Developing a student-run psychology service for at-risk youth: Framework and application

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Abstract
The Youth Psychology Service (YPS) in Toronto, Canada is a student-led organization that uses a street medicine model to deliver clinical services (e.g., psychotherapy, crisis intervention) to at-risk youth and professional services (e.g., consultation, training) to support staff and volunteers. YPS program goals include: (1) Increase access to psychological services in marginalized populations; (2) Develop community capacity to support mental health care; and (3) Expand training for students. YPS students, from Ryerson University, partnered with staff at St. Stephen's Community House, a not-for profit community service agency who serve approximately 650 individual youth in at-risk neighbourhoods. This descriptive report details the development of YPS and services delivered over the first year.

Résumé
L'organisation YPS de Toronto, au Canada, dont la gestion est assurée par des étudiants, offre des services de psychologie destinés aux jeunes. L'organisation repose sur un modèle de médecine de rue pour offrir des services cliniques aux jeunes à risque (par ex. psychothérapies et interventions en situation de crise) et des services professionnels au personnel de soutien et aux bénévoles (par ex. consultations et formations). Les objectifs du programme YPS comprennent : (1) accroître l'accès des populations marginalisées à des services psychologiques; (2) développer la capacité de la communauté à soutenir les soins de santé mentale; (3) favoriser la formation des étudiants. Les étudiants de l'organisation YPS, lesquels proviennent de l'Université Ryerson, ont formé un partenariat avec le personnel de l'organisme de services communautaires sans but lucratif St. Stephen's Community House, lequel œuvre auprès de plus ou moins 650 jeunes habitant dans des quartiers à risque. Ce rapport descriptif décrit l'évolution de l'YPS et des services que l'organisation a fournis au cours de sa première année.

Introduction

One in five youth in Canada experience mental illness (Canadian Mental Health Association [CMHA], 2016). Despite the prevalence of mental illness, youth's needs are egregiously underserved (Rickwood, Deane, Wilson, & Ciarrochi, 2005). In the United States, 80% of American youth who need mental health services do not receive them (National Survey of America's Families, as cited in Kataoka, Zhang, & Wells, 2002). Approximately one-quarter of youth in Ontario do not know who to talk to about their mental health (Boak, Hamilton, Adlaf, Henderson, & Mann, 2016). Left untreated, mental illness in youth can have significant economic cost (Public Health Agency of Canada, 2015) and deleterious effects on academic functioning (e.g., Suldo, Thalji, & Ferron, 2011), physical health (Brown, Lubman, & Paxton, 2011), and increased severity of mental health concerns in adulthood (Kuehn, 2005). A meta-analysis has found that a variety of evidence-based mental health approaches (e.g., cognitive behavioural therapy) can help reduce distress and impairment in youth (Weisz, Sandler, Durlak, & Anton, 2005). Several barriers hinder access to these services, including cost, location, and beliefs about mental health (Gulliver, Griffiths, & Christensen, 2010). This means that youth who are socially or economically marginalized are at the greatest risk for mental illness (Kataoka et al., 2002). Thus, the important public health questions for youth mental health are not only "What treatment works?" or "For whom does treatment work?" but "What treatment is accessible?"

Family doctors are the default mental health providers for most Canadians because psychologists are not covered by provincial health insurance. General practitioners, however, frequently underserve low income areas and have limited capacity for long-term treatment (Leahy et al., 2015). At-risk youth are also less likely to access health services through conventional medical settings. This can be explained by higher rates of perceived stigmatized from youth when interacting with doctors and higher levels of mistrust in providers working in institutional settings (Gulliver et al., 2010; Santiago, Kaltman, & Miranda, 2013). Outreach and drop-in settings run by community staff are more successful in connecting with at-risk youth, but staff often lack appropriate mental health training or resources to address their needs (Weissman et al., 2006).

Student-Run Clinic Model

Student-run clinics (e.g., Liberman et al., 2011) are an innovative delivery method for affordable, high-quality health care in disadvantaged populations (e.g., those with no insurance or low income). Student-run clinics use senior students of various clinical service disciplines (e.g., medicine, dentistry) as healthcare providers and often as the organizers or administrators. This model has been applied to the psychological treatment of adults, resulting in symptom reduction, improved treatment engagement, and increased client satisfaction (Lawrence, Bryant, Nobel, Dolansky, & Singh, 2015; Liberman et al., 2011). It is likely that the characteristics of this delivery model will also be effective with youth. Youth report perceiving younger clinicians as more open and understanding (French, Reardon, & Smith, 2003). As a result, youth may benefit from receiving services from student therapists who, as one would expect, are typically younger than licensed providers.

