NYSP

# National Youth Screening Project
## Phase Two Report

Enhancing youth-focused, evidence-informed treatment practices through cross-sectoral collaboration

camh
Centre for Addiction and Mental Health

# National Youth Screening Project
## Phase Two Report


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We would also like to thank Health Canada for the continued funding support that made dissemination and local dialogue about the findings and implications possible.

## National Youth Screening Project Networks

Five communities participated in Phase Two of the project, each with a local lead agency.
*(Refer to Appendix A for network summaries)*

| Community | Lead Agency | Network Leads |
|---|---|---|
| Cape Breton Region, Nova Scotia | **Cape Breton District Health Authority** | **Lead:** Samantha Hodder<br>**Coordinator:** Brandy MacNeill |
| Kelowna, British Columbia | **ARC Programs** | **Lead:** Shane Picken<br>**Coordinator:** Nicole Jackson |
| Prince Edward Island | **Health PEI** | **Lead:** Margaret Kennedy<br>**Coordinators:** Shauna Reddin, Karen Blancquiere |
| St.John's, Newfoundland and Labrador | **Choices for Youth** | **Lead:** Linda Warford |
| Thompson, Manitoba | **Addictions Foundation of Manitoba** | **Lead:** John Donovan |

# Project Team: Centre for Addiction and Mental Health

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# Table of Contents

## St. John's, Newfoundland and Labrador



## Thompson, Manitoba



## Appendices

# List of Tables

# Background

Youth with substance use or mental health concerns, or both (Concurrent Disorders (CD)) seek service in many sectors including the specialized addiction and mental health sectors, as well as education, justice, housing, outreach, and support, and primary health services. There is increasing awareness of the challenges (e.g., homelessness, legal problems, poor educational/vocational achievement, increased suicide risk, increased risk for substance dependency and psychiatric disorders continuing into adulthood) faced by youth with substance use, mental health, and CD however, screening across sectors is not consistent (Chaim, Henderson, & Brownlie, 2013; Rush, Castel, & Desmond, 2009; Rush, Urbanoski, Bassani, Castel, & Wild, 2009). As a result, at the individual level, the full range of needs youth are experiencing may not be identified and addressed. In addition, at the system level, there has been insufficient documentation of needs to inform system planning.

Considering these issues, the National Youth Screening Project (NYSP) was designed to examine effective ways to build capacity for consistent screening and documentation of youth needs across sectors, as well as to build cross-sectoral collaboration to increase local capacity to meet youth needs. The value of bringing the "voices" of youth and families to all aspects of work (including service planning and research) related to youth services has been increasingly understood and appreciated. The project was carried out in two phases, Phase One (2010-2013) and Phase Two (2013-2014). Along with broad dissemination of the Phase One project findings, reaching out to youth and families for their opinions and recommendations was a major focus of the second phase of the project (Henderson & Chaim, 2013; Wong, Zimmerman, & Parker, 2010; Mental Health Commission of Canada, 2009; National Treatment Strategy Working Group, 2008; Suleiman, Soleimanpour, & London, 2006).

# Overview

The NYSP was a collaborative initiative that brought cross-sectoral youth-serving providers, youth, and family members/supporters together to engage in a project to learn about youth substance use, mental health, CD and related needs in their communities; to build capacity for evidence-informed care; to consider what is working well and what challenges exist; and to make recommendations for system improvement. The NYSP was funded under Health Canada's Drug Treatment Funding Program (DTFP) and was completed in two phases. In Phase One cross-sectoral networks of youth-serving agencies in 10 communities worked collaboratively to enhance service provider capacity to identify and address substance use and CD amongst youth ages 12-24 and to improve pathways to care. This was accomplished through network development, capacity building, implementation of a screening tool to identify substance use and mental health problems (GAIN Short Screener (CAMH Version) (GSS-CV)), and data collection to learn about local youth needs based on completed screeners. See Appendix B for information about the GSS-CV). Reports describing local findings and recommendations were developed, along with an overall report summarizing the findings across the participating communities. The national and local reports can be found online at **eenet.ca**. In the second phase of the NYSP, Phase One findings were broadly disseminated and consultations were held in five communities with three key stakeholder groups: youth, family members and service providers, agency leaders and policy makers. The aim of the consultations was to provide an opportunity for each stakeholder group, particularly youth and families, to examine the local findings and make further recommendations based on local need and context.



[1] The term "family" refers to family as defined by each individual youth and may include family of origin, extended family, other caregivers, family of choice (i.e. friends, etc. ).

# Phase One Summary

During NYSP Phase One the project team worked collaboratively with decision-makers and service providers in 10 communities across Canada to increase early intervention opportunities and improve pathways to treatment for youth (aged 12-24 years) with substance use concerns and co-occurring mental health problems (CD).

The objectives of Phase One included:

- To build collaboration amongst youth service providers across sectors by developing/enhancing community based networks across Canada
- To use a common screening tool (GSS-CV) with youth seeking services to enhance consistent identification and treatment planning for youth with substance use and mental health concerns
- To obtain feedback from service providers regarding the feasibility and utility of the GSS-CV 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:
    - Identifying needs of youth
- To inform planning processes across agencies that relate to:
    - Identifying commonalities and differences in youth
    - Identifying gaps in the continuum of services

As noted above, the objectives were achieved through four key project activities including:

- Network development
- Capacity building – participate in training in one or more of the following: youth CD, youth screening and intervention, research project protocol
- Screening implementation - implement GSS-CV with service-seeking youth
- Data Collection – participate in a six month data collection period, administering the GSS-CV and a demographic background information form, and with consent, submitting a copy to the project team for analysis

Each network included representation from a minimum of 4 sectors including substance use, mental health, health, justice, child welfare, education, housing, outreach and support. Eight of the communities participated in all project activities, including network development, capacity building, screening implementation and the research components of the project; one participated in capacity building and screening (Nunavut); and one participated in network development only (Yellowknife, NWT).

# Table 1 | *Participating Communities in NYSP Phase One*

| Province | Community |
|---|---|
| British Columbia | Kelowna<br>Prince George |
| Manitoba | Thompson |
| Newfoundland and Labrador | St.John's |
| Nova Scotia | Cape Breton Region<br>Pictou County, Cumberland County,<br>and Guysborough/Antigonish/Strait Region |
| Prince Edward Island | All communities across the province |
| **Territory** | **Community** |
| Northwest Territories | Yellowknife<br>Dehcho Region |
| Nunavut | All communities across the territory |

**Summary of Participation:**

- Total number of participating communities: **10**
- Total number of distinct agencies: **69**
- Total number of distinct services: **82**
- Total number of sectors represented: **9**
- Total number of service providers trained: **553**
- Total number of youth that participated (shared GSS-CV for analysis): **1305**

Through collaborative processes, local and national findings were reviewed, recommendations developed (refer to Appendix C for key overall national project findings) and reports generated. Across networks, there were a number of common findings that were the basis of recommendations suggesting directions for future work, with the ultimate goal of ensuring access to effective, coordinated, evidence-based treatment practices for youth with substance use problems across Canada. Key recommendations included implementation of consistent screening for substance use and mental health concerns across service sectors, integration of developmentally- and trauma-informed and specific practices and services, and consideration of the unique needs of youth in the context of the social determinants of health (e.g. sex, gender, legal involvement, living arrangements) (Henderson & Chaim, 2013).

In addition to learning about youth needs, the project provided the opportunity to demonstrate, through pre-post service provider surveys, the promise of such projects to increase service provider knowledge and enhanced self-efficacy related to addressing substance use, mental health and CD, along with increased inter-agency communication and collaboration. The key national recommendations from Phase One can be found in Appendix D of this report.

The project had an impact on practice and policy within and beyond the pilot agencies and communities. Community network leads have reported that, resulting from the positive experiences and feedback related to the project activities and outcomes, the GSS-CV continues to be used in clinical practice in many agencies and training has been extended to additional service providers including those from sectors (e.g. education) that did not participate in the project as fully.

***"Using the screener facilitated network building. Being in a network increased opportunities for consultation and referral."***

***"It has resulted in some additional partnerships among network members who are now delivering some programs together to at-risk youth."***

# Phase Two Summary

Through the NYSP Phase One, local reports were prepared documenting project activities, findings and recommendations specific to each of the 10 participating communities, as well as a national report, summarizing the project across all sites. The reports were developed through a collaborative process that included the following steps: the data were analyzed jointly with the respective community network representatives in person or through webinar; recommendations were developed through a collaborative dialogue; reports were drafted by the project team; reports were reviewed by the community network; feedback was provided to the project team; the reports were finalized and disseminated by the project team. Due to time and funding constraints, there was limited opportunity to share the project findings beyond the core network membership, often comprised of one representative from each participating agency. Phase Two of the project provided the opportunity to disseminate the findings and recommendations to system stakeholders at the local, provincial/territorial and national levels, and to consider the implications of community, regional and sector differences. Moreover, Phase Two provided the opportunity to share the findings with youth, family members, and service providers, agency leadership and policy/decision makers who did not have the opportunity to provide their feedback and recommendations in Phase One.

The objectives of Phase Two were to:

1. **Hear the voice of youth and families** to contextualize the findings of the NYSP Phase One, consider the implications for improved access to care, and develop consumer-informed recommendations for service-delivery systems;

2. **Share with local, provincial/territorial and national system stakeholders** (e.g., service providers, decision-makers, system planners, policy-makers, academics) the findings of the NYSP Phase One, highlighting regional, community and sector differences in findings about youth needs, service provider capacity and screening feasibility and utility, and to gather feedback about findings, the implications of the findings, and possible next steps.

In order to meet these objectives, consultation meetings were held with groups of local youth, family members, and other stakeholders (i.e. service providers, educators, agency leadership, decision makers and policymakers) in five communities across Canada: Cape Breton Region, Nova Scotia; Kelowna, British Columbia; Prince Edward Island; Thompson, Manitoba; and St. John's, Newfoundland and Labrador. These consultations provided the opportunity to discuss the findings, consider what is currently working well locally with respect to addressing substance use and CD, further articulate youth needs and system challenges, and build on the recommendations made in Phase One. Phase Two provided a unique opportunity to hear from a broad range of stakeholders. In particular, it provided the opportunity to hear from youth and family members, whose invaluable perspective is essential and frequently missed.

# Phase Two Project Methods: What We Did

## Consultation Meetings Summary

Between November, 2013 and March, 2014, supported by the local network leads and coordinators, Joanna Henderson and Gloria Chaim, project leads, conducted 12 consultation meetings across the five participating communities. See Table 2 for a summary of the consultation meetings.

### Table 2 | *Consultation Meetings Summary*

| Site | Date(s) | Number of Consultation Meetings | Type of Consultation Meetings Offered | Consultation Meeting Delivery |
|---|---|---|---|---|
| Cape Breton Region, Nova Scotia | January 15th 2014 | **3** | Service Provider<br>Youth<br>Family | In-person |
| Kelowna, British Columbia | December 4th 2013 | **1** | Service Provider | Webinar |
| Prince Edward Island | January 16th and 17th, 2014 | **3** | Service Provider<br>Youth<br>Family | In-person |
| St.John's, Newfoundland and Labrador | March 4th 2014 | **2** | Service Provider<br>Youth | In-person |
| Thompson, Manitoba | November 26th 2013 | **3** | Service Provider<br>Youth<br>Family | In-person |

# Implementation Process

Following the release of the Phase One report, project team leads contacted the network leads to gauge their interest in participating in Phase Two of the project. Each of the network leads were notified of the opportunity to bring the local and national findings back to the participating communities and share them with groups of youth, family members, and service providers, policy and decision makers to elicit their feedback to further develop recommendations generated in Phase One. Between July 2013 and January 2014, five networks identified their interest in participating in Phase Two of the project. Through teleconference meetings between the project team and the network leads consultation questions and process were determined, along with logistical plans including participant groups, and the number, type and delivery method of the consultation meetings. It was agreed that the project team leads would prepare marketing materials, handouts and discussion questions for the meetings while the network leads would engage local stakeholders, youth and family members to ensure the local communities' awareness of the consultation opportunity. A particular effort was made to engage youth and family members where possible. Process and logistics of consultation meetings were tailored for each community in order to ensure applicability and enhancement to the local community context.

During the service provider, youth and family meetings, the NYSP project team leads presented an overview of the project which included the local and national findings from Phase One. Findings that were featured in the presentation included demographics of youth participants, youth substance use and mental health problems as identified through the completed submitted screeners (GSS-CV), as well as youth rates of legal involvement, suicide-related concerns, and trauma-related distress (see Appendix C). A facilitated discussion followed the presentation of findings, separately with each stakeholder group (see Appendix F for discussion questions). The discussion questions were developed in consultation with local network leads, to provide an opportunity for local stakeholders to discuss what is working well, gaps, and recommendations related to the local youth needs identified through the project.

For the project timeline across Phases One and Two, please refer to Appendix E.

# Analysis of Stakeholder Discussion

During the consultation meetings with youth, participant ideas were recorded by participants and submitted, as well as by the facilitators; for all the other consultations, meeting discussions were recorded by the facilitators. For analysis, notes from each meeting were then compiled and entered into a database by research staff. Notes were coded by research staff using codes representing key ideas and concepts developed through other work by the authors (Chaim, Brownlie, & Henderson, 2013; Chaim & Henderson, 2014). Data were examined, overall, by site, and by consultation type (i.e. youth, family members, and other stakeholders). Prominent themes were identified and are described in the section entitled "Project Findings: What We Learned" and examples are provided throughout.

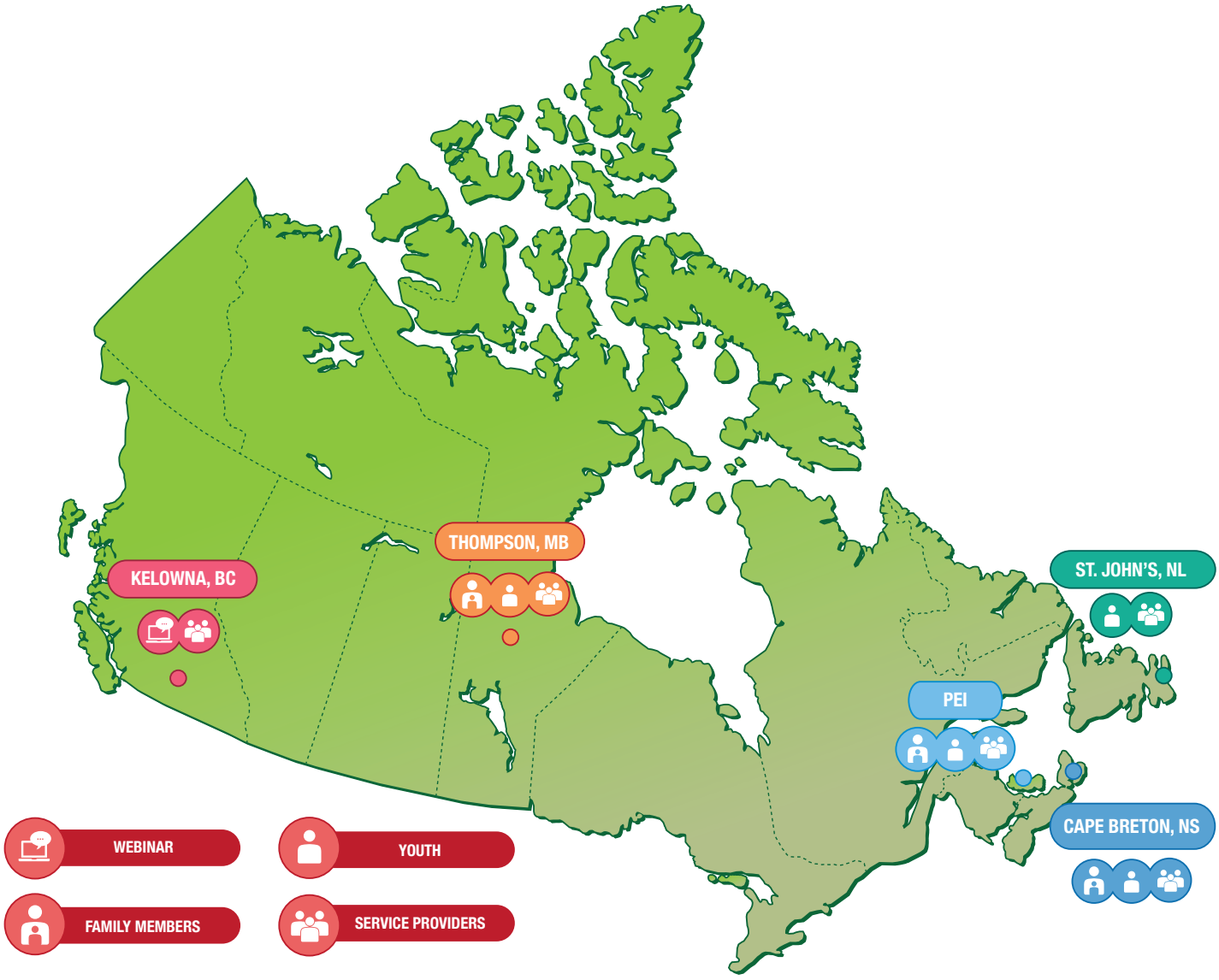
# Phase Two Project Findings: What We Learned (Across Sites)

## Findings: Who We Heard From (Across Sites)

### Table 3 | *Participant Demographics (Across Sites)*

| Site | Number of Service Providers | Number of Youth | Number of Family Members |
|---|---|---|---|
| Cape Breton Region, Nova Scotia | 29 | 56 | 14 |
| Kelowna, British Columbia | 4 | 0 | 0 |
| Prince Edward Island | 22 | 6 | 6 |
| St.John's, Newfoundland and Labrador | 8 | 15 | 0 |
| Thompson, Manitoba | 11 | 25 | 32 |

# Map of Consultation Meetings



# Findings: What We Heard (Across Sites)

The consultations provided opportunities for stakeholders to share their perceptions about what is working well in their local community, gaps and challenges, and recommendations for enhancement or change, related to youth substance use and concurrent disorders needs. The discussion of findings has been organized into the following themes: access, service components, service delivery model, service attributes, service provider attributes, health equity and the social determinants of health, and policy and funding issues.

The discussion following provides a brief summary of what we heard from stakeholders across all of the communities. There was general agreement in all of the communities across the stakeholder groups that participated in each community and there were also many commonalities across communities regarding what is working well, gaps and recommendations.

For Phase One summaries, and Phase Two findings and recommendations specific to each community, please refer to the site specific tabs of this report.

# Access

## Availability

In each community, stakeholders identified services available locally that they thought were excellent and accessible to the youth and families that needed them. At the same time, stakeholders identified significant gaps in their respective communities.

