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Centre for Addiction and Mental Health

Ontario Youth Screening Project

Provincial Report

Funded through a CIHR Emerging Team Grant

Ontario Youth Screening Project Report

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Acknowledgments

The Ontario Youth Screening Project Team would like to acknowledge the commitment, dedication and hard work of the many people throughout Ontario who contributed to this project.

We would like to thank the CAMH Provincial System Support Program (PSSP) leadership team for their enthusiastic support of this project, making it possible for PSSP staff to act as network coordinators, and to assist us in identifying communities and agencies that would be interested in collaborating on this project. Sincere appreciation goes to the network coordinators in the six participating communities for providing on-going leadership to the respective networks and working diligently to ensure full implementation of the project protocol; to the agency leads who were prepared to commit to participate in a cross-sectoral collaboration, adapt program protocols to integrate consistent administration of a screening tool and dedicate staff time to participate in the project; to front-line service providers who were willing to take the time to explore new practices, and to engage youth in a screening process for clinical and research purposes; and, most of all, to the youth who participated in completing the screeners and consented to sharing them with the project team. We would also like to thank the Canadian Institutes of Health Research (CIHR) for the funding support that made this project and dissemination of the findings possible.

Ontario Youth Screening Project Networks

Networks were established in six communities, each with a network coordinator and agency leads (Refer to Appendix A for a map of participating communities and Appendix B for implementing summaries for participating networks).

Community	Network Coordinator	Partner Agencies	Agency Leads
Brantford and Brant County	Kim Baker	Contact Brant	Jane Angus
		Brant County Health Unit	Marie Green
		Woodview Children's Centre	Lorraine Jeffrey
		St. Leonard's Community Services, Addiction and Mental Health Services	Julie Smith
Haldimand and Norfolk	Kim Baker	Haldimand-Norfolk Resource Education and Counselling Help (R.E.A.C.H)	Deborah Young
		Children's Aid Society of Haldimand and Norfolk - Children's Services Department	Dawn Perrier
Niagara	Kim Baker	Attachment and Trauma Treatment Centre for Healing (ATTCH)	Lori Gill
		Community Addiction Service of Niagara	Paul Niesink
		Contact Niagara for Children's and Developmental Services Inc.	Kaarina Vogin
		John Howard Society of Niagara Inc.	Samantha Messier
		Niagara Resource Service for Youth (The R.A.F.T.)	Ryan Barton
		Niagara Region Public Health	Laurie Columbus
		Pathstone Mental Health	Lee-Ann Standish

Community	Network Coordinator	Partner Agencies	Agency Leads
Ottawa	Shauna MacEachern	St. Mary's Home	Vicky Green
		Youville Centre	Brydie Johnson
		Eastern Ontario Youth Justice Agency	Leigh Couture
Sudbury	Sandra Watson	Canadian Mental Health Association - Sudbury/Manitoulin Branch	Elizabeth Puddy
		Child and Family Centre	Claire Valtins
		Sudbury Action Centre for Youth	Kylie Raine
		Sudbury Restorative Justice	Amanda Chodura
Timmins	Sylvie Guenther	South Cochrane Addictions Services	Sarah Bondarenko
		District School Board Ontario North East	Denise Plante-Dupuis
		Conseil Scolaire Public du Nord-Est de l'Ontario (CSPNE)	Gerry Lajoie

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GAIN SS License

Chestnut Health Systems: Copyright holder for all *Global Appraisal of Individual Needs* instruments, including *Global Appraisal of Individual Needs - Short Screener (GAIN SS)*

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Executive Summary

Co-occurring mental health and substance use problems ("Concurrent Disorders" (CD)) among youth are costly to individual youth, their families, the community and our health and social service systems. Despite this, effective strategies for identifying youth experiencing CDs and for working together as a system to meet youth needs are slow in coming. Accordingly, through the Ontario Youth Screening Project, we sought to examine new ways of working collaboratively to identify youth experiencing mental health and substance use problems and to support improved access to needed services.

The Ontario Youth Screening Project (OYSP) was funded by the Canadian Institutes of Health Research (CIHR) through funding to an Emerging Team in *Innovations in Child and Youth Concurrent Disorders*[1].This initiative provided an opportunity to extend the work of the GAIN Collaborating Network project completed in 2009 to Ontario communities outside of Toronto. The project involves cross-sectoral youth-serving agencies from six Ontario communities working together to implement a common screening tool for mental health and substance use problems for six months with all youth aged 12 to 24 years presenting to participating agencies for service. In addition, participating service providers completed questionnaires about their experiences with the project. Information from completed youth screeners was analyzed for each community to provide locally relevant information about the needs of youth presenting to participating agencies. Data across all sites were also analyzed to examine the needs of youth across sectors, age groups, and sex, and to understand the experiences of participating service providers.

The six participating networks involved seven service sectors: addictions; child welfare; education; health; housing, outreach and support; justice; and mental health. The project's findings draw from data gathered from 1073 youth and 255 service providers. They indicate that many youth presenting for service across sectors are experiencing significant substance use and/or mental health concerns, and close to one-third of youth are experiencing co-occurring substance and mental health issues. Notably, the findings indicate that the needs of female and male youth as well as younger and older youth differ substantially. Moreover, high rates of suicide-related concerns, especially among young adolescent girls, as well as possible trauma-related distress among all youth highlight the need for early identification of suicide-related concerns and for trauma-informed services. Data gathered from participating service providers indicate that screening is feasible and useful, and that collaborative projects such as this one, can enhance service provider knowledge about substance use, mental health and concurrent disorders and interagency collaboration.

The project leads would like to express their gratitude to the youth, families, service providers, agency leads and coordinators, and many others whose persistent hard work made this project possible. We hope that the findings will be informative for service planning and will enhance the service system for youth with mental health and substance use concerns.

[1] Beitchman, J, Henderson, J, McMain, S, Rush, B, and Wolfe, D. Co-Investigators: McCay, E, Chaim, G, Cheung, A, Goldstein, A, Skilling, T, Boak, A, Mann, R, Cunning, S, Brownlie, E, Ballon, B, Fjeld, J, and Atkinson, L. Mitigating risk and creating effective treatments: Improving services to children and youth with co-morbidities through discovery, collaboration, innovation, and integration. Canadian Institutes of Health Research (CIHR) - Emerging Team Grant CB101832

Ontario Youth Screening Project

Overview

Project Summary

The Ontario Youth Screening Project (OYSP) was funded under the Canadian Institutes of Health Research (CIHR) through an Emerging Team Grant to work collaboratively with cross-sectoral youth serving networks in six communities across Ontario. The goal of the project was to implement a common screening tool to identify youth substance use and mental health concerns. Each network was composed of a minimum of two sectors that included addictions, mental health, justice, child welfare, education, housing, outreach and support and health. Each agency agreed to participate in one or more of four key project activities: Network Development, Capacity Building, Screening Implementation and Data Collection (see Appendix D). Through this process, the team had the opportunity to examine rates of co-occurring substance use and mental health concerns (frequently referred to as concurrent or co-occurring disorders (CD)) in different service sectors, across the adolescent and emerging adulthood age spectrum. As well, the project aimed to explore service provider perceptions of interagency referrals; perceived interagency collaboration; and youth CD-related attitudes, knowledge, and practices at different time points in the project.

The overall objective of OYSP was to enhance service provider Concurrent Disorder (CD) capacity, increase early intervention opportunities, and improve pathways to treatment for youth (aged 12-24 years) with substance use and mental health problems, and their families. This was done through building sustainable stakeholder collaborations and providing CD-related capacity development opportunities in six communities.

Context

Background

In Ontario, 467,000 to 654,000 children and youth have at least one diagnosable mental health disorder, and there are indications that these disorders are increasing in frequency (Ministry of Children and Youth Services, 2013). Substance use in adolescents is also common. In the most recent Ontario Student Drug Use and Health Survey (OSDUHS), forty percent of Ontario youth in grades 7 to 12 reported use of drugs, one-half reported using alcohol, and one-fifth reported binge drinking in the past year (Boak, Hamilton, Adlaf & Mann, 2013). Within community samples, adolescents with a substance use disorder are up to six times more likely to be diagnosed with a mood disorder, two times more likely to be diagnosed with an anxiety disorder and 14 times more likely to be diagnosed with a conduct/oppositional disorder (Roberts, Roberts, & Xing, 2007). Similarly, children with externalizing (disruptive) behaviour disorders and internalizing disorders (anxiety or depression) initiate substance use at earlier ages and are more likely to develop problematic substance use than children without these disorders (Armstrong & Costello, 2002).

Youth with CDs have multiple vulnerabilities including impairments in functioning, behavioural problems, poor academic/vocational performance, increased suicide risk, and adverse health effects – including increased risk for substance dependency and psychiatric disorders continuing into adulthood (Clark, Power, Le Fauve, & Lopez, 2008; King, Gaines, Lambert, Summerfelt, & Bickman, 2000; Lewinsohn, Rohde, & Seeley, 1995; Rush, Castel, & Desmond, 2009). Notably, the extent of co-morbidity appears to be higher among youth than among adults (Roberts et al., 2007; Grisso, Vincent, & Seagrave, 2005) resulting in calls for special attention to youth-focused screening, assessment and treatment planning (Grisso et al., 2005). CDs are also associated with greater severity of disorder, poorer prognosis, increased treatment challenges and greater unmet need for treatment compared to individuals with mental health or SU disorders alone (Bijl & Ravelli, 2000; Clark et al., 2008; Kessler, Chiu, Demler, Merikangas

& Walters, 2005; Urbanoski, Cairney, Bassani, & Rush, 2008; Vida, Brownlie, Beitchman, Adlaf, Atkinson, Escobar, Johnson, Jiang, Koyama, & Bender, 2009). The majority of children and adolescents with significant mental health or substance use concerns do not receive specialized treatment, although they often present to other service systems such as primary care, emergency services or the youth justice system (Waddell, McEwan, Shepherd, Offord, & Hua, 2005; Reid, Evans, Brown, Cunningham, Lent, Neufeld, Vingilis, Zaric, & Shanley, 2006). This is partly a result of the lack of adequate problem identification in service systems as well as poor cross-sectoral communication and coordination. The term "no wrong door" has been aptly embraced across sectors as a way to meet the need for a collaborative approach that facilitates timely access to care (e.g., National Treatment Strategy Working Group, 2008; Mental Health Commission of Canada, 2009).

Integrated models of service delivery are needed across the continuum of care to improve outcomes and reduce the high individual and societal costs associated with CDs (Rush et al., 2009). Routine and effective screening for, and assessment of, mental health and substance use concerns among children and adolescents is needed, particularly in service delivery settings where children, youth and families already present themselves for assistance. Many national (Health Canada, 2002) and international (Elster & Kuznets, 1994) expert panels and organizations have advocated for routine screening for mental health and substance use concerns in childhood and adolescence.

Choosing a Screening Tool for Youth

The importance of screening for both mental health and substance use concerns across sectors has been identified through a number of initiatives. From 2002 to 2006, the emphasis was primarily on the identification of useful adult tools and practices (Health Canada, 2002; Centre for Addiction and Mental Health, 2006).

In 2006, Rush and colleagues initiated a process to identify youth screening tools and processes, and conducted a comprehensive review and synthesis of screening tools for substance use and mental health disorders among children and adolescents (Rush, Castel, & Desmond, 2009).

Through these initiatives, the Global Assessment of Individual Needs Short Screener (GAIN SS) was identified as an ideal first stage screening tool for substance use and mental health concerns for youth and adults. In particular, it was recommended because it:

- Screens for both substance use and mental health issues;
- Is reliable and valid;
- Is brief (five to seven minutes to complete);
- Can be self-administered;
- Has been validated for individuals aged 10 years and older (including adults);
- Is low cost;
- Can be used in different service settings (e.g., treatment, primary care, etc.).

Collaborative Screening Initiatives 2003 - 2010

In 2003, CAMH merged its children's mental health and youth substance use services into the Child, Youth and Family Services (CYFS) and in 2005 a project was initiated to identify and implement a common screening tool for substance use and mental health concerns across the merged program. Based on the work of Rush and colleagues (2006), the GAIN SS was chosen and implemented. In addition, substance use and mental health-related staff attitudes, knowledge and practices were measured and staff feedback was gathered. Findings from that project demonstrated that many youth endorsed co-occurring substance use and mental health concerns, regardless of "presenting problem" and initial service request. As well, participating staff indicated that implementing a consistent substance use and mental health screening tool was feasible across diverse services and provided clinically useful information (Henderson, Chaim, & Rush, 2007; Skilling, Henderson, Root, Chaim, Bassarath, & Ballon, 2007).

Discussion about this project at workshops, conferences and network meetings generated interest within the Toronto-based Mental Health and Addiction Youth Network (MAYN) in replicating the project within their own agencies. In 2008, as a pilot project, a cross-sectoral network of 10 Toronto-based youth serving agencies (all members of MAYN), led by Gloria Chaim and Joanna Henderson committed to administer the GAIN SS, along with a standardised background information form to the youth (aged 12-24 years) seeking service at their agencies for a 6-month period. The *GAIN Collaborating Network* research findings resulted in a report describing youth needs across sectors and about the feasibility and utility of consistent screening and the GAIN SS in particular. Stakeholder discussion about the findings generated a number of service, system and research initiatives and suggested that the GAIN SS is a feasible and useful clinical instrument (Chaim & Henderson, 2009). The GAIN SS is also available in French.

Upon completion of the *GAIN Collaborating Network* project, findings were presented to local stakeholders including service providers, agency leaders and policy makers as well as at multiple international, national, and local conferences, meetings, and forums, most notably the *Annual Convention of the American Psychological Association* (2009) and *Issues of Substance* (2009). Through these knowledge sharing opportunities, interest in implementing the GAIN SS in youth serving agencies and in participating in collaborative research was generated in communities across Canada. In 2009, CIHR had a call for proposals for Emerging Teams interested in research on health issues of high importance to Canadians (CIHR, 2008). Henderson, Chaim and colleagues included in their Emerging Team grant proposal a replication of the GAIN-CN in four communities across Ontario (OYSP). Later in 2009, the Health Canada, Drug Treatment Funding Program had a call for proposals. With interest and stakeholder support from several provinces, Chaim and Henderson submitted a proposal to engage youth-serving agencies in an effort to examine the feasibility and utility of implementing a common screening tool across youth serving agencies in diverse communities in provinces and territories across Canada outside Ontario.

In 2010, Chaim and Henderson, in collaboration with the Toronto Concurrent Disorders Support Services Network, supported by the Toronto Central Local Health Integration Network, launched another screening project, working with a cross-sectoral group of 10 Toronto-based health and social service agencies focused on youth and adults seeking or receiving service at their agencies. Similar to the *GAIN Collaborating Network Project*, service providers' attitudes regarding feasibility and utility of the GAIN SS were positive and stakeholders reported that the research results were useful in identifying gaps in service and training needs for staff (Hillman, Chaim, & Henderson, 2011).

The Ontario Youth Screening Project was granted funding as part of a CIHR Emerging Team Grant in 2010. Also in 2010 the *National Youth Screening Project* was funded by the Health Canada Drug Treatment Funding Program. The *National Youth Screening Project* was completed in 2013 and the Ontario Youth Screening Project had the opportunity to benefit from the learnings of this project.

Objectives

- To build collaboration amongst youth service providers across sectors by developing/enhancing community based networks in Ontario;
- To use a common screening tool with youth seeking services to facilitate consistent identification and treatment for youth with substance use and mental health concerns;
- To obtain feedback from service providers regarding the feasibility & utility of the GAIN-SS as a screening tool;
- To examine the effectiveness of cross-sectoral collaboration as a knowledge translation strategy;
- To inform planning processes within agencies that relate to:

    (a) *Identifying commonalities and differences in youth seen;*

    (b) *Identifying gaps in the continuum of services.*

Implementation Summary

The Ontario Youth Screening Project (NYSP) was launched in the fall of 2011, with the anticipated goal of collaborating with 4 communities across Ontario. Ultimately 6 communities in Ontario participated in the project (see Appendix A). Networks included between 2 and 7 agencies, representing 7 sectors. All of the communities participated in the standard implementation of the project that included participation in all four project activities: network development, capacity building, screening implementation and data collection. (See Appendix B for implementation summaries by community, Appendix C for a description of the project activities and Appendix D for project activity participation details). Throughout 2012 and 2013 the project team provided training to 255 service providers from participating communities. The service providers participated in one full-day youth concurrent disorders capacity building session, with an emphasis on evidence-based screening practices, clinical use of the GAIN SS and implementation of the project protocol. Web-based training was provided for service providers who could not participate in the in-person sessions. In addition the service providers completed surveys about their own knowledge, attitudes and practices related to youth substance use, mental health and co-occurring concerns. These surveys were repeated at the end of the project when they also provided feedback about their perceptions of the feasibility and utility of implementing the screening tool in their practices and the impact of screening in particular and project participation more generally on their referral practices. All the service providers across the networks received the necessary tools and materials to implement the project activities.

The community networks were established based on shared interests and concerns, including interest in the opportunity to work together in research-community collaborations. Furthermore, the network members expressed a desire to lay the groundwork for on-going partnerships and collaboration through their participation in OYSP. The networks were interested in and committed to ensuring that knowledge gained through this collaborative effort be shared locally and provincially. To that end, presented in this report are the background and service needs of youth who participated in this project as well as information about service provider capacity and perceptions of the screening tool and related processes. Separate reports have been prepared for each community describing local processes, youth background and service needs as well as service provider perceptions of the screening tool for each of the participating communities.

Provincial Project Summary

- **Total number of distinct agencies: 23**
- **Total number of distinct services: 32**
- **Total number of service providers trained: 255**
- **Total number of GAIN SS received: 1073**
- **Total number of sectors represented: 7**

Development

A process to ensure broad dissemination of information about the opportunity to participate in the Ontario Youth Screening Project was undertaken. Information was shared about the project and consultations took place regarding fit and potential synergies with other projects through Addictions Ontario (currently Addictions and Mental Health Ontario) and the Ministry of Child and Youth Services, Working Together for Kids Mental Health initiative. The CAMH Provincial System Support Program leadership provided consultation and identified regional staff to assist in identifying communities and local agencies that might be interested in participating and ultimately to take on the role of Network Coordinator in the participating communities. This process was followed by invitations to discuss the project at various

local network tables including Student Support Leadership, Child and Youth Mental Health Networks, and Children's Services Tables. The network coordinators facilitated local processes to ensure potential participants had the information they needed to determine their participation (see local community reports for local detailed information). The project leads participated in teleconferences and/or in-person meetings with stakeholders as required, to discuss the objectives of the project and explore interest and feasibility. Similar to the pilot screening projects described previously, there was interest in participating in a project to build capacity to identify and address the complex needs of service-seeking youth, as well as in having the opportunity to document the needs of youth in the participating agencies, sectors and communities.

The Niagara region in Ontario was the first community to commit to the project, engage network membership, sign required collaboration agreements, secure required research ethics approval(s), participate in training and launch the 6-month data collection phase of the project that included administering the GAIN SS and a demographic information form to youth aged 12 to 24 years seeking service at the participating agencies. Training took place between November, 2012 and February, 2013. In each site the project team held the one-day training workshops on two consecutive days to allow for all agency staff to be trained. Capacity-building sessions through webinar were also available to communities if required. At the start of training, service providers who consented were surveyed regarding their attitudes, knowledge and practices related to youth substance use, mental health and co-occurring concerns. See the local reports described above for details of the process in each community as well as Appendix B for implementation summaries and Appendix E for a process summary. See Appendix F for the overall project timeline.

Roles

CAMH Project Leads:

- Provide resources for and support meetings of youth-serving agencies to support all aspects of project participation;
- Provide training to staff in identifying and addressing substance use and/or CD concerns in youth, implementing the GAIN SS and the data collection protocol;
- Provide all necessary screening and project-related materials;
- Provide templates and support for developing response, resource and referral guides customised for the community;
- Obtain ethics approval through CAMH and support each agency to comply with their ethics approval processes.

CAMH Network Coordinator:

- Identify local organizations, representing a minimum of two sectors to participate in the project;
- Vet prospective participating agencies for suitability;
- Act as a liaison between project leads and participating agencies during the term of the project;
- Ensure participating agencies are covered by an up-to-date license for use of the GAIN SS;
- Identify and facilitate agency leads to obtain local REB approval for the project;

- Support training provided by the project leads and facilitate provision of consultation as needed throughout the project;
- Facilitate pre and post service provider surveys of staff attitudes, knowledge and practices to all agency staff involved in the project;
- Facilitate data collection by the participating agencies.

Participating Agencies:

- Obtain license from Chestnut Health Systems Inc. or ensure up-to-date license for use of the GAIN SS;
- Comply with the agreed upon protocol by obtaining participant and parental consents as required, administering GAIN SS and submitting the data to the project leads for data entry and analysis;
- Ensure staff participation in project-related training;
- Maintain and store original data from participants as per REB policies and in accordance with legal requirements;
- Ensure that as many eligible youth as possible have the opportunity to be included in the project and that the rates of eligibility and consent are tracked.

Implementation Process

(See Appendix F for Project Timeline)

Prior to initiating project activities, agreements were signed between all participating agencies and CAMH.

A collaborative process was used throughout the project to develop joint goals, materials and processes as well as research questions and data analyses. Once the agency level training was completed and data collection was underway, the CAMH project team communicated with the participating agencies to maintain engagement, momentum, and compliance with the project protocol, problem-solve issues, and facilitate collaboration in the joint data analysis process.

Implementation Process

1. **November 2011 – September 2012 – Networking:**
   - (a) *Identified interested agencies*
   - (b) *Established cross-sectoral networks*
2. **February 2012 – February 2013 – Agreements and REB:**
   - (a) *Developed an agreement between CAMH and each participating agency*
   - (b) *Secured all required REB approvals*
3. **June 2012 – February 2013 – Capacity building**
   - (a) *Capacity building across sites was delivered using the package developed by the project leads*
   - (b) *Project leads administered service provider consents and the Service Provider Survey at the beginning of the training day*
   - (c) *Each Agency identified a lead to act as a "point person" for communication with the CAMH network coordinator, including receiving and distributing project packages to the participating service providers in their respective agencies*
   - (d) *Additional teleconference capacity building sessions were provided to train staff who could not attend the in-person sessions in the administration of the measures and the project protocol*
4. **November 2012 – June 2013 – Project launch:**
   - (a) *Distributed project packages (i.e. project instruction sheets, consent forms, GAIN SS, background Information forms, tracking sheets)*
5. **November 2012 – December 2013 – Project actively underway:**
   - (a) *Service providers obtained consent from youth and parents as required seeking service at their agencies, administered the GAIN SS and Background Information Form*
   - (b) *Anonymous copies of the completed measures and tracking sheets were submitted to the CAMH network coordinator on a monthly basis, and delivered to CAMH project leads at months 1, 3 and 6*

(c) *Consultation was provided as needed by the network coordinator and/or project coordinator/project leads*

(d) *Staff feedback forms were collected on completion of the data collection*

6 September 2013 – January 2014 –Preliminary data analysis meeting:

Discussed:

(a) *Data analysis questions*
(b) *Preliminary findings*
(c) *Fit with expectations and experiences of the community*
(d) *Lessons learned, including staff feedback on utility and feasibility of administering the GAIN SS to youth in their agencies*
(e) *Feedback from network coordinator and agency leads*
(f) *Potential recommendations based on findings*
(g) *Report dissemination plan*

Materials

Service Provider Project Package

Service Provider Survey Consent Form

The consent form described the project, confidentiality and plans for data management. Service providers' initials only were required to ensure anonymity.

Service Provider Survey

The Service Provider Survey is a self-report questionnaire that combines measures of service providers' 1) service-related knowledge, attitudes and practices regarding youth substance use, mental health, co-occurring disorders, and screening; 2) perceptions of co-occurring disorders-informed practices; 3) estimates of current use of CD-informed practices; and 4) experiences with inter-agency referrals and collaboration.

Project Flow Chart (See Appendix G)

A step-by-step one page project flow chart was developed for use by all service providers to facilitate consistency across providers.

Referral Resource Guide

Customized templates listing local resources for consultation and referrals for follow-up to endorsement of concerns on the GAIN SS were provided to each participating service provider.

Project Tracking Sheet

Tracking sheets were used to document rates of youth eligibility for project participation, consent/non-consent, participation/reasons for non-participation, and data collection completion and submission for each youth seeking service at each agency.

Feedback Survey

The feedback survey was designed to gather information from participating service providers regarding their perceptions of the feasibility and utility of administering the GAIN SS to youth in their setting and about the impact of the screening process on their practices.

Youth Project Package

Youth Consent Form

The consent form described the project, confidentiality and plans for data management. Youth initials only were required to ensure anonymity.

Parental Consent Form

The consent form described the project, confidentiality and plans for data management. Parental consent was required in addition to youth consent only where parental consent was required to obtain services for youth under 16 years of age. Parent's initials only were required to ensure anonymity.

Background Information Form

The Background Information Form is a one-page questionnaire used to gather demographic information about the participating youth. The questions seek information about the determinants of health frequently cited in the literature as associated with youth substance use and mental health concerns including age, sex, education, employment, income support, housing, legal involvement, ethno-racial identification, and language diversity.

