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

camh
Centre for Addiction and Mental Health
National Youth Screening Project Report

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Production of this report has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Acknowledgments

The National Youth Screening Project Team would like to acknowledge the commitment, dedication and hard work of the many people across Canada who contributed to this project. The support and encouragement that made this project possible started in the planning stages with representatives from agencies, networks and governments that provided advice, letters of support and expressions of interest in collaborating with us during the proposal stage and continued with network leaders, directors and managers who advocated for their communities and agencies to participate in the project. Sincere thanks are due to the network leads in the 10 participating communities across the country as well as to the network coordinators who worked tirelessly to support the agency leads and service providers in implementing the project protocol; to the agency leads who were prepared to commit to participate in a cross-sectoral collaboration, integrate consistent administration of a screening tool and dedicate staff time to participate in the project; to front-line service providers who were willing to take the time to explore new practices, and to engage youth in a screening process for clinical and research purposes; and, most of all, to the youth who participated in completing the screeners and consented to sharing them to contribute to our understanding of the needs of Canadian youth.

We would like to thank Health Canada for their commitment to capacity building, data collection and knowledge exchange, demonstrated by providing the funding support that made this project and dissemination of the findings possible.

National Youth Screening Project Networks

Networks were established in 10 communities, each with a local lead agency (Refer to Appendix A for a list of participating communities and Appendices B and C for network membership).

<table>
<thead>
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<th>Lead Agency</th>
<th>Network Leads</th>
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<tbody>
<tr>
<td>St. John’s, Newfoundland</td>
<td>Choices for Youth</td>
<td>Lead: Cheryl Mallard</td>
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<td></td>
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<td>Coordinator: Heather Quinlan</td>
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<td>Cape Breton Region, Nova Scotia</td>
<td>Cape Breton District Health Authority</td>
<td>Lead: Samantha Hodder</td>
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<td></td>
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<td>Coordinator: Brandy MacNeill</td>
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<td>Pictou County, Cumberland County, &amp; GUI</td>
<td>Pictou County, Cumberland County, &amp; GUI</td>
<td>Lead/Coordinator: Lynda McAllister</td>
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<td>Guysborough/Antigonish/Strait Region, Nova Scotia</td>
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<td>Location</td>
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<tr>
<td>Prince Edward Island</td>
<td>Health PEI</td>
<td>Margaret Kennedy (Lead) &amp; Shauna Reddin, Mathew Spidel, Karen Blancquiere (Coordinators)</td>
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<td>Thompson, Manitoba</td>
<td>Addictions Foundation of Manitoba</td>
<td>John Donovan (Lead) &amp; Lynn Sauve (Coordinator)</td>
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<td>Kelowna, British Columbia</td>
<td>ARC Programs</td>
<td>Shane Picken (Lead) &amp; Nicole Jackson (Coordinator)</td>
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<tr>
<td>Prince George, British Columbia</td>
<td>Northern Health Authority</td>
<td>Franca Petrucci (Lead) &amp; Nicole Jackson (Coordinator)</td>
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<tr>
<td>Dehcho Region, Northwest Territories</td>
<td>Dehcho Health and Social Services Authority</td>
<td>Justin Dalton (Lead/Coordinator)</td>
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<tr>
<td>Yellowknife, Northwest Territories</td>
<td>John Howard Society</td>
<td>Byrne Richards (Lead) &amp; Elizabeth Purchase (Coordinator) (during project initiation)</td>
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<tr>
<td>Nunavut</td>
<td>Department of Health and Social Services, Mental Health and Wellness Division, Government of Nunavut</td>
<td>Wendy Dolan (Lead) &amp; Jennifer Gagnon (Coordinator) (during project initiation)</td>
</tr>
</tbody>
</table>

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Executive Summary

In communities across Canada, substance use, mental health and co-occurring problems and disorders amongst youth are concerning, and often remain undetected. The related individual, family and community costs are high, yet the full extent of the situation is not known. A body of evidence identifying effective screening and intervention tools and approaches is emerging but gaps remain in implementation.

The National Youth Screening Project (NYSP), Enhancing Youth-Focused, Evidence-Informed Treatment Practices through Cross-Sectoral Collaboration, was funded under Health Canada’s Drug Treatment Funding Program (DTFP) to work collaboratively with youth-serving agencies in communities across Canada. The project aimed to enhance service provider capacity, increase early intervention opportunities and improve pathways to treatment for youth aged 12-24 years with substance use, and co-occurring substance use and mental health concerns (CD). This was done through building stakeholder collaborations that included CD-related capacity development for participating agencies in cross-sectoral youth serving networks in 10 communities and implementation of a common screening tool, the GAIN Short Screener, to identify youth substance use and mental health concerns amongst youth presenting for service. As well, in each community, a project report was developed summarizing key findings and recommendations. The project findings provide information about youth needs in the participating networks and service provider perceptions about the feasibility and utility of the screening tool. The project also examined the impact of participating in this collaborative project on service providers’ knowledge, skill, and practices related to youth substance use and CD, and on their referral practices. It is hoped that discussions about youth needs described in the project reports will be helpful in identifying service gaps and informing service planning.

The 10 participating networks were located in five provinces and two territories and included representation from nine sectors: addictions; child welfare; education; family services; health services; housing, outreach and support; justice; mental health; and social services. Local leads and coordinators worked with the project team throughout the project to engage network members and facilitate participation in all aspects of the project that included: network development activities, participation in local capacity building sessions, implementation of the screening tool and a background demographic questionnaire with service-seeking youth, submission of a copy of the questionnaires to the project team for analysis and participation in a joint data analysis and report development process. Most networks and member agencies participated in all of the project activities; some participated in a subset. A collaborative process was used throughout the project to develop joint goals, materials and processes as well as research questions and data analyses to inform the final local and national reports.

The findings of this project, based on data gathered from 1305 youth from eight communities, suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, more than half of participating
youth endorsed significant concerns in more than one domain, and two in five youth screened positive for co-occurring substance and mental health concerns. It is notable that the needs of female and male youth differed, as did the needs of younger and older youth. Rates of endorsement of experiences of traumatic distress and thoughts of suicide were also notable, highlighting the need for trauma-informed services, early identification of concerns and the need for access to specialized interventions. Following completion of the data collection phase of the project, most service providers reported that the screening tool was useful, feasible in their practice, impacted treatment decisions, and facilitated referrals. They also reported higher levels of knowledge about youth substance use, mental health and CD, increased self-efficacy and engaging in practices to address youth CD, and perceived increased cross-agency integration and collaboration.

Specific recommendations were developed with each community based on local findings. Despite differences in size and type of community, number of participating youth, service providers and agencies, a number of recommendations emerged that were common across most communities. These include development or enhancement of: gender-informed and gender-specific services, developmentally-informed and responsive services (i.e., for younger youth and older youth, and for transitionally aged youth (16 to 24 years)), trauma-informed and specific services, capacity for identifying and addressing suicide-related concerns, continued exploration of the impact of the social determinants of health on the manner and type of services available to youth, capacity building opportunities for service providers to identify and address co-occurring substance use and mental health problems across multiple sectors.

Overall, the findings suggest that participation in collaborative, cross-sectoral network projects to implement new practices are feasible and provide opportunities to engage a range of service providers and agencies in capacity building and research activities. Projects such as this also provide the opportunity to learn about youth needs, begin to identify services gaps and consider how to address them.

The project leads are extremely grateful to the youth, families, service providers, agency leads and coordinators, and the many others who made this project possible. We hope that the findings will provide a stepping stone to capacity improvements for youth with substance use and co-occurring problems.
National Youth Screening Project

Overview

The National Youth Screening Project (NYSP), Enhancing Youth-Focused, Evidence-Informed Treatment Practices through Cross-Sectoral Collaboration, was funded under Health Canada’s Drug Treatment Funding Program (DTFP) to work collaboratively with youth-serving agencies in seven communities across Canada to implement a common screening tool for youth substance use and mental health concerns. Each network was to include a range of agencies representing three or more sectors, including substance use, mental health, justice, child welfare, education, housing, outreach and primary health care. Each of the agencies was to participate in one or more of four key project activities: Capacity Building, Network Development, Screening Implementation and Data Collection (see Appendix D). Through this process, the project would have the opportunity to examine rates of co-occurring substance use and mental health concerns (frequently referred to as concurrent or co-occurring disorders (CD)) in different service sectors, across the adolescent and emerging adulthood age spectrums, and to examine the extent to which rates of CD are consistent with service provider expectations. As well, the project aimed to explore service provider perceptions of interagency collaboration, and substance use, mental health and CD-related attitudes, knowledge, and practices at different time points in the project.

The overall objective of NYSP was to enhance service provider CD capacity, increase early intervention opportunities and improve pathways to treatment for youth aged 12-24 years with substance use concerns and CD. This was done through building stakeholder collaborations and providing CD-related capacity development opportunities in ten communities.

Context

Background

Youth with CD experience difficulties in many areas of functioning, resulting in vulnerability to increased risk-taking behaviour, poor academic/vocational performance, increased suicide risk, and adverse health effects, including increased risk for substance dependency and psychiatric disorders continuing into adulthood (Rush, Castel, & Desmond, 2009). Unfortunately, effective, developmentally-informed interventions have yet to be established. From a public health perspective there is a desperate need to develop integrated models of service delivery across the continuum of care to improve outcomes and reduce the high individual and societal costs associated with CDs (Rush et al., 2009). Evidence suggests that universal screening for mental health and/or substance
Use disorders should be a routine part of client care in adults (Rush et al., 2009). However, effective and efficient screening, assessment and treatment approaches, especially for youth, are only beginning to emerge. At the same time, concerns about co-occurring substance use and mental health issues in youth have been identified in services across sectors including child welfare, youth justice, mental health, addictions, education, health care, housing and other social service agencies (Chaim & Henderson, 2009). There is a strong rationale for effective, consistent screening in youth service delivery settings (Rush et al., 2009).