***"For youth to get service is like rain in a desert. When I was going through treatment, I saw a psychiatrist once every 3 months and my therapist once a month. If there were more windows of opportunity, it would help treatment."***
— Youth (Cape Breton Region, Nova Scotia)

***The practice of streamlined access to psychiatric services and session for youth presenting with severe psychiatric needs is very helpful and effective."***
— Service Provider (Kelowna, British Columbia)

***"The only treatment available is medication."***
— Youth and Family Members (Prince Edward Island)

***"Here you have to sleep outside because can't get place for 4 days."***
— Youth (St. John's, Newfoundland and Labrador)

***"There are programs but you have to be a certain age. Some kids are too young—you need to be 12—my son is 10 and he's already been struggling for 2 years."***
— Family Member (Thompson, Manitoba)

## Awareness

Regardless of availability, across the communities, stakeholders identified that even when services are available, awareness is lacking amongst those that need services, as well as amongst service providers.

***"We have an addiction counsellor in school but don't hear about it until we need service and we have to say something to get it – there is no advertising about it. They should advertise that someone with addiction expertise is available."***
— Youth (Prince Edward Island)

***"You have to ask for services and probably 70% of kids fall through the cracks because they don`t know someone to ask."***
— Family Member (Thompson, Manitoba)

## Service Facilitators

A number of service facilitators were identified that support access to service, including, *transportation, location, cost, hours, eligibility criteria, and social media* and *use of technology*.

### *Transportation*

Transportation was a very important issue in all the communities. As noted above, location of the service and where the youth reside impact the type and cost of transportation required. For youth who need to involve family members in problem-solving transportation challenges, an additional barrier may be the impact on privacy and confidentiality for youth who may not want to share the fact that they are involved in services with others.

***"Continue funding for youth to attend appointments (mental health, addiction services, etc) if necessary, especially in rural areas and for low income families (offer taxi slips, other form of transportation) to get them to the appointment."***
– Service Provider (Cape Breton Region, Nova Scotia)

***"Have to be able to get drive from someone, no buses for rural youth."***
– Youth (Prince Edward Island)

## Location

There were two main of issues that were identified with respect to service location; the first related to the type of location and the second related to the geographic location. Many services are office-based and may not be in the types of locations that youth frequent or feel comfortable in (e.g. hospital). Stakeholders indicated that services located in the school are perceived to be most accessible for youth who are in school. For youth who are not in school, but also those who are, services that are community-based (e.g. community centres) or mobile are seen to be most accessible. All the participating communities serve youth who live in urban and rural areas, and most of the services are located in the urban areas. This makes it very challenging for youth who live in rural areas, or smaller communities, to access service due to length of travel time, lack of transportation due to high cost, lack of available public transportation, and a lack of a vehicle or someone to drive the youth.

***"Have headquarters in towns instead of just Sydney or just Glace Bay or whatever. Try and set up everywhere to get the word out and places where people hang out, skate, play sports or listen to music."***
– Youth (Cape Breton Region, Nova Scotia)

***"Need services where youth are living especially outside of Charlottetown."***
– Youth (Prince Edward Island)

***"Need programs for youth on the East side and West side of town—youth often won't cross to the other side as it is outside of their neighbourhood."***
– Family Member (Thompson, Manitoba)

## Cost

Generally, services in the participating communities are available at no cost, however due to access challenges related to local availability, long wait times, lack of transportation, and sometimes, lack of information about available services, youth and families resort to paying for service. Commonly cited examples were fees for specialist services for youth seeking a diagnosis in order to access services that require a diagnosis or for therapy (e.g. psychology). Stakeholders stated that service fees are impossible for many to pay, given the financial difficulties faced by many families, particularly in communities with high unemployment, expensive food and housing, and extremely limited income.

## Hours

The need for service hours outside of "usual" business hours was highlighted across communities. The need for evening and weekend services was also stressed.

***"Service could be better if there was service at any hour and not just at certain hours."***
– Youth (Cape Breton Region, Nova Scotia)

***"We ended up paying for services because we could."***
– Family Member (Prince Edward Island)

## *Eligibility Criteria*

Restrictive age criteria were the most commonly cited criteria that posed barriers to accessing services. For example, most "children's" services end at age 16 or 18 and youth continue to need youth-focused services. As a result, youth either move on to adult services that are not equipped to meet their needs or they drop out of service. In some of the communities, the need to extend the eligibility for services, particularly prevention and early intervention, to younger children (i.e. 6-11) was noted, given the young age at which they are initiating substance involvement. The need for a diagnosis, particularly to access mental health services, and/or a physician referral was also identified as a common barrier. Accessing medical, particularly psychiatry, or psychology services was identified as a major challenge, due to lack of those services available locally or very long wait lists. Another common challenge is that services may be inaccessible to youth with mild-moderate problems until they "get in trouble" and enter service through the justice system, or harm themselves or become extremely ill and enter service through the emergency department.

***"Almost have to wish for them [youth] to break the law so they will be picked up by the police and [be] kept safe."***
— Service Provider (Prince Edward Island)

## *Social Media and Use of Technology*

It was noted that the way youth communicate is changing and in order to communicate about service, appointments, or treatment, using technology is becoming increasingly important. It was suggested that service providers need to become comfortable and adept at using technology and that agency policy needs to support it.

***"Our ways of connecting with youth have to change."***
— Service Providers (Cape Breton Region, Nova Scotia)

## Coordination and Collaboration

Youth are often involved with more than one service provider and agency and may be involved with providers across multiple sectors (e.g. addictions, mental health, education, justice, child welfare, etc.). The importance of coordination and collaboration among providers and with youth and families was mentioned across sites. In some sites there are formal collaborative relationships and networks; across sites there are also informal collaborations. The importance of collaboration was cited particularly with respect to supporting youth transitioning from one service or sector to another (e.g. youth to adult services) or for youth with multiple, complex problems accessing or requiring service from more than one provider.

***"Need communication among all service providers working with the same kid."***
— Service Provider (Cape Breton Region, Nova Scotia)

***"Gather a group of youth service providers to put together a framework of best practices to share across Kelowna."***
— Service Provider (Kelowna, British Columbia)

***"There is a lack of continuum of service – 'a little bit here and here and nothing in between'."***
— Service Provider (Prince Edward Island)

***"Services often pass the buck, assuming other agencies working with youth are dealing with their concerns or withhold information."***
— Youth (Thompson, Manitoba)

## Timely Access

Long wait times, particularly for mental health services, were cited in every community. In some communities, wait times for some services, were said to be well over one year. Some solutions such as paying for services in the private sector or travelling to another community or large urban centre have significant costs associated and are generally not feasible for most youth and their families.

***"Services are available, but [there is a] huge wait."***
— Youth (Cape Breton Region, Nova Scotia)

***"People get into program and are selected even if they don't want it. But others who want it can't get in and are put on the wait list."***
— Youth (St. John's, Newfoundland and Labrador)

***"Parents and youth want help now!"***
— Service Provider (Thompson, Manitoba)

## Referral and Intake Processes

Challenges related to referral processes, include some of the challenges described with respect to eligibility criteria, such as requiring a diagnosis or requiring a physician referral, when access to a physician is limited. In addition, for younger youth, the need for parental consent in many services is seen to be a barrier, particularly by youth, who may not want their parents to know that they are seeking services. In some communities, it was noted that parents may have their own personal challenges and not be able to follow-through or may not be willing to consent.

***"Physician refused to refer my daughter who has anxiety for counselling and is treating her. Unless she has a crisis he has the power to refuse the referral."***
— Family Member (Prince Edward Island)

***"Youth may not want to tell parents they want to see a counsellor."***
— Youth (Thompson, Manitoba)

***"For many youth, parental consent is not an option— the parent is not supportive."***
– Service Provider (Thompson, Manitoba)

# Service Components

Stakeholders in all of the communities indicated a desire for a local comprehensive continuum of care, ranging from prevention and early intervention to residential services and aftercare. Given the size and geography of some of the communities, it is not feasible to have all components of the continuum located in close proximity to all the youth. For example, a very small community would not be able to regularly "fill" a group program; a centrally-based mobile crisis service would not be able to reach youth who live in a remote area in a timely manner. However, stakeholders in each community identified components of the continuum of care that are missing or inadequate and suggested solutions. Of note, the importance of including program components addressing family issues, including family support, family counselling and parenting support and training were highlighted along with youth-focused services.

***"No attention until you are in a crisis."***
— Youth (Cape Breton Region, Nova Scotia)

***"More drug/alcohol counsellors for youth that are not in the school system in Kelowna (there are only 2 at the present time)."***
— Service Provider (Kelowna, British Columbia)

***"Quick to pass out a pill, medication can be helpful, but need more."***
— Family Member (Prince Edward Island)

***"Need increased focus on facilitating family work/ family reconnection."***
— Service Provider (St. John's, Newfoundland and Labrador)

***"[There are] no or very little recreational programs or opportunities in outlying communities,"***
— Youth (Thompson, Manitoba)

# Service Delivery Model

Discussion regarding service delivery models intersected with other themes and included suggestions for a flexible model of care that addresses multiple youth needs, drawing on evidence and in particular addressing complex needs. Given the intersection with other themes, the service delivery model was not explicitly addressed in every community.

***"16-18 is a big gap. Youth fall through the cracks – youth services end at 19 but they may not be developmentally ready for adult [services]."***
— Service Provider (Cape Breton Region, Nova Scotia)

***"Need to better integrate cultural practices into conventional approaches."***
— Youth (Thompson, Manitoba)

# Service Attributes

Key overall attributes discussed included developmentally-, trauma-, and gender-informed care in the context of a "safe space". The inclusion of peer mentors/supporters was mentioned by many of the stakeholder groups, as was the importance of a focus on strengths and resilience-building and addressing stigma, both through public education efforts as well as with youth seeking service. Agency rules with respect to confidentiality and consent were the one area stakeholder groups expressed divergent views, generally with youth expressing a desire for confidentiality and parents expressing a desire to have access to information.

***"Stigma is hugest for those who need it [services] most."***
— Service Provider (Cape Breton Region, Nova Scotia)

***"There is high concern in Kelowna for suicidal ideation and suicide plans."***
— Service Provider (Kelowna, British Columbia)

***"People remember your past – it's hard to move on and get a second chance so people don't access services. [If you] go to get a job, they remember."***
— Youth (Prince Edward Island)

***"Increase services for grief and trauma….60-70 per cent of issues are related to substance use."***
— Youth (Thompson, Manitoba)

# Service Provider Attributes

There was agreement that it is important for service providers to be able to demonstrate caring, be non-judgmental, inspire trust, and maintain confidentiality. In addition to personal qualities, many stakeholders stated that it is important that service providers are well-trained and knowledgeable. In some communities, staff turnover was an identified concern, and there, commitment to the agency and to the youth served was seen to be very important. In addition, some service providers talked about their own personal challenges and the need for support to work with youth effectively while managing their own issues.

***"[We want] people who have been through the same things, [are] easy to relate to, around the same age, and have lots of information and ways to help."***
— Youth (Cape Breton Region, Nova Scotia)

***"Used to come to the table prepared to offer something for more complex clients but not so much anymore because of mandates and protecting my pot of resources."***
— Service Provider (Prince Edward Island)

***"…bring hope, show basic human kindness…"***
— Family Member (Thompson, Manitoba)

# Health Equity and the Social Determinants of Health

Each community identified the importance of responding to the needs of youth, considering their diverse experiences, backgrounds and ways they identify. In some communities specific groups of youth were identified (e.g. boys experiencing depression, teen mothers, African Nova Scotian youth, Aboriginal/First Nations youth, youth who identify as transgendered). In addition there was discussion about the impact of some of the broader social determinant of health on youth concerns and engagement with services, particularly in some of the communities (e.g. poverty, unemployment, lack of housing, food insecurity).

***"When families are struggling and need to put so much energy into managing to do without the BASIC needs, it is very difficult to encourage parents and young people to focus on positive health practices."***
— Service Provider (Cape Breton Region, Nova Scotia)

***"Need to address trauma across the age groups, thinking about both boys and girls."***
— Service Provider (Kelowna, British Columbia)

***"Families might say 'I don't want my kid on pills', but actually they don't have money for pills."***
— Service Provider (Prince Edward Island)

***"Increase in young people identifying as transgendered – demand for these services and supports will increase."***
— Service Provider (St. John's, Newfoundland and Labrador)

***"There is a housing crisis – how can you parent?"***
— Family Member (Thompson, Manitoba)

# Policy and Funding Concerns

Although policy and funding issues underlie much of the stakeholder discussion, they were not explicitly discussed by every group. Many of the recommendations made across the communities require policy and accompanying funding support ranging from resource allocation to increase service availability, create new resources, shift resources, to addressing policies related to cross-sectoral collaboration, confidentiality and service age restrictions.

***"No provincial framework around accepted screener for CD."***
— Service Provider (Kelowna, British Columbia)

***"Budget constraints in PEI result in a one size fits all approach, which professionals do the best with. We need a variety of services to meet mild, moderate and severe concerns."***
— Service Provider (Prince Edward Island)

***"If a community wants to care for its children than that's what they fund."***
— Family Member (Thompson, Manitoba)

# Limitations

This project has a number of limitations with regards to the range of the views expressed. Although efforts were made to include the perspectives of individuals from across the sites that participated in Phase One of the project, only 5 of the 10 Phase One communities participated. In addition, the views of participants may vary substantially from the views of others in their communities who did not participate. Lastly, most material was recorded by notetakers and as a result can be affected by the limitations of this methodology, particularly concerns about thoroughness and accuracy. Although caution needs to be exercised regarding the generalizability of the findings, it is of interest that what we heard during this phase of the project is similar to what was heard in Phase One of this project as well as views expressed by stakeholders in other projects recently conducted (Youth Services System Review (Chaim, Brownlie & Henderson, 2013 and Chaim & Henderson, 2014)).

# Next Steps

The need for sustainable system change and enhanced effectiveness and efficiency of services to address youth substance use and mental health concerns has been articulated by the stakeholders in the NYSP. Continued work focused in the following areas is needed:

1. Implementation of evidence-based practices (standardized screening, developmentally-informed and developmentally-specific services; gender-informed and trauma-informed services);
2. Enhancing service provider capacity to identify and respond effectively to youth substance use and co-occurring mental health concerns;
3. Enhancing system capacity to coordinate care and ensure smooth transitions within and between sectors, and between youth-focused and adult-focused services; and
4. Strengthening knowledge exchange within and between agencies and sectors, and expanding the existing knowledge base about effective knowledge translation and exchange and collaboration strategies within the youth-serving sectors.

# CAPE BRETON REGION TAB

# Cape Breton Region, Nova Scotia

The front section of this report describes the background of the National Youth Screening Project (NYSP) and the development and activities of Phase Two (i.e. community-based consultation meetings). The cross-site section of this report includes a comprehensive description of what we heard from all the stakeholder groups across the participating communities, including the Cape Breton Region, Nova Scotia community.

The following section includes a brief summary of the Cape Breton Region, Nova Scotia findings from the NYSP, Phase One (Henderson & Chaim, 2013), demographic information about the participants in the consultations, and unique findings and recommendations from the Phase Two consultation discussions pertaining to what is working well, challenges, and recommendations with respect to local youth needs related to substance use and concurrent disorders.

# Phase One Summary

*From the National Youth Screening Project – Phase One Local Report (Henderson & Chaim, 2013)*

In Cape Breton Region, Nova Scotia, 483 youth and 120 service providers participated in Phase One of the NYSP project. The findings of this project in Cape Breton, Nova Scotia suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, almost half of participating youth endorsed significant concerns in more than one domain, and one quarter 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 problem are warranted.

The findings of this project also support the need for gender-sensitive and developmentally-informed approaches with youth. The concerns and needs of male and female youth differed, as did the needs and concerns of younger and older youth. For example, 16 to 18 year old girls were more likely to report suicide-related concerns than boys, but in the older age category males and females did not differ significantly, with older male youth experiencing significantly more suicide-related concerns than younger male youth. Also, the health sector saw a greater proportion of female youth than other sectors and the justice sector had more male youth than other sectors. For more information on the local project findings for Cape Breton, Nova Scotia, please refer to Appendix C.

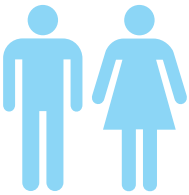
# Phase Two Findings: Who We Heard From

January 15th
2014

Service Provider, Youth, Family
Consultation meetings held

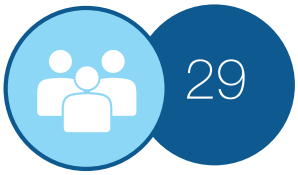
**3** Consultation Meetings

Consultation meeting delivery:
In-person




YOUTH


FAMILY MEMBERS




SERVICE PROVIDERS

# Phase Two Findings and Recommendations: What We Heard

The issues described below were highlighted specifically by Cape Breton Region stakeholders, given the unique circumstances in their region, along with any specific recommendations made. For a summary of issues identified across all sites, including the Cape Breton Region, please see the overall, across site, report.

# Access

***"Need to think out of the box about access."***
— Service Provider

## Availability

Although gaps in access to services for all age groups (i.e. 12-15 year olds, 16-18, and 19-24) were identified by all the stakeholder groups, some specific services were highlighted by services providers and youth as having made an important contribution and having increased access. For youth under the age of 18, CaperBase services, particularly the CaperBase outreach team, were identified as having increased service access and availability. In addition, some youth commented that youth who are in school can access supports and services through the guidance counsellor or school nurse. Access 808 and Phoenix House were mentioned as providing helpful services, particularly for transitional-aged youth, aged 16-24.

Some services are available (e.g. psychiatry), but access may be quite limited in duration or frequency (e.g. limited number of sessions). In addition, many comment that in order to get services, youth need to be in serious crisis or suicidal.

**Recommendations:**

- All stakeholder groups stressed the importance of increasing availability of services to youth across the region, either by extending services beyond the larger centres or by increasing access to youth by providing transportation to the centres.

***"Either you're nothing or suicidal."***
— Youth

***"For youth to get service is like rain in a desert. When I was going through treatment, I saw a psychiatrist once every 3 months and my therapist once a month. If there were more windows of opportunity, it would help treatment."***
— Youth

## Awareness

Youth stated that high school students and youth who are connected to adults and peers have an easier time finding out about and accessing services than those who are not connected. As such, it is particularly challenging for youth who are not in school to find out what is available. More broadly, it was noted that there is a lack of sufficient awareness of available services across population groups.