GAIN SS (CAMH Version)

The GAIN SS is a brief screening tool validated for use with individuals aged 10 years and older to quickly identify those who may be experiencing difficulties in one or more of four dimensions: 1) internalizing disorders (e.g., depression, anxiety); 2) externalizing disorders (e.g., ADHD); 3) substance use problems; and 4) crime and violence (Dennis et al. 2006). The tool was developed by Chestnut Health Systems and copyrighted in 2005. Chestnut Health Systems permitted CAMH: Child, Youth and Family Program to modify the GAIN SS in 2006, by adding seven items (not part of the original validation) at the end to screen for: eating-related issues, trauma-related distress, disordered thinking, and gambling, gaming and internet misuse concerns.

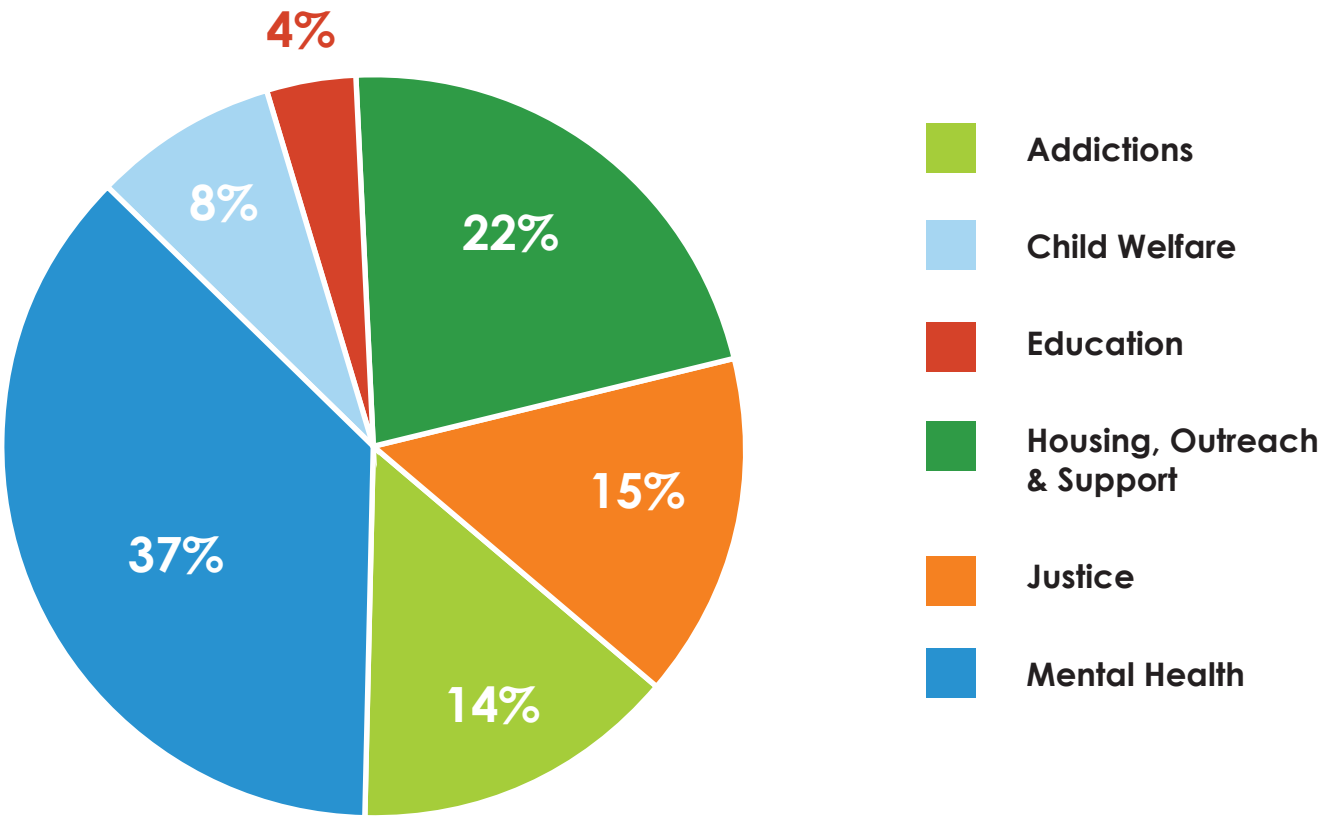
Findings: Youth Needs

Background Information about Youth

Who participated?

In total, 1073 youth participated from 7 different sectors: housing, outreach and support, justice, addictions, mental health, child welfare, education and health.

Figure 1: Sector Distribution of Participants



The mental health sector represents the largest portion of the participants (37%), followed by housing, outreach & support sector (22%), justice sector (15%), and addictions sector (14%). A small number of participating youth presented to the health services sector, however their data has been included under the mental health sector in order to protect confidentiality, and based upon feedback received from the service.

Over a quarter of the participants were from the Niagara region (26%). Around 20% of participants were from the Sudbury (23%) and Brant (19%) regions. Fifteen percent of youth were from the Ottawa region and 11% were from the Haldimand-Norfolk region. Six percent of participating youth were from the Timmins region (6%).

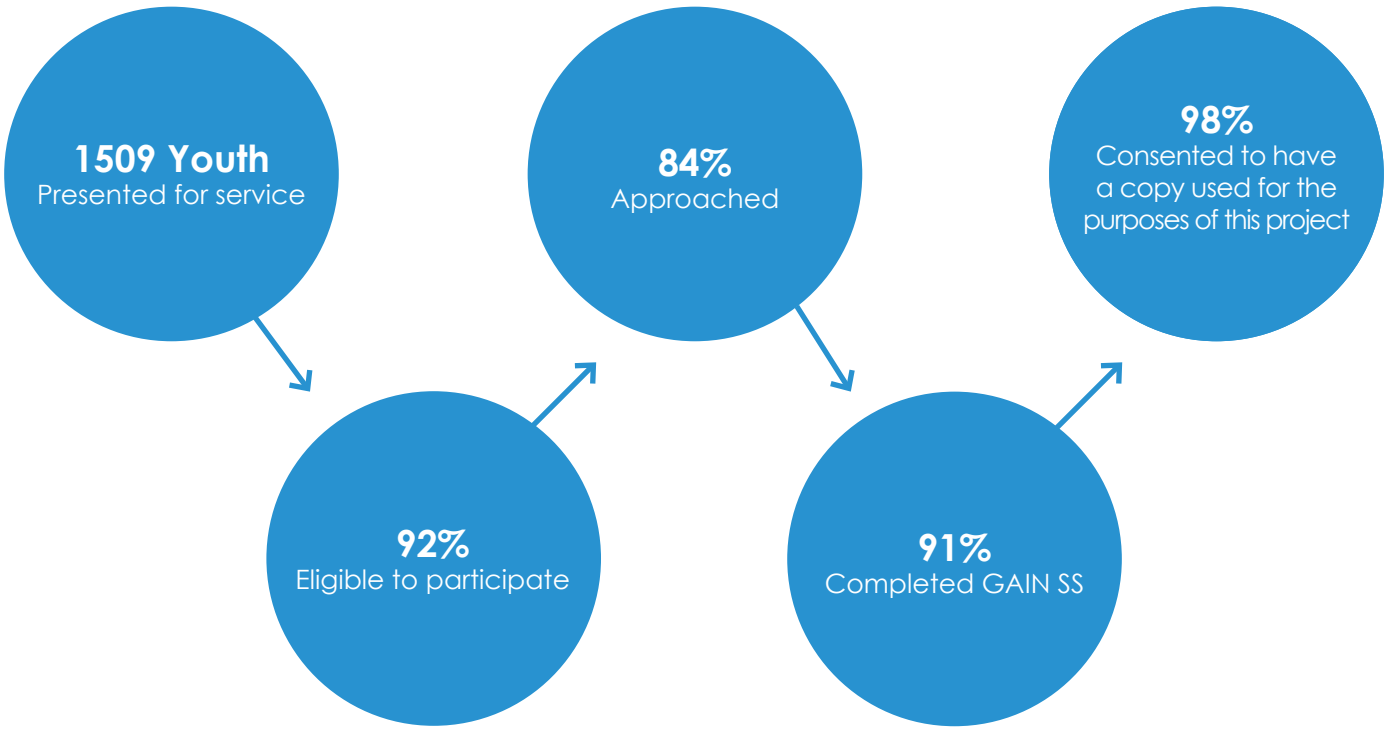
How representative is the sample of youth who participated in the project?

Service providers were asked to use tracking sheets to record each youth eligible to participate. Information collected on the tracking sheets included sex, age, consent response, and any comments on why individual youth may not have been approached or refused to consent. All participating services indicated an intention to use this approach to track participation rates: 87.5% of participating services submitted at least one completed tracking sheet for analysis.

According to the tracking sheets provided, 1509 youth presented for service to the participating services over the project timeframe. Of these youth 92% were eligible for the project (n = 1386). Reasons for ineligibility included the GAIN SS had already been administered (9%), immediate mental health concerns (e.g. youth was psychotic or suicidal) (12%), cognitive limitations (13%), age over 24 years (3%), youth was not a client (20%) and youth was at the end of service (7%). In addition, for 45 cases (37%) no information about eligibility/ineligibility was provided. Of the youth who were eligible to participate in the project, 1164 (84%) were approached for participation. The reasons reported for youth not being approached included clinician-based reasons (e.g., judgment, forgot; 3%), parents were unavailable to consent (2%), the youth was unavailable (e.g., left, no show; 91%), no forms were available (1%), and lack of time (3%). Of the youth who were approached, 91% completed the GAIN SS. Based on the tracking sheets, 9% (n = 108) of youth who were asked to complete the GAIN SS refused. Of the youth who completed the GAIN SS, 98% consented to have a copy used for this project. Of the youth who consented and participated in the study, 96% of the surveys were sent in and included in the analyses.

Overall then, based on these tracking sheet numbers, 71% of eligible youth contributed screeners for this report. It is also the case, however, that not all eligible youth were tracked. There is a discrepancy of at least 87 consenting cases, and based on the rates of consent documented using tracking sheets, this likely represents approximately 122 eligible cases that were not captured on tracking sheets. Accordingly, consideration should be given to representativeness of the sample and generalizability of the findings. The findings may or may not be relevant to youth who did not participate in the project.

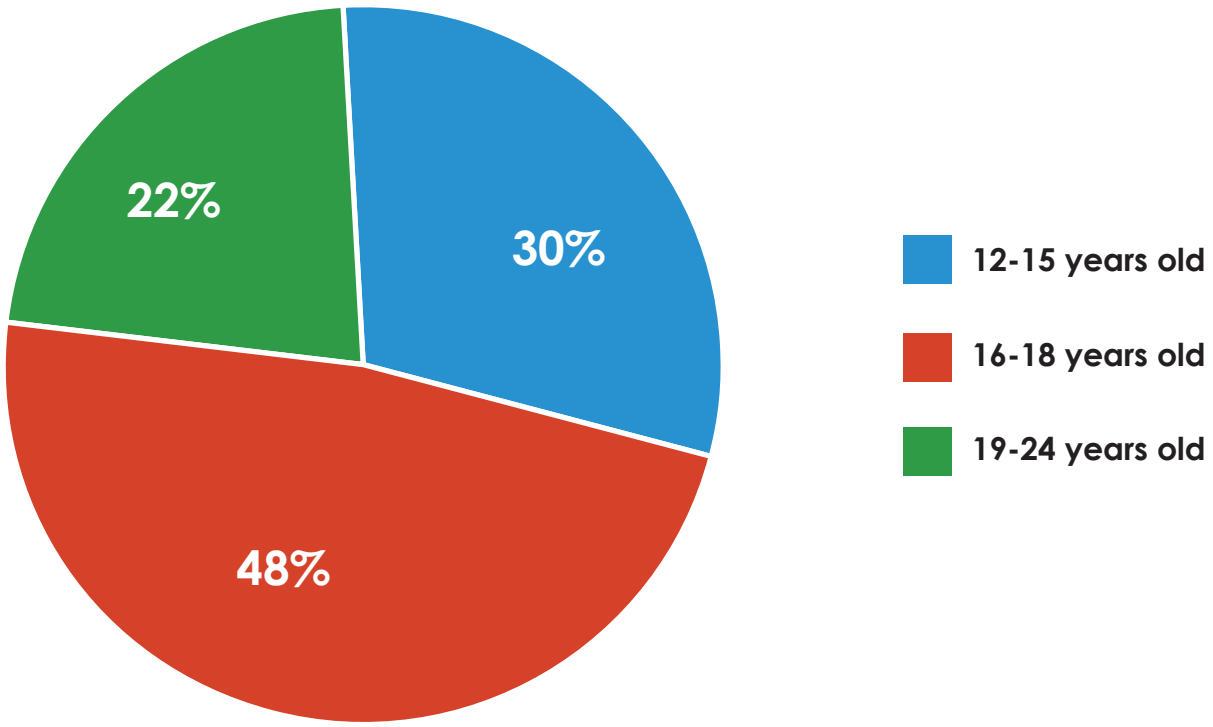
Figure 2: Youth participation rate based on submitted tracking sheets



What are the demographic characteristics of the youth who participated?

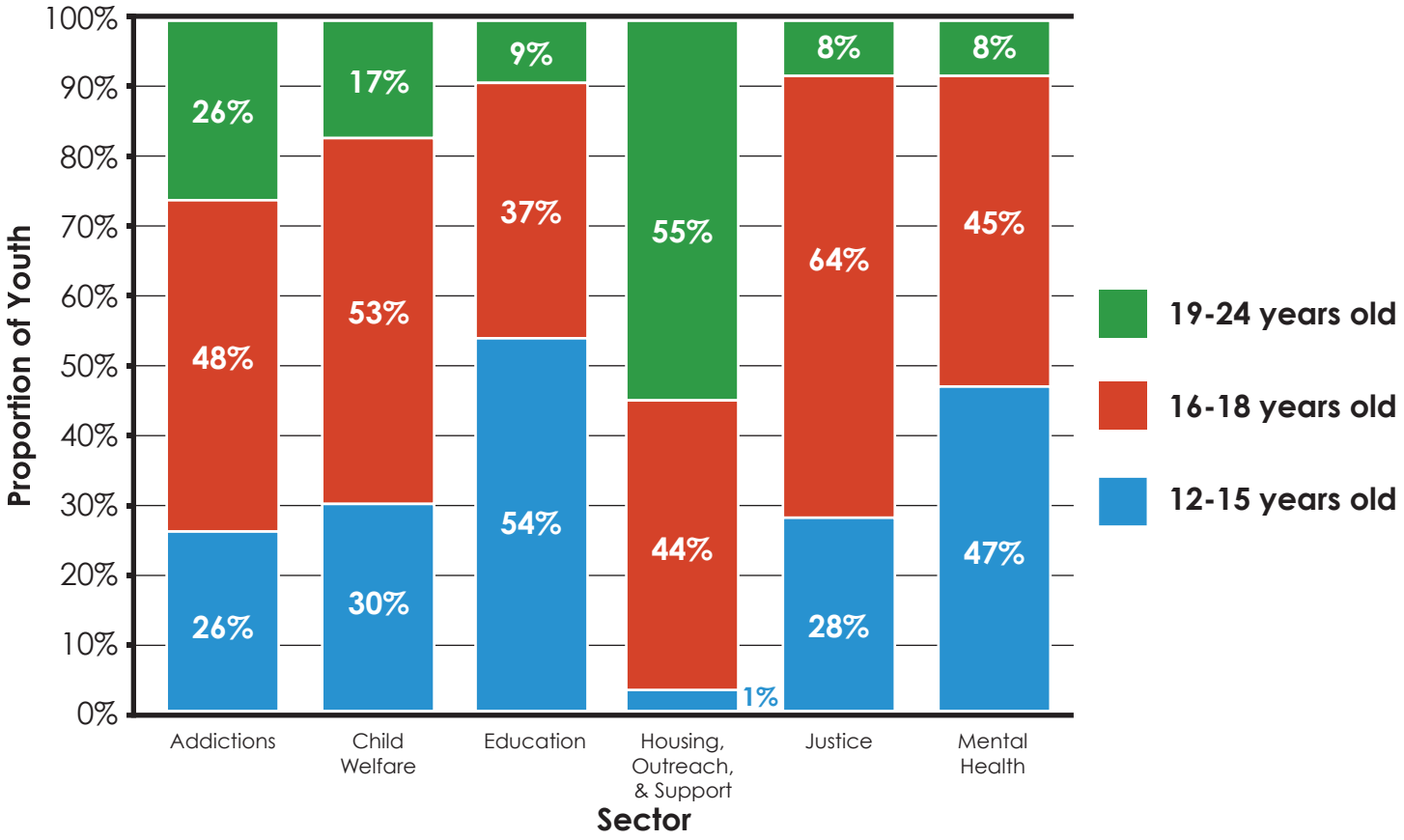
How old were participating youth?

Figure 3: Age Distribution of Participants



The participating youth ranged in age from 12 to 24 years with an average age of 16.9 years and a median age of 17 years. In Figure 3, the ages of participating youth are presented using age categories commonly used in service provision. As can be seen, close to half of the participating youth were in the 16-18 years age range.

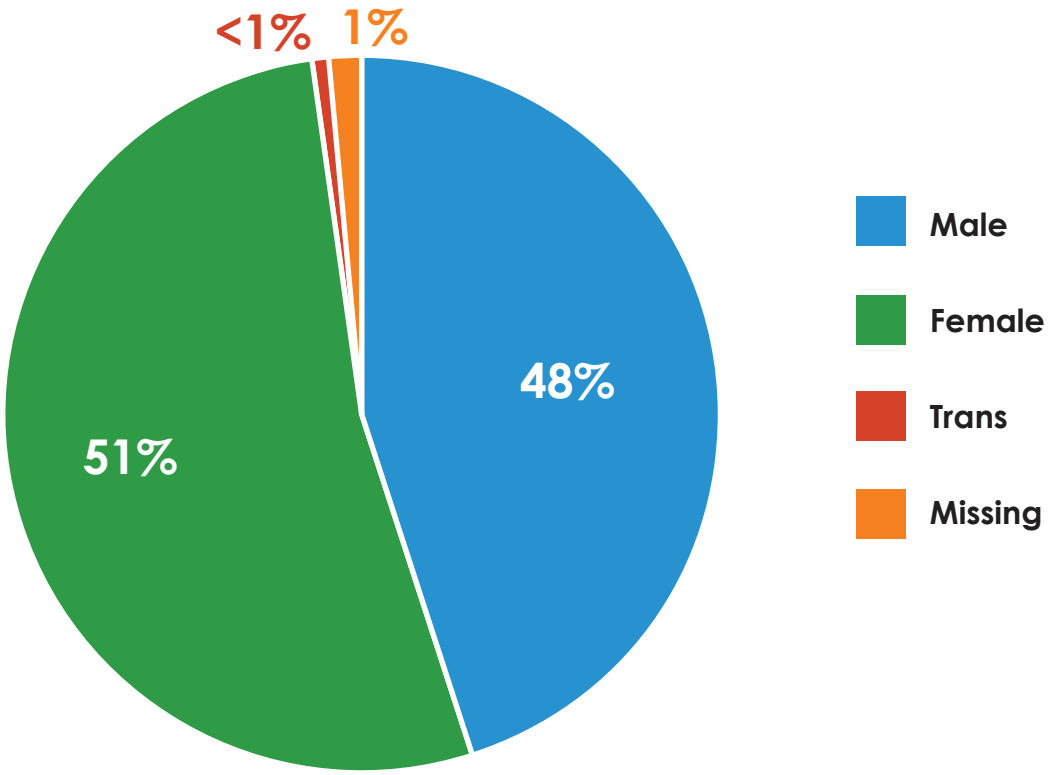
Figure 4: Age Distribution by Service Sector



When youth are grouped by sector, it can be seen that youth who participated from the housing, outreach and support sector were more likely to be in the oldest age group (19 to 24 years) than youth presenting to other sectors for service. Youth from the mental health and education sectors were more likely to be in the youngest age group (12 to 15 years) than youth from the other sectors.

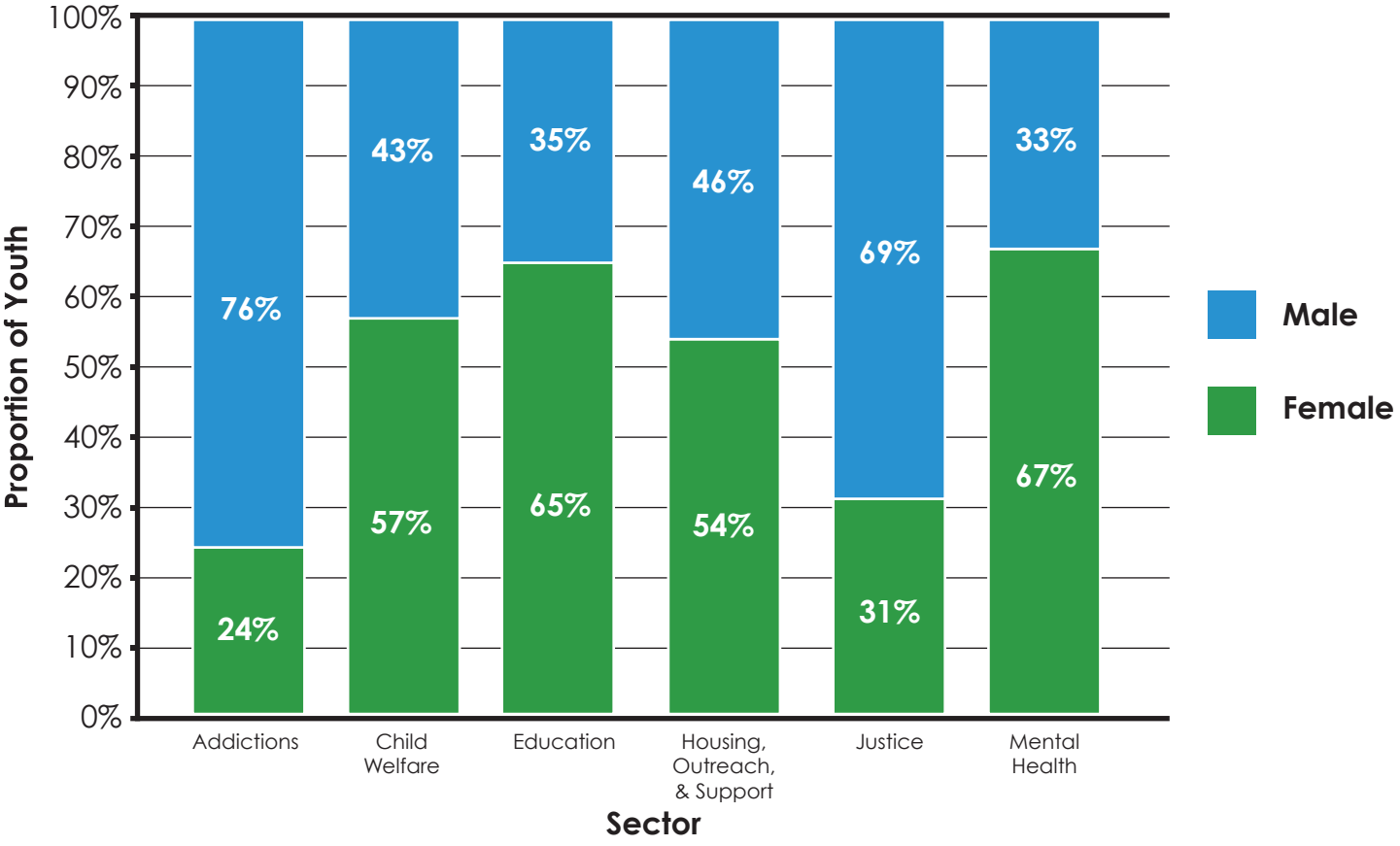
How many participants identified as male, female, trans or other?

Figure 5: Sex Distribution of Participants



There were approximately equal numbers of female and male participants. Fifty-one percent of participants were female and 48% were male, fewer than 1% were trans and 1% did not provide this information. Given the small number of youth who identified as trans, only youth who identified as male or female are included in subsequent analyses based on sex to protect confidentiality.

