# The Missing Middle Research Project

## Initial Findings and Implications for Youth Mental Health Services in British Columbia

June 2026

# Executive Summary

This report summarizes early findings from the Missing Middle Research Project. This partnered, qualitative study focused on exploring the 'Missing Middle' service gap and improving mental health care services for youth in British Columbia (BC). The report draws on interviews and focus groups with youth, family members, and health care providers across the province to better understand the experiences of young people with moderate mental health needs that exceed what can reasonably be addressed through primary care or episodic care alone, but do not consistently meet thresholds for acute, tertiary, or hospital-based services.

Young people, families, and health care providers alike described the Missing Middle as both a gap in service availability and a fragmented service landscape that that makes it difficult to find, access and remain connected to care. They affirmed that a meaningful service space is missing for youth with moderate yet still significant, complex, and often fluctuating mental health needs. Participants also described how fragmented care pathways, unclear referral processes, age-based service cutoffs, stigma, and loss of trusted relationships make it difficult for youth and families to stay connected to mental health care over time and as youth transition to early adulthood.

Initial analyses from the Project revealed five closely connected themes: (i) youth falling into an intermediate service gap; (ii) the challenges associated with navigating fragmented systems; (iii) the multiple intersecting transitions occurring during emerging adulthood; (iv) the role of relationships, continuity, and flexible support in effective care; and (v) the ways inequities and stigma shape each of these experiences. Together, these findings point to the value of models such as the BC Children's Hospital Transition and Linking to Care (TLC) Team, which aims to improve linkage, consultation, education, and continuity for youth with moderate mental health challenges and whose needs are not being met in the existing service landscape.

For health system organizations, policymakers, and clinicians, the findings support a clear direction: we must strengthen the middle of the youth mental health service continuum, while also improving the connections across it. This includes investing in intermediate supports, navigation and care coordination, transition-specific services, relational continuity, and equity-oriented approaches that do not rely on youth and families having the social, financial, or professional resources to advocate their way into care, or to attempt to manage on their own.

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# Background

Adolescence and young adulthood comprise a key stage for the development of mental health challenges, with 75% of mental illnesses first presenting by age 24.[1] As a result, many youth will access mental health services – particularly amidst the 'transition' ages of 16-24, a stage that is also marked by an often-challenging shift from child to adult mental health care. This developmental period is increasingly recognized as one in which young people require integrated, accessible, and developmentally appropriate mental health and substance use supports across community, primary care and specialist settings.[2] Yet, while mental health disorders account for approximately one-fifth of hospitalizations among children and youth in Canada, with this proportion reaching nearly one-quarter in 2021,[3] an even greater proportion of youth experience the Missing Middle phenomenon: being 'too well' for hospital and specialist services, yet 'too unwell' for primary care alone.[4]

Our recent work in BC context has described the Missing Middle as reflecting systemic gaps in mental health services and resources, where community-based mental health supports may be insufficient or inaccessible, while acute care services may not be needed or available.[5] Youth navigating the Missing Middle often seek crisis-oriented mental health services through emergency departments, where they do not consistently receive adequate follow-up care and referrals to community-based supports. As such, transition-aged youth are much less likely to be connected to mental health services and may experience worsening mental health symptoms, increasing distrust of the health care system, reluctance to seek future care, and negative impacts on quality of life.

The Missing Middle Research Project was developed to examine and respond to gaps in care experienced by transition-aged youth, with unmet mental health needs who are not adequately supported by existing services. The project was designed to guide the work of the BC Children's Hospital Missing Middle Program, including the Transition and Linking to Care Team, by eliciting the perspectives of youth, family members, and health care providers. Its objectives were to examine challenges and opportunities associated with mental health care for transition-aged youth in the Missing Middle and to gather the perspectives of families and providers that could inform program development, reform, and potential scale-up.