In Canada, there have traditionally been separate service delivery systems for health, mental health, substance use treatment and social services rather than integrated or collaborative models of service delivery. With recent calls to develop integrated models of service delivery in Canada (Health Canada, 2002), some agencies are beginning to offer integrated CD services, although little information is available about types and accessibility of these services. Emerging evidence suggests that cross-discipline collaborations may have particular benefits for improving access and meeting youth and family needs (McElheran, Eaton, Rupcich, Basinger, & Johnson, 2004; Murphy, Rosenheck, Berkowitz, & Marans, 2005). There are many barriers, however, to cross-discipline approaches, especially if the disciplines involved differ substantially in organizational culture, philosophy, values and practices (Oliver & Dykeman, 2003; Robillard, Gallitto-Zaparaniuk, Kimberly, Kennedy, Hammett, & Braithwaite, 2003). It has been argued that these barriers can be addressed through communication, relationship-building, joint educational opportunities and practice-based initiatives, although the specific impacts of these strategies have not been established (McElheran et al., 2004; Murphy et al., 2005; Oliver & Dykeman, 2003; Henderson, MacKay, & Peterson-Badali, 2010).

Although it is well known that youth presenting for service often have multiple co-occurring needs, the fragmented system is generally not set up to address them. There are many challenges including stigma, lack of resources, lack of knowledge and lack of attention to youth specific needs, as well as a frequent lack of collaboration and limited integration. The work of the Canadian Mental Health Commission (2006) and the National Treatment Strategy Working Group (2008) highlighted these issues and provided some fundamental principles to be considered and followed when planning new initiatives. Themes and recommendations identified across these documents such as “every door is the right door,” the need to improve access, the importance of attending to population specific needs, the need to collaborate within and across sectors, the importance of generating solid data to inform investments, and making knowledge exchange a priority, have informed this project as well as our previous collaborative screening network projects (GAIN Collaborating Network, 2009; Concurrent Disorders Support Services Screening Project, 2011).

Choosing a Screening Tool for Youth

The importance of screening for both mental health and substance use concerns across sectors has been identified through a number of initiatives. From 2002 to 2006, the emphasis was primarily on the identification of useful adult tools and practices (Health Canada, 2002; Centre for Addiction and Mental Health, 2006).
In 2006, Rush and colleagues initiated a process to identify youth screening tools and processes and conducted a comprehensive review and synthesis of screening tools for substance use and mental health disorders among children and adolescents (Rush et al., 2009).

Through these initiatives, the Global Assessment of Individual Needs Short Screener (GAIN SS: Dennis, Chan, & Funk, 2006) was identified as an ideal first stage screening tool for substance use and mental health concerns for youth and adults. In particular, it was recommended because it:

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

Collaborative Screening Initiatives 2003 - 2010

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

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

Upon completion of the GAIN Collaborating Network project, findings were presented to local stakeholders including service providers, agency leaders and policy makers as well as at multiple...
international, national and local conferences, meetings, and forums, most notably the Annual Convention of the American Psychological Association (2009) and Issues of Substance (2009). Through these knowledge sharing opportunities, interest in implementing the GAIN SS in youth serving agencies and in participating in collaborative research was generated in communities across Canada. In 2009, the Health Canada Drug Treatment Funding Program (DTFP) had a call for proposals. With interest and stakeholder support from several provinces, Chaim and Henderson submitted a proposal to engage youth-serving agencies in participating in a national youth screening project.

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

The National Youth Screening Project: Enhancing Youth-Focused, Evidence-Informed Treatment Practices through Cross-Sectoral Collaboration was granted DTFP funding in 2010.

**Objectives**

- To build collaboration amongst youth service providers across sectors by developing/enhancing community-based networks across Canada
- To use a common screening tool (GAIN SS) with youth seeking services to enhance consistent identification and treatment planning for youth with substance use and mental health concerns
- To obtain feedback from service providers regarding the feasibility and utility of the GAIN SS as a screening tool
- To examine the effectiveness of cross-sectoral collaborating as a knowledge translation strategy
- To inform planning processes within agencies that relate to:
  - Identifying needs of youth seen
- To inform planning processes across agencies that relate to:
  - Identifying commonalities and differences in youth seen
  - Identifying gaps in the continuum of services
Implementation Summary

The National Youth Screening Project (NYSP) was launched in the fall of 2010, with the anticipated goal of collaborating with 7 networks across Canada, including one from one of the Territories. Ultimately 10 networks from 5 provinces and 2 territories participated in the project (see Appendix A). Networks included between 3 and 18 agencies and services, representing 9 sectors. Eight of the networks participated in the standard implementation of the project that included participation in all four project activities: network development, capacity building, screening implementation and data collection. Two of the networks participated in an adapted implementation of the project, Nunavut and Yellowknife, Northwest Territories (NWT). (See Appendices B and C for implementation summaries by community, Appendix D for a description of the project activities and Appendix E for information about project participation details). Throughout 2011 and 2012 the project team provided training to 553 service providers across all 10 networks. In the eight networks that participated in the standard implementation, the service providers received a full-day youth concurrent disorders capacity building session, with an emphasis on evidence-based screening practices, clinical use of the GAIN SS and implementation of the project protocol. In addition the service providers completed surveys about their own knowledge, attitudes and practices related to youth substance use, mental health and co-occurring concerns. These surveys were repeated at the end of the project when they also provided feedback about their perceptions of the feasibility and utility of implementing the screening tool in their practices and the impact of screening in particular and project participation more generally on their referral practices. All the service providers across the networks received the necessary tools and materials to implement the project activities. Service providers in the two networks, Nunavut and Yellowknife, NWT; that participated in an adapted implementation, received training (one half-day to two days) specifically designed to address their communities’ needs and interests.

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

- Total number of distinct agencies: 69
- Total number of distinct services: 82
- Total number of service providers trained: 553
- Total number of GAIN SS received: 1,305
- Total number of sectors represented: 9

Development

A process to ensure broad dissemination of information about the National Youth Screening Project and the opportunity to participate was undertaken prior to the submission of the proposal as well as following the funding announcement in April 2010. This included presentations to the Federal Provincial Territorial Committee (FPT) and the DTFP Coordination Meeting hosted by the Canadian Centre on Substance Abuse in January 2011. A number of stakeholders provided letters of support to accompany the project application, indicating their interest in having their communities and/or agencies participate should the project be funded. Additional communities came forward following the announcement and a self-determined process was undertaken in each of the participating provinces and territories to confirm community and agency participation. The project leads participated in teleconferences and/or in-person meetings with stakeholders to discuss the objectives of the project and explore interest and feasibility. Similar to the pilot screening projects described previously, there was interest in participating in a project to build capacity to identify and address the complex needs of service-seeking youth, as well as in having the opportunity to document the needs of youth in the participating agencies, sectors and communities.

Cape Breton Region, Nova Scotia, was the first community to commit to the project, identify a lead agency, engage network membership, sign required collaboration agreements, secure required research ethics approval(s), participate in training and launch the 6-month data collection phase of the project that included administering the GAIN SS and a demographic information form to youth aged 12 to 24 years seeking service at the participating agencies. Training across sites took place between January, 2011 and March, 2012, including those participating in adapted versions of the project (Yellowknife and Nunavut in May). The project team held a one-day training workshop for service providers from the participating agencies, repeated on two consecutive days to allow for all agency staff to be trained, in each of the participating communities implementing the standard project. As noted previously, a half-day to two-day training was offered in the Northwest Territories and Nunavut. Prior to the training, the service providers that participated in the standard implementation of the project were surveyed regarding their attitudes, knowledge and practices related to youth substance use, mental health and co-occurring concerns. The standard project was launched in Cape Breton Region, Nova Scotia in April, 2011, followed over the course of the next fourteen months by
Thompson, Manitoba; Pictou County, Cumberland County, and Guysborough/Antigonish/Strait Region, Nova Scotia; Prince George, British Columbia; St. John’s, Newfoundland; Kelowna, British Columbia; Prince Edward Island; and lastly in the Dehcho Region, NWT in June, 2012. See the local reports described above for details of the process in each community as well as Appendix F for a process summary and Appendices B and C for implementation summaries for the standard and adapted implementation networks respectively. See Appendix G for the overall project timeline.

**Partners**

The networks included representation from nine sectors: addictions; child welfare; education; family services; health services; housing, outreach and support; justice; mental health; and social services. 42 agencies, representing 82 services, participated in the standard implementation of the project, and 27 agencies participated in the adapted implementation (See Appendices B and C for lists of agencies, services, and sectors in each community). Descriptions of participating agencies in each community are available in the local reports). All of the network member agencies participated in a minimum of two (Capacity Building and Network Development) of the four project activities, which included: Capacity Building, Network Development, Screening Implementation, and Data Collection. Please refer to Appendix D for a description of key project activities and Appendix E for a description of respective agency participation.

Roles, implementation processes and materials used will be described in the sections following and include information relevant to the partners participating in the standard implementation of the project. A subset of the information in each section is relevant to the stakeholders in the communities that participated in an adapted implementation of the project and varied in relevance to the individual communities. For example references to the project protocol are relevant only to networks and agencies that participated in the standard implementation. The process implemented in each community is fully described in the local community reports.

**Roles**

**National Project Team:**

- Provide funding (up to $24,000 over 18 months) for a local network coordinator, hired through the network lead agency;
- Provide resources for and support meetings of youth-serving agencies to facilitate all aspects of project participation;
- Provide training to staff in identifying and addressing substance use and/or CD concerns in youth, implementing the GAIN SS and the data collection protocol;
- Provide all necessary screening and project-related materials;
• Provide templates and support for developing response, resource and referral guides customized for each community;
• Obtain ethics approval through Health Canada and CAMH and support each agency to comply with their ethics approval processes.