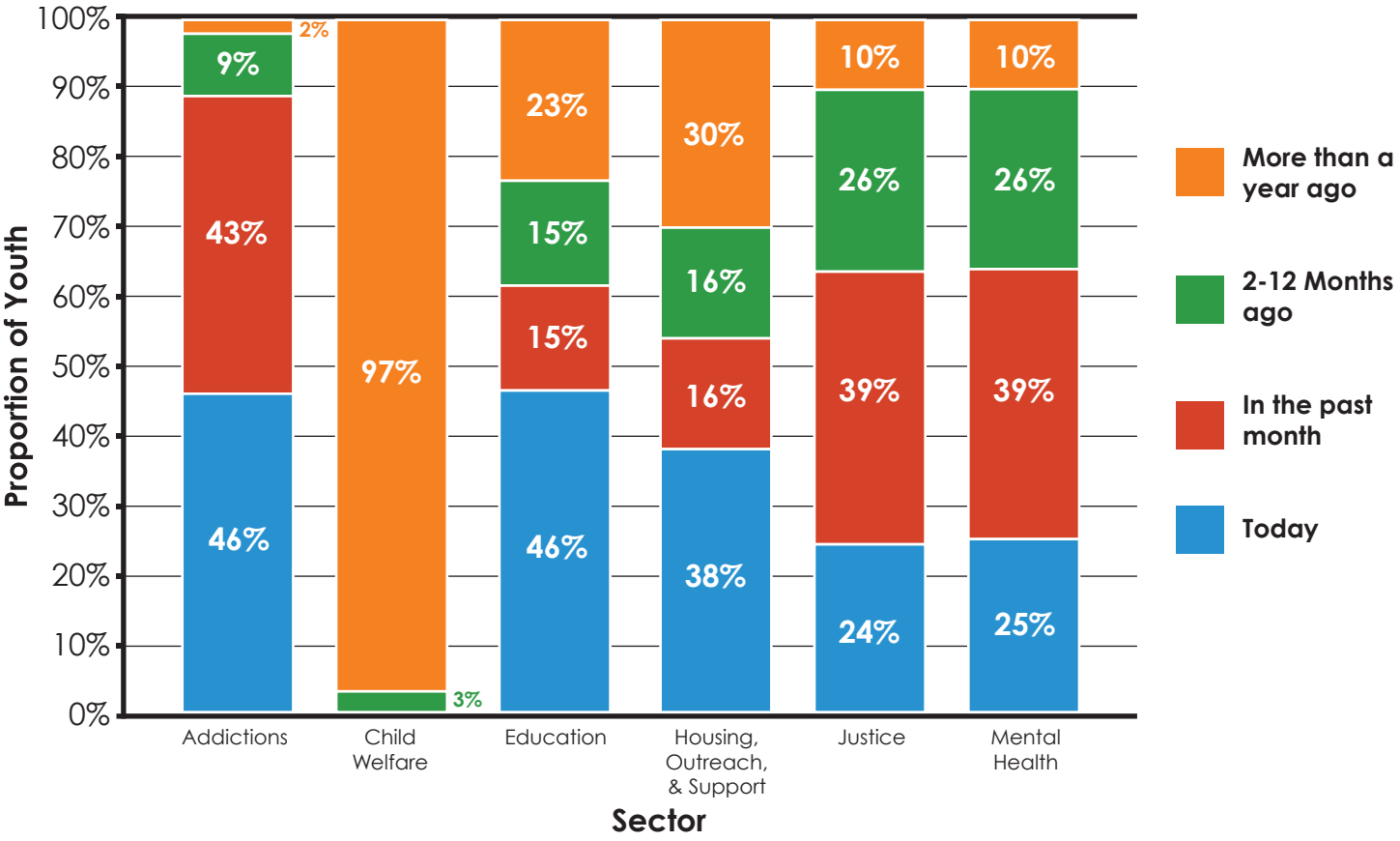
Figure 6: Sex Distribution by Service Sector



Comparing the sex distribution of participating youth across sectors reveals that the male to female ratio differs between sectors. Youth from mental health and education sectors had a greater proportion of female participants than the other sectors, and justice and addictions sectors had significantly more male youth.

How long had youth been receiving service prior to project participation?

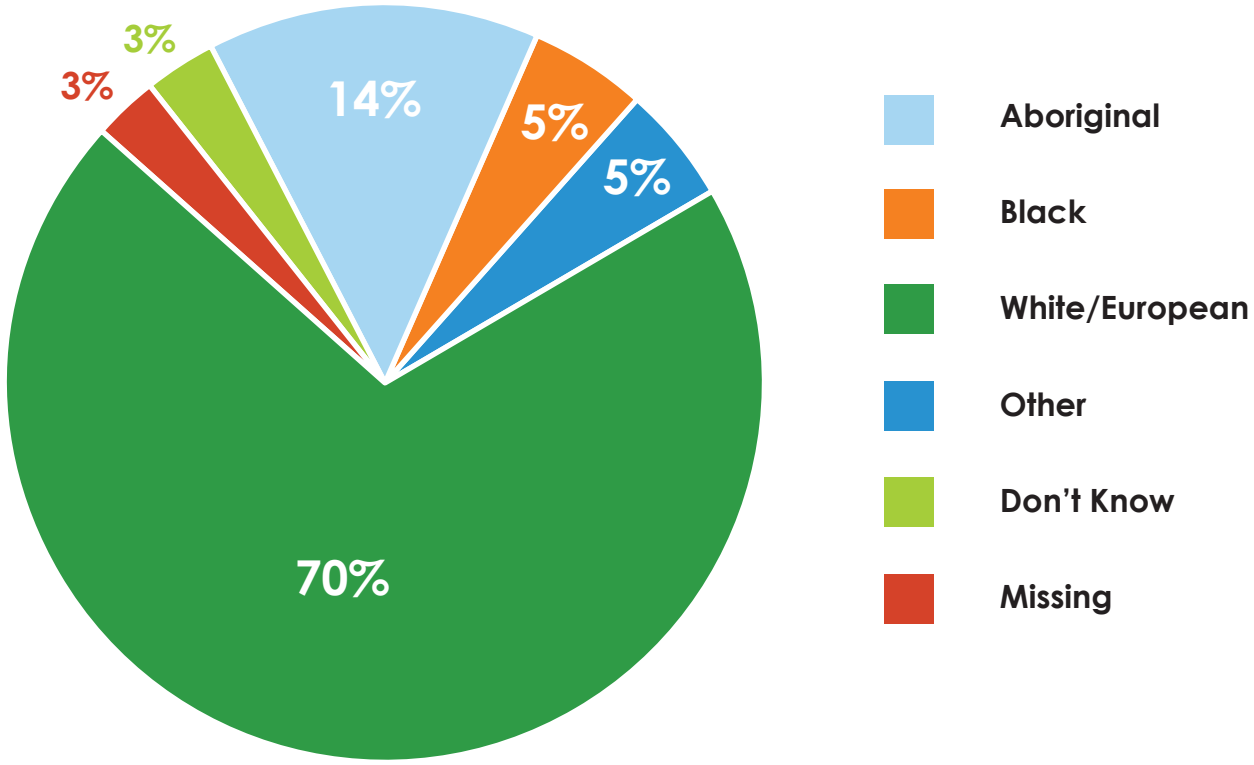
Figure 7: Service History by Service Sector



The majority of youth (56%) participating in the project across sectors had been involved with the participating service for one month or less (not shown), including 28% participating in the project on the same day as first accessing the service. This, however, differed significantly across sectors. The majority of youth from the child welfare sector had been involved with child welfare services for more than a year, and youth from the other sectors who participated in the project had become involved with service in the past month.

What ethnicities did youth report?

Figure 8: Ethnicity Distribution of Participating Youth



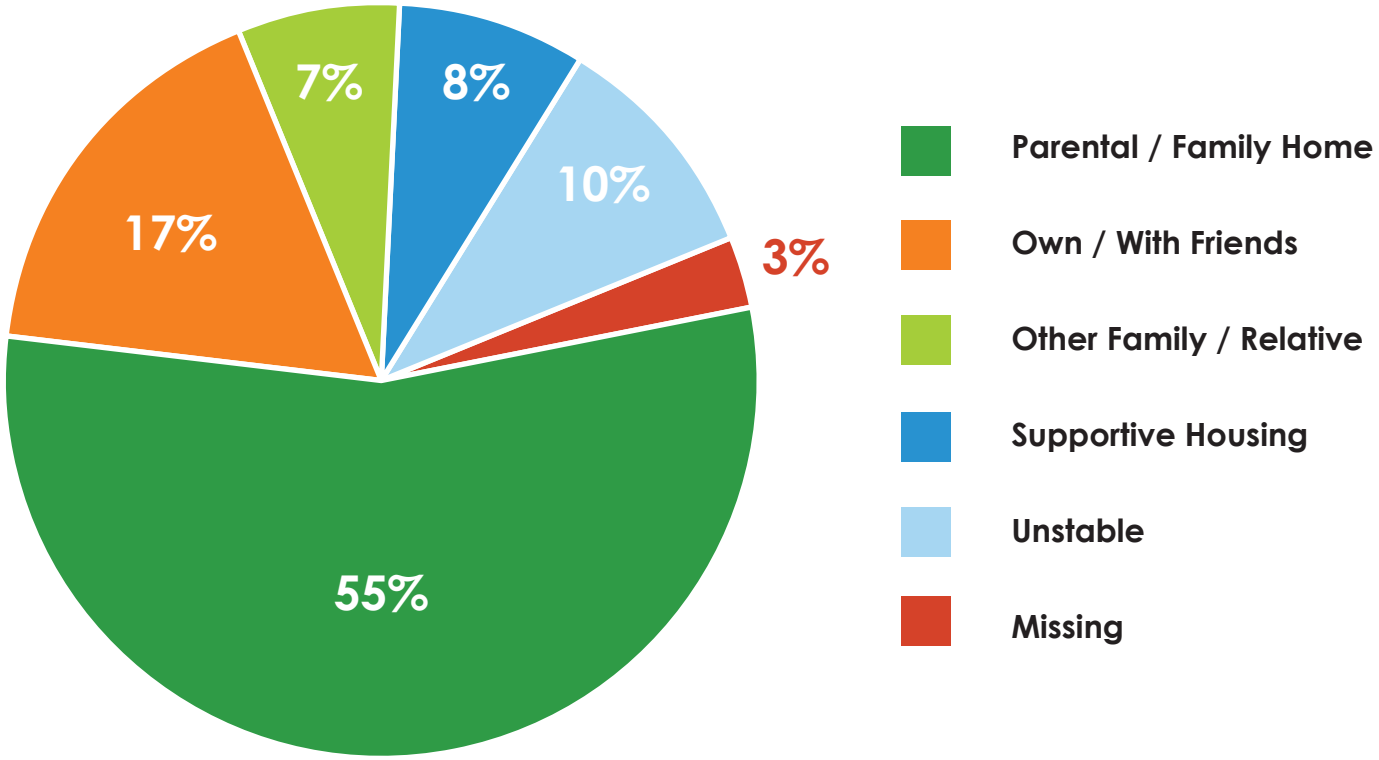
Six percent of participating youth endorsed more than one ethnicity. The rates of endorsement are as follows: White (70%), Aboriginal (14%), Black (5%), and Other (5%). Thirty seven participants did not complete this question.

Birth Country and First Language

The majority of participating youth reported being born in Canada (94%) while 3% reported being born outside of Canada and 3% did not answer the question. Those born outside of Canada reported having been in Canada for two to twenty-two years. The majority of participating youth also reported that English was their first language (88%), while 7% (n=86) reported a different first language and 5% left it blank. Of participants who indicated that their first language was not English, some provided information about their first language. French was the most reported first language after English (n=58).

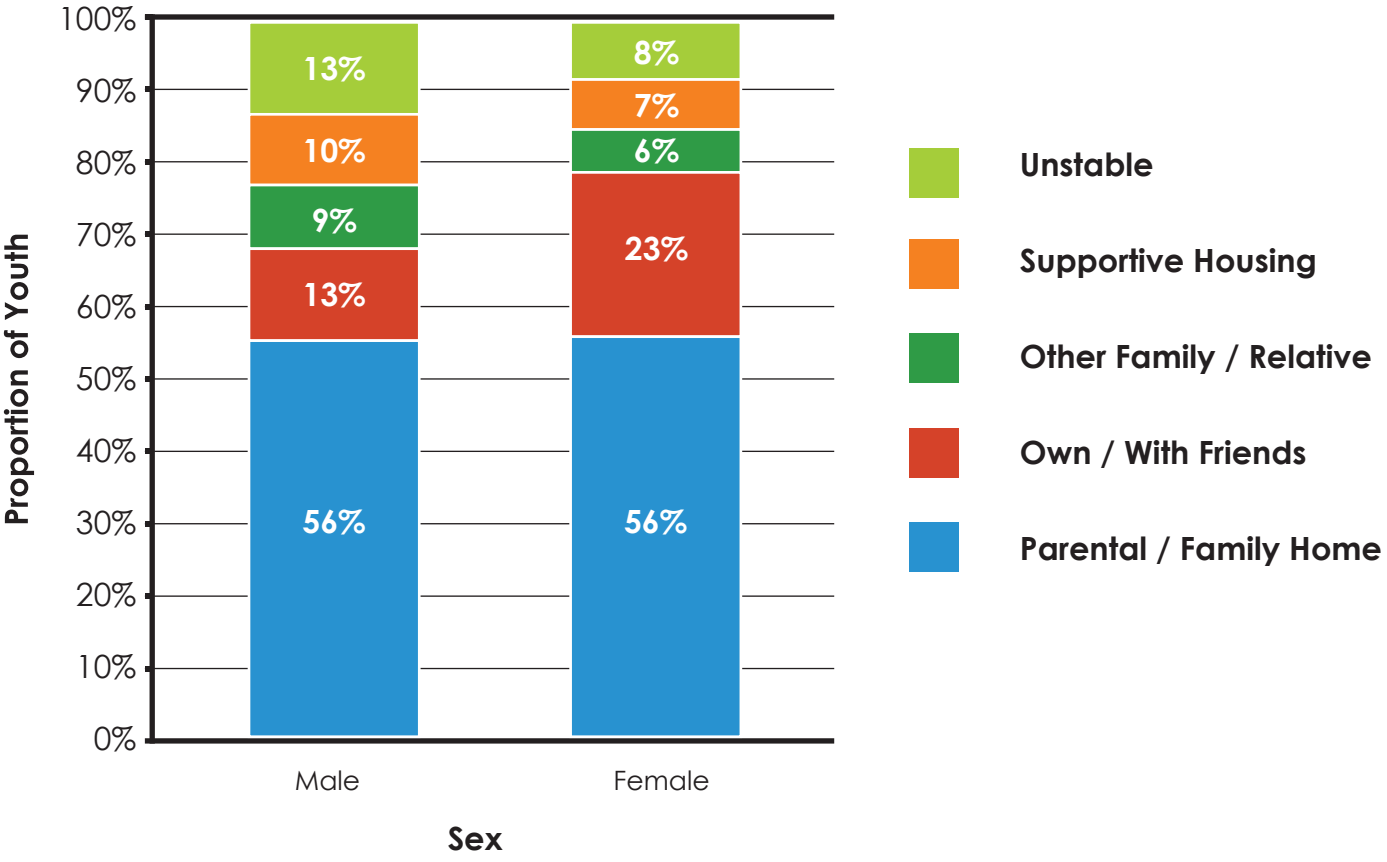
What living arrangements did youth report?

Figure 9: Living Arrangements



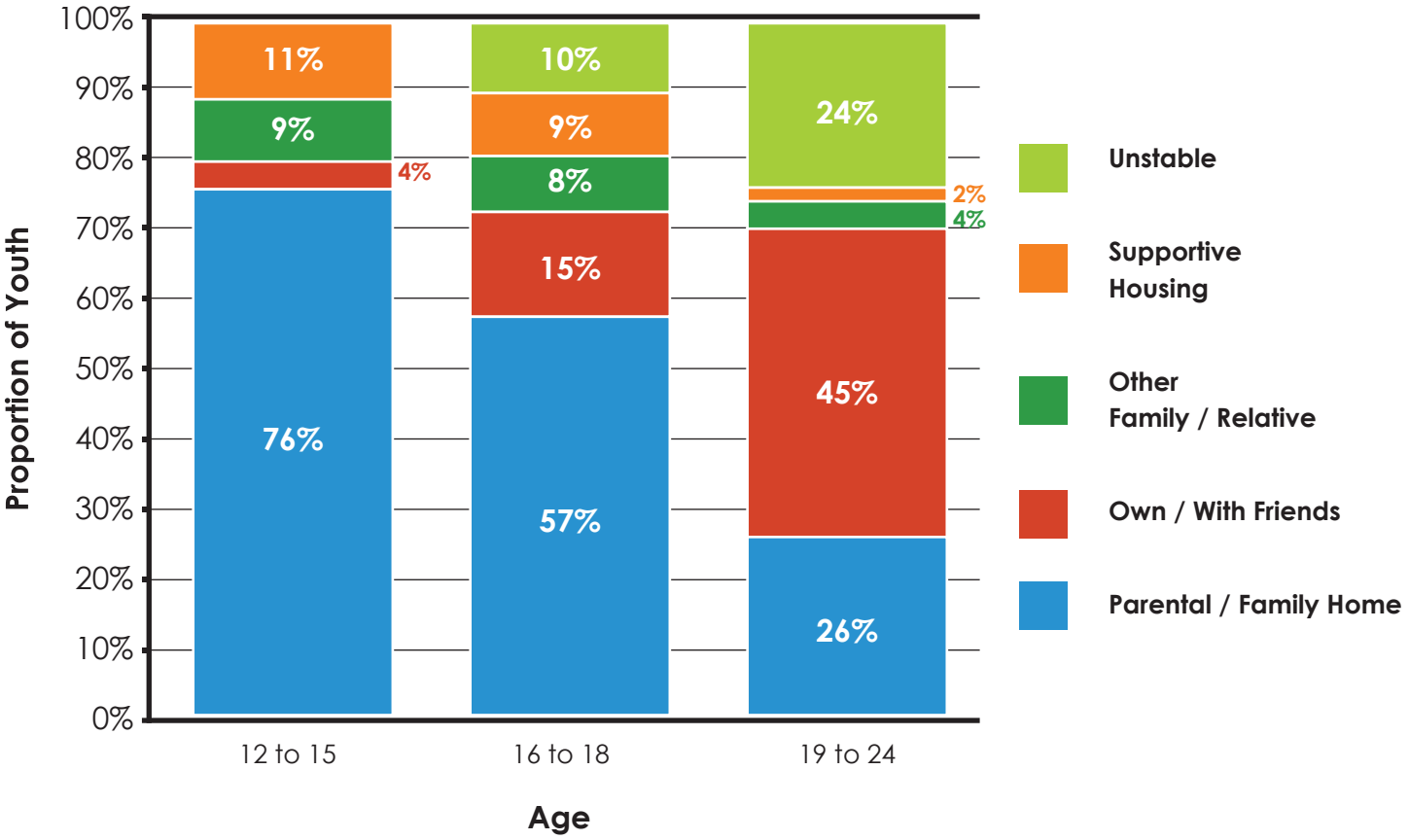
Most participating youth (55%) reported that they were living with parents, while 17% reported living on their own or with friends. Ten percent reported living in unstable housing (e.g. “shelter”, “on street”, “couch surfing”), 8% reported living in supportive housing (e.g. “group home”, “treatment facility”), and 7% reported living with other family or relatives. Three percent of participants did not provide this information.

Figure 10: Living Arrangements by Sex Categories



Examination of sex differences in living arrangements revealed significant difference in the living arrangements reported by male and female youth. Female youth (23%) were more likely to live on their own or with friends than male youth (13%), and male youth (13%) were more likely to have unstable housing arrangements than female youth (8%). Fifty-six percent of both male and female youth reported living in the parental/family home.

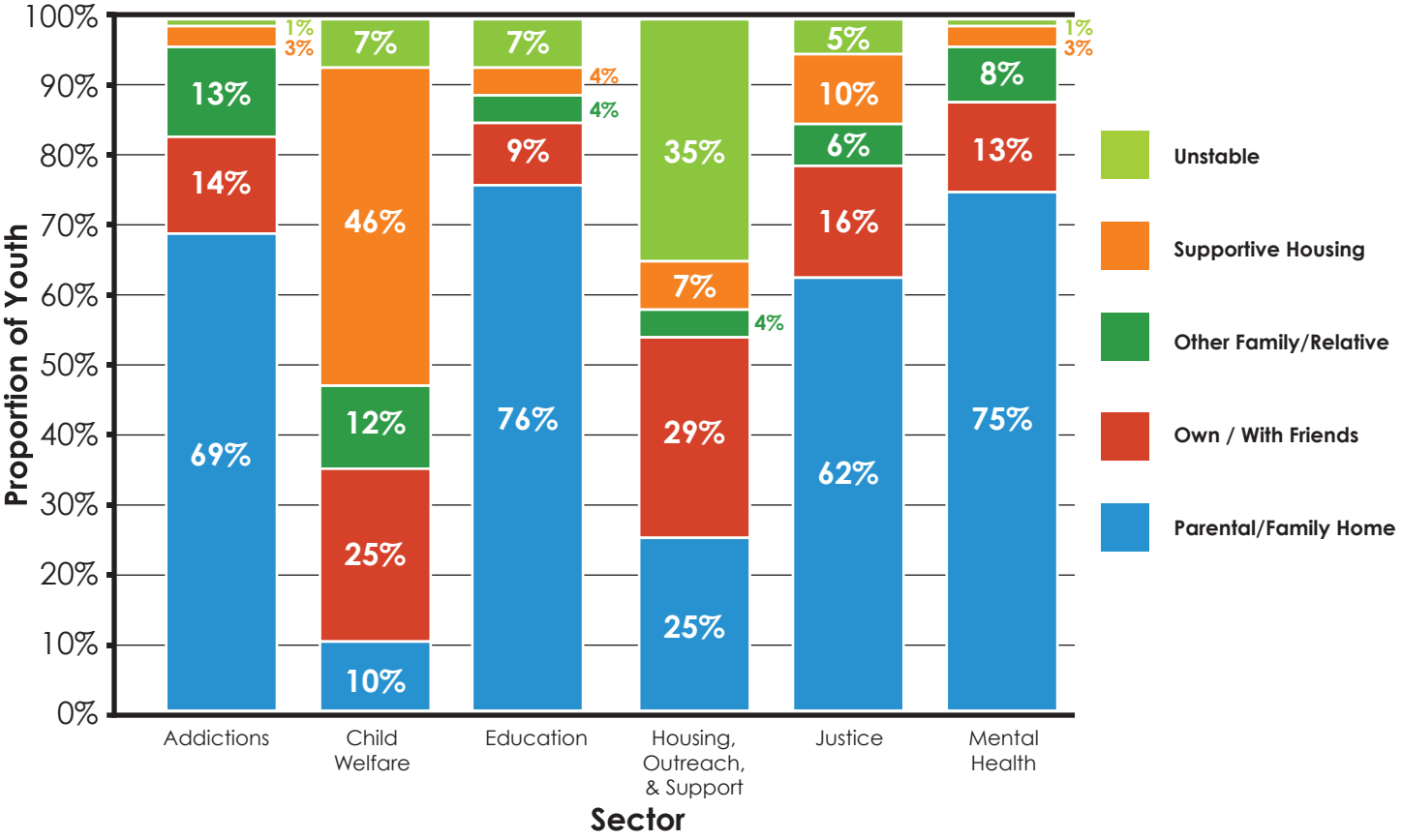
Figure 11: Living Arrangements by Age Categories



As can be seen in Figure 11, older youth reported a wider range of living arrangements as would be expected given their developmental stage, and were more likely to report living on their own or with friends.

Those who reported living alone or with friends (mean age = 19.2) and those who reported unstable living arrangements (mean age = 19.3) were significantly older than those who reported living with other family/relatives (mean age = 16.1), in supportive housing (mean age = 15.9), or in the parental/family home (mean age = 16.0).

Figure 12: Living Arrangements by Service Sector



As would be expected, given their older age and the mandate of the sector, youth presenting for service to the housing, outreach and support sector were more likely to report unstable housing than youth presenting for service to other sectors. As well, youth who participated through the child welfare sector were significantly more likely to be living in a supportive housing arrangement (e.g., group home).

How many youth reported legal involvement?

The majority of participating youth reported never having had any legal involvement (56%), whereas 31% reported having legal involvement in the past 12 months, 9% reported involvement more than a year ago, and 4% of youth did not complete this question.

How are participating youth doing in terms of education, employment and income?

Overall 60% of participating youth identified themselves as students. Of those who did not identify as students, 55% indicated that they were unemployed, 23% indicated part-time employment, 7% indicated they had full-time employment, 3% indicated that they were engaged in volunteer activities, and the remainder indicated involvement in self-employment, apprenticeship or other activities, or did not provide any information.

Age was related to educational, employment and income status. Youth aged 18 years and over who reported employment status (n = 360), indicated that their employment situations were as follows: unemployed (46%), attending school (34%), working part-time (11%), working full-time (7%), volunteering (1%), and self-employed (1%) (not mutually exclusive). In contrast, youth aged 17 years or younger (n = 711) indicated that they were students (73%), unemployed (19%), working part-time (14%), volunteering (4%) and working full-time (1%). Similarly, the most commonly reported income sources for youth 18 years and older were as follows: welfare (43%), no income (16%), employment (14%), disability (8%), parents/spouse (7%), family benefits (4%), and employment insurance (2%), while youth aged 17 years and younger reported their income sources to be parents/spouse (38%), no income (38%), employment (11%), family benefits (6%), welfare (5%), and disability (2%).

For youth 18 years and over, educational attainment was also examined revealing a broad range of educational achievements, including 5% of participants reporting grade 8 completion or less as their highest educational achievement, 62% indicating grades 9-11 as their highest achievement, 3% reporting high school completion without diploma, 22% indicating completion of high school with diploma, 3% received a CEGEP diploma, 3% completed some college but did not receive a certificate, and 1% have completed or are currently in undergraduate or graduate degree programs.