# What is the Missing Middle?

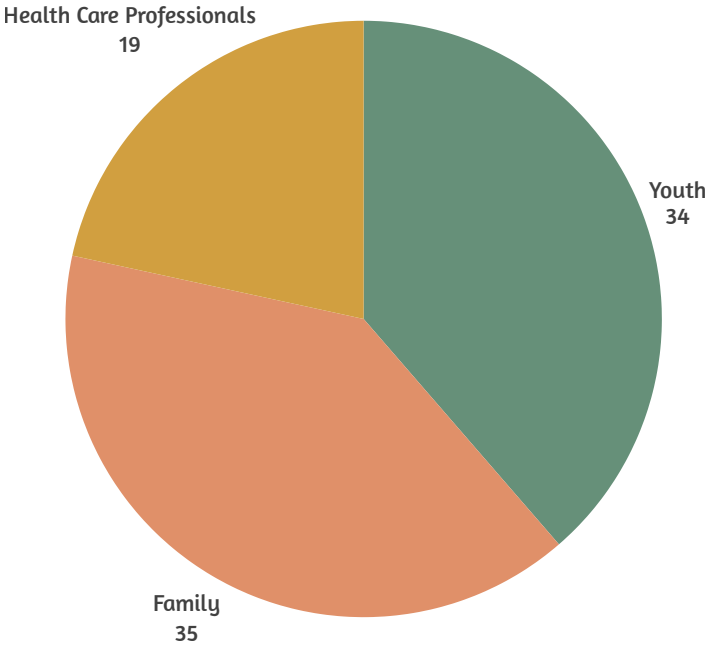
The Missing Middle refers to gaps in mental health services where community-based mental health supports are insufficient or are made inaccessible by persistent barriers, and yet acute care is not warranted, needed, or available.[5] Here, we refer to youth with moderate mental health needs who may be too unwell for primary care, episodic care, or low-intensity community supports alone, but are not considered unwell enough, acute enough, or sufficiently eligible for specialist, tertiary, or hospital-based services. The concept has been described in the youth mental health literature as a systemic service gap, rather than a characteristic of individual young people. Recent consensus work similarly frames the Missing Middle as a gap in which existing services are not meeting the needs of young people in a meaningful way, including through rigid eligibility criteria, limited service availability, and inadequate continuity or duration of care.[6]

In this study, participants' accounts reflected the dual nature of the Missing Middle. Youth and families identified a lack of appropriate intermediate supports for complex but non-acute mental health needs. At the same time, they described what happens when existing services are poorly connected: youth are required to continually do the work of retelling their histories to new health care providers, families become informal case managers, providers work around system limitations, and service transitions occur abruptly during an already vulnerable developmental period. The Missing Middle therefore appeared not only as an absence of a particular type of service, but as a broader gap in how care is organized, connected, and sustained for transition-aged youth.



# Demographics

This initial analysis draws on interviews and focus groups, conducted between 2025–2026, with **N=88 participants** across the province. Participants represented three groups: youth (N=34), family members (N=35), and health care providers (N=19). Interviews and focus groups explored participants' experiences seeking, providing, and navigating mental health care for transition-aged youth, with attention to service gaps, transitions, family involvement, and opportunities for improving care.




- Among youth, the average age of participants was 19.8, ranging from 15-25. 4 youth identified as boys/young men, 15 youth identified as girls/young women, and 13 identified as non-binary or trans, and 1 identified as Two-Spirit.
- Family members (largely parents) had an average age of 53.3, while the youth they supported had an average age of 19.4
- Health care providers had an average age of 36.3, and had an average of 8.7 years working in mental health care. Providers' roles included: nurses, social workers, occupational therapists, counsellors, and mental health workers.

### Youth Streams

In addition to examining the Missing Middle among all youth, we explored youth experiences among three specific streams, representing equity-owed groups:

**Racialized Youth**



**N=26, 76%**

**Queer Youth**



**N=13, 38%**

**Substance Use**



**N=4, 11%**

**Analysis of Participant Data**

The initial findings below were developed through thematic analysis across stakeholder groups. Rather than presenting youth, family, and provider perspectives separately, the report integrates these perspectives to reflect how participants collectively described the Missing Middle as a health system issue. The analysis is preliminary and intended to support rapid knowledge translation and discussions within and across provincial health system partners as the team conducts more targeted and fleshed out data analyses.

