6/30/2012

Youth at Risk Feasibility Study

Options for Youth in the Cape Breton District Health Authority

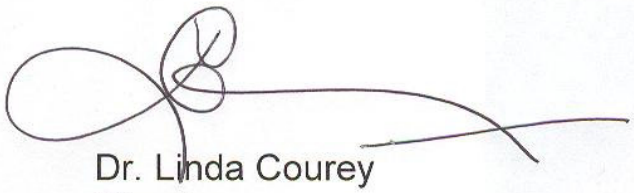
TDV Global

MEDAVIE HEALTH FOUNDATION

ACKNOWLEDGEMENT

This report would not have been possible without financial support provided by the Medavie Health Foundation. The Foundation's commitment to improving services for high-risk youth and willingness to partner with the Cape Breton District Health Authority has given us a wonderful opportunity to move forward. The report provides a sound and comprehensive assessment of the needs of high-risk youth in this area, a description of best practices in the delivery of services that are evidence-based and acceptable to youth and a review of existing services and service gaps. Most importantly, it also presents the perspective of our youth through their own voices. All of this information as well as the recommendations contained in the report will inform service planning in the months ahead.

On behalf of Mental Health and Addiction Services, Cape Breton District Health Authority, I would like to express my sincere appreciation for the generous support provided by the Medavie Health Foundation and my hope that we can continue to work together to improve the lives of youth at risk living in our community.



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Executive Summary

The culture of Cape Breton is rich in Celtic and francophone traditions. Community, family and sense of place have strengthened the population that has had to endure challenging times. They are considered both resilient and creative. And it is these characteristics in the population that are essential to shifting fortunes.

Demographic pressures continue to impact the island's economy and its social fibre. Out-migration of younger age groups has resulted in lower birth rates, an aging population and a declining tax base. In 2009, Novus Consulting concluded a study that projected population using current birth and death rates and immigration data. The study noted that in 2006, approximately 18% of the Cape Breton population was over 65. It also determined that, if nothing changes, as much as 36% of the population will be over the age of 65 by 2026.[1]

The most current migration data from Statistics Canada show that from 2004-2005 to 2008-2009, Cape Breton Island experienced a net out-migration of 6,200 individuals. Over 94%, or 5,858, of these people were under 45 years of age, and 61% were under 25.[2] In the near future, the shift of the baby-boom bubble into retirement is expected to have a greater impact in Cape Breton than in other areas of Canada due to the lack of younger people to replace current workers. One might expect that this would be a good situation, however if those who have migrated out do not return the capacity to replace workers with skilled workers is not available. This will have a net negative impact on generating new and sustaining existing business.

In 2010-2011, the Cape Breton economy continued to be challenged by high unemployment rates. The number of unemployed was up by 300 people compared with the previous year. The Cape Breton unemployment rate remains approximately double that of Canada.

[1] Enterprise Cape Breton Annual Report 2010-2011, http://www.ecbc-secb.gc.ca/index.php?cid=13&pid=159&lang=e

[2] Annual Demographic Estimates by County, Economic Region and Census Metropolitan Area, July 1, 2011 http://www.gov.ns.ca/finance/statistics/archive_news.asp?id=7528&ym=3

Fluctuations in Cape Breton's labour market tend to be more extreme due to concentrations in highly seasonal sectors such as primary industries and tourism.[3]

The economic situation has created an environment for the at-risk youth of Cape Breton which is fairly unstable. This instability touches on all aspects of their lives: housing, relationships, physical and mental health, income, employment, access to treatment and health care, and drug use. Lack of consistency in each of these areas builds and adds to the overall precariousness of their existence. The ability to move forward and establish stability in any one area is hampered by the stress emanating from another. Since youth must often address immediate needs and find ways of coping with their current realities, the ability to look to their future, stay healthy, and achieve their goals and dreams is seriously compromised.

The Study

The aim of the study was to evaluate the feasibility of creating a Drop-In Centre for youth ages 15 to 24. The study approach followed three distinct lines of information to draw on to design possible solutions:

- A comprehensive analysis of programs, initiatives and research that provided information on best practice. This was undertaken through a literature review and Case Studies of a number of programs;
- The development of an inventory of existing programs and services designed for youth from 15 to 24; and
- Direct discussion with youth themselves to determine needs and priorities.

The data provided the opportunity to see the gaps in service and the opportunities for change.

Best Practice

The review of Best Practice looked at a number of at-risk youth service areas including homelessness; Outreach; Independent Living; Youth Family Mediation and Reunification;

[3] Enterprise Cape Breton Annual Report 2010-2011, http://www.ecbc-secb.gc.ca/index.php?cid=13&pid=159&lang=e

School Based Service; Mentoring; Substance Misuse; LGBTQ Youth; and Youth Development. All of these services touched on the issues associated with the groups and many of them discussed the complex nature of the issues and the interconnectivity with mental health. This review of best practice in each of these areas highlighted the following as common best practice to each of the service areas:

- **Assessment and Screening:** should be holistic in nature, seeking out the root causes of at-risk behavior (e.g. mental health) leading to an understanding of the complex interrelationship of issues affecting the youth.
- **Service Integration, Taking the Services to the Youth and Youth Involvement:** there is great value in simplifying the services on behalf of the youth and eliminating barriers by taking the service to them. To succeed in making sure the services are the right ones the at-risk youth must be involved.
- **Mentors:** these role models do not exist in many of the youths lives – and are essential to providing the support they need.
- **Parents:** are the best role models if they can be engaged, that is of course if they aren't enabling or causing the at-risk behavior.
- **Training:** is essential to service providers who where the focus on needs to be skill development and sensitivity to the groups that characterize the at-risk youth (e.g. sexual orientation, race, culture (skater culture)).
- **Basic Needs:** where these needs must be addressed first. The foundation of basic needs must be stabilized first, and once looked after other support can be introduced to help in youth development.

What the Youth are Telling Us

The youth that were engaged in the interviews were primarily at-risk youth with some minor exceptions to enable a comparative base-line. Certainly, this information was skewed to represent this cohort.

The at-risk youth were open and honest regarding their current challenges, and in stating what is important to them. The discussion on drugs was always initiated by the youth – and for the most part considered that drug use was simply "recreational" in nature and something they used to "chill". When the concept of "chilling" was probed they indicated that they needed to chill because of the life challenges they were dealing with.

On the topic of education – the at-risk youth were very critical. They felt that teachers did not respect them and didn't care about whether or not they succeeded. For those who were still in school they trouble connecting the educational content to their futures. Yet they all understood the connection between education and succeeding in the future. For adult learners (over 17 most of who dropped out of school) stated that they now understood that they'd wasted so much time in not understanding the importance and value of education when they were younger.

Regarding Health, and the School Health Centres, most youth did not see a need to go to the centres except for birth control. The at-risk youth verbalized an issue of stigma attached to going to the School Health Centre because of this service many do not go for other reasons because of the connection to sexual activity. Most of the youth interviewed had family doctors and were comfortable in using the system. However, the majority stated that if there were other services at a Youth Centre – such as employment services which could be a reason for going – they would probably seek out health services as well.

The Social Services discussion was emotional. All of the youth were afraid that they would not be able to get off social assistance, and most of those interviewed were on some form of social assistance either individually (for those 19 and over) or as part of a family. They categorically stated they didn't like drawing from these programs, but saw few options. All of them saw that school and their education was the key to disconnecting from these support systems – however they didn't believe that the primary objective of their case workers was to help them become independent. Without exception they felt demeaned and unworthy in their dealings with Community Services.

Regarding justice, the youth echoed the frustration of the service providers. Those that became involved with the legal system saw little hope of improvement when their circumstances of poverty and dysfunctional family environments didn't change. They were clear that if you send someone to detox and then put them right back into a household of "users" then the chances of recovery will be very low.

The summary of need as stated by the at-risk youth:

- Integrate the services for me, I just can't get my head around what is out there to help me;
- Bring the services to me – I don't have any way of getting to them and I don't have any money;
- Respect me and I'll respect you back – and if you don't then I'll probably dis you back;
- Care about me, because no one else seems to; and
- Set the bar high for me, I know I can reach it – but you might have to help.

All of the youth indicated that technology was a birth right. They didn't struggle with it and they used it as a tool. Given an opportunity to use technology as a service entry point most of them said they would use it.

The Challenges

From the interviews and the literature, five high level challenges emerged, each of which represent the clear description of the problem:

- Youth are difficult to engage, and at-risk youth are even more challenging to connect with. Without youth engagement there is no solution. Regardless of the solution, at-risk youth must be involved.

- Productivity and effectiveness in providing the best solution for each at-risk youth depends on inter-department and organization cooperation. There are limitations with the legislation on sharing information to address this issue. Others have succeeded in overcoming this problem, and it imperative that any solution has the potential to address these issues.[4]

- To achieve what the Youth are asking will call for a dramatic shift in service culture, one that is holistic in nature and youth centric. As well, redefining youth from 15 to 25 also reflects some difficulties in the existing programs and processes. Shifting the service providers to a new baseline of services to reflect this requirement will have to be respectful of the changes, the culture and the need to manage transformation.

- There is some concern that regardless of the change that the deterioration of the situation and long reaching impact is faster than any benefit to be derived. Solutions that can be developed quickly for the greatest impact will be preferred, and any change that has merit should be considered in addressing the overall problem.

- Sustainment of any initiative is always of great concern. Too often pilot projects add services to address the issues for a prescribed period of time without looking at how the benefit and value can be sustained through time. This will always be an issue if change is considered incremental. Any solution that is put into place must have the opportunity to provide evidence of value and potential for identifying resource realignment opportunities.

[4] Social Media in Health Care, available at http://www.changefoundation.ca/docs/socialmediatoolkit.pdf

- The economy is certainly a major contributing factor to the issue. Chronic high unemployment and a segment of the society that has remained dependent on Government services does not help in developing a solution which will see the cycle of poverty being broken. However there have been successes, and by focusing on the at-risk youth there is an opportunity to cause this to change dramatically at least in the long term.

The Options

Three options were identified to support the delivery of services to youth. Each solution, except the status quo, would implement best practices as follows:

- Standardized assessment process that looks at the overall needs of at-risk youth, focusing first on the basic needs first;
- One-stop shopping to include health, social service, housing, employability and justice service access;
- At-risk youth are involved in the organizational governance model, on an ongoing basis, and be a part of developing services;
- Each solution has a volunteer component. The two functional areas of volunteerism are to be one-on-one mentoring and recreational activity support; and
- Resources are trained specifically in the at-risk segment they are dealing with (youth between 15 and 25) and any specific sub-population that increases the risk factors of behavior (e.g. drug use or LGBTQ for example).

Four solutions are described as follows:

Option A: The Drop-In Centre Model

The Drop-In Centre would be located in Sydney as the most central point to the CBDHA. It would be a physical space that integrated all four partner groups in the delivery of services to youth – including program representatives of health, mental health and addictions; community services; education; and justice. The operation would be available at times that were developed through the Youth Board, and may reflect non-traditional service hours to enable easier access by youth. As a drop-in centre the facility would have other services that may be recreational nature or reflect basic needs of at-risk youth such as food. The drop-in component would be designed based on direct input from the youth and would remain relevant by canvassing the youth on an ongoing basis. Adequate space would be required to conduct training and workshops, assessments, and counselling. All programs would be delivered from this one location. Technology and connectivity to IT systems would need to be integrated into the space to enable the processing of different

benefit programs. Out of office hour services (emergency) would be provided by existing emergency services. The space would be available, and preferred, as a point of integration for the delivery of programs delivered by non-profit organizations – this could include programs for young pregnant women or training to eliminate barriers to employment. Specifically the centre would develop a "brand" that establishes it as the place for at-risk youth to get help and support.

The drop-in centre would be staffed by three specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and reception (engager, enabler and coordinator and volunteer coordinator e.g. mentor management);

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time in the centre. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty.

The relationship between the Generalist and the Specialist would be one of referral. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist. Although the specialist team would initially consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option B: The Mobile Model

The mobile model takes the services to the youth as part of outreach. The team uses existing youth friendly program facilities. However the service integration would be integrated as in Option A with all four partner groups in the delivery of services to youth – including program representatives of health, mental health and addictions; community services; education; and justice. The operation would be available at times, and locations, recommended by the Youth Board, and may reflect non-traditional service hours to enable easier access by youth. The recreational components of the drop-in centre as in option A would not be available as designed but would key off of existing programs that exist in the space that this service was being delivered. An example of this is to use the Lighthouse Church facility where

Art and Music programs are drawing in at-risk youth, and the addition of this Mobile Model would be considered and augmentation to support the broader needs of the at-risk youth. Adequate space would be required to conduct training and workshops, health assessments, and counselling. Technology and connectivity to systems would need to be mobile to enable the processing of different benefit programs. Out of office hour services (emergency) would be provided by existing emergency services. Out of office hour services (emergency) would be provided by existing emergency services. The location scheduling of the mobile service would be developed to be most responsive to the needs of the at-risk youth and would be continuously reviewed. The intention is not to create new space but to compliment other programs space that will have been developed to respond to the needs of youth in the community. "Brand" recognition would not be space specific but program specific.

The mobile service would be staffed by three specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and reception (engager, enabler and coordinator and volunteer coordinator e.g. mentor management). The receptionist would travel with the team;

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time on the mobile team. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty. Scheduling of these services would require that each discipline would be required to be at each of the community sites and the frequency of those visits would be based on the demand.

The relationship between the Generalist and the Specialist would be one of referral as in Option A. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist. Although the specialist team will consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option C: The Technology Based Model

The technology based model is a virtual drop-in centre, or community, using the advanced social media. As a virtual drop-in centre the site becomes the go-to site for information, services and support for at-risk youth. Not only does it provide an integration point for benefits applications, information and forms but the system includes professional on-line support by a collection of youth service generalists and specialists that contribute guaranteed time to the site to provide on-line support to undertake assessments of needs in real time using IM (instant messaging). In addition, the site would provide opportunity for self-assessment and automated program response based on need. This site would be the one-stop shop for all youth services targeting their needs, and brand recognition would be based on developing the website as the best place to initiate service for at-risk youth.

From an operational perspective the records and data collection as part of the system would provide opportunity to capture outcome status and reports that generate the capability for ongoing evaluation and improvement to services for at-risk youth.

The mobile service would be staffed by the following specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and IT Developer to provide ongoing support to the site development, management of reports and the functions it provides;

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time on the mobile team. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty. Scheduling of these services would require that each discipline would be required to be at each of the community sites and the frequency of those visits would be based on the demand; and

- Volunteers: coordinating matching for mentors and developing activities that support the development of at-risk youth, using the site to develop the activity and generate the interest for these youth. Volunteers will also be individuals with specific competencies related to addressing the needs of at-risk youth – GPs, Medical Specialists, Psychologists and Social Workers. In this model these

individuals could come from anywhere.

The relationship between the Generalist and the Specialist would be one of referral as in Option A. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist but only when the youth gives permission for this activity to be undertaken. Although the specialist team will consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option D: The Status Quo
Continue to have services as they are currently delivered, without change.

Note: Although Option C: reflects the technology solution, it is suggested that this solution be considered as a required action regardless of which approach is selected. Moving forward with an interactive technical solution is not regarded as an option but a requirement in moving forward.

The following table represents the Options and Risk Analysis together. The recommended option can be identified from this table. The Transition Cost reflects the cost of moving from the Status Quo option to the other options. The steady state costs are the incremental costs. In this circumstance the Steady State costs do not reflect offsets from the system, but clearly this would be an implementation option and would decrease costs to the option, but would increase the system cost which still continues to provide the existing service. For example transferring a Psychologist into Options A, B or C would result in an increase in workload for Option D. These transfer costs were not considered, but should be viable if there is recognizable value and a clear business case to realign resources to a different service model.

The comparative areas that were used to compare options were defined by the CBDHA Mental Health and Addictions Staff.

Risk areas were identified. These were then evaluated by external individuals from the project looking at the models and providing rationale for the risk levels which were ranked numerically. The detail of the risk analysis is contained under the section on Options Analysis.

This resulted in the following summary table which highlights Option D the least effective and lowest cost. The high risk in this option resulted from not changing anything in the system, thereby accepting the current outcome level. Options B and C balance one another with similar risk levels but a difference in cost which establishes Option B as preferred to Option A. Option C is effective, and highly feasible, easy to access, has embedded best practice and is low in risk.

	Option A	Option B	Option C	Option D
Transition Costs	$236	$36	$103	$0
Steady State Cost (Recurring)	$440	$355	$107	$0
Feasibility	Med	Med	High	High
Effectiveness	High	High	Med	Low
Accessibility	Med	High	High	Low
Best Practice	High	High	High	Low
Engagement	High	High	High	Low
Sustainability	Low	Low	High	High
Total Risk	5.56	5.77	2.46	6.9

The recommended option is Option C: the Virtual Drop-In Centre. This option addresses all of the needs of the at-risk youth, and while Option B does this as well, the solution represents access 24/7 where other options do not. It is also the lowest cost and risk, other than the status quo which currently does not meet the needs of youth. It was also clear through the interviews that the youth had a high level of comfort in using technology as a service interface.

The technical option represents a solution that use advanced and proven, social media (note that OpenText a Canadian Company has significant experience in this realm and supporting

research indicates that social media does in fact result in social change[5] and is being used in the delivery of health services[6]. There are many recent examples – Egypt, the Arab Spring and others which contributed to social change that have yet to be supported with research, and the Mayo clinic is testing the boundaries of patient information in their web based health service delivery). This technical solution would be designed to capture all the elements of best practice, and would facilitate the integration of services and benefits – guided online by case managers. Communities of profession and interest would be brought to the table and made available through Instant Messaging. Assessments (self and managed), Case Management, Forms and evaluation benefit worthiness would happen online. A supporting knowledge repository would round out the services, so that at-risk youth could further understand the challenges they face. In addition, direct access to referral would facilitate the connection between a required professional and the youth – quickly identifying programs that provide the potential for the highest impact, for example identifying best services to meet their needs, availability and locale.

In addition to the opportunity to integrate services through technology, there is value in collecting data for analysis and program improvement on an ongoing basis. Although this could be part of the solution in all of the other options there would be an added cost, whereby the technology solution if developed with evaluation in mind would have this built in.

Essential to the need is to be nimble in responding to the changing needs of the youth. Technology can easily respond and have an immediate impact across the whole service spectrum with a new version release. Although this can happen in all other options there will be a time lag, and people do not easily accept change. That is not to suggest that the benefits change – but rather the services respond.

This approach uses existing resources, and enables additional resource contribution through the internet in delivering services. Granted this will be a change in culture – but it is expected that each of the service providers will see benefits to working in this manner, having access to a wide range of support solutions, such that the value in the changes exceeds the energy to resist change. Not only with the at-risk youth have access to a

[5] Machleder, Josh and Asmolov, Gregory, "Social Change and the Russian Network Society", Internews, August 2011

[6] Social Media in Health Care, available at http://www.changefoundation.ca/docs/socialmediatoolkit.pdf

variety of resources, the generalist Case Manager will also have access to information and expert advice in real time.

Although this option does not itself provide a face-to-face relationship with youth it does compensate with integrating systems and benefits that fit the needs of youth overall. The solution also provides for the face-to-face component through the mentorship program.

In addition to all of the positive attributes for the youth directly, this option also provides a risk management environment that enables the government to test other options, and once the concept of service integration proves its worth, will enable the system to reallocate resource to either option A or B should that be regarded as a viable option.

Ultimately this option addresses:

- The provision of integration of services that directly respond to the specific needs of the youth- as does Option A and B;
- The provision of additional resource (through the internet) that supports the questions and concerns of the youth, leveraging resource communities of expertise that is not limited to Cape Breton (this capacity building is not available in any other option);
- The delivery of services that respect best practices such as: standardized holistic assessments, building partnerships, using mentors, and non-judgmental engagement are examples of what can be built into the system. This solution is the only one that removes the human component and through process will establish best practice processes;
- Easy access to referrals based on a solid triage process, and although this will take place in Option A (constrained by access) and Option B (constrained by scheduled time of service), this is the only solution that enables full and easy access limited only by access to technology; and
- Taking the service to the youth, without limiting location and time which both Option A and B are constrained by.

The limitation of this approach is the personal relationships that do not exist face-to-face. That being said many of the youth are quite comfortable building trusting relationships online. Ultimately, this approach is to initiate dialogue with the youth, engage them by connecting through technology and then shepherding them toward resources and services that are tailored to their specific needs.

Conclusions and Recommendations

The provision of some form of integrated service for at-risk youth will make a significant impact, if the solution is bounded by best practice which includes: youth involvement; standardized holistic assessment of need; the provision of mentors; improves access and times that reflect when youth need the service; and access to basic needs. The recommendation is to start with a Web Based system that fully integrates the processes of programs and services setting the foundation as best practice. To succeed youth must be involved from the outset – and in particular the at-risk youth.

Use the web based experience to understand how to integrate services and processes, engage youth and eventually change the delivery system. This can be accomplished at the technology layer without affecting the system issues of the defined ages of support (e.g. Social Services provides support to age 16 through the Act), the sharing of information and the location of delivery.

The web based system cannot simply be the presentation of information. The design and delivery must be in a form that has a primary objective of establishing an interactive relationship with the youth. It must be broader than one directed service and have a mandate to bring together all the elements that support the growth and development of youth: education, housing, health and justice.

Design the system such that the virtual Drop-In centre becomes the destination point for youth and their communities of support. The focus must remain: (1) to engage youth; (2) to determine their needs through comprehensive assessment; (3) to integrate existing systems and services; and (4) to provide ongoing evaluation of their outcomes. The youth will use the system because it provides value to them specifically, and the communities of service will come because it will enable them to see how their services are contributing to help these youth. Ultimately, this point of integration will become critical to the ongoing evaluation of youth needs and services.

Reflecting back to the Challenges highlighted earlier in the report under the section titles "Challenges" this solution addresses many of these concerns.

- Engaging youth by including them as part of the solution and recognizing the value of using technology to provide easy and effective access;

- Sharing information which can now be accomplished through the system, and developed as imbedded protocol, being responsive to the limitations of security of information. This has been accomplished in other jurisdictions and has the potential to make a significant difference to the barriers that currently exist;

- Change of service culture is something that takes a generation. This system can be trigger for change, however the culture shift must be managed appropriately. Change will always be resisted and there is some risk that the system will in fact

cause any new system/process or approach to fail;

- Sustainability is always a significant issue, however this solution does not call for a wholesale change to the organizational structure that exists. The costs are minimal as it is just the interface that is being changed. Given the solution will embed measurement systems and data to show outcomes, there should be adequate information to demonstrate the value of the best practice concepts being put into place; and finally

- The economy which will see little or no benefit in the short term. That being said there is an argument that success in this model will eventually take youth from the dependent side of the equation to the contributing side – building wealth, paying taxes and providing leadership to others. This option does have an opportunity if it succeeds to impact the cycle of poverty.

Study Approach and Methods

The aim of the study originally was to:

> To study the feasibility of creating a Youth Access Centre in the CBRM as an approach to removing barriers thereby enabling access to mental health services and support**.**

This was modified to include all "at risk youth" in recognition that this population has by definition a higher incidence of mental illness. The objectives were:

1. To understand the prevalence and nature of at risk youth in the CBRM.
2. To understand the needs, current programs and the gaps.
3. To understand the issues related to program access.
4. To engage the community and families in establishing the current state of social determinants.
5. To understand the trends and best practices associated with success in addressing the needs of at-risk youth.

The study was to look at youth between the ages of 15 and 24. The geographic boundaries of this cohort were to be the boundaries of the Cape Breton District Health Authority. As an addition – First Nations Youth were to be included in the needs analysis.

Ultimately, the feasibility of some solution (to be designed) in service delivery was to be examined. To establish the necessary information to conduct this analysis the activities were divided into three areas: (1) Best Practice and the understanding of contemporary research on at-risk youth; (2) the building of an understanding of existing programs that support at-risk youth; and (3) hearing from the youth themselves. To frame the work the four pillars of service (education, health, social support and justice) were the common elements through the three activity areas and represent society's investment toward improving youth outcomes. The three lines of evidence were to be used to triangulate convergence of results.

> **Best Practice** in the area of at-risk programming was undertaken from two complimentary activities – the first of which was a comprehensive literature review, and the second was the development of four case studies that were intended to exemplify some of these Best Practices. This work was essential to the analysis on

current services, and in the development of service approach for any potential service change or addition.

Current Service Profile was developed to better understand what services were currently being delivered government and not-for-profit sectors. Each service provider was interviewed and given the opportunity to describe the program and its delivery mechanisms. At this point the service providers were not asked for their input regarding the challenges that face youth in accessing the services, or even if the service was responsive to a need or not. This decision was taken to ensure that whatever solution was derived was based on the needs of the at-risk youth and not the "systems" analysis of what they need.

Interviews with Youth happened in both a group setting, with some one-on-one dialogue to validate the information being collected. The original intention was to use an Asset Model questionnaire to move the discussion which would encourage the dialogue to engage the youth to express what they believe they need in life to succeed. Although a valid approach (tested with one of the not-for-profit programs) the time required to undertake this approach was well in excess of the time allotted. This approach was modified and the amended discussion guide is contained in Annex A to this report. The basic approach was to initiate the discussion on experiences of the youth in school – an experience that connected to them emotionally and they could easily articulate. The discussion then moved from the youth's school experience to health, social support and justice.

Methodology

Standard business case methodology was used. The following activities were undertaken:

- Development of Issues and Opportunities: through interviews and literature survey an appreciation of the issues and opportunity was developed. Interviews included service providers and clients. A complete list is included in Annex C.
- Development of solutions: Using the input from the interviews and the research a number of service options were developed. The status quo was included.
- Analysis of the options: the four options were analyzed from the perspective of effectiveness, accessibility, cost, best practice, engagement and sustainability.
- Analysis of the risk: The risk analysis identified key risk elements in both transition and steady state, and then assessed the comparative risk between options.

Study Context and Description of Cohort

The culture of Cape Breton is unique. It is considered a collection of collection of rural communities the centre of which is Sydney. Each of these communities, built around the industrial expansion of the island since the 1700's, has distinct character. Along with the Scottish and French heritage the population has a strong sense of community, individual responsibility to community and connection to place. Coal mining, although no longer and economic factor, still binds together a rich heritage and pride.

Demographic pressures continue to impact the island's economy and its social fibre. Out-migration of younger age groups has resulted in lower birth rates, an aging population and a declining tax base. In 2009, Novus Consulting concluded a study that projected population using current birth and death rates and immigration data. The study noted that in 2006, approximately 18% of the Cape Breton population was over 65. It also determined that, if nothing changes, as much as 36% of the population will be over the age of 65 by 2026.[7]

The most current migration data from Statistics Canada show that from 2004-2005 to 2008-2009, Cape Breton Island experienced a net out-migration of 6,200 individuals. Over 94%, or 5,858, of these people were under 45 years of age, and 61% were under 25.[8] In the near future, the shift of the baby-boom bubble into retirement is expected to have a greater impact in Cape Breton than in other areas of Canada due to the lack of younger people to replace current workers. One might expect that this would be a good situation, however if those who have migrated out do not return the capacity to replace workers with skilled workers is not available. This will have a net negative impact on generating new and sustaining existing business.

In 2010-2011, the Cape Breton economy continued to be challenged by high unemployment rates. The number of unemployed was up by 300 people compared with the previous year. The Cape Breton unemployment rate remains approximately double that of Canada.

[7] Enterprise Cape Breton Annual Report 2010-2011, http://www.ecbc-secb.gc.ca/index.php?cid=13&pid=159&lang=e

[8] Annual Demographic Estimates by County, Economic Region and Census Metropolitan Area, July 1, 2011 http://www.gov.ns.ca/finance/statistics/archive_news.asp?id=7528&ym=3

Fluctuations in Cape Breton's labour market tend to be more extreme due to concentrations in highly seasonal sectors such as primary industries (e.g. fisheries) and tourism.[9]

The economy of Cape Breton is not robust. The island's long history surrounding steel production, and supporting vertically integrated coal mines, has shaped not only its economic state today but has established a unique culture.[10] Popular concern is repeatedly expressed over a number of seemingly chronic problems: unemployment, underemployment, youth outmigration, the economic decline of the traditional natural resource-based industries, the difficulties in attracting new manufacturing and service industries, declining tax bases, a corroding infrastructure, a neglectful Halifax-dominated provincial economic agenda, a loss of excitement for the future, and a social malaise. With less tax money to work with to address these chronic problems, both from a development perspective and a social perspective, is challenging.

In the last 50 years the economy has shifted from a resource and industrial based, to a knowledge, service and tourism base with the health care as the largest employer and the MASH sector employing over 60% of the population[11]. This transformation reflects a fundamental shift in the types of resource that is necessary to support the economy. The resultant is a large, out of work population with low levels of skill, education and prospects to change the future.[12]

Generally, the landscape for the future is not apparent, and opportunities for youth to grow and prosper in Cape Breton are tenuous. Youth that have a large number of personal assets are not deterred by the challenges (many of them choosing to leave), and those that do not have these same assets struggle. These youth are most at-risk and see few prospects to change their futures.

It is important however that we acknowledge the nature of adolescent brain development, concluding that all young people between the ages of 16 and 24 are at risk – and will at

[9] Enterprise Cape Breton Annual Report 2010-2011, http://www.ecbc-secb.gc.ca/index.php?cid=13&pid=159&lang=e

[10] Allen Tupper, "Public Enterprise as Social Welfare: A Case for the Cape Breton Development Corporation

[11] Cape Breton Works, available at http://www.jcicapebreton.com/CapeBretonWorks.pdf

[12] Nielsen, Jens Kaalhauge, "Industrial Development in the Microstates in the North Atlantic Rim", UPEI Institute of Island Studies, 2001

some point make a choice that is high risk.[13] That being said some of these youth are dealing with very complex social and relationship issues pushing them into very high risk behavior. These at-risk youth have easy access to drugs and alcohol, low expectations of accomplishment from families that are struggling with their own personal problems and few prospects of ever getting out of the cycle of poverty. Exceptions to this are those that, regardless of socio-economic status, develop a mental illness – who make choices to deal with their illness through drug use as a way of self-medicating.

The at-risk youth of Cape Breton are living in instability. Instability touches on all aspects of their lives: housing, relationships, physical and mental health, income, employment, access to treatment and health care, and drug use. Lack of consistency in each of these areas builds and adds to the overall precariousness of their existence. The ability to move forward and establish stability in any one area is hampered by the stress emanating from another. Since youth must often address immediate needs and find ways of coping with their current realities, the ability to look to their future, stay healthy, and achieve their goals and dreams is seriously compromised.

[13] Dr. Ken Winters, Key Note Address 13th Annual Northern California Tobacco, Alcohol, Drug Educator, School Wellness & Youth Development Conference, "This is Your Brain on Adolescence", 2010

Literature Review and Best Practice

The literature review was conducted with the objective of identifying a body of evidence regarding Youth services – design, delivery and outcomes so that best practice could be identified. This body of evidence and the resulting best practice is intended to form the baseline of service description in recommendations that follow in the report.

The search, based on key word search, looked at various references – including periodicals, web bases and databases, to identify abstracts and articles that were relevant to the topic of Youth at Risk Services. Experts in the field of Youth/Adolescent health and high risk behaviour were also canvassed to identify additional material.

The following information is a summary of the topics review and best practice associated with Youth Services. This summary is supported by a detailed review contained in Annex B to this report.

Homelessness

Cape Breton is subjected to a unique form of homelessness – characterized by a rural condition. It is perceived that there are a large number of youth who do not live with their parents – or have their own place of personal residence. Couch surfing and transient living with relatives and friends are the norm in this community – and for the sake of identifying characteristics that cause this issue we are using the urban model. Total numbers of homeless youth are extremely difficult to estimate because of their transient nature (Smoller, 1999).