Lead Agency
• Identify local organizations, representing a minimum of 3 sectors to participate in the project as participating agencies;
• Vet prospective participating agencies for suitability;
• Act as a liaison between CAMH and participating agencies during the term of the project;
• Identify and facilitate agency leads to obtain local REB approval for the project;
• Obtain licenses from Chestnut Health Systems Inc. for use of the GAIN SS for participating agencies;
• Support training provided by the project leads and facilitate provision of consultation as needed throughout the project;
• Facilitate administration of pre and post service provider surveys to all agency staff involved in the project;
• Facilitate data collection by the participating agencies.

Participating Agencies
• Comply with the agreed upon protocol by obtaining participant and parental consents, administering GAIN SS and submitting the data to the lead agency for review;
• Ensure staff participation in project-related training;
• Maintain and store original data from participants as per REB policies and in accordance with legal requirements;
• Ensure that as many eligible youth as possible have the opportunity to be included in the project and that the rates of eligibility and consent are tracked.

Implementation Process
(See Appendix G for Project Timeline)

Prior to initiating project activities, two separate agreements were signed:

1. A two-party agreement between CAMH and the network lead agency.
2. A three-party agreement between CAMH, the network lead agency, and each of the respective participating agencies.
Each agreement described the project, roles, responsibilities, activities and commitments, as well as the data collection protocol. These agreements were developed and signed by the participating agencies.

A collaborative process was used throughout the project to develop joint goals, materials and processes as well as research questions and data analyses. The lead agency in each community was involved with the project throughout each stage of the project from initiation to completion. Once the agency level training was completed and data collection was underway, the lead agency, along with the project team at CAMH, regularly communicated with the participating agencies to maintain engagement, momentum, and compliance with the project protocol, problem-solve issues arising and facilitate collaboration in the joint data analysis process.

<table>
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<th>Implementation Process</th>
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<tr>
<td>1. April, 2010 – November, 2011 – Networking:</td>
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<tr>
<td>a. Identified interested agencies</td>
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<td>b. Established cross-sectoral networks</td>
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<tr>
<td>2. September 2010 – March 2012 – Agreements and REB:</td>
</tr>
<tr>
<td>a. Developed 2-party agreement between CAMH and lead agencies</td>
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<tr>
<td>b. Developed 3-party agreement between CAMH, lead agencies and all participating agencies</td>
</tr>
<tr>
<td>a. Capacity building across sites was delivered using a package developed by the project leads</td>
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<tr>
<td>b. Project leads administered service provider consents and the Service Provider Survey at the beginning of the training day</td>
</tr>
<tr>
<td>c. Each Agency identified a lead to act as a “point person” for communication with the Network Lead, including receiving and distributing project packages to the participating service providers in their respective agencies</td>
</tr>
<tr>
<td>d. Each network developed the project Referral Resource Guide to inform service provider responses to positive screens on the GAIN SS</td>
</tr>
<tr>
<td>4. April, 2011 – June, 2012 – Data collection launch:</td>
</tr>
<tr>
<td>a. Project packages i.e. Project Instruction Sheets, Consent forms, GAIN SS, Background Information Forms, Tracking Sheets, were distributed</td>
</tr>
<tr>
<td>5. April, 2011 – December, 2012 – Data collection underway:</td>
</tr>
<tr>
<td>a. Service providers administered the GAIN SS and Background Information Form and obtained consent from youth seeking service at their agencies</td>
</tr>
</tbody>
</table>
b. Anonymous copies of the completed measures and tracking sheets were submitted to the network coordinator on a monthly basis, and delivered to CAMH at month 1, 3 and 6

c. Consultation was provided as needed by the network coordinator and/or project coordinator/project leads

d. Staff feedback forms were collected on completion of the data collection

6. **February, 2012 – April, 2013 – Preliminary joint data analysis meeting:**
   
   Discussed:
   
   a. Data analysis questions and strategies
   
   b. Preliminary findings
   
   c. Fit with expectations and experiences of the community
   
   d. Lessons learned, including staff feedback provided on utility and feasibility of administering the GAIN SS to youth in their agencies
   
   e. Feedback from network and agency leads
   
   f. Potential recommendations based on findings
   
   g. Report dissemination plan

7. **March, 2013 – April, 2013  – Presentation of final reports**
   
   a. Local community reports were provided to local stakeholder groups in the participating communities
   
   b. National report was presented by webinar widely advertised to stakeholders across the country
Materials

Service Provider Project Package

Service Provider Survey Consent Form

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

Service Provider Survey

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

Project Flow Chart (See Appendix H)

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

Instructions for GAIN SS Use

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

Referral Resource Guide

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

GAIN SS Tracking Sheet

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

Feedback Survey

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

Youth Consent Form

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

Parental Consent Form

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

Background Information Form

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

GAIN SS (CAMH Version)

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

Who participated?

In total, 1305 youth participated from 9 different sectors:

FIGURE 1: SECTOR DISTRIBUTION OF PARTICIPANTS

Due to small numbers in child welfare, family services, education and social services, these sectors were included in housing, outreach and support, with the resulting sector sample sizes:

- 531 (41%) from addictions sector
- 194 (15%) from health sector
- 209 (16%) from housing, outreach, and support sector
- 130 (10%) from justice sector
- 241 (18%) from mental health sector

Seven percent of participants were from Northern networks (Thompson, Prince George, Dehcho) while the remaining 93% were from networks located in southern and/or urban areas of Canada.
How representative is the sample of youth who participated in the project?

Service providers were asked to use tracking sheets to record each youth eligible to participate. Information collected on the tracking sheets included sex, age, consent response, and any comments on why individual youth may not have been approached or refused to consent. All participating services indicated an intention to use this approach to track participation rates: 88% of participating services submitted at least one completed tracking sheet for analysis.

According to the tracking sheets provided 1517 youth presented for service to the participating services over the project timeframe. Of these youth 86% were eligible for the project (n = 1306). Reasons for ineligibility included the GAIN SS had already been administered (36%), immediate mental health concerns (e.g. youth was psychotic or suicidal) (24%), cognitive limitations (15%), age over 24 years (12%), youth was not a client (6%) and youth was at the end of service (2%). In addition, for 142 cases no information about eligibility/ineligibility was provided. Of the youth who were eligible to participate in the project, 1282 (98%) were approached for participation. The reasons reported for youth not being approached included clinician-based reasons (e.g., judgment, forgot; 49%), parents were unavailable to consent (25%), the youth was unavailable (e.g., left, no show; 24%), no forms were available (11%), and lack of time (8%). Of the youth who were approached, 92% completed the GAIN SS. Based on the tracking sheets, 8% (n = 108) of youth who were asked to complete the GAIN SS refused. Of the youth who completed the GAIN SS, 97% consented to have a copy used for this project.

Overall then, based on these tracking sheet numbers, 87% of eligible youth contributed screeners for this report. It is also the case, however, that not all eligible youth were tracked. There is a discrepancy of at least 177 consenting cases, and based on the rates of consent documented using tracking sheets, this likely represents approximately 205 eligible cases that were not captured on tracking sheets. Accordingly, consideration should be given to the impact of these limitations on the representativeness of the sample and generalizability of the findings. The findings may or may not be relevant to youth who did not participate in the project.

FIGURE 2: YOUTH PARTICIPATION RATE BASED ON SUBMITTED TRACKING SHEETS

- 1517 youth presented for service
- 86% eligible to participate
- 98% approached
- 92% completed GAIN SS
- 97% Consented to have a copy used for the purposes of this project
What are the demographic characteristics of the youth who participated?

*How old were participating youth?*

**FIGURE 3: AGE DISTRIBUTION OF PARTICIPANTS**

The participating youth ranged in age from 12 to 24 years with an average age of 16.8 years and a median age of 16 years. In Figure 3, the ages of participating youth are presented using age categories commonly used in service provision. As can be seen, more youth were in the 16-18 years age range than other age categories.
When youth are grouped by sector, it can be seen that youth who participated from the justice and housing, outreach and support sectors were more likely to be in the oldest age group (19 to 24 years) than youth presenting to other sectors for service.
How many participants identified as male, female, trans or other?

**FIGURE 5: SEX DISTRIBUTION OF PARTICIPANTS**

There were significantly more female than male participants \((p < .001)\). Fifty-three percent of participants were female and 45% were male, 1% were trans and 1% did not provide this information. Given the small number of youth who identified as trans, only youth who identified as male or female are included in subsequent analyses based on sex to protect confidentiality.
Comparing the sex distribution of participating youth across sectors reveals that the male to female ratio differs between sectors. Health services had a greater proportion of female participants than other sectors and justice had significantly more male youth.
How long had youth been receiving service prior to project participation?

FIGURE 7: SERVICE HISTORY BY SERVICE SECTOR

The majority of youth (58%) participating in the project across sectors had been involved with the participating service for one month or less (not shown). This differed significantly across sectors with approximately two-thirds of youth presenting to the addictions and health sectors for service recently (i.e., within the past month) while approximately two-thirds of youth presenting to the housing, outreach and support sector reported receiving service for 2 or more months.
What ethnicities did youth report?

FIGURE 8: ETHNICITY DISTRIBUTION OF PARTICIPATING YOUTH

Four percent of participating youth endorsed more than one ethnicity. The number of endorsements is as follows: White (n = 1044), Aboriginal (n = 151), ‘Don’t know’ (n = 55), Black (n = 36), ‘Other’ (n = 15), Arab* (n = 3), Filipino* (n = 2), South Asian* (n = 2), Chinese* (n = 1), Latin American* (n = 1), and West Asian* (n = 1) (*included in ‘Other’ in Figure 8). Forty-four participants did not complete this question (not represented in the figure).

Birth Country and First Language

The majority of participating youth reported being born in Canada (96%) while 2% reported being born outside of Canada and 2% did not answer the question. Those born outside of Canada reported having been in Canada for three to twenty years. The majority of participating youth also reported that English was their first language (95%), while 2% reported a different first language and 3% left it blank. Of participants who indicated that their first language was not English, some provided information about their first language as follows: French (n = 10), Mikamaq (n = 9), German (n = 2), Arabic (n = 1), Inuktitut (n = 1) and Serbian (n = 1).
What living arrangements did youth report?

