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ORIGINAL REPORT

Comparing Strategies for Providing Child and Youth Mental Health Care Services in Canada, the United States, and The Netherlands

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Abstract This paper reviews how child and youth mental health care services in Canada, the United States, and the Netherlands are organized and financed in order to identify systems and individual-level factors that may inhibit or discourage access to treatment for youth with mental health problems, such as public or private health insurance coverage, out-of-pocket expenses, and referral requirements for specialized mental health care services. Pathways to care for treatment of mental health problems among children and youth are conceptualized and discussed in reference to health insurance coverage and access to specialty services. We outline reforms to the organization of health care that have been introduced in recent years, and the basket of services covered by public and private insurance schemes. We conclude with a discussion of country-level opportunities to enhance access to child and youth mental health services using existing health policy levers in Canada, the United States and the Netherlands.

Keywords Mental health · Youth · Health care · Canada · United States · Netherlands

Introduction

Until recently, there has been very little cross-national focus on how mental health services, particularly for children and youth, are organized and financed. Large-scale modifications to existing health insurance schemes, such as the *Affordable Care Act* and more recent Congressional bills in the United States (US), have been intertwined with a broadening dialogue about the optimal structure, appropriations, and delivery of mental health services for young people. These discussions have been guided typically by previous research that has found that the availability and cost of health services highly influences a provider's willingness to refer to specialty services, and the subsequent uptake and engagement with services by children and youth (Flisher et al. 1997; Stiffman et al. 2004). The organization of providers and health insurance coverage are two central health systems components that intersect with economic, social, geographical, and other determinants of health to influence access to care (Cohen and Peachey 2014; Zwaanswijk et al. 2007).

In the current financial climate and rising demand for mental health services among young people, it is important to understand best practices internationally that can improve service accessibility, and reduce financial and organizational barriers to obtaining services at the patient level (Stiffman et al. 2010). The purpose of this review is to provide a synthesis of how mental health care services are organized and financed in three developed nations in order to understand differences in two key elements of mental health care policy that impact access to care: the organization of mental health services and health insurance coverage. This review builds on existing literature that has examined access to mental health care for children and youth in developed countries, and extends this work by focusing specifically on three countries that have similar levels of economic development and health outcomes (i.e., life expectancy): Canada, the US and the Netherlands (Naderi

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and Meier 2010; Prins et al. 2011; Sareen et al. 2007; World Health Organization 2016).

Context for Addressing Mental Health Concerns

There has been growing awareness that mental health problems are highly prevalent and have significant impact on children, youth, and their families. In the US, 21.4% of youth 13–18 years old are reported to have a serious mental illness (Merikangas et al. 2010). It has also been estimated that 29.1% of Canadians aged 13–19 years have mental health problems, and a 2006 cohort study of Dutch youth aged 11–16 found that 18–19.9% of boys and 15.8–22.8% of girls experienced mental health problems (Mental Health Commission of Canada 2012; Vollebergh et al. 2006). Concerns of mental illness extend to its serious impact on the lives of youth as well as on society more broadly. Notably, suicide is the second leading cause of death among youth globally (World Health Organization 2014). Moreover, in Canada, the economic burden of mental illness has recently been estimated at 51 billion dollars per year, including health care costs, lost productivity, and reduction of various quality-of-life health indicators (Smetanin et al. 2011). Families are also affected by a young person's mental illness, and caregivers of children and youth with mental health problems have been shown to experience higher rates of stress and psychological problems, as well as financial and employment challenges, disruptive changes to family functioning and daily life, and difficulty finding mental health care services (Rowe 2012; Ward-Griffin et al. 2005). To address these concerns, mental health has been elevated to the forefront of policy agendas in many developed countries, including Canada, the US, and the Netherlands, where there have been recent efforts to develop and implement changes to the organization, funding, and provision of child and youth mental health services (for a brief summary, see Table 1).