Delivering clinical services is also an important form of experiential learning in professional training (Coburn, Seryak, & Lander, 2016). Student therapists working in non-traditional health settings have greater exposure to the impacts of different social-determinants of health experienced by disadvantaged populations (Holmqvist, Courtney, Meili, & Dick, 2012). For example, a common part of clinical training is helping clients approach situations that cause them anxiety. Whether a client's avoidance is unhelpful or helpful becomes less clear when they live in a high crime neighbourhood and have ongoing experiences of victimization. Working with marginalized populations has been shown to generate greater levels of compassion, more positive attitudes, and increased social accountability in students (Holmqvist et al., 2012).

A Local Need for a Student-Run Psychology Service

Toronto, like many large Westernized cities, has a number of registered not-for-profit agencies struggling with limited resources to provide services to the youth and other marginalized populations; St. Stephen's Community House is one such agency. St. Stephen's Youth Services department engages with approximately 650 youth (aged 12 to 25 years) every year from some of the poorest neighbourhoods in Toronto. Youth Services operates September to June with one manager, seven full-time social service workers, and 21 part-time staff/volunteers. Staff run a drop-in space where approximately 70 youth come daily to receive hot meals and access programs addressing housing, unemployment, youth justice, sexual health, racism, and the integration of refugees and immigrants.

Since 2012, staff at St. Stephen's Youth Services have reported an increased number of mental health concerns from youth. Youth making reports were often female, socially isolated, and ethnically marginalized and often include descriptions of previous and ongoing trauma (e.g., physical or sexual assault). Staff have been able to offer some supportive counselling and crisis intervention, but are not trained to deliver mental health services.

Developing the Youth Psychology Service

The Youth Psychology Service (YPS) was founded by Ryerson University graduate students to address mental health service limitations. They approached a registered clinical psychologist to provide programmatic support and clinical supervision. Students attended a series of inter-organizational meetings between local agencies to develop a strategy for meeting the mental health needs of marginalized youth. Discussion highlighted the struggle to successfully make referrals to mental health services due to long waitlists, service location, and referral options not being perceived as appropriate options for youth. The consensus was to develop a means of delivering clinical services that was mobile and accessible in the youths' environment.

YPS follows a "street medicine" model of service delivery (Withers, 2011). In "street medicine," health care providers go into the community and provide services for clients who are otherwise unable or unwilling to attend routine health care settings (CMHA, 2016; Withers, 2011). YPS utilizes this approach by partnering with community organizations, and provides services in the settings where the organization connects with youth. Potential clients are therefore not required to come to a health care setting or university; student therapists go into the community centres and

shared spaces where youth frequent. Street medicine providers depend on community partnerships, such as St. Stephen's Community House, to connect with clients and build trust. The priority of this model is to be responsive to the barriers of accessing services.

The YPS program goals and strategies (see Table 1) are based on the following values: client-centered practice, evidence-based practice, diversity, inclusivity, accountability, and continuous learning. These values were selected from best clinical practice recommendations when working with youth (Garland et al., 2013) and the scientist-practitioner model of clinical training. Clinical services include consultation and psychoeducation (for youth and family members), assessment, and treatment. Students also provided professional support to staff (e.g., case consultation, training). For more information, visit http://www.ypsto.com.

Table 1. *YPS Program Goals and Strategies*

1. *Increase access to psychological services in marginalized populations.*
   - *Youth will never pay for services.*
   - *Clinical services are delivered in the community.*
   - *Promote awareness of mental health.*
2. *Develop community capacity to support mental health care.*
   - *Provide psychoeducation and training.*
   - *Consult with staff to develop case management plans.*
   - *Students support staff in developing record keeping systems.*
3. *Expand training for students.*
   - *One hour, weekly individual supervision.*
   - *Phone consultation available between supervision.*
   - *Sensitivity to social determinants of health.*

The First Year of Service Delivery

The Youth Psychology Service clinical records were reviewed to provide descriptive information of service delivery over the first year (October 2015 to July 2016). Clinical services were piloted by one student to explore the viability of YPS in terms of youth and staff acceptance of services and the degree of clinical supervision.

Client Characteristics

Clients (N = 8) were mostly male (62.5%) and ranged in age from 16 to 25 with a mean age of 19.2 years (SD = 3.3). All clients were from ethnic minority groups (e.g., Black, East Asian, South Asian, and Middle Eastern) and resided in marginalized areas. Half of the clients previously saw mental health providers, but had terminated services due to issues such as financial constraints and poor rapport. Clinical problems included symptoms such as low mood (87.5%), anger (37.5%), and suicidality (25.0%). Severity ranged from sub-clinical concerns to significant histories of hospitalization. Other psychosocial problems addressed in treatment included family and relationship problems (100%) and unemployment (37.5%).