**Recommendations:**

- Youth and service providers stressed the importance of increasing awareness about services through advertising to the general public.
- Service providers noted the importance of providing information that would increase the "perception of the acceptability of accessing services", along with detailed information about the services available.
- Youth talked about the importance of educating youth about substances and their impact.

***"People think weed is a gateway drug…it's really alcohol because you can buy it at parties and you are more likely to try other substances when you're drunk."***
— Youth

## Service Facilitators

### *Transportation*

Public transportation is lacking and many youth are not able to access services due to distance from services and lack of access to transportation (e.g. youth living in rural areas). Although some youth may have family members or others who can provide transportation, barriers such as a desire to keep their service involvement confidential, may make access impossible, particularly for younger youth.

**Recommendations:**

- Provide funding for youth to attend appointments, especially for low income families and those in rural areas (e.g. taxi chits)

***"Continue funding for youth to attend appointments (mental health, addiction services, etc) if necessary, especially in rural areas and for low income families (offer taxi slips, other form of transportation) to get them to the appointment."***
— Service Provider

## Location

There is a lack of services across the continuum of care, particularly in rural areas where often there are no services at all.

**Recommendations:**

- Establish services across the region, rather than only in the larger centres (e.g. Sydney)
- Provide services "where youth are" (e.g. sports arenas)

***"Have headquarters in towns instead of just Sydney or just Glace Bay or whatever. Try and set up everywhere to get the word out and places where people hang out, skate, play sports or listen to music."***
— Youth

***"Access tougher in rural communities – lack of transportation or a "safe" place to meet."***
— Service Provider

## Costs

Poverty was cited as a major contributing factor to substance use and mental health problems and related to challenges in accessing service. Youth and families lack resources to pay for private services which may be required due to lack of publicly available services and/or long wait times for existing services. A number of participants mentioned having paid for private services (e.g. psychology). In additions costs associated with transportation may be a barrier to access.

## Hours

Restricted service hours are a barrier (e.g. nurse available during class hours, but youth are not allowed to leave class). Youth commented that expanded hours have increased service access in some settings (e.g., nurses in Youth Health Centres in schools). Family members noted the lack of crisis response at night as a major concern.

**Recommendations:**

- Provide flexible hours of operation, including lunch hour (e.g., at school), evening and weekend hours
- Provide "walk-in" services in schools instead of requiring appointments
- Provide "after-hours" staffing to provide access to information, crisis response, etc.

***"Service could get better if it was more hours, more often. That would be pretty sick."***
— Youth

***"Service could be better if there was service at any hour and not just at certain hours."***
– Youth

## Use of Social Media and Technology

Both service providers and youth talked about the need to find new ways to reach youth, to increase their awareness of services, engage them and provide service.

**Recommendations:**

- Build service provider competence with respect to using technology
- Increase use of social media to reach youth

***"Our ways of connecting with youth have to change."***
— Service Provider

***"[Need] a kid's version of a news site where kids find out what going on for youth in Cape Breton with a helpline side bar."***
— Youth

## Coordination and Collaboration

The need for coordination and collaboration amongst providers and across sectors to facilitate service access for specialized services as well as to basic primary care, dental and other services was noted, particularly by service providers.

**Recommendations:**

- It was suggested that for youth that are in school, the school can act as the "gatekeeper"/coordinator of services.

***"Need communication among all service providers working with the same kid."***
— Service Provider

## Timely Access

All the stakeholder groups expressed concern about long wait times for service access. Wait time challenges included the lack of local services, particularly mental health and specialist services as well as the need to go on wait lists locally in order to be screened or assessed and then having to wait again once referred for different or specialist services. Service providers noted the need for "immediacy", to provide services when youth needs are high and/or when youth "are ready". Youth commented that the services are helpful, but the wait times are "too long". Family members raised the concern that lengthy wait times may result in youth not being seen.

**Recommendations:**

- Increase local services, particularly psychiatry, psychology and crisis services
- Increase the frequency and duration and duration of services

***"Services are available, but there's a huge wait."***
— Youth

***"I think it's good, but the wait to get into see your therapist is too long."***
— Youth

# Service Components

The existing outreach services and services available in schools were seen as very valuable and important to maintain and expand by all of the stakeholder groups. In addition, the need to develop specific services for transitional-aged youth, particularly in the 19-24 age range and for those not in school was identified, along with the need to increase involvement of peer mentors and supports in services.

Family members raised concerns about youth being sent to adult services, due to lack of youth-specific services. They also talked about the need for services outside of regular business hours.

Service providers talked about the importance of a comprehensive continuum of care, with school as an effective access point for youth who are in school but stressed the need for different services and processes to reach youth who are out of school. They did note that it is necessary, but not always the case, that school administration "buys into" service. They also mentioned programs that have been developed for schools but are not utilized (e.g. *Healthy Minds/Healthy Bodies*). A range of services were identified as lacking including shelter/housing, residential treatment, youth-friendly 24 hour crisis/emergency services and service to educate, engage and support parents and other family members. With respect to services for families, a number of barriers were identified including youth concerns regarding confidentiality, complications for families involved in the child welfare system, families not being aware that youth are involved with services or are struggling with substance use and/or mental health concerns.

Attention to the social determinants of health through services were also suggested including vocational counselling, assistance with job searches, and more availability of existing services and processes within the justice system (e.g. restorative justice).

**Recommendations:**

- Focus prevention efforts on youth 12-15
- Increase education for parents and family members
- Increase outreach services to identify youth in need of services
- Extend the role of guidance counsellors already present in schools to include addressing substance use and mental health concerns
- Increase youth specific services
- Arrange for on-call psychologist or psychiatrist
- Provide existing service components outside of regular business hours

***"Have to threaten your life to get transported by police."***
— Youth

***"No attention until you are in a crisis."***
— Youth

***"When parents are in a bad spot the services they should go to are the ones they are most afraid of (child welfare and family support) and instead they call the police."***
— Service Provider

# Service Delivery Model

Support groups and other services provided in schools were highlighted as effective and engaging by many of the participating youth, although some commented on stigma and other barriers in accessing services at school. The youth also spoke to the need for easier access to services, particularly more specialized substance use and mental health treatment services outside of school.

Many of the issues raised across stakeholder groups related to the service delivery model also were discussed in relation to some of the other themes and included issues related to transitioning for children around the age of 12, dealing with challenges related to puberty, moving from elementary to middle school/high school and for transitional-aged youth, 16-24. Age restrictions limiting eligibility were cited as barriers to responding to the developmental and service needs of youth (e.g. housing, financial support, child welfare services, employment).

***"There are concerns that a student can become disconnected from school, whether it's because they graduate or drop out. After 19, [there are] concerns that they no longer have external, safe support, whether it be services offered through school or an agency."***
— Service Provider

***"16-18 is a big gap. Youth fall through the cracks – youth services end at 19 but they may not be developmentally ready for adult [services]."***
— Service Provider

***"Pressures on 19-24 year olds who go to post-secondary institutions, the 'drinking and drug culture' in universities."***
— Service Provider

# Service Attributes

Stigma and shame were identified across stakeholder groups as significant barriers that prevent youth and parents from reaching out for services. Stigma experienced by male youth was commented on in particular by youth and family members/supporters (e.g., male youth who need help for mental health concerns, stigmatizing responses from peers and teachers). Service providers commented on the barriers to parental service access and engagement due to stigma and fear related to seeking services such as family services and child welfare.

Youth indicated a need for services that provide a safe space (e.g. individual services if "afraid" of large groups), validate youth experiences rather than "minimize" youth experience of concerns/mental health problems, particularly for younger youth (e.g. don't say" it's just a phase"), and can ensure confidentiality (e.g. health centres inform parents of youth involvement).

***"Stigma is hugest for those who need it [services the] most."***
— Service Provider

***"Stigma for males – they're told to 'suck it up"***
— Youth

# Service Provider Attributes

All stakeholders discussed the need for caring service providers, who inspire trust, are flexible and can maintain confidentiality. Youth also identified the importance of peer support and providers with lived experience.

***"Stop being so judgmental, stop yelling and grounding."***
— Youth

***"[We want] people who have been through the same things, [are] easy to relate to, around the same age, and have lots of information and ways to help."***
— Youth

# Health Equity and the Social Determinants of Health

Barriers and challenges related to health equity and the social determinants of health were discussed at length by all the stakeholder groups. Issues were highlighted in two key areas, the high rate of poverty in the region and issues for specific populations of youth.

With respect to poverty, it was noted that many families lack adequate resources for basic needs including adequate food and transportation to school and services. Many service providers raised the concern that poverty was directly related to the rate of substance use and determined accessibility. They stated that many youth lack resources for housing which can result in homelessness.

Challenges related to age, sex, gender and sexual orientation were highlighted. Various issues were raised related to the needs and experiences of male and female youth, as well as older and younger youth. Some stated that female youth need more help while some noted the lack of services that engage and address the needs of male youth.

Issues including lack of access, availability and stigma were noted for youth and families that identify with specific population groups (e.g. First Nations, African Nova Scotians).

**Recommendations:**

- Provide population-specific, gender- and developmentally- informed services, including specific services for boys/men, girls/women, First Nations youth, African Canadian youth, and LGBT youth.
- Increase availability of specific types of services to meet the needs of specific groups (e.g. shelters for females)
- Provide staff training to develop competency in gender-specific care
- Engage service providers that reflect the population served (e.g. more male staff, LGBT staff, etc.)
- Use a symbol to demonstrate safe space/services (e.g. pink triangle)
- Provide funding to *Gay-Straight Alliances*

***"Poverty issues are huge - no one wants to own/take responsibility for this."***
— Service Provider

***"Feels like our young men are falling apart."***
— Service Provider

***"Boys and girls have different problems."***
— Youth

*"In rural communities, often times religious youth groups offer excellent support and services, however, if you identify as LGBT, you may not feel like you can access those services."*
— Service Provider

*"When families are struggling and need to put so much energy into managing to do without the BASIC needs, it is very difficult to encourage parents and young people to focus on positive health practices."*
— Service Provider

# Policy and Funding Concerns

Some service providers were concerned about the impact of school policies that suspend or expel youth from school after missing a certain number of classes "with or without an excuse". They were concerned about the increased risk and vulnerability for youth not in school.

**Recommendations:**

- Review policies impacting youth and services required, given existing policies.

# KELOWNA TAB

# KELOWNA
# BACK OF TAB

# Kelowna, British Columbia

The front section of this report describes the background of the National Youth Screening Project (NYSP) and the development and activities of Phase Two (i.e. community-based consultation meetings). The cross-site section of this report includes a comprehensive description of what we heard from all the stakeholder groups across the participating communities, including the Kelowna, British Columbia community.

The following section includes a brief summary of the Kelowna, British Columbia findings from the NYSP Phase One (Henderson & Chaim, 2013), demographic information about the participants in the Phase Two consultations, and unique findings and recommendations from the consultation discussions pertaining to what is working well, challenges, and recommendations with respect to local youth needs related to substance use and concurrent disorders.

# Phase One Summary

*From the National Youth Screening Project – Phase One Local Report (Henderson & Chaim, 2013)*

In Kelowna, British Columbia, 113 youth and 43 service providers participated in Phase One of the NYSP project. The findings of this project in Kelowna, British Columbia suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, almost three quarters of participating youth endorsed significant concerns in more than one domain, and almost two thirds 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 project also support the need for gender-sensitive and developmentally-informed approaches with youth. The concerns and needs of male and female youth differed, as did the needs and concerns of younger and older youth. For example, 12 to 15 year old girls were more likely than any other group to report suicide-related concerns. Also, older youth were less likely to be living with family, and possible family supports, than younger youth. For more information on the local project findings for Kelowna, British Columbia, please refer to Appendix C.

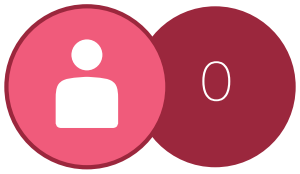
# Phase Two Findings: Who We Heard From

December 4th 2013

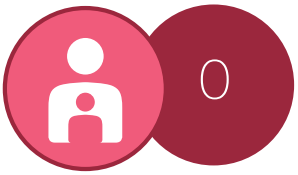
Service Provider Consultation meeting held

**1** Consultation Meeting

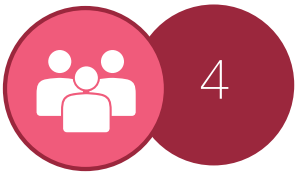
Consultation meeting delivery: Webinar




YOUTH




FAMILY MEMBERS




SERVICE PROVIDERS

# Phase Two Findings and Recommendations: What We Heard

The issues described following were highlighted specifically by Kelowna, British Columbia stakeholders, given the unique circumstances in their region, along with any specific recommendations made. For a summary of issues identified across all sites, including Kelowna, British Columbia, please see the overall, across site report.

## Access

### Availability

Stakeholders identified a practice of "streamlined access" to psychiatric services for youth presenting with severe psychiatric needs as very helpful and effective; however, overall, they identified a lack of access to psychiatric services as a serious concern for the youth in their community. A gap in service availability was also noted particularly for youth who are not in school as there are only two addiction workers available to that population.

**Recommendations:**

- Increase availability of psychiatric services
- Develop a provincial framework that trains doctors in concurrent disorders; links groups of doctors together through provincial training
- Develop a smooth referral pathway from school counsellors to physicians in the community
- Increase support and services for family members/youth supporters

***"The practice of streamlined access to psychiatric services and session for youth presenting with severe psychiatric needs is very helpful and effective."***
— Service Provider

### Awareness

The importance of ensuring that youth, families and the general public are aware of services available was discussed.

**Recommendations:**

- Use posters, webinars and social media to reach youth to inform them of services and decrease stigma related to accessing services
- Develop a resource guide to mental health services for youth ages 0-18 and 19-24, that is available to service providers, youth and families

# Coordination and Collaboration

Many comments were made regarding the importance of developing processes for collaboration across services and sectors. This discussion advocated for a service delivery model that is coordinated and collaborative. Referral and intake processes and service wait-times for youth, particularly those with severe needs, were also discussed in this context. The importance of "speaking the same language" was noted.

**Recommendations:**

Stakeholders made a number of suggestions and recommendations regarding initiatives underway, being considered or recommended that would improve access to services for youth, primarily focused on coordination and collaboration including:

- Implement a common screening tool across sectors to facilitate identification and referrals
- Develop a process to link school counsellors to physicians in the community in an effective way
- Develop a process for streamlined access and referrals for youth with very severe needs
- Develop processes to facilitate smooth transition from child/youth to adult services, noting that this process will require training for service providers
- Develop a process for referral from emergency department to community-based services
- Facilitate the development of a collaborative network for youth, families and service providers

***"Gather a group of youth service providers to put together a framework of best practices to share across Kelowna."***
— Service Provider

# Service Facilitators

## *Use of Social Media and Technology*

Use of technology was mentioned by some of the stakeholders as a potential way to reach, engage and communicate effectively with youth and families who may not otherwise be able to connect with services.

**Recommendations:**

- Use technology to administer tools (e.g. an app for the GAIN SS)
- Use Skype/other technology to engage with family members/youth supporters who may not be able to attend sessions with youth (e.g. parents who work, live out of town, etc.)

# Service Components

Recent collaboration between mental health and addiction treatment providers, particularly in schools have been an important contribution to the service system. It was noted that addressing family/caregiver needs and involving them in service (e.g. group support, counselling with their youth) is very important, including assisting them to understand substance and mental health issues, referral networks, and what to expect as their youth engage with the system. Although there are services such as The Force in place to help parents navigate the system, there is additional need for increased community-based family support and counselling.

**Recommendations:**

- Consider program development in schools and the justice system to address youth needs related to concurrent disorders (CD) and to enhance or develop programs so that they provide care that is responsive to developmental-, gender-, and trauma-specific needs
- Continue and build on school-based programming and provision of clinical services
- Develop a process for stream-lined access to psychiatric services, particularly for very high risk youth
- Develop a protocol to facilitate smooth transition from the emergency room to the community
- Build capacity for service delivery for youth who are not in school
- Build on existing family counselling and support services

***"What support do the families get? Need literacy, understanding of referral networks, and what can families expect when a youth is going through these types of issues."***
— Service Providers

***"More drug/alcohol counsellors for youth that are not in the school system in Kelowna (there are only 2 at the present time)."***
— Service Provider

# Service Attributes

With respect to service attributes, the discussion focused on the need for enhanced developmentally-, gender-, and trauma-informed care, including, in particular, an ability to address self-harming behavior, suicidal ideation and suicide plans. A screener for identifying level of suicide risk and a related protocol are in the pilot phase in response to these issues. In addition there is a need to address CD, particularly given the high rates experienced by youth in the school system. The importance of a well-informed, well-trained service provider community was discussed to facilitate optimal services, understanding and implementing evidence-informed approaches.

**Recommendations:**

- Training of practitioners across sectors in the areas required to meet the needs of youth in this community (e.g., evidence-informed practices including youth screening, CD, developmentally-, gender- and trauma-informed care)

***"There is high concern in Kelowna for suicidal ideation and suicide plans."***
– Service Provider

# Health Equity and the Social Determinants of Health

Service providers in Kelowna focused on the need for developmentally- and trauma-informed services with a particular focus on differentiating the diverse and complex needs of both male and female youth.

**Recommendations:**

- Implement developmentally-informed and trauma-informed services.
- Implement gender-informed and specific services to address the unique needs of boys and girls identified through NYSP Phase One, particularly the internalizing and trauma-related concerns of younger girls.

***"Need to address trauma across the age groups, thinking about both boys and girls."***

— Service Provider

# Policy and Funding Concerns

Stakeholders suggested that review of NYSP and other such information by policy makers is important in informing planning, particularly in relation to screening processes, service delivery needs, and resource/staffing allocation.

**Recommendations:**

- Implement a common screening tool across sectors/services
- Use results of screening to guide service planning and development (e.g. implement responsive services in settings where high needs have been identified)
- Support development of a referral network that facilitates needed service access for youth
- Support provincial training for physicians in CD
- Review/revise policies to facilitate seamless integration of agency-based addiction counsellors in schools (currently perceived to conflict with guidance counsellor role; however, the roles are complementary)

***"No provincial framework around accepted screener for CD."***

— Service Provider

# PRINCE EDWARD ISLAND TAB

# PRINCE EDWARD ISLAND BACK OF TAB

# Prince Edward Island

The front section of this report describes the background of the National Youth Screening Project (NYSP) and the development and activities of Phase Two (i.e. community-based consultation meetings). The cross-site section of this report includes a comprehensive description of what we heard from all the stakeholder groups across the participating communities, including the Prince Edward Island community.