# Finding 1:
## Youth are falling into an intermediate health gap

Across youth, family, and health care provider interviews, participants described a service landscape that often responds exclusively at the extremes of need. Youth with lower-intensity concerns may be directed toward primary care, brief counselling, episodic care, or community-based supports, while youth in acute crisis may access emergency, inpatient, or specialist services. Between these points, participants described a large group of young people whose needs are significant, complex, and persistent, but who do not consistently meet thresholds for more intensive care.

*"The stuff that your doctor can offer is not enough, and the stuff that the hospital offers is too much." (Youth, 24)*

*"It feels like they have to be jumping off the bridge before they actually get a psychiatrist." (Parent of a 17-year-old)*

*"If I say you're not sick enough, then you're probably going to get sicker to tell me that you need this. And we do see that all the time." (Provider, Registered Nurse)*

Participants' accounts suggest that this service gap can lead youth into a downward spiral where mental health deteriorates to the point of crisis. Youth and families may seek help repeatedly, only to be told that their needs are not acute enough, do not rise to meet set diagnostic criteria, or are not well-matched to available program mandates. Providers similarly described circumstances in which young people's mental health may worsen while they wait to receive help or feel compelled to present as more distressed in order to be taken seriously. The resulting experience is not simply one of delayed access, but of prolonged uncertainty, repeated help-seeking, frustration, and in some cases, eventual crisis-oriented care when earlier support may have been more appropriate or even preventative.

In addition to placing strain on the acute care system, the Missing Middle gap also creates pressure on primary care and community providers, who may remain involved even when youth require a level of psychiatric, psychosocial, or multidisciplinary support beyond what they can reasonably provide alone. One family member described a primary care provider repeatedly consulting other providers while trying to support a youth on multiple psychiatric medications; another described the urgent need for an intermediate level of support that could provide continuity without requiring hospitalization. These accounts illustrate the value of models that can bridge primary, community, and specialist services before crisis becomes the main route into care.

# Finding 2:

## Navigating care requires substantial personal and family effort

Once a youth's care needs enter the "Missing Middle" intermediate zone, accessing care often depends on the ability of youth and families to locate services, understand complex eligibility criteria, coordinate referrals, advocate persistently, and carry information between providers. Participants described care systems that can be experienced as a collection of separate programs rather than offering more coherent care pathways or cohesive models of support. Services may exist, but the onus is often placed on youth and families to find them, determine whether they qualify and continue searching if rejected.

*"Sometimes I don't know where to go... I just go to the emergency room. I think if there was someone I could talk to who could understand and give me some answers to my questions, I wouldn't go." (Youth, 20)*

*"It's my full-time job advocating for her to get any kind of service and care... These kids should not be slipping through the cracks." (Parent of a 17-year-old)*

*"I'm a counsellor, but I also am doing things like I'm doing a lot of case management, and trying to find people, and trying to navigate systems for clients, because there's nobody else to do it." (Provider, Registered Nurse)*

Family members often became the continuity mechanism when the system itself did not provide one. They described keeping track of youths' mental health histories, searching for programs, calling numerous providers, managing appointments, advocating during crises, and trying to ensure that information followed their child from one setting to another, especially when their children were too unwell or dependent on parents/guardians to do so themselves. One family member used the language of "work" to underscore the labour of negotiating care as requiring days of phone calls, research, and follow-up, noting that many families do not have the time, flexibility, or resources to do this work.