Although services are financed, planned, and delivered differently across Canada, the US, and the Netherlands, it is important to understand the common array of service providers that interact with children and youth with mental health problems because of the impact of referral requirements and insurance coverage on access to health care (Peachey et al. 2013; Prins et al. 2011; Stiffman et al. 2004). In all three countries, primary health care settings are where most youth with mental illness are diagnosed, treated, and referred for either specialist or tertiary services (Goodrich et al. 2013; Wang et al. 2007). In particular, general practitioners (also known as family physicians) are the prevailing access point or "gate keepers" for secondary and tertiary level mental health services (Xierali et al. 2013). For example, research in the Netherlands has found that 61.1% of sampled adolescents enter mental health care via referrals by family doctors, and the remaining 38.9% access services via other providers, such as school-based health care professionals (Zwaanswijk et al. 2007). The education system and schools, which can vary across jurisdictions regarding available resources to detect and address mental health problems, are important venues for reaching and providing services to youth with mental illness (Kutcher and Wei 2012). Over 98% of secondary schools and 67% of primary schools in the Netherlands have access to Special Care Advice Teams that assist with the detection and treatment of mental health problems among children and youth (Forti et al. 2014). Additionally, non-profit organizations and private mental health care providers deliver services to children and youth with mental health problems, such as private practice psychologists in Canada (Cohen and Peachey 2014). Depending on individual circumstances, youth may also receive services through child welfare and juvenile justice agencies if they are under the care of the government, or charged with breaking the law (McCormick et al. 2015).

Rationale for International Comparisons

This paper focuses on mental health services for children and youth in Canada, the US, and the Netherlands because they have similar levels of economic development, overall social and demographic profiles, and health care systems (Exter et al. 2004; Kutcher 2011; Rice et al. 2013). Previous research has also found that the perceived need for mental health services is very similar in these countries (Sareen et al. 2007). Furthermore, because each country has developed strategies in the past 5 years to improve access to health care services, they are ideal case studies for examining recent health policies that support enhanced access to services for children and youth. For example, the Mental Health Commission of Canada released the *Evergreen Framework* for child and youth mental health services, as well as a subsequent national mental health strategy in 2012, and all Canadian provinces and territories have introduced individual mental health strategies (Goldbloom and Bradley 2012; Hampton 2010; Kutcher 2011; Kutcher and McLuckie 2009; Peachey et al. 2013).

In the US, mental health has also become a national population health priority. The Office of Disease Prevention and Health Promotion (2015), in their *2020 Healthy People Initiative*, identified broad goals for addressing access to services and improving mental well-being (National Alliance on Mental Illness 2014). Some of the objectives included efforts to bolster the proportion of children who receive treatment to 75.8% and increase screening for mental health problems in juvenile residential facilities from 58

Table 1 Mental Health Priorities in Canada, the US, and the Netherlands

	Countries		
	Canada	US	Netherlands
Federal initiative	Mental Health Commission of Canada's *Changing Directions, Changing Lives* (2012)	Office of Disease Prevention and Health Promotion's (part of the U.S. Department of Health and Human Services) *Healthy People 2020 Initiative* (2015)	Dutch Association of Mental Health and Addiction Care's *National Agreement on the Future of Mental Health Care* (2012)
Select national priorities	• Promote and provide mental health care services, and prevent mental illness and suicide • Reduce disparities in access to mental health services	• Improve mental health through prevention and by ensuring access to appropriate, quality mental health services • Reduce adolescent suicide attempts	• Create a program to reduce stigma • Establish a plan to reduce the division between mental and physical health care
Role of provincial/state systems	Set priorities, partially fund services, and provide health care services	Set priorities, partially fund services, and provide health care services	Fully operate youth care system (began January 2015)
Select provincial/state priorities	1 Timely, high-quality services (British Columbia, Ontario) 2 Early identification of mental health problems (Ontario) 3 Foster healthy communities (Nova Scotia, Ontario) 4 Early intervention and treatment (Nova Scotia, Ontario)	1 Health equity (Oregon) 2 Full continuum of behavioural services (Oregon) 3 Healthy communities that prevent chronic illness (Mississippi, New York, Oregon)	Not available

to 64% (Office of Disease Prevention and Health Promotion 2015). In the Netherlands, a similar national health care initiative was developed to guide planning and resource allocation for mental health services. Specifically, a Dutch mental health policy for 2012–2017 was agreed upon by ten key groups, including the national government, Dutch Psychiatric Association, and the Dutch Association of Psychologists [Administrative Agreement on the Future of Mental Health Care 2013–2014 (2012)]. A central component of this agreement was to reorient health care services away from institutions by reducing the number of psychiatric inpatient beds by one-third, and bolstering treatment in the community by enhancing the role of general practitioners and other mental health care providers.