The following section includes a brief summary of the Prince Edward Island findings from the NYSP Phase One (Chaim & Henderson, 2013), demographic information about the participants in the Phase Two consultations, and unique findings and recommendations from the consultation discussions pertaining to what is working well, challenges, and recommendations with respect to local youth needs related to substance use and concurrent disorders.

# Phase One Summary

*From the National Youth Screening Project – Phase One Local Report (Chaim & Henderson, 2013)*

In Prince Edward Island (PEI), 332 youth and 99 service providers participated in Phase One of the NYSP project. The findings of this project in PEI in suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, almost 2/3 (64%) of participating youth endorsed significant concerns in more than one domain, and more than half (55%) of youth screened positive for co-occurring substance and mental health concerns, primarily co-occurring substance and internalizing concerns (42%). In particular, youth seeking service in the Addictions sector were the most likely to endorse concurrent disorders. 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 project also support the need for gender-sensitive and developmentally-informed approaches with youth. Although in some areas the concerns and needs of male and female youth were similar, in others they differed significantly, as did the needs and concerns of younger and older youth. For example, girls in the youngest age categories were more likely to report suicide-related concerns than boys and than older females, whereas in the older age category males and females did not differ significantly. Notably approximately one half of youth who screened positive for concurrent disorders, had previous legal involvement; almost three quarters of male youth and one third of female youth. For more information on the local project findings for PEI, please refer to Appendix C.

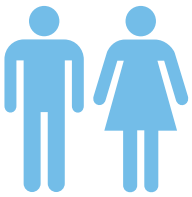
# Phase Two Findings: Who We Heard From

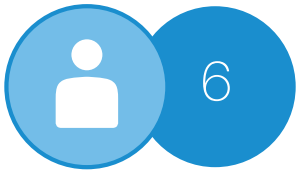
January 16th and 17th 2014

Service Provider, Youth, Family Consultation meetings held

**3** Consultation Meetings

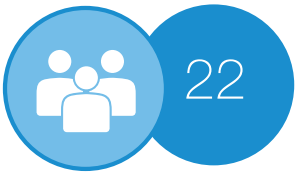
Consultation meeting delivery: In-person






YOUTH


FAMILY MEMBERS




SERVICE PROVIDERS

# Phase Two Findings and Recommendations: What We Heard

The issues described following were highlighted specifically by PEI stakeholders, given the unique circumstances in their region, along with any specific recommendations made. For a summary of issues identified across all sites, including the PEI, please see the overall, across site report.

## Access

### Availability

All the stakeholder groups identified a number of gaps in service including prevention services in elementary schools, services for younger youth (i.e.12-15), including education about mental health and substance use, "beyond alcohol", youth-focused withdrawal management, services for opiate addiction (i.e. Methadone program), specialized programs for youth (e.g. mental health) and long-term treatment and services for transitional-aged youth. Youth and family members commented on the predominant use of medication and youth noted that there is only one doctor who prescribes methadone.

Youth noted that the *Strength Program* is helpful but very short, only 2 months, which they felt was not sufficient. Similarly with respect to residential treatment, there are only 6 beds and the program is 12 months long, so the wait is very long.

Family members noted the lack of services, particularly psychiatry and psychology, and stated that increased access to "off-Island" treatment is required (e.g., *Portage*). They also noted that service availability is extremely limited once a youth is not in school. Services that address eating disorders and trauma are also required. Service providers also mentioned the limited access to out of province services for transgendered youth. For youth who do go out of province for services, there is a need for follow-up and extended care services.

**Recommendations:**

- Initiate prevention services in elementary schools
- Increase access to off-Island treatment / develop residential capacity on the Island
- Facilitate service access for youth not in school
- Increase access to specialized services for transitional-aged youth, including transitional housing.

***"The only treatment available is medication."***
— Youth

## Awareness

Both youth and family members talked about youth not knowing how to find help and the importance of information being available through the school. Youth commented that there is some information about services on school websites but that it is not accessed by youth. *Kids Help Phone* is available and there are signs for it posted around the school.

There is limited awareness of the diverse needs of youth, particularly boys and trans youth, making it difficult for them to reach out. Youth raised concerns about parents not having enough information or understanding that youth, especially boys, can be struggling with mental health concerns such as depression. In addition they raised concerns that parents provide cigarettes for their children and stores often sell cigarettes to underage youth.

**Recommendations:**

- Advertise services on school announcements and posters around the school, at bus stops.
- Create advertising that demonstrates the diverse needs of youth including trans youth, boys experiencing depression and other emotional problems.

***"Need more education for parents, for example need more education regarding addiction in kids and letting them know that kids with addictions are not just 'bad."***
— Youth

***"We have an addiction counsellor in school but don't hear about it until we need service and we have to say something to get it – there is no advertising about it. They should advertise that someone with addiction expertise is available."***
— Youth

## Service Facilitators

### *Transportation*

There is no public transportation available to youth in some parts of rural PEI or services are very limited, so youth have to get a ride in order to access treatment. This creates barriers to accessing services both because of the challenges associated with getting rides and issues related to confidentiality. Cost of transportation is also a barrier.

**Recommendations:**

- Provide financial support and actual transportation for youth in rural areas.

***"Have to be able to get drive from someone, no buses for rural youth."***
— Youth

## *Location*

Services need to be available across communities (i.e. services are only available in Charlottetown and Sunnyside). Service providers also suggested providing services in places that youth frequent, rather than only in formal treatment facilities and schools.

***"Need services where youth are living especially outside of Charlottetown."***
— Youth

## *Costs*

Some family members commented on the need to pay to access service in a timely manner (e.g. psychology).

***"We ended up paying for services because we could."***
— Family Member

## *Eligibility Criteria*

When talking about access to mental health services, along with substance use treatment services, family members and service providers talked about barriers to access including:

- Requiring a diagnosis to get service
- Age restrictions including counsellors not being willing to see children under 12, lack of financial and housing assistance for youth under 14, 16 year olds being able to choose to leave care, inability to mandate youth to treatment, and " no services for youth over 18"
- Challenges related to parental involvement in youth treatment without youth consent.

Service providers stated that there are different services and access challenges related to addiction and mental health services, stating that the access to addiction services for youth in schools works well, including access to family counsellors and family groups. For mental health service, unless the need is "acute", there is a lengthy wait for service.

***"Almost have to wish for them [youth] to break the law so they will be picked up by the police and [be] kept safe."***
— Service Provider

***"There is no housing availability in Charlottetown to support youth seeking treatment."***
— Youth

## Coordination and Collaboration

Service providers talked about the importance of collaboration particularly between mental health and addiction services.

**Recommendations:**

- Develop processes and protocols for file sharing
- Coordinate service delivery amongst providers

***"There is a lack of continuum of service – 'a little bit here and there and nothing in between'."***
— Service Provider

## Timely Access

There is either no service available or wait times are very long (i.e. many months). Youth and family members stated that it can take 2-3 years to get help due to the many youth waiting for service and limited service availability as described above. Family members noted that there are long waits for services, even if they are willing to pay. They stated that there is a 3 year wait list for psychological testing in the school system and that "there is one psychologist for all of PEI."

**Recommendation:**

- Increase availability of local services

***"If kids do seek help—depends on the level of crisis (harm) on how quickly they are given help or referred."***
— Family Member

***"Kids who self-harm get a reaction."***
— Family Member

***"When parents reach out for help, they get knocked back and then give up."***
— Family Member

## Referral and Intake Processes

Family members talked about various difficulties accessing service directly as well as facilitating referrals between sectors, services and various service providers. Some family members stated that their children were able to access services once they were involved with the law (e.g. youth outreach worker through the police) or child welfare services.

**Recommendation:**

- Increase direct or self-referral options

***"Had to get help for addiction issues through Child and Family Services."***
– Family Member

***"Physician refused to refer my daughter who has anxiety for counselling and is treating her. Unless she has a crisis he has the power to refuse the referral."***
– Family Member

# Service Components

Family members mentioned the need for service components across the continuum of care, including increased outreach and early intervention (i.e. "start reaching children before junior high") and long-term care. They also talked about the importance of engaging parents so that parents can understand how to be helpful and supportive to their children as well as peer support components for youth. In addition, they stressed the importance of services and providers helping youth to develop coping strategies, as opposed to relying solely on medication.

Service providers talked about the need for more community-based services for youth including education, prevention, social skills groups, and support for children whose parents have substance use and mental health problems. They suggested having places where "youth can hang out with minimal involvement from professionals". Service providers also talked about the importance of increasing services for families, although a number exist (e.g. family counsellors, family program at *Strength*) but are insufficient to meet the need.

**Recommendations:**

- Increase efforts with respect to early identification and provision of assessments in schools
- Provide services including counselling for parents

***"Quick to pass out a pill, medication can be helpful, but need more."***
— Family Member

# Service Attributes

The importance and challenges related to confidentiality were discussed by all the stakeholder groups. Youth talked about the importance of confidentiality given the challenges related to seeking help in a small community where "everybody knows everybody". Service providers stated that for younger youth (i.e. 12-15), where parental consent is required, many parents refuse to consent as they may be concerned that the youth will talk about family issues. At the same time, family members raised concerns about the barriers that confidentiality creates for parents with respect to being able to support their children.

Youth talked about the importance of peer support. Youth also talked about stigma as a barrier to seeking treatment, especially since seeking help can become a barrier to getting a job as youth perceive that there is a reluctance to hire people who have had mental health or substance use problems.

Family members talked about the importance of a "safe space" and "meeting youth where they are at". Service providers, in addition, commented that services need to include "fun" elements.

Service providers noted the need for trauma-informed care, given the high rate of endorsement of trauma concerns, and self-harming behaviours, particularly among female youth.

Some service providers also talked about the importance of a health promotion perspective as opposed to focusing only on problems and disorders.

**Recommendations:**

- Ensure that youth and families are aware of agency policies related to confidentiality
- Consider changing policies that serve as a barrier to seeking service
- Consider expanding peer-based services and services provided in "youth-engaging" spaces and contexts

*"We can't just reconfigure what currently exists; we tend to pathologize everything so there is an increased stigma to seeking help."*
— Service Provider

*"People remember your past – it's hard to move on and get a second chance so people don't access services. If you go to get a job, they remember."*
— Youth

*"…confidentiality between the youth and service provider…it's hard for parents to know how to help."*
— Family Member

*"When a kid is in a crisis, we work as a team with the counsellor; after that, it's like a black box."*
— Family Member

*"Peer program was amazing - it really engaged my daughter."*
— Family Member

# Service Provider Attributes

Family members talked about the importance of caring supportive service providers that engage with the family as well as the youth. Service providers talked about the current challenges in being as flexible and responsive as they would like to be, given resource constraints.

*"Used to come to the table prepared to offer something for more complex clients but not so much anymore because of mandates and protecting my pot of resources."*
— Service Provider

# Health Equity and the Social Determinants of Health

The need for services to address the needs of specific populations groups has addressed including the need for services that engage and address the needs of adolescent boys who have difficulty getting their needs addressed as they are "brushed off" by adults, especially when expressing concerns such as depression. The need for services specific to transgendered youth was identified.

Poverty and unemployment were discussed in terms of impact on youth substance use and CD and impact on engagement with services. Poverty was discussed as a barrier to service including the inability to afford housing, clothing, and adequate food which affects a youth's ability to focus on addressing substance use and mental health needs. In addition, service providers commented on the impact on families of unemployment and situations such as "fathers working in Fort McMurray".

*"Families might say 'I don't want my kid on pills', but actually they don't have money for pills."*
— Service Provider

# Policy and Funding Concerns

Service providers stressed the importance of government investment in services, based on studies demonstrating need. They made many statements, as did youth and family members, about the focus on acute, crisis concerns, and the lack of attention and access to help for emerging concerns, before they become acute.

**Recommendations:**

- Provide more resources for treatment

***"Budget constraints in PEI result in a one size fits all approach, which professionals do the best with what they have. We need a variety of services to meet mild, moderate and severe concerns."***
— Service Provider

***"We study too much and then don't put the investment in to implement necessary services. Twenty years ago a study was done that gave a great overview with input from staff, parents, youth on how to make services more user-friendly and effective and the province never implemented [any of the recommendations]. We just kept studying! And findings have all been similar—but over the years as money gets tight we tend to lose services."***
— Service Provider

***"Message to 'do it smarter, spread it further'— is a fallacy – we need more resources."***
Service Provider

# ST. JOHN'S TAB

# ST. JOHN'S BACK OF TAB

# St. John's, Newfoundland and Labrador

The front section of this report describes the background of the National Youth Screening Project (NYSP) and the development and activities of Phase Two (i.e. community-based consultation meetings). The cross-site section of this report includes a comprehensive description of what we heard from all the stakeholder groups across the participating communities, including the St. John's, Newfoundland and Labrador community.

The following section includes a brief summary of the St. John's, Newfoundland and Labrador findings from the NYSP, Phase One (Chaim & Henderson, 2013), demographic information about the participants in the Phase Two consultations, and unique findings and recommendations from the consultation discussions pertaining to what is working well, challenges, and recommendations with respect to local youth needs related to substance use and concurrent disorders.

# Phase One Summary

*From the National Youth Screening Project – Phase One Local Report (Chaim & Henderson, 2013)*

In St John's, Newfoundland and Labrador 107 youth and 53 service providers participated in Phase One of the NYSP project. The findings of this project in St. John's, Newfoundland and Labrador suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, almost half of participating youth endorsed significant concerns in more than one domain, and one quarter 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 problem are warranted.

The findings of this project also support the need for gender-sensitive and developmentally-informed approaches with youth. The concerns and needs of male and female youth differed, as did the needs and concerns of younger and older youth. For example, girls in the youngest age categories were more likely to report suicide-related concerns than boys, but in the older age category male and female youth did not differ significantly. Also, female youth with legal involvement were much more likely to have screened positive for concurrent disorders than female youth without legal involvement. For more information on the local project findings for St. John's, Newfoundland and Labrador, please refer to Appendix C.

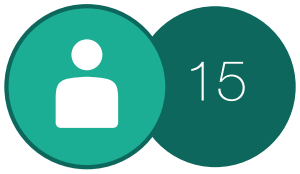
# Phase Two Findings: Who We Heard From

March 4th
2014

Service Provider and Youth
Consultation meetings held

**2** Consultation Meetings

Consultation meeting delivery:
In-person




YOUTH


FAMILY MEMBERS


SERVICE PROVIDERS

# Phase Two Findings and Recommendations: What We Heard

The issues described following were highlighted specifically by St. John's, Newfoundland and Labrador stakeholders, given the unique circumstances in their community, along with any specific recommendations made. For a summary of issues identified across all sites, including the St. John's, Newfoundland and Labrador community, please see the overall, across site report.

# Access

## Availability

Youth commented on the lack of services, particularly support services, including housing, shelter and "recovery beds", particularly for youth 16-18 who are no longer eligible for child welfare services and not yet eligible for adult services. Service availability issues are further discussed in the section on service components below.

**Recommendations:**

- Increase availability of needed services

***"Here you have to sleep outside because can't get a place for 4 days."***
— Youth

## Awareness

Youth noted the need for increased promotion of services. They cited *Choices For Youth* as an example of a service that "does a good job" of promoting and informing youth about services and events by posting information on their door, in monthly newsletters and by posting flyers at other agencies.

**Recommendations:**

- Increase information dissemination to increase awareness of services by posting information in community locations that youth frequent.

## Service Facilitators

### *Transportation*

Transportation was identified as a significant issue. For example, it is frequently not possible to travel to St. John's for service and return home the same day, requiring overnight accommodation which is not affordable for most youth and their supporters.

### *Location*

Services are located in an urban centre (e.g., St. John's), creating a significant barrier to care for youth who live in smaller centres and rural areas.

### *Eligibility Criteria*

Both youth and service providers identified some of the barriers to service created by service eligibility criteria. For example, youth mentioned that they need to be receiving social services in order to be eligible for housing which is a barrier, particularly for youth who would like to maintain employment, despite low pay. Service providers stated that the requirement for child welfare/child protection to be involved in order for families and children aged 12-16 to receive services addressing substance use is a significant barrier. They also commented that there are different requirements in different parts of the province regarding eligibility criteria which creates further confusion.

**Recommendations:**

- Consider the role of service facilitators as service components and delivery models are developed i.e. consider models that reach youth in innovative ways, such as using technology, various outreach models etc. This is discussed in more detail below.

## Coordination and Collaboration

Service providers talked about the importance and potential benefits of collaboration but that services and access are limited. See reference to examples such as *Nav Net* in the section on service delivery models below.

## Timely Access

There are long wait times, amongst other barriers related to intake and referral procedures, for family physician services, psychiatry (e.g., one psychiatrist for a large region), and social services. Youth complained of being on hold (e.g., with social services) for up to 4 hours, getting voicemail but having no phone to receive a call back. If the youth has a phone, they need to wait by the phone to get a call.

**Recommendations:**

- Increase drop-in services to provide timely and easy access.

***"People get into program and are selected even if they don't want it. But others who want it can't get in and are put on the wait list."***
— Youth

# Service Components

Youth and service providers identified the need for a continuum of care that spans early identification/ intervention and drop in services to outreach and treatment services, including holistic services addressing the social determinants of health, including housing, employment (e.g. job experience opportunities, resume building) and recreational services. Youth also identified the need for services for specific groups of youth, including services for youth coming out of jail, (e.g., social supports and treatment) and continuing care and support for youth coming out of care (i.e. child welfare) at age 16, continuing up to age 24. They also identified the need for specific services and supports such as access to psychology services, AA, and supports and services for families. They noted a particular lack of services for transitional-aged youth, ages 17-24.

Service providers identified efforts that have been made over the past few years to increase access and availability of services and enhance the continuum of care including drop-in, outreach and mobile crisis services, as well as an early psychosis program. There is a focus on work to reunite youth (aged 16-18) with families where possible, rather than focusing only on alternate housing arrangements. They also identified a need for services to be delivered in schools given the increasing rates of substance use and mental health concerns, and challenges for schools to respond. Despite this, administrative challenges to having agency staff provide services in schools were noted. *Kids Help Phone* was cited as a helpful resource with good uptake in Newfoundland.