*"But that required me working four days a week, not working, being retired, and four days a week, drilling, researching, phoning, contacting. Some families don't have that luxury. They have to go to work." (Parent of a 37-year-old)*

This navigation burden intersects directly with equity (see Finding 5). Families with more time, professional knowledge, confidence in health care settings, financial resources, employment flexibility, English-language fluency, transportation, or existing connections may be better positioned to advocate their way through fragmented systems. Youth without these supports, or whose families are themselves under strain, may be more likely to remain disconnected. The Missing Middle is therefore not only a clinical service gap, but also a gap that can widen existing inequities in access to care.

# Finding 3:

## Missing Middle youth experience overlapping transitions impacting their mental health and care

Participants consistently described transition-aged youth as navigating several transitions at once. Some of these transitions were formal service transitions, particularly the movement from child and youth services into adult mental health services. Others were developmental and social: finishing school, entering post-secondary education or employment, moving away from home or to a new community, changing peer networks, navigating housing and finances, and renegotiating family involvement. These shifts often occur at the same time that service systems reduce support or expect greater independence.

*"The minute that I aged out, the struggle to get any kind of person to see me was immediately evident... all of a sudden I turned 19, and I can maybe have a visit with someone [a health care provider] once a month." (Youth, 23)*

*"My daughter's file was closed at 18, because she was aging out." (Parent of a 23-year-old)*

*"We know that when you turn 18, you don't become just an adult... it makes no sense that our system cuts people off at 18." (Provider, Registered Nurse)*

Families and providers described adult services as operating with different assumptions about independence, capacity, engagement, and family involvement. For some youth, this meant that supports became less frequent or less coordinated at the same time that expectations for self-management increased. Family members also raised concerns about youth leaving home or moving for post-secondary education, work, or other travel, particularly when this meant losing informal supports, a known provider, or a pathway that had finally started to work.

These accounts suggest that transition planning must extend beyond a simple referral from one program to another. Transition-aged youth may need support navigating a broader period of instability and change, including shifts in geography, school, work, housing, family roles, peer supports, and identity development. Transition and linking to care models and service delivery teams are well-positioned to respond to this complexity when they are able to support not only service handoffs, but the practical and developmental realities that shape whether a young person can remain connected to care.

# Finding 4:

## Relationships, continuity, and flexible support help bridge the gap

While participants described substantial barriers to care, they also offered a clear picture of what meaningful support can look like. Youth, family members, and providers repeatedly emphasized the value of having longstanding relationships with their care teams, receiving follow-up, and encountering providers who were patient, and willing to understand the fuller context of a young person's life and mental health trajectory.

*"There was just a lot of impatience... what was very important for me was just being patient and being gentle and kind with the process." (Youth, 21)*

*"Having continuity of care was a massive support for me. Because the strain of not knowing who's going to see your kid... We need somebody who's familiar with her case." (Parent of a 17-year-old)*

*"Going to them and meeting them where they're at... they still need support. They're not ready for adult services." (Provider, Registered Nurse)*

Participants also described concrete forms of continuity that would make the system easier to move through: a person who checks in after a referral or discharge, a provider who knows the youth's history, a team that can consult across programs, and a service that can connect youth to the right support rather than leaving families to search on their own. One family member described an ideal mental health program as:

*"If I didn't have [my counselor], then I wouldn't be aware of all the resources, or be able to have a conversation, ask questions, and see what would fit." (Youth, 20)*

*"I would hope that it would be a connector to other mental health services, but also a continuity. So we're coming back, 'How's this working? Do you need a different kind of thing?'" (Parent of an 18-year-old)*

Such descriptions closely align with the rationale for programs such as the Transition and Linking to Care Team. Case consultation, provider education, youth-informed practice guidance, and 'warn handoffs' during referrals can create continuity in places where the broader system is experienced as siloed. Providers involved in consultation-oriented work described the benefit of being present in spaces where complex transition cases are thoughtfully managed, allowing support to occur through relationships with teams as well as through individual referrals.

At the same time, participants' emphasis on relationships points to a system-level issue. Continuity of care and provider-patient relationships cannot depend only on individual clinician commitment or goodwill. It requires resourcing, manageable caseloads, flexible mandates, time for consultation, shared care planning, and policies that allow youth to be supported across transitions rather than discharged at hard boundaries. In this sense, sustaining relational practice is both a clinical practice issue and a system-level, model of care design challenge.