How do the demographic characteristics of male and female youth compare?

Table 1: Demographic Comparison of Male and Female Participants

	Male	Female
Average Age	17.1	16.8
Born in Canada	96%	97%
English First Language	93%	90%
Unstable Housing	13%*	8%
Legal Involvement	55%*	29%

***p<0.05**

As can be seen, when male and female youth were compared on a number of demographic variables it was revealed that more male youth were significantly more likely to have unstable housing, and were significantly more likely to have past or current legal involvement.

Clinical Needs of Youth Based on the GAIN SS

The GAIN SS is a well-validated and reliable screener for mental health and substance use concerns in youth and adults. It has four 5-item subscreeners embedded within the overall measure to screen across four domains: Internalizing (INT) disorders (e.g., mood, anxiety disorders), Externalizing (EXT) disorders (e.g., attention deficit/hyperactivity disorder), Substance Use disorders (SUB), and engagement in Crime/Violence (CV). In order to fully understand the findings presented in this report, it is important to understand the scoring decisions that informed the analyses. The GAIN SS has been shown to have excellent sensitivity and specificity. These rates change, however, depending on how the GAIN SS is scored and analyzed.

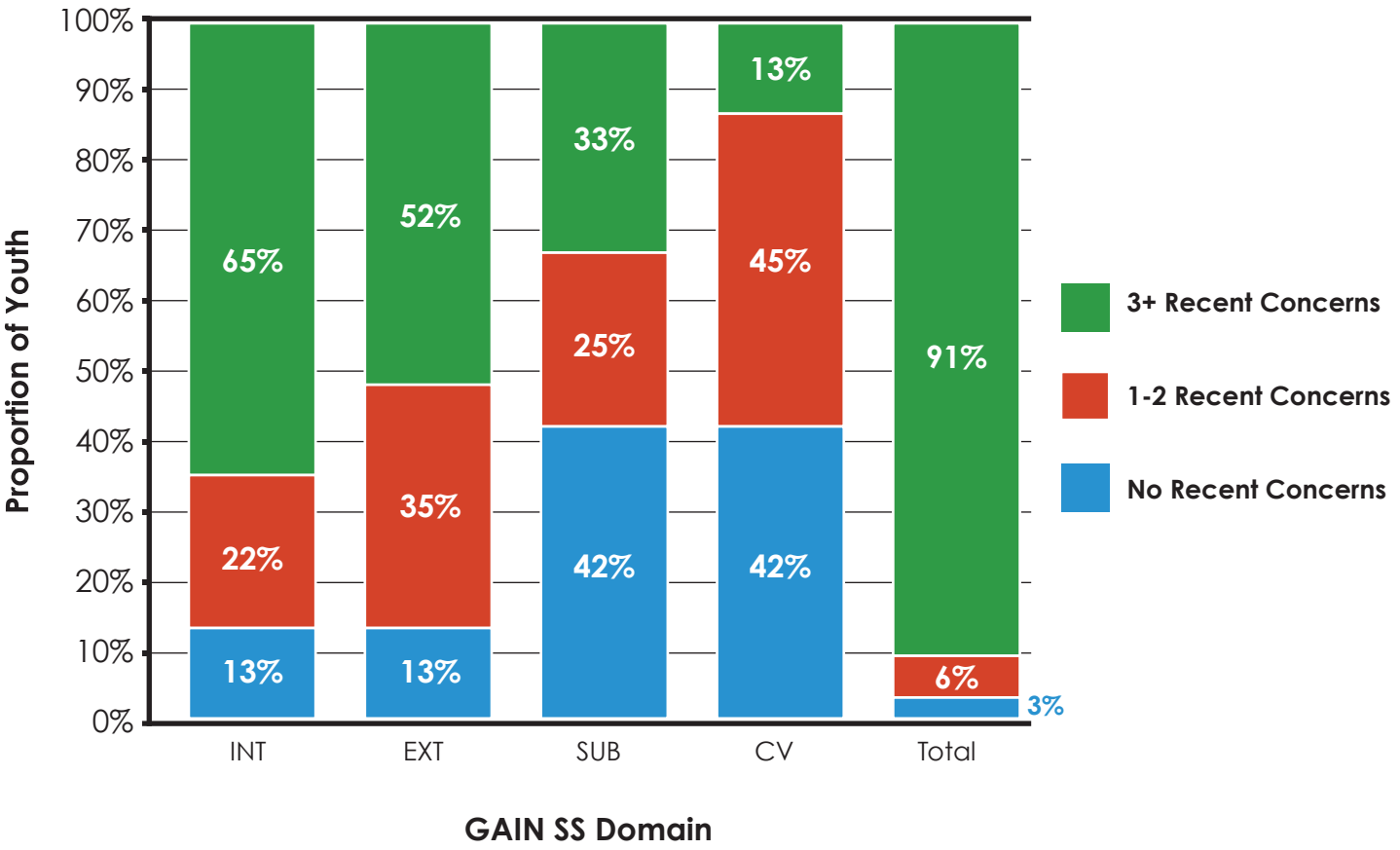
Within each subscreener using a moderate threshold of at least one recent (2-12 months ago) or current (past month) concern has excellent sensitivity (94-98%) for identifying youth who will meet diagnostic criteria for disorder, but lower (71-76%) specificity, i.e. lower accuracy in ruling out youth who will not meet diagnostic criteria for disorder. Using a high threshold of three or more recent or current concerns within one domain improves the specificity to 96-100%, but results in decreases in sensitivity (49-68%). Using a threshold of three or more current or recent concerns endorsed across all domains (total) will identify 91% of youth who will meet diagnostic criteria for a disorder and will rule out 90% of youth who will not have a disorder (Dennis et al., 2006).

Depending on the service setting, use of each threshold may be more appropriate. For example, in settings where the rates of clinically significant mental health and substance use problems are expected to be low (e.g. primary care), use of the moderate threshold may be most appropriate. In settings where individuals are seeking service for mental health and substance use concerns, use of the high threshold may be more informative.

For this project, a modified version of the GAIN SS was used (GAIN SS CAMH Version) which includes 7 additional items following the original subscreeners. These additional items provide information about eating behavior, thinking-related issues, traumatic distress, and gambling, gaming and internet overuse. Sensitivity and specificity data for these items are not yet available and these items are not scored.

How many youth endorsed concerns on the GAIN SS?

Figure 13: Number of Concerns Endorsed by GAIN SS Domain

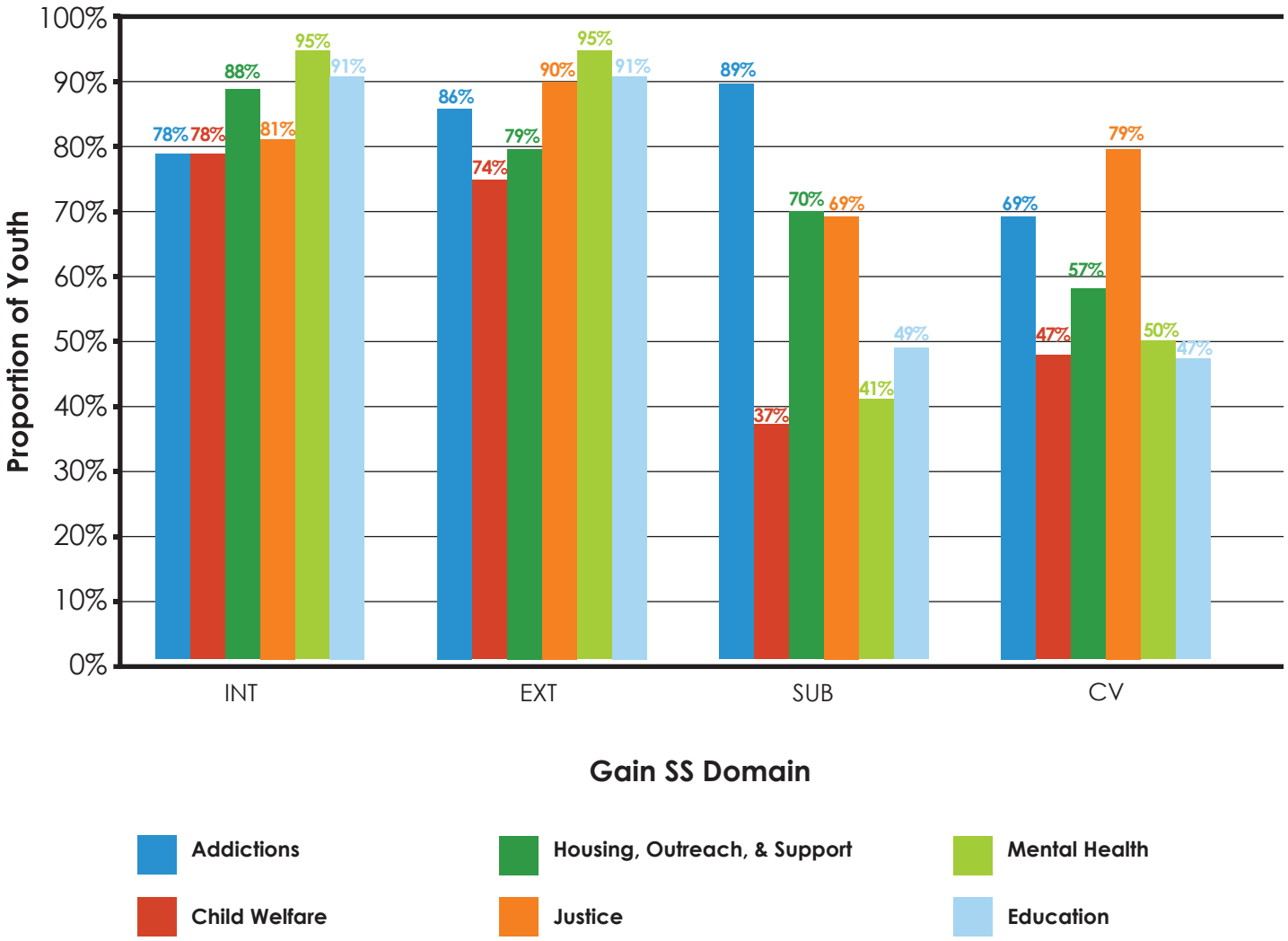


As can be seen in Figure 13, approximately two-thirds of participating youth endorsed 3 or more recent internalizing concerns, suggesting that with a full diagnostic assessment they may meet criteria for a diagnosis in the internalizing domain (e.g. mood disorder, anxiety disorder, etc.). Similarly, in the externalizing domain, more than 50% of youth endorsed 3 or more recent concerns. In the problematic substance use domain, one-third of youth endorsed 3 or more recent concerns.

Endorsement of 3 or more concerns on the crime and violence subscreener was less common, but nevertheless, 13% of participating youth reported 3 or more recent indications of crime and violence problems. Most youth (91%) endorsed 3 or more recent concerns across the 4 domains and would be highly likely to meet criteria for a diagnosis with a full diagnostic assessment.

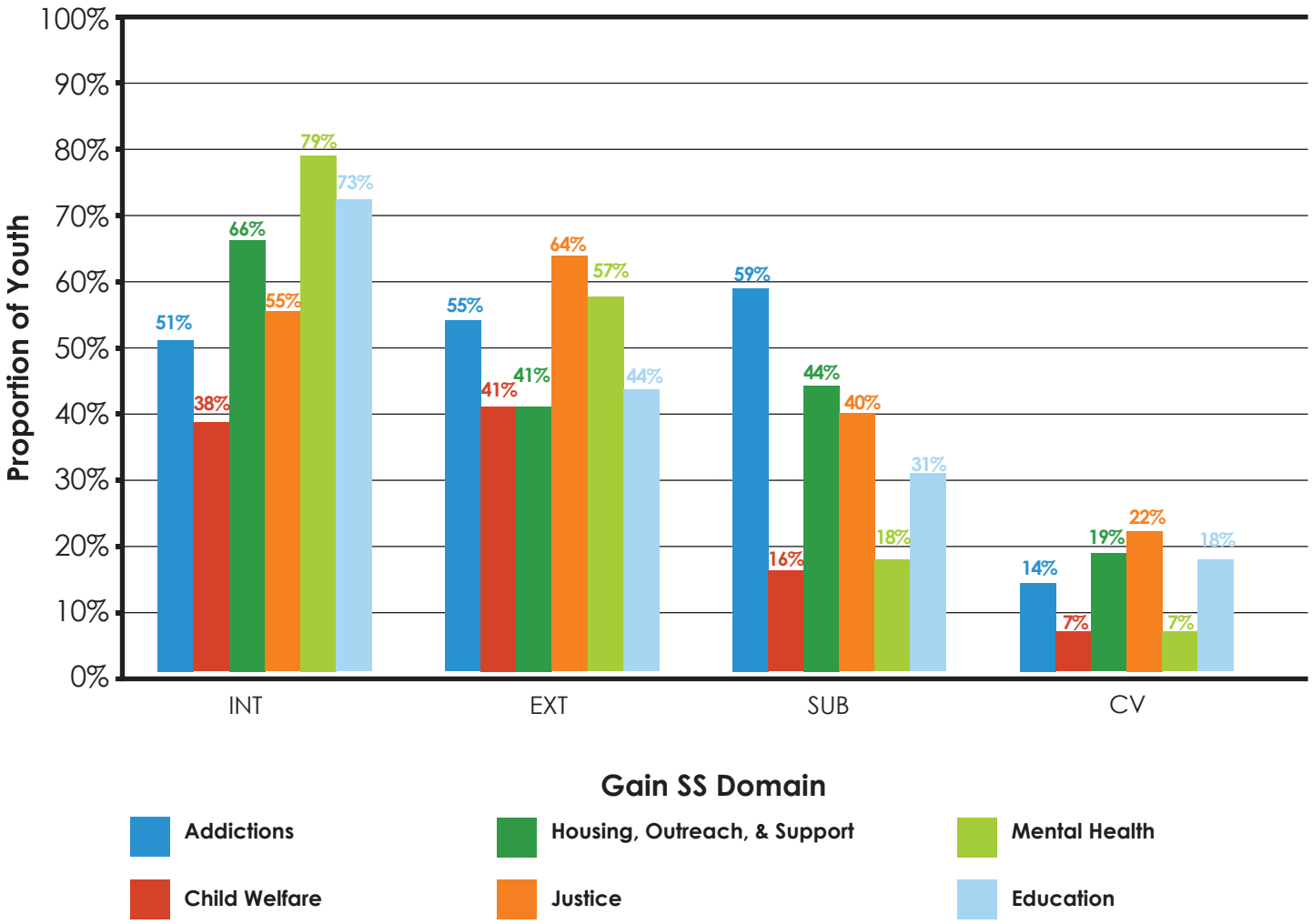
How do the needs of youth differ across sectors?

Figure 14 : Clinical Needs using Moderate Threshold (1+ Endorsements) by Service Sector



In Figure 14, the needs of youth by service sector are presented. Using the threshold of 1 endorsement to identify youth who screen positive, more than three quarters of youth, regardless of sector, screened positive for internalizing concerns. Similarly, more than 70% of youth across sectors screened positive for externalizing concerns. Within the substance use and crime and violence domains, rates of endorsement ranged from one-third to over three quarters (37-89%) across sectors.

Figure 15: Clinical Needs using High Threshold (3+ Endorsements) by Service Sector



Using a threshold of three or more recent or current concerns within one domain improves the specificity (i.e. fewer false positives) of the GAIN SS screener and allows identification of youth with higher severity of needs.

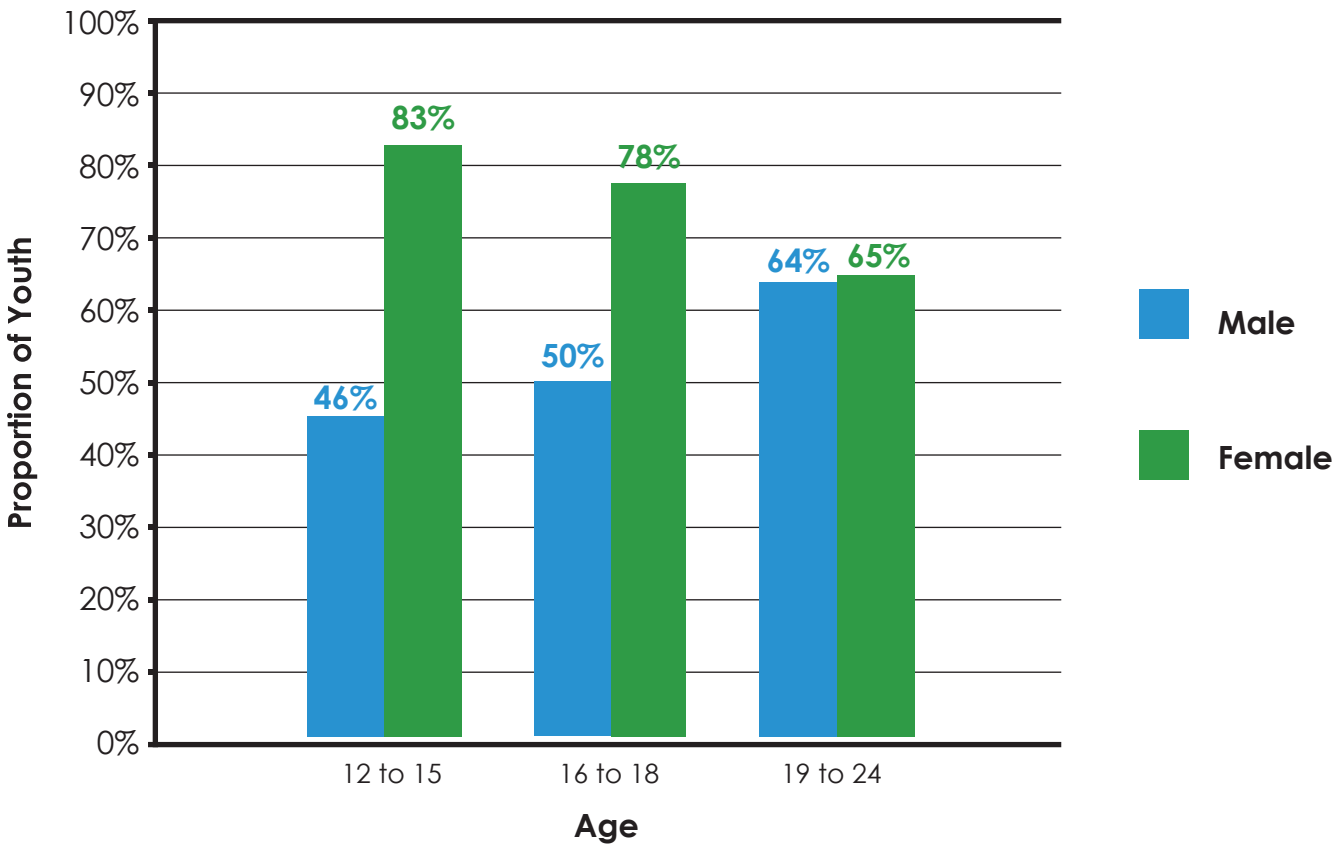
As can be seen in Figure 15, the majority of youth presenting for service to mental health and education sectors have the highest levels of internalizing concerns (79% and 73% respectively), while those presenting to the child welfare sector had lower levels of internalizing concerns (38%). Within the externalizing domain, the majority of youth presenting to the justice, mental health and addictions sectors reported experiencing high levels of externalizing difficulties (64% and 57% respectively), while youth from the child welfare and housing, outreach and support sectors reported lower levels of externalizing difficulties (41% each).

In the substance use domain, youth in the addictions sector had the highest rates of endorsement of problematic substance use with almost 60% of participating youth indicating that they had experienced 3 or more symptoms of problematic substance use in the past year. In addition, approximately 40% of youth presenting for service to the housing, outreach and support sector and the justice sector indicated experiencing 3 or more symptoms of problematic substance use in the past year. Youth from the child welfare (16%) and mental health (18%) sectors reported the lowest endorsement rates of problematic substance use.

In the area of crime and violence, rates of endorsement were substantially lower than other domains. Youth from the justice sector reported the highest rate of crime and violence endorsement (22%) while youth from the child welfare and the mental health sectors reported the lowest rate of endorsement (7% each).

Who endorsed <u>internalizing</u> mental health concerns (e.g., depression, anxiety)?

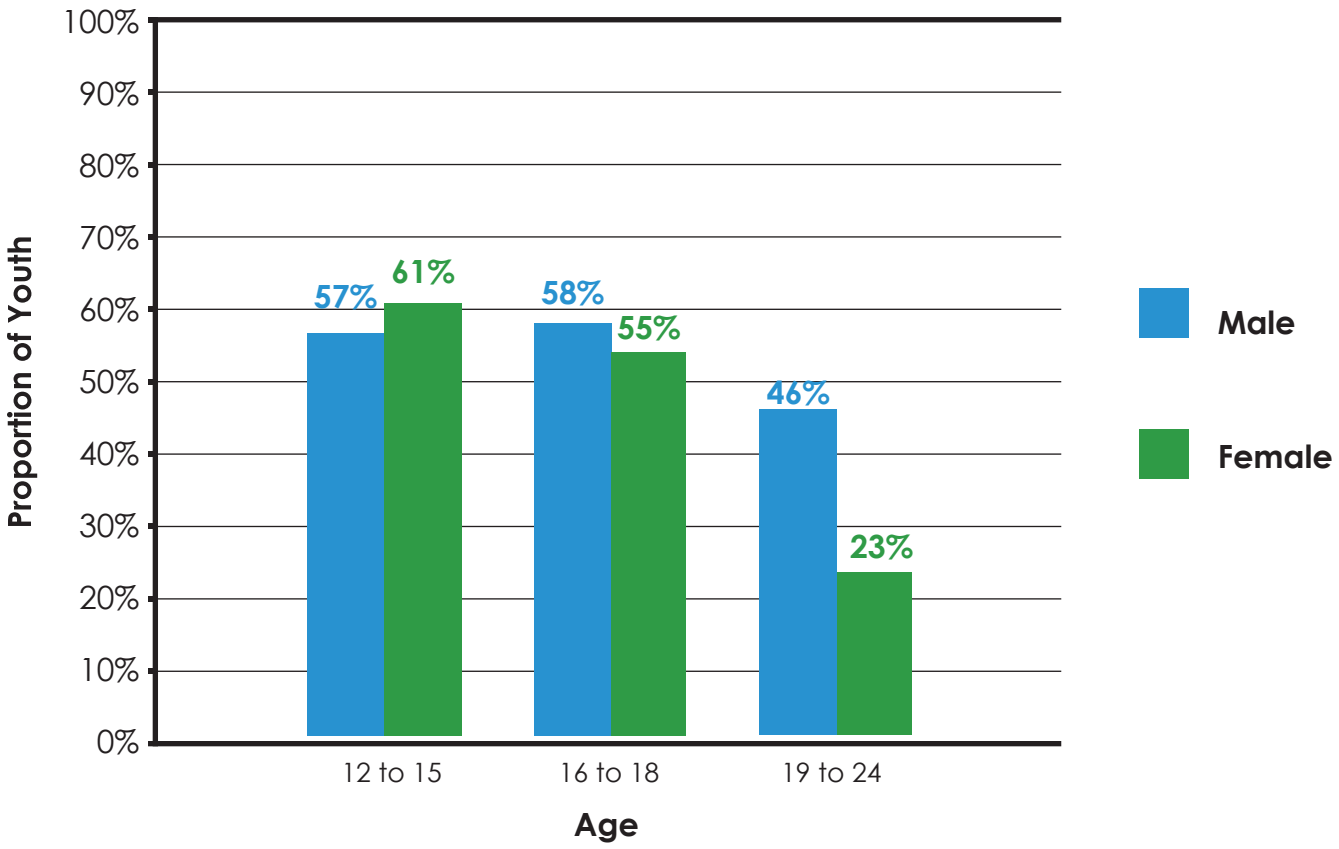
Figure 16: Internalizing Concerns by Age and Sex Categories



Female youth overall (77%) were significantly more likely to screen positive for internalizing concerns than male youth (52%) (not shown). Male youth 18 years and younger were less likely than female youth 18 years and younger to endorse internalizing concerns. In the oldest age category, however, male youth were just as likely as female youth to endorse internalizing concerns.

Who endorsed externalizing mental health concerns (e.g., impulsivity)?