**Recommendations:**

- Increase focus on prevention rather than focusing only on providing reactive services
- Develop processes for agency staff to deliver substance use services in the school system, collaboratively with school staff
- Develop processes and protocols to use social media, other technology, including apps to reach youth that are not coming in for service
- Expand the use of transition workers and transitional supports for youth with CD, mental health and eating disorders to support transition from the child to adult system
- Increase the capacity for case navigation and case management
- Implement parent support and parenting programs
- Increase support for family reconnection for older adolescents

***"Shouldn't give up on them at 16; need to support them through 24 years old."***
— Youth

***"Need increased focus on facilitating family work/ family reconnection."***
— Service Provider

# Service Delivery Model

*Eastern Health* has implemented a centralized intake model and is developing two treatment centres that include family involvement as a core component of the model. *Nav Net* was also identified as a system "table" that has been developed, led by a coordinator, to "system manage" youth with complex needs. Currently 8 youth are receiving this service. It is important to identify someone who will coordinate the care for youth with complex challenges so that someone can be "responsible for their care."

**Recommendations:**

- Develop service models that meet the needs of youth with very complex challenges including youth with FASD, ADHD, and PDD
- Create a checklist when working with youth that includes questions to determine if the youth has FASD and/or a trauma history

# Service Attributes

Youth identified service attributes that are important to them including harm reduction approaches, trauma-informed care and service engagement without parental involvement. Service providers noted that it is challenging to provide youth services in the way that they would like as parental consent is required for service access for youth under 16. In addition, parents often call requesting services for older youth, who refuse service involvement. In addition, involvement with child protection does not provide access to prevention and support services as it did in the past.

Service providers reported efforts that are underway to engage youth and provide services tailored to meet their needs. Examples included providing $10 Telus cards so that they can communicate with youth and provide an incentive for service engagement. *My Life/My Choice* and *Just Us Women* programs (*Naomi Centre*), address trauma and sexual violence for women, provide training for service providers to offer a prevention group focused on sexual exploitation and trauma, and build inter-disciplinary staff teams (e.g. PHN and nurse practitioner based at *Choices For Youth*). Service providers reported that use of texting has had a positive impact on maintaining a connection to service and has decreased missing person reports. At the same time, providers are concerned about the increased use of technology versus face to face communication and are concerned that youth are increasingly vulnerable with respect to some of the risks involved in engaging with others through social media.

**Recommendations:**

- Explore how to best implement technology, particularly to reach youth who don't come for services, but also considering the high rate of internet and gaming misuse.

***"Young people are vulnerable in terms of what they put out on social media."***
— Service Provider

***"Need services youth can access without parents."***
— Youth

# Health Equity and the Social Determinants of Health

Youth reported a lack of beds (i.e. shelter, housing), particularly for young women, younger youth, and youth who have children. Youth also talked about inadequate funding for food and shelter. Service providers also raised concerns about adequacy of shelter services and supports with respect to the high rate of repeat shelter users as well as the low level of functioning and high needs of many of the shelter users (e.g. autism spectrum difficulties, FASD, ADHD). There is a lack of referral options, so *Choices For Youth* supports youth until age 29, despite the fact that, at that age, there is still a lack of appropriate resources and supports.

Service providers expressed concern about seeing an increase in youth involved in gangs and organized crime. They also identified the importance of addressing and developing specific services to meet the needs of youth who identify as sex workers, youth who are sexually exploited, trans youth, and young women. Some specific issues of concern included a reported increase in youth involved in sex work using intravenous drugs, lack of health care that meets the needs of trans youth (some reported needing to go to Toronto for care). A *Trans Needs Committee* has been established and that is seen as promising in terms of a group that can advocate and potentially initiate local services/supports.

**Recommendations:**

- Identify a tool to identify a youth's "developmental age" and functioning level to better understand needs
- Increase service provider understanding of what to expect from youth with complex needs and increase knowledge of potential services and supports

***"If there were more programs for people affected by trauma like a mother's death then there wouldn't as many behavioural problems or substance use."***
— Youth

***"Increase in young people identifying as transgendered – demand for these services and supports will increase."***
— Service Provider

# THOMPSON TAB PLACEHOLDER

# THOMPSON TAB PLACEHOLDER

# Thompson, Manitoba

The front section of this report describes the background of the National Youth Screening Project (NYSP) and the development and activities of Phase Two (i.e. community-based consultation meetings). The cross-site section of this report includes a comprehensive description of what we heard from all the stakeholder groups across the participating communities, including the Thompson, Manitoba community.

The following section includes a brief summary of the Thompson, Manitoba findings from the NYSP, Phase One (Chaim & Henderson, 2013), demographic information about the participants in the Phase Two consultations, and unique findings and recommendations from the consultation discussions pertaining to what is working well, challenges, and recommendations with respect to local youth needs related to substance use and concurrent disorders.

# Phase One Summary

*From the National Youth Screening Project – Phase One Local Report (Chaim & Henderson, 2013)*

In Thompson, Manitoba 34 youth and 43 service providers participated in Phase One of the National Youth Screening Project (NYSP). The findings of this project in Thompson, Manitoba suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, half of participating youth endorsed significant concerns in more than one domain, and over 40% of youth screened positive for co-occurring substance and mental health concerns. In addition, the vast majority of youth presenting to the addictions sector had significant co-occurring mental health concerns. These findings suggest that recent efforts to improve capacity to address co-occurring substance use and mental health problem are warranted and that the need for mental health services for youth with problematic substance use is high.

The findings of this project also support the need for gender-sensitive and developmentally-informed approaches with youth. The concerns and needs of male and female youth differed, as did the needs and concerns of younger and older youth. For example, 16 to 24 year old male youth were more likely to report externalizing difficulties than same-aged female youth and younger youth. Also older female youth were more likely to endorse problematic substance than younger female youth but problematic substance use by male youth did not differ significantly by age. For more information on the local project findings for Thompson, Manitoba, please refer to Appendix C.

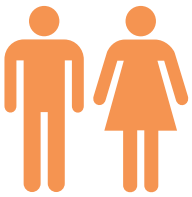
# Phase Two Findings: Who We Heard From

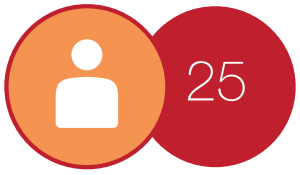
November 26th 2013

Service Provider, Youth, Family Consultation meetings held

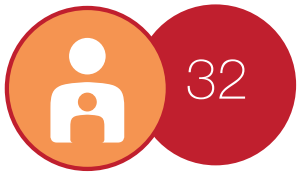
**3** Consultation Meetings

Consultation meeting delivery: In-person






YOUTH




FAMILY MEMBERS


SERVICE PROVIDERS

# Phase Two Findings and Recommendations: What We Heard

The issues described following were highlighted specifically by Thompson, Manitoba stakeholders, given the unique circumstances in their region, along with any specific recommendations made. For a summary of issues identified across all sites, including the Thompson, Manitoba community, please see the overall, across site, report.

# Access

## Availability

All stakeholder groups highlighted the new (8 months old) mobile crisis services as very helpful but the need to serve younger children was stressed. Bridging services for children leaving the children`s services, including child welfare, system at age 18 are needed to support youth so that they can transition to adulthood successfully.

Lack of specific services were noted including crisis services "around the clock", family therapy ( currently there is a two-year wait), after-school recreational programs (e.g. gym, bowling, cross-country skiing), a shelter for male youth, and a residential treatment centre for youth. Family members noted that some youth would like to be in child welfare care, as they perceive youth in care to have access to recreation, food, etc. It is important to build access to these resources for youth in the community. Challenges include lack of funding as well as staff and volunteers who can provide supervision (all volunteers have to have a police check which may be a barrier).

**Recommendations:**

- Extend age range and hours for services, especially mobile crisis
- Support transitions to adult services by providing a bridge period
- Increase availability of specific services to meet the needs of local youth

***"There are programs but you have to be a certain age. Some kids are too young – you need to be 12 – my son is 10 and he's already been struggling for 2 years."***
— Family Member

## Awareness

Youth and family members talked about the need to find ways to inform youth and families about existing services and how to access them.

***"We don`t need more services, we need more awareness of the services we do have."***
— Youth

***"You have to ask for services and probably 70% of kids fall through the cracks because they don`t know someone to ask."***
— Family Member

# Service Facilitators

## *Transportation*

Family members talked about the challenges related to transportation creating barriers in accessing services. However, youth mentioned *Operation Red Nose* (i.e. a free taxi service for individuals under the influence of substances during the holiday season) as an example of a helpful support in regards to transportation.

**Recommendations:**

- Expand the use of free taxi services beyond the holiday season for youth in need

## *Location*

Youth highlighted the need for services in out-lying communities in addition to those in Thompson. With respect to accessing services in Thompson, family members stated that programs, including recreational programs, are needed for youth in different areas of town.

***"Need programs for youth on the East side and West side of town—youth often won't cross to the other side as it is outside of their neighbourhood."***
— Family Member

## *Eligibility Criteria*

Service providers and family members discussed barriers to service related to eligibility criteria including:

- Need for parental consent
- Age restrictions (e.g. if under 18 and not in school, there is no access to the public health nurse, unless the youth is pregnant)

Family members also commented that youth "have to be in trouble first", before they can be eligible for help. They mentioned child and family services and justice services as gateways to treatment, but stated "it shouldn't be like that".

***"For many youth, parental consent is not an option – the parent is not supportive."***
— Service Provider

***"I have a teen and I want help but there is nowhere to go for help – you have to be 'at risk' to get help – there`s criteria – you have to be in trouble to get service."***
— Family Member

## Coordination and Collaboration

Youth and service providers talked about the importance of collaboration and coordination across services as youth are often involved with multiple providers from different sectors. They cited a number of examples of effective collaboration, including the recently established *Youth At Risk North (YARN)* and services for sexually exploited youth. There were a number of examples of collaborative work including cross-training (e.g. *Addictions Foundation of Manitoba (AFM)* staff trains school counsellors to run groups). They also talked about the importance of case conferences with everyone involved. Youth, in particular, expressed concerns that when agencies don't share information they may assume incorrectly that other providers are dealing with the concerns.

***"Services often pass the buck, assuming other agencies working with youth are dealing with their concerns or withhold information."***
— Youth

## Timely Access

Service providers and youth raised concerns about wait times, particularly wait times for services following emergency visits and for mental health services. In addition, family members added that if their service involvement is interrupted, there is generally a wait time to resume treatment.

***"Parents and youth want help now!"***
— Service Provider

***"Very long waiting lists especially for mental health services."***
— Youth

## Referral and Intake Processes

Both service providers and youth talked about some of the barriers related to the referral process, particularly for mental health services including the need to fill out a lengthy form (i.e. "nine page form") and the need for parental consent.

***"Youth may not want to tell parents they want to see a counsellor."***
— Youth

# Service Components

There was an emphasis on the need to identify and address problems early, with recommendations to focus services for children 6-11 years old.

Services providers noted that drop-in counselling offered by *AFM* on-site at schools is very helpful and suggested that mental health services be expanded from appointment based service to youth "known to them" to include drop-in services as well. Youth suggested using the school as a hub for multiple services, during and after school. They also suggested expanding services for youth who are not in school, to include a focus on vocational skill development, like *Youth Build*.

Outreach was identified as important, particularly to reach youth not attending school. The mobile crisis team operating from 2:00 p.m. to 2:00 a.m. was seen to be very helpful. It is funded to serve youth 12-21, but service providers said that the team is flexible and willing to serve other ages. It was noted that there is an important need to be available for younger children. In addition, it was stated that mobile crisis has been able to divert youth from the emergency room and will go the emergency to pick up youth up if they are called by the youth or family member. Mobile crisis workers are able to assess and refer including to hospital and Medivac if necessary. Services for sexually exploited youth also reach out to youth. In addition it was noted that an 8 bed youth crisis-stabilization facility was being constructed. Youth specific AA and NA meetings were also identified as a helpful part of the continuum of services and youth suggested offering them at school as well.

Holistic programming including leisure, recreation, vocational and life skills development were recommended to be provided at school and after school in the community, including consideration to provide programming in out-lying communities. Youth generated a long list of examples including music, art, boxing, dance, skating, opportunities to get work experience and work preparation skills (e.g. hunting, fishing, chainsaw course, etc.). Some of these experiences can be used to raise money as well (e.g. cutting and selling wood).

**Recommendations:**

- Identify and address problems early by focusing on services for children 6-11 years
- Expand the hours of the mobile crisis team to 24 hours
- Expand the range of services available in schools
  (e.g. mental health drop-in, youth-specific AA and NA, and holistic programming)
- Expand services for youth who are not in school, focusing on vocational skill development

***"They've [youth] been sitting there waiting in the hospital since 9:00 AM that morning to see someone. Because our mobile team works from 2 AM – 2PM, they assess the person immediately."***
— Service Provider

***"[There are] no or very little recreational programs or opportunities in outlying communities."***
— Youth

# Service Delivery Model

Service providers stated that a collaborative model of service delivery is important and that there is a need to consider incorporating some of the holistic strategies used in the adult system with youth (e.g. mindfulness, acupuncture). In addition inclusion of cultural practices, traditional teaching and ceremonies were highlighted as important and helpful by youth and families, for all family members, individually and as a group. It was recommended that programming be family focused and that providing transportation, food and babysitting make it possible for family members to attend.

Service models that include peer support and mentorship were recommended (e.g. *SOS (Students Offering Support)*, *Big Brothers*, *Big Sisters*) and models that bring youth and parents together, social, recreational, and treatment, including parenting programs.

**Recommendations:**

- Integrate cultural practices and traditional teaching in treatment agencies
- Develop service models that include outreach both to engage youth and families in treatment as well as to reach out to youth to bring them to school and programs.
- Develop service models that include peer support and mentorship.
- Build service models that facilitate the engagement of youth and families together.

***"Sweatlodge is a place to talk about what you are feeling and you can bring your kids."***
— Family Member

***"Need to better integrate cultural practices into conventional approaches."***
— Youth

# Service Attributes

A number of service attributes were highlighted:

**Confidentiality:** Service providers talked about the importance and challenges of ensuring confidentiality (i.e. "You know everyone"). Family members raised some questions about the ability to trust that service involvement will be kept confidential, citing examples such as being questioned about service involvement when applying for a job.

**Trauma-informed care:** Stakeholders highlighted the need for trauma-informed and -specific services (e.g. services for youth with experiences of sexual trauma).

**Resilience-building:** Related to the discussion about trauma and coping skills, along with youth empowerment, given common reports of traumatic experiences amongst youth and families, building resilience and helping youth develop coping skills was discussed.

**Safe space:** Family members and youth talked about the need for a safe space for service, education and housing. Youth talked about the need for strategies to prevent weapons, drugs and cigarettes from being brought into school and other places youth frequent. They also talked about using support groups to talk about feelings as helpful.

**Stigma:** Stigma was described as a barrier to service and other programming. For example, youth would benefit from increased access to recreational programming, and "ice time at the arena is reserved for hockey, not for youth with challenges".

**Recommendations:**

- Provide staff training in trauma-informed care
- Promote and offer safe spaces for service, education, and housing
- Increase awareness and prevention efforts among school administration regarding weapons and substances that may be brought onto school property.
- Increase access to recreational programming

***"Increase services for grief and trauma….60-70 per cent of issues are related to substance use."***
— Youth

***"Skills for living with addictions for example some youth stay home from school to protect mom - people at the house may put their mom's life in danger."***
— Service Provider

***"Kid's coping skills are to lock themselves in a room, as a response to mom's drinking."***
— Service Provider

***"Youth need to learn skills instead of smoking a joint."***
— Service Provider

# Service Provider Attributes

Service providers talked about their own need for support and help with their own personal issues at times interfering with youth engagement. At the same time, they talked about getting support from colleagues and working collaboratively. Youth noted the need to address the high rate of staff turnover.

Family members identified the ability to be non-judgmental, to inspire trust and to ensure confidentiality as important service provider attributes.

***"In Thompson, we know who to call and there is a better working environment."***
— Service Provider

***"…bring hope, show basic human kindness…"***
— Family Member

# Health Equity and the Social Determinants of Health

Poverty and a severe shortage of affordable housing were cited as major contributors to substance use and mental health problems, family problems and difficulty connecting and following through with treatment.

As mentioned above, incorporation of traditional and cultural programming was recommended by youth and families.

Youth talked about *GLOW (Gay, Lesbian, or Whatever)*, a school committee that raises awareness and addresses LGBT youth issues, particularly in school settings.

Youth talked about gender-related pressures (i.e. boys needing to be 'macho' and girls needing to look and dress a certain way), and the need for sex and gender issues to be considered in treatment.

Young women who are pregnant or parenting frequently drop out of school. Youth said that supports provided by *Futures* and *Baby is Best* are very helpful and need to be expanded.

**Recommendations:**

- Establish a 'Pride Day' in Thompson
- Establish a day care in the schools
- Expand supports for women who are pregnant or parenting

***"There is a housing crisis – how can you parent?"***
— Family Member

***"We need a pride day for LGBT people in Thompson since there are awareness walks and things like that in Winnipeg."***
— Youth

# Policy and Funding Concerns

Services providers commented that participating in projects such as the NYSP to increase opportunities to learn more about youth needs and to build practice skills are important and need to be supported by policy makers and funders as well as at the service leadership levels.

Family members talked about the importance of funding recreational programs and cultural programs, particularly nights, including late nights in the summer when it is light. They talked about effective programming run by the *Boys and Girls Club* that has had to reduce hours. Youth suggested that the *Boys and Girls Club* open a second building so that there would be one building on each side of town, reducing transportation challenges.

