Implementating

The Choice and Partnership Approach

at headspace Darwin.

Sharing the learning

June 2023

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Summary

This report presents key learnings from an evaluation of the implementation of the Choice and Partnership Approach (CAPA) in an early intervention, community-based youth mental health service (headspace Darwin) delivered by a non-government organisation in Australia's Northern Territory (Anglicare NT).

The CAPA model emphasizes collaborative and individualized care, tailoring interventions to the specific needs of each young person and family. It has a focus on service demand and capacity management, an element which has attracted critique, but which appeals to services attempting to manage growing referrals and long wait times.

The evaluation was focused on exploring staff views of CAPA and its implementation, as well as assessing fidelity to the CAPA framework. We utilized primarily qualitative methods, including staff interviews, service data and document review.

Our analysis suggests that the CAPA model has been generally well-received by staff who report feeling empowered in their work with young people through embracing an overt strengths approach, enhancement of practice skills and provision of more responsive services.

The analysis also identified challenges as staff had to step outside their comfort zones to develop skills and confidence within the new framework. Integration of the 11 CAPA components into the requirements of teams working with young people with complex issues requires further work. Indeed, some aspects of CAPA have been difficult to adapt to this specific context. While service data indicates wait times for appointments are beginning to reduce, continued support and monitoring of the framework in action is required.

Our learning highlights that context matters. In the context of this early intervention youth focused service, with multiple programs, partnerships, locations, and funding streams as well as mixture of salaried staff and private providers, CAPA looks quite different to its original context. This in turn impacts fidelity to the model.

An ongoing commitment to supporting all staff with necessary skills and creating space for practice reflection are helping headspace Darwin work to towards ensuring CAPA works to meet headspace Darwin's specific needs.

1. Introduction

From mid 2021, headspace Darwin (Anglicare NT's Youth Mental Health Service) began planning for, and then implementing, the Choice and Partnership Approach (CAPA).

> CAPA is defined by its developers, York & Kingsbury (2013) as 'a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management' (capa.co.uk/introducing-capa).

There is a steadily growing body of research on implementation of CAPA, in locations such as the United Kingdom, Canada, New Zealand and Australia. Existing research is mostly focused on the use of CAPA in government provided child and adolescent mental health services (CAMHS).

There is less research focused on the use of CAPA in the context of early intervention, community-based youth mental health services delivered in non-government organisation (NGO) settings. This report presents an overview of the key learning we have drawn from a process evaluation focused on exploring the implementation of CAPA, in such a context.

We provide an overview of the existing research about the use of the CAPA, highlighting some areas of promise and debate before the explaining the headspace Darwin context. Our evaluation methods and findings are detailed, which includes an overview of the implementation, an assessment of fidelity to the CAPA framework, analysis of staff views, and the reflections of the implementation consultant.

We aim to highlight the strengths, challenges and new learning gained from the implementation of CAPA in this context.

2. Background

2.1 The Choice & Partnership Approach.

The CAPA framework was developed in the United Kingdom by York and Kingsbury (2005) and has evolved over time with York and Kingsbury's book, *The Choice and Partnership Approach: A Service Transformation Mode*l being published in 2013. A CAPA website was also established by York and Kingsbury (capa.co.uk). The site provides up to date information and resources to explain and facilitate the use of the CAPA. This includes education, implementation and evaluation tools, case studies and linkages to a network of CAPA using services across the globe. A collaborative, empowerment-focus philosophy infuses much of the CAPA language, with the website stating:

> CAPA is focused on the service user and their family. The stance is collaborative and provides choices. For the clinician there is a shift in position from an 'expert with power' to a 'facilitator with expertise'.

As a service delivery model, CAPA prescribes specific operating instructions, including models to calculate patient demand, service and worker capacity, and flow through the service (York & Kingsbury, 2013). There is a set of guiding principles and components that should be followed to be truly 'doing' CAPA. Pajar et al. (2022, page 2) summarise four main CAPA principles as follows:

- Operations are grounded in lean health care, demand and capacity models, and queue theory;
- families and patients..... are co-experts in treatment planning;
- treatments are evidence-based and delivered by appropriately trained staff; and
- clinics use real-time data about patient demand and flow, provider capacity, and clinical outcomes to respond to changes in patients' needs.

The CAPA model includes 11 components, which all need to be in place for CAPA to be most effective. These are; Leadership, Language, Handle Demand, Choice Framework, Full Booking to Partnership, Selecting Clinician, Core and Specific Work, Job Plans, Goal Setting, Peer Group Discussion and Team Away Days (York & Kingsbury, 2013). These 11 components also form the basis of implementation evaluation tools provided on the CAPA website (capa.co.uk/evaluation/evaluation-summary).

What this looks like in a Child and Adolescent Mental Health (CAMHS) setting for a young person who is accessing a service is as follows: The young person is referred/refers themselves to a service and is offered a face-to-face 'Choice' appointment, as soon as possible (within a day or two).

The initial Choice appointment is empowerment focused, with the aim of understanding and defining the presenting issues from the young person's viewpoint. There is an assessment of risk, identification of possible solutions, education about, and exploration of, treatment options (including internal services, external options, and no treatment).

The Choice appointment is intended as a therapeutic single session, with clinicians providing brief intervention or psychoeducation as appropriate. The young person and clinician (and family if present) develop a collaborative treatment plan. If no further intervention is needed, the service can end there.If external services are required, then referrals are organised.If the young person chooses to continue with the service, then a 'Partnership' appointment is arranged with a clinician whose skills match the young person's needs. A young person can access as many Partnership appointments as their plan requires. Partnership is organised into 'Core' and 'Specific' types. Core partnerships meet the needs of most young people and involve the use of evidence-based psychological interventions. Specific Partnerships are implemented if particular intervention skills are required, such as those of a psychiatrist as opposed to psychologist or social worker (Pajer et al., 2022).

While adapting the CAPA framework to suit the context is encouraged, services are discouraged from engaging in 'CAPA lite' (capa.co.uk/introducing-capa/capa-lite/). That is, using only some of the 11 components or adopting CAPA principles while making minimal changes to practice. According to the website, adopting CAPA lite is likely to result in CAPA 'not working'.