FIGURE 9: CURRENT LIVING ARRANGEMENTS

Most participating youth (69%) reported that they were living with parents, while 11% reported living on their own or with friends, 6% reported living with other family members, 6% reported living in supportive housing (e.g. “group home”, “treatment facility”) and 5% reported living in unstable housing (e.g. “shelter”, “on street”, “couch surfing”). Three percent of participants did not provide this information.
Examination of sex differences in living arrangements revealed no differences in the living arrangements reported by male and female youth.
As can be seen in Figure 11, older youth reported a wider range of living arrangements as would be expected given their developmental stage, and were more likely to report living on their own or with friends.

Those who reported living alone or with friends (mean age = 19.4) and those who reported unstable living arrangements (mean age = 18.8) were significantly older than those who reported living with other family/relatives (mean age = 17.1), in supportive housing (mean age = 16.5), or in the parental/family home (mean age = 16.2).
As would be expected given their older age and the mandate of the sector, youth presenting for service to the housing, outreach and support sector were more likely to report living outside the parental/family home than youth presenting for service to other sectors.
How many youth reported legal involvement?

The majority of participating youth reported never having had any legal involvement (56%), whereas 28% reported having legal involvement in the past 12 months, 12% reported involvement more than a year ago, and 4% of youth did not complete this question.

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

Overall 50% of participating youth identified as students. Of those who did not identify as students, 50% indicated that they were unemployed, 25% indicated part-time employment, 12% indicated they had full-time employment, 6% indicated that they were engaged in volunteer activities, and 2% indicated that their employment status was ‘unknown’.

Age was related to educational, employment and income status. Youth aged 18 years and over who reported employment status (n = 416), indicated that their employment situations were as follows: unemployed (46%), working part-time (21%), attending school (18%), working full-time (16%), and volunteering (5%) (not mutually exclusive). In contrast youth aged 17 years or younger (n = 870) indicated that they were students (66%), unemployed (26%), working part-time (19%), volunteering (7%) and working full-time (2%). Similarly, the most commonly reported income sources for youth 18 years and older were as follows: employment (27%), welfare (27%), no income (21%), parents/spouse (18%), and employment insurance (8%), while youth aged 17 years and younger reported their income sources to be parents/spouse (43%), no income (28%), employment (12%), family benefits (9%), and ‘unknown’ (5%).

For youth 18 years and over, educational attainment was also examined revealing a broad range of educational achievements, including 4% of participants reporting grade 8 completion as their highest educational achievement, 53% indicating grades 9-11 as their highest achievement, 5% reporting high school completion without diploma, 25% indicating completion of high school with diploma, 3% achieved a trade/vocational certificate, 2% received a CEGEP diploma, 4% completed some college but did not receive a certificate, and 1% have completed or are currently in undergraduate or graduate degree programs.
How do the demographic characteristics of males and females compare?

TABLE 1: DEMOGRAPHIC COMPARISON OF MALE AND FEMALE PARTICIPANTS

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>17.3</td>
<td>16.5*</td>
</tr>
<tr>
<td>Born in Canada</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>English First Language</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Unstable Housing</td>
<td>6%</td>
<td>4%*</td>
</tr>
<tr>
<td>Legal Involvement</td>
<td>58%</td>
<td>28%*</td>
</tr>
</tbody>
</table>

*p<.05

As can be seen, when male and female youth were compared on a number of demographic variables it was revealed that male participants were significantly older than female participants. Also, significantly more male youth reported unstable housing than female youth and significantly more male youth reported legal involvement than female youth.
Clinical Needs of Youth Based on the GAIN SS

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

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

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

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

FIGURE 13: NUMBER OF CONCERNS ENDORSED BY GAIN SS DOMAIN

As can be seen in Figure 13, more than two-thirds of participating youth endorsed 3 or more recent internalizing concerns, suggesting that with a full diagnostic assessment they may meet criteria for a diagnosis in the internalizing domain (e.g. mood disorder, anxiety disorder, etc.). Similarly, in the externalizing domain, almost 60% of youth endorsed 3 or more recent concerns. In the problematic substance use domain, 45% of youth endorsed 3 or more recent concerns. Endorsement of 3 or more concerns on the crime and violence subscreener was less common, but nevertheless, almost one quarter of participating youth reported 3 or more recent indications of crime and violence problems. Most youth (91%) endorsed 3 or more recent concerns across the 4 domains and would be highly likely to meet criteria for a diagnosis with a full diagnostic assessment.
How do the needs of youth differ across sectors?

FIGURE 14: RECENT CLINICAL NEEDS USING MODERATE THRESHOLD (1+ ENDORSEMENTS) BY SERVICE SECTOR

In Figure 14, the needs of youth by service sector are presented. Youth presenting for service to the addictions sector had higher rates of overall endorsement across domains (not shown). Using the threshold of 1 endorsement to identify youth who screen positive, more than three quarters of youth, regardless of sector, screened positive for internalizing concerns. Similarly, more than three quarters of youth across sectors screened positive for externalizing concerns. Within the substance use and crime and violence domains, rates of endorsement ranged from almost half to over three quarters (45-79%) across sectors.
Using a threshold of three or more recent or current concerns within one domain improves the specificity (i.e. fewer false positives) of the GAIN SS screener and allows identification of youth with higher severity of needs.

As can be seen in Figure 15, the majority of youth presenting for service to mental health, housing, outreach and support, and addictions have high internalizing concerns, while those presenting to health and justice report lower but still concerning rates of high severity internalizing concerns (51% and 47% respectively). Similarly, within the externalizing domain, the majority of youth presenting to addictions and mental health reported experiencing high severity externalizing difficulties, while fewer (45-52%) youth from the other sectors reported these difficulties.

In the substance use domain, youth in the addictions sector had the highest rates of endorsement of problematic substance use with almost two thirds of participating youth indicating that they had experienced 3 or more symptoms of problematic substance use in the past year. In addition almost half of youth presenting for service to the housing, outreach and support sector also indicated experiencing 3 or more symptoms of problematic substance use in the past year. Though lower, a substantial proportion (20-37%) of youth presenting for service to the health, mental health and justice sectors also indicated experiencing 3 or more symptoms of problematic substance use in the past year.
In the area of crime and violence, rates of endorsement were substantially lower than other domains, although approximately one third of youth presenting to the addictions sector endorsed 3 or more crime and violence problems.

Examination of the needs of youth from northern sites ($n = 92$) compared to youth from southern sites ($n = 1213$) revealed that youth from northern sites were significantly more likely to endorse internalizing concerns and slightly more likely (trend) to report problematic substance use than youth from southern sites (not shown).
Who endorsed *internalizing* mental health concerns (e.g., depression, anxiety)?

**FIGURE 16: RECENT INTERNALIZING CONCERNS BY AGE AND SEX CATEGORIES**

The majority of female youth (73%) and more than half of male youth (58%) who participated in this project screened positive for significant internalizing concerns (not shown). Male youth 18 years and younger were less likely than female youth 18 years and younger to endorse internalizing concerns. In the oldest age category, however, male youth were just as likely as female youth to endorse significant internalizing concerns. For both male and female youth, older youth were significantly more likely than younger youth to endorse internalizing concerns.
Who endorsed externalizing mental health concerns (e.g., impulsivity)?

FIGURE 17: RECENT EXTERNALIZING CONCERNS BY AGE AND SEX CATEGORIES

As shown in Figure 17, male youth aged 12 to 15 were more likely to endorse externalizing concerns than same-aged female youth. For both male and female youth, older youth were less likely to endorse significant externalizing concerns.
Who endorsed problematic substance use?

FIGURE 18: RECENT SUBSTANCE USE CONCERNS BY AGE AND SEX CATEGORIES

More than half of male youth (52%) and more than a third of female youth (39%) across all age groups endorsed significant substance use concerns (not shown) and older youth were more likely to report significant substance use concerns than younger youth. Male youth 18 years and younger were more likely than female youth 18 years and younger to endorse problematic substance use, but differences in rates of endorsement for older (19-24 years) male and female youth are not significant.
Who endorsed difficulties with crime and violence?

FIGURE 19: RECENT CRIME AND VIOLENCE CONCERNS BY AGE AND SEX CATEGORIES

Crime and violence problems were more commonly endorsed by male youth than female youth, particularly in the 2 youngest age categories. Rates of endorsement did not differ significantly by age for male or female youth.
How many youth endorsed suicide-related concerns?

FIGURE 20: RECENT SUICIDE CONCERNS BY AGE AND SEX CATEGORIES

Given the clinical importance of suicide-related concerns, the single item related to suicide-related thinking and behavior from the internalizing subscreener was examined. Overall, approximately half (47%) of youth indicated suicide-related concerns at some point in their lifetime (not shown): 14% of participating youth indicated that they had thought about suicide in the past month, 17% reported having thought about suicide in the past 2 to 12 months and 16% reported suicide-related concerns more than 12 months ago. Fifty-three percent of youth indicated they had never thought about suicide. When we examined rates of endorsement by sex and age category it was revealed that female youth in the younger 2 age categories were significantly more likely than male youth in the younger age categories to endorse suicide-related concerns. In the oldest age category, however, male and female youth did not differ. Older female youth were significantly less likely than younger female youth to endorse suicide-related concerns. Rates of endorsement did not differ by age for male youth. Youth from northern sites and southern sites did not differ in their rates of endorsement of suicide-related concerns (not shown).
How many youth endorsed additional areas of concern, like trauma-related distress?