**Recommendations:**

- Support opportunities to participate in projects that provide capacity-building and information on local youth needs
- Increase funding for recreational programs such as those run by the Boys and Girls Club

***"If a community wants to care for its children than that's what they fund."***
— Family Member

# APPENDICES TAB

# APPENDICES
# BACK OF TAB

# Appendix A: Network Summaries

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

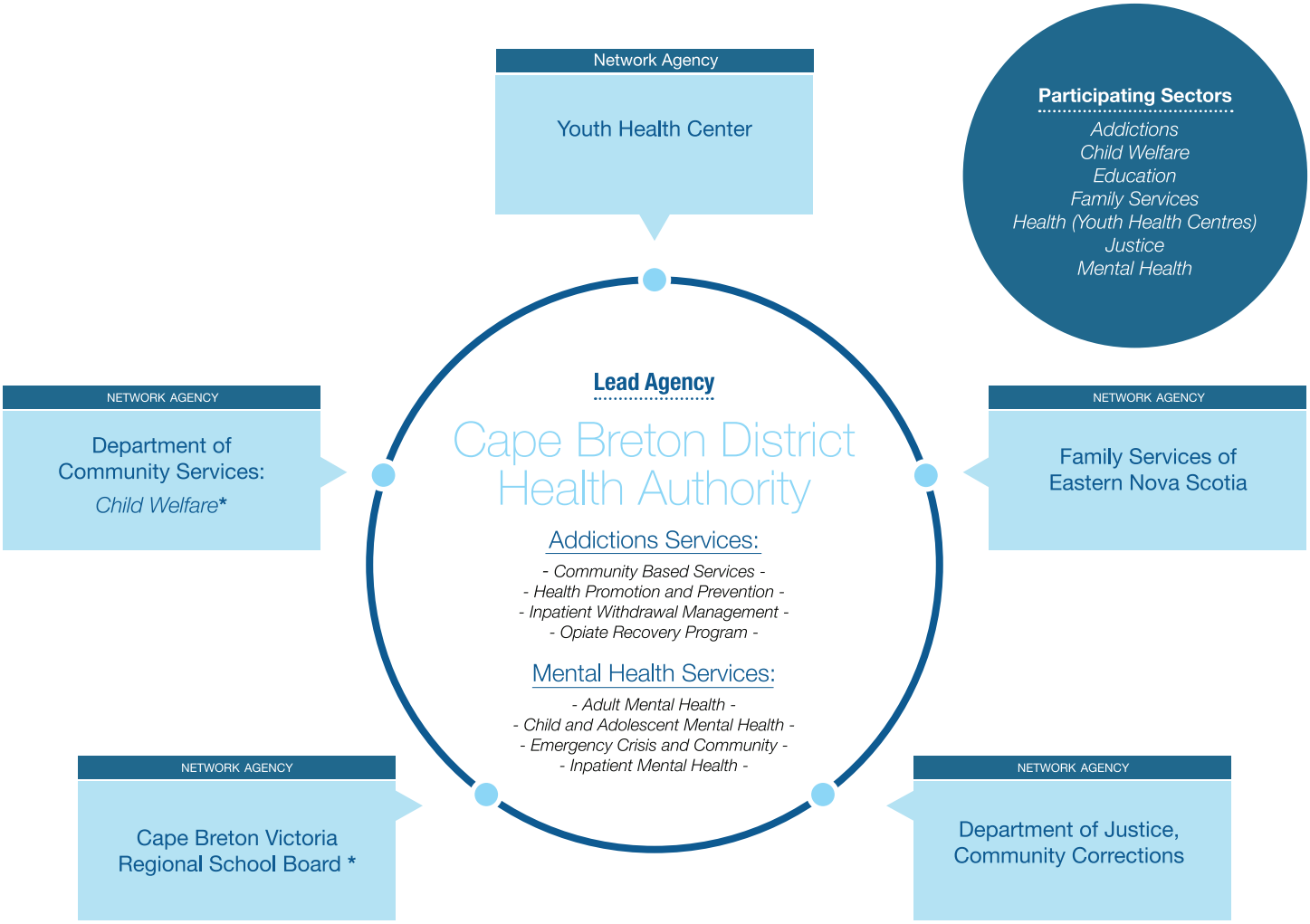
## Phase One

- 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
- Final results webinar presentation

## Phase Two

- Consultation meetings in the local community

# Cape Breton Region, Nova Scotia Network

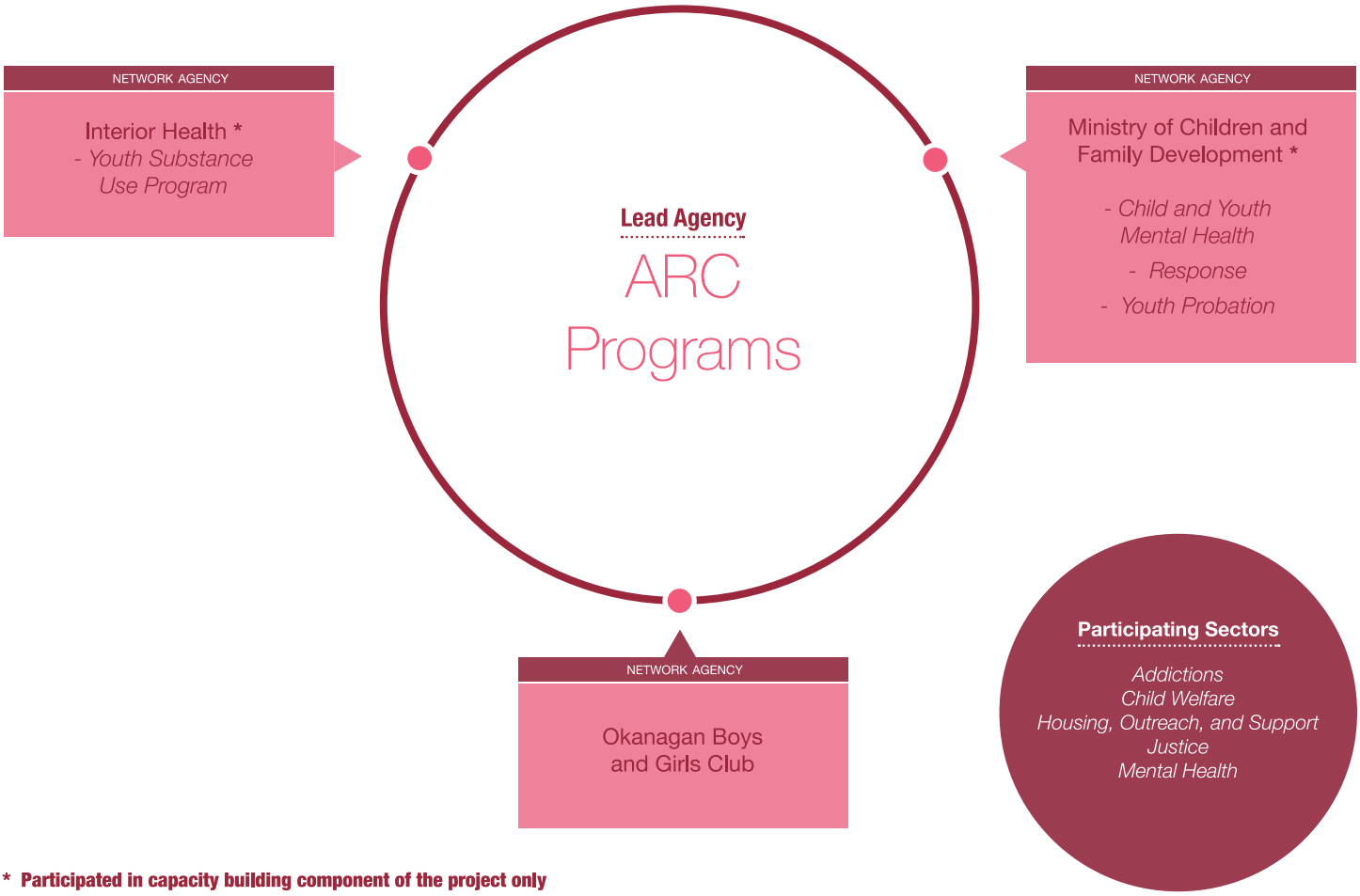



*** Participated in capacity building component of the project only**

## Network Summary:

- Capacity building: January, 2011
- Service providers trained: 120
- Data collection range: April 2011 – September 2011
- GAIN-SS collected: 483
- Joint data analysis: February, 2012
- Consultation meetings: January, 2014

# Kelowna, British Columbia Network

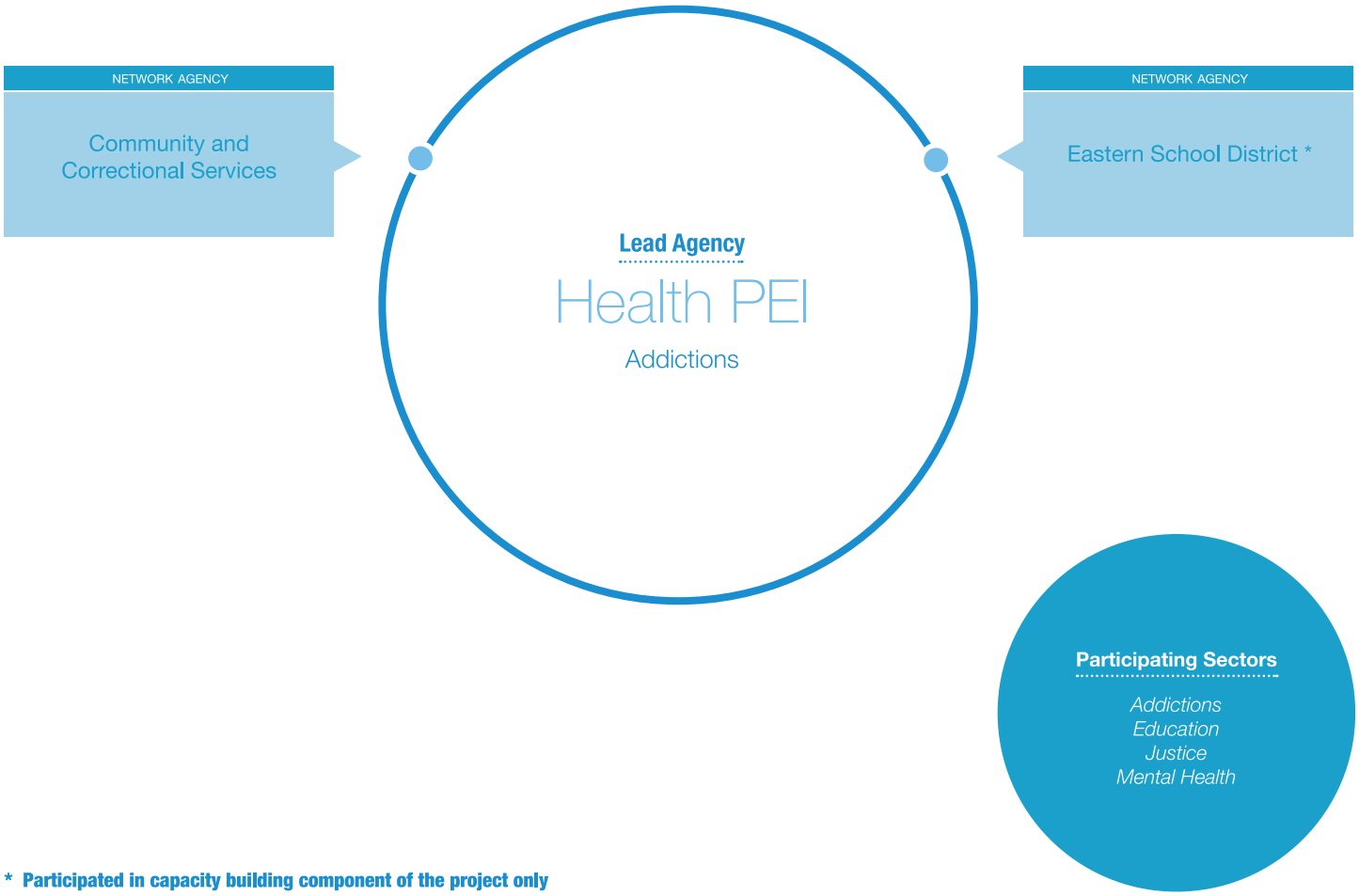



*** Participated in capacity building component of the project only**

## Network Summary:

- Capacity building: December, 2011
- Service providers trained: 43
- Data collection range: January 2012 – October 2012
- GAIN-SS collected: 113
- Joint data analysis: December, 2012
- Consultation meeting: December, 2013

# Prince Edward Island Network

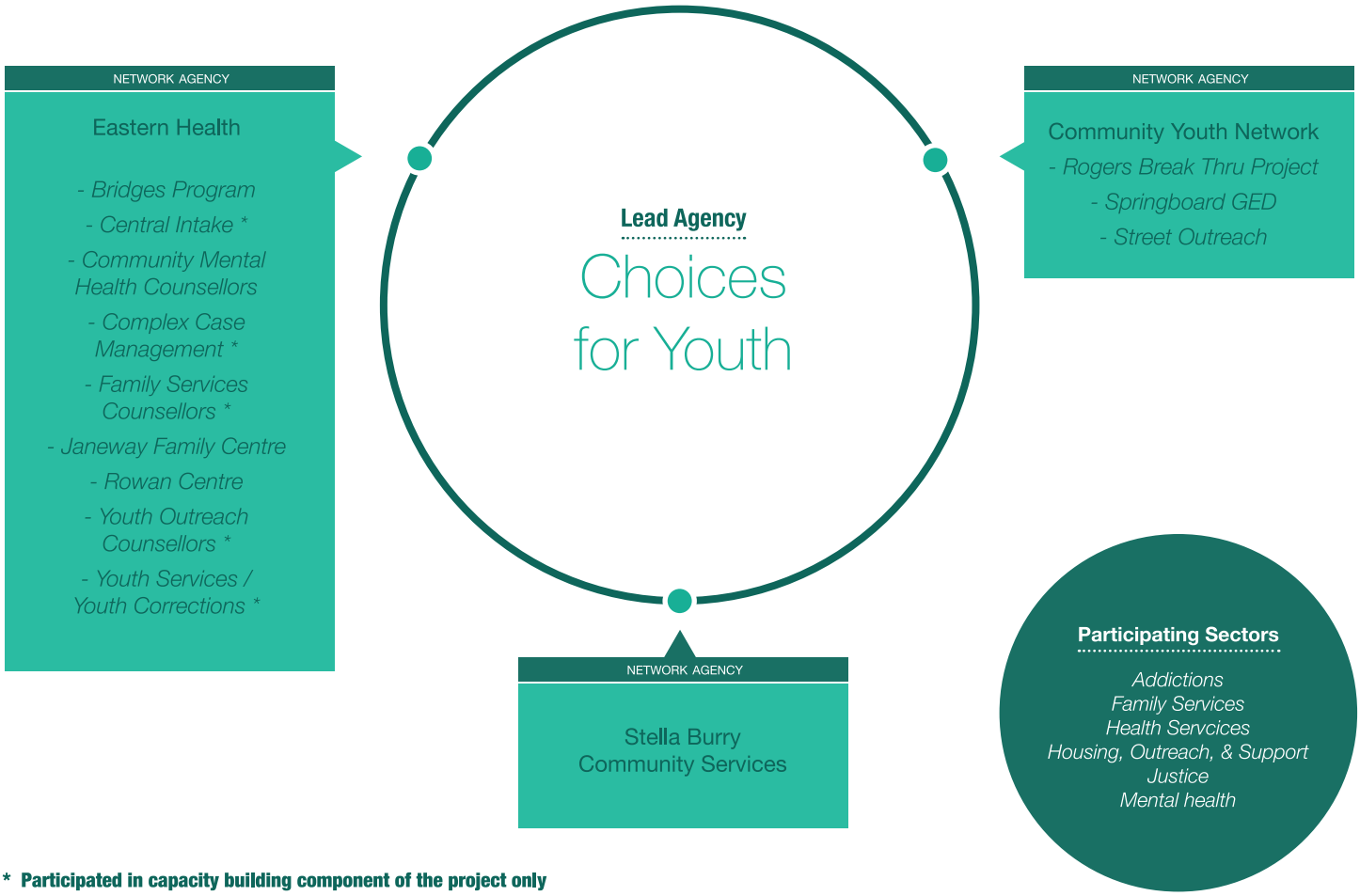



*** Participated in capacity building component of the project only**

## Network Summary:

- Capacity building: *November, 2011*
- Service providers trained: *107*
- Data collection: *February 2012 – August 2012*
- GAIN-SS collected: *332*
- Joint data analysis: *October, 2012*
- Consultation meetings: *January, 2014*

# St John's, Newfoundland and Labrador Network

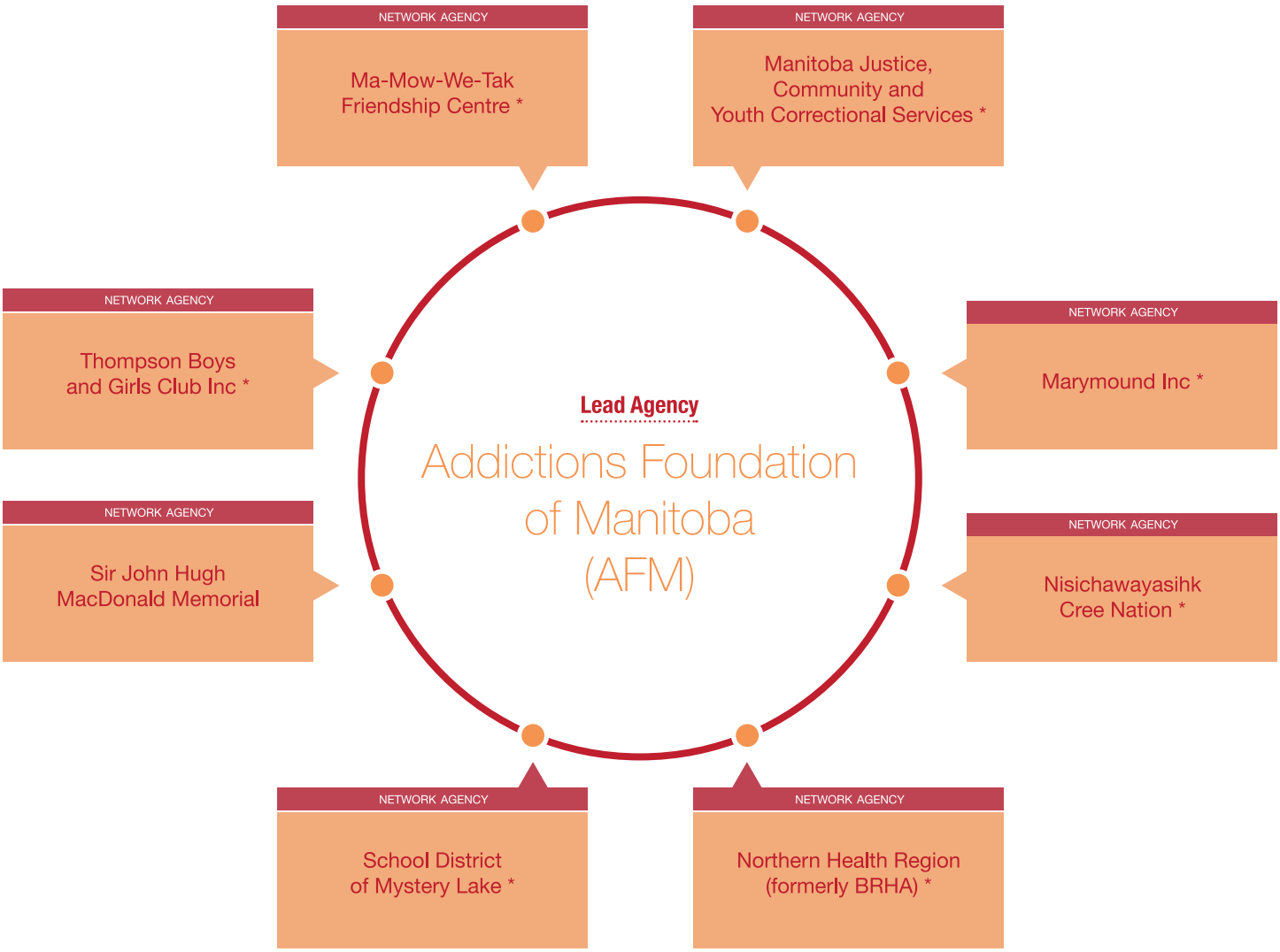



*** Participated in capacity building component of the project only**

## Network Summary:

- Capacity building: *April, 2011*
- Service providers trained: *72*
- Data collection range: *January 2012 – July 2012*
- GAIN-SS collected: *107*
- Joint data analysis: *October, 2012*
- Consultation meetings: *March, 2014*

# Thompson, Manitoba Network




*** Participated in capacity building component of the project only**

## Network Summary:

- Capacity building: *March, 2011*
- Service providers trained: *43*
- Data collection range: *September 2011 – June 2012*
- GAIN-SS collected: *34*
- Joint data analysis: *September, 2012*

**Participating Sectors**

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

# Appendix B: The GAIN Short Screener (CAMH Version) (GSS-CV)

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.