Areas of Best Practice

Assessment and Screening	Determination of drug use, mental health status and state of family circumstance Kurtz et al., 2000; Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999; Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998
Community of Origin	Need to maintain connection, particularly important in First Nations Ensign & Gittelsohn, 1998
Targeted Prevention	Start in school system to

	establish that there are options to running away Robertson and Toro, 1998
Integration of Services and Programs	Sorhaindo, Annik and Feinstein, Leon, 2007; Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991
Case Management	Follow a process which requires assessment, ongoing follow-up and evaluation Morse, 1999
Basic Needs	These need to be satisfied first – food, housing, health Cauce, Morgan, Wagner,Moore, Sy, Wurzbacher, Weeden, Tomlin & Blanchard, 1994; McCarthy & Hagan, 1992; Terrell, 1997

Outreach

The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased services. Many of the youth that outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services, have had negative experiences with service-providers, and have been victims of violence (Sullivan-Mintz, 1995).

Areas of Best Practice

Engaging Youth	Need to be relevant to youth, involve youth to identity opportunities Rose-Krasnor, L., Brusseri, M., McCart, S. & Pancer, S. M. 2007; Erickson and Page, 1998; Schulman, 1999
Peer Outreach Workers	Best to select those with similar experience Knowles, L., 2002; Erickson and Page, 1998; Podschun, 1993; Schulman, 1999; Cleghorn et al, 2000; Johnson et al, 1998

Early Intervention	Erickson and Page, 1998; Schulman, 1999; Johnson et al, 1998
Community Partnerships	Communities will take responsibility for broader program/recovery needs and at-risk youth will respond Camino, L., 2005; Hall, M., McKeown, L., & Roberts, K., 2004; Eccles and Gootman, 2002; Finn, J. & Checkoway, B., 1998; Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al.,1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996;Yates et al., 1991; Gleghorn et al. 2000; Johnson et al. 1998; Erickson and Page,1998
Follow-up	Shulman, 1999; Gleghorn et al.,2000
Hiring and Training of Staff	Must be sensitive and caring Winarski, 1998; Barrow, 1988; Shulman, 1999; Erickson and Page, 1998
Assessment and Screening	Rapid assessment to determine priorities and immediate action, should be holistic in nature Erickson and Page, 1998; Johnson et al. 1998; Shulman, 1999; Gleghorn et al., 2000
Cooperate with Law Enforcement	Wortley, Scott, 2008; Johnson, et al. 1998

Independent Living

Adolescents aging out of the child welfare system are particularly vulnerable to poor health, under education, unemployment, and homelessness. Most graduates need help in making transition from a dependency status to self-directed community living. At a minimum, transitional assistance includes help in finding a place to live, getting a job, maintaining employment, gaining access to health/dental care, and budgeting and managing money.

The majority of youth who emancipate from the system and who are expected to assume responsibility for their lives require tangible assistance (Loman, 2000).

Areas of Best Practice

Nurturing Connections	Building connections with community, business, schools, mentors, and peers Camino, L., 2005; Hall, M., McKeown, L., & Roberts, K., 2004; Eccles and Gootman, 2002; Loman,2000; Collins, 2001; Johnson et al., 1998; Muskie et al., 2000; Westat, 1998
Supporting Education Achievement	Through mentors and role models Knowles, L., 2002; Loman, 2000; Collins, 2001; Johnson et al., 1998; Muskie et al., 2000
Training	Life skills, employment Dworkin, J.B., Larson, R. & Hansen, D., 2003; Knowles, L., 2002; Loman, 2000; Collins, 2001; Johnson et al., 1998; Muskie et al.,2000

Youth Family Mediation Re-unification

Preservation of the family, which may involve rebuilding family connections, provides the necessary supports to help high-risk youth avoid risk behaviors and delinquency (Thompson et al., 2001; Kumpfer, 1999). The research empirically supports reunification of youth with their families after they have run away from home, or been thrown out. Youth who returned to their parental homes after being homeless reported more positive outcomes in school, employment, self-esteem, criminal behavior, and family relationships than adolescents discharged to other locations (Thompson, Pollio, & Bitner, 2000). Similarly, other research has demonstrated that youth who failed to reunify with their families had longer shelter stays, increased hopelessness, and suicidal thoughts and behaviors; reported more family problems; and had a more pessimistic view of the future than those who returned to their families (Teare, Furst, Peterson, & Authier, 1992; Teare et al., 1994).

Areas of Best Practice

Recruitment of Parents	Provide best mentors, if they are not the cause of

	at-risk behaviour Dadds, Spence, Holland, Barrett, & Laurens, 1997; Dishion & Andrews, 1995
Positive approaches to prevention and change in the family	Multi Dimension Family Prevention Model, Functional Family Therapy (FFT) Szapocznik et al. 1989; Alexander at al., 2000
Asset Building	Key is in engaging the broad community as part of the solution Benson 1997, 1993; Benson et al. 1995; Alexander at al., 2000

School-Based Services

Parent/teen conflict and academic failure are some of the problems youth face that can escalate into risk behaviors, delinquency and dropping out of school. Conflict at home due to poverty, parental substance misuse, abuse or miscommunication can trigger high risk youth into risk behaviors, dropping out of school, or running away and ending up on the streets (Dishion et al., 2000). The middle school years are perhaps the last vantage point for intervening in the school, as in high school, many high risk youth will be expelled or drop out of the public school environment, and therefore, will be much less accessible (Dishion & Andrews, 1995).

Areas of Best Practice

Prevention Requires Early Intervention	Short term yields short term benefits, focus on long term programs, start in Grade 6, the school should be at the centre Durlak & Wells,1997 and Lorion, et al.1994; Webster & Stratton, 2001
Services Linking Child/Youth, Families and School	School should be the central integrating partner, parents (or adult) essential to youth attitude toward school

	Knowles, L., 2002; Loman, 2000; Collins, 2001;Dishion &Kavanagh, 2000

Preventing Dropping Out of School	**Changing education when there is a high risk of dropping out, use integrated services** **Rossi, 1996; Vitaro, Brengden, & Tremblay, 1999; Prevatt, 1998**
Linking to Community Services	Integration Greenberg et al. 1999; Donovan, Jessor, & Costa, 1988; Dryfoos, 1990; Elliott, Huizinga & Menard, 1989; Jessor, Donovan & Costa, 1991

Youth Mentoring

Since the growth of mentoring programs for high-risk youth began in the early 1980s, a number of studies have been conducted to determine the benefits for youth. As a result, the field has gradually built a body of evidence confirming that mentoring can have many positive benefits. Mentorship programs have been found to have a positive influence, especially where youth are matched with mentors who have experienced similar issues and have a genuine respect and affection for youth.

Areas of Best Practice

Program Design	To succeed should be structured to ensure best match, and that mentoring should result in improving outcomes De Anda, 2001, Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996; LoSciuto et al., 1996; Rogers & Taylor, 1997
Recruitment and Screening	Best to have adults who like to spend time with youth and not about saving them, some form of common connection (e.g. race, life

	experience) De Anda, 2001, Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996; LoSciuto et al., 1996; Rogers & Taylor, 1997
Training and Competencies	Mentors should be trained Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996
Relationship Building	Steady connection and involvement, limited access to youth's family Jones, K., & Perkins, D., Zeldin, S., Camino, L., & Mook, C. 2005, 2006, Mech et al., 1995; Sipe, 1996; Novotney, 1999

Substance Misuse

The progression from casual substance use to dependence can be more rapid in adolescents than in adults (Winters, 1999). Once dependant on substance misuse, adolescents almost never enter treatment as a self-referral. Instead, they are typically referred by a parent, juvenile justice system official (judge or probation or parole officer), school official, child welfare worker, or representative of some other community institution. Adolescents require greater intensity of treatment than adults and this is often reflected by a greater tendency to place adolescents in more intensive levels of care (Mee-Lee, Shulman, Fishman, & Gastfriend, 2001).

Areas of Best Practice

Identifying Specfic Groups of Youth and Barriers	The Group is important to the program – culture, support structures, partners Canadian Center on Substance Abuse and Center for Addiction and Mental Health, 1999; Currie, 2001; Greenbaum et al., 1996; Roy, 1999; Smart and Ogborne, 1994
Contact and Engagement	Bring the service, the integration of partners, to the youth – they will not go to you Rose-Krasnor, L., Brusseri, M., McCart, S. & Pancer, S. M. 2007; Erickson and Page, 1998;

	Schulman, 1999

LGBTQ Youth

Although the empirical evidence varies by type of problem, LGBTQ youth appear to be at greater risk of depression, suicide, runaway behavior, and chemical dependency than their heterosexual peers (Durby, 1994; Gonsiorek 1988; Mallon, 1997; Morrison & L'Heureux, 2001). Of these problems, suicide has been the most studied. Studies have consistently shown extremely high suicide attempt rates among gay and lesbian youth (D'Augelli and Hershberger, 1993; Proctor and Groze, 1994; Schneider et al., 1989).

Areas of Best Practice

Program Design	All partners must be equally sensitive to LGBTQ youth Child Welfare League of America, 1991; Mallon 1992, McMillen 1991; Phillips and McMillen, 1997
Supporting Youth with Gender Issues	Activities of inclusion, building relationships, and support systems within the family and external to the family Gonsiorek, 1988; Remafedi, 1990; Dempsey, 1994
Anti-Harrassment Policy	Must be more than words on paper Phillips and McMillen, 1997
Assessing and Addressing High Risk	Focused on determination of high risk behaviour – use existing programs Kurks et al., 1991; Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999; Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Noell and Ochs, 2001; Morrison and l'Hereux, 2001
Hiring Staff	Encouragement of supporting programs and services who employ gay and lesbian staff

	Phillips and McMillen, 2001
Training	Essential in shifting attitudes and should be included in all partner organizations to combat prejudice and intolerance Phillips and McMillen, 2001

Youth Development Approach

Over the last thirty years there has been a widespread proliferation of prevention and positive youth development programs. More recently, there has been a greater focus on evaluation of programs emphasizing positive youth development (National Institute of Child Health and Human Development). Interest in positive youth development has grown as a result of studies that show the same individual, family, school, and community factors often predict both positive (e.g., success in school) and negative (e.g., delinquency) outcomes for youth. Such factors as developing strong bonds with healthy adults and maintaining regular involvement in positive activities not only create a positive developmental approach, but also can prevent the occurrence of problems.

Areas of Best Practice

Identifying Specfic Groups of Youth and Barriers	Development programs should reflect youth groupings Johnson et al., 1998; Social Development Research Group, 1997; Benson and Saito,2000; Batavick, 1997; Scales and Leffert, 1999; Zeldin, 1995
Building Youths' Strengths and Competencies	Youth driven and focus on community and look for opportunities to initiate and strengthen relationship with family (or adult) Johnson et al., 1998; Social Development Research Group, 1997; Benson and Saito, 2000; Batavick, 1997; Scales and Leffert, 1999; Zeldin, 1995
Family Support Approach	Parenting skills training and finding opportunities to build parents strength – at-risk parents too must be involved in design and

Discussion

This review of best practice provides an opportunity to see some areas of convergence of these practices signaling that applying them for the broad population of at-risk youth would make the largest impact. These practices are:

- **Assessment and Screening:** that is holistic in nature, seeking out the root causes of at-risk behavior (e.g. mental health). Tools that are supported with research will provide the best results. Training in the use of these assessment and screening tools is essential as it using them as the basis of developing the structure of Case Management and plans to improve the outcomes of the Youth.

- **Service Integration and Taking the Services to the Youth:** it was clear from multiple sources in the literature that any barriers to access will cause the youth not to access the service – travel is one of those barriers. In addition, many of these youth are dealing with difficult situations (dysfunctional families, poor mental and physical health, poor life skills) and adding the requirement to sort through the services, assess what they need and then plan to accessing them is too difficult. Providing the services in an integrated form simplifies at least one thing in their lives.

- **Mentors:** for the most part these youth have no role models, so it is not surprising that they are moving through their lives in the manner they are – angry, frustrated, disrespectful of authority and making choices that put them at risk. Mentors, who build a relationship of trust, support and unconditional love, will result in improved outcomes (improved school attendance, better marks, contribution to community, shift of peer group, and the development of life skills).

- **Parents:** the research clearly indicates the importance of the family unit. Although it is important to be careful that it is not the family at any cost approach, building the capacity within the family to be a family is the preferred path and the best for the at – risk youth in improving their outcomes. Working with parents to develop parenting skills, and engaging them in an active and constructive manner with their youth will result in improvements. Parents do make the best mentors.

- **Training:** it is important that training is a fundamental part of any strategy or practice development. Training that develops skills and is sensitive to the groups that characterize the at-risk youth (e.g. sexual orientation, race, culture (skater

culture)).

- **Basic Needs:** address these needs first. Stabilize the situation and then look at how to support the youth in their development.

Case Studies

Lighthouse Youth Services Cincinnati

Targeted Ages: 12 to 24

Lighthouse Youth Services was founded in 1969 in Cincinnati by a small group of African American women from the Baptist Women's Fellowship who, along with other community volunteers, sought a better future for young people and their families. Having become aware of the high number of young people in their city who had been incarcerated in state juvenile correction institutions and who were returning to the same difficulties that had led them into trouble in the first place, these volunteers set out to open the first group home for girls in the state of Ohio. From the beginning Lighthouse has pioneered the development of programs and services, some of which have become national models of innovation and efficacy.

Lighthouse Youth Services is a multiservice agency providing social services to children, youth and families in southwestern Ohio. Operating since 1969, Lighthouse is nationally recognized as an innovator in services for families in crisis, for homeless youth and young adults, for youth learning to become self-sufficient, and in foster care for abused or neglected children. It has emerged from a simple volunteer program based organization to a $22 million enterprise that has permanent professional staff and an army of volunteers – serving in program delivery, organizational management and a successful mentoring program.

Lighthouse operates the area's only direct access, around the clock sanctuary for homeless, abused, neglected or abandoned youth; and a juvenile corrections facility with a success rate more than double that of traditional facilities. In all, Lighthouse operates 19 different programs and a charter school.

Serving the city's population of less than 300k at any given time there are over 400 children, youth and families in Lighthouse residential care. Each day Lighthouse staff members serve over 1000 children and families through its community based services. Last year, the agency served over 4000 young people and families. Central to their lives are concerns about homelessness, hunger, loneliness and safety.

Two of the anchor services that are establishing significant breakthroughs in youth outcomes are:

Home Based Services: which have been regarded as leading best practice in the USA. These services are comprised of multiple programs working individually, or cooperatively, based on a wrap-around model. Programs focus on school, community and work as the basic theme areas – along with some specialized programs that address gender issues in female youth and substance abuse. The programs are focused on youth between the ages of 12 – 24 (program dependent) with a unifying idea behind these services that staff will do whatever it can to help children and youth remain safely in their homes or to transition through the juvenile justice or child welfare systems. Although the team has trained and certified case managers, councilors and therapists – it is the intention of the team to integrate the required support to provide for the best care plan for each of their clients.

Home based services provide living arrangements for 16 to 18 year old youth in varying degrees of supervision. The intention of this is to support the youth in developing the life skills necessary to succeed on their own. As with the other services in this division they are wrap around.

The Lighthouse Community School: has demonstrated exceptional impact. The School (LCS) specializes in highly individualized, flexible, and intensive strategies to meet the educational needs of youth in the child welfare system. The school takes pride in employing unconditional positive approaches to foster a safe, stable community that develops effective social skills and enhances academic progress.

LCS strives to be the permanent educational home for children in the child welfare system who need stability through multiple placements. LCS is responsive to caseworkers who place children in the school, understanding the challenges they face in meeting the educational needs of the children whom they serve.

Lighthouse Community School effectively deals with social and emotional barriers. Eighty four percent of the students with a mental health diagnosis who have been in LCS all year show significant gain in employability and life skills. Even though 78% of the students enrolled in LCS had a DSM IV diagnosis such as ADHD or bipolar disorder, all of the students eligible to graduate did in fact graduate. Services are wrapped around each of the students so that the multiple barriers have limited impact.

LCS works with local school districts to provide transportation. The school is sponsored by Cincinnati Public Schools. There is no tuition.

Community volunteers are active at the school, including Ethicon-Endo Surgery and GE. There is a school basketball team, volleyball team, art classes, computer lab, and library with a student staff ratio of 5/1. The school is grade 6 through to grade 12.

Undercurrent Glace Bay

Targeted Ages: 12 to 19

Undercurrent Youth Centre is a youth centric facility initiated by the Lighthouse Church in Glace Bay. The Church has a mandate to serve the community, Glace Bay and its surrounding communities. The centre serves youth of all backgrounds – and does not limit participation to those in the church. Undercurrent exists to provide:

- Mentorship by youth workers and trained volunteers;
- Facilities to support sports activities that respond to what youth are looking for: basketball, skateboarding, rock climbing, floor hockey and indoor soccer;
- A safe environment free from drugs, alcohol and profanity; and
- Programs for youth and their parents help them learn life lessons, develop new skills, and how to contribute to the community.

The centre has been extremely successful in establishing a safe place for youth in the community. The facility is based in the church, however the church based activities are kept separate from the youth programs – with the exception of a faith based youth club one night a week. The Pastor has been successful in partnering with services targeted at youth – in particular Justice and Addictions. His focus has been engaging youth through activities and then using the activity as the vehicle to initiate a dialogue. This approach compliments the outreach approach of Addiction Services and through this partnership has given rise to programs in Art, Drama and Music along with the sports activities. It is through these programs that youth are provided the opportunity to build assets, self esteem and life skills. The focus of the building was to start small, with some key engaging activities, and some appropriate partners. Using the indoor skate park was an essential engaging activity – drawing in significant numbers of male youth which has been a struggle in the community to link males with programs. The centre uses the simple tenets of mutual respect and strong role models and mentors. Although the outcomes of youth have not been measured (given the short time of operation) the attendance to the activities has been strong. Attending the activities has also provided introduction to other services such as addictions/prevention counselling and youth parenting skills development. The space provides an environment which is non-judgmental and inclusive – a base of faith foundation, but also essential to engaging youth and initiating dialogue.

The Undercurrent Youth Centre uses technology as an essential component for communicating with youth. This vehicle provides information on programs, upcoming events and access to general information about the centre. The basic components are a Website, Facebook and a Twitter feed. The technology is active and current.

SHOUT Toronto

Targeted Ages: 16 to 24

The SHOUT Clinic provides primary, interdisciplinary care to youth between the ages of 16 and 24 through a trauma informed and harm reduction philosophy. The clinic in the heart of the downtown Toronto provides responds to the needs of at-risk youth through a number of programs designed in response to their diverse and complex needs.

The cornerstone of their service is the intake assessment. This process was developed based on the social determinants of health as defined in the Ottawa Charter for Health Promotion. These determinants of health (which include income, shelter, food, social isolation, education, employment, safety, social justice and equity) allow Shout staff to conduct a comprehensive assessment of the level of risk for each client and to set priorities for service. All clients receive an intake interview before accessing services at Shout.

On completion, the Case Worker draws from Health, Dental, Mental Health, Social Services and Health Promotion in support of the specific needs in care. What SHOUT has learned is that treating one specific area (Health) without addressing the complex interaction of Mental Health and Housing will result in negligible improvement. Not only does the staff look at the holistic needs of the youth – but they respond with an integrated manner to address all of the issues. For example, it is difficult to ask a young person to go to the hospital to have some tests done when they don't have bus fare or a health card. So being clinically correct with the solution is irrelevant if the young person cannot follow through.

The Mission of Shout is to "Improve the Health of the people of their community". They truly believe that health extends past the physical mechanics of the body and is best defined by the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of

living. It is a positive concept emphasizing social and personal resources as well as physical capacity.[14]

The SHOUT clinic is a safe, respectful and non-judging clinic staffed by advocates for at-risk first and professionals second.

Phoenix House

Targeted Ages: 12 to 24

Phoenix House provides a continuum of care consisting of long-term and multi-level services to at-risk and homeless youth. The mission of the organization is to break the cycle of poverty and homelessness by working with youth in building the skills and confidence they need to flourish.

Phoenix began in 1987 with the first program - Phoenix House. It was through the vision of community-minded individuals who saw a growing need to assist youth that Phoenix was born. The organization has grown as the needs of youth have grown. The following are the programs that support youth in need:

> **Phoenix Prevention Program** – The Phoenix Prevention Program has emerged from an understanding that preventative measures and early intervention can help to address the cycle of homelessness that so often begins in youth. It offers community education and therapeutic intervention for at-risk youth and their families. This program recently received the EVA's National award for innovation in community development. The outreach approach brings together opportunity for youth to build resiliency, while still living at home. The program offers an afterschool place for young people and a number of initiatives designed to link at-risk youth with making change in their community. Part of the program is the development of leadership skills – an approach which will eventually be a fully community based sustained program.
>
> **Phoenix Centre for Youth** – a street-front, walk-in service offering counselling, referral to community resources, advocacy, health services, food, showers and laundry facilities.

[14] SHOUT, http://www.ctchc.com/

Phoenix Youth Shelter – a 20-bed shelter facility offering a range of services including safe emergency accommodations; clothing; food and other daily essentials; counselling and therapeutic support to enable youth to move forward to a safer, healthier and more productive lifestyle

Phoenix House – a ten-bed, long-term residential facility for males and females. It offers safe, supportive housing for youth learning skills for independent living.

Supervised Apartment Program – three independent homes in which three clients reside with a live-in support person. The Supervised Apartment program provides a long-term, supportive living situation for youth enhancing skills needed for the next level of independent living

Phoenix Learning and Employment Centre – the goal of the Phoenix Learning and Employment Centre is to provide youth with opportunities for pre-employment, employment, life-skill and academic development.

Health Services – the Health Service offers comprehensive on-site health care at Phoenix Youth Shelter, Phoenix Centre for Youth and Phoenix House.

Special Initiatives (SPIN) - offers innovative programming designed to develop youths' skills and competencies through activities that reflect the interests and talents of the youth.

Parent Support - this program provides young moms and dads with access to workshops, counselling, as well as baby-care items and food.

Follow Up Program - youth are reassured that when they turn 25, they can still stay connected.

As the organization has grown the fundamental underpinnings of safety and comfort have been maintained and are considered essential to their success.

headspace Australia

Targeted Ages: 12 to 25

headspace, the National Youth Mental Health Foundation, was launched in 2006 as part of the Australian Government's commitment to the Youth Mental Health Initiative (YMHI). The program was in direct response the growing issues of mental illness in this population, and a situation that only 30% of young women and 13% of young men sought help. headspace was established to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young people aged 12-25-years-old. Its aims are to achieve this by:

- Providing holistic services via Communities of Youth Services (CYSs);
- Increasing community capacity to identify young people with mental ill-health and related problems as early as possible;
- Encouraging help-seeking by young people and their Guardians;
- Providing evidence-based, quality services delivered by well-trained professionals; and
- Impacting on service reform in terms of service coordination and integration within communities and at an Australian and state/territory government level.

headspace governance follows an inclusive model – where involvement of youth at the decision table is essential to its success in staying relevant to the needs of the youth population they serve.

headspace.org.au is fast becoming the first point of contact with the service and information on youth mental health and well-being. The website has close to 700,000 hits (60,000 average monthly). One of the most popular searches were the stories of youth who had experienced the services. The innovation in communication doesn't stop there – the headspace organization uses print, television and radio media – along with musicians and other role models to engage the youth. The social media portal has become the hub for other forms of communication including YouTube, facebook and Twitter.

headspace aims to provide multidisciplinary services to young people with mental health issues in 30 CYSs throughout Australia across four key areas: primary health, mental health, alcohol and drug use, and social and vocational support. Findings (Annual Report 2010) show that:

- Service access focused significant resources at the National and Local levels to promote awareness – the efforts in this regard has resulted in a significant increase in youth between the ages of 15 and 24 accessing the services. Access referral modes include the Health System, schools (and other community based institutions), family and self-referral. Within 3 years headspace in 30 locations provided service to 23,000 youth who accessed the service on average 6.8 times.
- Comparison with young people in the population at large suggests that CYSs are attracting young people with higher than average psychological distress and who also need support in other areas of the life, such as economic participation and substance use.
- The most frequently occurring diagnoses for young people attending headspace were anxiety and depressive disorders. Almost half of those with a primary diagnosis had received at least one other diagnosis, highlighting the high prevalence of co-morbidity in young people attending headspace.
- Young people using headspace services were also more likely than those in the population at large to have poor physical health, be neither studying nor working,

have poor or no contact with family members (even when living at home), and be higher than average users of alcohol, tobacco and other drugs.
- Young people access and remain engaged with headspace because of its youth friendly nature. Aspects of youth friendliness include the non-clinical environment, the good location of most CYSs, non-judgmental and trusting relationships between young people and their practitioners, a sense of control over service experiences, low or no cost services, and appointment reminders.

headspace aims to maximize outcomes for young people and their families by providing holistic, high quality services by wrapping services based on individual need. The following outcomes were realized:

- Both the qualitative and the quantitative data showed that most young people surveyed reported improvements in their mental health, with reduced levels of psychological distress. Young people also found that headspace helped them develop strategies to manage their mental health, as well as greater insight into their own behaviour.
- More than half the young people surveyed reported improved physical health since using headspace. There were also significant decreases in the frequency of alcohol and drug use and almost 80% of young people stating that their ability to manage their emotions without using had improved.
- Approximately 50% of young people believed that headspace had improved their ability to go to school, or to work or find work. Improved willingness to engage with work or education was largely attributed to psychological support received through headspace, rather than support from vocational service providers.
- Most young people described improved relationships with family and friends since accessing headspace services, although this was dependent on the nature of individual relationships. These changes were attributed to improved communication, increased self-awareness and the development of coping strategies to deal with challenging relationships.
- The findings indicate that headspace may be more impact on young people presenting with mild to moderate mental health problems, with whom early intervention is possible. These people are more likely to be aged 12-17 than older youths aged 18-25.
- The impact of headspace did not differ greatly between men and women, or between service users in regional and urban locations.
- Families and significant others generally felt that headspace had had a positive impact on the mental health of the young people they cared for and consequently on their own lives as well. However, there was some criticism concerning the lack of support available for Care Givers through the centres.
- Good practice 'episodes of care' are seamless and coordinated from the time a young person is referred to headspace through to their exit. An episode of care usually begins when a young person is referred to headspace. They are then assessed and

further referred to different practitioners within and outside headspace and access services (that are coordinated and case reviewed) until they are ready to exit.

- Holistic services were also a positive experience for young people. 68% of those surveyed had seen at least two headspace practitioners, most commonly a GP and psychologist. The multidisciplinary nature of headspace increased the accessibility of services for young people, and enabled young people to address issues across their whole life.
- headspace has improved the quality of services by using evidence-based practices, providing appropriate training and supervision for staff, and by informally evaluating services.
- Service integration and coordination amongst service providers also helped to maintain service quality. Coordination activities are facilitated through shared infrastructure, clear governance, and individual leadership and attitudes. The barriers to coordination were time and funding constraints and prohibitive organizational cultures.

Lessons Learned

These service providers are leading lights in dealing with the needs of at-risk youth. Although they differ in size from the smallest in the basement of a Church through to the $23 million a year service in Cincinnati they do provide some interesting common elements. These common elements are themselves telling in that they flow very much from the best practice research, indicating that in the absence of best practice with Cape Breton service providers there is a significant opportunity for change and improvement.

- Provide a safe environment staffed with people who: do not judge; listen; and are respectful to the unique circumstances of the youth.

- Engage the youth by encouraging them to be involved in the service, encouraging them to communicate what they need and what is important – and then letting them participate in the solution. Hours of operation and location are two decisions they can help with.

- Hire staff and volunteers that are mentors with life experience – they will give hope to the youth. The at-risk youth will see that regardless of their experience they are not alone and others have been able to make a change.

- Take the service to the youth.

- Apply an holistic needs analysis of the youth. Health is understood to be broader than the physical working of the body. Solutions need to respond to the diverse needs of the youth and look to all elements of the social determinants to achieve the desired outcome improvement.

- Design appropriate ways to engage at-risk youth and it is important to understand that it is a significant challenge. Look for non-traditional activities to get them in, build trust and then start talking about what their needs are and how you might be able to help.

- Don't be complacent. A good program today may not be tomorrow. The lives of youth are changing at the speed of light. Maintain relevancy – change and adapt as they change.

A Special Case: Parents are Dads Too

The "Parents are Dads Too" program is offered by the Family Place Centres in Sydney. It is a program that is discussion based and takes a group of men who are at-risk through a number of topics that reflect what they need for parenting. Although the program has some structure, it is intended to be an opportunity for men to raise and discuss issues that they are living with as parents.

The men (many of whom are youth between the ages of 17 and 24) meet weekly. They have had significant challenges in their lives. Drug use and interaction with the law are common characteristics. What drew them together however was that they were parents and it was this common element that enabled them to share and trust one-another. The group does go up to age 55 and this dynamic between the older men and youth was extremely interesting to witness. In some cases individuals had been coming for 3 years. There are 19 in the group and they regularly have all members attending. Some of them may have been directed to the program from the justice system – but they keep coming back because it is something that helps them deal with the challenges of their lives.

The group established clear rules for respect and language. The facilitator is female and the only female in the room. Although the Family Place Centre is a safe and non-judgmental place for the group, the men are quick to point out issues amongst themselves of behavior and poor choices – so they are judgmental with one another. They talk about their very difficult lives growing up - multiple foster homes, large dysfunctional families, and abuse. During the interviews many of them admitted to turning to drugs and alcohol, and in a moment of introspection, admitted that they were self-medicating to deal with mental health issues and dysfunctional families. They indicated that using drugs was their only escape. What they came to realize within the Men are Parents Too group is that the meetings provided unconditional support, love and nurturing, all of the things that their families did not provide growing up. Hence, this discussion group had become their family. And, without exception, they all wanted to make a difference for their kids and they indicated that this group was providing the hope that they could.

Given the success of this group there was a belief amongst the members that they could help others to see that the path they took was not the best one. They acknowledged the challenges of replicating the model – and that much of the success could be attributed to

the members and the facilitator. However, they also believed that sharing their life experiences with at-risk youth could result in some positive changes these young people.

Perspectives

The following external perspectives were solicited through interviews with key informants.

A Parent Perspective

A parent described her experience with her son, who by her admission represents an at-risk youth. She is a single parent of two children – one male 17 and one female 19. She has been married twice, both marriages ended in divorce because of alcohol abuse by the spouses. Each marriage lasted 16 years, and the second marriage was the only Father her son knew growing up. She is, and has been for over 20 years, gainfully employed and, although not highly paid, was able to provide a good home in a typical middle class family area. She did feel guilty for not being able to provide extra-curricular opportunities for her children. This guilt was intensified by both her children who resented the situation and couldn't understand why all their friends had these opportunities but they could not. Her employer required her to work in the afternoons and evenings, with weekends off. To compensate she always made sure that she was at home in the afternoon as her son arrived from school. She has been in treatment through her adult life for depression.

She noticed her son was struggling in school when he was in grade 6. This concern was generated from reports from teachers on his struggles and his anger at home. It was his behavior at home that led her to start looking for the problem and the solution. She started a two year process that introduced her to the Child and Adolescent Mental Health system for evaluation. Part of that evaluation required input from the teacher. This same teacher, who reported on the boy's poor behavior, indicated to the Psychiatrist that he was not a problem in class. This was contrary to the teacher's earlier claim that the boy could not focus, was constantly standing up, moving around and being disruptive. The parent agreed with the teacher's claims and she was convinced that her son had some form of learning disability or mental illness. At this point she believed that all the doors were closed and there were no options for further support until Junior High School. Between the grades of 6 and 9 the boy's situation worsened, he became angry, started skipping school and explored drugs. The Mother felt that the mainstream school system had written her son off as someone who would not succeed in school.

In grade 9 he was channeled to the Southside Learning Centre. This was the first time in four years that the Mother saw any hope for her son. There was a dramatic shift in his behavior. The individualized attention helped him to see that he was capable of learning the material – but that he needed to develop tactics to deal with issues such as "distraction" during the day. The attention and support he received were critical elements to the shift his Mother saw as helping him to turn things around. She worked alongside the staff in helping to complete the grade 9 program and prepare him for High School.