# Finding 5:

## Equity and Stigma shape experiences across the Missing Middle

Several participants raised equity considerations related to the Missing Middle challenge and the ways it can unfairly disadvantage marginalized youth. Participants described how social determinants of health (e.g., housing, early childhood development), stigma, identity, geography, and family resources influenced access to services, experiences with care, and the ability to remain connected over time. The Missing Middle can therefore be understood as an equity issue in and of itself: youth whose mental health needs are already insufficiently met within existing systems may face even greater barriers when they are also navigating wider social challenges, such as stigma, poverty, limited family advocacy capacity, or rurality with limited regional service availability.

Mental health and substance use stigma were particularly evident in accounts of being dismissed, blamed, or treated as less legitimate than those presenting with physical health concerns. One family member described an emergency department encounter in which a youth's symptoms were minimized despite the family's concern and the youth's distress. Accounts of downplaying and dismissal illustrate how stigma can influence not only interpersonal encounters, but also the degree of urgency, credibility, and care afforded to youth presenting with mental health concerns.

> *"[The nurse] goes, 'There are sick people in this hospital. She needs to quit crying'... and he goes, 'This is a mental health problem.'" (Parent of a 23-year-old)*

Youth and families also described the importance of culturally safe, identity-affirming, and neurodiversity-informed care. Participants spoke about Indigenous and racialized youth, 2S/LGBTQ+ youth, autistic and neurodivergent youth, and youth who use substances encountered services that did not always feel designed for them, or safe and inclusive. In some cases, the issue was not the absence of a particular service, but the absence of a tailored and responsive service that could establish trust, understand identity and context, and offer support without stigma or assumptions.

# Finding 5:

## Equity and Stigma shape experiences across the Missing Middle

*"I felt like I was dismissed because... I'm not a white, cis, three-year-old boy, which is what the diagnostic criteria [for autism]... was based around." (Youth 18)*

*"They did not have any counselors that were particularly LGBTQ2IA+ affiliated... Teens know. Ideally, they want to be helped by somebody who's part of their community, who really gets it." (Parent of a 17-year-old)*

Geography also shaped access to care. Rural and remote participants described fewer services, limited after-hours crisis options, and providers filling multiple roles because there was no one else to do the work. These geographic barriers intersected with transportation, family availability, and service capacity. For youth who use substances, youth without stable housing, or youth with complex co-occurring needs, the Missing Middle may be experienced not as a single gap, but as a series of exclusions from services that are not designed to hold complexity.

*"Our hospital is not open overnight in this town... if they have a mental health crisis in the middle of the night or after 5pm... that is a huge barrier to care." (Provider, Registered Nurse)*

Across findings, equity considerations sharpen the case for coordinated and flexible models of care. Services that rely heavily on self-navigation are least accessible to youth and families with fewer resources. Services that require crisis-level acuity may disadvantage youth whose distress is serious but not easily discerned within narrow eligibility criteria. Services that are not culturally safe, inclusive and affirming, or substance use-informed may be available in name but inaccessible in practice. Addressing the Missing Middle gap therefore requires attention not only to service availability, but also to fit, trust, dignity, and the social conditions that shape access to high-quality care.

# Health System Implications




The most direct implication of these research findings is the need to strengthen the middle of the youth mental health service continuum. Participants described a service landscape in which primary care, brief counselling, emergency care, and tertiary services do not consistently meet the needs of youth with moderate mental health challenges. Health systems must consider how to resource intermediate models of care that can provide timely assessment, stabilization, short- to medium-term support, integrated mental health and substance use care, family-inclusive support, and rapid connection to specialized consultation when needed.