Mental Health Care Services

Health Care Insurance Schemes

A complex array of mental health services are financed through a combination of public and private payers in all three countries. Publicly funded health insurance is available in Canada to all citizens and permanent residents, and insurance coverage and eligibility is determined by each province and territory. In contrast, youth in the United States can receive coverage from one of three sources: (1) Medicaid, a health care program for people with low incomes and limited resources; (2) private health insurance, which may be an employee benefit or purchased directly; and (3) the Children's Health Insurance Program (CHIP), which provides coverage for youth from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance. Notably, based on the Affordable Care Act (ACA) in 2010, eligibility for Medicaid coverage was substantially expanded and states were required to include mental health services as an "essential benefit" in their insurance programs (Barry and Huskamp 2011). In addition to Medicaid, youth may also be covered through private health insurers, with varying amounts of coverage for mental health care services (Rice et al. 2013).

In the Netherlands, health insurance is made available primarily through private insurance providers (Rosenau and Lako 2008; Schäfer et al. 2010). Traditionally, there has been a two-tiered insurance system in the Netherlands: (1) compulsory insurance for individuals who are below a certain income threshold, and (2) voluntary insurance for those who have exceeded this threshold (Muiser 2007; Prins et al. 2011). However, major health care reforms introduced in 2006 required *all residents* to obtain private health care coverage for basic services and private insurance companies to cover all applicants regardless of pre-existing conditions (Schäfer et al. 2010). Furthermore, Dutch youth under the age of 18 must now be registered with their caregivers' insurance fund, although the insurance premiums for youth are subsidized completely by the government (Forti et al. 2014; Muiser 2007).

Financing of Health Care and Governance Structures

Across Canada, the US, and the Netherlands, mental health care services are funded similarly through federal or state-based governments that collect and distribute funding to smaller jurisdictions (e.g., provinces, municipalities, health care organizations) for health care delivery. Although federal governments collect and reallocate funding, the provision of health services is typically decentralized to allow specific locales to make decisions on the types of services that are provided (Buck 2003). Specifically, in Canada, funding for outpatient and inpatient youth mental health care is under the direct responsibility of provincial or territorial ministries of health, with service delivery of outpatient and inpatient care, emergency, and community mental health provided by smaller health regions (Escober-Doran et al. 2010; Jacobs et al. 2010). Public sector funding for youth mental health services may also be provided through non-health ministries (Jacobs et al. 2010). For example, the Ministry of Children's and Youth Services in Ontario funds a variety of mental health services and the Ministry of Children and Family Development provides services in British Columbia for youth with mental health problems.

Public funding for youth mental health care in the US is provided through a combination of federal, state, and local governments. Medicaid is a joint partnership between the federal government and the 50 states and it insures the largest proportion of children and youth (Howell 2004). Although various federal guidelines (e.g., mental health parity) are followed, states individually decide what child and youth services to cover in their jurisdiction with the funding provided by the federal government. Since enrollment requirements were revised in 2010, almost half of all American children have been eligible for Medicaid or CHIP (Center for Medicaid and CHIP Services 2015). Additional youth mental health services are supported through funding provided by federal government agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), which has responsibility for providing services through the Children's Mental Health Initiative and the Centers for Medicare and Medicaid Services Psychiatric Residential Treatment Facility Demonstration Program (Centers for Medicare and Medicaid Services 2014; Mann and Hyde 2013). Similar to Canada and the Netherlands, children and youth in the US also have varying access to mental health programs provided locally through schools, the juvenile criminal justice system, and non-profit organizations (Sundararaman 2009).