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

FIGURE 21: RECENT ADDITIONAL CONCERNS BY SEX CATEGORIES

As can be seen, both male and female youth were most likely to endorse experiencing distressing memories/dreams, a potential sign of trauma-related distress. Thinking-related concerns, such as thoughts of being followed and/or hallucinations (not associated with substance use), were also endorsed by many youth: over a third of male youth and over 40% of female youth. Among female youth, eating-related concerns were endorsed by one third of participants and approximately one quarter of both male and female youth indicated significant difficulties associated with videogame playing and internet use. Few youth endorsed concerns about gambling. Across all areas of concern except videogame/internet use and gambling, female youth had higher rates of endorsement than male youth.
Concurrent Substance Use and Mental Health Concerns

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

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

FIGURE 22: ENDORSEMENT OF CONCURRENT DISORDERS

Did not screen positive for internalizing or externalizing mental health concerns, nor problematic substance use
Overall, 56% of youth screened positive for more than one area of concern, and 41% of participating youth screened positive for possible concurrent (substance and mental health) disorders. As can be seen in Figure 22, 31% of all participating youth screened positive for co-occurring internalizing, externalizing and substance use concerns, 6% endorsed concurrent internalizing and substance use concerns, and 4% endorsed concurrent externalizing and substance use concerns. When we examined just those youth who screened positive for concurrent disorders, we found that 90% screened positive for internalizing concerns and problematic substance use, 85% screened positive for externalizing concerns and problematic substance use, and 75% screened positive for both internalizing and externalizing concerns, as well as significant substance use concerns.
How did rates of Concurrent Disorder endorsement compare across service sectors?

FIGURE 23: ENDORSEMENT OF CONCURRENT DISORDERS BY SERVICE SECTOR

Youth from the addictions sector were more likely to endorse concurrent disorders than youth presenting to other service sectors. Over half of youth presenting to the addictions sector screened positive for concurrent disorders. The lowest rates of concurrent disorders were found in youth presenting to the health service sector. Rates of endorsement of concurrent disorders did not differ for youth from northern and southern sites (not shown).
Who was more likely to endorse Concurrent Disorders?

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

FIGURE 24: ENDORSEMENT OF CONCURRENT DISORDERS BY AGE AND SEX CATEGORIES

Overall male youth were significantly more likely to endorse concurrent disorders than female youth (46% vs. 37%, respectively, not shown), this discrepancy is particularly apparent in the youngest age category. Rates of endorsement of concurrent disorder also varied by age: older youth were more likely to endorse concurrent disorders than younger youth.
Did rates of Concurrent Disorders differ for youth with different living arrangements?

**FIGURE 25: ENDORSEMENT OF CONCURRENT DISORDERS BY AGE AND HOUSING CATEGORIES**

For the purposes of these analyses living arrangements were reduced to two categories: 1) parental/family home and 2) living outside of the parental/family home. Younger youth who live outside of the parental/family home, especially youth aged 16 to 18 years old, were more likely to endorse concurrent disorders than youth living in the parental/family home. For older youth (aged 19-24 years), there was a slight trend for youth living in the parental/family home to be more likely to report concurrent disorders.
Are students more or less likely to endorse Concurrent Disorders?

FIGURE 26: ENDORSEMENT OF CONCURRENT DISORDERS BY EDUCATION STATUS

When we compared youth who identified as students to those who did not, it was revealed that students aged 18 years or older were less likely than non-students to endorse concurrent substance use and mental health concerns (38% vs. 50% respectively).
Do rates of Concurrent Disorders differ by employment situation?

**FIGURE 27: ENDORSEMENT OF CONCURRENT DISORDERS BY EMPLOYMENT STATUS**

When we compared youth who identified as employed to those who did not, it was revealed that employed youth, both under 18 years old and 18 years and older, were less likely than unemployed youth to endorse concurrent substance use and mental health concerns.
Are youth who have had legal involvement more or less likely to endorse Concurrent Disorders?

FIGURE 28: ENDORSEMENT OF CONCURRENT DISORDERS BY LEGAL SYSTEM INVOLVEMENT

For the purposes of the following analyses, legal involvement was reduced to two categories: 1) no legal involvement and 2) previous legal involvement. Youth who reported legal involvement were significantly more likely to endorse concurrent disorders (53%) than youth who reported no previous involvement with the legal system (33%) (not shown). As can be seen in Figure 28, this difference is apparent for both male and female youth. Approximately half of youth (54%) who screened positive for concurrent disorders reported previous legal involvement (not shown).
Which factors are most important in understanding the Concurrent Disorder needs of youth presenting for service in participating communities across Canada?

Given that a number of interrelated factors (e.g., age and service sector) could be related to endorsing both problematic substance use and mental health concerns, we examined these factors together in one model to understand which factor(s) are most important in understanding who screens positive for concurrent disorders. The factors included in this analysis were age, sex, service sector, living arrangements, legal involvement, educational/employment status, and region (northern vs. southern).

When all of these factors were considered together age, service sector, and legal involvement were shown to be most important in understanding which youth are more likely to endorse both substance use and mental health concerns. More specifically, older youth were more likely to endorse both substance use and mental health concerns. In addition, even when we control for differences associated with age and other factors, youth presenting for service to the addictions sector were more likely to endorse both substance use and mental health concerns. Lastly, even after controlling for the impact of other factors like age and sex, youth who had legal involvement were more likely to endorse concurrent concerns.
How many participants endorsed multiple areas of concern in their lives?

FIGURE 29: COMPLEXITY OF NEEDS

In order to understand how many participants experience multiple areas of concern we also examined the following social determinants of health, along with mental health and substance use concerns: 1) housing ("unstable" or "supportive"), 2) education/occupation (under 18 and not a student or 18 and older and not a student and not employed), 3) legal involvement (past or current legal involvement), 4) internalizing concerns (high severity), 5) externalizing concerns (high severity), and 6) substance use problems (high severity). Notably, 51% of participants reported having 3 or more factors and 11% of participants reported experiencing 5 or more of the 6 factors (not shown). Results did not differ for male and female youth. Youth from northern sites, however, did have significantly more factors than youth from southern communities (2.9 vs. 2.5 factors, respectively). Overall, these findings highlight the complexity of the needs of the individuals who are presenting for service and participated in this project.
Findings: Service Provider Perspectives
Service Provider Perspectives

This project included a feedback survey administered at the end of the data collection period to gather information regarding service providers’ perceptions of the feasibility, utility, and impact of using the GAIN SS. In addition, the project included a survey about service providers’ attitudes, knowledge, and practices regarding youth substance use, mental health, concurrent disorders, screening, and interagency collaboration administered before and after participation in the project.

Utility and Feasibility of the GAIN SS

FIGURE 30: SERVICE PROVIDER PERCEPTIONS OF GAIN SS UTILITY AND FEASIBILITY

The feedback survey about the feasibility and utility of the GAIN SS was completed by 149 service providers from across sectors. The majority of service providers who provided feedback reported that the GAIN SS was useful, impacted treatment decisions, and facilitated referrals. The majority of service providers also recommended using the GAIN SS despite over half of participating service providers reporting a perceived disruption from its use. Over two-thirds of service providers indicated that participating in this network project had facilitated inter-agency communication or relationships at least some of the time. Service providers from the addictions sector had significantly more positive views about the GAIN SS, while service providers from the mental health sector reported the least favourable opinions.
Notably, service providers who found the training more helpful, used the GAIN SS with a greater proportion of their clients. Those service providers who used the GAIN SS with a greater proportion of their clients were more likely to report that the GAIN SS provided useful information, impacted service delivery, and facilitated referrals than service providers who reported using the GAIN SS with a smaller proportion of their clients. In addition, those service providers who reported using the GAIN SS with a greater proportion of their youth clients were less likely to find the GAIN SS disruptive and more likely to report that they would recommend use of the GAIN SS.

Agency lead & service provider comments about the feasibility and utility of the GAIN SS

“I think the tool assisted us in being more aware of concurrent disorders…more aware of each other’s programs…more youth being assessed for concurrent disorders… more referrals from outside agencies.”

“Once they (service providers) started doing it, they realized how quick and useful it is. It blows my mind that there was resistance to using it.”

“We need to get better at using tools. 60% of our programs are using it; would like to see it at 100%.”

“We need to ask questions, use screeners…young people are not connecting regarding substance using behaviours. We need to ask the questions and connect the dots – substance use, school problems, behaviour problems…”

“I have found using the GAIN really helpful in my work. I do work in a hospital unit and suggested the use of the GAIN SS to start conversations with their patients.”

“Helped central intake to prioritize referrals; having referral information from the GAIN was useful.”

“Service Providers referred to disruption related to the research protocol—consents, photocopying, etc., not the screener specifically. Staff are uncomfortable with research and asking for consent, NOT youth, youth were happy to do it.”

“At the beginning until people really understood… once they got into the groove of explaining it, they got more comfortable and later didn’t see it as disruptive.”

“We should extend the screener to other agencies, to adults and youth.”
Service Providers’ Attitudes, Knowledge and Practices

As indicated previously this project included a survey of service providers that measures the substance use, mental health, and concurrent disorders-related knowledge, attitudes and practices of service providers and their perceptions of interagency collaboration. It was administered before (Time 1) and after (Time 2) participation in the project. At the beginning of the project training (for standard implementation sites), all participating service providers were invited to complete the survey and 410 service providers completed the survey. Following the data collection period, service providers who had participated in administration of the GAIN SS were invited to complete the Time 2 survey: 149 service providers completed the Time 2 survey. A subset of 80 participants completed both the Time 1 and Time 2 surveys. The addictions service sector represented the largest proportion of the sample at both times, followed closely by mental health. At least three-quarters of the sample at each time was comprised of front-line clinicians.