Services

Table 2 summarizes service provision and student supervision. Clinical service delivery was three hours, once a week. The number of individual sessions varied from 1 to 17 (median = 2.5), depending on distress, impairment, and client motivation. As part of informed consent, clients were made aware of other local service providers and treatment options. The potential benefits and limitations of YPS and other services were discussed. For example, some of the benefits of YPS are that it is a free service and that it can be accessed in a familiar location. Alternatively, the YPS service provider is only a supervised graduate student and has less experience than a registered clinical psychologist. All clients explicitly expressed their preference to be seen by the YPS student therapist rather than be referred out to another service provider.

Table 2. *Service Provision*

Activity	Hours
Clinical Services	71.0
Outreach	31.5
Individual Therapy	23.5
Crisis Intervention	11.5
Client Consultation	4.5
Professional Services	11.5
Professional Consultation	2.5
Staff Training	3.0
Program Evaluation	6.0
Supervision	65.0
Individual Supervision	32.5
Group Supervision	3.0
Peer Supervision	2.5
Total	147.5

Cognitive (e.g., thought records) and behavioural strategies (e.g., contingency management) were used in 25% and 50% of sessions, respectively. Other strategies included psychoeducation (65% of sessions), skills training (55%), and mindfulness (35%). Examples of psychoeducation include identifying and differentiating emotions, such as fear and anger, which

arise during interpersonal conflict. Psychoeducation on emotions was sometimes paired with teaching the "time out" skill to get youth to remove themselves from a situation when they are not able to successfully manage their behaviour, reduce their distress and create a solution, and return to the situation.

Crisis intervention related to increased risk for self-harm or suicide was available both during regular service delivery hours and between sessions. The focus of these contacts was to assess risk and provide strategies to increase safety.

The final element of every consultation or therapy session was client feedback. Eliciting feedback is important not only for gauging the impact of services, but demonstrating to clients that their opinions and experiences are valued. Feedback was verbal and included closed and open-ended questions. Clients were asked at the end of each session to verbally rate the session on a scale form 1 "Much worse than expected" to 5 "Much better than expected" with 3 indicating the session met their expectations. The median score was 4 "Better than expected" with most sessions (65.2%) exceeding expectations to some degree. Only one session was rated 1 "Much worse than expected" and that involved the individual being involuntary hospitalized for imminent suicidal risk. Feedback also included qualitative questions, such as "What part of session, if anything, was helpful?" Clients identified learning about mental health, receiving individual strategies to cope with mental illness, and having someone to talk to as important benefits of their sessions.

YPS students met with St. Stephen's staff to identify staff learning goals, these included formal training on trauma-related disorders and harm-reduction approaches to substance use problems as well as setting up individual staff consultations. In separate case consultations for three youth, students and staff collaboratively created a formulation of the youth's problem and a plan for intervention. Feedback also occurred after staff interactions. A consistent theme in staff feedback was how YPS services helped them manage situations for which they felt unprepared (e.g., suicidality).

YPS students attended clinical supervision with a registered clinical psychologist working in the community. The ratio of service-to-supervision hours was almost 1:1—high compared to the minimum required, 20:1, in psychology internships (Association of Psychology Postdoctoral and Internships Centers, 2016). The high level of supervision supported student therapists in addressing challenging topics, such as reflecting upon how sociocultural identities influence relationships with staff and youth.

Discussion

The student-run clinic model is an emerging health care strategy to overcome barriers systematically excluding vulnerable segments of the population. Student-run clinics have been applied to the treatment of mental illness for adults but the authors of this paper were not able to identify any similar examples for youth. The Youth Psychology Service (YPS) was created to provide mental health services to at-risk youth and their families, as well as support community staff members. The Youth Psychology Service is not only student-run, but also student-led; students are responsible for delivering services and for the leadership and management of the organization. As a result, YPS has the potential to reduce systematic barriers to mental health care and empower the next generation of psychologists.

Data collected over the first year provided a snap shot of how mental health care could be delivered by graduate students and who it would reach. A supervised graduate student therapist partnered with a local not-for profit organization and was invited to deliver services within the organization's outreach settings. Clients referred for services experienced a wide range of psychological and social problems that created moderate to severe levels of distress and dysfunction in their lives. Systemic social barriers explained why many clients had failed to access services elsewhere; barriers, such as financial cost, location, and awareness, reduced clients' motivation to seek services elsewhere. Throughout their engagement with YPS, clients and staff reported that services exceeded their expectations and were interested in further involvement in the future. These findings support the continued development of YPS.

YPS will continue and expand services over the 2016-2017 year. Based on feedback from staff, YPS will expand programing to reach youth who are at different stages of readiness to discuss their mental health. Three different modalities will be used: outreach (in person and through social media), psychoeducation-based groups and workshops, and individual and group treatment. These clinical services, as well as the professional services offered to staff, will undergo program evaluation to examine what works, for whom it works, and who can access services. These results can be used to make decisions about the future development of YPS to further reduce barriers to mental health care and empower students to serve their community.

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