Recent Dutch policies have emphasized the decentralization of mental health services for children and youth (Hilverdink and Berg-le Clercq 2014). Prior to 2015, the Dutch Youth Care System was comprised of three service types: (1) universal services (e.g., child care, school), (2) preventive services (e.g., parenting support, general social work), and (3) specialized services (e.g., child protection services, youth mental health care services) (Bosscher 2014). As of January 1, 2015, municipalities are responsible for providing child and youth mental health services. Funding is delivered to municipalities based on a cost-allocation formula from the national government, where there is a single funding system for all youth care (Hilverdink 2013).

Publicly Funded Health Insurance

The availability and types of services covered by public health insurance programs are an important determinant of service accessibility. Health insurance coverage directly influences access to services by children and youth from low-income families that are unable to independently finance short or long-term treatment for psychological problems (Alang 2015; Bradley and Drapeau 2014; Cohen and Peachey 2014). There is variability in the type of mental health services and treatments that are covered by publicly funded health insurance in Canada, the US, and the Netherlands. Although youth are eligible for child and youth mental health services in all Canadian provinces and territories up to their 18th birthday, research has shown that youth who may be transitioning to adult mental health services can encounter barriers to care between 16 and 19 years of age, which, in turn, may impact treatment adherence and overall health outcomes during this critical period (Davidson and Cappelli 2011). In the Netherlands, youth mental health services are oriented towards patients either under 18 years of age or under 23 years of age depending on the treatment provider (Forti et al. 2014). However, health insurance coverage eligibility changes after age 18 in the Netherlands, and user fees for some services become applicable such as long-term hospital admissions over 365 days.

There is universal and unlimited access to hospitals, specialists, and family doctors in Canada, and all provinces employ a limited number of psychologists who provide publicly funded psychotherapy to children and youth (Peachey et al. 2013). Once youth transition to the adult system at 18 years of age, however, there is limited access to publicly funded psychological services, and the majority of these services require individual payment. Moreover, youth with mental health problems who do not have permanent resident status, are foreign visitors, or have lost or expired health care cards have limited access to publicly funded mental health services (Bunn et al. 2013).

The US currently requires all Americans to have either privately or publicly funded health insurance that includes coverage for mental health services, although this may change with legislative reforms under different administrations. The uninsured and Americans who receive Medicaid were the most impacted by the ACA due to relaxation of eligibility requirements and expansion of covered services (Buck 2003, 2011). Similar to Canada, there are significant variations in the type and amount of youth mental health services covered by public insurers at the state-level, and some states have reduced funding for child and youth mental health services in recent years (Cummings et al. 2013; Howell 2004). A similar approach has been used in the Netherlands where all residents must obtain basic health insurance from a private provider of their choice, and any additional coverage can be purchased from a private insurer at their discretion (Prins et al. 2011).

Privately Insured Mental Health Care Services and Out-of-Pocket Expenses

The availability and basket of services covered by private health insurance, or the requirement to pay for services out of pocket, are important factors that influence access to child and youth mental health services, particularly for youth from low-income families (Alang 2015; Cohen and Peachey 2014). There are commonalities across Canada, the US, and the Netherlands in the types of services not covered by public health insurance that require out-of-pocket payment or private health insurance. In Canada and the Netherlands, there is a requirement for private health insurance to obtain timely access to child and youth mental health services such as pharmaceutical drugs and psychotherapy. In Canada, private health insurance may be purchased from employers or groups depending on availability, and individuals can purchase health insurance at their own expense directly from insurance companies. Private health insurance for children and youth is often provided via parents or caregivers through private employer health plans or directly out-of-pocket. All Provinces and Territories have some level of publicly funded psychological services for children and youth under 18 years of age, however there are significant barriers to obtaining these services, including long wait-lists (Picard 2013). As an alternative, children and youth can obtain more timely access to private practice psychologists, social workers, and counselors in the community on a fee-for-service basis. These services are only covered by private insurance or out-of-pocket payment (Peachey et al. 2013). Most private health insurance plans in Canada cover individuals for private psychological services up to a maximum of $300–$500 dollars, which in some provinces can equate to only approximately 2–4 h of therapy (Nunes et al. 2014).