2.2 Research about the use of CAPA

CAPA has been in use since 2005, with increasing implementation by CAMHS and other services across multiple locations up to the current time (Campbell et al., 2022; Pajer et al., 2022). Accompanying this uptake is publication (peer reviewed journal articles and unpublished evaluation reports) exploring this use. Here we examine two recent reviews of CAPA and consider some of the critiques.

A 2022 scoping review focused on community mental health and addiction services, sought to determine 'to what degree does CAPA work, for whom, and under what circumstances?' (Campbell et al., 2022, p.2). The authors identified 48 evaluation reports (covering 36 different evaluations) from the period 2006 to 2022. Importantly, they point out that regardless of context (e.g. organisation type, implementation location, health system structures) 'the transformation of mental health services through the implementation of CAPA is often undertaken by small teams without the resources to conduct formal evaluations or research' (p.8). To reflect this implementation and learning context, their scoping review included of a range of evaluation report types, methods and quality. This variation meant that a systematic review and meta-analysis was not possible.

Campbell et al. (2022) found that the primary motivation to implement CAPA was often a desire to reduce client wait lists and wait times for service. Of the 11 key components of CAPA, they note that the 'Handle Demand' aspect of 'Choice' was cited more often than that of 'Language'. Yet, the importance of inclusive, collaborative language was identified as a 'core theme' in terms of moving from a diagnostic assessment process to a collaborative partnership approach. In one evaluation, clinician views on this shift in language were mixed, particularly with 'more experienced clinicians who held on to the traditional language of assessment and treatment' (Campbell et al., 2022, p. 6).

2.2 Research about the use of CAPA (continued)

The importance of examining fidelity to CAPA components, to understand the outcomes attributed to the model, was also highlighted in the Campbell et al. (2022) review. They report that only nine of the 36 evaluations reviewed considered fidelity. Their analysis also 'captured inaccuracies in the interpretation and application of CAPA, which likely contribute to unsuccessful implementation' (Campbell et al., 2022, p. 8). They also highlight that examining the change processes needed to facilitate CAPA implementation in complex environments requires a 'consideration and capture of contextual factors' which was lacking in many of the evaluations reviewed (Campbell et al., 2022, p. 9). Access to this contextual information may assist the reader to understand why there were differences in interpretation and application of the model.

Another CAPA-focused scoping review was published in 2022, with a different approach and analytical method (Pajer et al., 2022). Seeking to summarize existing information about the use of CAPA in the delivery of CAMHS in any setting, Pajer et al., (2022) considered peer reviewed and 'grey' (non-published) literature on CAPA from its inception up to June 2021. Six published and three non-published studies met their review criteria. Each of these studies were also included in the previously discussed Campbell et al. (2022) scoping review. Studies in the Pajer et al review were centred on CAMHS sites in England, Scotland, Australia, and Canada.

> 'The review categorised the aims of the nine studies into seven types of research objectives: 1) wait time to first appointment; (2) wait time to second appointment; (3) patient flow; (4) quality of care; (5) patient experience; (6) provider experience; and (7) fidelity to the CAPA model. .....We did not find any cost-benefit, cost-utility, cost- effectiveness, or cost-minimization studies. The four most frequently studied objectives were wait time to first appointment, patient flow, patient experience, and fidelity to CAPA' (Pajer et al., p. 5).

Of the two studies that examined quality of care, (Fuggle et al., 2016; Naughton et al., 2018), one (Fuggle et al., 2016) found that achievement of patient goals was higher with CAPA. However, the Naughton et al (2018) study found no significant differences in pre and post CAPA quality of care data (Pajer et al., p.5). Four of the nine studies in the review looked at patient experience of CAPA. Questionnaire responses for parents and young people were 'generally positive'. Qualitative data provided a more complex picture, raising wait time concerns, limited numbers of sessions (Taylor & Duffy, 2010), and limited understanding of client's treatment plans by young people and their parents (Robotham and James, 2009).

The experience of service providers working within a CAPA model was considered in three of the nine studies in Pajer et al's review (Fuggle et al., 2016; Robotham and James, 2009; Robotham et al., 2010). Strong and supportive leadership, and full implementation of the 11 CAPA components were important for positive staff experiences of, and attitudes towards, CAPA. Aspects considered positive by staff were 'enhanced collaboration with patients', 'increased staff-patient transparency' and 'awareness of the relationship between closing cases and reducing wait times. The study by Fuggle et al. (2016, cited in Pajer et al., 2022, p.7) pointed out providers 'anxiety about insufficient time for administrative tasks'.

As with Campbell et al.'s (2022) review, Pajer et al. noted only four of the nine studies examined model fidelity. Two studies (Naughton et al., 2015; Robotham and James, 2009) described fidelity to the model as 'challenging' with 'only some of the 11 Key Components being used' (Pajer et al., 2022, p.7).

2.2 Research about the use of CAPA (continued)

Critique of CAPA is less well documented. In their research exploring the 'McDonaldisation' of Canadian mental health social work, Johnstone et al (2022) highlight the 'amoral rationalizing principles of New Public management' (p.228) that underpin the theory and practice of the CAPA model. York and Kingsbury (2013) developed the model to be smooth, client-centred and collaborative. The 'Choice and Partnership' language reflects the espoused empowerment, and flexible service delivery, focus. However, Johnston et al. (2022) argue that its rationalist theoretical roots mean practice is dependent on consistent flow through (and out of) the service, as well as clients self-reliance and resources (p.229).

The Johnstone et al. interviews with social workers revealed that all who were working within the CAPA model were critical of it (p.231), experiencing 'job dissatisfaction and professional disrespect' (p.237). Their reasons centred around the commodification of mental health through using marketing principles to deliver human services. Using the 'Mcdonaldisation' frame, this was examined in terms of efficiency, calculability, predictability, and control. The research found that staff experienced a perceived divide between management and clinical staff, feelings of being 'monitored and scrutinized' (p.234), the deskilling and devaluing of professional judgement and critical thinking, ethical tension in relation to social work's social justice mandate, low morale, and high staff turnover.

2.3. The headspace Darwin and newly established satellite context

Darwin, or Garramilla, is the remote capital city of Australia's Northern Territory (NT), located on the lands of the Larrakia people. Smaller than many regional centres, the greater Darwin area has a population of 139,902 people with a median age of 34 years (ABS, 2021).