<table>
<thead>
<tr>
<th>Agency lead comments about administering the service provider surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>“At Time 1, there was a captive audience. Time 2 was challenging across the board. If we could have had everyone back, put the survey in front of them, we would have had more completed.”</td>
</tr>
<tr>
<td>“There was a lot going on when the Time 2 request came. There were a lot of changes in progress and we had a lot of staff turnover.”</td>
</tr>
</tbody>
</table>
In general, at the start of the project, service providers reported positive attitudes about youth substance use and mental health concerns and high levels of relevant knowledge and practices. Nevertheless, following participation in this initiative, service providers reported significantly higher levels of knowledge regarding youth substance use and mental health issues. This was evident in comparing all time 1 and time 2 participants as well as when analyses examined only the subset of participants who completed questionnaires at both baseline and following the project (n = 80).
FIGURE 32: KNOWLEDGE, ATTITUDES, AND PRACTICES REGARDING CONCURRENT DISORDERS, SCREENING AND SERVICE INTEGRATION

Similar to findings regarding service providers’ attitudes towards addressing youth substance use and mental health concerns (e.g. Figure 31), service providers’ attitudes toward addressing youth concurrent disorders and screening were positive and remained so throughout the project. Knowledge about youth CD, self-efficacy for addressing CD and engaging in practices to address youth CD, however, were lower at the start of the project and increased significantly with participation in the project. In addition, perceptions of integration and collaboration across agencies to address youth CD also increased. This pattern of results is consistent across the full sample and the matched subset that completed the survey at both the beginning and end of the project.

Sector and site differences

Looking across the service sectors (as self-reported by service providers), the strongest impact of this initiative occurred within the addictions sector, although many similarities across sectors were apparent. Service providers from the addictions, mental health, and housing/shelter sectors reported an increase in knowledge regarding youth CD. Those from addictions and housing/shelter sectors also reported increases in self-efficacy for addressing CD, CD-informed practices, and integration of services across agencies. In addition, service providers in the addictions sector reported an increase in knowledge of youth mental health following participation in the project. Patterns of results in the mental health and youth justice service sectors were similar, though changes were not statistically significant. It was not possible to perform comparisons for the child welfare, education, and health sectors due to low numbers of service providers from these sectors completing the questionnaires at
follow-up. As well, differences in sample sizes across individual sites, as well as northern and southern sites limited the comparisons that could be conducted. Based on preliminary analyses, however, there do not appear to be significant overall differences between sites that are not better accounted for by differences in sector representation.

**Agency role differences**

Managers/administrators and those in front-line clinical positions reported similar increases in knowledge about youth substance use, mental health, and CDs. Changes in practice and integration of services were particularly evident among clinicians.

<table>
<thead>
<tr>
<th>Agency lead &amp; service provider comments about knowledge, attitudes and practices and service integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>“… consistent screening… everyone is singing from the same songbook.”</td>
</tr>
<tr>
<td>“The screener has helped improve communication between service providers in different agencies.”</td>
</tr>
<tr>
<td>“Need to look at how we can integrate mental health services into traditional programs.”</td>
</tr>
<tr>
<td>“Need to collaborate; youth don’t fit into ‘nice little boxes of services’.”</td>
</tr>
<tr>
<td>“Impact of not identifying early is huge – we are seeing those kids now.”</td>
</tr>
<tr>
<td>“Build capacity in agencies so they don’t all have to refer to us (addictions agency).”</td>
</tr>
<tr>
<td>“Using the screener facilitated network building. Being in a network increased opportunities for consultation and referral.”</td>
</tr>
<tr>
<td>“We are more attentive to making sure mental health is immediately addressed as well as substance use.”</td>
</tr>
<tr>
<td>“We need more training. This (data) proves what we’ve been saying… it helps to make the statement (need for CD training) loud and clear.”</td>
</tr>
<tr>
<td>“The Referral Resource Guide has allowed (services providers) to realize the gaps in the services they have.”</td>
</tr>
</tbody>
</table>
Summary of Findings, Discussion and Recommendations
Summary of Findings

Demographics

- Youth presenting for services to addictions, child welfare, education, family service, health services, housing, outreach and support, justice, mental health, and social service sectors contributed information to this report.
- Youth from across the age range participated, with differences in age being apparent across service sectors.
- Similar numbers of male and female youth participated from all sectors, with slightly more female youth.
- White/European (80%) and Aboriginal (11%) were the most commonly endorsed ethnicities amongst participants. Most youth reported being born in Canada and having English as their first language.
- Most (69%) participating youth were living in the parental/family home at the time of participation. As would be expected, youth living outside the parental/family home were significantly older than youth who reported living in the parental/family home.
- More than one third of participating youth indicated that they had experienced legal involvement.

Youth Needs

- Youth presenting to all participating sectors are experiencing significant substance use problems, with the highest rates of serious problematic substance use in the addictions sector (63%), followed by the housing, outreach and support sector (48%). Health services had the lowest rate of problematic substance use (20%), though still one fifth of participating youth endorsed serious substance use problems.
- Youth presenting to all participating sectors are experiencing significant internalizing mental health concerns, with the highest rates in the mental health sector (82%), followed by the housing, outreach and support sector (74%). Youth from the justice sector had the lowest rates of endorsement of significant internalizing difficulties, with approximately half of youth (47%) indicating concerns in this area.
- Youth presenting to all participating sectors are experiencing significant externalizing mental health concerns, with the highest rates in the addictions sector (66%), followed by mental health (63%). Youth from the health sector had the lowest rates of endorsement of significant externalizing difficulties, with approximately half of youth (45%) indicating concerns in this area.
- Fifty-six percent of youth screened positive for more than one disorder across problematic substance use, internalizing disorders and externalizing disorders and 31% screened positive for all three disorders.
Forty-one percent of youth screened positive for co-occurring substance and at least one mental health disorder across sectors, with the highest rates of concurrent disorders among youth from the addiction sector (57%), followed by youth from the housing, outreach and support sector (43%). The lowest rates were among youth who presented for service to the health service sector where almost a fifth of youth (17%) screened positive for concurrent disorders.

The concerns and needs of male and female youth differed significantly in a number of domains. For example, female youth aged 18 years or younger were more likely to screen positive for internalizing disorders than same-aged male youth. Male youth aged 18 years or younger, on the other hand, were more likely to screen positive for problematic substance use than same-aged female peers.

The needs and concerns of younger and older youth also differed substantially. For example, younger youth were more likely than older youth to screen positive for externalizing mental health problems. Older youth, on the other hand, were more likely than younger youth to screen positive for problematic substance use.

Forty-seven percent of youth endorsed lifetime suicide-related concerns, 31% in the past year and almost a fifth (17%) in the past month. Rates were particularly high among younger female youth.

Approximately half of youth (52%) endorsed trauma-related distress, with rates significantly higher among participating female youth (60%) than participating male youth (41%).

Youth from northern sites (N=92) were significantly more likely to screen positive for internalizing disorders. There were no differences in rates of endorsement of concurrent disorders or suicide related concerns.

### Service Provider Survey

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

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

- Service providers reported significantly higher levels of knowledge about youth concurrent disorders, self-efficacy for addressing concurrent disorders and engaging in practices to address youth concurrent disorders following participation in the project.

- Perceptions of integration and collaboration across agencies to address youth concurrent disorders were higher following participation in this project.
Discussion

Youth Needs

This project aimed to gather evidence about the substance use and mental health needs of youth aged 12 to 24 years presenting for service to cross-sectoral youth-serving agencies in participating communities across Canada. Data about the needs of 1305 youth from 8 communities were examined for this report. Based on information provided by service providers, this sample of youth represents the majority of youth seen at participating services during the project timeframe. Nevertheless, caution should be exercised in generalizing findings to youth who did not participate, as their needs may differ in unknown ways.

The findings of this project suggest that many youth presenting for service, regardless of which sector they present to, are experiencing significant substance use and/or mental health concerns. Moreover, more than half of participating youth endorsed significant concerns in more than one domain, and 2 in 5 youth screened positive for co-occurring substance use and mental health concerns. These findings suggest that recent efforts to improve capacity to address co-occurring substance use and mental health problems are warranted.

The findings of this report also provide support for the need for gender-sensitive approaches with youth given that the concerns and needs of male and female youth differed. As well, it suggests a need for developmentally-informed services that reflect the differing needs of younger and older youth.

Of particular note is the high rate of endorsement of suicide-related concerns. Almost 1 in 5 youth endorsed thoughts of suicide in the past month and almost half of youth indicated having thought about suicide in their lifetime. These rates highlight the need for suicide-related services, including early identification of concerns and high intensity mental health services.

Project and Implementation Processes

As described in this report there were several essential steps required to initiate, carry out and complete this project. First and foremost, local leadership was required to build a network through identifying, engaging and supporting partners from various youth service sectors. The interest, enthusiasm and initiative of the network leads were the drivers integral to the network development phase in each community. This included coordinating meetings with interested stakeholders to determine interest in project participation, prior to the initiation of the project and persevering through challenging administrative hurdles, particularly related to completing the required agreements and securing required research ethics approval(s). Ultimately the sustained hard work of the network coordinators, with the support of the network leads as well as the project leads, resulted in project participation, adherence to the project protocol and completion of the project. The project supported
the hiring of local network coordinators to carry out tasks related to the Lead Agency roles, particularly to support the local participating agencies. The intent was to support the projects while building local research capacity through participating in a collaborative research project. In some communities, including Dehcho Region, NWT, Nunavut and PEI, the NYSP complemented the Territorial and Provincial DTFP projects and the local leads and coordinators worked to integrate the project with work that was already underway in their communities. In other communities, such as Pictou County, Cumberland County and Guysborough/Antigonish/Strait Region, Nova Scotia and Thompson, Manitoba, where either a decision was made not to hire a coordinator or the coordinator was only involved for a limited period of time or in a limited manner (See Appendix F), the leads reported challenges in managing the project related tasks as effectively as they could have with more support.

Most of the communities exceeded their initial agreement to enlist partners representing three service sectors; some enlisting up to seven. In some of the communities, administrative challenges ranging from staff turnover to a school strike in one community, resulted in only a subset of agencies participating in all project activities (See Appendix F). The unanticipated extended period required to finalize formal agreements between the participating agencies (in one community, almost one year) as well as the delay between the training in the project protocol and the project launch (up to as long as six months), generated frustration and loss of momentum amongst some participating agencies and service providers. Once the project was officially launched, the project coordinators in some of the communities initiated a number of meetings, including a focus group (e.g., Prince George, B.C.) with service providers to reengage them with the project, explore ways to support and maintain their engagement, and generate enthusiasm and compliance with the project protocol. In addition, teleconference “mini-training” sessions were held for staff that had not been previously trained or for staff who requested a “refresher”.