In the US, most child and youth mental health services are funded by either private insurance or out-of-pocket payments (Garfield 2011). As of 2006, 39.7% of child and youth mental health service expenditures were through private insurers, and 21.3% were direct out-of-pocket expenses (Soni 2009). More recently, the *Mental Health Parity and Addiction Equity Act* (MHPAEA) required private insurers to cover mental health services at the same level as their coverage for physical health problems (United States Department of Labor 2010). The majority of employers have covered mental health services under their insurance plans (in compliance with the MHPAEA), and these plans often have more generous coverage than privately purchased insurance, perhaps due to cost-sharing and negotiated coverage by large corporate groups (Rice et al. 2013).

Youth mental health care in the Netherlands is generally covered under the required basic insurance plan that accounts for 11.3% of annual Dutch health care expenditures (Schäfer et al. 2010; Schut et al. 2013). However, coverage of mental health care in the Netherlands distinguishes between primary health care (less severe mental health problems requiring short-term treatment) and secondary care (more severe, chronic mental health problems requiring continuous treatment), and there are limits on what is covered by the basic plan (Forti et al. 2014). For example, the basic insurance plan covers up to 365 days in hospital through the *Health Insurance Act*. If additional institutionalization is required, funding for patient care is transferred to the *Exceptional Medical Expenses Act*, and once patients reach 18 years of age, user fees are payable (Kroneman et al. 2016). For outpatient mental health services, there is a requirement to pay a deductible up to €350 (approximately 450 USD) (Schäfer et al. 2010). In primary care, insurance covers eight sessions with a copayment of €10 (approximately 13 USD) for each session, whereas secondary care requires a copayment of €15.60 (approximately 20 USD) per session for an unlimited number of sessions (Forti et al. 2014).

Equity in Access to Mental Health Services

Pathways to Care

Although general practitioners are the central gatekeepers to specialized mental health services for children and youth in most developed countries there are subtle variations in practice that can greatly increase or reduce access to treatment (Anderson et al. 2013; McGrath et al. 2011; Nunes et al. 2014). As shown in Fig. 1, children and youth may access mental health services without a referral from a general practitioner depending on insurance or funding schemes. In some jurisdictions, youth can also access treatment directly through community services and the educational sector without a referral.

In Canada, general practitioners have a central role in referring youth to specialized or tertiary-level care, and they are usually gatekeepers for obtaining privately insured mental health services in the community. Although out-of-pocket payment for private practice mental health services usually does not require a referral from a general practitioner, insurance providers often require physician referral in order to reimburse individuals (Roberge et al. 2014). Moreover, a recent study assessing Canadian post-secondary students' health care plans found that 50% of them required a referral from a physician in order to access private mental health services (Nunes et al. 2014). Canadian general practitioners often report challenges referring patients to treatment due to long wait-lists or a general lack of services (Bradley and Dreapeau 2014; Peachey et al. 2013).

American youth access mental health services through a variety of pathways, with the most common being the primary health care sector; the education or juvenile justice system, and child welfare agencies (Maschi et al. 2009; Samargia et al. 2006). Previous research suggests that most youth receive basic mental health services in the educational system where youth may receive immediate supports or be referred to specialty mental health care (Farmer et al. 2003). Primary health care providers are the second-most popular pathway through which youth receive mental health services, however some providers experience difficulties identifying and providing services for youth with mental health needs (Stiffman et al. 2000).