In 2006, the Australian government committed funds for the establishment of a nation-wide system of Communities of Youth Services (CYS). Anglicare NT established a centre for early intervention youth mental health services as part of the first round of federal funding of national headspace Centres in 2006. The service has been operational in the Darwin, and later Palmerston, and surrounding areas since 2008.

Over time, as consistent with the national network of youth mental health early intervention 'one stop shop' services, the number of referrals to the Darwin service has increased, as it has nationally (headspace National Youth Mental Health Foundation, 2019). In response to the national picture of rising demand, six key recommendations were developed to address the issue of increasing wait times for service. Anglicare NT selected CAPA as strategy to address the wait for service issues and ensure timely access. headspace Darwin was inspired by the use of CAPA in organisations such as Wharaurau (formally The Werry centre, New Zealand wharaurau.org.nz), who's workforce development service and contextualised resources, highlight alignment to the Treaty of Waitangi and Māori models of care, and spoke to the importance of ensuring that CAPA is relevant to the Indigenous people of the land (York & Kingsbury, 2013 pg.184). This strategy aligned with the key recommendation of implementing quality improvement initiatives as a way to increase headspace Centres capacity to improve access to the right service and ensure that more young people receive timely and quality support (headspace, 2019).

2.3. The headspace Darwin and newly established satellite context (continued)

headspace Darwin and Palmerston currently employ approximately twenty clinical staff with qualifications in social work, psychology, nursing, and occupational therapy; and two social and emotional wellbeing workers, Aboriginal staff who contribute their cultural expertise and therapeutic skills to working with young people and families. headspace staff also includes three peer support workers who are trained to use their lived experience of using mental health services in supporting people to navigate and understand systems and access support. The team is also supported by four administration assistants and a leadership team who have responsibilities for clinical teams, systems, and operations.

These staff work across three clinical services: headspace Primary, headspace Early Psychosis (including Functional Recovery Group program) and Enhanced Care. headspace Darwin and Palmerston also provide nonclinical services such as work and study, peer support and community engagement groups. These services are housed at the headspace Darwin Centre and since 2022, also operate out of the satellite site of headspace Palmerston.

The headspace Centre Primary Service is designed to include the integration of primary health-care providers and access via Mental Health Treatment Plans (MHTP) through contracted private practitioners from allied health backgrounds alongside the salaried staff of the program. Given the contractual nature of this role, the number of private providers is known to frequently fluctuate. All clinicians working in the Primary Service provide evidence and outcome-based support to young people presenting for early intervention mental health support, with symptoms considered mild to moderate (Orygen, 2018).

The Early Psychosis Program based at headspace Darwin provides specialised recovery focused wrap around support to young people and their families, who are either assessed as at risk of psychosis or experiencing their first episode of psychosis. This team is supported by a consultant psychiatrist and psychiatric registrar and provides specialised evidence based therapeutic case management alongside medical management. The program practices from the 16 core components of the Early Psychosis Prevention and Intervention Centre (EPPIC) model of care (Orygen, 2012 EPPIC Model Briefing Pack) with strong partnerships with the public mental health system.

The Enhanced Care Service is funded to provide services utilising the Youth Enhanced Service model to support young people with complex mental health presentations or complex social situations along with mental health issues (Orygen, Youth Enhanced Service Model Mapping Tool).

2.3. The headspace Darwin and newly established satellite context (continued)

Prior to commencing implementation of CAPA at headspace Darwin, young people presenting at the service moved through several waiting periods before the commencement of active engagement in their recovery or change process (early intervention support). Waiting for early intervention support is seen as a contributing factor in poor future engagement with support, poorer outcomes and higher distress in young people and their families (McGorry & Mei 2018; headspace, 2019).

In the six month period prior adopting Choice appointments and CAPA, there was an average wait time of approximately 17.4 calendar days from referral to an initial assessment (phone or face-to-face) with the Access team (headspace Darwin, hAPI Tableau report data). Following this assessment, a multidisciplinary team would meet and decide on appropriate service pathways, the recommendation was then communicated to the young person/family. The time between this 'recommendation' and the young person receiving this service took on average 54 calendar days.

There existed an opportunity to improve timely access to support by providing support and pathway option discussions within an initial contact, incorporating ideas and evidence from Single Session Therapy and consultations (Gee et al., 2014; Westwater et al., 2020).

The active implementation of CAPA began in January 2022 commencing with Choice (Choice Framework, Language, Handle Demand) and Letting Go (Goal Setting and Care Planning, Peer Supervision Group) components and focusing on the philosophy of practice and skills required to facilitate Choice appointments. Choice appointments use principles from Single Session Therapy/Thinking, acknowledging this appointment may be the only appointment a young person chooses to attend (York & Kingsbury, 2013, The Bouverie Centre & La Trobe University).

2.4 The purpose of this report: Reflecting on the process of implementing CAPA

As noted at the outset, the aim of this report is to share our learning with others who may be considering adopting the CAPA within a similar, community service context. When author two (Tara) was tasked with implementing CAPA at headspace Darwin, she sought information about the experiences and learnings of others but found limited literature about the use of CAPA in similar contexts. Author one (Gretchen) is an independent social researcher and evaluator, contracted by headspace to provide evaluation mentoring and assist with exploring the process of implementing CAPA. The 'gap' in literature that explores the use of CAPA in practice contexts like ours, sparked our interest in bringing together and sharing key learnings.

3. Methods

We have used a mostly qualitative, multi-method process evaluation approach (Patton, 2014) that included a review of service documentation and data, thematic analysis of staff interviews, an assessment of fidelity to the CAPA model (using the CAPA Fidelity Assessment and Component Evaluation (FACE) tool. This is enhanced by some insightful reflections from Tara (the implementation consultant, and co-author). We bring these methods together to provide a holistic view of the experience at headspace Darwin and its satellite service. The evaluation received human research ethics approval from Menzies School of Health Research, Darwin, NT.

The document review (Bowen, 2009) of materials related to the implementation process (program planning, training, and activity monitoring documentation, funding applications, service satisfaction survey reports) was used in the evaluation process, to understand the implementation outputs, processes and to capture a descriptive summary of changes in service wait-times.