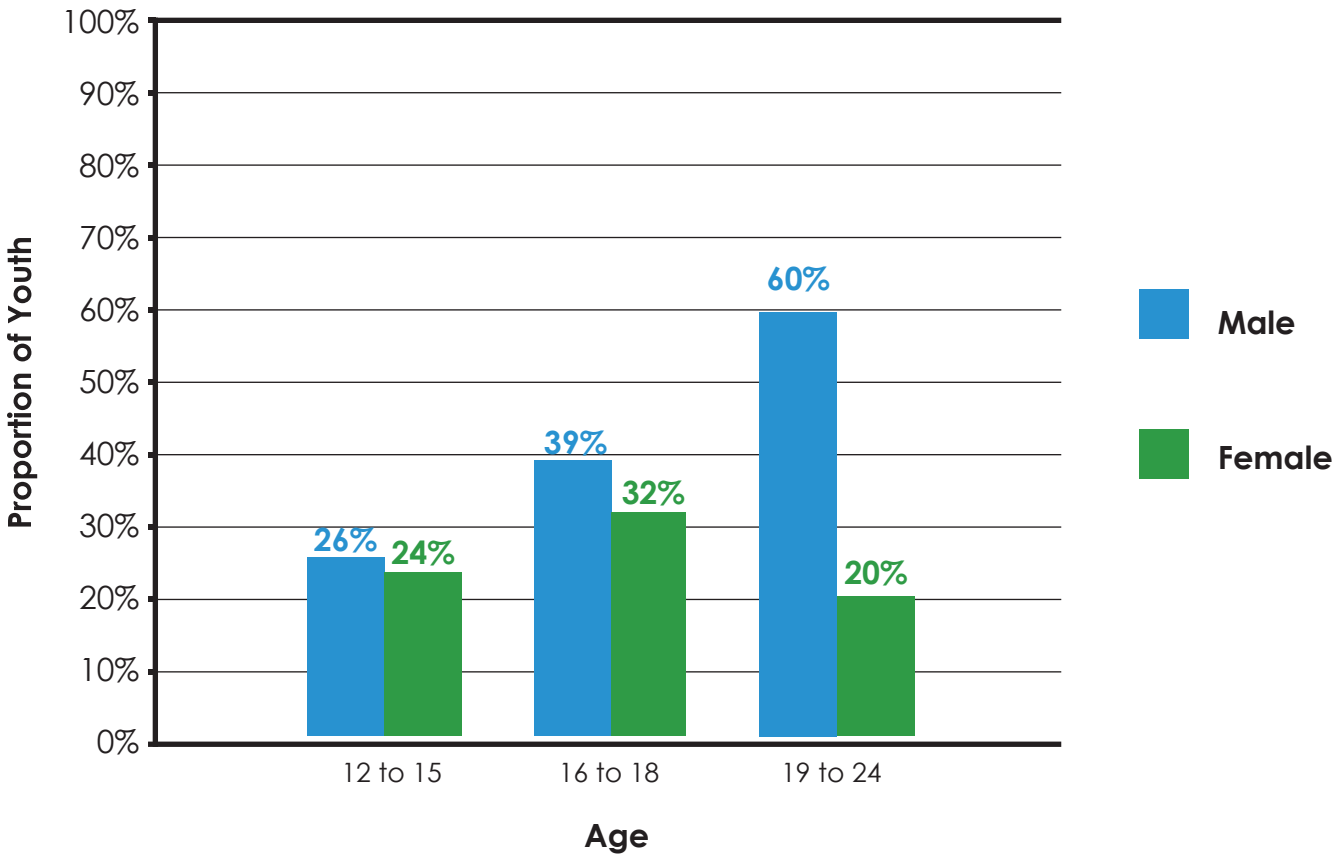
Figure 17: Externalizing Concerns by Age and Sex Categories



As shown in Figure 17, female youth aged 19-24 were less likely to endorse externalizing concerns than same aged male youth. At younger ages, however, male and female youth did not differ in their rates of screening positive for externalizing problems. For both male and female youth, older youth were less likely to endorse significant externalizing concerns.

Who endorsed problematic substance use?

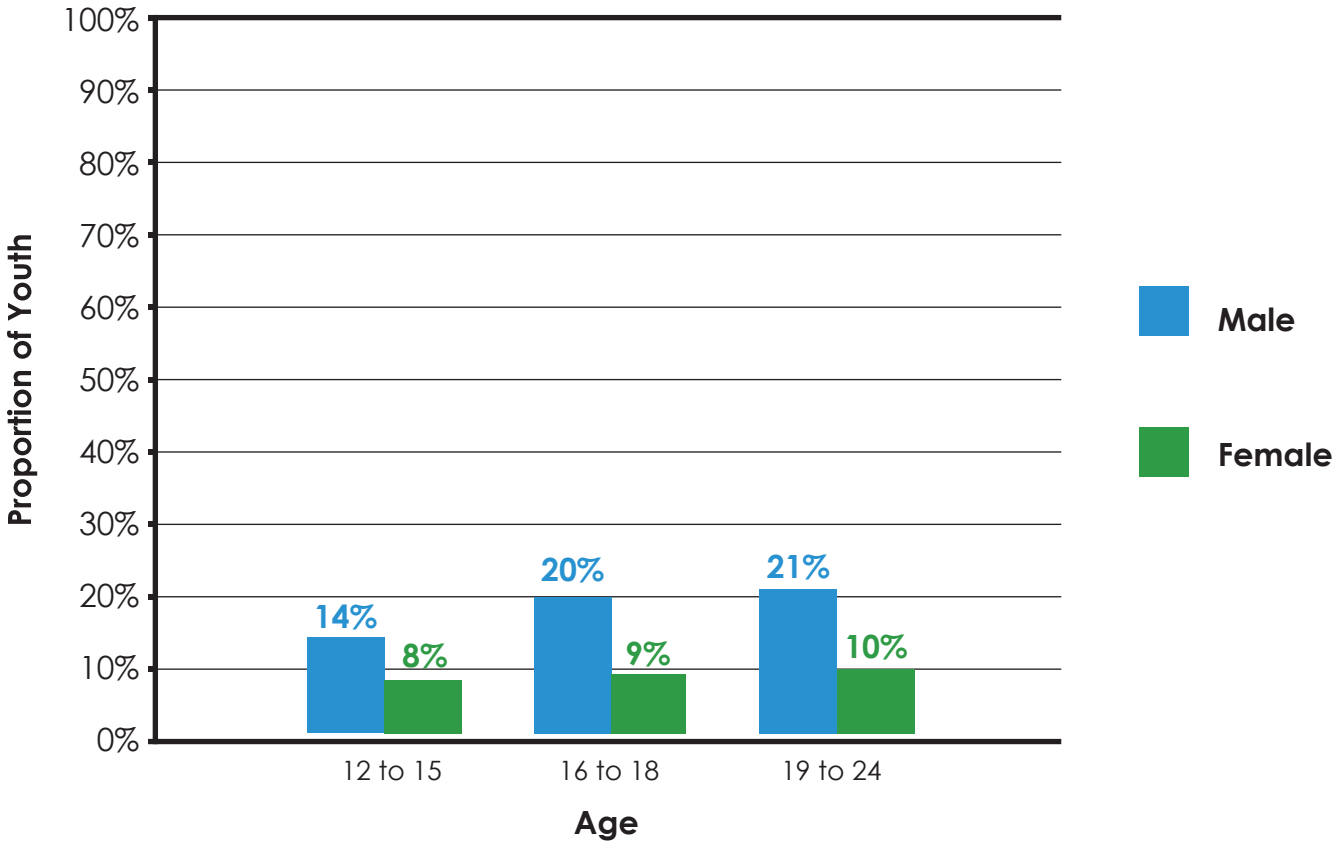
Figure 18: Substance Use Concerns by Age and Sex Categories



Male youth (41%) reported significantly higher level of serious problematic substance use than female youth (27%) (not shown) across age groups. This difference is particularly evident for male youth in the older age category (19 to 24).

Who endorsed difficulties with crime and violence?

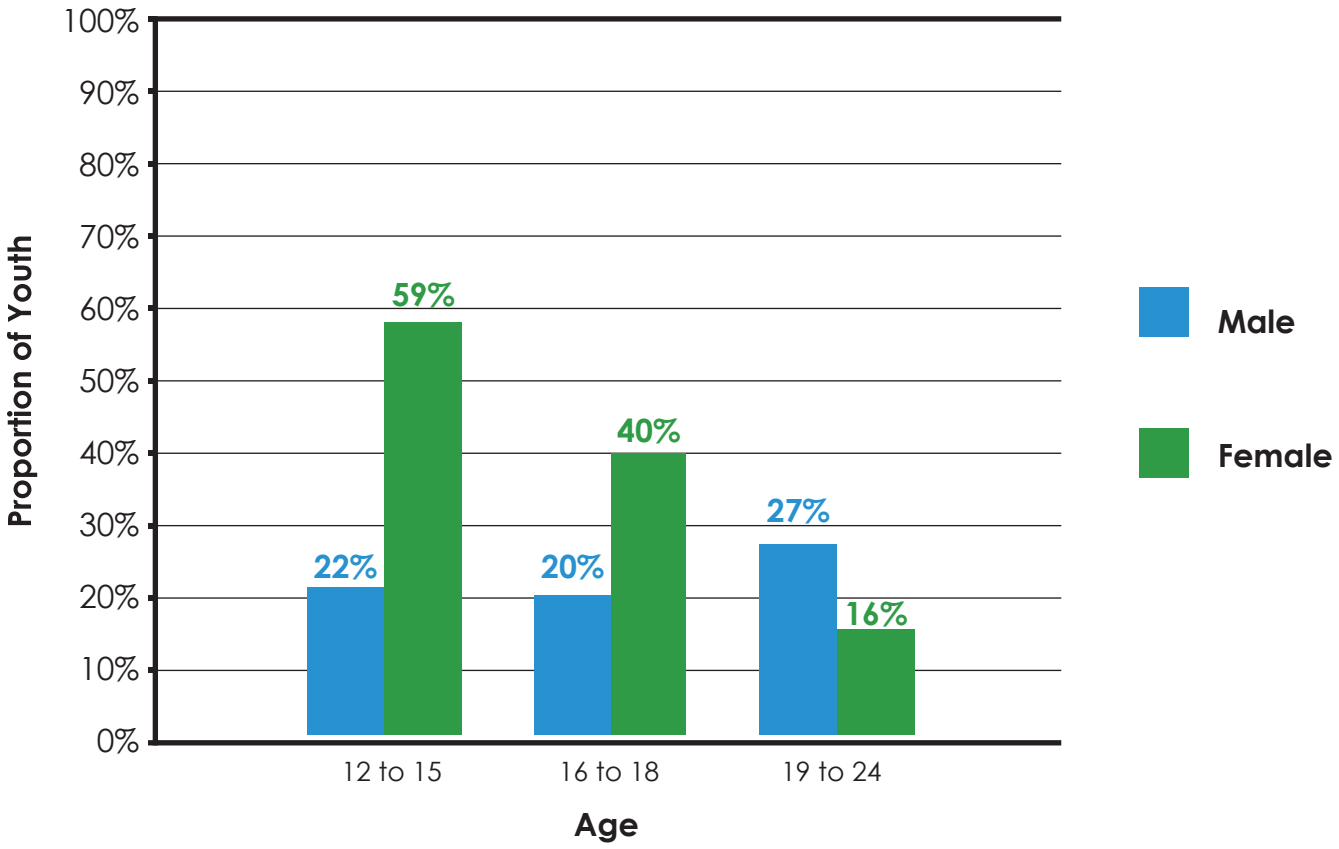
Figure 19: Crime and Violence Concerns by Age and Sex Categories



Crime and violence problems were significantly more likely to be endorsed by male youth (18%) than female youth (9%; not shown), particularly in the two older age groups. Rates of endorsement did not differ significant by age for male and female youth.

How many youth endorsed suicide-related concerns?

Figure 20: Suicide Concerns by Age and Sex Categories



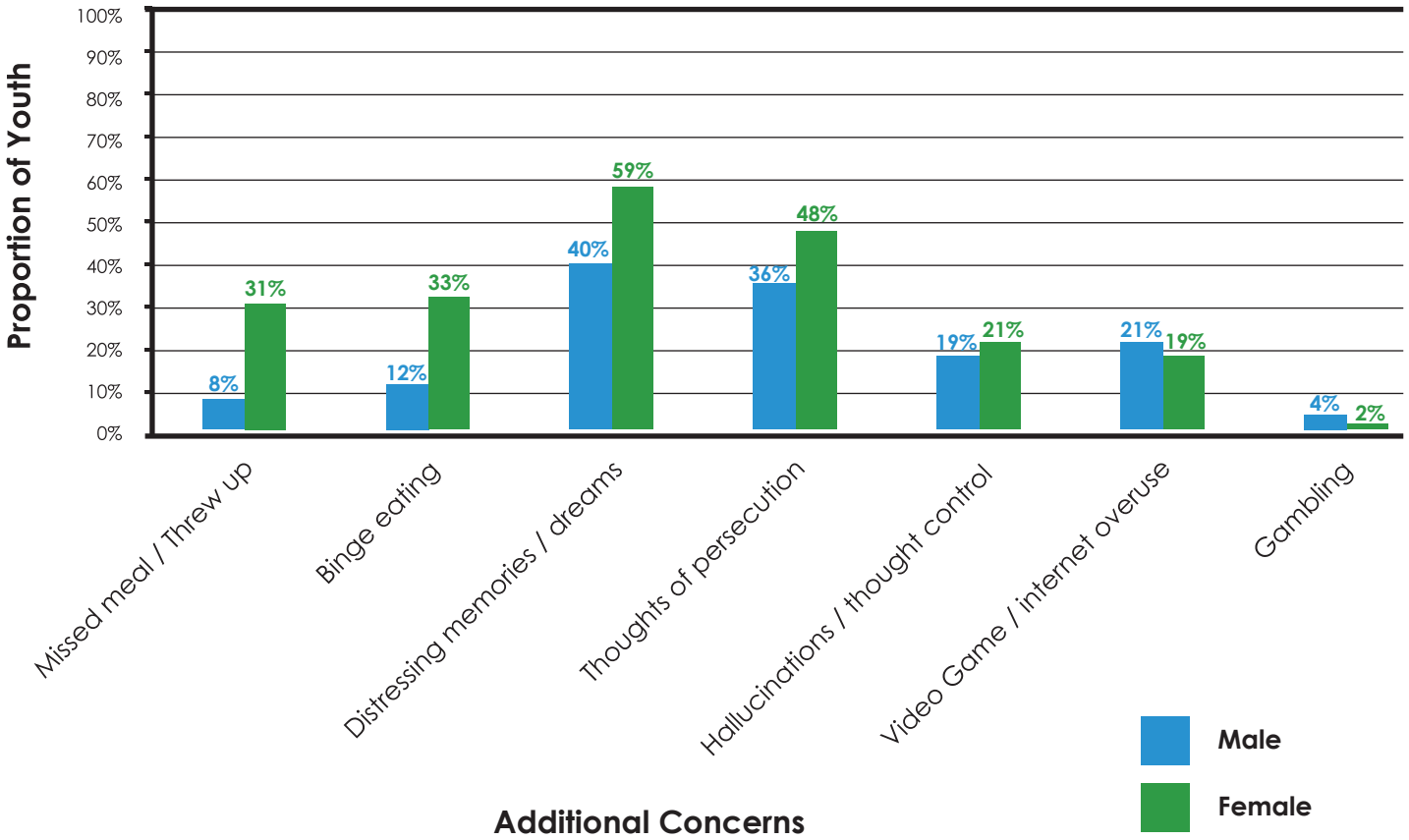
Given the clinical importance of suicide-related concerns, the single item related to suicide-related thinking and behavior from the internalizing subscreener was examined. Overall, close to half (46%) of the participating youth indicated suicide-related concerns at some point in their lifetime (not shown): 14% indicated that they had thought about suicide in the past month, 17% reported having thought about suicide in the past 2 to 12 months and 15% reported suicide-related concerns more than 12 months ago. Fifty-two percent of youth indicated they had never thought about suicide.

When we examined rates of endorsement by sex it was revealed that female participants (41%) were more likely to report suicide-related concerns in the past year than male participants (23%; not shown) particularly in the younger age categories. Of significant concern is the finding that almost 3 out of every 5 female youth aged 12 to 15 reported suicide–related concerns in the past year.

How many youth endorsed additional areas of concern, like trauma-related distress?

As part of the process of meeting the needs of stakeholders, and with the permission of Chestnut Health Systems, the copyright holders of the GAIN SS, we added 7 items to the end of the GAIN SS. The items that were added were not part of the original GAIN SS nor the validation study (Dennis et al., 2006), and as a result their reliability, validity, and utility are unknown. Nevertheless, it was identified by stakeholders that it would be important to ask about other areas of concern expected to be important for youth so that these areas could be explored further if youth indicated any concerns. The items were from the areas of eating concerns (2 items), traumatic stress (1 item), disordered thinking concerns (2 items), gambling concerns (1 item) and gaming/internet concerns (1 item).

Figure 21: Additional Concerns by Sex Categories



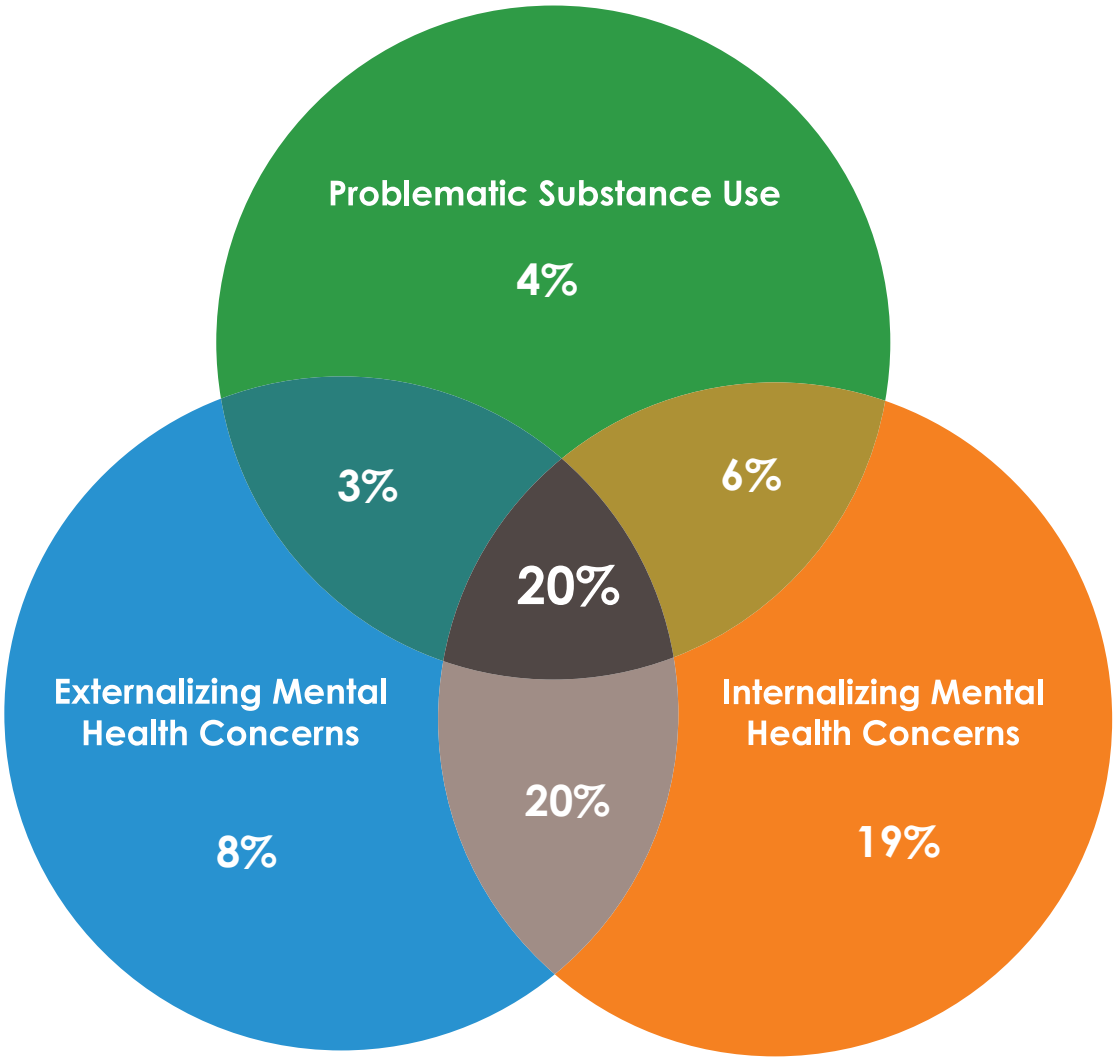
As can be seen in Figure 21, the most commonly endorsed concern for both male and female youth was experiencing distressing memories/dreams, a potential sign of trauma-related distress. Thinking-related concerns, such as thoughts of persecution were endorsed by many youth: close to half of female youth and over one-third of male youth. Female youth were significantly more likely to report distressing memories and thoughts of persecution than male youth. Female youth were also more likely to endorse eating related concerns than male youth, with approximately one-third of female youth reporting missed meals or binge eating. Approximately 20% of both female and male youth endorsed internet overuse but few youth endorsed concerns about gambling.

Concurrent Substance Use and Mental Health Concerns

This project used the GAIN SS to identify youth who are likely to have concurrent disorders (i.e., co-occurring substance use and mental health concerns). Youth who endorsed at least three recent concerns in the substance use domain as well as at least three recent concerns in either the internalizing or externalizing domain were identified as endorsing a concurrent disorder.

How many youth endorsed both substance use and mental health concerns?

Figure 22: Concurrent Disorders



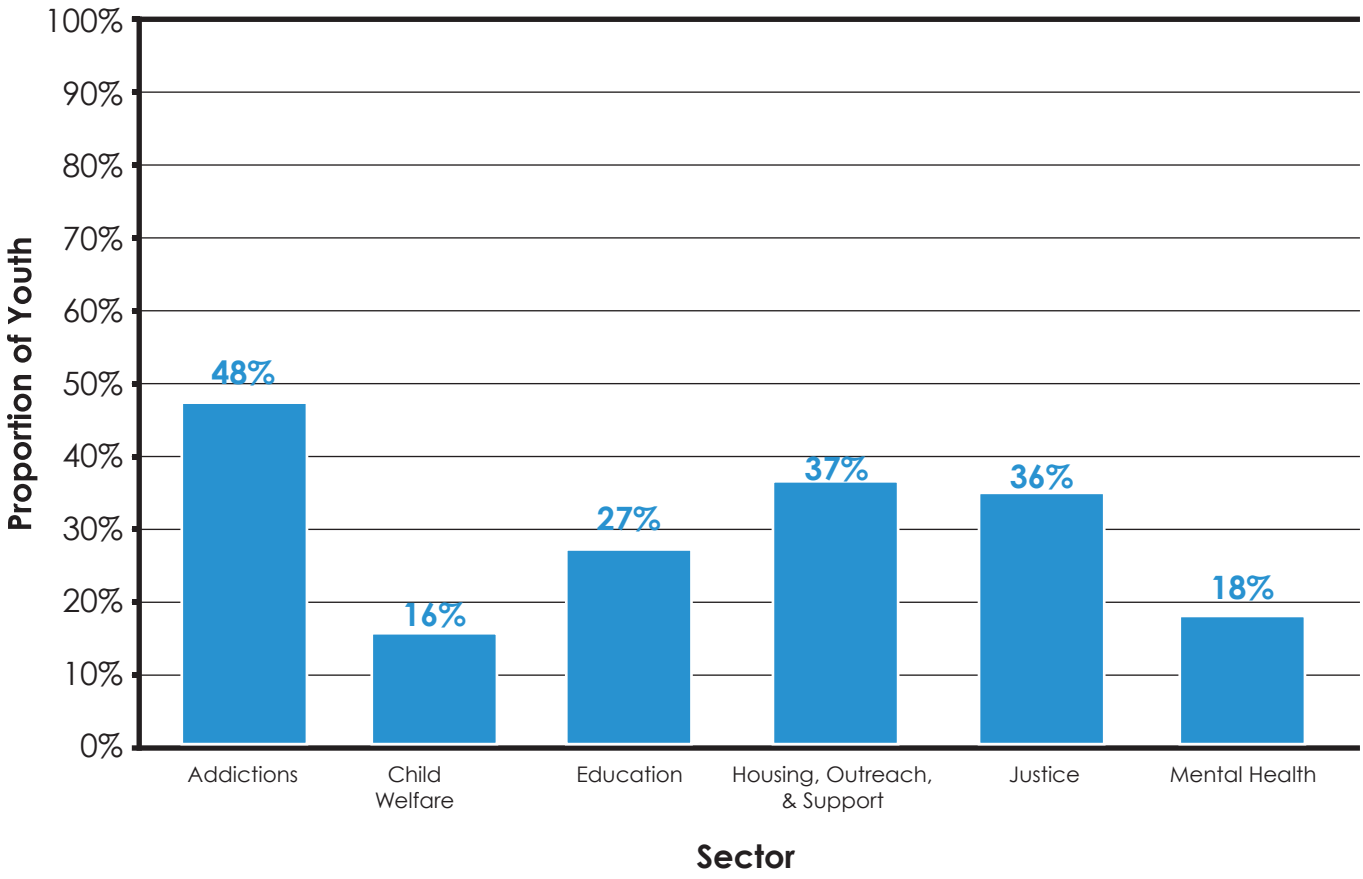
19% did not screen positive for internalizing or externalizing mental health concerns, nor problematic substance use

Overall, 49% of youth screened positive for more than one area of concern, and 29% of participating youth screened positive for possible concurrent (substance and mental health) disorders.

As can be seen in Figure 22, 20% of all participating youth screened positive for co-occurring internalizing, externalizing and substance use concerns, 6% endorsed concurrent internalizing and substance use concerns only, and 3% endorsed concurrent externalizing and substance use concerns only. When we examined just those youth who screened positive for concurrent disorders, we found that 89% screened positive for internalizing concerns and problematic substance use, 81% screened positive for externalizing concerns and problematic substance use, and 70% screened positive for both internalizing and externalizing concerns, as well as significant substance use concerns.