The young man started the Trades program at with high hopes. Unfortunately he could not cope with the distractions in a large school. He began failing, felt he could not succeed, started skipping and returned to drugs where he used more frequently. This situation resulted in his anger returning and an increase in his disrespect for his Mother. Frequently he abused his home relationship and invited friends over during the day to skip school and get "high". The Mother attempted to deal with the situation, but eventually realized that this abusive situation only had the potential to hurt her and compromise her own mental health. The Mother who believed that she had exhausted the systems for support (police and health) eventually made the decision to ask her son to leave. She felt that by sending her son out on his own might help him understand the good things that his Mother provided and hoped that he would ask to be allowed to come home.

The young man was not only angry now, but also harbours great resentment toward his Mother. He moved in with his Sister, and because his Mother was no longer supporting him, his Sister became his Guardian. Following this his Sister applied, and now receives social service benefits which has erased any hope his Mother had of the young man returning.

Her son shows no signs of remorse, is angry, has cut off communication, continues to use drugs and skip school. He has transferred his behavior to his Sister's home – and eventually the Mother believes he will also transfer the disrespect. She is convinced the cycle will continue, and is somewhat bitter that the system was not there to help her son.

The Justice System Perspective

Two service providers in the Justice system provided their views on at-risk youth, specifically those that they have come into contact with. They reflected on the complex nature of the problems in Cape Breton. The economy they admitted is not helping. With the closure of the mines and the steel plant decades earlier they reflected on the unemployment and dependence on government. They expressed concern that Cape Breton is a welfare state with few glimmers of hope to change that situation.

This of course has a direct affect on the Justice system. In the past alcohol drove family violence and high risk behavior resulting in action by law enforcement. Today, alcohol still exists, but added to it is a significant drug culture that has stepped up the issues of criminal behavior, a large portion of which is in dealing drugs. Access is easy and the demand is high. They noted that the families that were in trouble 50 years ago, and were well known, are the same families today but two generations later.

The correction facilities are filled with youth that have drug dependency issues. They qualified their point by indicating that social issues were the prime drivers for misuse. This is important because Justice views the Courts and incarceration as the last choice to deal with the problem. So when youth end up in the Corrections Facility they make sure that they have been to detox, after which they start to work on the areas of personal growth to help them so that they can make different choices when they get out.

There was some voiced frustration. There is documentary evidence to show that while these young men are being "treated" they actually improve significantly as they respond to structure and attention. However, their environmental problems are not being addressed. The poverty remains. The lack of employment remains. The dysfunctional families remain. The easy access to drugs to dull the issues remains. So they voiced the question – "What sort of hope is there that they will actually turn their lives around when we are not doing anything to correct the root causes?"

In some ways the environment that the Corrections Facility provides some of these young men a better place to be than their home lives. They had three square meals a day, they were drug free and didn't have to worry about where to get their next high, they had a gym to address their fitness, structure in routine where none existed and no pressure from family or friends. It was acknowledged that this was one reason for the high returns to incarceration.

The School Administrators Perspective

The school administrators spoke openly about the challenges of education in an economically depressed region. They spoke about the area's poverty, unemployment and the deterioration of family. In particular there was significant concern over families that had fathers working out west – and the resulting young men who were always angry and acting out. They also talked about these men not providing their role as pillars of the community. The role models are fewer and harder to find.

Hope for the future is low. The parent's lack hope has been passed onto their children.

The staff indicated that not every youth had this imprint – but what they feared was that it was growing and they didn't see anyone trying to stop it. They said we may not be able to help the unemployed generation of parents – but we should be trying to do something to change the future of our kids, otherwise they will only add to the problem when they become parents of the next generation.

There was a common opinion that the working generation "needed to stop reacting and start listening". They believed that generally kids are talking to their parents and teachers and that no one is listening. There was a sense that a difference could be made for the better if everyone started to be more receptive to what youth are saying.

One approach that was tabled to help was from the implementation of the STEP program. Teachers need to be perceptive of the students' issues. Ignoring these issues will reduce the impact that teaching will have. It was suggested that moving away from the program to discuss the issue and address the concern will create a more effective learning environment. If opening the discussion is not done to address the issue, then the kids are not listening – preoccupied with other thoughts. Generally it was believed that helping

youth through their problems was probably more valuable to them that the program material at that time.

The Francophone School Perspective

The guidance counsellor from the French school in Sydney provided an interesting perspective. She described the social situation as others had described it. The French students had the same issues and problems with deteriorating home lives and lack of hope for the future. They were of course in much fewer numbers in the High School – many of the youth changed to the English schools so that they could access sports and other academic services.

She saw a growing problem with learning disabilities and mental health. In all of these cases the kids were self-medicating using (mis-using) alcohol and drugs. Her greatest frustration was access to services that could provide support in French* – a requirement in the mandate of the school. Therefore there was no access to public health support and in school mental health counselling. She indicated that it would be great to be included as part of the Schools Plus program – she had some growing need in the Junior high, and she was concerned that if it wasn't dealt with before these kids got to high school it would manifest into some very serious problems.

*Note this recently changed with an addictions counsellor being available to provide French language services and has come to the school once.

The Health Providers Perspective

Two leading health providers in the Province were interviewed with the express purpose of exploring their view on the challenges – and what they believe are necessary changes or initiatives that would realize improvements in youth outcomes.

Interview with Dr. Linda Courey – Director of Mental Health and Addiction Services Cape Breton District Health Authority

Dr. Courey related the state of youth determinants of health to the consequences of poverty on the island. She drew direct lines from the economic state to social problems – dysfunctional family units, family violence, drug use, and social system dependence. All of which have resulted in increased demand on the mental health system either through rising cases of anxiety and depression or increases of drug addiction. She was quick to point out that it is hard to treat mental health when the social determinants of health (the state of which for the most part are contributing to the increase of mental health demand) are not being addressed.

From the perspective of youth specifically she highlighted a number of important issues:

- Youth between the ages of 16 to 18 are lost for the most part. They may have access to mental health services, but many don't seek these services out as they

don't relate their addictions or other social problems to mental health. Finding these youth is difficult as many of the most at need have rejected the any of the available support systems – school, health and social services.

- There are gaps in the Government systems and programs efforts to address the needs in a coordinated manner.
- Engaging youth is a problem – especially those who have opted out. In many cases they have found alternate systems to support their needs such as peer groups, and parents, who enable high risk behavior. Youth addictions prevention has been more successful by using outreach as the method of engaging the youth. The engagement approach used is primarily non-traditional or non-program where outreach engages youth through Music or Art as the touch point, and then through the skill of outreach workers build rapport and trust enabling the youth to open up and seek out addiction services.
- What we offer is not what they need – or so we assume, given that we haven't really asked them as part of developing our services.
- Given that Mental Health and Addiction services are second level (or clinic based) we are not funded for outreach – health prevention is. This complicates our services to youth in that many of them, those who are most in need don't have transportation to travel to the services.
- Even with the services we do provide we there aren't enough resources – as the demand grows there is continues to be downward pressure by the health system overall to reduce, and it's not necessarily that we don't have enough resources it may simply be that we are not using them in the most effective way to help the youth.
- Those youth most at risk are also the most difficult to reach as they have no connection to the system. Prevention fails because we are not reaching them, and the first time we have time with them is on the corrective side with justice or emergency health.
- Housing for youth is problematic, although we don't seem to have a large youth homeless population in the traditional sense, those who leave their homes have either left the island or are managing by staying with friends or relatives.
- There is no formalized agreement to work between departments, so it is cumbersome to integrate services in the best interest of our youth.

Dr. Courey highlighted that collaboration between service providers and engagement through outreach are essential elements if we are to turn things around. Some of the specific areas that were discussed that would make a difference are:

- Intervention must happen at the earliest possible period in the child's life. School is the most obvious point of contact, and before they are negatively affected by their personal choices for at risk behavior.
- Someone needs to take responsibility for the 16 year old and build a plan to support them through the ages between 18 and 19.

- There must be an individual focus – on the specific needs of each youth, which is holistic and is needs based.
- Our services must become needs based, driven from the youth and evaluated on an ongoing basis to ensure that they are useful and result in improvement to their outcomes. Overall the system needs to be informed by youth, and evaluated by youth.
- We need to start respecting our youth as valuable and contributing members of services and programs.
- We need to find a way to transform our rigid bureaucracy to a system which is resilient, flexible and needs based. A system which is constantly reinventing how to improve our youth outcomes.
- Prevention – where do we start? Our focus from a system perspective is reactive – when we know that there is huge potential from a cost benefit perspective if prevent high risk behavior from ever happening.

Dr. Stan Kutcher – Sunlife Chair for Adolescent Mental Health

Dr. Kutcher is not from Cape Breton, and is a highly respected international expert in adolescent mental health.

Dr. Kutcher distilled the situation to three specific issues in Cape Breton:

- The first point he made was the impact on the region of multi-generational poverty and unemployment which has resulted in families that compensate for the situation to survive. In many of the at-risk youth there are few parental role models that give youth something to draw from in their development, hence there is a real issue that this poverty will not be overcome. He observed that many of the disenfranchised accepted the status quo as "just the way it is". He highlighted that this situation is frustrating to service providers who see it as very difficult to counter.
- He also talked about the high incidence of alcohol consumption. He drew the relationship between Use – Misuse – Abuse and Dependence. Through recent research reviewed by him he suggested that much of the at-risk population was associated with the Misuse category. He could not comment on drug use, except that marijuana use in young people was much less damaging to the individual than alcohol use – where alcohol was ranked 4th in the list of substances that cause neuro-physiological damage and marijuana 10th.
- Dr. Kutcher also identified the significant issues of untreated mental illness in Cape Breton which leads to many other social issues – termination of education, self medication, crime, and family dysfunction. In the cases of youth he cited that self identification of mental illness was low and there has been low success, even opportunistic situations, to identify individuals who potentially are dealing with a mental disorder. He suggested, without reference to any prevalence data, that he believed the incidence of mental illness in Cape Breton by population was higher than the national or global norm of 1 in 5. He went on to suggest that those with mental

illness were less likely to leave the island and therefore as others left the result was a higher incidence by population.

Ultimately, each of these points leads to young people who do not have the requisite skills socially or intellectually to succeed – thereby feeding the ongoing cyclical problem and rewriting the future of the next generation even before it begins. He referred to work done for the Premier's Council two years ago that highlighted that 30% of grade 12 graduates are unable to read or write at a level that enables them to function in society.

Dr. Kutcher went on to speak candidly about the education system which he indicated he does not believe have developed to reflect the needs of students generally, and are struggling to address the complex needs of at-risk youth. Although he indicated that it is important to train young people for the workforce, he criticized the system in Nova Scotia as focusing attention to this task at the expense of basic educational fundamentals – problem recognition and resolution, social and life skills.

He was concerned that the economy in Cape Breton was a political and long-standing problem that in the short term could not be resolved. This situation is having an effect on the social baseline which is deteriorating and that the solution will not be found in the adult population but every effort and resource should be focused on the youth. With the current situation at-risk youth cannot understand hope as there are few role models to draw on.

He believes strongly that the school system is the primary opportunity for change. He lamented the fact that there is ongoing pressure on these school systems to change through budget reduction – and that direction from the political masters has resulted in program reduction instead of innovation. His words very clearly were that "Schools MUST be the vehicle to engage kids. They need to be innovative. Kids need role models. The importance of broadening education in arts and culture were as important as math and science" and from what he sees these "extra" things have become the targets of the system.

Dr. Kutcher recognizes the importance of technology. He is convinced that technology, given today's youth, can result in significant improvement in youth outcomes by taking services to them instead of having them come to the service. A social media solution, designed by youth, must be part of any solution. Many times through the discussion he emphasized this point and eventually he highlighted issues with drop-in centres. Drawing from research he suggested that without outreach as a component of the "centre" it will not work. Boys and Girls Clubs are good for the much younger population as they engage these youth and provide the safe and secure environment that they may not receive at home. But this Boys and Girls Club model cannot work with older populations unless they are modified to reflect approaches and services that are driven by the youth.

His discussion then highlighted three key intervention points in the school system that had the potential to make a change. He suggested that in Grade 3 that if the child was unable to read at a Grade 3 level (without exception) that the system intervened to find out why

and put together a program. In Grade 6 the student would be evaluated again similarly and if they do not meet the skills in reading and math that the system intervene and establish a plan of action so that the student is held back until the standard is reached. Likewise this would be repeated in Grade 10. In each case he indicated that the student not move past this grade until they could accomplish the requisite standard. He then moved the discussion to wrap-around services, something that he believes in and is astounded that – given the evidence – we don't use. He recommended that in each case of a student who is identified as not meeting the required skill should be assigned a mentor to help them through to success.

As a final note – Dr. Kutcher implored the study to consider using role models. Young people who have had similar experiences and had worked through the challenges to succeed. He suggested in the absence of school athletic and extra-curricular activities these mentors could be developing programs in the arts and sports in SCHOOLS, all the time standing as role models to the youth.

Programs and Services in Cape Breton District Health Authority

The age group range identified for this study is between 15 and 24. The programs and services in Nova Scotia for this cohort are offered under a number of legislative Acts. The Children and Family Services Act defines Child as a person under the age of 16 unless the context otherwise requires.[15] Community Services has established the age of Adult service to be 19. The Department of Health and Wellness delivers services through Regional Health Authorities to Children and Adolescents up to, but not including, the age of 19, and then from 19 upward as an adult. Further to this Canadian Law defines Youth as "a person who appears to be older than the age of 12 and under the age of 18".[16] Services by departments then are provided and segmented by those ages and include services from Health, Education, Social Services and Justice.

Government Services

Network for Children and Youth

The network for Children and Youth is and advisory committee comprised of about 20 professionals who are involved in youth services and have a mandate to inform policy based on front-line experiences in their work. Through the governance model this committee at advises an Executive Committee, and through them the Regional Leadership table. The objective of their advice is to realize change in the strategic direction for youth services based on the real experiences of implementing Government policy. Discussion focuses around: general strategy issues; schools; the early years; and youth issues.

Cape Breton District Health Authority – Mental Health and Addictions

[15] "Children and Family Services Act", http://nslegislature.ca/legc/statutes/childfam.htm

[16] "Youth Criminal Justice Act", http://laws-lois.justice.gc.ca/eng/acts/Y-1.5/page-1.html#h-2

Mental Health Services is a district-wide program that offers a broad range of general and specialized inpatient, outpatient and community-based mental health and addiction services to residents of all ages across the continuum of care. The services provided by this department are organized into three categories, Emergency and Acute Outpatient Services, Inpatient Services and Rehabilitation Services.

Adult Mental Health Services (Ages 19 and up)

Emergency Crisis Service: The Emergency Crisis Program at the Cape Breton Regional Hospital, responds to anyone whose life or well being is at risk and who requires immediate care. These individuals can receive emergency mental health services 24 hours a day, seven days a week. Acute Outpatient Services

Acute Outpatient Services: includes adult mental health clinics located in hospital sites or in the community, the Day Centre Program, an Eating Disorder Program and a Sex Offender Program.

- Mental Health Clinics are located in Sydney, Glace Bay, North Sydney, New Waterford and Inverness on a full time basis, and in Cheticamp, Neil's Harbour and Baddeck on a part-time basis. These clinics provide assessment and treatment for adults suffering from a wide range of mental health problems.
- The Day Centre Program is a short term daily program designed for adults with serious emotional disorders. Individuals in this program need intensive treatment but do not require 24-hour supervision or care. Structured group and individual sessions are provided by a multidisciplinary team to help patients cope with emotional, social and interpersonal crises.
- Eating Disorders Program provides assessment, diagnostic and treatment services to individuals of all ages with anorexia nervosa, bulimia nervosa and related conditions. Early identification and prevention initiatives as well as consultation to professionals and families are also important aspects of the program's mandate.
- Sex Offender Program is a provincial group-based, relapse prevention program provided by a psychologist in collaboration with the Department of Justice. Offenders are screened and assessed through Justice and the Provincial Sex Offender Program in Dartmouth and then assessed by the local psychologist to determine appropriateness. Structured groups are provided for 24 weeks and follow-up is provided through Probation Services.
- Seniors Mental Health Program involves the provision of consultation and education services to nursing homes and other care providers by community mental health nursing and psychiatry. Mental Health staff work in collaboration with local physicians.

Rehab Mental Health Services

The objective of this service is to develop recovery support using a community based approach. It is designed for adults 19 and older and serves predominantly those with schizophrenia (individuals who are dealing with thought disorder illness and are in and out

of the hospital). One of the objectives of the service is to stop the cycle of hospital admittance. To achieve this Rehab partners with Mental Health Services and community based programs. Two partner programs for individuals with diagnosed mental health disorders are: New Dawn Enterprises and Social Services who provide subsidized housing; and Pathways and Social Services who provide employment and work oriented training opportunities. Although Peer Support programs have been identified as providing value in recovery, there isn't adequate funding at this time to put this program into action.

Community Rehab Team: Uses a Case Management model and a multi-disciplinary team (Social Work, Nursing and Occupational Therapy). This is a voluntary program where the recovery approach is based on psycho-social models. Currently the average age of the service is mid 40's, and does not see many youth in the program.

Crossroads Clubhouse: Follows the internationally sanctioned Clubhouse[17] model, which focuses on work as part of the recovery equation. There are 260 members with approximately 160 actively involved. Active members attend the Clubhouse 2 to 3 times per week. Most members are over 40 years in age. The programs focus on psychosis, mood and serious anxiety/depression disorders. Crossroads does have the ACES program which is focused on the recovery of individuals up to the age of 30.

Depot Clinics: These clinics provide injection facilities for individuals with mental illness. The services follow the medical model and are hospital base, and provide an opportunity to connect with individuals who are being treated and requiring medication with other mental health services.

Child and Adolescent Mental Health Services

Child and Adolescent Services is an outpatient service involving a multidisciplinary team approach including psychology, psychiatry, social work and in-home behavioural interventionists.

The service provides assessment and treatment for children up to age 19 and their families, for a wide range of mental health disorders. General services are provided in Sydney, North Sydney, Glace Bay and Victoria County. Specialized services are provided as described:

[17] International Centre for Clubhouse Development (ICCD), available at http://www.iccd.org/

- Intensive Community-based Treatment Team (ICBTT) provides home, community and school based support for children and adolescents who are having major problems in their daily lives related to severe disruptive behaviour disorders or severe and persistent mental disorders. The multidisciplinary team (which includes psychology, social work, behavioural interventionists and case managers) works with all the systems that are involved in the lives of the clients who come to the program, e.g., home, school, community, work, peers, justice.
- Autism Intervention Program involves a multi-disciplinary team approach including psychology in-home behavioural interventionists, psychiatry, and occupational therapy. The program provides pre-school assessment, diagnosis and behavioural intervention, as well as clinicians help facilitate the transition to schools for children with Autism both in an outpatient and home setting. The Early Autism Program is part of a province wide initiative and utilizes the Pivotal Response Therapy (PRT) model for early intervention for children under the age of six years.
- Neurodevelopmental Clinic is comprised of psychologists, behavioral interventionists and psychiatry. The program provides assessment, diagnosis, and treatment of children with neurodevelopmental and mental disorders. Disorders include autism, Asperger's Syndrome[18], Tourette's Syndrome[19], cognitive delay, etc. The treatments utilized include cognitive and behavioural interventions, behavioral management, school consultation and in-home behavioral intervention.

Other programs being initiated and being evaluated are: integrated mental health/addictions assessment; Stop the Stigma Program which engages youth through the Youth Panel and First Voice; Mental Health Awareness for Schools at a teacher's PD day; and a new School Consultation Model which sees clinicians visiting 8 of the most problematic schools.

Addiction Services

Addiction Services is made up of a range of general and specialized programs designed to minimize harmful involvement with alcohol, other drugs and/or gambling. Addiction Services is closely aligned with Mental Health Services to ensure that individuals living with an addiction and a mental disorder receive coordinated care.

[18] Asperger's Disorder Homepage, available at www.aspergers.com
[19] Tourette's Syndrome of Canada, available at http://www.tourette.ca/

The approach used is that the service is provided to the community as close as possible to where people live. Care is coordinated and seamless to promote continuity of care and the clients are fully engaged in all aspects of the treatment from planning through to follow-up. The treatment is evidence-based and designed to address the specific needs of each individual/family, and plans are not restricted to addiction clinicians or professional, but clients are reviewed holistically and the Case Managers integrate the needed services (schools, probations, mental health etc.,) to establish the most comprehensive approach.

The following are considered the core programs offered by Addictions Services:

Health Promotion and Prevention (HPP): the objective of which is to increase the capacity of individuals and communities to take control over their lives and improve their health. To achieve the objective HPP develops activities based on the health promotion issues within various populations and settings and uses a broad range of strategies including policy initiatives, environmental strategies, community partnerships as well as lifestyle and public education initiatives. The focus is always on the health needs of individuals, families and communities and improving their quality of life by influencing the determinants of health; increasing protective factors and decreasing risk factors. Supporting special programs are:

- Adolescent Addiction Prevention Services: The CBDHA Addictions Adolescent team provides health promotion and addiction prevention targeted at teens. This includes individual early intervention counselling through Adolescent Outreach Workers. As well the adolescent team has organized three youth group programs that are offered on a regular basis throughout the year. This team has also developed specialized programs designed for the specific needs of an organization by working with a school or community to design and delivery specific purpose built programming. Services are provided to youth 13 – 18 years of age.
- Strengthening Families for the Future: is a prevention program for families with children between the ages of 7-11. This program utilizes strategies to help prevent children from developing problems with alcohol, other drugs, and gambling or mental health problems. This program is unique because it was designed specifically to: reduce risk factors; build individual resilience; and enhance family protective factors. The program is delivered over an 10 week period, once a week for 3 hours. Through structured facilitation the program has been successful at strengthening family relations.
- L.E.A.D.: this is a partnership program with the Cape Breton Victoria-Regional School Board (CBVRSB). Along with our partners we have developed, implemented, and are evaluating a substance abuse prevention peer leadership project. The project aims to strengthen the capacity of high school students to take action and promote activities that prevent, delay onset, reduce frequency of use, and/or the progression of substance use among junior and senior high school students as well as positively affecting the social and academic environments of their own schools and communities. The project also allows students to take action on the determinants of

illicit drug use through community involvement while supporting a number of Department of Education curriculum outcomes at both the senior and junior high school levels.

Community Based Services: Community Based Services provides a comprehensive range of addiction assessment, intervention, consultation and treatment services. The following are supporting programs:

- Adult Counselling: offers gender specific individual and group programming to adults harmfully involved with alcohol, drugs and/or gambling. This program also offers services to those who may be affected by another person's substance use or gambling.
- Adolescent Counselling: like counselling services to the adult services but youth centric. CHOICES is a voluntary assessment and treatment program assisting adolescents aged 13-19 with challenges around substance abuse, mental health issues and/or gambling through an integrated treatment approach.
- Addiction Day Program: is for adults harmfully involved with alcohol, drugs, and or gambling. The program provides a safe and supportive treatment environment which is relaxed and non-judgmental, and supported by individual and group discussion delivered through the Withdrawal Management Day Program and Structured Treatment Program. Typically after completion of the Addiction Day Program, clients are referred to Community Based Services in their own community for follow-up.
- Women Services: address women's specific experiences, issues and realities. The focus of services for women is to encourage the empowerment of women to choose and direct lifestyle changes and services based on self identified needs, rather than needs as perceived by others.
- Gambling Counselling

Cape Breton Victoria District School Board

STEPs to Success

STEPs to Success works with young people from Grade 4 through college is provided in 3 select schools in the region. The program seeks to break through the attitudes and substantive barriers (both personal and institutional) – that often make it difficult for low-income students to succeed in school and pursue higher education. The program operates on six basic principles as follows: students need to be engaged early and for the long-term since substantial changes in attitude and behavior do not occur overnight; the approach to closing the achievement gap is comprehensive; educational enrichment and exposure to new experiences is important for students learning - both in school and in their community; emphasis is on post secondary continuation and linking this emphasis to why it is important for the students future; close partnerships with parents and guardians as well as students

through are important for establishing sustainment of and support for continuing education; closing the achievement gap happens best through collaboration – within the school, but includes the community and other supporting agencies.

LEAD

See description above described as part of the Addiction Services.

Schools Plus

The Schools Plus program is positioned to tear down barriers to education using needs based designed programming that is responsive to the changing dynamics in the school. At the Macro level staff inform policy through the Child and Youth Network. At the school level the program is very much preventative. In each case the program aim is to strengthen the students linkages to family and community. It is currently operating in 9 schools, and is delivered by 2 staff members. The next year will see the program grow to a new family of schools without any increase in resource. The focus is on Elementary and Junior High School. The approach use to deliver this purpose built programming is through collaborating with other professionals in the community. Specific responsive programs include: Options to Anger; Free to Be You (an addictions prevention program); and the Incredible Years (in partnership with Community Services). It is not uncommon to invite subject expert in to deliver the program, or portions of it.

Adult Schools

Adult Schools provides educational programming in four sites (Sydney, Glace Bay, North Side and New Waterford). This program is serving 180 adults between the ages of 17 to 65. The curriculum is the same as the school system in achieving High School Leaving qualification (usually in two years) and enables individuals to seek post secondary education. The proportion of individuals who finish the program and continue with their education is high. The format also provides job preparedness so that those who chose not to go further with their education have skills to enter the workforce. The program is a non-traditional learning environment accommodating multiple needs – such as child care, work, doctor/counsellor appointments and court appearances. Funding for students is provided by Community Services in some cases and Employment Insurance in others. A few students are supported by their families but this is not the norm. Others self fund by working.

The student body has multiple barriers from social, to learning disabilities and everything in between. The school, more recently, is observing higher levels of individuals self-identifying with mental illness and a decrease in resiliency. They have also observed the mean age decreasing steadily.

The Learning Centres

Are special learning environments where the barriers to learning are so extensive that the student is at risk of not being able to go to high school. The program on the Southside is usually a one year Fast Track to high school. Learning profiles of each student are developed as part once the application process is completed and a learning plan is design

that bridges the gap. Ultimately the schools attempt to prepare the student so that they can go on and succeed in High School. The application process includes the student and the family to determine "fit". Once this is determined the staff work with the student and family to establish learning expectations.

Youth Health Centres

Each of the High Schools has a Youth Health Centre – the intention of which is to provide "one stop shopping" for youth health needs. The Centres are available during school hours and are staffed with a Secretary and Nurse, with additional support provided from a Physician on an occasional basis. These Health Centres have the ability for direct referral based on need. Services include: health and mental health assessments; health protection information; birth control information and support; STD testing; and counselling.

Department of Community Services

Child Welfare Program

The Child Welfare program goes to age 15. Only those youth who were already in care will continue past this age. This means that there are no services for youth between the ages of 16 and 19, until they have access to adult services.

Adult Services

Adult services are available to youth 19 and over. All of the programs hang from the Income Assistance program, which determines eligibility based on income level. If you qualify then there could be an amount of income support determined the individual's circumstance. This decision to receive IA then opens the door for housing and employment support. Persons with disabilities have access to other programs such as housing, drug costs, and employment. Individuals with a long-term mental illness qualify for these additional services.

Community Housing

Cape Breton Community Housing Association (http://www.cbcha.ca) provides a safe and supportive environment for people with mental illness during their recovery process. This is a Community Services funded organization, with 25% of the budget coming from fundraising. The programs are designed to assist clients in developing the skills necessary to live independently as they transition back to community living. All clients have access to programs that develop skills for activities of daily living, meeting vocational and educational goals, managing finances, developing and maintaining social relationships and coping with the impact of symptoms. Services are provided to anyone with a diagnosed mental illness between the ages of 18 and 80. The Association operates two Group Homes which house 9 clients in a 24/7 supervised environment and 9 Small Options Homes which are supervised on an as required basis and provide housing for three to four clients. Respite care is available in both settings as an emergency temporary placement.

The Association also manages an emergency shelter for homeless men. The shelter offers up to 10 beds on a first come first serve basis. Services include light meals, laundry, showering facilities and counselling and referrals. The maximum number of clients is 10, and although this number has not been reached the facility regularly has 9 clients in an evening.

Cape Breton Correctional Facility

The Cape Breton Correctional Facility is a medium security facility for males offenders who have been sentenced by the legal system. The facility houses 96 offenders, providing an environment of structure and discipline. Prior to entry individuals who have an addition with enter detox. Follow-on programs have been designed to support shifting behavior and are meant to be life changing with an aim of reducing individuals from re-offending. Programs include: Self-Discovery; Substance Abuse Management; Respectful Relationships; Anger Management (for those with anger issues); and Parenting. Offenders are incarcerated for up to 61 days. Disproportionate numbers are First Nations offenders. Large numbers are re-offenders. The frustration is that although the programs have merit, and individuals do leave the facility changed with intentions of straightening out their lives, they return to the same environment and pressures that formed their behaviours in the first place.

Not-for-Profit Services

This section provides a large sample of Not-for-Profit Organizations that operate in the Cape Breton District Health Authority and provide services to at-risk youth.

Elizabeth Fry

The Elizabeth Fry Society (http://www.elizabethfry.ca/) has a community based residential facility in the Sydney area. The objective of this facility is to provide safe refuge for young women transitioning back into society after incarceration. The supporting programs have been developed to focus on building resiliency and life and employability skills so that reintegration can happen effectively and limit recurring issues with law enforcement. There are 8 beds for emergency and transitional service, with an additional reintegration program that uses apartments as part of a structured plan of reintegration. The residential facility has cooking facilities and common space for group discussion and counselling. First contact with the society, and follow-on advocacy support, happens the moment a woman is charged by law enforcement. The Society will accept other women in need on a case-by-case basis as space is available. They have had experience in providing accommodation for women dealing with mental health issues – however, these situations have been challenging in that employees are not trained to provide support in this area. These exceptions to providing refuge have included youth (17 being the youngest) as space dictates and the circumstances are favourable for the youth. Referrals are usually through the Community Assessment Team – but there are other routes, and the Society has taken a referral from

the School Board. Funding for referrals on a per diem basis is provided from Community Services. At the time of the interview only one bed was being used of the 8 beds available.

The Society is currently working along with the John Howard Society on a Greenhouse Project to provide skill development opportunities, along with a small revenue stream.

Youth Inclusion Program

The Youth Inclusion Program (YIP) is a three year federally funded pilot project with the aim of supporting the needs of youth in an effort to channel positive behavior in youth at risk that typically would have been in trouble with law enforcement. The program is based on a UK Youth Justice model.[20] The North Side location for this program was a community collaborative decision of the Association of Safer Cape Breton Communities. The decision was based on a need, and assessment of service access. The North Side had high youth crime, high drug use and no services. The YIP uses a standard model of intake and case management for each youth. Goal setting and evaluation are cornerstones of the program. The organization provides a safe environment for youth 12 to 17 who are at risk. Referrals are managed by the Program Management Committee and youth workers provide the delivery of programs designed to build life skills and additional support for schools. The limit is 50 youth per year with 500 hours of intervention.

YIP has made a positive mark on the community. Petty crime has been reduced and the youth in the program are seen to be less likely to be destructive to property. Staff have identified mental health in these youth as a growing issue.

Educational Program Innovations Charity (EPIC)

EPIC (http://www.epiccharity.com) has a mandate is to advance marginalized learners through innovation, empathy, volunteerism, diversity and partnership. The Charity is focused on learners who are motivated but lack the resources or support systems needed to enhance their education. EPIC works within a 24 member network, all of whom deal with the needs of youth. It is from this network that they receive referrals into their programs, however most of them come from the School Board. The anchor program is a 2.5 hour per week peer-to-peer tutoring program. This time is divided into home work support and

[20] "Youth Inclusion Program", http://www.justice.gov.uk/youth-justice/prevention/youth-inclusion-programme-yip

social skills development. EPIC has a 15 youth limit per day and are always fully utilized – although attendance can be up and down. Outcomes are not measured.