The training curriculum material for the training/capacity building activities was developed in January 2011 (Pilot version) and modified based on participant feedback in February 2011 (Final version). Integral to the curriculum building process was an effort to ensure that the materials provided were relevant and accessible to the service providers that would be attending the training. Prior to each training the curriculum was reviewed to explore the need for any modifications and/or relevant updates. Based on this review an adapted version was developed for the Dehcho Region and Yellowknife, NWT, which were updated to include Northwest Territory relevant information and resources. In addition to this, interactive workbooks were created for Nunavut and the Dehcho Region, NWT. The project team developed three versions of the training package and two corresponding workbooks to ensure optimal learning and capacity building for the participants.

Providing more than one capacity building event, including teleconference training options for those who could not attend the “live” events, provided greater opportunity for all agency staff to receive training directly from the project leads. This helped to ensure that all aspects of the protocol were clearly and consistently communicated. Many agencies decided to send staff who would participate in the full project as well as staff who might use the screening tool with populations that were not part of this project (e.g., adults older than 24 years), as well as staff who would not be administering the
screener, given their role in the agency, but might receive youth who had been screened. As such, the capacity building component of the project had a broader reach than initially anticipated.

The project team encouraged the network leads and coordinators to facilitate regular network meetings to maintain engagement and provide on-going support and problem-solving as required. The project team also encouraged network leads to connect and support each other throughout each stage of this project. For example, many network leads and coordinators met in person at the Issues of Substance Conference 2011 in Vancouver at a networking event facilitated by the project team. In addition network lead/coordinator teleconferences were convened once the networks initiated the data collection stage. These meetings provided excellent opportunities for all the participating network leads and coordinators to share their experiences and learn from their project colleagues across Canada.

The project team regularly provided updates and information to various networks and committees and has presented information about the NYSP at conferences (see Appendix I) in an effort to maintain on-going engagement in knowledge exchange opportunities to continue to build capacity in the area of youth substance use and concurrent disorders and ensure that the learnings from this project are widely disseminated. As such, information about the NYSP has been shared with a diverse group of stakeholders including service providers, agency leaders, policy makers and researchers.

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

Staff concerns about potential challenges in engaging youth in screening and research processes are a common barrier to engaging service providers and community-based agencies in projects such as this one. The findings from this project across communities indicate that most youth who completed the screener, also agreed to participate in the research component of the project. Most of this information was captured on tracking sheets however where tracking sheets were not available, agency participants, anecdotally reported that across agencies that participated in all the project activities, 75-100% of youth were willing to complete the screener and also agreed to participate in the research component of the project. Other agencies reported that reduced participation rates in their agencies were reflective of youth reports that they had already completed the screener in another agency. In addition, some of the agencies reported seeing youth most often in crisis and as such administering the screener was not appropriate or feasible. This is very encouraging with respect to the feasibility of such initiatives and the potential of projects such as this to learn more about youth needs.

Following completion of data collection, through the network leads and coordinators, the project team learned that GAIN SS administration was continuing in some agencies in most of the communities
beyond the six month project data collection phase. Some agencies and services (e.g., CBDHA Addictions and Mental Health Services, Cape Breton, Nova Scotia), were planning to implement policies and protocols to establish on-going consistent implementation of the GAIN SS in their services. Others have continued to work to extend the capacity developed through participating in the project through their role(s) in other networks and committees. For example, in Thompson, Manitoba, the recently funded Youth At Risk North program (YARN) has received funds to provide screening training, with a focus on the GAIN SS, to other agencies in the region, particularly in the justice and education sectors. As well, some of the agencies that didn’t participate in the formal data collection portion of the project, nonetheless, had implemented the GAIN SS in their agencies (See Appendix E). This highlights the importance of considering unexpected consequences and suggests that an initiative such as this project may have the potential to significantly impact agency policy and protocol, cross-sectoral collaboration, and service provider practices.

During the course of the project a number of additional communities expressed interest in participating in a youth screening network project. Due to limited resources and since the original pilot youth screening project was completed in Ontario, it was decided to work with communities outside of Ontario. By linking to a Canadian Institutes of Health Research (CIHR) funded project, it has been possible to initiate a similar project, drawing on the learning from this project. In the last few months, youth screening networks have been launched in six communities in Ontario.

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

- Extending the intended reach of the project from 7 to 10 communities;
- Adapting the project to meet local community needs (i.e. Nunavut and Yellowknife, NWT);
- Extending the project reach and capacity building by providing training to agencies and service providers beyond those committed to full project participation;
- Extending the project reach and leveraging capacity building by linking the project to provincial and territorial DTFP projects;
- Extending the project reach and leveraging capacity building by linking the project to other initiatives (i.e. CIHR supported Ontario youth screening networks).
Agency lead & service provider comments about the project and the findings

“This is excellent data for us to have conversations about. There are really good opportunities here.”

“This project gave us really rich data that gives us information to base decisions on.”

“Having the data has opened my eyes to a sector that was in the back of my mind… justice system.”

“It is helpful to have evidence based data for planning where you are going with your resources.”

“Find this very useful, in validating needs of youth in our region.”

“No one is surprised by the findings. This is what we have been talking about. Now we have the data to show it.”

“Results raise the question of whether we should have separate substance use and mental health services or integrated services”

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

“If we can come together as a collaborative network, there is a lot that we can do.”
Limitations

The findings of this project are limited by a few important factors. The system to capture the extent to which the sample is representative of youth typically presenting to the participating services (service provider-completed tracking sheets) has limitations and the data indicate that some tracking sheets were not completed, although the extent of the problem is not clear. Accordingly, the generalizability of the findings is not known. Secondly, the screening tool is a high level screening tool intended to identify youth who would be likely to have a diagnosis with a full assessment and who thus would benefit from assessment and service planning. As a result, it does not provide detailed information about the areas of concern that are identified. Lastly, some communities and some sectors had lower rates of participation and/or smaller numbers of participants. This limited the analyses that could be conducted. Similarly, few participating youth identified as trans and as a result, the needs of these youth could not be explored.
Recommendations

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

- Gender-informed and gender-specific services should be considered to ensure that services delivered are designed to address the different types of difficulties male and female youth experience.
- Developmentally-informed and responsive services should be considered to ensure that services reflect the different needs of younger and older youth, especially transitionally-aged youth whose needs are often inadequately met by both youth and adult service systems.
- Implementation of consistent screening processes are recommended across sectors given the high rate of substance use and mental health concerns endorsed in both the specialized addictions and mental health sectors as well as in the other participating sectors, particularly the housing, outreach and support, and justice sectors.
- Response protocols tailored to agency mandate and capacity, considering local community resources, must be developed to guide and ensure consistent, appropriate service provider response to endorsement of concerns through the screening process.
- Continued capacity building regarding concurrent disorders across sectors is warranted given that over half of participants endorsed significant concerns in two or more domains. It is recommended that this be a particular consideration in the addiction and housing, outreach and support sectors, where the highest rates of concurrent disorders were found.
- This project aimed to improve early identification and pathways to care through evidence-based practice in the form of screening using a standardized tool. Subsequent projects should consider the importance of capacity building regarding interventions to address concurrent disorders, across sectors.
- The high rate of endorsement of suicide-related concerns highlights the need for targeted efforts to identify and address suicide-related concerns.
- To increase opportunities for early identification and intervention, consideration should be given to gathering similar information as was gathered through this project in other health care settings such as community based primary care, hospital emergency rooms and/or in other highly accessible settings such as educational settings.
- Building capacity for trauma-informed care across sectors is also suggested, given that 41% of male youth and 60% of female youth endorsed concerns related to traumatic distress.
The impact of social determinants of health on the manner and type of services available to youth should continue to be explored. For example, youth who had previous legal involvement, youth who had living arrangements outside the parental/family home, youth who were not employed, and older youth who were not in school had higher rates of screening positive for co-occurring substance use and mental health concerns. Developing strategies for early identification and intervention are warranted for youth, particularly those who are initiating engagement with illegal activities, disengaging from school, in group homes or shelters.

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

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

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

British Columbia
- Prince George
- Kelowna

Manitoba
- Thompson

Newfoundland
- St. John’s

Northwest Territories
- Yellowknife
- Dehcho Region

Nunavut
- Prince Edward Island
- Nova Scotia
- Cape Breton Region
- Pictou County, Cumberland County, and Guysborough/ Antigonish/Strait Region
Appendix B: Implementation Summaries for Standard Implementation Networks

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

- Youth concurrent disorders capacity building and screening and intervention protocol training, including pre-project service provider survey
- Six-month data collection phase
- Post-project service provider survey
- Preliminary data review meeting
- Final results webinar presentation
Cape Breton Region, Nova Scotia Network

Lead Agency

Cape Breton District Health Authority:
Addictions Services:
- Community Based Services
- Health Promotion and Prevention
- Inpatient Withdrawal Management
- Opiate Recovery Program
Mental Health Services:
- Adult Mental Health
- Child and Adolescent Mental Health
- Emergency Crisis and Community
- Inpatient Mental Health

Network Agencies

- Cape Breton Victoria Regional School Board *
- Department of Community Services:
  - Child Welfare*
- Department of Justice, Community Corrections
- Family Services of Eastern Nova Scotia
- Youth Health Center

* Participated in capacity building component of the project only

Participating Sectors:
- Addictions
- Child welfare
- Education
- Family services
- Health (Youth Health Centres)
- Justice
- Mental health

Network Summary:

- Capacity building: January, 2011
- Service providers trained: 120
- Data collection range: April 2011 – September 2011
- GAIN-SS collected: 483
- Joint data analysis: February, 2012
Dehcho Region, Northwest Territories Network