Secondary to this, navigation and linkage must be treated as core service functions. The work of finding care, explaining eligibility, coordinating referrals, and following up after handoffs should not fall primarily to families or to individual clinicians working outside their formal role. Programs like the BC Children's Hospital Transition and Linking to Care Team offer a promising model because they focus on broader health-system navigation: consultation, education, youth-informed practice, and linkages across services. Broadening similar models across regions could help make existing services more accessible, particularly for youth whose needs span program mandates.

The findings also support greater investment in transition-specific models of care. Transition-aged youth require more than a transfer at age 18 or 19, and again at age 24 or 25. They require developmentally informed supports that recognize shifting family roles, school and employment transitions, moving away from home, housing instability, changing peer networks, and the gradual development of independence and self-advocacy skills. Flexible age ranges, overlapping youth and adult services, shared care planning, and gradual handoffs would better reflect the realities described by participants.

Finally, continuity and relational care require system conditions that make them possible. Sustained relationships are difficult to build in systems defined by short mandates, high caseloads, long waitlists, and abrupt discharge points. Health system leaders can support continuity through resourcing, staffing, shared documentation or transition summaries, warm handoff protocols, interdisciplinary case consultation, proactive outreach, and the ability for teams to remain involved long enough to ensure that a youth has actually been engaged with the next point of care.

# Clinical and Team-level Implications

At the point-of-care level, youth and families described the importance of being believed, treated with dignity, and not reduced to eligibility criteria. Even when a program cannot accept a referral, clinicians can validate the seriousness of the youth's needs, communicate clearly about the decision, identify a concrete next step, and avoid leaving youth or families with a generic list of resources. Small relational practices – slowing down, explaining what is happening, checking in after a referral, asking who the youth wants involved in their care – can have a meaningful impact when youth have already experienced dismissal or discontinuity.

Clinicians and teams can also strengthen care by approaching transition-aged youth as whole people situated within families, peer networks, schools, workplaces, communities, and broader social conditions. Assessment and care planning should include not only symptoms and risk, but also housing, transportation, finances, school or work changes, substance use, identity-related safety, family involvement, and whether the youth has someone who can help them navigate the system. These factors may determine whether a referral is realistically accessible.

Participants' accounts also point to the importance of culturally safe, inclusive, affirming, and stigma-free care. This includes using nonjudgmental language around substance use, avoiding assumptions about risk or capacity, recognizing how autism and neurodivergence may present differently across gender and culture, and ensuring that 2S/LGBTQ+, Indigenous and racialized youth, as well as youth who use substances experience care as safe enough to engage. Education and consultation, particularly when grounded in youth and family perspectives, can support clinicians in providing care that is both clinically appropriate and relationally responsive.



For both systems and individual clinicians, the central message is similar: youth navigating the Missing Middle need more than a referral onward. They need someone, and/or an interprofessional team, to remain connected long enough to help them reach the next appropriate support. This is precisely where transition and linking to care models of service delivery and support hold immense value. By guiding providers, strengthening linkages, and attending to transition-aged youth as a distinct population, these models can help bridge a service landscape that youth and families often experience as fragmented, difficult to navigate, and unevenly accessible.

# Closing Reflections

These research findings illuminate that the Missing Middle is being experienced in British Columbia as both a missing service space and a continuity-of-care gap. Youth, families, and providers described a system in which many young people are facing serious mental health challenges that exceed the capacity of low-intensity supports alone yet are not considered acute enough for more intensive services. They also described the work required to navigate fragmented pathways, the instability of emerging adulthood, the importance of trusted relationships, and the ways stigma and inequities shape access to care.

For health system partners, these findings make a strong case for strengthening and broadening models of care that sit within and connect the middle of the service continuum. Programs such as the BC Children's Hospital Transition and Linking to Care Team are well positioned to address what participants repeatedly identified as missing within the current system: navigation, consultation, education, continuity, and developmentally appropriate support for youth whose needs do not fit neatly into existing service categories. Investing in these functions and partnered health system research to 'bridge' the Missing Middle has the potential to improve care experiences, reduce crisis-driven pathways, support families and providers, and build a more equitable mental health system for youth in BC.

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