Currently past clients of the program (ages 18 to 26) have been re-engaged through a discussion group called "Breakthrough" to develop a handbook on all things that would help youth at risk prosper.

AIDS Coalition: Queer Youth

Queer Youth is a special program supported by the AIDS Coalition with Federal government funding on a year-to-year basis. The objective of the program is to for the organization to keep apprized of the needs of youth who are LGBTQ in an effort to help reduce high risk behavior and suicide – both of which have higher incidence from the norm within the at-risk youth population. Guiding the work, and supporting efforts in improving awareness, the program works with a youth advisory board. Much of the effort is in matching the needs of this youth population to training given in various organizations, and in the building of awareness of the challenges these youth face. The organization has observed increased issues related to mental health with this population.

Service Canada: Skills Link

Skills Link (http://www.servicecanada.gc.ca/eng/epb/yi/yep/newprog/skillslink.shtml) is a Service Canada initiative offered through the YMCA employment centres. It is part of the Youth Employment Strategy[21] and is focused on removing barriers to employment for youth between the ages of 16 and 29. The program focuses on the development of employability and life skills to enhance the individuals opportunity to be employed. The program is comprised of the "Pre Employability Module" which prepares the individual to develop a resume and understand how to perform in an interview. It increasingly also addresses some basic life skills. Following this module each of the individuals will be sent on a work placement to gain experience. During this time the program manager continues to work with the employer and the youth to ensure that the work experience is beneficial for both. The program currently accepts 16 participants in the Sydney and surrounding areas and the success rate of post program hiring is about 65%.

[21] Youth Employment Strategy, http://www.servicecanada.gc.ca/eng/epb/yi/yep/newprog/yesprograms.shtml

Program staff noticed that many of the barriers the youth are dealing with today include issues of mental health. The program staff are not trained to deal with these issues, and are at this time becoming more familiar with the support services available for youth with mental health problems.

Community Cares Youth Outreach

The community CARES Youth Outreach project was established in 1998 in response to the perceived absence of youth engagement in community building and the gap in peer-assisted services for youth on the Northside (Sydney Mines). The outreach centre provides at-risk youth aged 16 to 30 support to develop assets through work, learning, leadership and life skills development. The program uses a partnership model which serves to support internal development of people and community.

Whitney Pier Youth Club

The Whitney Pier Youth Club (http://www.wpyc.ca/) provides a safe, supportive place where children and youth experience new opportunities, overcome barriers, develop positive relationships and build confidence and skills of life in the Whitney Pier area of Sydney. The centre follows the Boys and Girls Clubs of Canada structure. These clubs are considered leaders in providing after school and critical hours programs that are recognized for significantly contributing to the healthy development of young people – especially those in most need. By engaging families and others in the community, the centre helps children to grow up to be: healthy; confident; responsible and successful in life.

The model uses the youth network as a supportive system. The centre provides 15 programs to approximately 100 kids per day offered by trained youth workers. The objective is to break the cycle of poverty by providing a supportive environment with solid role models, the promotion of respect and empowerment and programs designed to build resiliency.

Attendance drops significantly in Junior High. Programs are not designed to engage this cohort, but there is a desire to broaden the base to engage these youth as well. The Club is budget is based on fundraising which is the principal activity of the Executive Director.

Undercurrent

Undercurrent Youth Centre is a youth centric facility initiated by the Lighthouse Church in Glace Bay. The Church has a mandate to serve the community, Glace Bay and its surrounding communities. The centre serves youth of all backgrounds – and does not limit participation to those in the church. Undercurrent exists to provide: Mentorship by youth workers and trained volunteers; facilities to support sports activities that respond to what youth are looking for: basketball, skateboarding, rock climbing, floor hockey and indoor soccer; a safe environment free from drugs, alcohol and profanity; and programs for youth and their parents to help them learn life lessons, develop new skills, and how to contribute to the community. The youth population it serves are between the ages of 12 to 19.

The Youth Centre also provides a home to services provided by other agencies such as Addiction Service.

Challenges

Through the research – including the literature, discussions with service providers and interviews a number of challenges were raised. Although solutions may not be available with changes in policy or major strategic initiatives they are brought forward here to keep top of mind as the solutions are developed and analyzed.

- Engaging Youth: without youth engagement there is no solution. It's not just taking the horse to water in this case, the issue is actually getting to the horse at all. We have not been particularly good at this, and it is of our own design. What the research points to is that YOUTH must be involved in telling us what will engage them. One youth indicated during the interviews that using free food was cool to introduce programs – but he made it clear that he had just been there for the food and had no intention of returning. The challenge is the food is the hook, it's what comes along with the food that is important and that's where the youth need to be involved. Also, it is important to remember that the most marginalized are not connected anywhere. What was learned through the best practices review is that we need to know the groups and through these groups eventually we will be able to reach the most disenfranchised.

- Sharing Information Essential: it was clear in what was heard that solutions and services need to be integrated. To enable this information between agencies need to be shared at the operational level. It is too late when a youth is in distress to be looking for the authority to share this information. There are legislative barriers. Someone needs to be searching for a legislative solution to this issue. It will take some political will to address the situation. A solution to this situation may actually be to co-locate the staff of multiple agencies in one facility and a "centre" governance model (including reporting) that establishes the ability to share information within the centre. It should be noted that technology designed to deliver

health services is already challenging health information legislation.[22]

- Change of Service Culture: much of the service providers are not client centric. It seems that many of them are specialists in narrow areas of function, completely beholden to the process and the rules. If the case doesn't fit the rule they are unable to look at the need, and so the issue isn't addressed. Changing the culture so that the service provider's work is all about solving the problem of the youth will take time and training.

- The Rate of Benefit is Slower than the Rate of Deterioration: it was the concern of many of the service providers that the region was not at a steady state of acceptable levels of youth problems. They see a growing decline from a social perspective as employment levels increase and those youth that have promise leave – thereby deteriorating the potential leadership pool. It was also clear that there wasn't a single easy solution, and no overarching strategy where initiatives knitted together in an effort to affect change to the particular problems in Cape Breton.

- Sustainability: as long as what is considered is incremental to address a gap and the overburdening of the system, sustainment of improved outcomes will not happen. The overall public envelope will not grow. Hence, adding resources Health will come from another service in government. Given that youth issues of service cross through three or more departments moving resources to solve the problem may create a greater problem somewhere else. Sustainment will have to come from the realignment of resources by changing the way in which services are delivered.

- The Economy: the government has taken an intervention approach since the closure of the coal mines. These initiatives have done little to address the massive unemployment of the devastation of industrial Cape Breton. Equally, the investment in the region by creating Government jobs is a false economy – with one civil servant providing services for another, or service industries supporting each other. Successful business leaders need to be brought together to explore how to change this landscape. The steel mill replacement, which is what the government saw as the silver bullet, will never materialize. Without these changes those that have the

[22] Social Media in Health Care, available at http://www.changefoundation.ca/docs/socialmediatoolkit.pdf

ability to leave to work will and the concentration of the unemployed (unemployable) will grow and so will the social issues.

Youth Driven Needs

General Overview of Interviews

Best practices indicate that in order for at-risk youth services to be relevant, at-risk youth must be involved in indicating their personal needs, priorities and in the ongoing evaluation of the services. As in the case study of "headspace" in Australia the involvement of at-risk youth in every part of the service governance was a key departure from the status quo and marked the shift to improved at-risk youth take-up of services and the resulting outcomes[23]. To this end interviewing youth in the Cape Breton District Health Authority was a critical component to identifying: the service need; gaps in existing systems; and opportunity for making a positive impact.

To obtain the pulse of at-risk youth 324 at-risk youth were interviewed, primarily in group discussions. This sampling was targeted to this demographic by selecting programs that were specifically designed to respond to at-risk youth. Six individual interviews were conducted to insure that information from the groups was valid, and not affected by the group dynamic. The gender distribution was 187 male and 137 female. Generally, clear trends emerged through the discussion in each of the groups – and these did receive validation through the one-on-one interviews.

		Female	Male
School System (Junior High and High School)			
Ages	15	17	22
	16	22	32
	17	23	20
	18	10	5
	19	0	1

[23] Muir, Kirsty, et al, headspace Evaluation Report, University of New South Wales Social Policy Research Centre, 2009


Total
72
79

	Female	Male
Grades		
9*	3	8
9	19	23
10	26	16
11	15	24
12	3	2
Special No Grade	6	7

Table 1: Distribution of School Youth Interviewed

		Female	**Male**
Adult Schools and Other Programs			
Ages	17	0	1
	18	5	6
	19	6	7
	20	14	14
	21	14	18
	22	13	11
	23	11	9
	24	2	14
Total		65	80
Grade Completed			
	7	1	0
	8	3	2
	9	23	15
	10	21	31
	11	7	20
	12 (incl GED)	7	10
	Post Secondary	3	2
Others Interviewed Not in Age Demographic but were Youth at Risk (not included in total		5	11

*Make-up year for youth interviewed) those preparing to re-enter the school system at the High School level.

Table 2: Non-School Youth Interviewed

The population canvassed was considered the most at risk – with the exception of two comparison groups (one in each of two High Schools). Detailed information on the groups used for interviews is contained in Annex C. Interviews were conducted as outlined in the following table:

Group	Comments
Family Place Centres	Discussions included both a men's group designed for new fathers and a number of women's groups established to

	support expectant mothers.
Adult High Schools	Comprised of youth who had dropped out of the school system, and in many cases the total support system, and were on a path to personal improvement and change. These youth represent those currently not in school as they too left the system when they dropped out.
Schools	A mixture of students by class programmed based on the selection by the Principals of those who would be considered most at risk. One control group was selected of youth that would be considered not at risk.
School Gay Straight Alliance	The members of the Gay Straight Alliance were selected youth at risk further marginalized based on sexual orientation.
Special Junior High Program	By entry requirements all students attending these educational programs are at very high risk – Southside and Northside learning centres.
First Nations	Eskasoni was targeted because of the significant population, and its self-contained school system. Students at the Training and Education Centre (TEC) were interviewed – including those at the Adult School. TEC provides education designed specifically for youth at risk.
ACES Program Crossroads	Discussions with individuals who have self-identified with serious mental health issues – for example schizophrenia, OCD, severe social anxiety disorder.

Table 3: Interview List

Interview Data

After introductions the discussion started by asking the group to describe their experiences at school. Using the Discussion Guide (Annex A) the group moved through the four pillars of education, health, social services and justice. During the discussion, at a time appropriate to the direction of the topics, the youth were asked about their high risk behavior. Each discussion ended with their views on technology and how technology might be used to support services. The following are the resulting findings – organized by question. If there were exceptions to general trends these exceptions are introduced based on where the data has come from, along with some analysis and rationale. The data is presented as a table segmented by two populations – those who are in the mainstream school system and then all others.

Note that these are the statements directly from the youth, from their context without analyzing or rationalizing what they said.

Discussion Area	Convergence Points Youth in Mainstream School	Convergence Points Youth Not in Mainstream School
	Education	
School Experience	• Teachers are just here for the paycheck • At-risk students believed they weren't respected – except for the Jocks, Preps and Nerds • At-risk youth expressed disdain for these groups • Nobody really knows what I'm capable of – students in developmental programs work to the program expectations regardless of their aptitude • They expressed feelings of being invisible • They were stressed because of the workload – especially with Junior High students • Without exception each group mentioned bullying – many had been the receiver of bullying of some form, all citing the internet as a problem and 10 students indicated that they had transferred schools because of bullying • Transition from Junior High to High School was identified as a high stress transition • Generally students looked forward to the increased freedom of choice in high school • Without exception the youth expressed dissatisfaction with the attendance policy, and thought that it was unfair • Most of the at-risk youth are struggling with the academic material • Many of the at-risk youth indicated that they were actively looking at dropping out – they saw no value in the education they were receiving	• Schools are just too big, especially high school, students felt lost and when they struggled they felt that the teacher wasn't there to help • Teachers favored those who excelled or were in sports • The felt that they were labeled as trouble even before arrival at high school • Skipping school was common, peer pressure, cycle of missing work and not understanding which led to not understanding and the rationale to skip more • Most dropped out for one of the following: couldn't cope with the work or the environment; drug use; had to go to work to help support the family; or pregnancy. Many had multiple reasons – e.g. drug use, pregnancy and drugs. • Those attending adult school now realize that they weren't stupid in mainstream school before they dropped out. Many took responsibility for this situation, but also suggested that the teachers were not approachable and the program didn't necessarily suit there learning needs • A significant portion of males, and some much fewer females, were kicked out of school. Males cited anger, disruption and absenteeism as the principal reasons. Females indicated that ejection was always for absenteeism.
Is the experience preparation for future	• Low comprehension of how anything taken in school has any relevance to what they will do in the future • Very little hope that what they do in high school will help them get a job, the exception were the students in the vocational programs • Most of them felt that to have any opportunity they would have to leave Cape Breton	• They articulated that chool did not prepare them for the future – however they recognized that they needed to go to school to have made a difference • It was common belief that to get any job today high school leaving was mandatory • Going back to school is providing the opportunity for the future • Most of the adult learners had children, and going back to

		school was opportunity for them to demonstrate how important school is to their kids
Service Accessibility	• Teachers should be there to help, but few of those interviewed said they would access this support • Some guidance counsellors were good, but others only wanted to help with course selection	• All felt Adult school, and the school's approach was best suited to their learning style – students stated that the small class size and individual attention, with teachers who actually knew who they were and cared whether they succeeded or not was an important differentiator from their original school experience • All the teachers at the adult school act as teachers, guidance and mentors – this is a good model, therefore access to needed academic and personal help is always available
Future Improvement	• Teachers need to respect students as people first • We need alternate ways of being educated • We have trouble getting up – we go to bed late and getting up to go to school for 9:00 is challenging – we're not awake until noon even when we're at school • We need more recreational activities – they seem to be available only to the favoured students • We need to deal with bullying – why is it always the victim that has to deal with the issue, what is that teaching us about society • We need more help transitioning into high school – more than just a tour of the school and an introduction into courses • More ongoing help planning my future • We need to be recognized for what we know in our learning – being put into low level courses without any challenge makes us work to that level • Expelling students doesn't work – for many students its exactly what they want, and unsupervised day off	• All of the comments in the other column • we don't like the fact that they are closing three of our schools, if I was at the beginning of the program I wouldn't go if I had to travel to Sydney – keep the schools open • give up more help at the beginning when we start, this was really difficult • help by taking the burden of our lives off our backs to make going to school the easy choice • find funding that is equitable, and doesn't penalize us if we chose to go onto post secondary education
Health		
General and Mental Health Accessibility	• 50% of females self-identified as having mental health problems – anxiety and depression, very few males self-identified • Some of the more serious cases individuals were under ongoing doctors care – these included serious depression	• In the adult school most of the females self-identified as having mental health issues and about 30% of the males also self identified • Most common were anxiety and depression – but some are living with a serious mental illness

	and anxiety • We really don't have any health problems – just normal teenage health problems • 15 year olds were unaware of the health centre, most of those interviewed didn't know what it was and where it was located • The boys, with minor exceptions, said they wouldn't go • There was a negative opinion of the health centres by the males, and females used the centres primarily for birth control • Although some had filled in mental health/addictions questionnaires most felt this was a waste of time as there was no one in the clinic to help them • Some of the boys were introduced during an addictions day and entred the clinic purely for the food • The majority stated that they used their family doctors in all their health issues except birth control stating that they had built trust with them • Those under care in the mental health system indicated that they were supported well and they had no issues with the service (once it started). They did indicate however that the referral process was long • Those who indicated they had dealt with depression and anxiety (out of the norm of just feeling sad or concern) said that the number one reason for not using the mental health system was the time it took to get a referral, and having to self-identify • Most of the students moving from Junior High to High School indicated prolonged anxiety – even those who were in the control group • In most cases when students were feeling depressed or filled with anxiety they turned to their friends for support, and not the health system or their parents	• This cohort was most likely to know about, and seek out the service, of addiction services • Those in the adult school where were under 25 were all familiar with the School Health Centres. Most of the females had used them
High Risk Behaviour	• Half of the students admitted to trying alcohol prior to Junior High and most of these students indicated that they became intoxicated with first use • Less than 5% stated that they didn't use alcohol regularly • no one admitted to using alcohol daily, but they did admit to binge drinking • students estimated that: 90% of students in High School had used marijuana sometime; 50% used regularly; and	• 90% of Adult School attendees had past substance abuse issues – and admitted that their abuse was in an effort to deal with difficult home and social situations and a way of self medicating • Those who used major drugs did not self identify, shame expected as the reason, but many admitted openly about being on a methadone program • Some of the adults continue to struggle with addiction –

	30% used daily (only limited by accessibility or cost) • students who admitted to daily use also openly admitted to having to decide whether or not to deal drugs to pay for their use • all students believed that both underage drinking and marijuana use was socially acceptable • no one admitted to personally using harder drugs, but had had the opportunity and they knew some who had • no one admitted to driving while under the influence of drugs or alcohol • the number one reason for using drugs or alcohol was just to chill with friends and when asked what they needed to chill about many of them just stated that their lives sucked and it made it all go away • even the daily users said that they were not addicted to using, and that weekly binge drinking was also not habitual • availability of drugs was widespread in the school and in the community and was easy to come by	and continue to use marijuana • In a majority of cases males chose to sell drugs to feed their addiction – and in many of these cases their behavior led to incarceration, this was not the case for females • Females admitted to drug use leading to unsafe sex practice and pregnancy • Some males reported alcoholism – and were actively involved in some form of addiction management program (AA for example) • everyone knew someone, either in the family or a friend, who had overdosed – many of these were brothers, husbands, most were male
Youth Health Needs	• Easy and timely access to mental health counselling • Desire to have service come to them and not have to go to the service – the exception to this were those who were currently under the care of a mental health professional who had no negative comment on the service	• Referrals to mental health take too long, and it needs to be easy and timely access to services
Social Services		
Role of Social Services and Service Experience	• The was little knowledge of the role of social services • There was a stigma in the school however as everyone knew which families were on social assistance • For those on social assistance it was a defeatist attitude victim type attitude for those who were not they looked down on others • Those on social assistance at this age were accepting of the situation, they did not voice shame, but they did voice anger that they didn't have the same opportunities and things that others had	• Without exception all had the experience in dealing with social services – most of which was negative • Individuals always felt that their case worker was a gate keeper and protecting public money – making the individual feel inadequate, a burden on society and that the onus of proof of need was on them • Few of them really knew what the entitlements were, and a common direction was for them to go to the web site to determine what benefits they could receive • Many times they did not have any communication with their case worker • Everyone felt that the role of social assistance should be to support the individual from getting off social assistance – the groups estimated that this was not the case in 80% of the circumstances • Housing was part of the problem – there were certainly few residences that motivated individuals to show signs

		of pride of ownership
Cycle of Poverty	• Clear desire to get a trade, leave the province and make money • Little hope however that they would be able to break the cycle	• Singular reason for returning to school was to break the dependency on DCS • Most of those on social assistance grew up with families who were on social assistance • Parents did not see any issues being on support services but the youth observed their poverty when looking at what others had • The majority of those on social assistance indicated that not only their parents, but their grandparents, aunts and uncles, also received services from DCS • Those who were between the ages of 16 and 19 were most critical if they had broken ties with their families and received no support. They were actually put into a position to survive of breaking the law either through theft, or dealing drugs
Family	• Many described dysfunctional families, but they did not blame their families for their troubles • Many had fathers working out west, which they didn't like – and these same youth voiced a desire to move out west to be with them as soon as they could • Other non-traditional family situations included living with Grandparents, Aunts and Uncles, or brothers/sisters – reasons for these circumstances included both parents working out west, separated divorced parents no longer able to parent, mental illness or addiction of a parent, incarceration, parenting skills not able to deal with youth behavioural issues • No one was able to describe role models or heroes in their lives	• All of the other comments in the other column • One exception is that some of these youth indicated that there was a direct relation between their families dysfunction and their problems of mental health and addictions – in each of these cases these realizations was a solid step in changing their lives. In each of these cases the youth actually rejected their families as they pursued recovery and change • Some of the youth returning to school indicated that it was because of family support that they were able to return – either financial support, or by providing child care
Social Service Support Needs	• Without exception they all indicated that they needed money – and that the money would be used to buy independence	• The difference between those in school and the older population is that the older population wanted work – not money • They observed that if the goal of social assistance was to help the youth to become employed then they would be off social assistance • They wanted parody with others who had gone back to school. It was difficult for them financial to support a family, child care and go to school

Justice		
Services	• Few of those interviewed had any conflict with the law • Typical issues tended to be public intoxication, and public nuisance • Those that had, were involved in the restorative justice system and thought that it was a good way to do something bad and not have to go to jail • Most did not see anything wrong with having marijuana on their person for their own use • All of them were very aware of the limits of drug offence (amounts of drug and type) and the punishment associated with it • It was the legal ramifications, and know exactly what that entailed, that stopped the decision of young people to deal drugs • Those interviewed knew the school Constables but had little cause to have any discussion with them and in fact avoided contact	• With two exceptions, all issues with the law were males • Offences included drug dealing, theft, family violence and public intoxication • There was a wide range of punishment that included local jails, the Cape Breton Correctional Facility and Federal Penitentiaries • Most of those who had run-in with the legal system had addictions problems • Although detox was mentioned as part of the process – none of the respondents felt that detox (other than to be clean in jail) did little to change their addictive drug habit • In most cases jail was not a life altering experience – for these youth it was not uncommon for a close family member to have been incarcerated • Programs in the system were fairly ineffective, each of them realized that for all the good these programs might have done they didn't change the environmental factors which cause the situation to have taken place (mental health, family poverty, unemployment) were not addressed • Individuals expressed the challenge of working for a low paying job and the stresses of bills and families, and easily going back to dealing drugs where the money was significant and the client base flourishing
Improvement Opportunities	• No one self identified having experience of being involved with the justice system and so didn't have any improvement suggestions	• Those that entered back into social society through one of the programs (adult school or the Fathers program) identified that they had to make the difference and make changes to their lives • Changing environment was the **MOST** important action to take – move, reject old friends, seek out others who had succeeded in moving from poverty and crime • Having a system that enabled the "victim self-help protection" program would be a game changer where the system relocated individuals and established a more directed program post incarceration – better and independent housing, employment, and life skills development

Interview Discussion

The interviews were without exception dynamic and filled with the youth's experiences. They held little back. Their stories were truthful, and raw. For the most part each group respected everyone in the room to have an opportunity to speak. When a particular individual in a session might dominate the dialogue the group tended to self-moderate and address it themselves. There were a couple of situations where the facilitator had to intervene. For the most part it was a guided discussion. Interestingly however, using the guide, the information that was off-topic (for example drug use) seemed to come up at the same juncture without prodding for example when the discussion on school turned to their personal experiences and reasons for dropping out.

In a couple of situations the discussion unearthed some difficult memories. These were dealt with in a sensitive manner and discussed fully with the administrators of the program. These situations revealed the emotional impact that their circumstances have on their daily lives.

Although drug use was easily disclosed – family violence and sexual impropriety was not and did not come up through the discussion, even though Administrators indicated that there was sexual abuse in some of the homes.

A recent study undertaken by the Wellesley Institute in Toronto asked youth what they saw as their need and priorities, their voice mirrored what the youth of Cape Breton articulated in the discussion groups.[24]

Education

There is no doubt that those youth interviewed understood the link between their education and their future prospects – even though family influences may not be supporting this notion.

[24] "Drugs, Homelessness and Health", http://www.wellesleyinstitute.com/publication/drugs-homelessness-health-homeless-youth-speak-out-about-harm-reduction/

> I stopped trying in Grade 6 when I was struggling with math and my teacher came over and asked me if I was stupid. Now I just get high every day.
>
> ***Grade 9 Student***

School is considered by at-risk youth an essential component for outcomes improvement and as the key to unlocking prosperity. Although the School Board has seen encouraging figures on students no longer dropping out of school in High School there is a disturbing trend that close to 30 per cent of high school students are disengaged, frustrated, alienated, and marginalized with their learning experiences in high school[25]. The Department of Education has been studying this problem and looking for new ways to engage students and to help them succeed. Actions include new courses that develop job-related skills, courses that give students experience volunteering and working in their communities, and new instructional approaches within the classroom. These, combined what is being learned in pilot projects such as Schools Plus, are intended to help students stay interested, motivated, and in school.

The at-risk youth stated that they have not been involved in any dialogue to help in addressing this issue of engagement (which of course reflects their feelings of not being respected and feeling invisible). Those at-risk students who are in programs developed for students who have learning challenges believe that the education system has low expectation regarding their achievement. Many admitted that they could achieve much more but had no motivation to do any more than they were doing. It should not surprise the system that, given the lack of challenge like this in school, these at-risk young people turn to getting high and disengaging.

[25] "Our Kids are Worth It", http://www.gov.ns.ca/coms/department/documents/First_year-Our_kids_are_worth_it.pdf

"I was struggling with school and failing. I moved to the Math Essentials and trades program. Now I'm being taught to add 2 + 2, do they think I'm stupid? Not only that, in English we're reading a book we did in Grade 5 and talk about an insult, the teacher is reading it to us.

Quote Grade 10 Math Essentials Student

This situation leads to the perception by youth that they are not respected – a fundamental human right. Respect calls for individuals to overlook and humble their pride and consider the other as an equal in regards to their right to be who they are. This type of respect should not be confused with esteem of someone's worth based on personal qualities or abilities – but the rather the fundamental rights that each person has no matter how different or seemingly unworthy they might be. There is popular belief that respect must be earned – that position establishes very clearly a power relationship and judgment between the teacher and the student. This type of relationship provides fertile fields for bullying and prejudice, and teaches the same behavior in students toward their teachers and others. More importantly a constructive school environment should suggest that "trust" should be earned – but respect is a given as one human being to another.

I was the first one in my family to see myself graduating high school and possibly head off to NSCC, or even University. I didn't have the same last name as my Dad and I wanted it that way – he didn't have a very good reputation in the community or the school for that matter. Many of the same teachers he gave a hard time to were still there teaching. One day I had a teacher accuse me of cheating. I hadn't, and they persisted taking the issue to school administration and further. I was still reluctant to bring my Father into the school because of his reputation – I knew that it would haunt me and jeopardize my future. Eventually I needed him to advocate on my behalf.

Quote from a Young Woman in a Family Place Program

This at-risk group is already marginalized by their peers, and for the most part the teachers. Many of these students arrive at the High School with a reputation, and this reputation goes past their own individual behavior. Frequently they are associated with a parent or relative who also holds a reputation in the community. Many times the youth has already been judged, and has little chance for success. In many cases they become invisible, struggling with the school work with a belief that there is no

one to turn to. Their inability to master the academics leads to frustration, embarrassment and attitude. They do observe the teachers treating others (those they believe are favoured) in a more respectful manner. They believe that no one is there for them and as such achievement is not important – survival is. The at-risk youth have no advocates, many times the parent of the at-risk youth is not engaged. Many of these youth come from dysfunctional families where the parents themselves struggle with their own problems. It is interesting to draw a parallel to two budget decisions to illuminate this point:

- the first is the closure of the North Side Learning Centre and the consolidation of the program to Southside Learning. All indications are that the need for this small individualized learning environment is growing. And from best practice needs to be in the community where the youth are. The results of the decision were unremarkable. There was no outcry, no parent revolt and no community standing up to protect the program; and

- The second was the elimination of the International Baccalaureate (IB) program from Sydney Academy. Granted this is a marquee program, with international credential designed to push the most gifted academic students. With this decision came a huge outcry from students, their parents and the community. Most recently the President of Cape Breton University sent a letter supporting the program and extolling its virtues in providing superb preparation for students intending to go to University. The decision was overturned.

In both high schools where interviews were conducted the Gay Straight Alliance (GSA) was a targeted group for discussion. The dialogue centred around their program and the mandate to create a safe environment for those questioning their sexual orientation by building awareness within the student population. The GSA members were well aware of the at-risk issues related to this group – in particular as being marginalized within a marginalized population. They spoke to the statistics related to increased levels of suicide and drug use.[26] There was consensus that they were not taken seriously by the school, every bit of work they did was an uphill battle, and when fighting for face time with the students there always seemed to be other more important things or no time. One of the students likened it to the Chess Club – a Club filled with a different type of people that were

[26] Today's Gay Youth: The Ugly, Frightening Statistics, available at http://www.pflagphoenix.org/education/youth_stats.html

tolerated. The members of the GSA continue to hear slurs and derogatory language amongst the students and even some of the teachers. There were no Teacher role models, and there were none in the community either. It is suggested in various research documents that the number LGBTQ persons within the population is somewhere between 7 and 10 percent, so the community should have LGBTQ role models and there is a strong possibility that some of the students are actually dealing with sexual identity issues and not having anyone to turn to. The hope of the group was that someday all the teachers would support the GSA easing the burden of improving awareness.

GAME CHANGER: The number one change in schools that youth at risk identified that would make a difference was that teachers respect them unconditionally. Each one said that it would change their behavior toward the teacher and believed that it would make a difference to their attitude toward education.

Health Services and High Risk Behaviour

Generally health services seemed to be meeting the need. There were few criticisms. Most of the students in the mainstream school system continued to use Family Physicians and were satisfied with the support. They were unconcerned regarding the confidentiality of their health status – and in some cases, such as unplanned pregnancy, they thought it eased the communication to parents by asking the Doctor to intervene on their behalf.

> I was a pot head. I'd get dressed and put on my makeup, get on the bus and go to school and then directly off the bus to the tracks behind the school. Five minutes later I'd be stoned. My parents didn't know but I did this every day. I thought I was cool, but now I know I was just stupid. How could I ever succeed in school as a pot head? Now I'm doing what I could have done then. What a waste.
>
> *Quote from Female Adult School Student*

Some of those interviewed used the School Clinics, primarily for consultations on birth control and sexual health status check up. Some of them reported that they had been screened for what seemed to be mental health and addictions. Few of them believed that they would use this access point to address mental health issues. For the most part, with the exception of serious mental health issues, youth said that in dealing with depression and anxiety it was easier to talk to a friend than to try and get into the system. Some of them had tried to get referrals but the wait time was so long that if they didn't deal with the

problem themselves it would become a much bigger problem. Some of them even admitted to using the ER route, feigning thoughts of suicide to be able to move up the priority list.

A negative view of the School Health Clinics is emerging. Males regarded the clinics as "the place where the Hoes go to get birth control". Although connected to the school and out of the way, it was obvious when someone was going to the clinic. Immediately it was presumed that they were going there for birth control or to be tested for STDs. Males even admitted to sending their girlfriends there for condoms. There were few that said they used the clinic for general health, drug education, or access to addictions counselling. Many of those who were interviewed said that the only time they went to the clinic was when they were given the school tour. And some even admitted to going to the Centre to get out of class. For those that used the clinic for birth control they indicated the service was good, they didn't feel that staff was judging them and the information and support they received was good. They indicated however, even though the service was good, most of them preferred to use their family physicians for other health services.

It was interesting to see the distribution of those who self-identified with mental illness. In the mainstream school system girls were more likely to disclose. For the most part they identified some form of anxiety disorder and depression. They did not see any stigma by disclosing – but they did say that those they disclosed to (parents or teachers) had little patience for a student telling them they suspected having a mental disorder. This extended in some cases to their family Physicians. With the population in the mainstream schools they saw no connection between their mental health and the use of alcohol and drugs which they put down to simply being recreational use – even though they may be daily habitual users.

> "I don't want to go to a Doctor for mental health problems when all they want to do is give me drugs, I have enough problems trying to deal with my addictions – I don't need any more drugs.
>
> *Quote from Adult School Student*

The other groups, not in the mainstream school system, told a very different story. They had begun to realize that they were dealing with mental health issues, issues generated from poverty, dysfunctional families, family violence, and struggles in school. Most of the females in the group self-disclosed and some of the males also identified mental health issues. In the case where these at-risk youth have disengaged from the mainstream system and disconnected from services for a time there were a higher number of serious mental disorders. These individuals for the most part were ridiculed and taunted for odd behavior. They were considered misfits and typically cut themselves off from friends and family – choosing isolation. In all cases of those identified with serious mental health issues the diagnosis was late in coming and their lives deteriorated very quickly. In these cases Teachers and Parents were not well equipped to deal with the situation. Most of this population mis-used (and in some cases abused) alcohol and drugs and all admitted that it was an act of self medicating – even though when

they were younger they believed they were just chilling with their friends and considered drug use as purely recreational. This group still struggles with their addictions, a large number are on methadone treatment for serious drug use recovery.