How did the rates of Concurrent Disorder endorsement compare across service sectors?

Figure 23: Concurrent Disorders by Service Sector

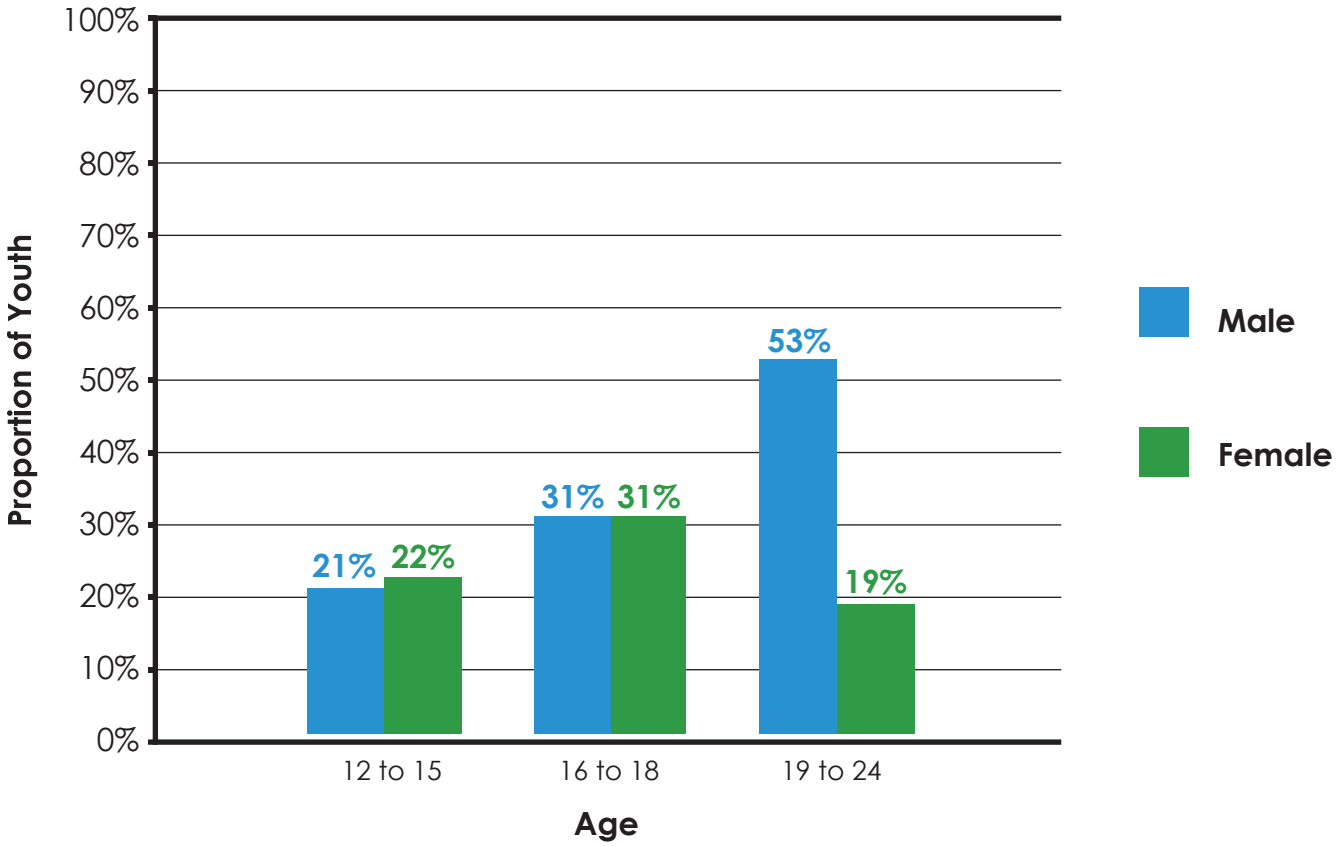


Endorsement of concurrent disorders varied across sectors. Youth from the addictions sector were more likely to endorse concurrent disorders than youth presenting to other service sectors, with almost half reporting both mental health and substance use concerns. The lowest rates of concurrent disorders were found in youth presenting to the child welfare sector (16%).

Who was more likely to endorse Concurrent Disorders?

Did rates of Concurrent Disorders differ for male and female youth or for younger and older youth?

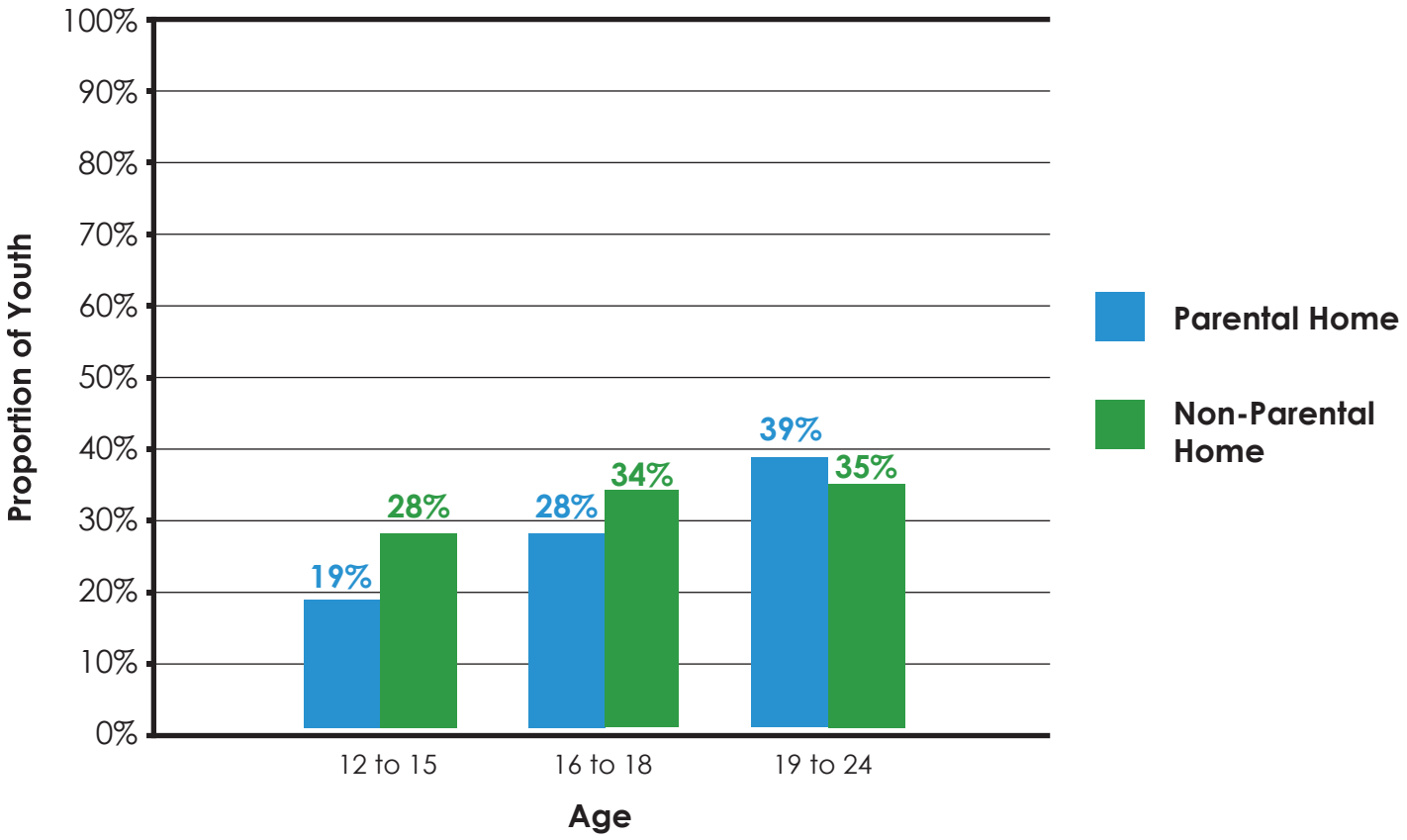
Figure 24: Concurrent Disorders by Age and Sex Categories



When examining male and female youth by age groups, male youth aged 19-24 were more likely to screen positive for concurrent disorders than same age female youth. Additionally, older youth were more likely to endorse concurrent disorders than younger youth.

Did rates of Concurrent Disorders differ for youth with different living arrangements?

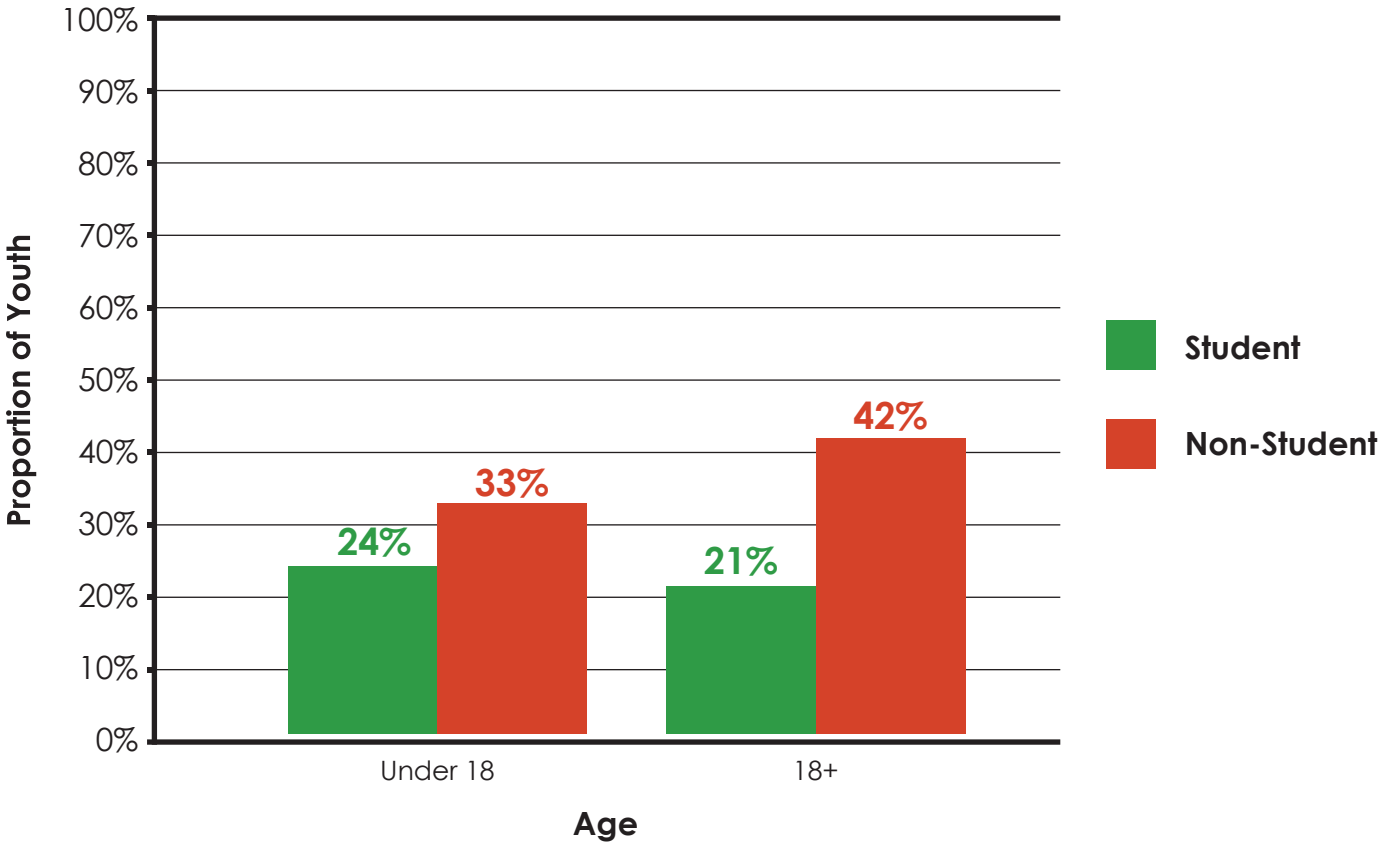
Figure 25: Concurrent Disorders by Age and Housing Categories



For the purposes of these analyses living arrangements were reduced to two categories:
1) parental/family home and 2) living outside of the parental/family home. Across age groups, rates of concurrent disorders did not differ between youth who live in the parental/family home and those who do not.

Are students more or less likely to endorse Concurrent Disorders?

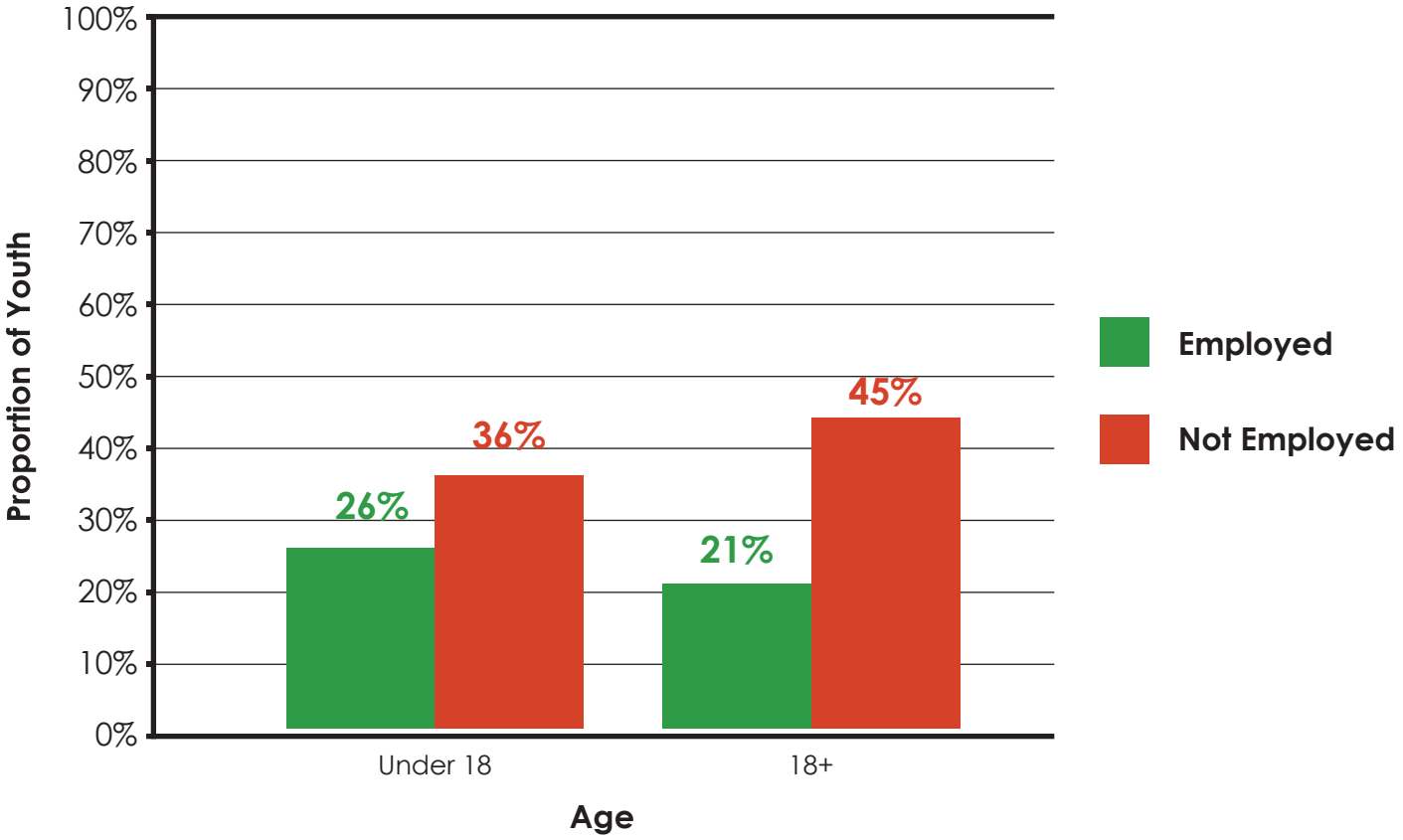
Figure 26: Concurrent Disorders by Education Status and Age



When we compared youth who identified as students to those who did not, it was revealed that youth who identified as students were significantly less likely to endorse concurrent disorder than non-students (24% vs. 38% respectively; not shown). This is true for youth under 18 as well as over 18 years of age.

Do rates of Concurrent Disorders differ by employment situation?

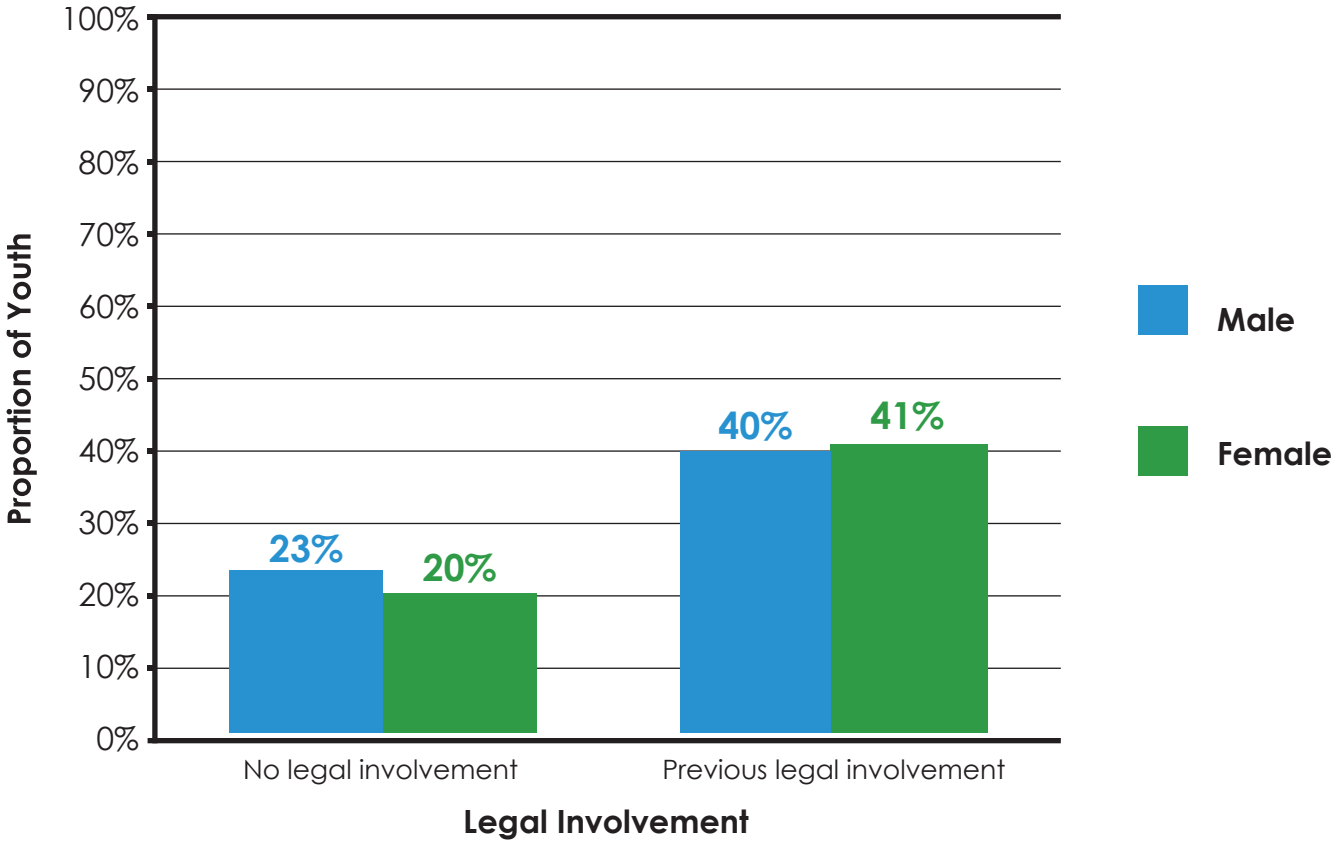
Figure 27: Concurrent Disorders by Employment Status and Age



When we compared youth who reported being employed to those who were not employed, it was revealed that employed youth were less likely than unemployed youth to endorse concurrent substance use and mental health concerns (24% vs. 41% respectively; not shown). Youth over the age of 18 who were not employed in particular were more likely to screen positive for concurrent disorders than same age youth who identified as employed.

Are youth who have had legal involvement more or less likely to endorse Concurrent Disorders?

Figure 28: Concurrent Disorders by Legal System Involvement and Sex



For the purposes of the following analyses, legal involvement was reduced to two categories: 1) no legal involvement and 2) previous legal involvement. Youth who reported legal involvement were significantly more likely to endorse concurrent disorders (41%) than youth who reported no previous involvement with the legal system (21%; not shown). There was no difference in rates of concurrent disorder endorsement between male and female youth across the legal involvement categories.

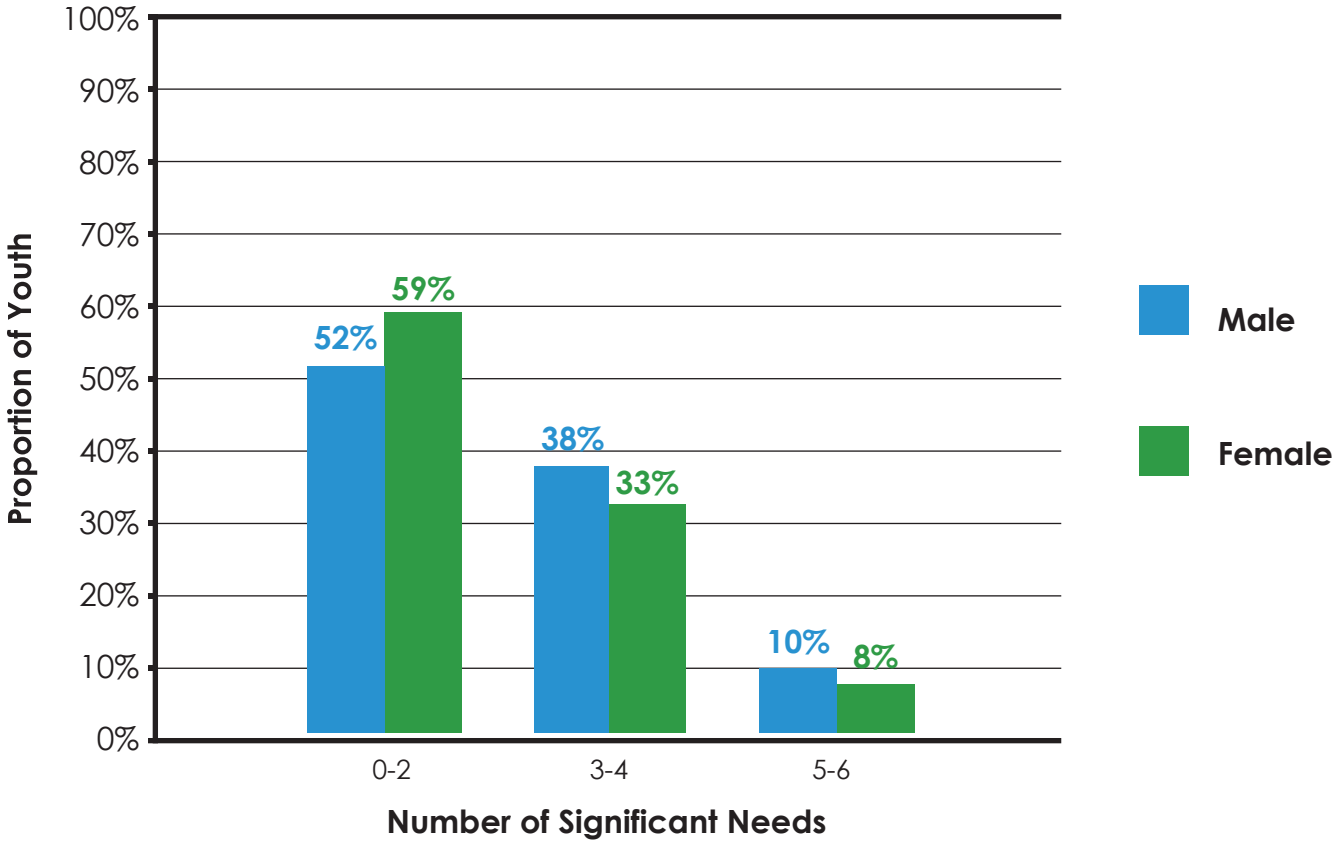
Which factors are most important in understanding the Concurrent Disorder needs of youth presenting for service in participating communities across Ontario?

Given that a number of interrelated factors (e.g., age and service sector) could be related to endorsing both problematic substance use and mental health concerns, we examined these factors together in one model to understand which factor(s) are most important in understanding who screens positive for concurrent disorders. The factors included in this analysis were age, sex, service sector, living arrangements, legal involvement, and vocational risk. Youth were deemed as having vocational risk if they were not in school when younger than 18 or if they were out of school and not employed when aged 18 or older.