Mental health services for children and youth in the Netherlands have undergone significant changes in recent years that place a much greater emphasis on treating child and youth mental health problems within primary health care practices. Although general practitioners have traditionally been a primary point of entry to child and youth mental health services, since 2014 referrals from general practitioners became a requirement for access to specialized services (Kroneman et al. 2016). Unfortunately, similar to Canada and the US, a substantial number of Dutch youth with mental health problems are not adequately diagnosed by general practitioners and may not receive appropriate services (van Beljouw et al. 2010). In addition to the traditional suite of primary health care physicians and referrals to specialist providers, primary care psychologists (PCPs) are available to treat youth with less severe mental health problems (Forti et al. 2014). PCPs can work in private practice in the community and group practices with general practitioners and typically provide cognitive-behavioral therapy or client-centered therapy (Verhaak et al. 2013). In the 2009 basic health insurance package, patients were covered for up to eight sessions with a PCP (Schäfer

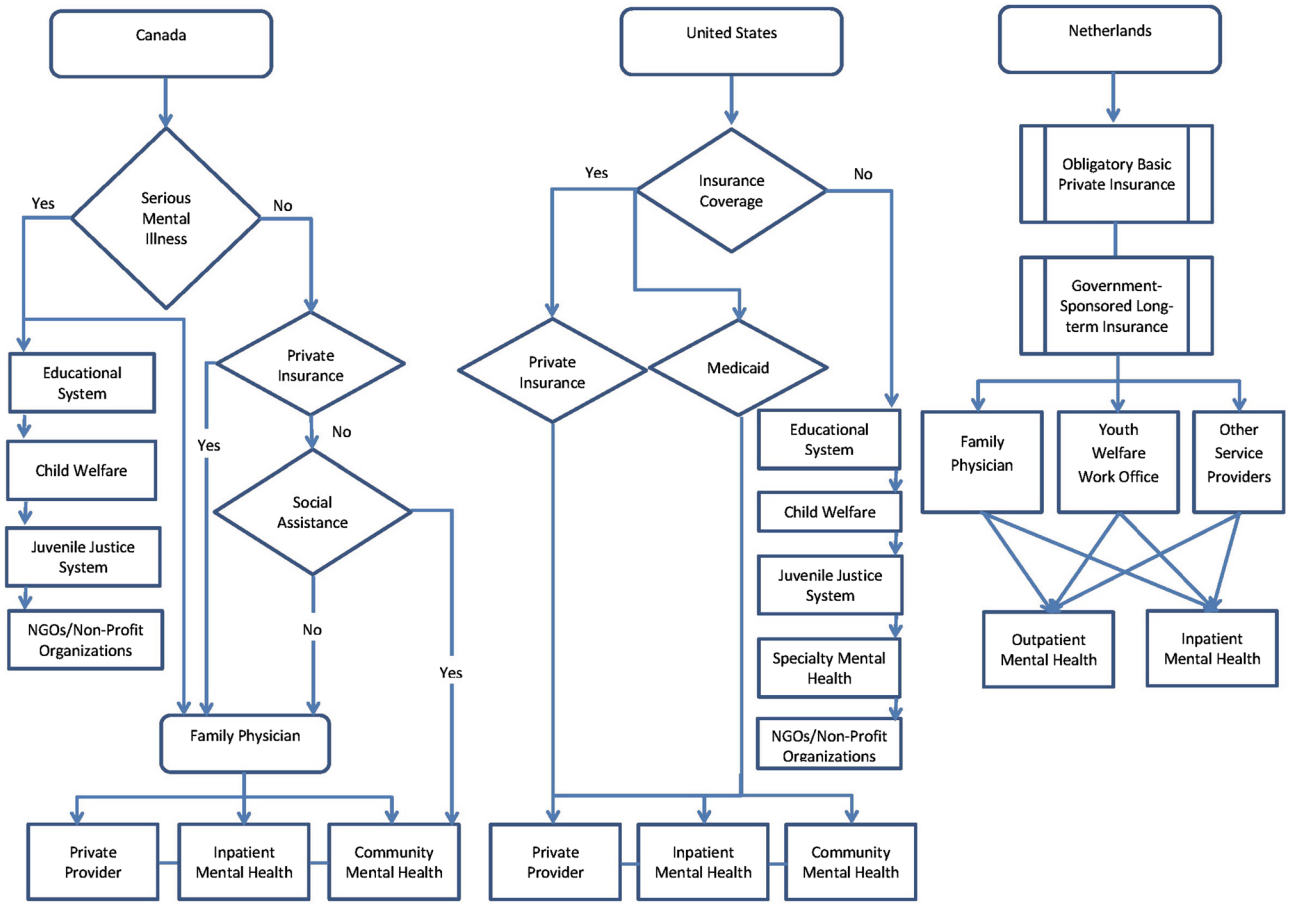

Fig. 1 General Pathways of Youth Mental Health Care and Funding Sources in Canada, the US, and the Netherlands. Although this figure represents general linear pathways within each country, individual jurisdictions and cases may vary in complex ways. Funding for these services is provided by levels of government (federal and state or provincial) and the private sector

et al. 2010), and supplemental insurance covered up to 12 sessions (Derksen 2009; Peachey et al. 2013). A recent study examining the outcomes of clients who had been treated by PCPs in the Netherlands found that most clients had significant improvements following the standard eight-or-fewer sessions (Verhaak et al. 2013). The overall utilization of PCP services among children and youth in the Netherlands grew in recent years perhaps due to the increased emphasis on primary health care for management of mental health problems (Zwaanswijk et al. 2011).

Discussion

Health Insurance Availability and Coverage

The availability and scope of services covered by public or private health plans are strong predictors of service utilization that can exacerbate existing socio-economic health inequities (Alang 2015). Being covered by publicly funded health insurance programs, such as Medicaid in the US, has been found to reduce cost-related barriers to service accessibility whereas excluding psychological services in the community (Canada) from public health insurance impedes access to care (Bradley and Drapeau 2014; Cohen and Peachey 2014). Although Canada, the US, and the Netherlands use a mixed private–public payer system, there is high variability in insurance coverage. Canada relies on universal public health insurance for traditional 'medical' services, and on individual private health insurance or personal finances for coverage of outpatient mental health services, including access to private counselors and psychologists in the community and pharmaceutical therapies (Levit et al. 2013). In contrast, the US and Netherlands generally require residents to obtain either publicly or privately funded health insurance for all medically relevant services, which typically includes coverage of treatments not covered by public health insurance in Canada (Naderi and Meier 2010). In recent years, the US federal government has compelled insurers to include mental health services as