GAME CHANGER: Regarding Health Services the youth said that if there were other reasons to go to the school based Health Centre (like looking for work) they would take advantage of going. There are just too many people that know your business.

Social Services

The discussions regarding social services were dramatically different depending on which group was in discussion. For the most part students in the mainstream school system did not disclose that they, or their families, receive social assistance. They avoided the questions. The Principals confirmed that many of their families were on social assistance. The "non" answering of the questions was telling in itself. It was this embarrassment that for many of them was the impetus to change the situation and they understood that their education was a key component to achieving this goal. For the most part these students still had connections with their families. However, it was difficult to gauge how supportive their families were in the student's success in school.

All the other interviews of those not in the mainstream school system painted a very clear picture. Ratings of this service were poor. There were some exceptions where the Case Workers were thought to be caring and very helpful in multiple roles of support and advocacy – but these were the exceptions. The standard response was that they either didn't know their case worker, phone calls were not answered and communication was not easy. When they did connect the individual felt that they were subservient and not deserving. They were made to feel that the onus of proof of need rested with the benefactor and generally they were made to feel as if given the chance they were always looking for ways to cheat the system. The worst part was how demeaning the whole process was – ultimately diminishing their self-esteem and hope for a better future. Typically Case Workers direct clients to the Community Services Website which shows complete insensitivity toward an individual who may only have a grade 7 or 8 reading level – or may in fact be illiterate.

Those in the Adult School regarded the opportunity to go back to school as the chance to change their lives and detach themselves from Community Services. Rather than leaving a good impression of societies support for those less fortunate, they are left with a system that establishes relationships of servitude indenture and dependence. It was the belief that the system was designed to constrain an individual's opportunities to achieve independence.

Other than financial support to go back to school – which is generally limited, individuals struggle with child care, transportation, work and family issues. Given the direct relationship between education, work and independence the group felt that Community

Services should be doing whatever it could to help the students succeed through adequate financial support and guidance in looking for and securing work. One person wondered why Community Services wasn't trying to work themselves out of a job.

A startling figure was the statistic that in Glace Bay 60 adults started the program, and within a month the numbers were down to 20. The three principal reasons for dropping out were: child care; addiction; and work/money. Some who left just couldn't commit – and there was a sense that most of the individuals who didn't stay with the program had mental health problems as well. Although not as dramatic in other locations, retention is a significant hurdle for the school.

GAME CHANGER: If social services had the ability to do whatever they needed to do to help individuals choosing to go to the Adult School to not drop out there would be a significant impact on the system as these at-risk youth move from the cost side of our social system to the revenue side through tax contributions.

Justice

It was clear that the youth in the mainstream school system had limited exposure with the law. There were some minor behavior issues, and some reprimands from law enforcement. Limited numbers had been part of restorative justice. What was interesting was that they easily described limits of drug possession that would be the tipping point to being charged. Most of their run-ins with the Police were because of public intoxication or disturbing the peace.

The older youth who were interviewed had had much more interaction with the law. There was a higher incidence of incarceration, house arrest and probation. The males in the group had most of the issues with the law. Issues related three groups: public intoxication and disturbing the peace; drug possession and drug dealing; and family violence. Most of the males expressed some degree of shame regarding incarceration – all of them said the experience wasn't horrible. In fact they described that they got off drugs, worked out and became fit, ate well, were away from the stresses of their families and friends and didn't have to worry about responsibilities. Although they left the Correctional Facility with all the good intentions of turning their lives around – most of them could not live up to these intentions. Primarily failure was because nothing had changed when they returned – same squalor, same dysfunctional family and same problems and worries. Many returned to drug dealing as an easy source of cash and access to the drugs. Although the statistics were not available the Superintendent of the Cape Breton Correctional Facility said that she had a large number of recurring visitors. She bemused that some of them preferred to be at the facility than at home.

I asked about their experiences with probation and most of them felt there was a change for the good. Probation Officers actually seemed to care that they didn't reoffend. They helped by trying to put together supports from other agencies – an example given was linking the individual up for anger management and the Fathers are Parents Too program both of which were instrumental in helping to change this individual's life around. Most in the Adult School program were long since out of the probation system – if they had been in it. In some cases attendance at some of these programs were conditions of parole – thereby encouraging ongoing shifts in behavior.

GAME CHANGER: Help the youth by finding ways to make changes to their environment so that the high risk behavior isn't easy to come back to. Maybe transition living apart from what was their situation prior to incarceration – building on the programs from the Correctional Centre and establishing tactics to address the temptations to return to how things used to be.

Discussions with First Nations Youth

Discussion groups were held at the Eskasoni Reserve Training and Education Centre (TEC). This school delivers a program designed to help youth who are most at-risk achieve High School graduation. In addition, there is an adult school program and these individuals were also invited to offer their opinions and stories.

The school has had a strong result, providing opportunity and hope to those youth who had lost their futures. A significant difference to the youth in developmental programs in the Cape Breton Victoria School Board was a sense of hope. All of the youth interviewed had goals in their lives and saw a future that was different from the lives they were living: better than their parents, strong family and most interestingly away from Eskasoni. Many of the young people identified a class structure of opportunity on Reserve and identified this as a significant reason for limiting opportunity. It was for this reason that they believed they needed to leave and seek opportunity somewhere else.

The reasons for disconnecting from the education system were no different from their peers in the rest of Cape Breton: poverty; deteriorating family; drugs; the inability to see a future; and struggling with school work and life's challenges. All of the students who participated spoke to the value the TEC was providing to them as a safe and nurturing environment. Teachers looked past the school work and tried to help the whole student – bringing together mental health, social service and academic support under one roof.

Drug abuse was commonplace, and characterized most of the social and family dysfunction of the Reserve. Most of those who participated in the discussion admitted to using, and some abusing. One of the differences in their attitudes compared to their white peers regarding drug use is that they stated that use was related to making all the difficult things in their lives disappear. They quickly made the connection to mental health and suggested

that drug use was a self-medicating action. A majority of the female population admitted to dealing with anxiety, and most had had been the target of bullying.

All of those who were interviewed had aspirations of continuing their education either in University or Community College to obtain a trade. They all believed in themselves and that they had the capability to do whatever they set out to accomplish.

To achieve positive outcomes at the school the teachers are very important. Understanding the First Nations culture is essential to providing an effective learning environment. There are many situations that non-native teachers might regard as unacceptable, are considered a normal way of life. At the same time – the youth openly expressed the importance of having non-native teachers in helping them understand the cultural differences external to the Reserve in preparation for continuing on with their education. Many of these youth, with the creation of on Reserve schooling, have had limited exposure to the white population of Cape Breton and some expressed difficulty working in English.

Discussion on Technology

The discussion on the use of technology was initiated with all youth interviewed. The following are the salient points:

- Everyone had access to the internet in some form, some of them owned smart phones (phones that have connect ability to the internet).
- Without exception all of the youth had facebook accounts, or have had one.
- Most of the youth had used the internet to seek out information regarding their health, or other issues they were dealing with in their lives.
- All of the youth indicated that internet access, and their phones, were the last possessions they would give up. They expressed discomfort in not having their cell phones and internet.
- Most of the youth indicated that if all the services that they needed were presented through the internet they would access them – as long as they provided value to them.
- Some of the youth were concerned about discussing personal issues on the internet with a stranger, and were concerned about confidentiality.
- Some of the youth were more comfortable discussing personal issues on the internet with anonymity.

- For the most part youth saw a virtual drop-in centre would be good, but would also like to see a real place where the services were integrated.

Options and Options Analysis

Options

Four options were identified to support the delivery of services to youth. Each solution, except the status quo, would implement best practices as follows:

- Standardized assessment process that looks at the overall needs of at-risk youth, focusing first on the basic needs first;
- One-stop shopping to include health, social service, housing, employability and justice service access;
- At-risk youth are involved in the organizational governance model, on an ongoing basis, and be a part of developing services;
- Each solution has a volunteer component. The two functional areas of volunteerism are to be one-on-one mentoring and recreational activity support; and
- Resources are trained specifically in the at-risk segment they are dealing with (youth between 15 and 25) and any specific sub-population that increases the risk factors of behavior (e.g. drug use or LGBTQ for example).

Four solutions are described as follows:

Option A: The Drop-In Centre Model

The Drop-In Centre would be located in Sydney as the most central point to the CBDHA. It would be a physical space that integrated all four partner groups in the delivery of services to youth – including program representatives of health, mental health and addictions; community services; education; and justice. The operation would be available at times that were developed through the Youth Board, and may reflect non-traditional service hours to enable easier access by youth. As a drop-in centre the facility would have other services that may be recreational nature or reflect basic needs of at-risk youth such as food. The drop-in component would be designed based on direct input from the youth and would remain relevant by canvassing the youth on an ongoing basis. Adequate space would be required to conduct training and workshops, assessments, and counselling. All programs would be delivered from this one location. Technology and connectivity to IT systems

would need to be integrated into the space to enable the processing of different benefit programs. Out of office hour services (emergency) would be provided by existing emergency services. The space would be available, and preferred, as a point of integration for the delivery of programs delivered by non-profit organizations – this could include programs for young pregnant women or training to eliminate barriers to employment. Specifically the centre would develop a "brand" that establishes it as the place for at-risk youth to get help and support.

The drop-in centre would be staffed by three specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and reception (engager, enabler and coordinator and volunteer coordinator e.g. mentor management);

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time in the centre. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty.

The relationship between the Generalist and the Specialist would be one of referral. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist. Although the specialist team would initially consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option B: The Mobile Model

The mobile model takes the services to the youth as part of outreach. The team uses existing youth friendly program facilities. However the service integration would be integrated as in Option A with all four partner groups in the delivery of services to youth – including program representatives of health, mental health and addictions; community services; education; and justice. The operation would be available at times, and locations, recommended by the Youth Board, and may reflect non-traditional service hours to enable easier access by youth. The recreational components of the drop-in centre as in option A would not be available as designed but would key off of existing programs that exist in the space that this service was

being delivered. An example of this is to use the Lighthouse Church facility where Art and Music programs are drawing in at-risk youth, and the addition of this Mobile Model would be considered and augmentation to support the broader needs of the at-risk youth. Adequate space would be required to conduct training and workshops, health assessments, and counselling. Technology and connectivity to systems would need to be mobile to enable the processing of different benefit programs. Out of office hour services (emergency) would be provided by existing emergency services. Out of office hour services (emergency) would be provided by existing emergency services. The location scheduling of the mobile service would be developed to be most responsive to the needs of the at-risk youth and would be continuously reviewed. The intention is not to create new space but to compliment other programs space that will have been developed to respond to the needs of youth in the community. "Brand" recognition would not be space specific but program specific.

The mobile service would be staffed by three specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and reception (engager, enabler and coordinator and volunteer coordinator e.g. mentor management). The receptionist would travel with the team;

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time on the mobile team. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty. Scheduling of these services would require that each discipline would be required to be at each of the community sites and the frequency of those visits would be based on the demand.

The relationship between the Generalist and the Specialist would be one of referral as in Option A. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist. Although the specialist team will consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option C: The Technology Based Model

The technology based model is a virtual drop-in centre, or community, using the advanced social media. As a virtual drop-in centre the site becomes the go-to site for information, services and support for at-risk youth. Not only does it provide an integration point for benefits applications, information and forms but the system includes professional on-line support by a collection of youth service generalists and specialists that contribute guaranteed time to the site to provide on-line support to undertake assessments of needs in real time using IM (instant messaging). In addition, the site would provide opportunity for self-assessment and automated program response based on need. This site would be the one-stop shop for all youth services targeting their needs, and brand recognition would be based on developing the website as the best place to initiate service for at-risk youth.

From an operational perspective the records and data collection as part of the system would provide opportunity to capture outcome status and reports that generate the capability for ongoing evaluation and improvement to services for at-risk youth.

The mobile service would be staffed by the following specific functional groups:

- Administration: Executive Director (responsible for the overall leadership and strategic direction of the centre, integrating the service providers, integrating the needs of youth in the response through services, skills development in staff and fundraising) and IT Developer to provide ongoing support to the site development, management of reports and the functions it provides;

- Generalist: trained to undertake holistic assessments of the at-risk youth, integrating youth services regardless of service system, emergency crisis response, triage, basic counselling (such as developing and supporting the goals and objectives of youth, basic CBT), life skills trainers, mentor management, monitoring of improvement; and

- Specialist: these functions include a General Practitioner, Psychologist and Social Worker working part-time on the mobile team. All would be able to undertake some common functions such as CBT, but for the most part would focus on their specific areas of specialty. Scheduling of these services would require that each discipline would be required to be at each of the community sites and the frequency of those visits would be based on the demand; and

- Volunteers: coordinating matching for mentors and developing activities that support the development of at-risk youth, using the site to develop the activity and generate the interest for these youth. Volunteers will also be individuals with specific competencies related to addressing the needs of at-risk youth – GPs, Medical Specialists, Psychologists and Social Workers. In this model these

individuals could come from anywhere.

The relationship between the Generalist and the Specialist would be one of referral as in Option A. The intent would be that through the holistic assessment of needs a Case would be established and managed by the Generalist – with support from the Specialist but only when the youth gives permission for this activity to be undertaken. Although the specialist team will consist of a GP, Psychologist and Social Worker this team would be adjusted based on the need.

Option D: The Status Quo
Continue to have services as they are currently delivered, without change.

Note: Although Option C: reflects the technology solution, it is suggested that this solution be considered as a required action regardless of which approach is selected. Moving forward with an interactive technical solution is not regarded as an option but a requirement in moving forward.

Costing Approach

Note: Costing estimate information may be found at Annex D. The costing approach assessed the incremental costs of transition to the state of delivering integrated services for youth from the current state to each of the four end states. It also assessed the steady state incremental costs that will be incurred following implementation.

The cost data is based on reasonable estimates. These estimates provide the orders of magnitude comparative data in both the transition and steady state, supporting a senior management decision on future option. It should be noted that these costs are considered high level and a detailed costs analysis of the selected solution will need to be undertaken.

Transition Costs

Transfer Training

The costs associated with establishing the capability to provide integrated services as a generalist so that a counsellor is confident to support 80% of the needs of the youth, and refer to a specific expertise based on the particular need.

One- Time Capital

The costs associated with changes to the infrastructure to meet the needs of establishing the space to provide the solution.

Change Management

Represents the costs associated with changing policy, designing or amending business processes, benefits, programs and communications (planning and materials).

Steady State Costs

Ongoing Infrastructure

These costs would reflect the rental of office space and equipment.

Certification and Standardization

Establishing the capability to respond to the complex needs of youth clients requires a clear understanding of the service standards and the quality of the services provided. Process improvement and quality assurance are contained in these costs. Although the operational costs would be covered by the ED in their salary, there is a need to have external review of the operation to ensure it is maintaining the system (e.g. ISO registration for example).

Operation Resources

Operational resources are represented by either personnel costs or the cost of a contract.

Risk Analysis Methodology

The options are susceptible to risk during transition and in the steady state. The risk analysis compared the five options on their relative risk profiles, looking specifically at service delivery, financial, reversibility and other risks. Each risk area was defined by a series of risk statements, each of which was weighted in reference to all other statements. The risk was evaluated and weighted, establishing an overall risk level for each option.

Comparative Analysis

Option A: Drop-In Centre Model

Description of End State

Clients cared for under this drop-in centre approach would be all Cape Breton Regional District Health Authority youth between the ages of 15 and 24. All youth in this age group would have access regardless of status with Community Services in drawing benefits.

The Youth Drop-in Centre would be led by a Director (whose principle role is to lead the staff, assess effectiveness of the service and fundraise) and staffed by trained generalists that have the skills to undertake assessments, match youth needs with a variety of services and access the specialists as referral on-site. The Executive Director would develop the youth client needs analysis and ongoing policy and program development. The ED would also be responsible to develop the organization, service standards and quality assurance measurement indices. The process development would be holistic in nature looking at all elements that are needed to be responsive to youth in an integrated manner to improve outcomes. The generalist would be able to undertake such activities such as youth assessments, organize program attendance, mentor match, provide birth control information and assess accommodation needs and solutions. The overall objective would be to remove many of the youth's stressors that have the potential to become triggers for mental illness and drug use. The needs would be developed from a holistic view of the youth and help to establish areas of most need and priority. Assessment tools would be developed to best accomplish this, looking to existing tools for guidance.

Initially core specialists would include a general practitioner, a social worker and a psychologist – resident at the centre part time 2 days per week. With the one day overlap (reflects 1/3 of a day) the core specialists would conduct a case management meeting with the generalists. Access to these resources would be through the Generalist on a referral basis. The core specialist group would also have common skills in the area of counselling and some therapeutic approaches. Any complicated case, as assessed by the core specialist team, would be referred into the system. The goal would be to deal with 80% of the referred cases.

Generalist processes would include triage and those that indicated "most at risk" would be prioritized and move forward on the list. Standards of practice would guide the processes and on an ongoing basis the ED would evaluate the effectiveness of the process.

Using the Generalist as the gate keeper and basic service provider the volume of clients has been estimated on a 1 hour per visit per client. With three Generalists on staff the number of clients serviced in a week (using an 80% productivity figure) they will see 96 clients on average per week.

Summary of Costs	$ thousands
Transition	
Transfer Training – in-depth orientation of staff on the generalist holistic approach to service delivery.	$10
One Time Capital – offices and support equipment for 1 Director, 3 generalists, 1 specialist, 1 nurse and 1 support staff, and leasehold improvements. *	$200
Change Management – ED .5 year for transition to prepare the business practices, policies, communications material and the organization.	$35.5
Net Total Transition Costs	$245.5
Steady State	
Ongoing infrastructure – lease, insurance and operating costs – such as phone.	$30
Certification and Standardization – ISO registration to support external review of system.	$5
Salaries	$397
Net Total Steady State Costs	$431

*Note: Based on a facility that includes reception room, multi purpose lunch room, 6 offices, a work room, file room and two breakout type rooms. The leasehold improvement rate is based on total reconfiguration of the space – including wiring, plumbing and communications. If a space meets the need without renovation the cost for transition will be reduced by $110K.

Feasibility

This solution reflects the Australian model of headspace with the added benefit of integrating the services and benefits of departments over and above health as in the SHOUT experience in Toronto (e.g. the programs delivered by Community Services). This approach is in direct response to the request by youth to have a central point of integration for all services they might need. More importantly the integration in situ enables the service provider access into a comprehensive support plan for the client recognizing the value of bringing together education, knowledge of high risk behavior, housing, etc., and eliminating calls for coordination.

This Option will challenge the system and require staff to become aware of a broader set of programs, benefits and services. The cultural shift for staff to move from providing a single service to multiple services will be challenging, and for the system to enable this to happen will also be difficult. From the staff perspective the way of changing attitudes is to demonstrate the value that they bring to the table. From the systems perspective it will require the system respond in a "special" manner to the pilot to enable it to succeed. Appropriately level of oversight will need to be established to ensure that the system does not cause failure. These costs (for senior level oversight) have not been included.

Although Nova Scotia policy doesn't support this model, amendments can go into effect before they are enacted. Therefore the legal position doesn't necessarily restrict change. Moving in this direction addresses the issue from Community Services perspective that youth between 16 and 19 do not have access to any service. This is beneficial in addressing this population's needs – but there could be a funding gap regarding the increased demand for benefits from this population. Given that there is a fixed envelope of resource this could be problematic.

This can only be feasible if there is political will to see change in approach and future realignment of resources. Given that realignment is across Adult and Child and Adolescent Mental Health there may be some issues in realigning half a position from each group without causing some imbalance in service on either side.

Success may in fact create issues with feasibility. While the Drop-In Centre grows its client base, and improves outcomes, the Health system may not see reduction in demand from their end. The health system is considered inadequately mismatched with the demand. Therefore, all the Drop-In Service may provide is picking up some of the demand which isn't being serviced. As the Drop-In Centre succeeds and needs additional resource to be transferred and realigned to this different service model there may be no resource to transfer. The result then may be dissatisfaction with the clients that instead of waiting 6

weeks for the mental health system to respond to a referral they now see the wait times at the Drop-In Centre.

Effectiveness

Adopting best practice and integrating the services into an individualized comprehensive care plan will only result in improvement to the outcomes through the elimination of duplication and confusion. In addition, by using the generalist model staff will be able to move between functions in the Drop-In centre increasing the productivity of the service delivery. It also promotes knowledge of the end-to-end process and the relationship of the benefits and programs in contributing to changing the individual's outcomes.

Effectiveness includes being able to address growing demand without loss in quality then this can only happen by growing the FTE's in response. And as discussed in feasibility realigning resources for this age group is challenging, whether this is a transfer of position or an increase in funding.

In addition, to be most effective, there needs to be an outreach component to the centre. This was not included in the cost. Outreach would take the services out as a way of bringing the at-risk youth in.

Accessibility

Accessibility for those in Sydney is marginal. Transportation system are poor, and many of the at-risk youth do not have access to transportation. Accessibility for any other at-risk youth is poor (those not in Sydney). Most at-risk youth do not have access to a vehicle and inter community transportation is not responsive enough. This situation may be mitigated somewhat if the Centre includes a transportation budget. This is currently not included in the cost analysis above.

To further complicate this situation the at-risk youth indicated that travel was a barrier.

Best Practice

Best practice has been integrated into the solution by including standards of practice that respond to the observations made by youth, with the exception of one important component. Experience has demonstrated that to be most successful the services need to be taken to the youth, and although the service could be considered taken to the youth of Sydney it doesn't meet this best practice for any other youth. If this was a lead-off approach where Sydney is considered the pilot to demonstrate value with the intention of building similar supports in other communities then the best practice element can be satisfied.

Engagement

The issue in Best Practice is associated primarily with engaging youth. One component of engaging youth is taking the service to them. Engagement will really rest in how the Centre provides the hook to initiate dialogue. Without outreach however this impact will low.

On the positive side it is the opportunity to have all the resources that youth need to affect change in one place and they have indicated that this would be attractive. Given the move to use youth in the governance model then this will become a primary function of these young people.

Sustainability

Cost will be an issue. Once proven the benefits of improved outcomes and increased take-up of the service will justify the realignment of resource. Unfortunately the Centre may only be picking up demand that is not being serviced now because there is inadequate capacity. Two considerations may address some of the challenges of sustainability:

- recruit a full time General Practitioner whose costs are offset through the Nova Scotia health insurance system; and
- investigate partnering with the Homelessness initiative who have just been provided funding for a drop-in centre.

If the Option A partners with the homeless initiative the costs associated with space and some of the resource can be reduced by approximately $110 which was identified as the leasehold improvement cost, and an initial operating cost of the receptionist for three years. These costs could be amortized in a rental agreement with the Partner organization thereby eliminating large upfront cost, and providing benefit to the Partner in establishing the right financial conditions to move their initiative forward.

Sustainment of this approach will only come from the ability to rationalize the realignment of resource from the current program envelope, to this model – even with success in fundraising this will need to happen. Therefore, it is essential in moving forward that clear value be determined if this is to be assessed over a period of time. As stated earlier however, success with the centre may create issues regarding sustainability of the Option. If there is no clear reduction on the current system side of demand, then success will drive expectations of service through the Centre with no solution to responding to the increased demand.

Developing revenue streams is another way in which support sustainment. Using the employment component of the social service at the Centre in the development of Centre hosted social enterprises there could be an opportunity to generate revenue to support the ongoing operation. Although initially funded by government programs in employability and training, these initiatives could then be transferred to revenue generating businesses. If this were to be the direction of the Centre due consideration would have to be taken to additional administrative overhead.

Option B: Mobile Outreach

Description of End State

Clients cared for under this mobile drop-in centre approach where the service would be taken to the youth. Scheduling would provide services in multiple communities throughout the week to youth between the ages of 15 and 24. All youth in this age group would have access regardless of the status with Community Services in drawing benefits. Local community facilities that already provide services to youth would be used (e.g. undercurrent at the Lighthouse Church in Glace Bay where addiction services are already working, and the schools health clinics broadens their services).

The Mobile Outreach would be led by a Director (whose principle role is to lead the staff, assess effectiveness of the service and fundraise) and staffed by trained generalists that have the skills to undertake assessments, match youth needs with a variety of services and access the specialists as referral on-site. The Executive Director would develop the youth client needs analysis and ongoing policy and program development. The ED would also be responsible to develop the organization, service standards and quality assurance measurement indices. As with the Centre Option the process development would be holistic in nature looking at all elements that are needed to be responsive to youth in an integrated manner to improve outcomes. The generalist would be able to undertake such activities such as youth assessments, organize program attendance, mentor match, provide birth control information and assess accommodation needs and solutions. The overall objective would be to remove many of the youth's stressors that have the potential to become triggers for mental illness and drug use. The needs would be developed from a holistic view of the youth and help to establish areas of most need and priority. Assessment tools would be developed to best accomplish this, looking to existing tools for guidance.

Initially core specialists would include a general practitioner, a social worker and a psychologist – who would travel with the team 2 days per week. With the one day overlap (reflects 1/3 of a day) the core specialists would conduct a case management meeting with the generalists. Access to these resources would be through the Generalist on a referral basis. The core specialist group would also have common skills in the area of counselling and some therapeutic approaches. Any complicated case, as assessed by the core specialist team, would be referred into the system. The goal would be to deal with 80% of the referred cases. The number of clients served would be the same as the Option A.

Generalist processes would triage the case and those that indicated "most at risk" would be prioritized and move forward on the list. Standards of practice would guide the processes and on an ongoing basis the Integrated Youth Services service office would evaluate the effectiveness of the process.

Summary of Costs	$ thousands
Transition	
Transfer Training – in-depth orientation of staff on the generalist holistic approach to service delivery.	$10
One Time Capital – there are no one time investment costs. The vehicle is considered a recurring expense and is therefore amortized as an operating expense over 5 years. The Director position would be part time and a request would be made to the hospital to use a vacant office.	$0
Change Management – ED as per Option A for establishing the organization.	$35.5
Net Total Transition Costs	$45.5
Steady State	
Ongoing infrastructure	$12
Certification and Standardization – ISO registration to support external review of system.	$5
Salaries – includes 2 days per week of a core specialist, part time director (.5), coordinator and three generalists.	$330
Net Total Steady State Costs	$347

Feasibility

Option B differs from Option A in that the services are brought to locales where youth are and uses existing community services as a value add. This option recognizes the existing

relationships with Youth in the communities and takes advantage to grow acceptance from this network to others. Therefore the take-up should be faster than in Option A. This approach also provides a central point of integration one-stop shop for all services youth are looking for. More importantly the integration in situ enables the service provider access into a comprehensive support plan for the client recognizing the value of bringing together education, knowledge of high risk behavior, housing, etc., and eliminating calls for coordination. It also recognizes the value of the community based programs that have been already developed and tailored to meet the needs of at-risk youth in their community.

This Option will also challenge the system and require staff to become aware of a broader set of programs, benefits and services. The cultural shift for staff to move from providing a single service to multiple services will be challenging, and for the system to enable this to happen will also be difficult. From the staff perspective the way of changing attitudes is to demonstrate the value that they bring to the table. From the systems perspective it will require the system respond in a "special" manner to the pilot to enable it to succeed. As in Option A appropriately level of oversight will need to be established to ensure that the system does not cause failure. These costs (for senior level oversight) have not been included.

Although the policy doesn't support this model, amendments can go into effect before they are enacted. Therefore the legal position doesn't necessarily restrict change. Moving in this direction addresses the issue from Community Services perspective that youth between 16 and 19 do not have access to any service. This is beneficial in addressing this population's needs – but there could be a funding gap regarding the increased demand for benefits from this population.

This can only be feasible if there is political will to see change in approach and future realignment of resources. Given that realignment is across Adult and Child and Adolescent Mental Health there may be some issues in realigning half a position from each group without causing some imbalance in service on either side.

Success may in fact create issues with feasibility. Much like the Drop-In Centre model as client base grows because of improved outcomes, the Health or Social Services system may not see reduction in demand at their end. See Option A.

An additional issue is presented in that it may be difficult to attract talent to the team given the transient nature of the service. This may not be attractive to the professional.

Effectiveness

As in Option A adopting best practice and integrating the services into an individualized comprehensive care plan will only result in improvement to the outcomes. In addition, by taking the service to the at-risk youth there will be the added benefit of capturing programs and services that are community based in any plan that is developed with the youth.

If effectiveness includes being able to address growing demand without loss in quality then this can only happen by growing the FTE's in response.

Accessibility

Good. Taking the service to the youth is what the youth are asking for. Recognizing existing community based relationships with programs will enable rapid take-up of the services. It was clear from at-risk youth requirements that if they needed to travel from Glace Bay to New Waterford for the service they probably would not. Given that this service is mobile and not available every day in each community, the success of one day a week may cause issues in that the Youth may wish to have the service available more frequently in their communities. The result in this circumstance is that accessibility is not achieved.

Best Practice

All elements of Best Practice implemented.

Engagement

Just because the service is being delivered to the youth doesn't mean that they will actually engage and access the service. Innovative methods to connect – using local programs – will need to be executed, and this is a benefit over Option A the Centre. Considering the involvement of youth in governance there should be high probability that the youth will be engaged. This was the experience in Australia and Toronto.

Sustainability

Cost will be an issue, but not as serious as Option A. Once proven the benefits of improved outcomes and increased take-up of the service will justify the realignment of resource. As in Option A the Mobile service may only be picking up demand that is not being serviced because there is inadequate capacity. There is a possibility that the General Practitioner costs can be picked up as a cost to health insurance system and not a cost to the program.

As in Option A the employability component, and the opportunity to develop revenue, should be explored as part of the sustainment of the organization.

Option C: Technology Virtual Drop-In Centre

Description of End State

A social network environment virtual Drop-In Centre would be designed to capture best practices, and through the software ensure that standards of practice are maintained. The Site would be dynamic and include open and secure sections. Communities (a term used in social media to reflect individuals who have a common interest) would be developed and then relationships built between them following designed business rules. Open Text, a billion dollar Canadian Company, has a simple and robust solution to enable ease of development and maintenance of social media sites[27]. It has significant capacity to integrate all elements that enhance communication including video, document repository and search, Twitter and Facebook integration as well as a dynamic Instant Messaging system.

Clients cared for under this virtual drop-in centre approach would be all Cape Breton Regional District Health Authority youth between the ages of 15 and 24. All youth in this age group would have access regardless of status with Community Services in drawing benefits.

The Virtual Youth Drop-in Centre would be led by a part time Director whose principle role is to manage/schedule professional resources to be available to respond. One generalist and one health care professional would be on standby to support youth entering the site looking for information or support for a particular problem. Other generalists and specialists would be available to support the virtual centre as they wish (this group could be international and recruited such that the Community is not restricted to Cape Breton). The Executive Director would develop the youth client needs analysis and ongoing policy and program development. The ED would also be responsible to develop the virtual organization, service standards and quality assurance measurement indices. As in the other options process development would be holistic in nature looking at all elements that are needed to be responsive to youth in an integrated manner to improve outcomes, and in this option would be fully embedded into the system design. The generalist would be able to undertake such activities such as youth assessments, organize program attendance, mentor match, provide birth control information and assess accommodation needs and solutions. The overall

[27] Open Text, available at http://www.opentext.com/2/global/global-eim.htm

objective would be to remove many of the youth's stressors that have the potential to become triggers for mental illness and drug use. The needs would be developed from a holistic view of the youth and help to establish areas of most need and priority. Assessment tools would be developed to best accomplish this, looking to existing tools for guidance.