When all of these factors were considered together legal involvement and vocational risk were shown to be most important in understanding which youth are more likely to endorse both substance use and mental health concerns. More specifically, past legal involvement and being out school/work were significantly associated with higher rates of concurrent mental health and substance use concerns.

How many participants endorsed multiple areas of concern in their lives?

Figure 29: Complexity of Needs



In order to understand how many participants experience multiple areas of concern we also examined the following social determinants of health, along with mental health and substance use concerns: 1) housing ("unstable" or "supportive"), 2) education/occupation (under 18 and not a student or 18 and older and not a student and not employed), 3) legal involvement (past or current legal involvement), 4) internalizing concerns (high severity), 5) externalizing concerns (high severity), and 6) substance use problems (high severity). Notably, 44% of participants reported having 3 or more factors and 9% of participants reported experiencing 5 or more of the 6 factors (not shown). Results differed for male and female youth with male youth reporting a higher number of needs than female youth (2.57 vs 2.17; not shown). Overall, these findings highlight the complexity of the needs of the individuals who are presenting for service and participated in this project.

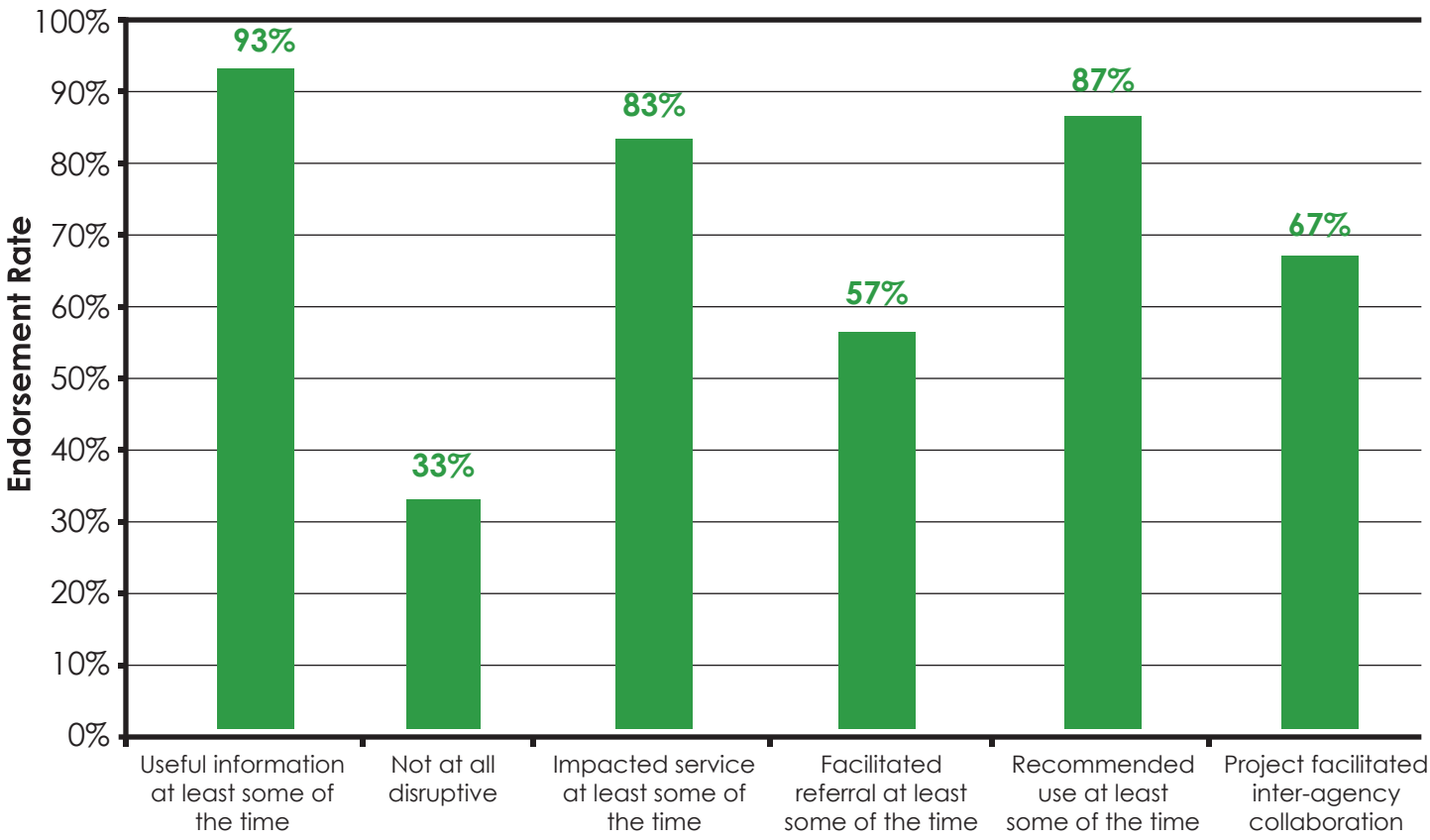
Findings:
Service Provider Perspectives

Service Provider Perspectives

This project included a survey about service providers' attitudes, knowledge, and practices regarding youth substance use, mental health, and concurrent disorders. Questions about interagency collaboration and interagency referral practices were also included in the survey. In addition, the project included a feedback survey that gathered information regarding the feasibility, utility, and impact of using the GAIN SS.

Utility and Feasibility of the GAIN SS

Figure 30: Service Provider Perceptions of GAIN SS Utility and Feasibility



The feedback survey about the feasibility and utility of the GAIN SS was completed by 75 service providers from across sectors. The majority of service providers who provided feedback reported that the GAIN SS was useful, impacted treatment decisions, and facilitated referrals. The majority of service providers also recommended using the GAIN SS despite two-thirds of participating service providers reporting a perceived disruption from its use some of the time. Over two-thirds of service providers indicated that participating in this network project had facilitated inter-agency communication or relationships at least some of the time. Service providers from the education sector had the most positive views about the GAIN SS, while service providers from the child welfare sector reported the least favourable opinions.

Notably, service providers who found the training more helpful, used the GAIN SS with a greater proportion of their clients. Those service providers who used the GAIN SS with a greater proportion of their clients were more likely to report that the GAIN SS provided useful information, impacted service delivery, and facilitated referrals than service providers who reported using the GAIN SS with a smaller proportion of their clients. In addition, those service providers who reported using the GAIN SS with a greater proportion of their youth clients were more likely to report that they would recommend use of the GAIN SS.

Service provider comments about the feasibility and utility of the GAIN SS in their practices

"The partners expressed value in using the tool with their youth population and all of the four participating agencies are committed to continue using the tool beyond the data collection period of the project."

"Really positive experience and youth did not mind being screening for things that may have been missed."

"The screener gave us a better understanding of our clients and allowed us to suggest the right options for them with respect to addictions and mental health. It was quick to complete and easy to interpret, which allowed us and our clients to receive immediate feedback. It also validated our client's concerns about themselves without being invasive."

"GAIN SS helped facilitate discussion during appointments around their needs, referral and treatment planning."

"The GAIN SS has proven to be a valuable resource for our agency. Parents and youth are given a better understanding of the underlying issues affecting their child and seek the appropriate interventions."

"Found it user friendly; would love to continue using it and learning how to analyze the information for our internal use and for clinical purposes."

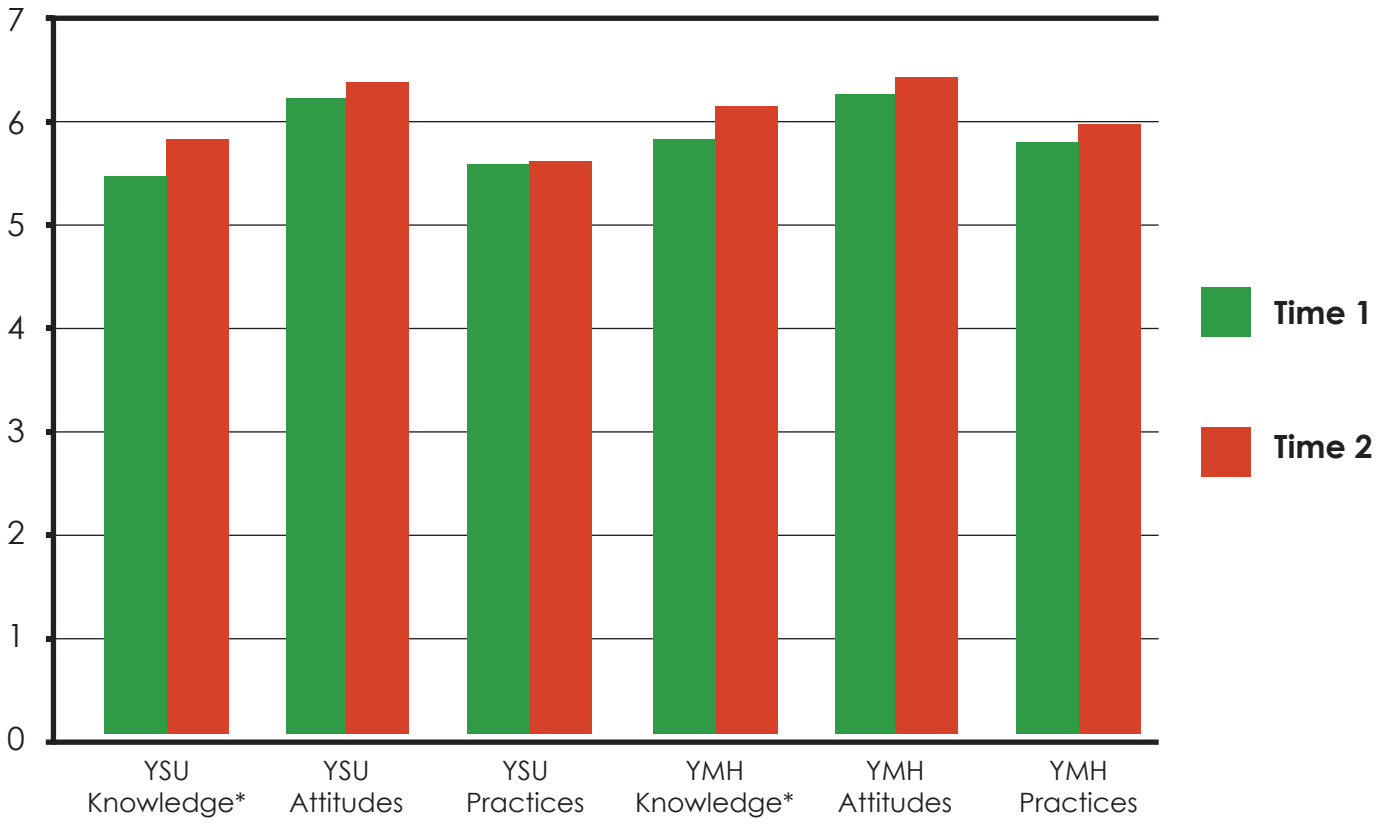
"Some staff and programs liked the idea of a quick screener, some did not. When used, it became part of the larger picture, the more fulsome assessment and plan."

"It was a quick and easy on the spot assessment for the youth involved in the program."

Service Providers' Attitudes, Knowledge and Practices

As indicated previously this project included a survey of service providers that measures the substance use, mental health, and concurrent disorders-related knowledge, attitudes and practices of service providers and their perceptions of interagency collaboration. It was administered before (Time 1) and after (Time 2) participation in the project. At the beginning of the project training, all participating service providers were invited to complete the survey and 211 service providers completed the survey. Following the data collection period, service providers who had participated in administration of the GAIN SS were invited to complete the Time 2 survey: 75 service providers completed the Time 2 survey. A subset of 40 participants completed both the Time 1 and Time 2 surveys. The mental health sector represented the largest proportion of the sample at both times. At least 70% of the sample at each time was comprised of front-line clinicians.

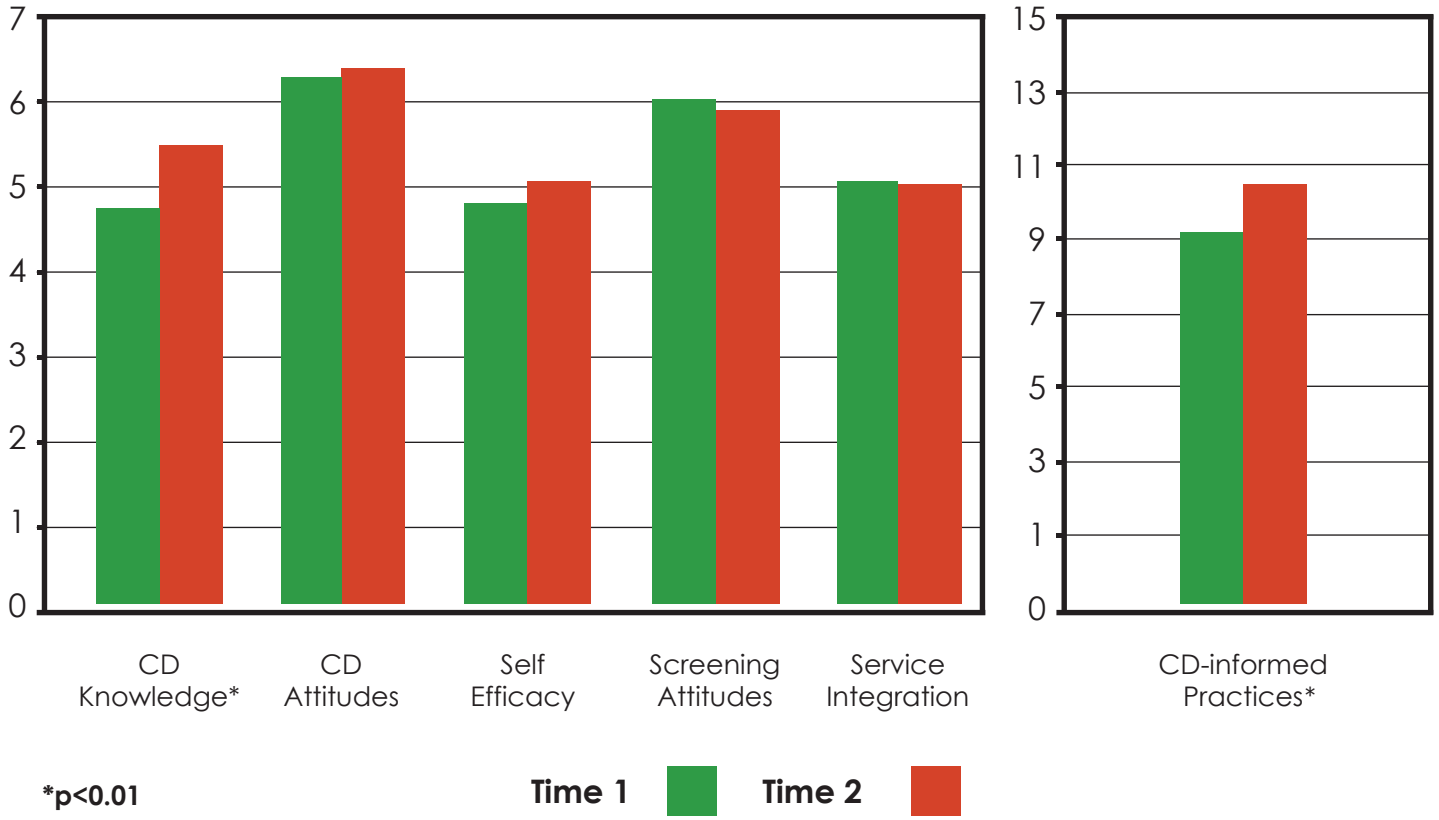
Figure 31: Knowledge, Attitudes, and Practices Regarding Youth Substance Use and Mental Health



***p<0.05, Note: Each scale score range is 1-7**

In general, at the start of the project, service providers reported positive attitudes toward addressing youth substance use and mental health concerns and high levels of relevant knowledge and practices. Nevertheless, following participation in this initiative, service providers reported significantly higher levels of knowledge regarding youth substance use and mental health issues. This was evident in comparing all time 1 and time 2 participants as well as when analyses examined only the subset of participants who completed questionnaires at both baseline and following the project (n = 40).

Figure 32: Knowledge, Attitudes, and Practices Regarding Concurrent Disorders, Screening and Service Integration



Note: The CD Practices scale range is 0-22; whereas the range for all other scales is 1-7.

Similar to findings regarding service providers' attitudes towards addressing youth substance use and mental health concerns (e.g. Figure 31), service providers' attitudes toward addressing youth concurrent disorders and screening were positive and remained so throughout the project. Knowledge about youth CD were lower at the start of the project and increased significantly with participation in the project. Similarly, participants' CD-informed practices increased significantly with participation in the project.

Sector and site differences

Looking across the service sectors (as self-reported by service providers), the strongest impact of this initiative occurred within the mental health sector, where knowledge and self-efficacy regarding concurrent disorders, as well as knowledge of youth substance use increased significantly. Service providers from the justice sector showed significantly more positive attitudes towards youth substance use and screening for concurrent disorders. Service providers from the child welfare sector reported significantly higher levels of knowledge regarding youth mental health issues. It was not possible to perform comparisons for the addiction, education, housing, outreach and support, and health services sectors due to the small number of service providers from these sectors completing the questionnaires at time 2.

Agency lead & service provider comments about knowledge, attitudes and practices and service integration

"The results of the screener helped inform the child's Plan of Care if mental health and addictions issues were identified."

"I found the tool to be a useful way to bring up subjects that might be relevant to some of the participants that I see, and in a way that seemed more conversational than intrusive: we might talk about a topic in a way that was just expanding on one of the questions rather than me asking it at another time that might make it seem random and irrelevant."

"Referral sheet was really helpful. Parents also really appreciated this and found it helpful…empowering parents to get involved in their youth's treatment and then follow-up with them."

"The GAIN-SS Project allowed us to incorporate a mental health and addictions screener into our existing process. Using a standardized screener with youth ensures that we are asking the right questions, accurately identifying needs, and connecting youth to the most appropriate services and supports in the community."

"Using the GAIN-SS caused one program to ask more in-depth questions than usual during the assessment phase of the program. This resulted in increased knowledge by the staff of the resources available and how to connect youth with those resources."

"[The GAIN SS] helped to open up communication and facilitate the referral process…It made it much easier for youth to open up."

Summary of Findings, Discussion and Recommendations

Summary of Findings

Demographics

- Youth presenting for services to addictions, child welfare, education, housing, outreach and support, justice, mental health and health services sectors contributed information to this report.
- Youth from across the age range participated, with youth presenting for service to outreach, housing and support sector being more likely to be in the older age category than youth presenting to other sectors and youth presenting to the mental health and education sectors being more likely to be in the youngest age category than youth presenting to other sectors. Similar numbers of male and female youth participated overall, with more female youth participants presenting to the mental health and education sectors, and more male youth participating from the justice and addictions sectors.

- White/European (70%) and Aboriginal (14%) were the most commonly endorsed ethnicities amongst participants. Most youth reported being born in Canada and having English as their first language.

- More than half of participating youth (55%) reported that they were living in the parental/family home at the time of participation. Seventeen percent of youth reported living on their own or with friends, with female youth being more likely than male youth to report this living arrangement. Notably, 10% of youth reported being in unstable housing situations, with male youth being more likely to report this housing situation than female youth.

- Forty percent of participating youth indicated that they had experienced legal involvement.

Youth Needs

- Substantial proportions of youth, regardless of sector, are experiencing significant internalizing mental health concerns. Rates range from 38% in the child welfare sector to 79% in the mental health sector. Notably, 73% of youth who presented for service within the education system screened positive for significant internalizing difficulties. Moreover, 83% of girls aged 12 to 15 years across sectors screened positive for internalizing mental health problems.

- Close to half of youth (46%) indicated lifetime suicide-related concerns, 31% in the past year, including 14% in the past month. Rates were particularly high among younger female youth, with almost 60% of girls aged 12 to 15 years reporting suicide-related thinking.

- Youth presenting to all participating sectors are experiencing significant externalizing mental health concerns, with the highest rates in the justice sector (64%), followed by mental health (57%). Within the child welfare and the housing, outreach & support sectors almost half of youth (41%) indicated significant externalizing difficulties.

- Serious problematic substance use is a significant problem for a substantial proportion of the youth who participated across sectors and within sectors, rates ranged from 16% of youth presenting for service to the child welfare sector to 59% for youth presenting for service to addictions services.

- Almost half of participating youth (49%) screened positive for more than one disorder across problematic substance use, internalizing disorders and externalizing disorders and 20% of participating youth screened positive for all three disorders.

- Twenty-nine percent of youth screened positive for co-occurring substance and at least one mental health disorder across sectors, with the highest rates of concurrent disorders among youth from the addiction sector (48%), followed by youth from the housing, outreach and support sector (37%), and youth from the justice sector (36%). Rates of screening positive for concurrent disorders were longer among youth presenting for service to the child welfare (16%), mental health (18%) and education (27%) sectors.

- The concerns and needs of male and female youth differed significantly in a number of domains. For example, young female youth (18 years or younger) were significantly more likely to screen positive for internalizing concerns than young male youth, although in the oldest age category rates of serious internalizing concerns for male and female youth did not differ significantly. For externalizing mental health problems the findings were reverse. Male youth over 18 years old were significantly more likely to report serious externalizing mental health concerns than same-aged female youth, but rates of externalizing problems did not differ for male and female youth 18 years or younger. Across age categories, male youth were significantly more likely to report serious problematic substance use and crime and violence problems.

- Male youth aged 19 to 24 had the highest rate of concurrent substance use and mental health problems (53%), although notably approximately 1 in 5 boys and girls aged 12 to 15 years also screened positive. When the characteristics of youth who screened positive for concurrent disorders were examined, it was found that youth with previous legal involvement and youth who were not in school/employed were more likely to screen positive for co-occurring substance use and mental health problems than other youth.

- Half of youth (50%) indicated trauma-related distress, with rates significantly higher among participating female youth (59%) than participating male youth (40%). Female youth were also more likely than male youth to indicate eating related problems.

Service Provider Survey

- Most service providers reported that they found the GAIN SS provided useful information, impacted treatment decisions, facilitated referrals and recommended using the GAIN SS. Over two-thirds of service providers indicated that participating in this network project had facilitated inter-agency communication or relationships at least some of the time.

- Service providers reported significantly higher levels of knowledge regarding youth substance use and mental health issues following participation in this initiative.

- Service providers reported significantly higher levels of knowledge about youth concurrent disorders and CD-informed practices following participation in the project.

Discussion

Youth Needs

This project aimed to gather evidence about the substance use and mental health needs of youth aged 12 to 24 years presenting for service to cross-sectoral youth-serving agencies in participating communities across Ontario. Data about the needs of 1073 youth from 6 communities were examined for this report. Based on information provided by service providers, this sample of youth represents the majority of youth seen at participating services during the project timeframe. Nevertheless, caution should be exercised in generalizing findings to youth who did not participate, as their needs may differ in unknown ways.

The findings of this project suggest that many youth presenting for service, regardless of sector, are experiencing significant substance use and/or mental health problems. Moreover, approximately half of participating youth indicated significant problems in more than one domain, and close to one-third of youth screened positive for co-occurring substance and mental health concerns. These findings suggest that recent efforts to improve capacity to address co-occurring substance use and mental health problems are warranted.

The findings of this report also provide support for the need for gender-sensitive approaches with youth given that the concerns and needs of male and female youth differed. In addition, the needs of younger and older youth differed and support the need for developmentally-informed approaches.

Notably almost half of all youth participants, and in particular, almost 60 percent of girls aged 12 to 15 years indicated having thought about suicide in their lifetime. These rates highlight the need for suicide-related services, including early identification of concerns and high intensity mental health services.

Project and Implementation Processes

As described in this report, there were several essential steps required to initiate, carry out and complete this project. Providing information about the project and potential for participation through existing cross-sectoral provincial and community-based youth networks and other stakeholders was an essential first step to identifying communities and local agencies to form community-based youth screening networks. In Ontario, the unique role of the CAMH Provincial System Support Program, provided the opportunity to have regional CAMH staff, familiar with the communities, often with pre-existing relationships, perform the role of local network coordinators. The network coordinators provided the essential link between the community-based agencies and the project team and their initiative was integral to the network development phase in each community. This included coordinating meetings with interested stakeholders to provide information and confirm project participation, prior to the initiation of the project and supporting agencies through challenging administrative hurdles, particularly related to completing the required agreements and securing required research ethics approval(s). Ultimately the sustained hard work of the network coordinators, with the support of the project leads, resulted in project participation, adherence to the project protocol and completion of the project. Most of the communities exceeded their initial agreement to enlist partners representing two service sectors; enlisting up to five. In almost all participating communities, every agency participated in all project activities.

The training curriculum material for the training/capacity building activities was developed for the *National Youth Screening Project* in January 2011 (Pilot version) and modified based on participant feedback in February 2011 (Final version). Integral to the curriculum building process was an effort to ensure that the materials provided were relevant and accessible to the service providers who would be attending the training. Prior to each training the curriculum was reviewed to explore the need for any modifications and/or relevant updates.