Semi-structured interviews with headspace staff in Darwin and Palmerston were undertaken across December 2022 and January 2023. A convenience sample (Tranter, 2016) was used. Potential participants (48 headspace staff) were emailed evaluation information and invited to participate in an interview (individually or as part of a group as per their preference). Participation was voluntary and interviews took between 30 to 60 minutes. In total there were three individual, and three group interviews comprising a total of 16 participants. Interviews were conducted by Gretchen. Initial questions in the interviews were broad, with the first one being 'could you tell me about your thoughts on the CAPA in the context of headspace Darwin?' Further prompts such as, 'what have been the strengths and challenges of the approach?'. This provided space for the discussion to go where the participants wanted to take it. More focused questions were asked later in the interviews which were aimed at exploring the implementation of 11 CAPA components in more detail.

A general inductive thematic analysis (Thomas, 2006) was used to analyse the interviews. This provided 'a systematic procedure for analysing qualitative data in which the analysis is likely to be guided by specific evaluation objectives' (Thomas, 2006, p. 238). Our objective was to understand staff views of the CAPA model and explore their experience of the strengths and challenges of implementation. Integrating this with information from the document review, we also sought to examine fidelity to the 11 CAPA components. Interview transcripts were analysed into codes, then organised into categories or 'themes'. The emerging themes were discussed and refined by both authors.

A draft analysis was provided to participants for comment and reflection, a critical part of building overall credibility and trustworthiness of the analysis (Patton, 2014; Stake, 2010). In this way a set of final set of themes was developed.

Data from these sources formed the basis of an assessment of implementation fidelity using the **CAPA Fidelity Assessment** and Component Evaluation (FACE) tool (https://www.capa.co.uk/resources/capa-face/). **Reflections** from Tara form the final piece of the picture.

4. Results

4.1 Implementation processes and a gradual change in access to early intervention support

After selecting CAPA in 2021, and the employment of an implementation consultant (author 2) late that year, the implementation process began in earnest in January 2022. This involved developing an implementation plan, including ongoing education, supervision, and training opportunities for staff at all levels, designing a new service model and establishing new referral and service protocols, along with associated changes in administration, reporting and governance systems required for the transition from 'old' to 'new' (CAPA) ways of working.

The initial CAPA components of implementation focus were those of Leadership and Management, Team Away Days, Language, Handle Demand, Choice Framework (renamed to Choice Philosophy as per Whararau, New Zealand), Small Group Peer Supervision and Goal setting and Care Planning. From June 2022 the CAPA Choice Appointment commenced as part of the new CAPA informed service model with the local name of 'First Step appointment'. The centre's service model also changed to include a new daily referral review meeting, shared across the services as per the Handle Demand CAPA component and new appointment booking processes and language prompts for all staff.

At the time of writing, the implementation of all 11 CAPA components remains an ongoing process, which is well underway, but after 12 months, is not yet complete.

4.2. Snapshot of wait times and primary services flow

headspace Darwin, and headspace National, collect a variety of data concerning referrals and flow through the service, along with service feedback and self-assessment measurements (via regular headspace National overseen minimum data set surveys) from the young people who attend the service.

Whilst we do not have a comprehensive data set at this stage due to the simultaneous service redesign and implementation project of headspace Palmerston (an integrated satellite service impacting both data collection and the statistic systems for headspace Darwin) we do have the initial quarter 1 snapshot of wait time and flow through the Primary services of 2023. These emerging trends appear to support the perceptions articulated in the staff focus groups (see section 4.3) of changes to flow of young people through the service and reduced waiting times for primary services.

Table 1. Overview of service wait times and primary service flow

Wait measure	Data source	Results	Analysis comments
Wait in calendar days first appointment at headspace	hAPI wait time 1 data review. 3-month period 2023 01/01/2023-31/03/2023	For the first 3 months of 2023, the average wait in calendar days is 13.5 days (N=96) for first service at headspace Darwin And 14 days (N=60) for first service headspace Palmerston	Wait time for first service within two weeks for both headspace Darwin and satellite service headspace Palmerston.
Wait in calendar days for chosen headspace service (After first appointment)	hAPI wait time 2 data. 3-month period 2023 01/01/2023-31/03/2023	36.4 Calendar days, (4.9 weeks) headspace Darwin (N=30) 46.3 (6.6 weeks) Calendar days headspace Palmerston (N=20)	Analysis trends of quarter 1 2023 we are starting to see a reduction of wait time for primary services at headspace Darwin which may be attributed to increased choice and redirection to appropriate care combined with successful implementation of a single session approach at first service. The new satellite service headspace Palmerston is slightly higher, which may be attributed to less salaried staff and private provider access in the first quarter.
Number of young people on wait list for chosen primary service	Analysis number of young people documented as waiting on physical wait list spreadsheet for primary service allocation management.	Total average number of young people waiting for primary service during quarter 1, 2023. 01/01/2023-31/03/2023 = 11.26 young people on average waiting for service across this period.	The first quarter of 2023 is beginning to show positive improvement to flow of young through service with reductions to the numbers of young people queuing for primary service stream at headspace Darwin and headspace Palmerston.
Type of first service provided by primary service	Analysis of nature of service for first service (Intake/Access) type Options: Single session Therapy (as first service) Initial Screening/Needs identification Initial assessment (psychosocial assessment e.g., ››HEADSS) Engagement	68.8% (N=99) of first service at headspace Darwin were single session therapy over 01/01/2023-31/03/2023 61% (N=58) of Intake/access (first service at headspace Palmerston) were single session therapy over 01/01/2023-31/03/2023	Trend showing over half of all first service appointments at both headspace Darwin and headspace Palmerston are facilitated utilising single session therapy principles.

When looking at wait times for the first quarter of 2023, we can see the numbers are moving in a pleasing direction. As outlined at the outset of this report, prior to the implementation of CAPA wait time for first appointments were on average 17.4 calendar days for headspace Darwin. Now they are currently within two weeks for both headspace Darwin (13.5 days) and headspace Palmerston (14 days).

For young people choosing to return for service, the wait in calendars days is moving in the right direction across both sites. The average wait at headspace Darwin is now 34.4 days and 46.3 days for Palmerston. It is important to note that a straight 'pre and post' comparison is not possible due to the implementation of headspace Palmerston. However, young people appear to be waiting less time for service and receiving Single Session Therapy as first service more often post-CAPA than pre-CAPA.