an essential benefit in their health plans, whereas in Canada pharmaceutical therapies and the majority of psychological therapy are only available through partial or restricted reimbursement from private insurance or out-of-pocket expenditures and typically only following a referral from a general practitioner (Barry and Huskamp 2011). In the Netherlands, patients must pay a deductible to access community-based mental health services and specialized mental health services have low deductibles and are generally not limited by the number of sessions (Schäfer et al. 2010). Enhancing access to mental health care services could be improved in Canada by adopting the individual mandates used in the US and the Netherlands, which would expand insurance to families that do not have coverage (Rosenau and Lako 2008). It is also possible that the basket of services covered by publicly funded health insurance could also be expanded in Canada, similar to CHIP in the US, to include psychological health care services and pharmaceutical drugs for children and youth that are currently uninsured or partially covered by private health insurance plans (Howell 2004). Addressing income-related gaps in mental health care accessibility could improve the availability of services in the community, and also work to reduce reliance on costly hospital services that have been increasing among children and youth in recent years (Cohen and Peachey 2014; Rogers et al. 2017).

Regional Variations in Mental Health Care Availability

One of the central determinants of access to mental health services is the geographic availability of services. In particular, rural and northern places in Canada and the US have been consistently found to have very limited access to mental health services, which in turn, often requires families to travel long distances to urban areas for specialty consultations or treatment (Cummings et al. 2013). The availability of mental health services in rural and northern communities is directly tied to how services are organized and funded across the overall health system at the national and regional level (Jiménez-Rubio et al. 2008). Financing of mental health services for youth has been decentralized in the Netherlands in recent years, which is also consistent with Canada's practice of making provinces responsible for funding and delivering the vast majority of health care services. In contrast, federal-level reforms in the US have influenced how states plan and deliver mental health services. The models used to deliver and fund services among the three countries has created variability in the proportion of funding allocated to child and youth mental health by region, and province or state (Jiménez-Rubio et al. 2008). The Netherlands has implemented a federal cost-allocation formula for funding programs that is delivered by municipalities in the area of child and youth mental health services (Kroneman et al. 2016; Schäfer et al. 2010). This single funding stream, and the formula used to allocate funds, is much different than current practice in Canada and the US where mental health care services are planned and financed more locally by provinces, states, or regional health authorities. The Dutch approach to earmarking funding for mental health services in government transfers could work to address concerns in Canada and the US that mental health services are inequitably funded and highly variable in the types and quality of available services by region (Mossialos et al. 2015).