# Appendix C: National and Local Findings

**NATIONAL YOUTH SCREENING PROJECT**
ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

## NATIONAL FINDINGS

### 1305 PARTICIPANTS

45% MALE PARTICIPANTS

53% FEMALE PARTICIPANTS

* 1% OF PARTICIPANTS IDENTIFIED AS TRANS

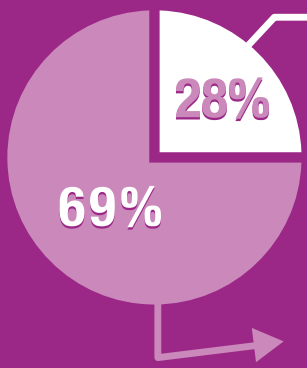
* 1% DID NOT ANSWER THE QUESTION

95% ENGLISH AS FIRST LANGUAGE

80% WHITE/EUROPEAN

96% BORN IN CANADA

16.8 YEARS OLD



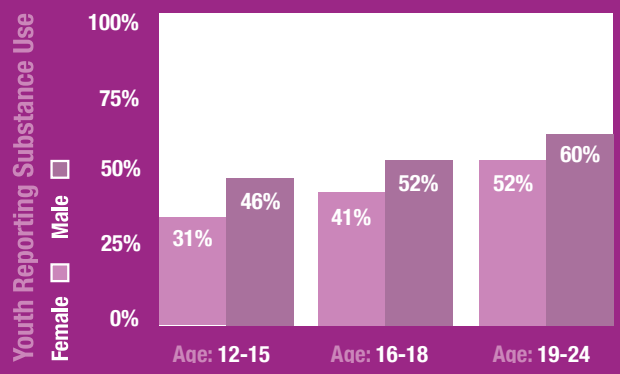

Live on their own, with friends or other relatives, in supportive housing, or in unstable housing

Live at home with their parents

* 3% DID NOT REPORT LIVING ARRANGEMENT


* 4% DID NOT ANSWER THE QUESTION

### PROBLEMATIC SUBSTANCE USE

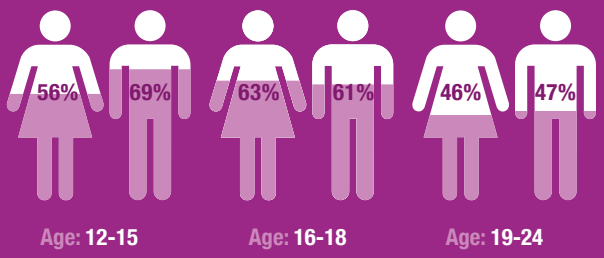



### EMOTIONAL CONCERNS

NATIONAL YOUTH SCREENING PROJECT
ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

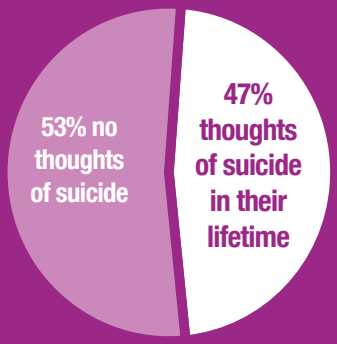
# NATIONAL FINDINGS

## BEHAVIOURAL CONCERNS




Age: 12-15 | Age: 16-18 | Age: 19-24

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS

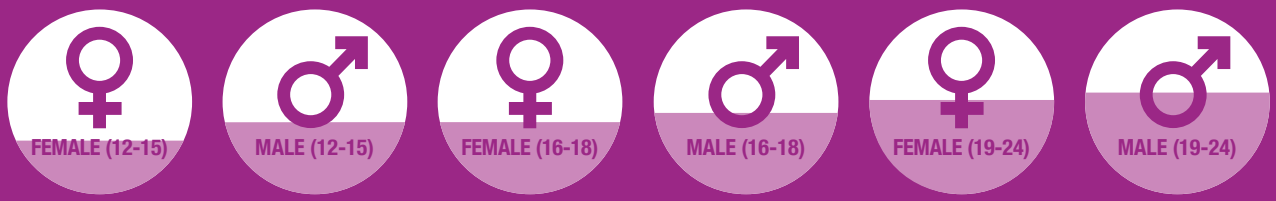

## TRAUMA-RELATED DISTRESS

**41% Male**

**60% Female**

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

⚧ = NOT REPORTED DUE TO SMALL NUMBERS




29% | 39% | 39% | 44% | 51% | 55%

For more national project findings, download the full report here: http://eenet.ca/drug-treatment-funding-program

NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# CAPE BRETON REGION, NS

## 483 PARTICIPANTS

36% MALE PARTICIPANTS

62% FEMALE PARTICIPANTS

* 0.4% OF PARTICIPANTS IDENTIFIED AS TRANS

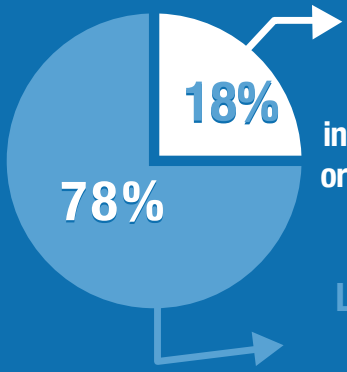
* 1.7% DID NOT ANSWER THE QUESTION

96% ENGLISH AS FIRST LANGUAGE

83% WHITE/EUROPEAN

96% BORN IN CANADA

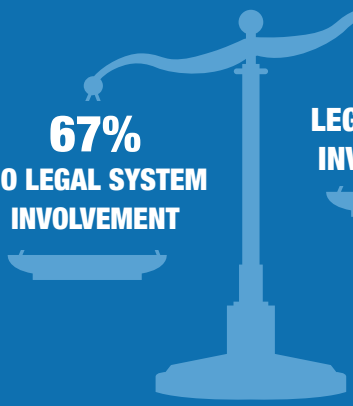
16.6 YEARS OLD




Live on their own, with friends or other relatives, in supportive housing, or in unstable housing

Live at home with their parents

* 4% DID NOT REPORT LIVING ARRANGEMENT

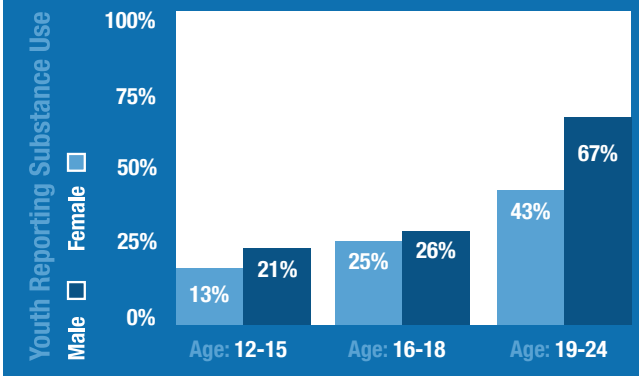


67% NO LEGAL SYSTEM INVOLVEMENT

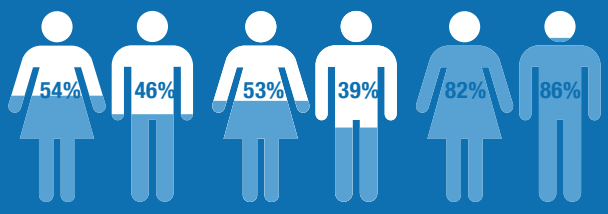
29% LEGAL SYSTEM INVOLVEMENT

* 4% DID NOT ANSWER THE QUESTION

## PROBLEMATIC SUBSTANCE USE




## EMOTIONAL CONCERNS

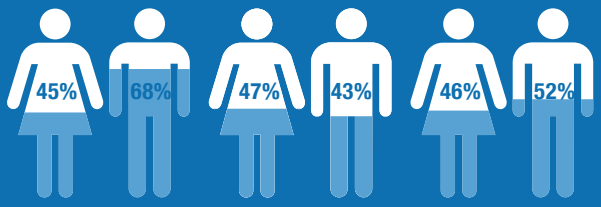


NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

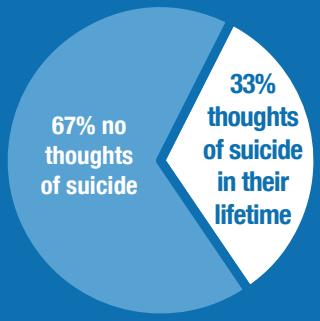
# CAPE BRETON REGION, NS

## BEHAVIOURAL CONCERNS




Age: 12-15 | Age: 16-18 | Age: 19-24

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS

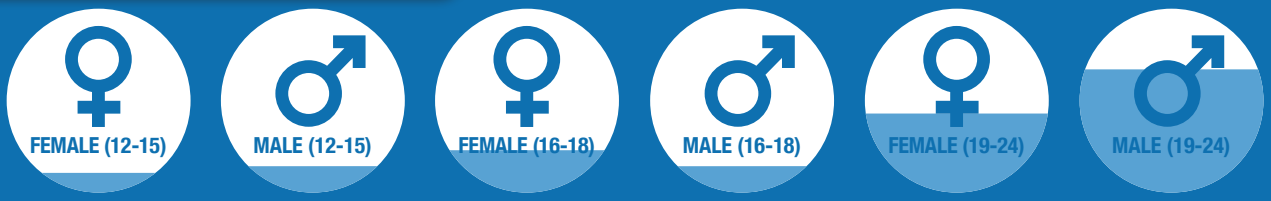

## TRAUMA-RELATED DISTRESS

**39% Male**

**50% Female**

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

⚥ = NOT REPORTED DUE TO SMALL NUMBERS




11% | 19% | 23% | 19% | 43% | 67%

For more local project findings, download the full report here: http://eenet.ca/drug-treatment-funding-program

NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# KELOWNA, BC

## 113 PARTICIPANTS

43% MALE PARTICIPANTS

53% FEMALE PARTICIPANTS

* 1% OF PARTICIPANTS IDENTIFIED AS TRANS

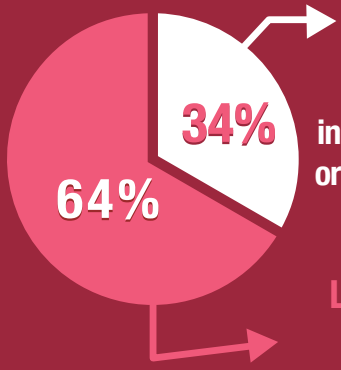
* 3% DID NOT ANSWER THE QUESTION

96% ENGLISH AS FIRST LANGUAGE

63% WHITE/EUROPEAN

93% BORN IN CANADA

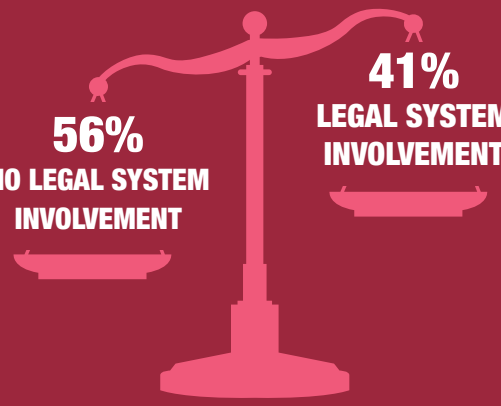
15.6 YEARS OLD




Live on their own, with friends or other relatives, in supportive housing, or in unstable housing

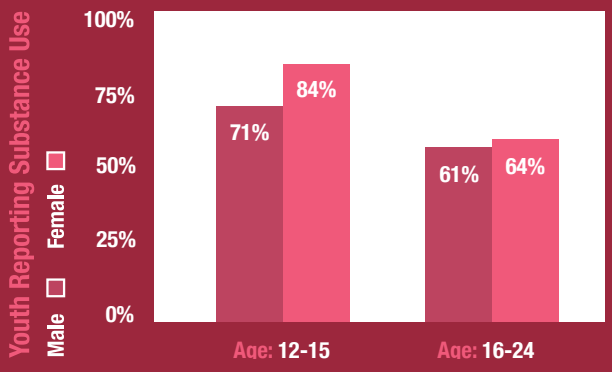
Live at home with their parents

* 2% DID NOT REPORT LIVING ARRANGEMENT

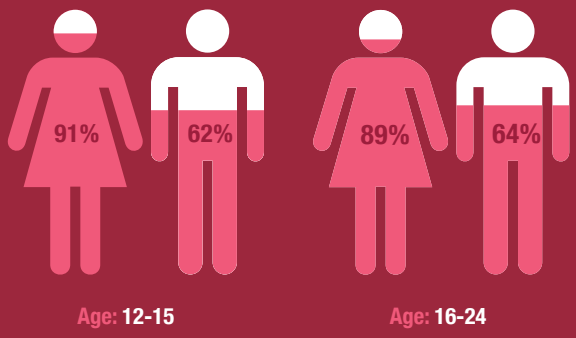



* 3% DID NOT ANSWER THE QUESTION

## PROBLEMATIC SUBSTANCE USE




## EMOTIONAL CONCERNS

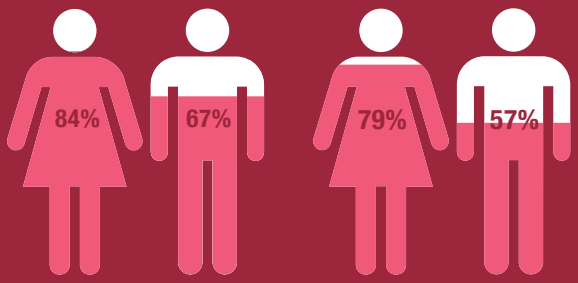


NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

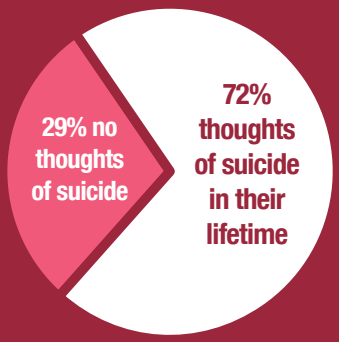
# KELOWNA, BC

## BEHAVIOURAL CONCERNS




Age: 12-15 Age: 16-24

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS

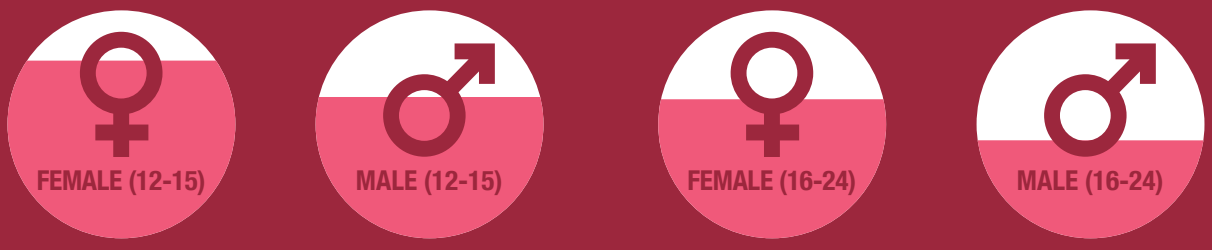

## TRAUMA-RELATED DISTRESS

51% Male

76% Female

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

⚥ = NOT REPORTED DUE TO SMALL NUMBERS




78% 62% 61% 43%

For more local project findings, download the full report here: http://eenet.ca/drug-treatment-funding-program

NATIONAL YOUTH SCREENING PROJECT
ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# PRINCE EDWARD ISLAND

## 332 PARTICIPANTS

60% MALE PARTICIPANTS

39% FEMALE PARTICIPANTS

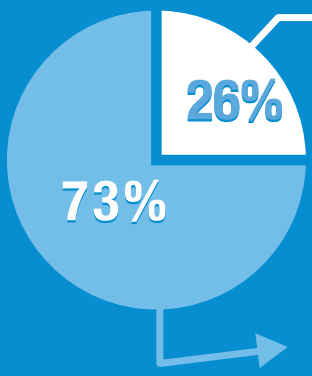
* 1% DID NOT ANSWER THE QUESTION

95% ENGLISH AS FIRST LANGUAGE

89% WHITE/EUROPEAN

98% BORN IN CANADA

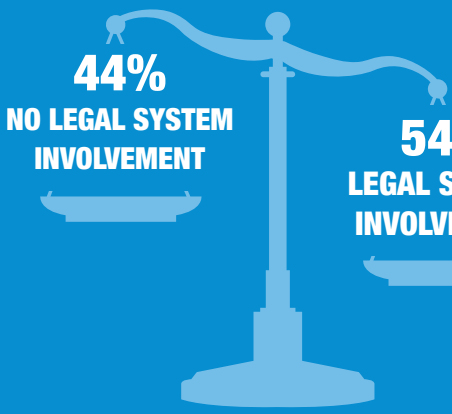
17.3 YEARS OLD




Live on their own, with friends or other relatives, in supportive housing, or in unstable housing