4.3. Staff interviews

The 16 staff interviewed included a mix of clinical (10), administration (1), peer support (1) leadership/clinical combined (3) and leadership only staff (1). Staff length of employment at headspace ranged from a few months to five years. Because of the visibility of the service in the Darwin region and the relatively small sample size, potentially identifying features such as role, profession, or length of employment are not attached to participant quotes.

4.3.1. Strengths of the CAPA implementation at headspace Darwin.

Three themes were highlighted in our exploration of the strengths of the CAPA model and its implementation. Table 2 provides an overview of these themes, which are then discussed in detail.

Table 2. Strengths of CAPA implementation at headspace Darwin

Theme	Sub theme (with number of participants who mentioned it)
Empowerment	Empowering young people and their families (12)
	Empowering for workers (7)
Responsive services	Flexibility in service provision (7)
	More engagement in assessments (5)
	Reducing waitlists (7)
Service fit	Building on what was already happening (6)
	Aligns with headspace Darwin values (3)

Empowerment

Working in an empowerment-focused way was familiar to many staff, but most felt that the CAPA processes helped to 'build in' empowerment practices through ensuring choice, collaboration, and a strengths focused philosophy in the following ways.

Empowering for young people and their families

Almost all participants (12/16) felt that maintaining a focus on empowerment with young people and their families was a key aspect of CAPA. Empowerment was enacted through choice in the type and length of service provided. This involved young people being able to choose the kind of engagement they wanted, who that would be with, and for how long. We see this in the following quote:

I like the philosophy of it, because it's about empowering and giving the young person choice, about the sort of help they are wanting or not wanting.

Because headspace is an early intervention service, the option for young people to choose 'no further service' was also an important one. As the following quote explains:

We often have young people and families who might have been referred [by other people or organisations]. They come and do the First Step, we talk them through it, do some brief intervention. They may decide that's enough for them. That's really empowering for them, to know that they don't have to continue with a service, just because they've been referred.

Empowerment was also enacted through using a strengths approach to practice, which positions young people as experts in their own lives. This helped young people and families to explore the ways they have handled problems in the past, identifying and naming helpful strategies so they can be used to address the current issues.

Some staff, particularly those who had previously been involved in intake (Access) services, were excited by the level of collaboration between worker, young person and family that is built into the CAPA process. The pre-CAPA intake procedure was described by one staff member as a process of '*information extraction'*, involving '*a lot of form filling*' and '*not a lot of actual engagement with the person*'. The following quote about goal setting demonstrates the change.

It's in their own words. It's a lot more involved, everyone in the room is more collaborative. We are way more guided by the young person.

Empowering for staff

Seven of the 16 participants discussed feeling more empowered in their practice since the CAPA implementation. Staff whose roles had involved mostly intake and assessment processes felt empowered in developing and using a broader range of skills. This included communication, engagement, and brief therapy skills. The following comment makes this clear:

I'm more confident in my own skills. I can trust myself a little bit more.

Staff discussed a sense of more meaningful engagement with young people and families than they had experienced pre-CAPA. Some highlighted increasing confidence because they were assisting young people in practical and immediate ways. We see this in the following quote.

The empowerment and choice aspects make me feel more confident in providing a service .....being able to collaborate with a young person around what they are wanting.

Clarity around service provision (expectations, goals, length, content, and type) for workers and young people was also seen as empowering by some participants, as is demonstrated here:

Having that discussion early on about when therapy will end and making use of the time so much more efficiently [is empowering]. If you had 10 sessions, maybe you don't always do a lot in some of those sessions. It helps to make the most of the time you do have.

Responsive Services (focus and flexibility)

Closely linked to empowerment, is the idea of more responsive service provision. This was notable from the focused assessment process (via the Choice 'First Step' appointment). Which was seen as more collaborative and change-focused than the previous practice, as we see here:

[Previously] we had laptop in front of us and it was like 'tell me everything', we would get their whole history. There wasn't a lot of actual engagement. But now we are guided by them. They are writing the form if they want to, they get to write down their concerns and thoughts.

Flexibility in service provision was highlighted by seven participants. This included a focus on working with what the young person needs '*right now'* and the client's ability to say '*enough for now'.* That is, the young person could stop the service when they felt they had achieved what they needed, as we see in this quote.

I like the philosophy of 'enough for now'. If a young person isn't engaging, it might be that it is enough for them, for now.

Staff in leadership roles highlighted the importance of using service data to understand the flow through the service. An example shared by a participant was learning that for headspace Darwin, the average number of sessions a young person engaged in was four. Knowing this helped clinicians to feel confident with the CAPA emphasis on brief intervention, which in turn, helps to streamlining flow though the service. This was reported to reduce waitlist time (seven participants noted this), as expressed here:

It's really great for young people not come here out of guilt. That's really effective at a service level because then we can see more young people, and have a shorter waitlist.

Service Fit

CAPA appeared to fit well with headspace as a service. Many of the pre-CAPA practice philosophies and approaches, already in place at headspace Darwin, resonated with the CAPA model (particularly around strengths approaches, use of service data, brief interventions and integration of Peer Support workers). Therefore, many participants expressed a sense of '*we were doing that already, but CAPA has formalised it*', as we see in these comments.

A lot of CAPA philosophy is similar to how things were done, so it's more about formalising and giving structure to that. Ensuring useful practices are used more often. I like that element.

Peer Support workers are really important as they can help young people understand CAPA and to really think about what they want to change at this point in time, what would that look like, what would that feel like?

4.3.2 Challenges in the CAPA implementation at headspace Darwin.

Three themes were found in in terms of CAPA challenges. Table 3 provides an overview of these, following this, each theme is explored in detail.

Table 3. Challenges in CAPA implementation at headspace Darwin

Theme	Sub theme (with number of participants who mentioned it)
Stepping out of comfort zone	Learning the CAPA language, components, and processes (6)
	Differences between 'old' and new role requirements (4)
	Ensuring room for critique (1)
Integration and fit	First Step appointment format doesn't always'fit' (6)
	Integration with Early Psychosis and Enhanced Care processes (4)
Community expectations about service	Long term engagement and a 'certain number of sessions' (4)

Stepping out of comfort zone

CAPA rests on a set of assumptions about empowerment and 'lean' service provision with strategies involving single session thinking and redesign of the service systems as core elements. Staff working within the approach have been required to trial new organisational processes related to managing referrals and applying the underpinning ideas and well as practical elements such as language and philosophy within new meeting spaces. Six participants discussed how learning CAPA language, concepts and processes takes time and requires an ongoing commitment to learning.