Primary Health Care

In each of the three countries included in this review, primary health care is the central component of the health care system, and family doctors are gatekeepers to specialty services. The scope of primary health care practices and the ability of general practitioners to recognize mental health problems have been found to be a key determinant of the early diagnosis and treatment of psychological disorders among children and youth (Anderson et al. 2013). In the Netherlands, there has been a focus on integrating psychological services by inserting mental health professionals (e.g., PCPs) into primary health care (e.g., family physician practices) in order to increase treatment accessibility (Exter et al. 2004; Schoen et al. 2007). There has been a similar emphasis on primary health care in some Canadian provinces, such as in Ontario where Family Health Teams were introduced in 2005 and Quebec where 95 mental health care teams were established through health and social service centers (Fleury et al. 2012). The interdisciplinary structure of Ontario's Family Health Teams are based on the needs of the community (Gocan et al. 2014). Family Health Teams in Ontario can provide in-house counseling services and visiting psychiatry services, and social workers are employed in some Family Health Teams to work with patients and consult with general practitioners (Mulvale et al. 2008). Although there are challenges with integrative and inter-sectorial teams of service providers (e.g., common communication of diagnostic and treatment decisions, privacy issues), this approach has been successfully instituted in multiple systems (e.g., Palinkas et al. 2014; Watson et al. 2014) and could be implemented elsewhere. A recent evaluation of Family Health Teams in Ontario (Canada) found high patient satisfaction and improved access to health care services, although there continued to be high wait-times for mental health services and limited programming for children and youth with mental health problems (The Conference Board of Canada 2014). The integration of mental health care in family physician practices has the potential to increase the early diagnosis and treatment of mental health problems among children and

youth, and improve general practitioner capacity to diagnose and treat patients in the community (Kates et al. 2011; Stiffman et al. 2000).

Requiring referrals to specialty mental health care services (e.g., psychologists) can create barriers to care by prescribing how children and youth enter, interact, and remain connected to health care providers (Peachey et al. 2013; Stiffman et al. 2004). Referrals to specialist mental health services are generally not required in the US but vary by health insurance plan, whereas referrals are required in Canada and the Netherlands. Not requiring referrals for reimbursement or access to services has the potential to shift some demand from general practitioners to community resources that have more frequent contact with children and youth (Anderson and Lowen 2010). Reducing referral requirements can also encourage school-based service providers and others in the social services sector who are often in an advantageous position to recognize behavioral changes to more efficiently direct children and youth to mental health services.

Conclusion

In recent years, the mental health of children and youth has been a priority in the three identified countries, and there have been both stagnant (Canada) and significant (US and the Netherlands) reforms to health insurance schemes that generally improve access to mental health care. Reducing barriers to mental health care utilization by children and youth must be addressed at the systems-level in terms of how services are organized and funded, and also at the individual level by limiting referral requirements. General practitioners are central to the delivery of basic health care in all three countries; however, there are varying requirements for referral to specialist services, which determine patient pathways to care. Addressing barriers to services that are embedded in national health care systems and policies requires taking an international approach to identifying best practices that improve access to mental health care services by children and youth. Furthermore, regardless of changing political climates, it is important that reforms within each country should continue to advance the well-being of youth based on objective national and international health outcome data.

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Compliance with Ethical Standards

Conflict of interest The authors have no conflict of interest to declare.

Ethical Approval This article does not contain any studies with human participants performed by any of the authors.

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