With the exception of real people being available to respond to queries through the site in real time, most of the work will be associated with content management. This solution requires one full time IT professional and the resource from the from the Integrated Youth Services service office.

Generalist processes would be fully automated, including assessments. Any concern generated from the activity on the site (e.g. someone undertakes an assessment after having read the literature on suicide) will trigger a flag and an action by one of the on-line staff.

In addition, the web based approach enables to key differences to the service – the ability for youth to undertake self-assessment, retrieve relevant information to support their needs and information on outcomes and value of the service.

Summary of Costs	$ thousands
Transition	
Transfer Training – training developed and integrated, and delivered, on-line.	$0
One Time Capital – development of partnership with Social Network environment, web design and leasehold improvement	$60
Change Management – 2 policy analysts for .5 year. Communications material.	$53
Net Total Transition Costs	$103
Steady State	
Ongoing infrastructure – web support and an office for the IT professional	$7
Certification and Standardization – conducted through embedded processes.	$0
Salaries – Part time program director and full time IT resource.	$74
Net Total Steady State Costs	$81

Feasibility

The feasibility of this approach is high. The one challenge is the technical cultural divide between those seeking service through the internet and those providing the service. Youth look at technology as ubiquitous, and the normal way of addressing many of the activities they undertake in their lives. The service providers may not necessarily transfer to this approach readily.

Security, from a systems perspective, will see this as too difficult – however security has advanced significantly. This concern will of course need to be addressed if the true value of this solution is to be realized. There are even cases in health service provision that has succeeded through the internet[28].

Not hitting the mark out of the starting gate will cause this approach to fail fairly dramatically and rapidly. There are many statistics on the amount of time an individual will spend waiting for system response before they give up and go somewhere else. Rigorous testing prior to launch is essential and there must be heavy youth involvement.

Organizing the Professional Community to contribute will be challenging. There should be a number of communities to be responsive and these will need to be organized according to the function they are providing to the service.

Automating Community Services intake process, with support of generalist on-line advice could be difficult given the fairly rigid approach taken by this department. However, tackling this may be the necessary impetus for change that benefits the Department overall.

On-line professional support in this model does not have to be restricted to local specialists, but there may be many professionals who could join the community and provide support to youth through the system.

Effectiveness

The potential is to be very effective. Especially in streamlining referrals and organizing appointments. The multi-dimensional approach, which includes access to all sorts of supporting documents and information, will enable all aspects of the youth needs to be addressed.

Accessibility

This model is the most accessible. This approach would provide services 24/7 with online IM Counselling at guaranteed hours. Other hours may be available but only as professionals access the system and contribute their own personal time.

Best Practice

[28] Social Media in Health Care, available at http://www.changefoundation.ca/docs/socialmediatoolkit.pdf

All elements of best practice would be integrated into the design of the site – thereby assuring that the service does in fact follow the protocols that are most capable of delivering improved outcomes. As opportunities for improvement are discovered, either internally within the boundaries of the virtual Drop-in Centre, or from other experiences, these can easily be integrated into the design and implemented creating a fairly instantaneous impact.

Engagement

It is clearly understood that youth are already engaged with technology. That doesn't mean that thought in design of the site along with the functions and ways it delivers services shouldn't be carefully developed. Strong involvement by youth is essential to ensure engagement. The one risk, as stated earlier, that technology will present is that there is a rapid rejection of technology if it doesn't provide value to the youth.

Sustainability

Sustainability is high as much of this will have a volunteer community integrated through the site providing support to the youth. Active involvement with the youth in the undertaking and maintaining its content – even potentially as employment opportunities for youth – will assure that the site maintains relevancy as the landscape change, regardless of how quickly this happens.

Involvement with GPs funded by the health insurance system will not be available.

Employment revenue streams through social enterprise could be however and this will need to be evaluated as in the other options.

In addition, the web interface provides a unique opportunity to generate revenue through the site with ongoing business and government sponsorship. This could easily reach proportions that enable the creation and development of programs for youth. It also supports the opportunity to fundraise.

The social network approach to service is unique. There is significant opportunity to use this model as part of developing research partnerships and revenue bringing additional competencies and capacity to support the services to youth. Open Text was interested in supporting other research in this area in an effort to support social change – where their contribution would be the technology, system support and design, and then depending on

the research dollars attracted would consider being a partner.[29] It is expected that other organizations would regard this as an opportunity as well.

Option D: Status Quo

Description of End State

The existing service delivery model would continue to be delivered in the manner it is now. Social service would be delivered up to the age of 16 and then offer services for as an adult starting at 19. Likewise – Mental Health and Addiction Services would cut off Youth at 19 and transfer the cases to Adult services.

Programs would remain unchanged.

Summary of Costs	$ thousands
Transition	
Transfer Training – in-depth orientation of staff on the generalist holistic approach to service delivery.	$0
One Time Capital – offices and support equipment for 1 Director, 3 generalists, 1 specialist and 1 support staff.	$0
Change Management – 2 policy analysts for .5 year. Communications material.	$0
Net Total Transition Costs	
Steady State	

[29] Discussions Rob Gair (TDV Global) and Debra Lavoie (Open Text) 3 March 2011.

Ongoing infrastructure	$0
Certification and Standardization	$0
Salaries	$0
Net Total Steady State Costs	$0

Feasibility

The feasibility is high as there is no change.

Effectiveness

As it is with no improvement to the service, which youth are voicing that it doesn't meet their needs. Effectiveness is considered the lowest of the options.

Accessibility

The services for the most part are difficult to access. They are confusing, not located in areas that are easily accessible (the exception is Addictions which takes the service to the youth through outreach and the ICBTT which does the same).

Best Practice

There is room for improvement, and certainly each service could review their service and adjust based on the concepts provided through this review. In particular taking the input from at-risk youth to improve services. Some of the services have taken some of the practices and applied them – the Family Place Centres, Addictions and undercurrents are good examples. What is missing however is the integration best practice that has the potential to be a game changer.

Engagement

With the exception of the programs listed earlier there has been very little thought go into mechanisms to engage youth. Without regular contribution from at-risk youth in the process of youth engagement there will be no change and no improvement.

Sustainability

Easily sustained, however is subject to budget and government priority changes.

Risk Analysis

Risk Categories

- **Service Delivery Risks -** are those that could reduce the ability of the service to be delivered to at-risk youth compromising quality, response and delivery time.
- **Financial Performance Risks -** are those risks that could cause the service to fail to achieve its costs objectives, for example, forecasted operating costs.
- **Reversibility Risks -** is the difficulty or risk involved in restoring the service to the status quo if, after change to one of the above business cases, it proves unsuccessful.
- **Other Risks** – external to the service provisions and include certain political realities.

Risk Methodology

The risk analysis compared the five business cases on their relative risk profiles. The approach applied a risk level of 1 through 5 to each of the risk elements across the four business cases. Risk elements were defined by using an enterprise model (inputs into the Youth Services, processing within the service and outputs to the client). The risks and their relative weights were developed through a discussion between **TDV Global**, service providers and Dr. Jeff Derevensky (Director of the International Centre for Youth Gambling Problems and High Risk Behaviours). They are based on the experiences of the team (TDV, service providers and Dr. Derevensky) and remain subjective in nature.

The Risk Model

Each major risk category was given a weighting factor as shown below to account for its relative importance.

Risk Category	Weighting
Service Delivery	**1**
Financial Performance	**1**
Reversibility	**.25**

Other Risks	**.5**

Within each of the major risk categories there was a further breakdown into sub-category risk elements. Each sub-category was also given a weight as illustrated below.

The risk of each element, and for the each business case, was put into the model as an un-weighted number from one to five. These risk values can be view as the raw consequence of the risk should it occur, time the probability of occurrence.

Un-Weighted Risk	Legend
1	Lowest
2	Less than average
3	Average
4	Greater than average
5	Highest

The un-weighted risk values of each of the four business cases was multiplied by the element weight, summed with all other risks in the same category, divided by the sum of the element weights for each category and then multiplied by the category weighting factor. This process was repeated up the hierarchy: the weighting factor to represent the importance of that level of the hierarchy and to normalize for the row count. As each category was summed, the value was then normalized to assign an overall risk value from one to five.

Service Delivery Risks

The first major risk category examined was the service delivery. The at-risk Youth service would be seen to have failed its mandate if it failed to effectively respond to a youth's needs. Service delivery risk was regarded major importance since it represents the reason for this project.

Service can be compromised by a variety of risks. Failure to respond to a client's needs can happen sporadically, and can become chronic if people, processes, and capacity and so on are not available and/or managed. If such failure was of sufficient frequency and magnitude, the Departments would be regarded as not fulfilling their mandates.

Client Service Provider Relationship

It is important when looking at this element of risk, that it must be measured against what the client is looking for and not what the system is looking for. Therefore, although there is no change to the existing system, the needs of youth based on what they have indicated are not being met. For this reason the status quo marks high risk on the service review.

Capacity Exceedence

If the service provider cannot meet the service demands, then clients seeking service may not receive service. This is most likely to take place if the demand was not defined properly and the relationship between the Drop-In Centre and the Departments did not permit for expansion of the service to compensate. This may result from inexperienced management and Generalists that have difficulty conducting effective triage resulting in problems differentiating between the need for priority help.

Non-Crisis Demand by the Client

Clients are confused about the purpose of the service, and when in need of help do not understand the prioritization. They may expect that they will respond as if they had an immediate need. If the Generalists are unable to correctly execute their roles addressing the most important issues first and they spend most of their time addressing low level information type queries they will be unable to meet the more critical need with significant adverse impact.

Adverse Impact on Client

The more independent the service provider is from the client, the more the service provider is likely to pursue objectives that differ from the needs of the client. Hence, as discussed above the transformation of the mandate of the crisis line to something that does not respond to the client need. For example if there is not ongoing dialogue with the youth to gauge their needs and priorities.

Conflict with Service Delivery to CBDHA

In this circumstance CBDHA might become less responsive to the Drop-in Centre through time as the Centre succeeds in delivery integrated services. When the centre calls for support for a client, and CBDHA cannot respond because of other commitments the Drop-In centre cannot fulfill its mandate.

Job Specific Information Inadequate

If the Generalists did not nave specific knowledge of the social characteristics of youth they would be at a disadvantage in providing the service.

Human Resources Risk

Inadequate Incentives

Management science is rife of examples of successful and unsuccessful employee incentive schemes. Typically incentive schemes involve monetary compensation. Given the unionized environment of Healthcare workers there is little flexibility to use incentives to change behaviour and achieve the desired results. There is less impact on the technology solution as individual contributing to the Social Network community are doing so from their existing jobs.

Management Risk

Inadequate Administration Performance

Not unlike the issue in compensation, these new positions of Generalist and Core Specialist with broad responsibility, have few comparators with the existing service delivery profiles. Option D does not have that same shift, and the contributors to the service retain their job definitions.

Inability to Adapt to Change

The success of transition into the future steady state is dependent on the ability of the staff to adapt to the change. The greater the amount of change on the workforce, the greater the risk of the change process failing. Option B in this case would have the highest risk. Option D would have the least followed by Option C and then A.

Inadequate Management Performance

Various considerations may result in the different business cases exhibiting a greater or lesser risk of inadequate management performance. For example, management that is tied directly to the Regional service providers would use supporting departmental objectives and priorities' in their decision making. As the relationship shifts further away from the department, management performance does not necessarily respect the same parameters. The Technology Virtual Drop-In Centre solution, where there is a community of experts providing support as demand presents itself through social media, may not follow the same Departmental protocols in executing the mandate. This would be considered highest risk. Likewise management decision taking should be looking at holistic care in their pursuit of the best result. Therefore the status quo, which cannot respond to these needs is high risk.

Operations

Inadequate Quality Assurance

Response to client needs may stretch the expertise and capacity of the staff. They may not be able to deliver services in a productive manner as the demand increases – stressing the quality of the resulting support. In some cases, the knowledge level of the Generalist approach may challenge their ability to deliver the intent, and again there is a risk of declining service quality. In Options A through C however there is a quality management

system, and ongoing evaluation of the system through audit, as an integrated solution as part of the solution.

		Option A	Option B	Option C	Option D
	Weight	**Risk**			
Total Service Delivery Risk	1	2.16	2.14	0.8	3.05
Client/Service Provider Relationship					
Capacity Exceedence	.9	3.33	3	1	5
Non-Crisis Demand by the Client	.9	3	3	1	4.67
Adverse Impact on the Client	.5	2	2.33	1.33	5
Conflict with the Service System	.1	2.33	2.33	1	4.67
Job Specific Knowledge Inadequate	.9	4.33	4.33	1	5
Human Resources					
Inadequate Incentives	.1	3.67	3.67	1	4.33
Management					
Inadequate Administration	.5	3.33	2.67	1	4.33
Inability to Adapt to Change	.9	4	4	2.33	4.33
Inadequate Management Perf	.9	3.67	3	2	4.67
Operations					
Inadequate Quality Assurance	.9	2	2.33	1	4

Financial Performance Risk

Risk of Financial Failure

The risk of financial failure increases with inexperience, and distributed cost control centres. Organizations are always under pressure to obtain adequate dollars to operate, looking to government to provide relief. Any portion of an operating budget that depends on fundraising increases the risk.

Inadequate Cost Controls

Cost controls within the public sector are difficult to control as conflicting priorities sometimes shift decisions away from the identified priorities and the annual operating plan. Therefore the technology solution will have less risk as it is less dependent on the shifting priorities.

Cost Implications of Not Providing the Service

The implications result in consequences to primary health care costs, the loss of life or increased burden on the social support system. The status quo provides for the greatest financial risk. Increasing service effectiveness in any way will diminish the risk levels, however these figures will be adjusted based on capacity to meet all the service demands and the ease of access. Option C will have the lowest risk factor.

		Option A	Option B	Option C	Option D
	Weight	**Risk**			
Total Financial Performance Risk	1	2.27	2.53	1.02	2.78
Risk of Financial Failure	.5	4	4.67	1	3.33
Inadequate Cost Controls	.5	3	3.33	1.33	4.33
Implications of Not Providing Service	.9	3.67	4	2	5

Reversibility Risks

If a business case fails to meet its service delivery and financial performance targets (number of clients effectively dealt with per budgeted dollar), the approach would require some correction. Should correction not address the deficiency then the service delivery option would need to be reconsidered. The following categories were evaluated and scored:

Legal Difficulties

Legal difficulties relate to the cancelling of contracts. In delivering the service the Drop-In Centre would have established a service precedence. Given ongoing service obligations, and in some cases lengthy treatment, CBDHA and DCS may be taking increasing legal risk associated with service termination. Any option that involves a contract would be at greater risk than other options (e.g. employment contracts).

Regarding the aspect of liability – services are governed at all times by due diligence of employee selection. Therefore, the risk associated with this is equal across the board with the exception of the status quo (no new employees) and Option C which doesn't "hire" staff specifically for their role. However, transition issues related to reversibility are not considered different between options. The exception to this is Option E where there are no liability issues as there is no "reversibility" due to failure.

Financial Difficulty

These risks will be proportionate to the investment costs. Therefore the highest risks would be directly related to the cost of the solution. In this case Option D would have the lowest risk.

Difficulty in Restoring Processes

The greatest risk will be associated with any option that required the rewriting of business process to accommodate the service delivery. The greater the process complexity the more difficult to restore past practice. Therefore Option D will have no risk, and Option C minimal as processes will be built into the technology. Both other solutions will be highly complex.

		Option A	Option B	Option C	Option D
	Weight	**Risk**			
Total Reversibility Risk	.25	0.47	0.44	0.26	0.16
Legal Difficulty	.5	4.33	4.33	3	1
Financial Difficulty	.5	4	3.33	1.33	1
Difficulty in Restoring Processes	.9	1.67	1.67	1	1

Other Risks

Risk of Adverse Media Attention

Anything to do with the mismanagement of at risk youth is newsworthy in Cape Breton. Not attending to this issue is the highest risk (Option D). Doing nothing is not an option. Every instance of a youth suicide, fatal accident or drug overdose will cause the media to examine what hasn't been done. In this case the most progressive solution would be considered visibly more appealing as long as the service does not deteriorate with implementation.

Risk of Chaos

The probability of occurrence and consequence of chaos increases as the complexity of the change takes place. Chaos effects could include business process confusion, roles and

responsibilities and priorities confusion. Chaos can lead to the breakdown of processes, procedures and controls. Options A and B are the most complex change with B being slightly more difficult.

Impact on All Levels of Services

The greatest risk would be associated with shifts in other service providers funding. Therefore the risk is not to the initiative but to others service organizations that see a re-alignment of resources to pay for the new approach. Therefore the greatest risk is to Option D and then the others will be specifically related to the impact that they make and the costs.

		Option A	Option B	Option C	Option D
	Weight	**Risk**			
Total Other Risks	.5	0.66	0.66	0.38	0.91
Adverse Media Attention	.9	1.67	1.67	1.67	5
Chaos	.5	4.33	4.33	1	1.67
Impact on other service providers	.1	3	3	2.67	1

Summary Findings and Conclusions

The following table represents the Options and Risk Analysis together. The recommended option can be identified from this table. The Transition Cost reflects the cost of moving from the Status Quo option to the other options. The steady state costs are the incremental costs. In this circumstance the Steady State costs do not reflect offsets from the system, but clearly this would be an implementation option and would decrease costs to the option, but would increase the system cost which still continues to provide the existing service. For example transferring a Psychologist into Options A, B or C would result in an increase in workload for Option D. These transfer costs were not considered, but should be viable if there is recognizable value and a clear business case to realign resources to a different service model.

The comparison topics were defined by the CBDHA Mental Health and Addictions Staff.

Risk areas were identified. These were then evaluated by external individuals from the project looking at the models and providing rationale for the risk levels which were ranked numerically. The detail of the risk analysis is contained under the section on Options Analysis.

	Option A	Option B	Option C	Option D
Transition Costs	$245	$45	$103	$0
Steady State Cost (Recurring)	$431	$347	$81	$0
Feasibility	Med	Med	High	High
Effectiveness	High	High	Med	Low
Accessibility	Med	High	High	Low
Best Practice	High	High	High	Low
Engagement	High	High	High	Low
Sustainability	Low	Low	High	High
Total Risk	5.56	5.77	2.46	6.9

Results identified in the summary table which highlights Option D the least effective and lowest cost. The high risk in this option resulted from not changing anything in the system, thereby accepting the current outcome level. Options B and C balance one another with similar risk levels but a difference in cost which establishes Option B as preferred to Option A. Option C is effective, and highly feasible, easy to access, has embedded best practice and is low in risk.

The recommended option is Option C: the Virtual Drop-In Centre. This option addresses all of the needs of the at-risk youth, and while Option B does this as well, the solution represents access 24/7 where other options do not. It is also the lowest cost and risk, other than the status quo which currently does not meet the needs of youth. It was also clear through the interviews that the youth had a high level of comfort in using technology as a service interface.

The technical option represents a solution that use advanced and proven, social media (note that OpenText[30] a Canadian Company has significant experience in this realm and supporting research indicates that social media does in fact result in social change[31] and is being used in the delivery of health services[32]. There are many recent examples – Egypt, the Arab Spring and others which contributed to social change that have yet to be supported with research, and the Mayo clinic is testing the boundaries of patient information in their web based health service delivery). This technical solution would be designed to capture all the elements of best practice, and would facilitate the integration of services and benefits – guided online by case managers. Communities of profession and interest would be brought to the table and made available through Instant Messaging. Assessments (self and managed), Case Management, Forms and evaluation benefit worthiness would happen online. A supporting knowledge repository would round out the services, so that at-risk youth could further understand the challenges they face. In addition, direct access to referral would facilitate the connection between a required professional and the youth – quickly identifying programs that provide the potential for the highest impact, for example identifying best services to meet their needs, availability and locale.

[30] http://www.opentext.com/2/global/global-eim.htm

[31] Machleder, Josh and Asmolov, Gregory, "Social Change and the Russian Network Society", Internews, August 2011

[32] Social Media in Health Care, available at http://www.changefoundation.ca/docs/socialmediatoolkit.pdf

In addition to the opportunity to integrate services through technology, there is value in collecting data for analysis and program improvement on an ongoing basis. Although this could be part of the solution in all of the other options there would be an added cost, whereby the technology solution if developed with evaluation in mind would have this built in.

Essential to the need is to be nimble in responding to the changing needs of the youth. Technology can easily respond and have an immediate impact across the whole service spectrum with a new version release. Although this can happen in all other options there will be a time lag, and people do not easily accept change. That is not to suggest that the benefits change – but rather the services respond.

This approach uses existing resources, and enables additional resource contribution through the internet in delivering services. Granted this will be a change in culture – but it is expected that each of the service providers will see benefits to working in this manner, having access to a wide range of support solutions, such that the value in the changes exceeds the energy to resist change. Not only with the at-risk youth have access to a variety of resources, the generalist Case Manager will also have access to information and expert advice in real time.

Although this option does not itself provide a face-to-face relationship with youth it does compensate with integrating systems and benefits that fit the needs of youth overall. The solution also provides for the face-to-face component through the mentorship program.

In addition to all of the positive attributes for the youth directly, this option also provides a risk management environment that enables the government to test other options, and once the concept of service integration proves its worth, will enable the system to reallocate resource to either option A or B should that be regarded as a viable option.

Ultimately this option addresses:

- The provision of integration of services that directly respond to the specific needs of the youth- as does Option A and B;

- The provision of additional resource (through the internet) that supports the questions and concerns of the youth, leveraging resource communities of expertise that is not limited to Cape Breton (this capacity building is not available in any other option);

- The delivery of services that respect best practices such as: standardized holistic assessments, building partnerships, using mentors, and non-judgmental engagement are examples of what can be built into the system. This solution is the only one that removes the human component and through process will establish best practice processes;

- Easy access to referrals based on a solid triage process, and although this will take place in Option A (constrained by access) and Option B (constrained by scheduled time of service), this is the only solution that enables full and easy access limited only by access to technology; and

- Taking the service to the youth, without limiting location and time which both Option A and B are constrained by.

The limitation of this approach is the personal relationships that do not exist face-to-face. That being said many of the youth are quite comfortable building trusting relationships online. Ultimately, this approach is to initiate dialogue with the youth, engage them by connecting through technology and then shepherding them toward resources and services that are tailored to their specific needs.

Conclusions and Recommendations

The provision of some form of integrated service for at-risk youth will make a significant impact, if the solution is bounded by best practice which includes: youth involvement; standardized holistic assessment of need; the provision of mentors; improves access and times that reflect when youth need the service; and access to basic needs. The recommendation is to start with a Web Based system that fully integrates the processes of programs and services setting the foundation as best practice. To succeed youth must be involved from the outset – and in particular the at-risk youth.

Use the web based experience to understand how to integrate services and processes, engage youth and eventually change the delivery system. This can be accomplished at the technology layer without affecting the system issues of the defined ages of support (e.g. Social Services provides support to age 16 through the Act), the sharing of information and the location of delivery.

The web based system cannot simply be the presentation of information. The design and delivery must be in a form that has a primary objective of establishing an interactive relationship with the youth. It must be broader than one directed service and have a mandate to bring together all the elements that support the growth and development of youth: education, housing, health and justice.

Design the system such that the virtual Drop-In centre becomes the destination point for youth and their communities of support. The focus must remain: (1) to engage youth; (2) to determine their needs through comprehensive assessment; (3) to integrate existing systems and services; and (4) to provide ongoing evaluation of their outcomes. The youth will use the system because it provides value to them specifically, and the communities of service will come because it will enable them to see how their services are contributing to

help these youth. Ultimately, this point of integration will become critical to the ongoing evaluation of youth needs and services.

Reflecting back to the Challenges highlighted earlier in the report under the section titles "Challenges" this solution addresses many of these concerns.

- Engaging youth by including them as part of the solution and recognizing the value of using technology to provide easy and effective access;

- Sharing information which can now be accomplished through the system, and developed as imbedded protocol, being responsive to the limitations of security of information. This has been accomplished in other jurisdictions and has the potential to make a significant difference to the barriers that currently exist;

- Change of service culture is something that takes a generation. This system can be trigger for change, however the culture shift must be managed appropriately. Change will always be resisted and there is some risk that the system will in fact cause any new system/process or approach to fail;

- Sustainability is always a significant issue, however this solution does not call for a wholesale change to the organizational structure that exists. The costs are minimal as it is just the interface that is being changed. Given the solution will embed measurement systems and data to show outcomes, there should be adequate information to demonstrate the value of the best practice concepts being put into place; and finally

- The economy which will see little or no benefit in the short term. That being said there is an argument that success in this model will eventually take youth from the dependent side of the equation to the contributing side – building wealth, paying taxes and providing leadership to others. This option does have an opportunity if it succeeds to impact the cycle of poverty.

Annex A: Discussion Guide

Cape Breton Youth Dialogue

Discussion Guide

The following document is a discussion guide for facilitating an understanding of the needs of youth in Cape Breton. The needs profile is to establish what services are most important for youth and how they might best be delivered.

The discussion is centred around the concept of developmental assets, and this will be cross-referred to a questionnaire and comments by youth linked to high risk behaviour. The questionnaire will be administered on a voluntary basis.

Youth Discussion Guide for Determining Needs

This discussion guide is intended to provide a directed discussion with a group. Group size should typically be 7 (+ or – 3).

Originally, the intention of this discussion was to move the participants through 8 developmental asset areas, seeking first personal experiences and then to capture ideas to address the needs of youth, the priorities and the best methods of delivering services. This approach in the first run was not practical. The time to achieve the result was too long. In addition there was some concern that the questions to initiate dialogue may in fact repress discussion, although this was not the case in the first application of the guide. The approach was altered and is reflected in this document. The principal focus now is based on the experience that youth have had with each of the various services pillars – education, health, social services and justice. The general flow of each facilitated session is to have the group relate the conversation to personal experiences and move the discussion toward what is important and how change could make a difference.

This is meant to be a guide and as such the facilitator is to lead discussion along the road – stimulating dialogue in a certain direction. Usually the order of the dialogue is not important – however starting with the school experience will provide the best initiator in opening up discussion, even for those not in school.

Each facilitated session is to start by describing what will take place and the overall objective of the discussion.

> **Overall Objective: the overall objective of the discussion group is to get an understanding from youth about what they need in life to succeed. How they regard what they have, what is missing and how things could change for the best.**

Once the objective has been described the facilitator MUST indicate to the participants that data will not be tracked to an individual. This information will NOT be gathered. Any individual through the discussion who has concerns regarding their personal situation (e.g. causing anxiety or other mood issues) should be encouraged to meet with the guidance counsellor at the end of the session. Any stories, that are used by the participants discussion for explanation, that would be helpful in the report will be identified at the session for their potential to be beneficial and the individual will be asked for their permission of use. Once again their personal information will NOT be used in the report.

The facilitator is encouraged to start the discussion by describing the subject for discussion, the aim and objective of the discussion, asking the group if they have any questions on the objective and then opening up the discussion. The facilitator may use these topic areas to stimulate discussion, should the group be unresponsive. What is important through this discussion is to capture any stories – because it is the stories that will help in shifting from

the analytical framework to the specific challenges and opportunities. It is the stories that will provide for connecting the ideas in a practical manner.

Although the Asset approach is not being used – there are some useful elements and questions that could help in generating dialogue. That being said – the questions may be too personal in nature and the facilitator must gauge the group appropriately to understand what would best result in open dialogue and not shut it down.

Throughout the discussion there will be opportunity for the group to introduce high risk behavior. It is important to capture this and find out why Youth make these choices. If topics such as drug and alcohol use, or gambling for example are not brought up – they should be introduced. This is of course dependent on the group dynamics.

General Tombstone Information of Group

1. Numbers in the group.
2. Ages of each.
3. Gender – number of males, number of females.
4. Grade level of each.
5. If not in school – highest level of education achieved.

NOTE: Individual names are NOT to be taken.

Discussion Guide

Start with the purpose of the discussion. It is good to start by acknowledging that the system is failing youth, and that because of this the challenges that they face are becoming more and more difficult to overcome. Acknowledge the growing complexity of issues that youth are dealing with, and that the system of services needed to be looked at more closely – and this is why they are participating. Explain that the discussion is to learn from them so that they can help to initiate change.

Each session should start with school experience. For most youth at risk this area is easiest to initiate clarity of their experience with the system and services.

School

1. Tell me what you think about school?

2. Based on those experiences do you feel like school is preparing you for your future? How do you see school contributing to opportunity?

3. Has anyone experienced depression or anxiety – feelings that they can't seem to handle? How do you deal with these?

4. Drawing from the discussion – ask about the services that are available, if they use them (or not) and why?

5. Move the discussion to how things could be different in the school to help?

Health

1. The discussion on needs in the school will open up questions of Youth health – certainly for those in school there is an easy transition using the school health centres. Find out if these services are used? And why.

2. If discussion on drug use (or alcohol) is introduced – initiate dialogue on: their choices, how they looked for support from the system and how successful the system was in supporting recovery. Look for successes, and look for failures.

3. Open up the discussion on Youth health perceptions, needs. Ask them what is most important to them.

4. Introduce the concept of ages and access and get their input.

Social Services

1. Using the discussion on age and access to services – ask them about access to social services. What is important here is to determine what they believe the role of social services is, and what they see as working? Or not working? And why?

2. Initiate discussion around changing "the cycle" – and how this might be done? Focusing around what is important to them and why.

3. Watch for the discussion around family – for example their futures being predicted by the reputation of their families. Also – be sensitive to issues related to family and family supports. Remark on any reference to family dysfunction.

Justice

1. Depending on the groups experience with Justice – ask about justice as a service, what they expect and how this could be different.

Now move the discussion toward the "ideal" service centre – what would they see? Use the Australian model of Head Space to initiate this discussion, and then broaden it to include all services. Ask them to identify what is most important to them, and the characteristics of a

centre that they would like to see. Initiate the discussion on age and service access. Ask them about who they would like to see in the centre – and why.

Wrap up by asking some questions regarding use of technology – the internet, smart phones and face book. Ask about the use of the internet as a resource to addressing their needs in other areas, how much they count on it, and if they would use it as a resource to help solve problems. Spark discussion around security, and their feelings about sharing confidential information in web based environment.

Annex B: Best Practice Detail

Homelessness

Cape Breton is subjected to a unique form of homelessness – characterized by a rural condition. It is perceived that there are a large number of youth who do not live with their parents – or have their own place of personal residence. Couch surfing and transient living with relatives and friends are the norm in this community – and for the sake of identifying characteristics that cause this issue we are using the urban model.

Numbers of homeless youth are extremely difficult to estimate, as is the case with any transient and ill-defined population. Estimates for Canada are as high as 65,000 (Gordon Laird - 2007). This number only evaluates homelessness through statistical capture of youth entering some form of shelter. What we do know however is that the characteristics of these youth are that they are troubled, often consisting of disrupted home environments, extreme family conflicts, psychological, physical and sexual abuse, and neglect. These negative home experiences are associated with a host of other problems. Poor performance in school and conflict with teachers is common, and many report a history of conduct problems and depression. The results of these experiences for most street youth is a life on the street, either as runaways, or having been thrown out as is the case with an estimated one-fifth to one-half of street youth. In addition, there are a high number of these youth who migrate to large urban centres (40% to 50% of urban homeless youth are from rural regions of the country – TYPS 2006)

Prevention programs are the first line of defence against homelessness, targeting youth in grades 5-8 and teaching them about services, supportive adults they can trust to help them, location of shelters and their legal rights.

Causes of youth homelessness cites family breakdown, a lack of affordable housing and increasing poverty as major factors contributing to the problem. Characteristics of homeless youth include:

- Disrupted home environments
- Extreme family conflicts
- Psychological, physical, emotional and sexual abuse, and neglect (sexual abuse and neglect have been found to be particularly linked to runaways)
- High rates of substance abuse among their parents
- Families are often on social assistance
- Witness higher levels of marital discord
- Witness domestic violence

- Frequent household moves and changes of school
- Poor performance in school
- Conflicts with teachers
- History of conduct problems
- Involved in gang activity
- Higher percentages of white male youth live on the streets

Once homeless, reaching these youth as early as possible is critica, as they usually have multiple health problems which are exacerbated by cold, hunger and the high-risk behaviours they participate in to survive. In assessing these youths' needs, it is crucial to find the underlying reasons for drug and alcohol misuse, mental health issues and their reasons for leaving home. Well-trained and multi-disciplinary staff who work from a strength approach rather than dwelling on pathology, are essential as well as a developed network of community resources in areas such as medical, legal and recreational services.