Just getting my head around how the process is different has been a bit challenging. I think that's the main thing.

For some participants, the activities they undertake on a day to basis have changed, and this difference between old and new role requirements would take some time to adjust to. We see this in the following comment.

Before CAPA I was only doing assessment, I hadn't done any therapy. It was very daunting. I was a bit scared, but now we are doing a lot more professional development around that....That was initially a challenge but it's okay now.

Keeping a critical eye on the impacts of the CAPA model was also highlighted, and this may not always be comfortable for an organisation. Building in processes that enable staff to question, challenge and explore the implications of embracing a new model was seen as very important, as was creating safe space to do this.

Integration and fit issues.

While headspace has an early intervention focus, it also provides services to young people with complex needs (through the Early Psychosis and Enhanced Care services). Participants who work primarily in these spaces had concerns about the fit between the 'First Step' and their ability to thoroughly assess the needs of a young person coming to the service with complex issues, as the following quote highlights.

If you get a young person with complex issues, it's hard to stick with the First Step format. You might switch to be a more of a process of gathering more information to help make more of an informed choice around what will be most helpful for them.

The issue of time to adequately assess risk was also raised in the following comment:

High levels or risk or complexity can sometimes be hard to fit within the CAPA First Step appointment.

Integration and fit issues (continued)

It takes time to integrate with specific CAPA processes related to the above issues. Participants pointed out that integrating the assessment requirements the Early Psychosis and Enhanced Care teams, alongside practicing from a Choice Philosophy was a '*work in progress'*.

As the implementation of CAPA rolls out it is hoped that this becomes smoother. For now there exists some variation within services that have experienced selective component implementation of CAPA. The following quote provides some insight into variations in practice;

We have quite a large, comprehensive assessment for people coming into Early Psychosis. They maybe don't have as much choice. If [support is] not with our team then, I suppose it's external. The two models (CAPA and Early Psychosis) run parallel. They fit, kind of, together, in terms of what we can offer in our program. We can offer choice and support, or meeting people where they are at. But they are working in parallel, especially in the Mobile Assessment and Treating Team assessment phase.

Community expectations about service

An interesting observation discussed by four participants was the idea of community expectations about what engagement with headspace should entail. There was sometimes an assumption of a long-term engagement, in the form of '*around 8-12 sessions*' between a young person and a counselor. This meant clinical staff spent more time explaining CAPA and why one session may be enough for now. Participants wanted to ensure people felt supported, as the following comment highlights.

Often people are asking us about the number of sessions. I feel like there's worry and concern in the community and people are wanting to know that they will be supported. That's something we are continuing to learn how to navigate, how to give people the choice while also making them feel like they are well supported.

4.4 CAPA fidelity assessment

The CAPA Fidelity Assessment and Component Evaluation (FACE) tool was used to assess progress to fidelity of the CAPA framework. The FACE is a self-assessment tool (see https://www.capa.co.uk/resources/capa-face/) which was completed by Tara in collaboration with the Anglicare NT CAPA implementation committee, using evidence from the process evaluation to inform their consensus rating on each item. The item count below indicates headspace Darwin has 74.6% compliance to CAPA fidelity.

Table 4: CAPA fidelity scores

Component		**FACE grade**	**Count**
1	Leadership and management	Good	5.0/6
2	Language	Strong	7.0/7
3	Handle demand	Good	8.0/9
4	Choice framework	Good	12.0/15
5	Full booking to partnership	None	0.0/2
6	Selecting partnership clinician by skill	Poor	1.0/3
7	Extended clinical skills in core work	Moderate	2.0/4
8	Job plans	Poor	1.0 /4
9	Goal setting and care planning	Strong	4.0/4
10	Small group peer supervision	Good	4.0/5
11	Team away days	Good	3.0/5
Overall rating = good		*Total item count = 47.0/63*	
Specific areas			
Collaborative practice		Good	20.7/25
Demand and capacity		Moderate	7.0/13
Skill mix and layering		Moderate	5.0/8
Leadership and governance		Good	14.3/17
Clinician Variation			
Consistent practice across clinicians		Good	14.0/19

4.5 Reflections from the Implementation Consultant

Reflection on challenges: Project barriers

The CAPA Component Implementation and Fidelity Assessment (CAPA FACE) tool distils CAPA down into simple, specific measures that aim to capture very complex phenomenon. With this, and similarly with the CAPA component rating scales (CAPA-CRS provided to support implementation planning) the task at hand when commencing implementation of CAPA can be easily underestimated. In this section of our report, I (Tara) discuss my reflections on some reasons for this initial underestimation.

A challenge, that was not immediately apparent when commencing planning utilising the CAPA CPRS items, was the **complexity of the inter-relatedness of enabling factors for each of the 11 CAPA components.** An example of this identified challenge is noted when considering the items describing the Choice Framework (in the CAPA-FACE). The fidelity items speak to key elements of the facilitation of the Choice "First Step "appointments. These key elements when examined, link to clinician knowledge, skillsets, and experience level but also, to the end state of redesigning a service model and implementation of new internal procedures and systems (e.g., referral management, shared diaries, targets, and processes around collaborative communication and planning with young people and families). This is just one CAPA component, where the task of implementation planning involved a web of imagined future states, capacity building, tool development and organisational restructure

The capa.co.uk advice of "where to start" suggests the seemingly straightforward strategy of focusing on component-based analysis and development of implementation action plans. The interconnectedness of components impacted the ability to develop contained action plans, this in turn impacted our ability to find a straightforward strategy for distilling required actions and providing 'simple' ways forward. It was our experience that substantial knowledge of organisational policy, culture, fidelity models and systems were required to attempt to find where to start.

