., O’Reilly, A., Dolphin, L., O’Keeffe, L., & Moore, J. (2019). Measuring the performance of the mental health continuum—short form (MHC-SF) in a primary care youth mental health service. *Irish Journal of Psychological Medicine*, 26, 1–5. https://doi.org/10.1017/ipm.2018.55

Health Service Executive [HSE]. (2018). Independent evaluation of jigsaw service model 2018. Community Consultants.

Hetrick, S. E., Bailey, A. P., Smith, K. E., Malla, A., Mathias, S., Singh, S. P., O’Reilly, A., Verma, S. K., Benoit, L., Fleming, T. M., Moro, M. R., Rickwood, D. J., Duffy, J., Eriksen, T., Illback, R., Fisher, C. A., & McGorry, P. D. (2017). Integrated (one-stop shop) youth health care: Best available evidence and future directions. *Medical Journal of Aust*, 207(10), 55–518. https://doi.org/10.5694/mja17.00694

Houses of the Oireachtas Committee on the Future of Healthcare. (2017). Sláintecare Report. Houses of the Oireachtas.
Illback, R. J., & Bates, T. (2011). Transforming youth mental health services and supports in Ireland. *Early Intervention in Psychiatry, 5*(1), 22–27. https://doi.org/10.1111/j.1751-7893.2010.00236.x

Illback, R. J., Bates, T., Hodges, C., Galligan, K., Smith, P., Sanders, D., & Dooley, B. (2010). Jigsaw: Engaging communities in the development and implementation of youth mental health services and supports in the Republic of Ireland. *Journal of Mental Health, 19*(5), 422–435. https://doi.org/10.3109/096382203728141

Jigsaw. (2020). Annual Report. Retrieved 19 August 2021, from http://annualreport2020.jigsaw.ie/

Killackey, E., Hodges, C., Browne, V., Gow, E., Varnum, P., McGorry, P., & Jigsaw. (2020). Annual Report. Retrieved 19 August 2021, from http://annualreport2020.jigsaw.ie/

Lundy, L. (2007). “voice” is not enough: Conceptualising article 12 of the United Nations convention on the rights of the child. *British Educational Research Journal, 33*(6), 927–942. https://doi.org/10.1080/01411920701657033

Malla, A., Iyer, S., Shah, J., Joobr, R., Boks, P., Lal, S., Fuhrer, R., Andersson, N., Abdel-Baki, A., Huitt-MacLeod, D., Beaton, A., Reaume-Zimmer, P., Chisholm-Nelson, J., Rousseau, C., Chandrasena, R., Bourque, J., Aubin, D., Levasseur, M. A., Winkelmann, I., ... Network, A. O. M. Y. M. H. (2019). Canadian response to need for transformation of youth mental health services: ACCESS open minds (Esprits ouverts). *Early Intervention in Psychiatry, 13*(3), 697–706. https://doi.org/10.1111/eip.12772

Law, D. (2011). Goals and goal-based outcomes (GBOs): Some useful information. CAMHs Press.

Lundy, L. (2007). “voice” is not enough: Conceptualising article 12 of the United Nations convention on the rights of the child. *British Educational Research Journal, 33*(6), 927–942. https://doi.org/10.1080/01411920701657033

Malla, A., Iyer, S., Shah, J., Joobr, R., Boks, P., Lal, S., Fuhrer, R., Andersson, N., Abdel-Baki, A., Huitt-MacLeod, D., Beaton, A., Reaume-Zimmer, P., Chisholm-Nelson, J., Rousseau, C., Chandrasena, R., Bourque, J., Aubin, D., Levasseur, M. A., Winkelmann, I., ... Network, A. O. M. Y. M. H. (2019). Canadian response to need for transformation of youth mental health services: ACCESS open minds (Esprits ouverts). *Early Intervention in Psychiatry, 13*(3), 697–706. https://doi.org/10.1111/eip.12772

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). Reducing risks for mental disorders: Frontiers for preventive intervention research. National Academy Press.

O’Reilly, L., O’Reilly, A., O’Brien, G., Buckley, R., & Illback, R. (2015). Description and outcome evaluation of jigsaw: An emergent Irish mental health early intervention programme for young people. *Irish Journal of Psychological Medicine, 32*(1), 71–77. https://doi.org/10.1017/ipm.2014.86

O'Reilly, A., Donnelly, A., Rogers, J., Moloney, O., O'Brien, G., & Doyle, E. (2021). Measuring parent satisfaction in jigsaw—a primary care youth mental health service. *Mental Health Review Journal.* https://doi.org/10.1108/MHRJ-04-2020-0024

O'Reilly, A., Illback, R., Peiper, N., O'Keeffe, L., & Clayton, R. (2015). Youth engagement with an emerging Irish mental health early intervention programme (jigsaw): Participant characteristics and implications for service delivery. *Journal of Mental Health, 24*(5), 283–288. https://doi.org/10.3109/09638237.2015.1019050

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*(9569), 1302–1313. https://doi.org/10.1016/S0140-6736

Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowen, J., & McGorry, P. (2019). Australia’s innovation in youth mental health care: The headspace centre model. *Early Intervention in Psychiatry, 13*, 159–166. https://doi.org/10.1111/eip.12740

Settipani, C. A., Hawke, L. D., Cleverley, K., Chaim, G., Cheung, A., Mehra, K., Rice, M., Szatmari, P., & Henderson, J. (2019). Key attributes of integrated community-based youth service hubs for mental health: A scoping review. *International Journal of Mental Health Systems, 13*, 52. https://doi.org/10.1186/s11033-019-0306-7

Simmons, M. B., Parker, A. G., Hetrick, S. E., Telford, N., Bailey, A., & Rickwood, D. (2014). Development of a satisfaction scale for young people attending youth mental health services. *Early Intervention in Psychiatry, 8*(4), 382–386. https://doi.org/10.1111/eip.12104

Twigg, E., Barkham, M., Bewick, B. M., Mulhem, B., Connell, J., & Cooper, M. (2009). The young Person’s CORE: Development of a brief outcome measure for young people. *Counselling and Psychotherapy Research, 9*, 160–168. https://doi.org/10.1080/14733140902979722

Vusio, F., Thompson, A., Laughton, L., & Birchwood, M. (2020). After the storm, solar comes out: A new service model for children and adolescent mental health. *Early Intervention in Psychiatry, 2020*, 1–8. https://doi.org/10.1111/eip.13009

Wilson, J., Clarke, T., Lower, R., Ugochukwu, U., Maxwell, S., Hodgekins, J., Wheeler, K., Goff, A., Mack, R., Horne, R., & Fowler, D. (2018). Creating an innovative youth mental health service in the United Kingdom: The Norfolk youth service. *Early Intervention in Psychiatry, 12*(4), 740–746. https://doi.org/10.1111/eip.12452

World Health Organization [WHO]. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Commission on Social Determinants of Health.