Negotiating the best care situations for these youth is likely to include keeping them in the same community and being in contact with friends and family. Reunification is also an ideal situation if intensive family intervention works in providing a safe and secure environment for youth. However, researchers warn to be very cautious about this possibility, as up to 70% of these youth have been victims of physical or sexual abuse (Kurtz et al. 2000). If returning to legal guardians is not an option, finding an appropriate transition or independent living program without rigid rules and with good foster parenting/supervisory practices will provide these youth with appropriate support and guidance. These comprehensive interventions must be replaced with comprehensive aftercare involving regular re-assessment, and further intervention to prevent youth from returning to a destructive lifestyle.

Previously homeless youth who have become successful adults advise professionals looking after runaway and homeless youth not to feel sorry for them and not to show favouritism, but to develop personal relationships, put themselves in the youth's shoes, and to be trustworthy and listen to them.

Lack of job readiness, education or experience also contributes to youth homelessness. The vast majority of homeless youth have not completed high school. Increasing poverty is also a significant cause of youth homelessness, as is the poor economy in Cape Breton. Youth experiencing economic pressure are tending to move to urban centres. When they arrive in these cities, youth often find themselves without resources and can easily become homeless. So in fact we can rightly say that the urban youth homeless issue has a fundamental link to rural issues.

The following table reflects best practice:

Area of Practice	Characteristic
Assessment and Screening	Readiness of youth to receive help and their perception of staff as trustworthy Medical needs in order to implement interventions and prevention as early as possible Drug use and determining the underlying causes for substance misuse as this differs greatly depending on the youth. Researchers caution that too heavy a focus on drug use alone is ineffective and that drug use is likely a symptom of other problems that need to be addressed just as urgently Mental health problems i.e. suicidality (has been found to be a major problem among disenfranchised youth with suicide attempt rates between 20 and 40%), depression, and histories of maltreatment and abuse Reasons for running away or leaving home to determine if reunification with family is in the youth's best interest – however careful assessment must be undertaken as to the suitability of family members or other guardians as caretakers Assessment of youth's social networks is important (i.e. assess whether or not to break ties with peer groups or is some peer support a potential benefit and a necessary part of helping youth It is crucial to find the underlying reasons for drug and alcohol misuse, mental health issues and their reasons for leaving home
Basic Needs	The basic needs of the youth must be dealt with prior to job development or training – needs such as security, accommodation, food and health services.
Community of Origin	Keeping youth in their community from which they came in order to stay connected with friends and family who often remain critical players for youth after they have left home
Targeted Prevention	Using the school system for ages 12 to 15 to provide for alternatives and resources

Area of Practice	Characteristic
Integration of Services and Programs	Coordinating services among providers and interagency cooperation is essential
Case Management	There is strong support to indicate that case management approaches are effective for helping homeless youth with mental health issues into needed services and, more importantly, into stable housing

Outreach

The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased services. Many of the youth that outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services, have had negative experiences with service-providers, and have been victims of violence.

Canadian research on youth at risk indicates that the vast majority of them are in some manner (physically or socially) disconnected from their families. Typical reasons for this separation are because of circumstances in the home such as conflict, neglect, or abuse. What is important to note through the research is that early intervention (e.g. in the first two weeks after separation) provides the highest success in reconnecting youth with their families - perhaps due to fearfulness and uncertainty that they can cope with the circumstances of life without their parents. Mobile outreach activities are therefore a vital aspect of service provision to this population.

Outreach is the initial and most critical step in connecting, or reconnecting youth to needed health care, mental health, recovery, and social welfare. Outreach is primarily directed toward finding youth who might not use services due to lack of awareness or active avoidance. Outreach focuses on establishing rapport and eventually engaging youth in the services they need and will accept. Outreach programs attempt to engage homeless youth who are not served or underserved by existing agencies. This distinction is significant because the outreach model was developed to meet the large service gap found among this population.

They may be highly vulnerable and considered "difficult to serve" often because they are estranged from family and unable to trust traditional adult service providers.

When youth are disengaged from family they quickly start forming strong relationships with other youth who become replacements for their families. Given their lack of trust of adults and the system that already has failed many of them, youth at risk are likely to take advantage of services that are short term in nature. For example, youth access health care clinics more than other types of services because this requires less change in their immediate circumstances and keeping more control over their live. Services need to be client centred as youth need to feel in control and in many cases know best what their needs are. Over time as a relationship of trust builds with the outreach workers, these youth will be more receptive to intermediary services, and then can be slowly moved into longer-term services.

Engagement then, is the key to outreach. Utilizing a sensitive and positive approach to building a relationship with these youth is essential, this includes providing incentives and recreational activities to initiate a connection and being humble, honest, caring i.e., remembering past discussions, and perhaps willing to share personal information that these youth can relate to.

Identifying the needs of different youth subcultures and other pertinent characteristics of the youth at risk community is not only important for successful engagement but also for informing program design. Developing youth subculture specific activities and promotional/educational material has enhanced youth participation and adherence to youth services.

Outreach workers are essential in this process and certain characteristics have been identified which enhances the relationship building so essential for successful access to youth services. Characteristics include being creative, non-judgmental, flexible, realistic expectations, commitment, cultural competency, team player and having good judgment and street sense.

The use of peer outreach workers in combination with adult support and supervision to conduct outreach to youth has proven to be a successful intervention. This involves matching peers to the characteristics, values, and norms of the different youth at risk sub-cultural groups (e.g., hiring youth who can serve as positive role models, who are or were at risk themselves).

This model of outreach has proven to be effective for changing peer norms and encouraging youth to seek services, promoting preventive behaviors, and discouraging risky behaviors. Also, there are benefits to the peer outreach workers that include increased self-esteem and development of life skills.

Outreach programs should actively seek out the expertise of peers and youth at risk because they can contribute significantly in the development of program design, implementation, and evaluation. Numerous studies have demonstrated that many of these

youth at risk have the expertise, skills, and insight that professionals who have never experienced the contemporary issues facing youth today, lack.

This argues for enhanced street outreach through which staff can build the trust of young people, offer intermediary services, and then slowly move them into longer term services. Cooperation between law enforcement agencies and runaway and homeless youth centers enables police officers to utilize outreach workers to mediate between family and youth or to place youth out of the home into safe accommodation. Building trust and respect for each other's roles with youth is key to making this work. Developing resources to help police staff understand youth's issues and conversely, educating social workers on the role of police officers has worked very well.

Area of Practice	Characteristic
Engaging Youth	Engaging youth is the most critical aspect of outreach and this is best accomplished by: • Identifying and defining subgroups within the youth population • Using incentives • Providing recreational activities as a recruitment strategy and initial connection • Building the trust of youth is critical for them to eventually become receptive to intermediary services, and then slowly, longer-term services • Using peer outreach workers who were once at risk themselves to provide positive role models and provide support to these youth Providing client-centered services also enables youth to feel in control while identifying what they feel is their most pressing needs Providing services that are short term in nature and non structured. Given their lack of trust of adults and the system that already has failed many of them, these youth are likely to take advantage of services that are short term in nature
Peer Outreach Workers	Using peer outreach workers (in combination with adult support and supervision) to match peers and youth who possess the same characteristics, values, and norms results in the following: • Changes in peer norms • Encouragement to seek services • Promotion of preventive behaviors

Area of Practice	Characteristic
	• Discouragement of risky behaviors • Increased self-esteem and development of life skills for peer outreach workers Seeking the expertise of peers/formerly homeless and street youth to contribute in the development of program design, implementation, and evaluation as these youth have specialized expertise, skills, and insight that are invaluable
Early Intervention	Providing intervention as soon as possible after youth have disengaged from their families is critical because youth befriend peers who replace their families resulting in higher prevalence of criminal behavior and drug use making it harder for them to return home as time progresses
Community Partnerships	Form partnerships/linkages among youth serving agencies, in particular with medical outreach services, i.e., providing easy access to short term health care clinics allows these youth to seek and receive medical help while keeping control over their lives Integrate with existing youth services programs i.e. basic needs of food, shelter and clothing, youth centers, medical services, STD testing or treatment, drug treatment, Employment making it easier for the youth to access the multiplicity of services they require to address their needs
Follow-up	Providing short term follow-up with respect to immediate tasks at hand and long term follow-up to ensure the youth's situation remains in stable
Hiring and Training of Staff	Hiring outreach workers who possess the following characteristics: sensitive, honest, humble and caring Educating and training of outreach workers in ways that support effective engagement of youth: creative, non-judgmental, flexible, realistic expectations, commitment, cultural competency, team player and good judgment and street sense
Assessment	Providing a basic triage assessment to help identify and

Area of Practice	Characteristic
	respond to potential life threatening problems Conducting an assessment of youth's comprehensive, holistic needs before providing services and linkages to meet these needs through an informal process over a period of time as the relationship builds
Cooperation with Law Enforcement	Increasing cooperation between law enforcement and youth services, for example: • Increasing communication between • Improving collaboration, referrals, and services in at-risk circumstances and their families • Reducing unnecessary adjudication and incarceration of these youth Collaboratively developing resources, for example: • Educational videos depicting effective ways for law enforcement agencies to work with runaway and homeless youth • Training curriculum to help youth service providers understand law enforcements role in dealing with runaway and homeless youth • Sponsor training sessions to help social workers understand law enforcement procedures for handling status offenders • Runaway prevention curriculum for students (grade 6 to 8) letting youth know their alternatives • Resource card with telephone numbers for community resources and informing youth of their rights • Radio enabling youth service workers to monitor police calls and intervene when youth were involved

Independent Living

Adolescents aging out of the child welfare system are particularly vulnerable to poor health, under education, unemployment, and homelessness. Most graduates need help in making transition from a dependency status to self-directed community living. At a minimum, transitional assistance includes help in finding a place to live, getting a job, maintaining employment, gaining access to health/dental care, and budgeting and managing money. The majority of youth who emancipate from the system and who are expected to assume responsibility for their lives require tangible assistance.

The tasks required of youth transitioning from the family (regardless of definition) care to independent living are ominous, for all. For youth at risk these include: daily living skills, maintaining a residence; home management; shopping; money management; utilization of community services; utilization of leisure time; and personal care, hygiene, and safety; personal decision making and communication skills; evaluating personal educational needs; planning for a job or career; securing and maintaining employment; securing a residence; and planning for health care needs.

There are numerous stressors that youth at risk transitioning from dependence to independence are likely to be dealing with, namely, long-standing historical stressors (e.g., dealing with the pain of loss or maltreatment), maturational development, the transition out of care/custody (and all the transitions associated with it), and normal (e.g., arguments with friends, transportation problems) or individually unique stressors (e.g. sexual orientation). In addition, these youth encounter many problems which include: difficulty learning and thus graduating from high school, trouble accessing health care, problems finding a job which pays enough to support them, this leads to difficulty finding housing food and clothing, involvement in alcohol and drug misuse and often eventually, being apprehended by the law.

Independent Living programs do have a positive effect on the outcomes of these youth and can be separated into the following life skills, education, and employment training components: assisting youth in identifying a mentor, relative, or staff member who can provide on-going support; assisting youth in establishing/re-establishing or working through redefining their relationships with family; operationalizing a youth development philosophy in agencies and programs; providing greater focus on vocational training, computer training and driver's education; providing youth who are struggling educationally and who do not plan to pursue post-secondary education with the educational support necessary to complete a high school degree or GED; completing and reviewing life skill assessments with youth; and providing "real world" opportunities for youth to practice life skills.

In addition, researchers suggest that social opportunities and social policy can play a key role in supporting or inhibiting successful transition. They suggest longer and more flexible periods of support are needed as well as concrete assistance in attaining important ends such as college education and stable housing. The body of evidence points to the importance of parental support financially and emotionally.

Youth made it very clear that one of the most important things to them prior to during transition to independence is that they have a relationship with a caring person that they can rely on. The importance of a few caring adults in these youths' lives at this time cannot be overstated. The support these youth need is monetary, emotional and social and can come from, immediate and extended family members, foster families, mentors, and the many staff encountered.

Area of Practice	Characteristic
Nurturing Connections	Assisting youth in identifying a mentor, relative, or staff member who can provide on-going support Assisting youth in establishing/re-establishing or working through redefining their relationships with family Exploring resources of families and relatives for all youth in cases where reunification is no longer considered a case goal, for example: • Living with family or extended family upon discharge • Monthly contact with family and relatives • Families providing emotional support, advising youth on problems, giving them monetary support
Supporting Education Achievement	Providing youth who are struggling educationally and who do not plan to pursue postsecondary education with the educational support necessary to complete a high school Diploma Identifying home environments and transitional apartments with independent living which typically results in higher educational achievement Programs that promote educational stability and approach education in a comprehensive, integrated manner are most likely to promote the completion of high school and encourage enrollment in post-secondary education
Life Skills Training	Providing training in the following: • Daily living skills, including maintaining a residence; home management; shopping; money management; banking; utilization of community services; utilization of leisure time; and personal care, hygiene, and safety • Personal decision-making and communication skills • Evaluating personal educational needs • Planning for a job or career • Securing and maintaining employment • Securing a residence • Planning for health care needs • Building a positive self-image and self-esteem Training programs should provide real-world practice experiences where youth have the opportunity to internalize and personalize what they have learned about a skill and

Area of Practice	Characteristic
	feel confident in the ability to use this skill in the future
Employment Training	Assisting youth to change mentality, attitude or outlook on life is a critical element in becoming continually employed and participating in the following activities brings about this change: • Activities that engage and expose young adults with successful role models • Activities that build self-confidence and self-esteem • Activities that teach interpersonal and communication skills • Activities in which young adults feel support and genuine concern • Activities that help young adults realize their educational objectives • Activities that allow young adults to be of service in the larger community
Peer Support	Reducing the sense of isolation and the stigma of being in out-of-home care by providing opportunities for youth in independent living programs to meet other young people in similar situations through such activities as seminars, camps, conferences, reunions
Mentorship	Mentorship programs link youth with an adult who understands their needs and models positive life skills. Different mentorship programs include: • Transitional life-skills mentor is the most common and provides social support, friendship and a role model in making the transition to independent living • Cultural-empowerment mentors are from the same cultural or ethnic group as • the youth • Corporate-business mentors come from the business community and provide jobs, monitor work experience, and offer career development to youth who are motivated to participate • Mentors for young mothers are experienced mothers matched with a young pregnant female • Mentor homes model involves four to six adolescents placed with an adult mentor who guides youth in relation to education, employment, community services and so on

Youth Family Mediation Re-unification

Preservation of the family, which may involve rebuilding family connections, provides the necessary supports to help high-risk youth avoid risk behaviors and delinquency. The research empirically supports reunification of youth with their families after they have run away from home, or been thrown out. Youth who returned to their parental homes after being homeless reported more positive outcomes in school, employment, self-esteem, criminal behavior, and family relationships than adolescents discharged to other locations. Similarly, other research has demonstrated that youth who failed to reunify with their families had longer shelter stays, increased hopelessness, and suicidal thoughts and behaviors; reported more family problems; and had a more pessimistic view of the future than those who returned to their families.

The reported incidence of serious parent-adolescent conflict may be as high as 15-20% and the research shows that elevated levels of conflict and negative family communication have been associated with a number of adolescent problem behaviors including drug use, higher rates of school drop-out, running away from home, suicide, and delinquency. High degrees of parent conflict also have been associated with adolescents who have conduct disorder, oppositional defiance disorder and attention deficit/hyperactivity disorder.

Providing intervention family-based services to get youth back with the family as soon as possible is key, however, the first and most difficult task facing family support workers is recruiting and engaging high-risk parents. Reasons for this may include poverty and substance abuse. Family poverty leads to youth violence and delinquency and successful mobilization of outside resources to meet the family's identified priorities helps to overcome the family's hopelessness, resistance, and distrust of professional helpers.

Other factors affecting high-risk youth delinquency and involvement in risk behaviors is lack of supervision and monitoring which appears to be particularly salient as a cause of violent offences. Violent crimes peak just after the close of school at about 3:00 p.m. suggesting lack of parental supervision and latch key status. The Carnegie Council on Adolescent Development (1994) study found that about 40 percent of adolescent's non-sleeping time is spent alone, with peers without adult supervision, or with adults who might negatively influence their behavior.

There are a myriad of intervention and youth/family mediation programs offered in many communities, however, high-risk families also need community agencies to collaborate resources and create partnerships so their needs can be addressed more easily. Families need to be dealt with respectfully and non-punitively as well as given concrete actions to work on improving their communication and interaction skills. In addition, specially trained

family support workers are needed to recruit high-risk parents into accessing these services and a significant amount of time as well as incentives need to be utilized for recruiting and engaging high-risk parents.

There are also peer mediation programs at school to help reduce conflict for high-risk youth and gain confidence and self esteem in the peer mediators themselves.

The findings suggest that family-based intervention and mediation services are having a positive impact on high-risk families and ultimately keeping high-risk youth in the home or in contact with family to support them through this transitional period to independence.

That being said – if the family are themselves at risk, with limited ability to address these risks (such as parents who have issues with substance abuse) the re-unification value is much more tenuous. In addition, testing the evaluation of the families circumstances must be a priority before re-engaging the family as part of the intervention.

Area of Practice	Characteristic
Recruitment of Parents	Many programs establish affiliation with local schools to anchor outreach and recruitment facilitating access to populations by providing (a) information for contacting families (phone numbers and mailing addresses), (b) direct referrals of some children exhibiting academic and behavior problems, and (c) an initial level credibility with most parents Maintaining close working ties with local community leaders and organizations offers a higher degree of community visibility and acceptability Featuring culturally congruent interventions and employing staff with ties to the community increases acceptability by parents Employing former participants and other parents to advocate for the program Providing specialized training to staff regarding recruitment of parents and devoting a significant portion of time to this arduous task is necessary Providing participation incentives and provision of funds to counteract barriers to participation (e.g., transportation fees, on-site child care) are indispensable catalysts for reliable participation

Area of Practice	Characteristic
	Developing caseworker and agency behaviors which build a working relationship with parents by communicating in a non-punitive and supportive manner through clear and concrete behaviors between the caseworker and client, such as: setting of mutually satisfactory goals, providing services that clients find helpful, focusing on client skills rather than insights, and spending sufficient time with clients to demonstrate skills and provide necessary resources
Multi Dimension Family Prevention Model	Positive modality for preventing anti-social behavior in youth. It combines the advantages of standard prevention models with those of psychosocial treatment models. Implemented in the family's home the intervention works to create a resilient family environment.
Functional Family Therapy	Functional Family Therapy (FFT) is an outcome driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviours and related syndromes.
Asset Building	Building external and internal assets assists youth as follows: External Assets (relationships and opportunities provided to youth) • Support (e.g., care and communication provided by parents and other family members) • Empowerment (e.g., youth given useful roles; feel safe and valued) • Boundaries and expectations (e.g., parental monitoring and discipline; parents and teachers set high expectations) • Constructive use of time (e.g., family influence on after-school activities and religious involvement) Internal Assets (values and skills developed by youth) • Commitment to learning (e.g., doing homework and being motivated to achieve); • Positive values (e.g., helping others and delaying sexual activity) • Social competencies (e.g., planning and decision-making skills) • Positive identity (e.g., personal power; sense of purpose)

Area of Practice	Characteristic
Community Partnership and Collaboration	Creating stronger partnerships with youth development organizations that have as their focus not just preventing problems and risky behaviors, but promoting positive youth development by building youths' developmental assets, i.e., the YMCA, for example, is a traditional youth-serving organization that recently adopted programming accountability by more intentionally focusing on building youths' assets Implementing Search Institute's "Healthy Communities Healthy Youth" initiative. Over 200 communities across the country are now involved. This initiative seeks to motivate and equip communities to nurture competent, caring, and responsible children and adolescents by helping individuals and organizations to collaborate across sectors and take both formal and informal (personal) actions to build youths' and communities' assets

School-Based Services

Parent/teen conflict and academic failure are some of the problems youth face that can escalate into risk behaviors, delinquency and dropping out of school. Conflict at home due to poverty, parental substance misuse, abuse or miscommunication can trigger high risk youth into risk behaviors, dropping out of school, or running away and ending up on the streets. The middle school years are perhaps the last vantage point for intervening in the school, as in high school, many high risk youth will be expelled or drop out of the public school environment, and therefore, will be much less accessible.

Characteristics of High-Risk Children/Youth - High-risk youth heavily involved in behaviors that have potentially damaging consequences share many common characteristics. These often include: early "acting out"; evidence of an absence of nurturing parents; having been a victim of child abuse; disengagement from school; involvement with a negative peer group; depression; residence in disadvantaged neighborhoods; and little exposure to the work world. These youth come from high-risk families who ideally need intervention services in elementary years if risk antecedents are severe (before antisocial, aggressive behavior crystallize at age eight).

Recruiting High-Risk Parents Within the School Context - Recruiting parents of these children/youth is crucial and often the most difficult aspect of assisting these youth and their families. Researchers believe providing a multilevel family centered prevention program within the school context works best in order to reach high risk parents and

provide them with the services they need. Multilevel refers to types of program interventions offered, these are: universal programs available for all students and families, selected programs which are general targeted programs for students and families identified or seeking help; and indicated family interventions specifically designed for children/youth and their families identified as at-risk.

Global and Targeted Prevention Programs - Global and targeted prevention interventions directed at risk and protection factors (rather than problem behavior), and targeted at middle school (grades 5-7), have proven effective if they involve some experiential components and are not simply knowledge-based. Screening to identify at-risk families is also effective if multilevel intervention services are available, especially, which link teachers, parents and children/youth. Programs using performance training methods work best e.g., videos, live modeling, role-playing, practice sessions. For those youth who miss intervention services at the middle school level, School-Linked Health Centers provide a venue and access point. Involvement of a caring adult and being able to ensure privacy regarding health issues are at the core of ensuring high-risk youth participate in interventions and services available. Once this is established, multiyear programs and coordinated, collaborative strategies are required in each community.

Improving Parenting Practice - early adolescence is an optimal developmental vantage point for targeting parenting practices to reduce adolescent problem behavior. Researchers point that antisocial behavior in childhood appears to provide a basis for accumulative risk associated with peer rejection, poor academic skills and eventual involvement in a deviant peer group. They feel that, given the right support, parents can have a major role in preventing their child from engaging in high-risk activities. Parent supervision in particular, may youth from escalating patterns of problem behavior in high-risk neighborhoods. It was also found that parenting practices can serve a protective function within a disrupted community.

Improving School Success - Research shows that in providing early intervention to potential at risk, and at-risk, students in elementary and junior high school, the most key element to success in school at all ages is care, concern and advocacy by a supportive adult. Attachment and identification with a meaningful adult motivates or reinforces a child's desire to learn, resulting in improved academic performance and increased attendance. It was found that pulling students out of class was not effective but integrated classroom support or coordinating separate studies with regular classroom was most successful. Research has pointed to the risk of kids dropping out was four times higher for a student held back a year. Researchers suggested academic tutoring is a key activity that helps keep kids in school: keeping students engaged in school; developing or finding community partnerships; involving parents; using better tracking management information systems. They also found that external incentives work at all ages, elementary it was help in homework, middle school it was counselling, high school it was paid work. Offering

multiple coordinated services worked best. For example vocational educational components worked well to engage students and leads to improvement of overall performance.

School-Linked Health Centers - School Linked Health Centers (SLHCs) provide easy access to adolescents in school and are also able to reach dropouts, homeless, runaway youth, those in detention centers, shelters and other social service programs. SLHCs are free to determine services offered based on needs of the adolescents within their population without being affected by school control which is often restrictive, e.g., regarding sexual health. Research shows that adolescents underuse the healthcare system, the major reason being that they fear others learning of their health issues. A second major reason for avoiding health services is a problem with being able to access these services. In order to better meet adolescent health service needs many communities have established school based and school-linked health centers (SLHC) giving adolescents an entry point into the health care system and gaining their trust through assured confidentiality.

Area of Practice	Characteristic
Prevention Requires Early Intervention	Screening for antisocial and/or aggressive behavior in children/youth (ideally before age eight when this behavior crystallizes), which can be caused by: an absence of nurturing parents; having been a victim of child abuse; disengagement from school; involvement with a negative peer group; depression; residence in disadvantaged neighborhoods. These youth come from high-risk families who ideally need intervention services in elementary years if risk antecedents are severe Intervening in the lives of youth before problems start, or when they are in their early phases, may help alter their life trajectories toward success
Prevention Models	Short-term preventive interventions produce time-limited benefits, at best, with at risk groups whereas multi-year programs are more likely to foster enduring benefits Developing programs which are developmentally focused and take a skill enhancing perspective Developing program content which is broad-based and includes cognitive, behavioral, and affective components Utilizing programs which use performance training methods, e.g., videos, live modeling, role-playing practice exercise, weekly home practice sessions in an experiential manner so

Area of Practice	Characteristic
	that adolescents are able to address developmental and social norms and social reinforcement by using skills necessary to assess risk and avoid/resist the behaviors Beginning prevention programs in grade 6 or 7 works best, with booster programs in one year Providing ongoing intervention starting in the preschool and early elementary years may be necessary for children with serious conduct problems who may be more resistant to treatment Providing a coordinated set of programs targeting multiple negative outcomes is possible through preventive interventions directed at risk and protective factors rather than at categorical problem behaviors Providing a package of coordinated, collaborative strategies and programs is required in each community as there is no single program component that can prevent multiple high-risk behaviors, and for school-aged children, the school ecology should be a central focus of intervention
Services Linking Child/Youth, Families and School	Screening to identify at-risk families is effective if multilevel intervention services are available, especially which link teachers, parents and children/youth Incorporating a multi level family centred prevention program within a school context is essential to reach high risk parents Ensuring program length is greater than 20 hours for children and families at elevated risk of developing problems Developing prevention programs which educate the child and also instil positive changes across both the school and home environments, improves the child's behavior, as well as the teacher's and family's behavior, building a better relationship between the home and school Ensuring prevention programs focus on parents and teachers strengths Utilizing programs which use performance training methods, e.g., videos, live modeling, role-playing practice exercise, weekly home practice sessions

Area of Practice	Characteristic
	Ensuring children/youth have the care, concern and advocacy of a supportive adult increases their desire to learn and improves their academic performance, as well as increases attendance Utilizing programs which are sensitive to barriers of low socio-economic families and are culturally sensitive
Preventing Dropping Out of School	Integrating classroom support or coordinating separate studies with regular classroom is much more successful than pulling students out of class Tutoring at-risk students is much preferable to making them repeat a year as they are four times more likely to drop out of school if they are held back from same age youth Keeping students engaged in school through the use of external incentives works at all ages: elementary aged children received help in homework; middle school youth received counselling; high school youth preferred paid work Developing or finding community partnerships, involving parents, and using better tracking management information systems all assist in preventing these at-risk youth from dropping out Offering multiple coordinated services worked best Engaging students through vocational educational components leads to improvement of overall performance
Linking to Community Services	Integrating prevention programs with other community care systems of treatment helps create sustainability for prevention Developing School-Linked Health Centers (SLHCs) provides access to adolescents both in and out of the school system and programming on issues not allowed within the school system, such as sexual health Utilizing programs which emphasize the clinical skills of the intervention staff

Youth Mentoring

Since the growth of mentoring programs for high-risk youth began in the early 1980s, a number of studies have been conducted to determine the benefits for youth. As a result, the field has gradually built a body of evidence confirming that mentoring can have many positive benefits. Mentorship programs have been found to have a positive influence, especially where youth are matched with mentors who have experienced similar issues and have a genuine respect and affection for youth.

The Big Brothers/Big Sisters mentoring program evaluation (Tierney and Grossman,1995) provides the most conclusive and wide-ranging evidence that one-on-one mentoring alone can make a difference in the lives of youth. Little Brothers and Little Sisters were 46 percent less likely than their control group counterparts to initiate drug use and 27 percent less likely to initiate alcohol use during the study period. They were less likely to hit someone and skipped only half as many days of school as did control youth. These youth felt more competent about their ability to do well in school and received slightly higher grades by the end of the study.

One of the strongest conclusions that can be drawn from the research on mentoring is the importance of providing mentors with support in their efforts to build trust and develop a positive relationship with youth. Volunteers and youth cannot be simply matched and left to their own devices; programs need to provide an infrastructure that fosters the development of effective relationships (Sipe, 1996).

Commonalities of Youth and Mentors

Studies of mentoring programs for high-risk youth have concluded that the most successful mentors are those who grew up in the same way as the youth, often coming from the same neighborhood, who have been involved in the same behavior these youth are involved in or contemplating becoming involved in, who have made a successful transition away from risk behavior and perhaps making positive life choices, and are able to talk to them in their own language.

Mentorship Programs for Specific Groups of Youth

Mentorship programs can be tailored to meet the needs of specific groups of high-risk youth and many examples of such programs are outlined in detail in the next section called 'Review of Literature for Youth and Peer Mentoring'. Some examples of specific mentoring programs are:

- Transitional life skills which gradually teach the skills needed to adapt from foster care to living independently

- Cultural empowerment taught by successful citizens of racial minorities to youth from the same culture
- Corporate/business training to provide youth with employable skills
- Parenting skills provided by competent mothers to teen moms
- Live-in adult students demonstrating good study ethics and a balanced lifestyle of work, care of home and positive recreation
- Gang member prevention given by previous gang members to keep youth from crime and delinquency; youth in residential correctional facilities shown alternative lifestyles to crime and delinquency by adults who also found themselves in the justice system as youth
- Elderly mentors providing care and attention to youth because they have the time and they once were disenfranchised like the youth they are helping; gay lesbian who provide empathy and support for youth who are dealing with their homosexual or bisexual orientation

Outcomes of Mentoring Programs
Research shows there are many benefits to adult mentoring programs and these include:

- Increase in employment
- Greater academic achievement
- Improved attendance
- Staying away from alcohol and drugs
- Avoiding fights
- Getting along with family
- Not using knives or guns
- Staying away from gangs
- Avoiding friends who start trouble
- Increase in school involvement
- Decrease in gang membership, arrests and violence related injuries
- Enhancement in youth's knowledge and refusal skills regarding alcohol, tobacco and
- other drugs
- Increase of youth's sense of self worth and feelings of well-being and reduction in feelings of sadness and loneliness

Not all the mentorship programs experienced significant improvements in adolescent behavior, for instance, the peer teen outreach for youth on the street to become aware of HIV/AIDS prevention did not significantly change the high-risk sexual behavior of the at-risk youth, even after learning about the risks and protective factors.

Mentors Provide a Caring Adult for High-Risk Youth
A recurring theme throughout the research with high-risk youth is the importance of being able to rely on a caring adult in their lives. When interviewed about the type of mentor characteristics which matter the most, youth reiterated that mentors who have a genuine

caring for and enjoy being with youth make more of an impact than those who feel a sense of responsibility but cannot relate well to this age group.

Considerations for Successful Mentorship Programs

Providing orientations for both youth and the mentors prior to the matchmaking process helps avoid misconceptions and shows them how to make the most of the experience. Time needed to spend together can vary from occasional meetings to present middle-class role models to youth, to a minimum of one interaction per week for at least a few hours in order to establish a significant relationship between the mentor and youth. Finding the right task that interest both parties is key to developing a good rapport and environment that is comfortable. Programs should also include time for the mentors to get together to provide each other with emotional support, share experiences, and develop solutions to common difficulties.