Live at home with their parents

* 1% DID NOT REPORT LIVING ARRANGEMENT

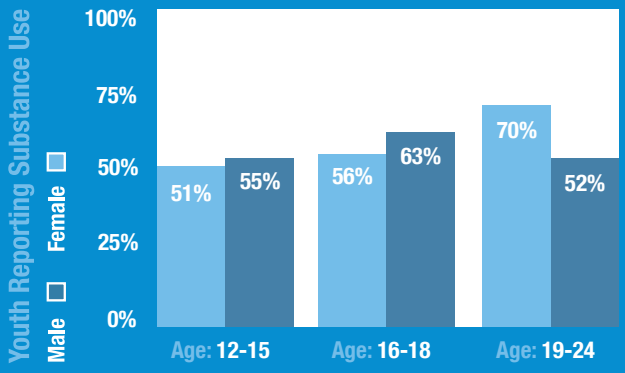


44% NO LEGAL SYSTEM INVOLVEMENT

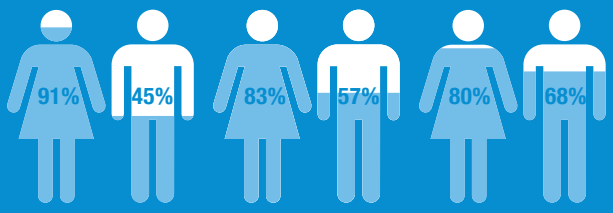
54% LEGAL SYSTEM INVOLVEMENT

* 2% DID NOT ANSWER THE QUESTION

## PROBLEMATIC SUBSTANCE USE




## EMOTIONAL CONCERNS



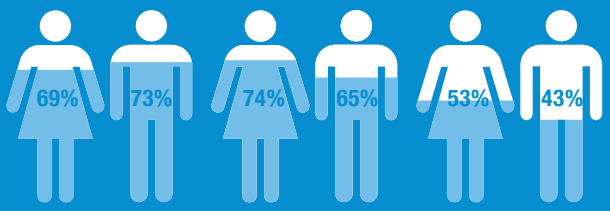

Age: 12-15 Age: 16-18 Age: 19-24

NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

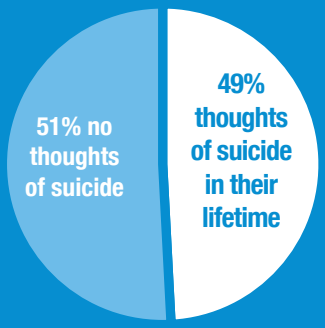
# PRINCE EDWARD ISLAND

## BEHAVIOURAL CONCERNS




Age: **12-15** Age: **16-18** Age: **19-24**

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS


## TRAUMA-RELATED DISTRESS

**39%**
**Male**

**68%**
**Female**

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

⚥ = NOT REPORTED DUE TO SMALL NUMBERS

| FEMALE (12-15) | MALE (12-15) | FEMALE (16-18) | MALE (16-18) | FEMALE (19-24) | MALE (19-24) |
|---|---|---|---|---|---|
| 51% | 49% | 56% | 56% | 70% | 51% |

For more local project findings, download the full report here: http://eenet.ca/drug-treatment-funding-program

NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# ST. JOHN'S, NL

## 107 PARTICIPANTS

48% MALE PARTICIPANTS

50% FEMALE PARTICIPANTS

* 1% OF PARTICIPANTS IDENTIFIED AS TRANS

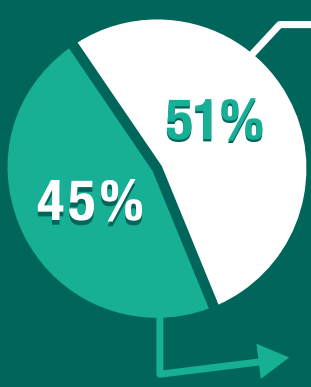
* 1% DID NOT ANSWER THE QUESTION

95% ENGLISH AS FIRST LANGUAGE

85% WHITE/EUROPEAN

96% BORN IN CANADA

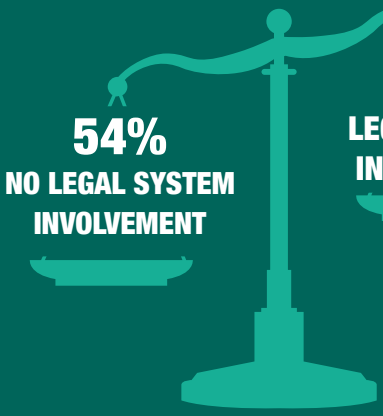
18.2 YEARS OLD




Live on their own, with friends or other relatives, in supportive housing, or in unstable housing

Live at home with their parents

* 4% DID NOT REPORT LIVING ARRANGEMENT

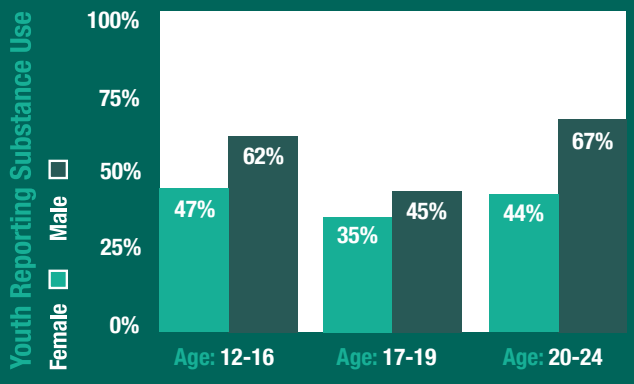


54% NO LEGAL SYSTEM INVOLVEMENT

41% LEGAL SYSTEM INVOLVEMENT

* 5% DID NOT ANSWER THE QUESTION

## PROBLEMATIC SUBSTANCE USE




## EMOTIONAL CONCERNS

NATIONAL YOUTH SCREENING PROJECT

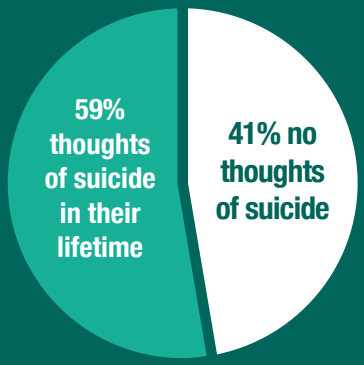
ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# ST. JOHN'S, NL

## BEHAVIOURAL CONCERNS


Age: 12-16 Age: 17-19 Age: 20-24

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS

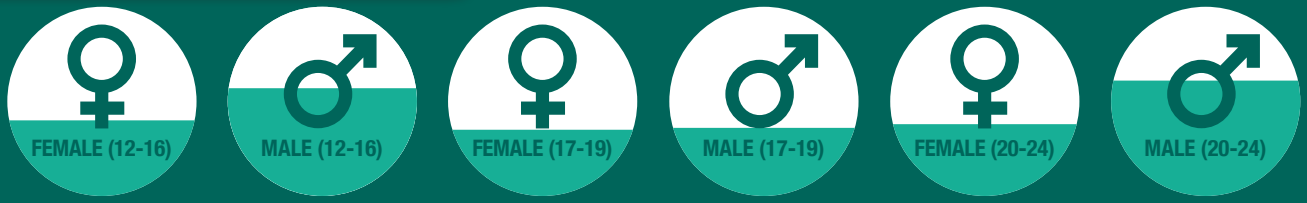

## TRAUMA-RELATED DISTRESS

**42% Male**

**59% Female**

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

⚧ = NOT REPORTED DUE TO SMALL NUMBERS




40% 57% 35% 36% 38% 61%

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NATIONAL YOUTH SCREENING PROJECT

ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

# THOMPSON, MB

## 34 PARTICIPANTS

50% MALE PARTICIPANTS

47% FEMALE PARTICIPANTS

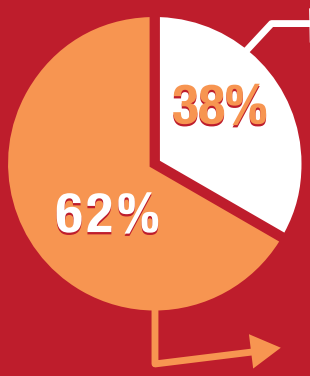
* 3% OF PARTICIPANTS IDENTIFIED AS TRANS

94% ENGLISH AS FIRST LANGUAGE

83% ABORIGINAL

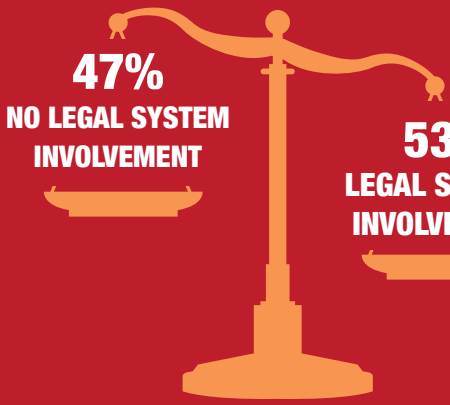
100% BORN IN CANADA

15.2 YEARS OLD

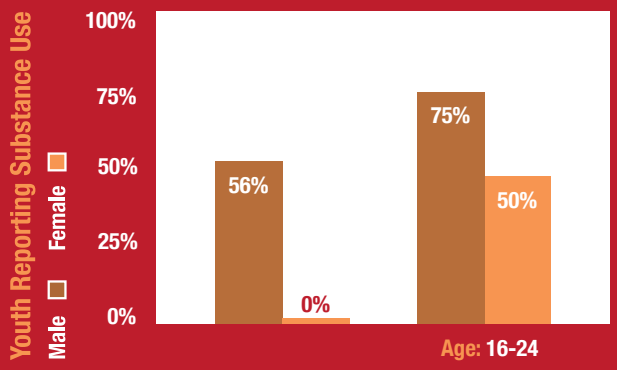



Live at home, on their own, with friends or other relatives, or in unstable housing

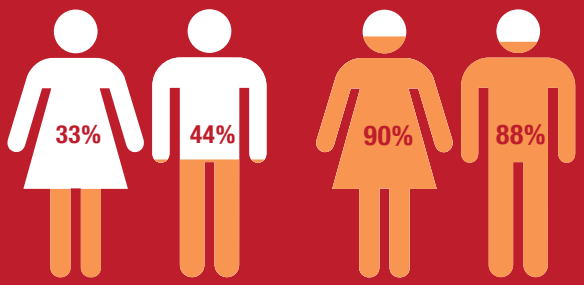
Live in supportive housing




## PROBLEMATIC SUBSTANCE USE



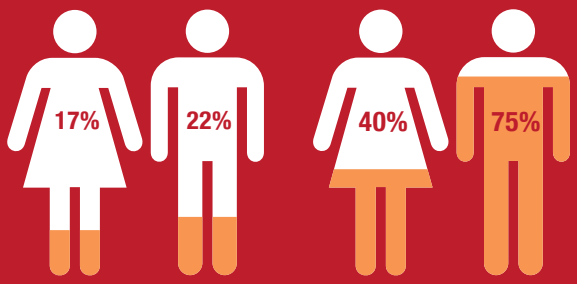

## EMOTIONAL CONCERNS



NATIONAL YOUTH SCREENING PROJECT
ENHANCING YOUTH-FOCUSED, EVIDENCE-INFORMED TREATMENT PRACTICES THROUGH CROSS-SECTORAL COLLABORATION

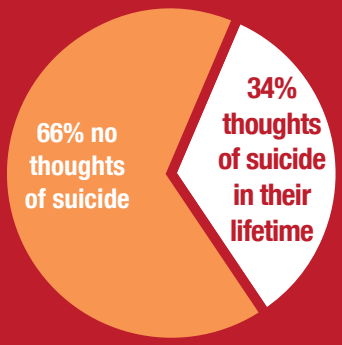
# THOMPSON, MB

## BEHAVIOURAL CONCERNS




Age: 12-15 Age: 16-24

## SUICIDE-RELATED CONCERNS




## CONCURRENT DISORDERS

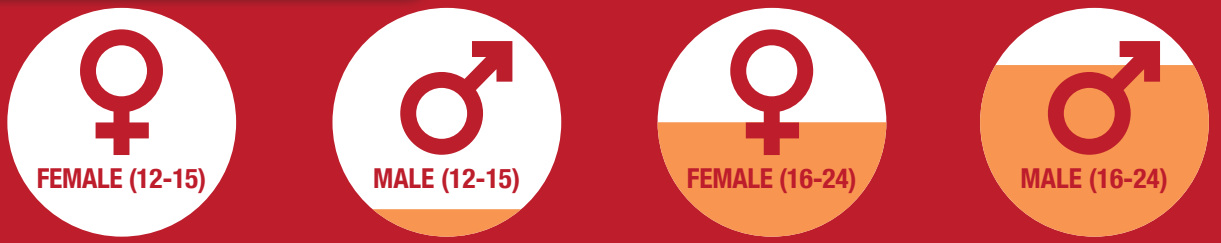

## TRAUMA-RELATED DISTRESS

53% Male

44% Female

## YOUTH WITH SUBSTANCE USE AND MENTAL HEALTH CONCERNS

= NOT REPORTED DUE TO SMALL NUMBERS




0% 22% 50% 75%

For more local project findings, download the full report here: http://eenet.ca/drug-treatment-funding-program

# Appendix D: Key National Recommendations from Phase One

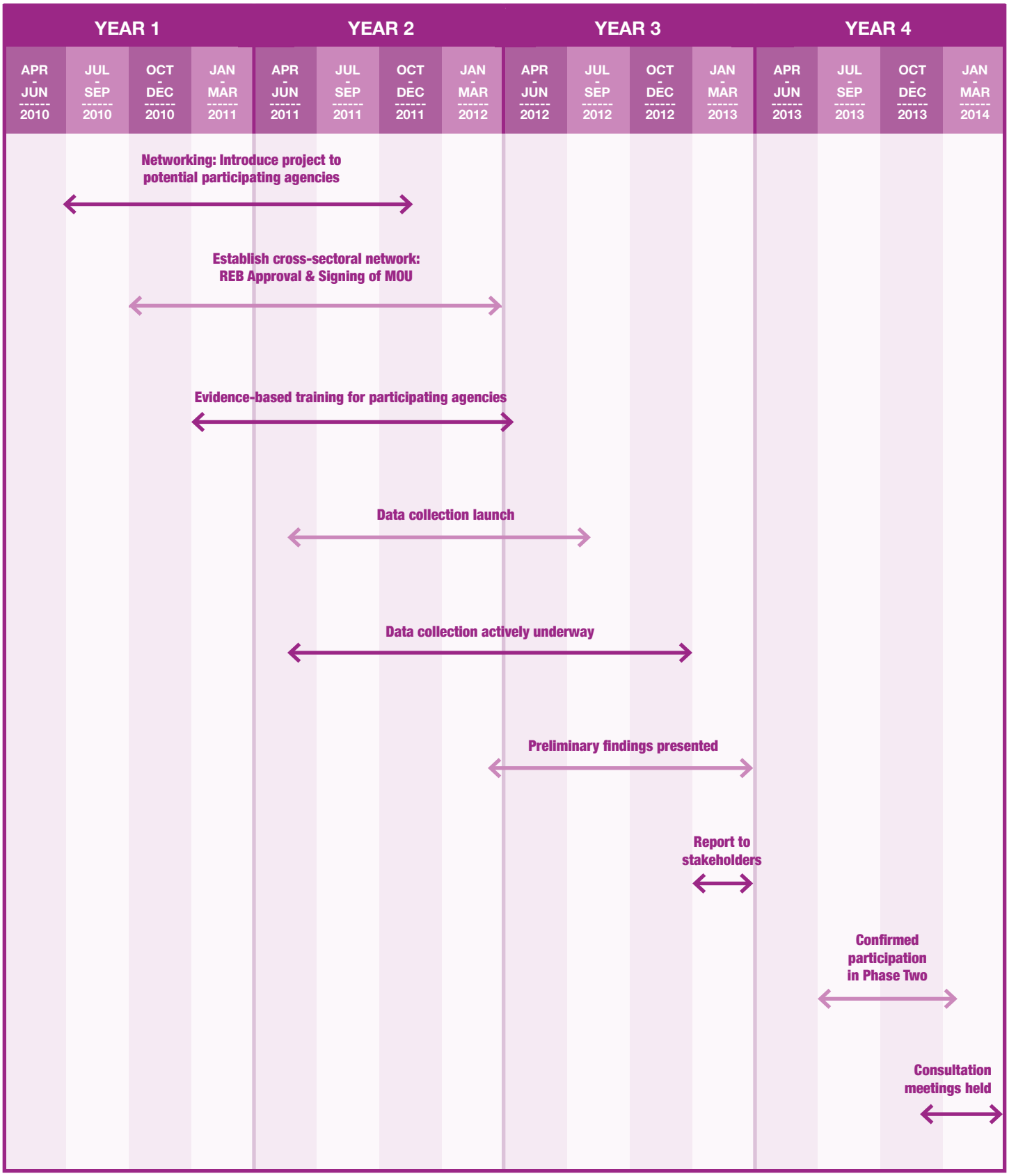
- Consistent screening with a common screening tool across sectors continue (and/or be expanded) as it appears to be a feasible and useful practice for improving identification of the substance and mental health-related needs of youth and for facilitating opportunities for timely access to service.

- Given the differing needs of youth at different developmental stages, services delivered to youth aged 12-24 years should be developmentally-informed and developmentally-specific in order to meet the unique needs of youth at different stages of development. Moreover, transitions between different service systems, such as from youth to adult services, should be closely examined to identify gaps in services and difficulties in the transition process. Lastly, innovative solutions should be developed to address these system shortfalls.

- Services delivered to youth should reflect the unique needs of youth, considering sex and gender (at different developmental stages).

- Given the high-rate of trauma-related distress reported by youth, services delivered to youth should be trauma-informed. Moreover, where appropriate, trauma-specific services that are developmentally-informed should be developed.

# Appendix E: Project Timeline



# Appendix F: Discussion Questions

Given what we have learned through this project about the service needs of the participating youth, we would like to take this opportunity to talk with you about the services that are available, what is working well and what is missing here in [insert community] from your perspective. We also would like to hear what you would recommend to improve the service system.

**What is working well?**

**What are the gaps and challenges?**

**What are your recommendations for system enhancement or change?**

Potential Sub-Prompts for the above questions:

1. What is it like to get services for youth in [insert community]? Prompts: easy? hard?
2. Where do you go to get help?
3. How helpful are the services that are currently available?
4. What would make the services/the system more helpful?
5. Are there any other kinds of services that were not mentioned in this discussion i.e. housing, outreach, employment etc?

Youth who participated in the project said they were experiencing issues with:

- Emotional issues (feeling sad, depressed or anxious)
- Behavioural issues (getting into fights or trouble with the law)
- Drug or alcohol use
- Hurting themselves

1. Do you think we may have missed any issues that youth in [insert community] are currently facing?
2. Are services different depending on what your worries or problems are?
3. Would you go to different places to get help with different problems?
4. Would services be different if you were:
    a. *A boy*
    b. *A girl*
    c. *Younger -12-14*
    d. *Older -16-18 or (transitional-aged youth) 19-24*

5. Are there currently any services available for your family members or supporters?
    a. *Are these services helpful?*
    b. *What is missing?*

# Appendix G: References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