Many of the component's fidelity (refer to CAPA-FACE) rests on redesign of service, new or significant change to systems being developed to meet/enable an end state described in the items on the tool. In our experience, this has **required a diverse skillset** including a strong understanding of clinical work practices, fidelity models, data collection and analysis, system configuration and process mapping, alongside project management science, workshop design and facilitation skills and best practice change management approaches. It has been a challenge to pull together these skills in a cohesive working group and it must be acknowledged that headspace Darwin was in a fortunate position of funding an implementation consultation role to support the project. Many organisations and services would not have this additional capacity and support; therefore, it would be anticipated that the challenge would be felt at a greater level.

Taking a collaborative, best practice approach to change management in a service such as headspace Darwin, with its many stakeholders, many engaged leaders, and many projects on the go, proved to be a process challenge. It was difficult to gain consensus, develop a clear plan to meet everyone's learning and processing styles and every program's fidelity requirement. **Finding the balance between collaboration and ensuring a clear direction to follow,** especially when implementing a "system free" approach, is difficult and messy.

4.5 Reflections from the Implementation Consultant (continued)

A further context consideration is the structure of the headspace Darwin service, of one that is not simply made up of salaried staff who can all provided therapeutic support. Rather, it is a **multidisciplinary clinical and non-clinical staff group** who can provide therapeutic, peer and cultural support. Of those providing therapeutic support, there are staff who are salaried by the organisation using core funding. These clinicians work as a team during the week to provide primary services, and these services are also provided by contracted private practitioners, as per the headspace funding model. Private providers work sessional hours, sometimes just three hours per week, using the Medicare rebate model. This situation limited the renumerated time available to provide training and cultural support. It provides a challenge in fully implementing all components of CAPA within the bounds of the CYS service design and the limit to core funding is a significant consideration in headspace Centre contexts (Muir et al, 2009).

Reflection on strengths: Helpful project strategies

An asset in the implementation of CAPA has been its **overall alignment with headspace model of integrity components** which are required to be in place for a headspace Centre and shape the delivery of the Primary Services. CAPA was found to align even further with the philosophy, collaborative principles and service design framed by YES Model and EPPIC model – utilised by headspace Darwin's Enhanced Care and Early Psychosis programs. In particular, the CAPA components (Choice Framework (Philosophy), Language, Handle Demand and Care Planning & Goal Setting) firmly centre service around young people and their families as the drivers of their own care and change process. The implementation of these components and that of goal setting and care planning, actively elevate their voice, aligning strongly with both Youth Participation and Family and Friends Participation components from headspace.

Although there was alignment found with the three key overarching fidelity models their existence did influence the approach taken to CAPA implementation. Rather than focusing on the warnings against a "CAPA lite" implementation, there was a need to concentrate on the higher-level intentions of CAPA. Specifically, we chose to **focus on ensuring service that was led by young people and families,** that is accessible, and outcome focused, with improved internal transparency of practice, capacity, and activity (York & Kingsbury, 2013 pg.3). These foci were most helpful for our leaders in the CAPA implementation processes.

Finally, the knowledge gained through **pre-implementation consultations with other services who had experience with CAPA has been critical.** This knowledge informed the approach taken by headspace Darwin during the planning phase, providing direction to the implementation strategy that chose to reinforce and make overt, the otherwise assumed, strengths-focused collaborative practices within its services. Commencing with the Choice Philosophy, the expectation that clinicians act as a facilitator of change, using shared decision-making practices alongside young people and families, was a key strategy used by the leadership team. Linking this philosophy to a value-based motivation for change, provided a clear place for staff and leadership to understand and reflect together.

5. Discussion

In this section we bring together all the findings presented in this report to explore the new learning that might assist other services embarking on CAPA implementation.

5.1 Staff are impacted differently depending on role and length of time at the service.

Our interviews with staff revealed some quite different experiences with CAPA depending on the role and length of time working at the service. Newer staff, who joined the service in 2022 have only known their workplace as a CAPA one. They have needed to be orientated to CAPA, but it has not changed anything about their role.

There was more change for those workers who had been at the service prior to the 2021 CAPA implementation. Particularly for those who had previously been involved in 'intake only' work (in what was called the Access Team). These participants had a stronger sense of being challenged to refresh or extend their brief intervention skills within CAPA, as their role expanded to include more therapeutic practices.

Some staff also found themselves in an educative role of sharing ideas with family and community about what a mental health service can be. This was focused on dispelling assumptions about young people being 'passive' recipients in a long process of therapy rather than active participants in a (briefer) process of learning and change.

Interestingly, staff did not express negative feeling about this, and some were enthusiastic about the change. However, they acknowledged some nervousness and a lack of confidence in their therapeutic skills at the outset, but noted they felt supported in their development and were becoming more comfortable over time. This finding run counter to the research by Johnstone et al. (2022) where social workers experienced a perceived divide between management and clinicians, feelings of being 'monitored and scrutinized' the deskilling and devaluing of professional judgement and critical thinking and ethical tensions (p.234). We acknowledge our study is much smaller, involving a range of staff with various professional backgrounds, undertaken early in the implementation process, in a different practice context. Johnstone et al.'s study does, however, remind us of the importance of keeping a critical eye and being open to unpacking the challenging aspects of CAPA, and this was an idea also raised in our study.

5.2 Implementation takes time, ongoing learning and support

We have emphasised that the CAPA implementation is a work in progress. Change has meant engaging with all staff about their practice assumptions and philosophies, their beliefs about working young people and the strengths-appraoch idea of 'power with' rather than 'power over' (McCashen, 2018). In a multidisciplinary team, there are different understandings of, and levels of comfort with, a strengths approach to practice, and the meaning of collaboration with young people and their families.

Exploring this and working with all staff to develop a shared foundation, along with the practical resources that facilitate this, takes significant time and is ongoing. In headspace Darwin's context, this has meant support from leadership for resourcing the implementation consultant role for an initial 12-month period, then extended for a further nine months. This role encompassed the development and/or updating of context-specific resources to reflect CAPA language requirements and working with all levels of staff to create a deep understanding of the underpinning concepts of collaboration (with young people and as well as with each other). The critical importance of ongoing support from leadership is highlighted in a number of larger scale evaluations of CAPA implementations (for example, Campbell et al., 2022; Robothom, et al., 2010)

Working out how CAPA will fit with each of the three service areas in our specific context is also a work in progress. As previously noted, headspace Darwin has three clinical service areas (Primary, Early Psychosis and Enhanced Care). Young people experiencing complex issues are mostly engaged with the Enhanced Care and the Early Psychosis Teams. Integrating the CAPA framework into the work of these programs, each with their own specific requirements (which are also closely tied to their funding) commenced with the Primary Services and has extended into the other areas over time. This involves ensuring all headspace Darwin staff hold a shared philosophy, focusing in on the Choice Philosophy and Letting Go components, and focusing in on the Primary Services for full implementation of all 11 components. While this way of implementing CAPA is not generally recommended in the CAPA literature, it has fit our specific context and service needs.