Area of Practice	Characteristic
Program Design	Types of mentorship programs fall into one of five categories: **1.** *Transitional life skills mentors* - 80% of programs use this model which is open to recruitment of mentors irrespective of age, sex religion, race or socioeconomic status and matching is done by youth's showing an interest in a mentor **2.** *Cultural empowerment mentors* - matches youth from a minority cultural or ethnic group with an adult from the same group **3.** *Corporate/business mentors* - matches older foster adolescents with interested businesses, and social agencies serve as the brokers attempting to bring together motivated adolescents and mentors **4.** *Mentors for young parents* - is difficult to find mentoring mothers because this is such a diverse population, local newspaper can run a human interest article showing photos of the teens and their babies and asking for volunteer mothers to mentor these young women **5.** *Mentor homes* places four to six foster adolescents in a home with one adult mentor who guides youth involvement in terms of education, employment, community involvement, etc., these mentors are usually college students who go to school themselves and receive a small salary and free room and board Developing and implementing practice standards for mentor volunteers and youth i.e. screening, training, matching, meeting requirements, and supervision is essential

Area of Practice	Characteristic
	The longer matches lasted, the more positive effects mentoring had (as relationships continue the youth are more open to receiving a larger array of support, advice and guidance from the mentor) Setting up tasks is important for mentors and students to have something to do or work on together. Tasks can absorb initial nervous energy, and provide a basis for conversation between partners
Recruitment and Screening	Screening provides programs with an opportunity to select those adults most likely to be successful as mentors by looking for volunteers who can realistically keep their commitment and who understand the need to earn the trust of the youth they are mentoring Finding adults who want to volunteer because they enjoy spending time with young people, rather than because they feel compelled to save youth seem to make the greatest strides Common ethnic and racial ties are an advantage in connecting with youth. These ties mitigate barriers to trust and provide youth with role models that look like them Common class backgrounds are an advantage in connecting with youth. Studies of mentoring programs have concluded that the most successful mentors are those who grew up in the same way as the youth, often coming from the same neighborhood and able to talk to them in their own language
Training and Competencies	Orientation and training ensure that youth and mentors share a common understanding of the adult's role and help mentors develop realistic expectations of what they can accomplish. While mentoring is a familiar concept in the adult world, it is often a foreign concept to underserved adolescents. Working to avoid misconceptions and training young people to make the most of the experience is an important step. Most practitioners agree that some kind of orientation/training for adult mentors is needed i.e. adolescence development, an urban environment, and poverty, etc.
Relationship Building	Support and supervision helps negotiate problems in the relationship (they need to seek and use advice and support

Area of Practice	Characteristic
	from program staff) Mentors need to maintain a steady and involved presence in the lives of youth They need to respect the youth's views and desires Pay attention to the youths' need for fun They need to become acquainted, but not overly involved, with the mentees' families Ensuring that pairs meet regularly over a substantial period is important for developing positive relationships Scheduling enough time together is essential in being able to establish a significant relationship. A minimum of one interaction per week of at least a few hours in duration seems to be the standard

Substance Misuse

The progression from casual substance use to dependence can be more rapid in adolescents than in adults. Once dependant on substance misuse, adolescents almost never enter treatment as a self-referral. Instead, they are typically referred by a parent, juvenile justice system official (judge or probation or parole officer), school official, child welfare worker, or representative of some other community institution. Adolescents require greater intensity of treatment than adults and this is often reflected by a greater tendency to place adolescents in more intensive levels of care.

The most serious substance misuse problems are found within Aboriginal youth who begin illicit substance use at a very early age (sniffing solvents before age 11); are up to six times more at- risk for every alcohol-related problem than other Canadian youth; and who are over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations. Implicit within the Aboriginal culture is a reluctance to seek treatment for these youth because a number of parents are dealing with substance misuse problems in their own lives.

Effective treatment needs to incorporate cultural elements into services such as appropriate language, inclusion of a spiritual component (beliefs and practices), aboriginal staffing of adults who provide positive role models, culturally appropriate outreach which make a very

big difference in engaging these youth, and connection of Aboriginal youth to Aboriginal social service systems and support.

The research repeatedly purports that youth experience concurrent substance misuse and mental health disorders, conduct disorder and depression being the most frequent mental health disorders identified. Barriers to proper services include poor integration and coordination between the mental health and substance misuse treatment systems. It has been found that adolescents presenting for treatment typically demonstrate a higher degree of co-occurring psychopathology, which frequently precedes the onset of problem substance use and often does not remit with abstinence.

The numbers of youth who inject drugs and/or are living with HIV/AIDS, Hepatitis B and Hepatitis C tends to be low but the barriers to receiving effective treatment are great. These youth experience great isolation and because of racial minority, sexual exploitation, or differing sexual orientations, see very few options for themselves. In the few places where effective methadone maintenance programs do exist, these youth lack access to these services.

There is a strong correlation between substance misuse and involvement in the justice system. Many youth were either on probation/parole/bail or awaiting trial; had been in a correctional establishment in the past six months; and were affected by FAS or related disorders resulting in behaviors which make treatment participation difficult. Barriers include a lack of treatment available in either the justice or substance misuse treatment systems; correctional workers who lack knowledge and understanding of treatment options and do not make referrals to appropriate community-based programs; and the "closed culture" of juvenile offenders which makes group treatment difficult.

Four treatment modalities for substance misuse were examined, these included: a 12-step program approach which views "chemical dependency" as a disease that must be managed throughout one's life with abstinence as a goal; the Behavioral Treatment Approach which views substance misuse as a learned behavior that is susceptible to alteration through the application of behavior modification interventions; the Family-Based Treatment approach focuses on the manner in which adolescent functioning is related to parental, sibling, and extended family functioning, as well as to patterns of communication and interaction within and between various family subsystems; and the Therapeutic Communities Treatment approach which provides long-term residential programs reserved for adolescents with the most severe substance misuse and related problems, requiring a 6 month to fifteen month stay at a facility.

All treatments showed improvement in reduced substance misuse at 6-month and one year follow-ups. However, in all treatment approaches (except therapeutic communities which did not perform a follow-up past one year), longer-term follow-ups show no difference between treatment groups and control groups. The Multidimensional Family based Treatment resulted in additional positive changes including improved behavioral ratings of family and improved grade scores. The implication from these findings suggests there is a

need for further treatment at one year post treatment with follow-up studies to determine effectiveness. It also suggests MDFT out performs other treatments areas of improving family dynamics and school grades.

Focusing on contact and engagement is an essential part of substance misuse treatment. Developing and supporting school-based or a community prevention activity provides a less threatening "window" through which youth can enter treatment. Other contact and engagement strategies include: training professionals who are first point contact with youth such as school teachers, counsellors and mental health workers and maintaining a collaborative relationship with these workers; incorporating strategies to facilitate access to supportive family members, even prior to contact with youth; locating treatment programs close to youth such as malls, schools, the street, mental health centers, clubs, and recreational facilities; and providing diverse recreational activities which are enjoyable and non-threatening helps establish trust and positive client-staff relationships.

Treatment programs need to ensure youth feel physically and emotionally secure, protected and comfortable and are treated in a respectful, non-judgmental way. Youth need to make sense of information given to them and feel they can relate to staff, as well as be part of developing program goals and identifying youth needs. The research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device. Among resilient children, protective factors appear to balance and buffer the negative impact of existing risk factors.

From a substance misuse prevention perspective, protective factors function as mediating variables that can be targeted to prevent, postpone, or reduce the impact of use. Taken together, the concepts of risk and resilience enhance understanding of how and why youth initiate or refrain from substance misuse.

Area of Practice	Characteristic
Identifying Specfic Groups of Youth and Barriers	Identifying specific groups of youth and the program-related or structural barriers these youth experience is helpful in identifying where present practices need to change in order to become best practices. These groups and barriers are: ***Street Involved, Homeless and Marginalized Youth***: • A lack of immediate accessibility to (24-hour) services including access to safe detoxification services Restrictive treatment entry requirements which may be difficult for street involved youth to meet • A lack of adjunctive services, such as safe and secure housing, which are prerequisites to effective treatment utilization ***Youth with Concurrent Substance Use and Mental Health Disorders***:

Area of Practice	Characteristic
	• Poor integration and coordination between the mental health and substance misuse treatment systems ***Youth Who Inject Drugs and/or are Living With HIV/AIDS, Hepatitis B and Hepatitis C***: • The isolation and general marginalization of youth who inject drugs and distance (emotional/physical) from mainstream systems • A high level of distrust and hostility toward the mainstream system which makes disclosure of problems difficult and makes youth who inject drugs reluctant to participate in treatment • The lack of accessible and effective methadone maintenance programs for older youth and for those who require or qualify for this form of treatment • The lack of specialized services which recognize the distinctive needs of youth who inject drugs and/or those living with HIV/AIDS ***Aboriginal Youth***: • Appropriate language • Inclusion of a spiritual component (beliefs and practices) in treatment • Aboriginal staffing • Culturally appropriate outreach • Connection of Aboriginal youth to Aboriginal social service systems and support ***Youth Involved in the Criminal Justice System:*** • A lack of treatment available in either the justice or substance misuse treatment systems. The correctional system typically does not provide treatment and the substance misuse system may not make treatment accessible to juvenile offenders, particularly if legal issues are unresolved • Correctional workers may lack knowledge and understanding of treatment options and not make referrals to appropriate community-based programs • The "closed culture" of juvenile offenders which makes group treatment difficult
Four Treatment Modalities	Current approaches to the treatment of adolescent substance misuse fall into the following four main modalities: *12 step*, *behavioral or cognitive behavioral*, *family based*, and *therapeutic communities*. Each of these models views the problem of adolescent substance use—its etiology, maintenance, and resolution—from a slightly different angle

Area of Practice	Characteristic
Contact and Engagement	Location and physical accessibility of treatment includes going to where these youth are such as malls, schools, street, mental health centers, clubs, recreational facilities and a strong liaison with and presence within schools was emphasized Program approach and philosophy needs to include: • An accepting, respectful and non-judgmental approach to youth • Familiarity with youth reality and language • Treatment goals and purpose to be determined by youth and youth needs (client centered) • The importance of establishing a physically and emotionally secure environment for treatment (where youth feel protected, comfortable and where their basic needs are met) Program outreach strategies needs to include: • Training other professionals who are the first point of contact with youth such as school teachers and counsellors, mental health workers, street workers • Maintaining supportive/collaborative relationships with these workers • Incorporating strategies to facilitate access to supportive family members even prior to contact with youth Program structure and content needs to include: • Provision of diverse recreational activities which are enjoyable and nonthreatening and which establish trust and positive client-staff relationships • The importance of developing and supporting school-based or community prevention activities as a less threatening "window" through which youth can enter treatment

LGBTQ Youth

Although the empirical evidence varies by type of problem, LGBTQ youth appear to be at greater risk of depression, suicide, runaway behavior, and chemical dependency than their heterosexual peers. Of these problems, suicide has been the most studied. Studies have consistently shown extremely high suicide attempt rates among gay and lesbian youth.

Several authors have urged youth service agencies to become more responsive to the needs of their gay, lesbian, and bisexual clients. There is a dearth of evidence-based best practices for this population of youth with most of the literature discussing both the dilemmas faced by LBGTQ youth seeking services and obstacles facing agencies attempting to serve them.

Area of Practice	Characteristic
Program Design	Youth service agencies need to become more responsive to the needs of their gay, lesbian, and bisexual clients Sensitivity toward gay and lesbian youth need to be embedded in programs designed to increase employees' understanding of the social realities of varying client groups Implementing diverse comprehensive programs need to include: • In-service training • Non-discrimination policies • Participation in culturally specific celebrations and holidays • Advocacy • Employment strategies • Client and staff groups that explore diversity • Efforts to create a climate that welcomes all people
Supporting Youth with Gender Issues	Implementing group-based after-school services for at-risk youth to provide a historical perspective of human rights charters in Canada as an effort to increase youth empowerment, self-esteem, and respect for varying cultures (i.e. such a program could include key events and figures in the human rights movements for women, Aboriginal, and gays and lesbians) Support gay youth NGOs that provide LBGTQ youth opportunities to learn and practice social skills, share and exchange information, develop friendships, obtain peer support, explore the meaning of their sexual identity, and find positive role models (such groups decrease emotional and social isolation, help members clarify values, and encourage responsible decision making)
Anti-Harrassment Policy	Youth-serving agencies need to demonstrate a commitment to the safety of all clients by providing zero tolerance policies against violence, emotional maltreatment, and direct or inadvertent mistreatment. Providing policies with a strong stance against physical aggression and verbal harassment

Area of Practice	Characteristic
	sends important messages regarding gay and lesbian youth
Assessing and Addressing High Risk	Services and treatment need to be based on sexual behaviors, not sexual orientation (complete sexual histories should be taken to provide the necessary information pertaining to treatment and services) LBGTQ youth need to be identified and assessed for suicidal risks, substance abuse, home and school problems that may precipitate running away or dropping out of school, and emotional problems. Providing mental health services to deal with the high rates of depression and suicidal ideation is essential for LBGTQ adolescents Service providers need to become aware of community resources and make referrals as needed All LBGTQ youth need comprehensive HIV prevention education (information should be presented in ways that show respect for youth regardless of sexual orientation)
Hiring Staff	Hiring staff who demonstrate a commitment to providing services that foster self esteem and acceptance of LBGTQ youth (agencies and schools must strive to hire open-minded, and supportive employees). Three strategies to achieve this end are: • Communication of anti-discrimination policies • Recruitment and employment of gay and lesbian staff members • Assessment of attitudes during interviews Hiring staff members who reflect the client population is important (i.e. including different ethnic groups, religious affiliations, and sexual orientations)
In-Service Training	To guarantee adequate coverage of sexual minority matters, the following strategies for in-service training need to be incorporated: • Gay and lesbian concerns are incorporated into all training sessions • General information is presented at seminars about gay and lesbian youth • issues • Role-plays are used to develop appropriate language usage

Area of Practice	Characteristic
	• Experiential exercises are used to develop natural, appropriate responses Sensitivity to gay and lesbian concerns need to be incorporated into all training sessions (i.e. staff education regarding youth suicide would not be complete without discussing elevated levels of attempted suicide among sexual minority adolescents and the reasons for this Staff need to practice using gender-neutral language and intervening when hurtful, homophobic language is used. Appropriate language usage has repeatedly been emphasized as crucial to successful interventions with sexual minority youth Agencies need to develop diligence in training and approaches to practice. For an agency to be consistently sensitive to the needs of its clients, efforts to welcome sexual minority youth and to understand their social realities should be institutionalized To serve gay and lesbian youth better, agencies need to be guided by philosophies that embrace diversity and translate these into concrete actions It is essential for service providers to understand the meaning and experience of being gay and a teenager in order to provide competent and sensitive services Service providers also need to promote therapeutic goals that promote physical, social, and emotional development in order to facilitate a healthy transition to adulthood
Suicide Prevention	Prevention of LBGTQ youth suicide needs to include treating the environments that interface with LBGTQ youth in addition to treating the adolescent themselves Practitioner need to assess *individual, micro, and macro system* risk factors of suicide for LBGTQ youth The following *individual* factors for increased risk of suicide need to be assessed regarding the following factors: • Psychiatric history • Family history of suicide • Substance abuse • Availability of a lethal method

Area of Practice	Characteristic
	In addition to the above individual risk factors (common for all sexual orientations), LBGTQ youth are more at risk for suicide and need to be additionally assessed regarding the following if they: • Acknowledge their sexual orientation at an early age • Report a sexual abuse and/or familial abuse history • Do not disclose their sexual orientation to anyone • Self-present with high levels of gender non-conformity • Report high levels of intrapsychic conflict regarding their sexual orientation • Are "double minority" (i.e. lack of acceptance from their racial/ethnic community) The *micro system* risk factors (individuals environment) needs to be assessed i.e. youth's positive or negative interface with teachers, parents, counsellors, friends, religious communities, neighborhoods and youth serving agencies needs to assessed • Lack of tolerance due to homophobic attitudes in teacher, peers, and family members increases suicide risk of LBGTQ youth • Negative experiences with practitioners (i.e. mental health and youth care providers) could further isolate a LBGTQ youth and put them over the edge in terms of suicidal • Lack of information regarding LBGTQ youth isolation and oppression in mental health care providers may contribute to misdiagnosis and a lack of preventative care for potentially suicidal LBGTQ youth • Families with rigid role structures and an inability to accept change have increased rates of suicide in family members. Thus a family that is unwilling to support, accept, and affirm a child that is questioning their sexual orientation or coming out may contribute to an increased risk for suicidal ideation and attempts • Lack of informed support networks in the LBGTQ youth's immediate environment may increase risk for suicide attempts and completions (access to programs that affirm all sexual orientations and decrease isolation for LBGTQ youth may decrease all forms of self-destructive behavior, including suicide risk) The *macrosystem* risk factors (e.g. human rights law/legislation, profession ethical guidelines for psychologists, counsellors and teacher, mass media, school, provincial and federal policies and prevalent cultural values) may indirectly influence suicide risk for LBGTQ youth

Area of Practice	Characteristic
	• When LBGTQ issues are prominent in the press, anti-gay violence often escalates, and threats, harassment and violence may put youth at increased risk for self-injurious behaviors • A second macrosystem factor in suicide risk assessment for LBGTQ youth is the presence or absence of school policies that set expectations for educators to neither tolerate nor participate in homophobic and/or anti-gay rhetoric (e.g., in performing a suicide risk assessment for a particular LBGTQ youth, if the young person attends school at an institution with (1) a non-discrimination policy which includes sexual orientation; (2) diversity training for staff and teachers on issues; and (3) diversity training for other students which includes LBGTQ issues, that student is less likely to face harassment and homophobia in school and therefore may be less likely to engage in self-injurious behaviors • Pressure can come from racial, ethnic, religious, national, and/or community cultural values

Youth Development Approach

Over the last thirty years there has been a widespread proliferation of prevention and positive youth development programs. More recently, there has been a greater focus on evaluation of programs emphasizing positive youth development (National Institute of Child Health and Human Development). Interest in positive youth development has grown as a result of studies that show the same individual, family, school, and community factors often predict both positive (e.g., success in school) and negative (e.g., delinquency) outcomes for youth. Such factors as developing strong bonds with healthy adults and maintaining regular involvement in positive activities not only create a positive developmental approach, but also can prevent the occurrence of problems.

The extensive review of programs in this area concludes that a wide range of positive youth development approaches can result in positive youth behavior outcomes and the prevention of youth problem behaviors. Effective programs showed positive changes in youth behavior, including significant improvements in:

- Interpersonal skills
- Quality of peer and adult relationships
- Self-control
- Problem solving
- Cognitive competencies
- Self-efficacy

- Commitment to schooling, and academic achievement

Effective programs showed significant improvements in problem behaviors, including:

- Drug and alcohol use
- School misbehaviour
- Aggressive behavior
- Violence
- Truancy
- High risk sexual behavior

The evaluations of numerous studies have demonstrated that promotion and prevention programs that address positive youth development constructs are definitely making a difference. Although a broad range of strategies produced these results, the themes common to success involved methods to:

- Strengthen social, emotional, behavioral, cognitive, and moral competencies
- Build self-efficacy
- Shape messages from family and community about clear standards for youth behavior
- Increase healthy bonding with adults
- Peers and younger children
- Expand opportunities and recognition for youth
- Provide structure and consistency in program delivery
- Intervene with youth for at least nine months or more
- Combining resources of the family, the community, and the community's schools

Area of Practice	Characteristic
Identifying Specfic Groups of Youth and Barriers	Effective programs addressed a range of positive youth development objectives yet shared common themes. All sought to strengthen social, emotional, cognitive and/or behavioural competencies, self-efficacy, and family and community standards for healthy social and personal behaviour Positive youth development programs need to involve the community in utilizing it's many resources to enhance the other youth, family, and school strategies Target community involvement and factors more broadly, through influencing local city or neighbourhood policies for youth, or through the use of mass media

Area of Practice	Characteristic
	Implement youth competency strategies by targeting youth directly with skills training sessions, to peer tutoring conducted by at-risk youth, to staff training that resulted in better classroom management and instruction Develop program guidelines or manuals (curricula) that help those delivering the program to implement it consistently from group to group, or from site to site Allow sufficient time (nine months) for evidence of behaviour change to occur, and to be measured within the programs Increase healthy bonding with adults, peers and younger children Combine resources of the family, the community, and the community's schools Supporting local collaborations in offering youth people constructive after school activities that are based on a youth development model Requiring agencies to develop a common vision for meeting the needs of youth and for promoting relationships between youth and caring adults Fostering meaningful youth participation in program design and delivery and offer a range programs and develop linkages with other community agencies to ensure that young people have access to services and chances for academic, social, and personal growth Youth development requires collaboration. No single community organization can provide the range of developmental, preventive, and intervention programs and services required to give young people the experiences they need to mature into successful adults. Rather, creation of such programs requires collaborative planning by a community's youth-serving agencies, other social service and educational institutions, policymakers, community leaders, and young people Shifting to the youth development approach requires educating service providers, policymakers, families, and communities. Youth service professionals interested in shifting their organizational focus to youth development will

Area of Practice	Characteristic
	need to educate families and the community about adolescent development Youth development requires creating a shared vision for youth and community. Youth service providers, in conjunction with their professional collaborative partners, youth, and community members, should develop not only a shared language that includes definitions of adolescent ages and developmental stages, but also a shared understanding of what that language means. They must decide what youth need to develop into healthy, self-sufficient, and involved adults and how those needs can best be met by the larger community. Through that collaborative process, they can begin discussing the youth development framework and how it might translate into a vision for young people within their community. Implementing a youth development approach may require organizational change. The youth development approach is based on the paradigm that youth and communities are partners in developing and delivering services and opportunities for young people and in strengthening communities. Many youth agencies believe in involving youth and communities. Putting that belief system into practice to its fullest extent, though, often requires that organizations re-examine their missions, structures, and decision-making procedures. Evaluation indicators of youth development must be designed. Before discussing how to move to a youth development approach, agencies need to define the goals of such an approach for the young people served. On the basis of these goals, they can develop measurable outcomes that are clearly linked to youth development programming. Agency staff, accompanied by an experienced evaluator, might begin by discussing behavioral changes that indicate positive development among young people. These might include, for example, improved interpersonal skills or goal development. Agencies also can include young people and families in the design of outcome measures by conducting focus groups, individual interviews, or surveys, for example. Advocating for all young people demands that youth agencies

Area of Practice	Characteristic
	pay considerable attention to creating positive images of youth in the media and the community. Media images and societal attitudes profoundly affect both the resources that are dedicated to young people and the way that services and programs are designed. Too often, media messages convey negative images of unintended pregnancies, drug use, crime, and violence.
Building Youths' Strengths and Competencies	Encourage youth to take an active role in shaping and building their family and their Community Implementing development programs that encourage competency development through youth-adult partnerships, enabling youth to plan artistic or community organizing projects and creating opportunities for youth to care for younger or elderly persons in their community Award and nurture youth leaders, recognize youths' strengths, encourage independent decision making, and create opportunities for youth to belong to a valued group Focus on how the environment affects youth development (youth development theory and practice are not rooted in descriptions of problems) i.e. impact of the youth's family and neighborhood on differences in developmental pathways, expectations of the youths' role within their culture and community, and the way that youth see themselves Involving youth in planning and decision making is central to the youth development movement Providing an asset/strengths-based programming approach - the focus shifts from providing services that respond to consumer problems to providing supports and opportunities that enable personal growth Providing empowerment rather than treatment - traditionally, social and mental health services have been designed to reduce deficits through treatment-based behavioral, psychodynamic, or case management models. Staff need to act as catalysts to consumer empowerment by providing supports and opportunities for families and youth to contribute to their own development and to be involved in programs. Preparing staff to play this critical role requires significant investment in training and support by program

Area of Practice	Characteristic
	managers and administrators Insuring consumer involvement in planning and community development - is central to both the family support and youth development approaches. Research in youth development has shown that "when young people have ongoing chances to have a voice, to make decisions, to contribute, to make choices, then they are more likely to achieve positive outcomes". This is true for three reasons: participation allows youth to develop skills, enables them to take ownership of the program or activity, and ensures that the program or activity reflects youths' strengths, interests and needs. Use of systems theory and the ecological perspective – the ecological perspective views all people in the context of their social, cultural, and physical environment. It recognizes that interdependence is more realistic than independence and healthier than dependence. Both family support and youth development practice aim to work with children, youth, parents, and other community members with respect and appreciation for their racial and cultural identity and the family and community structures that support them. The role family support and youth development practice is to work with and seek to strengthen these systems, rather than to supplant them. Systems theory asserts that each member of a system contributes to its structure. This can be interpreted to mean that each member holds the power to change the structure of the family and community in which they live Recognizing the resources of both youth and parents - A collaborative program that involves families and youth can thrive by using the strengths of both. Parents can mentor, tutor, and provide other supports for youth, while youth can care for younger children, create murals and theatre productions, or improve the physical environment. Both parents and youth can work together in planning and organizing programs and community activities. The community would benefit from their knowledge and ideas and a new generation of leaders would be able to learn from their elders.
Family Support Approach	Social service staff members are trained in cultural competence: respect for people from different racial and cultural backgrounds, knowledge about the norms and customs of different cultures, and celebration of this diversity

Area of Practice	Characteristic
	Staff members take on roles that resemble extended family and are committed to altering the structure of the agency and the social service system to create this atmosphere Family support works best in agencies where staff members are enabled to transform client involvement and input into policy and administration, making the entire system more effective and responsive than agencies that operate in a typically hierarchical fashion Family support programs always start with the community as a source of ideas and knowledge, have home visiting or at least create a homelike program environment, and demonstrate flexibility through drop-in child care and service options Focus remains on the family as a unit, celebrating its strengths and striving to retain its integrity and enhance its functioning Efforts to strengthen community ties and natural helping networks follow readily While social workers usually make up the core staff of a family support program, the use of community members as paraprofessionals can help a program be more responsive and feel more comfortable to participants Understanding the Population - to begin a family support program, planners and professionals must have an understanding of the community's structure and an appreciation of its strengths. Spending time in the community and speaking with those who live there help greatly Family Involvement and Empowerment - the parents suggest that organizers support and encourage parents' talents, keep in mind that the community belongs to the parents, create stipends or paid positions to encourage a feeling of partnership, be role models, be open to letting parents experiment and express their views, avoid belittling language, and never come with their own agenda Involve and engage families in positive youth development programs through: • Parent skills training • Using strategies that involve parents in program

Area of Practice	Characteristic
	implementation • Strategies that involve parents in program design and planning Encouraging parent participation sends a message to parents that they have the skills and the knowledge to know what is best for their children and their communities Parents who are involved in programming that affects their children are more likely to be more involved in the lives of their children

Annex C: Interview List

The following interviews were conducted:

Education

Ambrose White
Student Services
Cape Breton Victoria Region School Board

Bruce Macdonald
Principal
Breton Education Centre

Brendon Dugas
Principal
Memorial High School

Kerry Fernandez
Schools Plus

Heather Patterson
Adult Schools

Catherine Collins
Northside Learning Centre

Delores Boudreau
Centre scolaire Etoile de l'Acadie

Susan Kelly
Student Services
Cape Breton Victoria Region School Board

Theresa MacKenzie
Principal
Glace Bay High School

Joe Chisolm
Principal
Riverview High School

Vanessa Tingley
VP Centre scolaire Etoile de l'Acadie

Steve MacDougall
Southside Learning Centre

Bobby Jackson
Adult Schools

Helen Boone
Cape Breton University

Government

Donna Deveaux-MacLeod
Child and Youth Network

Sean Butler
Child Services

Carol MacLellan
Family Services

Linda Alderson
Adult Mental Health

Brian Orm

Peggy Vessallo
Family Services

Mary Beth Leblanc
Youth Health Centres

Sam Hodder
Addictions Services

Dr. Julie MacDonad
Child and Youth Mental Health

Dr. Linda Courey

Adult Mental Health

District Mental Health

Nadine Wadden
Crossroads – ACES Program

Superintendent Theresa Edwards
Cape Breton Correctional Facility

Brad Fury
Probations Department of Justice

First Nations

Daphne Hutt-MacLeod
Mental Health Services
Eskasoni Health

Elizabeth Cremo
Eskason School Board
Director

Mental Health Team
Eskasoni Health
Eskasoni First Nations

Joanne Macdonald
Acting Principal
Unama'ki Training and Education Centre

Angeline Denny
Mi'Kmaw Family Services
Eskasoni First Nations

Not-for-Profit Organizations

Joanna Latulippe-Rochon
Executive Director
Family Place Centres

Anne Ellen
Elizabeth Frye

John MacEachern
Association for Safer Cape Breton Communities

Heather MacNeil
Youth Inclusion Program
North Sydney

Barry Waldman
Youth Peers
EPIC

Tom Urbaniak
Youth Housing
University of Cape Breton

Michael Gillis
Youth LGBTQ
AIDS Coalition

Lisa MacKenzie
Skills Link
YMCA/Federal Government Partnership

Shawn Jackman
Skills Link
YMCA/Federal Government Partnership

Dave Eveleigh
Community Housing

Ron Neville
Youth Homelessness Initiative

Dave Sawler
Undercurrent
Lighthouse Community Church

Angela Hiscock
Needle Exchange

AIDS Coalition

Youth Interviewed By Organization

Breton Education Centre	Memorial High School
Sydney Adult School	Glace Bay Adult School
New Waterford Adult School	Sydney Mines Adult School
Southside Learning Centre	Northside Learning Centre
Men are Parents Too Program	Babies Club Sydney
Babies Club Glace Bay	Unama'ki Training and Education Centre

Annex D: Costing Data

Space Allocation Calculation: Drop-In Centre[33]

Total Number of FTEs	Number of People	
Director	1	200 ft^2
Generalists	3	100 ft^2 per fte
Core Specialist	1	100 ft^2
Support Staff Reception	1	100 ft^2 plus reception area
Special Purpose Space		
Combined Lunch/multi purpose room	20	75 ft^2 + 25 ft^2 per person
Secure File Room	1	200 ft^2
Examination Room	1	150 ft^2
Reception/Waiting	20	100 ft^2 + 10 ft^2 per person
Work Room	1	100 ft^2
Break-out Room	3	200 ft^2
Total Square Footage Required:		~ 2,500 ft^2

[33] Office Space Calculator - http://operationstech.about.com/od/startinganoffice/a/OffSpaceCalc.htm

Increase for potential growth – 10%	~ 2,750 ft^2
Pricing for Lease (no reference for Sydney found)	$2,000/month
Furniture Estimates[34]	$30/square foot

Leasehold Improvements (ranges from $40 to $75 per square foot) $40 per square foot selected based on lower employment costs.

FTE Costs for Employees[35]

Physician (based on an annual salary of $160K)	$65,000 for 16 hours
Psychologist	$30,000 for 16 hours
Social Worker	$24,000 for 16 hours
Director (full time)	$71,000
Generalist (Counsellor)	$46,000
Nurse (full time)	$69,000

Vehicle Costs based on the cost of ownership model[36]

Mini van (5 year period)	$42,000 or $700 / month
This includes maintenance and fuel for 15,000 miles and depreciation of the vehicle, the cost of borrowing	
Insurance	$300 / month

Training Costs

[34] Furniture Estimate, http://www.fastfacility.com/FastInfo/info5.asp
[35] Living in Canada – Canadian Salaries by Region, http://www.livingin-canada.com
[36] The True Cost of Ownership, http://www.vtpi.org

Transition Training is based on the need to establish a new approach which is client focused, holistic and assessment based.

Training estimate is based on a two week program full time, program development, and lost wages.

Trainer per diem costs (includes the training material development with content provided) $1,000/d which represents an average variation as reviewed through the internet. Therefore the transition training is $10,000.

ISO Registration[37]

Based on 3 day initial registration audit (every 4 y):	$4,500
Issuing of Certificate	$5,000
Annual Audit (includes report and certificate):	$3,000
Total (for four years)	$18,500
Per Year Cost	$4,700

[37] ISO Registration Costs available at http://www.9000world.com/index.php?app=ccp0&ns=display&ref=isofaq&sid=9hzx19007kx3j8nsf6w7utp726nc7j93#basics06

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