Providing more than one capacity building event, including teleconference or webinar training options for those who could not attend the "live" events, provided greater opportunity for all agency staff to receive training directly from

the project leads. This helped to ensure that all aspects of the protocol were clearly and consistently communicated. Many agencies decided to send staff who would participate in the full project as well as staff who might use the screening tool with populations that were not part of this project (e.g., adults older than 24 years), as well as staff who would not be administering the screener, given their role in the agency, but might receive youth who had been screened. As such, the capacity building component of the project had a broader reach than initially anticipated.

The network coordinators facilitated regular network meetings with the agency leads, with the project leads in attendance as required to maintain engagement and to provide on-going support and problem-solving. These meetings provided excellent opportunities for the agency leads to share their experiences and learn from their project colleagues in their communities.

The project team regularly provided updates and information to local, provincial and national youth networks and committees, and has presented information about the OYSP at conferences (see Appendix H) to continue to build capacity in the area of youth substance use and concurrent disorders and ensure that the findings from this project are widely disseminated. As such, information about the OYSP has been shared with a diverse group of stakeholders including service providers, agency leaders, policy makers and researchers.

The local project reports were developed collaboratively. The project team presented preliminary findings to each community network via teleconference and webinar to engage in a joint process for analysis of the data and related recommendations. A draft of each local report was sent to the network coordinators for review with their network, including agency leads, service providers and other important stakeholders in the communities. Final feedback was incorporated, and the final local reports have been shared with the communities.

Staff concerns about potential challenges in engaging youth in screening and research processes are a common barrier to engaging service providers and community-based agencies in projects such as this one. The findings from this project across communities indicate that most youth who completed the screener, also agreed to participate in the research component of the project. For one community in which the school boards participated, school board policy stipulating that the research team could not access youth screeners without parental consent limited the amount of youth screeners that could be sent to the research team, regardless of the youth's desire to participate in the project. As such, the participation rates for youth presenting to the education sector may be lower than other participating sectors.

Following completion of data collection, through the network coordinators and agency leads, the project team learned that GAIN SS administration was continuing in some agencies in all of the communities beyond the six month project data collection phase. One agency in Brant and Brantford County was considering using the GAIN SS during the intake process in place of a full assessment in help facilitate referrals. In Niagara, one of the agencies reported using the GAIN SS as a pre-post tool to monitor client progress and outcomes. This agency is also considering using the GAIN SS during the intake process in place of a full assessment. The Timmins network members reported that an additional school board that did not participate in the project, has initiated use of the GAIN SS with its students, based on the experience of the participating school boards. In addition, one of the participating school boards from Timmins is planning to present the local project report to its executive team to demonstrate the utility of the GAIN SS and advocate for its continued use. This highlights the importance of considering unexpected consequences and suggests that an initiative such as this project may have the potential to significantly impact agency policy and protocol, cross-sectoral collaboration, and service provider practices.

In sum, there were a number of positive outcomes of the Ontario Youth Screening Project that went beyond the initial objectives and expectations of the project, including:

- Extending the reach of the project to include 6 communities;
- Extending the project reach and capacity building by providing training to agencies and service providers beyond those committed to full project participation;
- Extending the project reach and leveraging capacity building by linking the project to a national-level screening project;
- Extending the project reach and leveraging capacity building by linking the project to other initiatives.

Agency lead & service provider comments about the project and the findings

"I felt the process was great. The instructions were clear, and I always felt I could get answers if needed, easily. I felt well supported with the process."

"I would say that participating in the project was helpful for the youth I work with and also myself. The tool helped to have an open discussion around mental health and addictions. It also helped the youth to see their scores in front of them. Most youth did not realize how mental health and/or addictions really affected their lives."

"…dream or memory piece…interesting because youth in CAS care all seemed to check these boxes… seeing that those talking about past trauma were actually checking off the boxes is validation of the screener's effectiveness."

"[Staff using the GAIN SS] were finding issues where they thought there were issues, however areas were popping up that they did not expect to come up."

"Staff loved doing this, provided insight to issues they may not have been aware of, opened doors to pathways they may not have gone down."

Limitations

The findings of this project are limited by factors related to the screening tool as well as the extent and type of engagement of the participating service providers, type of agencies that participated and the number of male and female youth in each age group. The GAIN SS is a high level screening tool intended to identify youth who would be likely to have a diagnosis with a full assessment and who thus would benefit from assessment and service planning. As a result, it does not provide detailed information about the areas of concern that are identified. Service providers and services engaged with the project to differing extents which may have impacted the findings in unknown and/or ways that may not be obvious.

Recommendations

The recommendations in this provincial report were developed based on the project findings, looking at youth needs and service provider perceptions across the participating community networks. Community-specific recommendations can be found in the respective local community reports.

- Gender-informed and gender-specific services should be considered to ensure that the services delivered are designed to address the different types of difficulties male and female youth experience. For example, female youth (younger age categories) were more likely to endorse internalizing concerns and suicide-related concerns; male youth were more likely to endorse substance use and crime and violence related concerns than female youth. Additionally, significantly more male youth screened positive for concurrent disorders than female youth across age categories.

- Developmentally-informed and responsive services are indicated in order to meet the needs of youth as they move from early to later adolescence and into the transitional-aged youth group (19 to 24 years), especially those who are aging out of child and youth focused services and seeking and/or receiving services in the adult service sector. The increase with age in rates of endorsement for problematic substance use and concurrent disorder concerns, in particular for male youth, is notable.

- Continued capacity building regarding concurrent disorders across sectors is warranted given that approximately half of participating youth endorsed significant concerns in more than one domain. It is notable that rates of concurrent disorders were high across a number of sectors including the addictions, justice, and housing, outreach and support sectors. This project aimed to improve early identification and pathways to care through evidence-based practice in the form of screening using a standardized tool. Subsequent projects should consider the importance of capacity building across sectors regarding enhanced collaborative care, referral practices and interventions to access appropriate services to address substance use and concurrent disorders.

- Building capacity for trauma-informed care across sectors is also suggested, given that half of all participating youth endorsed concerns related to traumatic distress. Consideration should be given to gender-specific services addressing trauma, given the high endorsement of traumatic distress by both male and female youth.

- Given the high rate of endorsement of suicide concerns, particularly amongst the younger female youth efforts to ensure early identification of concerns are recommended across sectors. Consideration should be given to extending consistent brief screening practices and to gathering similar information as was gathered through this project in other health care settings such as community based primary care and hospital emergency rooms and/or in settings accessible to youth such as educational settings.

- While this project examined youth needs at one point in time in service delivery, consideration should be given to the potential utility of repeating administration of the screening tool at subsequent points in the service delivery process for the purposes of monitoring within treatment progress and post-treatment outcomes.

- Given the importance of being able to respond in an effective and timely manner to positive screening results, it is recommended that all service providers contact agencies for the most up-to-date information on services. In addition, it is recommended that the local Children's Services Committee continue to address referral capacity and knowledge of resources to enhance network-building, referral capacity and knowledge of resources.

- Further study is recommended to examine the relative impacts of training, agency policy, protocols, monitoring, supervision and administrative support on implementation of new practices, such as the implementation of a consistent screening tool and process, as was examined in this project.

- Support for local cross-sectoral networks, working collaboratively to screen and provide services is indicated, given the reported increase in inter-agency communication, collaboration, and referrals by participating service providers and agency leaders. Participation in joint training and collaborative projects is also indicated to foster on-going knowledge and skill building and to facilitate collaboration to bring together the multiple resources often required to meet the complex needs of youth.

Appendices

Appendix A: Participating Communities

Participating Communities		
West	**North**	**East**
Brant and Brantford County	Sudbury	Ottawa
Haldimand and Norfolk	Timmins	
Niagara		

Appendix B: Implementation Summaries for Participating Networks

Implementation of the Ontario Youth Screening Project involved participation by agencies and service providers in the following:

- Network meetings
- Youth concurrent disorders capacity building and screening and intervention protocol training, including pre-project service provider survey
- Six-month data collection phase
- Post-project service provider survey
- Preliminary data review meeting
- Report dissemination at the local level

Brantford and Brant County Network

Network Agencies	Agency Leads
Contact Brant	Jane Angus
Brant County Health Unit	Marie Green
St. Leonard's Community Services, Addiction Services	Julie Smith
Woodview Children's Centre: Child and Family Counselling	Lorraine Jeffrey
Woodview Children's Centre: Youth Justice	

Participating Sectors

- Addictions
- Health
- Mental Health
- Justice

*Health Services in the data analysis was collapsed into the Mental Health sector due to a small number of submitted screeners from the health unit.

Network Summary:

- Capacity building: November, 2012
- Service providers trained: 67*
- Data collection range: January, 2013 – September, 2013
- GAIN-SS collected: 206
- Joint data analysis: October, 2013

*The Brant and Brantford County Network participated in a joint capacity-building training with the Haldimand and Norfolk Network.

Haldimand and Norfolk Network

Network Agencies	Agency Leads
Haldimand-Norfolk Resource Education and Counselling Help (R.E.A.C.H.)	Deborah Young
Children's Aid Society of Haldimand and Norfolk - Children's Services Department	Dawn Perrier

Participating Sectors		
• Child Welfare	• Housing, Outreach & Support	• Justice

Network Summary:

- Capacity building: November, 2012
- Service providers trained: 67*
- Data collection range: January, 2013 – September, 2013
- GAIN-SS collected: 119
- Joint data analysis: October, 2013

*The Brant and Brantford County Network participated in a joint capacity-building training with the Haldimand and Norfolk Network.

Niagara Network

Network Agencies	Agency Leads
Attachment and Trauma Treatment Centre for Healing (ATTCH)	Lori Gill
Community Addiction Service of Niagara	Paul Niesink
Contact Niagara for Children's and Developmental Services Inc.	Kaarina Vogin
John Howard Society of Niagara Inc.	Samantha Messier
Niagara Resource Service for Youth (The R.A.F.T.)	Ryan Barton
Niagara Region Public Health	Laurie Columbus
Pathstone Mental Health	Lee-Ann Standish

Participating Sectors

- Child Welfare
- Housing, Outreach & Support
- Justice
- Mental Health
- Addictions
- Health*

*Health Services only participated in the capacity-building activities associated with this project.

Network Summary:

- Capacity building: October, 2012
- Service providers trained: 66
- Data collection range: November, 2012 – August, 2013
- GAIN-SS collected: 285
- Joint data analysis: September, 2013

Ottawa Network

Network Agencies	Agency Leads
St.Mary's Home	Vicky Green
Youville Centre	Brydie Johnson
Eastern Ontario Youth Justice Agency	Leigh Couture

Participating Sectors		
• Mental Health	• Housing, Outreach & Support	• Justice

Network Summary:

- Capacity building: January, 2013
- Service providers trained: 31
- Data collection range: March, 2013 – September, 2013
- GAIN-SS collected: 159
- Joint data analysis: October, 2013

Sudbury Network

Network Agencies	Agency Leads
Canadian Mental Health Association – Sudbury/Manitoulin Branch	Elizabeth Puddy
Child Family Centre	Claire Valtins
Sudbury Action Centre for Youth	Kylie Raine
Sudbury Restorative Justice	Amanda Chodura

Participating Sectors		
• Mental Health	• Housing, Outreach & Support	• Justice

Network Summary:

- Capacity building: January, 2013
- Service providers trained: 61
- Data collection range: June, 2013 – November, 2013
- GAIN-SS collected: 246
- Joint data analysis: November, 2013

Timmins Network

Network Agencies	Agency Leads
South Cochrane Addictions Services	Sarah Bondarenko
District School Board Ontario North East	Denise Plante-Dupuis
Conseil scolaire public du Nord-Est de l'Ontario (CSPNE)	Gerry Lajoie
Participating Sectors	
• Addictions • Education	

Network Summary:

- Capacity building: February and March, 2013
- Service providers trained: 30
- Data collection range: April, 2013 – December, 2013
- GAIN-SS collected: 63
- Joint data analysis: January, 2014

Appendix C: Key Project Activities

Network Development

Member agencies that participated in the Network Development activity played a foundational role in building a collaborative network, starting with preliminary discussions regarding project participation. These agencies participated in several meetings with the project team, in addition to network specific meetings and training. The agency leads and broader network membership also collaborated with the project team to carry out the project.

Capacity Building

Service providers and agency leads from interested agencies participated in a half-day evidence-based youth co-occurring disorders capacity building session and a half-day screening and intervention protocol training session. During this session, where agencies had committed to full project participation and had obtained research ethics approval, service providers also completed the Service Provider Survey. Some agencies that participated in the Capacity Building activities were interested in participating in the full project but were not able to due to resource or administrative challenges, such as difficulties completing legal and/or ethics processes in the required network timeframe.

Screening Implementation

Member agencies that participated in the full project implemented the GAIN SS with youth seeking services at their agencies. Some agencies chose to implement the GAIN SS with the youth seeking service for clinical purposes, but did not participate in the full data collection component of the project (see below).

Data Collection

Member agencies that participated in the full project participated in a six month data collection period. During this time, the GAIN SS and Background Information Form were administered to consenting youth seeking service at their agencies and a copy was sent to the project team. The data was prepared by the project team and a local community report was generated through a collaborative process between the project team and the participating agencies.

Appendix D: Project Activity Participation

Sector	Agency Name	Project Activity			
		Network Development	Capacity Building	Screening Implementation	Data Collection
Addictions	St.Leonard's Community Services, Addiction Services	X	X	X	X
	Community Addiction Service of Niagara	X	X	X	X
	South Cochrane Addictions Services	X	X	X	X
Child Welfare	Children's Aid Society of Haldimand and Norfolk – Children's Services Department	X	X	X	X
Education	District School Board Ontario North East	X	X	X	X
	Conseil scolaire public du Nord-Est de l'Ontario (CSPNE)	X	X	X	X
Health Services	Niagara Region Public Health	X	X		
Housing, Outreach, and Support	Haldimand-Norfolk Resource and Counselling Help (R.E.A.C.H.): Union House Developmental Services Transitional Age Youth Program CAPC	X	X	X	X
	Niagara Resource Service for Youth (The R.A.F.T.)	X	X	X	X
	St.Mary's Home	X	X	X	X
	Sudbury Action Centre for Youth	X	X	X	X

Sector	Agency Name	Project Activity			
		Network Development	Capacity Building	Screening Implementation	Data Collection
Justice	Woodview Children's Centre: Youth Justice	X	X	X	X
	Haldimand-Norfolk Resource Education and Counselling Help (R.E.A.C.H.): Youth Justice Services	X	X	X	X
	John Howard Society of Niagara Inc.	X	X	X	X
	Pathstone Mental Health[1]	X	X	X	X
	Eastern Ontario Youth Justice Agency	X	X	X	X
	Sudbury Restorative Justice	X	X	X	X
	Canadian Mental Health Association - Sudbury/Manitoulin Branch[2]	X	X	X	X
Mental Health	Brant County Health Unit	X	X	X	X
	Contact Brant	X	X	X	X
	Woodview Children's Centre: Child & Family Counselling	X	X	X	X

(1) Youth presenting to Pathstone Mental Health fall under the "Justice" sector as they presented to the agency's Youth Mental Health Court Worker Program. Youth presenting to other programs at Pathstone Mental Health were screened by Contact Niagara and thus fall under the sector of "Mental Health"

(2) Canadian Mental Health Association – Sudbury/Manitoulin Branch provides support to youth under 18 in the justice sector

Sector	Agency Name	Project Activity			
		Network Development	Capacity Building	Screening Implementation	Data Collection
Mental Health (Cont'd.)	Contact Niagara for Children's Developmental Services Inc.	X	X	X	X
	Attachment and Trauma Treatment Centre for Healing (ATTCH)			X	X
	Youville Centre	X	X	X	X
	Canadian Mental Health Association – Sudbury/ Manitoulin Branch[3]	X	X	X	X
	Child & Family Centre	X	X	X	X

[3] Canadian Mental Health Association – Sudbury/Manitoulin Branch support to youth over 18 in the mental health sector

Appendix E: Process Summary

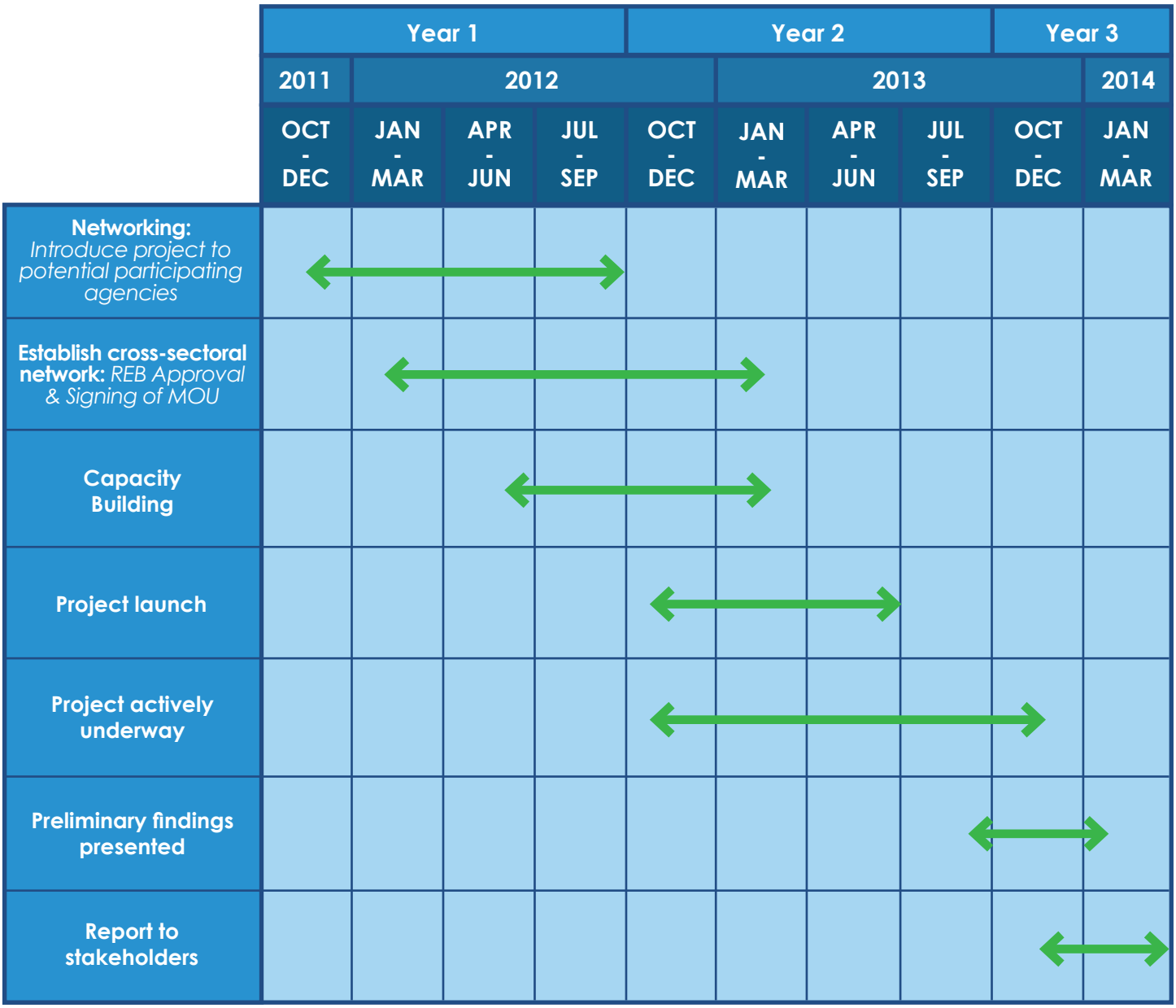
Project Summary

- Total number of agencies: 23
- Total number of services: 32
- Total number of service providers trained: 255
- Total number of GAIN SS received to date: 1073
- Total number of sectors represented: 7

Network	Project activities	Number of agencies	Number of services	Number of people trained	Time lag between training & data collection
Brant and Brantford County	All	5	5	67*	1 month
Haldimand and Norfolk	All	2	5	67*	1 month
Niagara	All	7	11	66	No time lag
Ottawa	All	3	3	31	1 month
Sudbury	All	4	5	61	4 months
Timmins	All	3	3	30	1 month

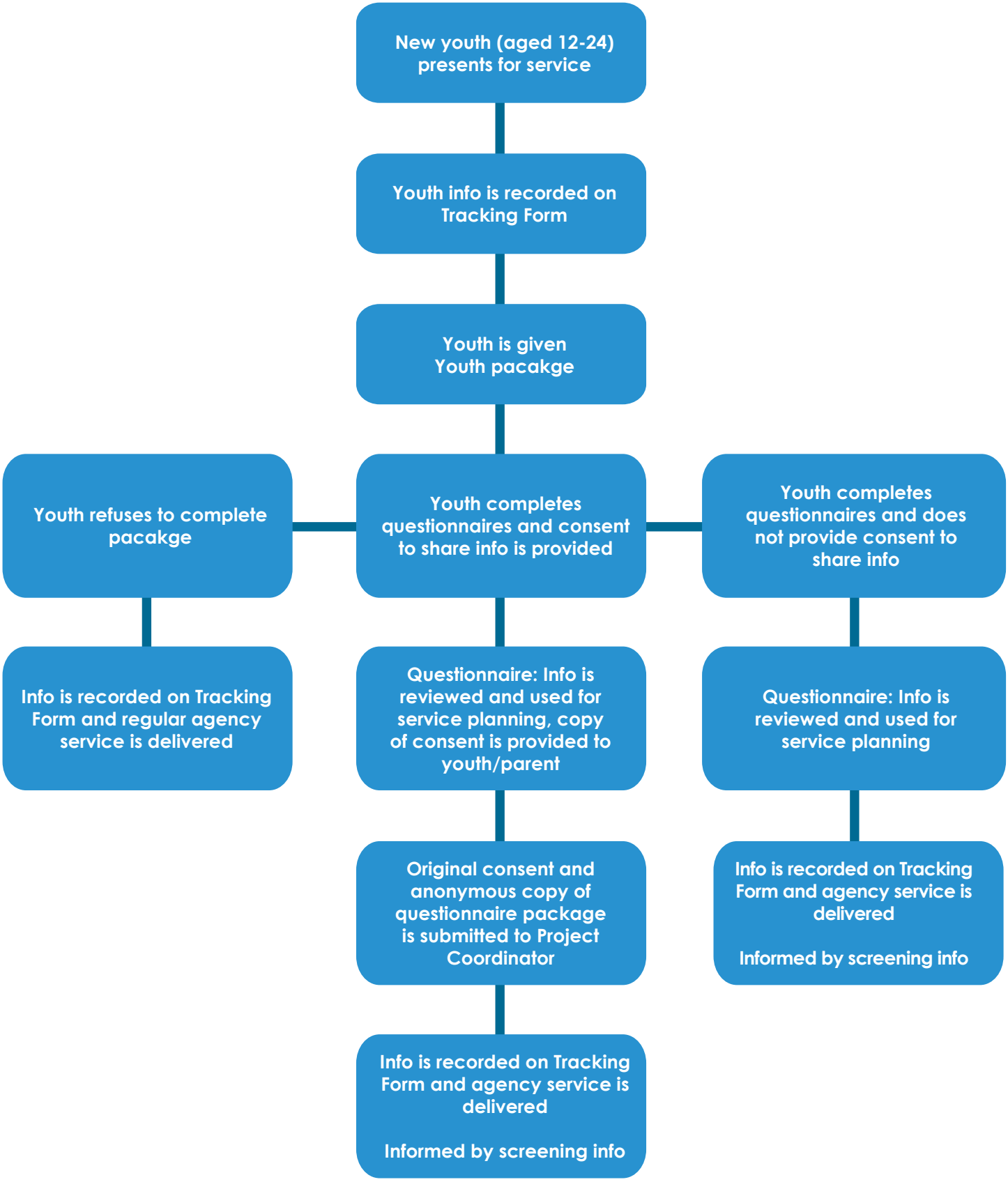
* The Brant and Brantford County Network participated in a joint capacity-building training with the Haldimand and Norfolk Network.

Appendix F: Project Timeline



Appendix G: Project Flow Chart

Ontario Youth Screening Project: Project Flow



Appendix H: Sample Project-Related Knowledge Exchange Activities

- Children's Mental Health Ontario Annual Conference (November 18 – 19, 2013), Toronto, Ontario
  - ↳ *Facilitating Access and Addressing Barriers: Collaborating with Youth, Family Members and Cross-sectoral Service Providers*
- Summit for Children and Youth Mental Health (April 3-4, 2014), Coalition for Children and Youth Mental Health, Toronto, Ontario
  - ↳ *The Ontario Youth Screening Project: A cross-sectoral capacity-building initiative*
- Canadian Association for Health Services and Policy Research (CAHSPR) Conference (May 12-15, 2014), Toronto, Ontario
  - ↳ *Using stakeholder-informed research to influence system change: Findings from a national initiative to enhance cross-sectoral collaboration and improve pathways to care for youth*
- The Canadian Psychological Association's 75th Annual Convention (June 5-7, 2014), Vancouver, British Columbia.
  - ↳ *Creating collaborative communities supporting youth: The National and Ontario Youth Screening Projects.*

Appendix I: References

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