5.3. Context matters

The CAPA originators stress 'the components are system free. This has facilitated local adaptation in a wide variety of services, cultures, and health systems across the world' (www.capa.co.uk). However, in our experience, our service context does impact the implementation design and potentially our ability to meet full CAPA fidelity compliance requirements in ways that were aligned with those noted as 'challenging aspects' on the CAPA website. This website (capa.co.uk/introducing-capa/capa-lite/) points out 'the most challenging aspects of implementation are working in a Choice Framework, changing Language, Full Booking from Choice to Partnership, Small Group Peer discussion, Team Job Planning (including doing a clinical skills mix analysis and keeping the team job plan up to date) and having Team Away Days'. It is notable that 'challenging aspects' include six (over half) of the 11 components. In contrast to the warnings that if all 11 components are not implemented CAPA will be not working, our staff interviews highlight that implementation of aspects that reinforce collaborative practices and client led services, without full implementation of CAPA can have a positive impact and do not necessarily result in complaints of 'CAPA not working'.

We are cautioned against 'CAPA lite' but encouraged to adapt to our context. It is a tricky balance to strike, for fear that we might be 'doing it wrong'. At the outset of this report, we explained the differences in the headspace Darwin context, so CAPA here will necessarily need to be different than that of a CAMHS. We are encouraged to treat implementation like cooking, starting with the exact recipe and then adapting to make our own (York & Kingsbury, 2013, pg. 10) however in our project experience and timeframes, the adapting to make it our own was required sooner rather than later. In our experience there appears to be benefit in implementing 'CAPA lite' when the components chosen for this task reinforce models already existing and contribute to creating or reinforcing a common language, way of practice and collaborative shared decision making with young people and families.

We found the CAPA fidelity measures reflect the original CAMHS context, therefore some aspects did not translate easily, or required further time and resources to adjust, to our context. Specialist CAMHS require a level of experience and skill to provide treatment and support for complex, no longer 'early' intervention, mental health issues. headspace Centres at a core level are early intervention support services, although, as noted, headspace Darwin does provide more intensive mental health support options. As reflected earlier, implementation design decisions were made to fit our three service areas at headspace Darwin. This included a phased introduction of the components alongside decisions to selectively implement components into different service areas.

There are further key considerations we wish to highlight. It has been challenging to utilise the 'CAPA formulas' that underpin the Job Planning components. Some elements of the Job Planning and Handle Demand components involve having clear cut caps on referral demand and redirection (non-acceptance) descriptions. These have not fully resonated with our headspace Centre, which is essentially funded by the Federal Government to ensure enhanced access for a vulnerable cohort through a 'no wrong door' approach to referrals. Similarly the use of averages to inform capacity planning and segmentation of work has required adaptation to work in our Centre. This is because we house three clinical services overarching a spectrum of support levels. Further, the structural service design of a headspace Centre includes a mix of salaried staff and private provider staff utilising the Medicare rebate system which combine to make up the primary service capacity. This mix impacts the ability to fully implement CAPA components, particularly those that connect to the key idea of Partnership.

Despite the warnings against 'CAPA lite', partial implementation of CAPA can be useful in some circumstances such as ours. Importantly it has contributed to enhancing the overall integration of services and reinforcing underpinning aligned philosophy and principles. While there is ongoing work to be done, we are well underway with the implementation of CAPA at headspace Darwin. It has been an empowering, but challenging process, and early evidence suggests improvements in wait times and service flow.

6. Next Steps

In this final section, we provide an overview of the evaluation recommendations. These are drawn from the Choice and Partnership Approach Implementation Demand Management and Enhanced Access Project Evaluation Report (Anglicare NT, May 2023)

Overall Recommendation

The initial findings from the process evaluation point to the overall progression towards all project goals with alignment to the philosophy and key best practice points outlined within the existing models; headspace Model of Care, the YES Model and the EPPIC Model. It is recommended that the Implementation Committee continues with the progression of implementation and sustaining strategies to enable the use of CAPA as a framework across the Anglicare-NT headspace Division sites.

Recommendation 1.

CAPA Implementation Committee to ensure a sustainable strategy for the effective continuation of the Foundational CAPA components: Leadership and Management and Team Building Time (AKA Team Away Days) as sites move from active implementation to sustaining and embedding and the CAPA Implementation Consultant role concludes on the 30th of June 2023.

Recommendation 2.

CAPA Implementation Committee to continue with implementation approach that considers headspace context restraints and does not strive for full rating on CAPA-FACE particularly for CAPA component; Full booking, Selecting clinician by skill, Time plans (job plans).

Recommendation 3.

Anglicare NT headspace Division leadership team to continue to utilise a continuous quality improvement reflective approach within leadership meetings and add an agenda item that supports the continued progression toward project goals alongside sustaining CAPA within headspace Darwin and wider division.

Recommendation 4.

CAPA Implementation Committee ensure mechanisms are in place for reporting/analysis of demand and capacity, including wait times for service, service queues or wait list analysis and quality of appointments provided. Ideally this analysis will occur every quarter to continue with continuous improvement and use of CAPA in relation to increasing access to timely support.

Recommendation 5.

Anglicare-NT Executive Manager and Operations Managers to prioritise resources to support the progression of the goal, *Aboriginal and Torres Strait Islander young people and families have access to culturally safe and appropriate services headspace Darwin,* in particular focusing on the development of an Anglicare NT headspace Division specific approach to operationalising the Social and Emotional Wellbeing Framework for use, and to combine this with CAPA and other overarching models in use.

Recommendation 6.

Anglicare-NT Executive Manager and Operations Managers to delegate overarching needs analysis of current induction processes and structures and employ a broad quality improvement approach to ensuring all relevant guiding operational documents and procedures are easily found and understood and that key tools and systems, including those newly implemented, are part of a new staff induction process.

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