**Lead Agency**

Dehcho Health and Social Services Authority

**Network Agency**

Dehcho Health and Social Services Authority

- Fort Liard Health *
- Fort Liard Social Services
- Fort Providence Health *
- Fort Providence Social Services
- Fort Simpson Health *
- Fort Simpson Social Services
- Health Cabins
  - Nahanni Butte
  - Trout Lake
  - Wrigley

* Participated in capacity building component of the project only

**Participating Sectors:**

- Health services
- Outreach
- Social services

**Network Summary:**

- Capacity building: March, 2012
- Service providers trained: 21
- Data collection range: June 2012 – December 2012
- GAIN-SS collected: <12
- Joint data analysis: April, 2012
Kelowna, British Columbia Network

Lead Agency

ARC Programs

Network Agencies

Interior Health *
- Youth Substance Use Program

Ministry of Children and Family Development *
- Child and Youth Mental Health
- Response
- Youth Probation
- Youth Services

Okanagan Boys and Girls Club

Participating Sectors:
Addictions
Child welfare
Housing, outreach, and support
Justice
Mental health

* Participated in capacity building component of the project only

Network Summary:
- Capacity building: December, 2011
- Service providers trained: 43
- Data collection range: January 2012 – October 2012
- GAIN-SS collected: 113
- Joint data analysis: December, 2012
Pictou County, Cumberland County, and Guysborough/Antigonish/Strait Region, Nova Scotia Network

Lead Agency
Pictou Health Authority
- Addiction Services
- Mental Health
- Public Health

Network Agencies
Cumberland Health Authority
- Addiction Services
- Mental Health
- Public Health

Department of Justice and Correctional Services
- Cumberland Corrections
- Guysborough Antigonish Strait Corrections
- Pictou County Corrections *

Family Services of Eastern Nova Scotia
- Family Services of Antigonish *
- Family Services of Pictou County

Guysborough Antigonish Strait Health Authority
- Addiction Services
- Mental Health
- Public Health

Maggie’s Place Family Resource Centre *

Pictou County Centre for Sexual Health

Pictou County Women’s Centre *

Restorative Justice

Participating Sectors:
Addictions
Family services
Health services
Justice
Mental health
Outreach, housing, & support

Network Summary:
- Capacity building: February, 2011
- Service providers trained: 88
- Data collection range: September 2011 – August 2012
- GAIN-SS collected: 178
- Joint data analysis: October, 2012

* Participated in capacity building component of the project
Prince Edward Island Network

Lead Agency

Health PEI
- Addictions
- Mental Health

Network Agencies

Community and Correctional Services

Eastern School District *

* Participated in capacity building component of the project only

Participating Sectors:
Addictions
Education
Justice
Mental health

Network Summary:
- Capacity building: November, 2011
- Service providers trained: 107
- Data collection: February 2012 – August 2012
- GAIN-SS collected: 332
- Joint data analysis: October, 2012
Prince George, British Columbia Network
Lead Agency

Network agencies

Northern Health Authority
- Youth Community Outpatient Services

Central Interior Native Health Society *

Family Young Men’s Christian Association (YMCA) of Prince George *

Future Cents

Intersect Youth and Family Service Society

Ministry of Children and Family Development *

School District 57

Participating Sectors:
Addictions
Child welfare
Education
Mental health
Housing, outreach, & support

* Participated in capacity building component of the project only

Network Summary:
- Capacity building: February, 2011
- Service providers trained: 19
- Data collection: December 2011 – June 2012
- GAIN-SS collected: 50
- Joint data analysis: September, 2012
St John’s, Newfoundland Network

Lead Agency

Choices for Youth

Network Agencies

Community Youth Network
- Rogers Break Thru Project
- Springboard GED
- Street Outreach
- Youth at Promise

Eastern Health
- Bridges Program
- Central Intake *
- Community Mental Health Counsellors
- Complex Case Management *
- Family Services Counsellors *
- Janeway Family Centre
- Rowan Centre
- Youth Outreach Counsellors *
- Youth Services / Youth Corrections *

Stella Burry Community Services
- Naomi Centre

Participating Sectors:
- Addictions
- Family services
- Health services
- Housing, outreach, & support
- Justice
- Mental health

* Participated in capacity building component of the project only

Network Summary:
- Capacity building: April, 2011
- Service providers trained: 72
- Data collection range: January 2012 – July 2012
- GAIN-SS collected: 107
- Joint data analysis: October, 2012
Thompson, Manitoba Network

Lead Agency
Addictions Foundation of Manitoba (AFM)

Network Agencies
- Ma-Mow-We-Tak Friendship Centre *
- Manitoba Justice, Community and Youth Correctional Services *
- Marymound Inc *
- Nisichawayasihk Cree Nation *
- Northern Health Region (formerly BRHA) *
- School District of Mystery Lake *
- Sir John Hugh MacDonald Memorial
- Thompson Boys and Girls Club Inc *

Participating Sectors:
Addictions
Child welfare
Education
Justice
Mental health
Outreach, housing, & support

* Participated in capacity building component of the project only

Network Summary:
- Capacity building: March, 2011
- Service providers trained: 43
- Data collection range: September 2011 – June 2012
- GAIN-SS collected: 34
- Joint data analysis: September, 2012
The adapted implementation of the National Youth Screening Project was developed when an interested community was unable to participate in all the activities in the standard implementation. The adapted implementation focused on supporting the communities to facilitate network building and collaboration among their youth serving agencies, as well as capacity building to address youth substance use, mental health and co-occurring concerns. Adaptations made to the project for the two networks that participated in the adapted implementation were customized to address the particular needs and interests of each community.
Nunavut Network

Lead Agency

Department of Health and Social Services (Government of Nunavut)
- Mental Health and Wellness Division

Youth Worker Base Location (Agency)

- Clyde River (Ilisaqsivik Society)
- Kugluktuk (Kugluktuk Wellness Community Centre)
- Rankin Inlet (Pulaarvik Kablu Friendship Centre)

Network Summary:
- Capacity building: May, 2011
- Service providers trained: 3
- Joint review of draft report: March, 2012
Yellowknife, Northwest Territories Network

- Aurora College
- Centre for Northern Family (CNF)
- Community Justice
- Correctional Services of Canada (CSC) - Parole
- Department of Justice
- DITSS
- Early Childhood & School Services (ECE)
- Government of Northwest Territories (GNWT) - Health and Social Services (HSS)
- Government of Northwest Territories (GNWT) - Probation Services
- John Howard Society
- Katimavik

- MACA - Sports, Recreation and Youth
- NYSOF - Justice
- Royal Canadian Mounted Police (RCMP)
- Sidedoor Youth Centre
- Stanton Territorial Health Authority (STHA)
- V-Girls Campaign
- Yellowknife Association for Community Living (YKACL)
- Yellowknife Catholic Schools
- Yellowknife Education District 1 (YKI)
- Yellowknife Dene First Nation (YKDEN)
- Yellowknife Foster Family Association (YFFA)
- Yellowknife Health and Social Services Authority (YHSSA)
- Yellowknife Stanton Hospital

Network Summary:

- Capacity building: May, 2011
- Service providers trained: 37
- Joint review of draft report: March, 2012
Appendix D: Key Project Activities

Network Development

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

Capacity Building

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

Screening Implementation

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

Data Collection

Member agencies that participated in the full project participated in a six month data collection period. During this time, the GAIN SS and Background Information Form were administered to youth seeking service at their agencies and, where consent was provided, a copy was sent to the project team. Analyses and a local community report were generated through a collaborative process between the project team and the participating agencies.
## Appendix E: Project Activity Participation

<table>
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<th>Agency • Service</th>
<th>Agency Lead</th>
<th>Project Activity</th>
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| Addictions   | Cape Breton Region           | Cape Breton District Health Authority (CBDHA):                                                                                                           | Brandy MacNeill  
Brandy MacNeill  
Barry McNeil  
Samantha Hodder  
Priscilla McIntyre  
Sharon MacKenzie                                                           | Network Development: Yes  
Capacity Building: No  
Screening Implementation: No  
Data Collection: No                                                                 |
|              | Kelowna                      | ARC Programs                                                                                                                                             | Nicole Jackson                                                                                         | Network Development: Yes  
Capacity Building: No  
Screening Implementation: No  
Data Collection: No                                                                 |
|              |                              | Interior Health Youth                                                                                                                                     | Ginger Nickoli                                                                                            | Network Development: Yes  
Capacity Building: No  
Screening Implementation: No  
Data Collection: No                                                                 |
|              | Pictou County, Cumberland County, and Guysborough/ Antigonish/Strait Region | Cumberland Health Authority  
Guysborough Antigonish Strait Health Authority  
Pictou County Health Authority  
Health PEI Addiction Services                                                                 | Gaelene Parsons  
Tara MacDonald  
Kaylin Comeau  
Sean Morrison  
Ron Aylward                                              | Network Development: Yes  
Capacity Building: No  
Screening Implementation: No  
Data Collection: No                                                                 |
<p>| | | | | |
|              |                              |                                                                                                                                                    |                                                                                                        |                                                                                 |</p>
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| Mental Health | Cape Breton Region | Cape Breton District Health Authority (CBDHA):  
- Adult Mental Health 
- Child and Adolescent Mental Health 
- Emergency Crisis and Community 
- Inpatient Mental Health | Karen Shea, Julie MacDonald, Linda Parris, Corinna Simon |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         |         | ARC Programs | Nicole Jackson |  
- Ministry of Children and Family Development 
- Child and Youth Mental Health |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         | Kelowna |         | Karen Wnuk |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         | Pictou County, Cumberland County, and Guysborough/Anigoni/Straight Region | Cumberland Health Authority 
- Mental Health | Heather MacKenzie |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         |         | Guysborough Antigonish Strait Health Authority 
- Mental Health | Tara MacDonald |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         |         | Pictou County Health Authority 
- Mental Health | Lee Johnson |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
|         | Prince Edward Island | Health PEI Community Mental Health | Janice Smith |  
- Network Development |  
- Capacity Building |  
- Screening Implementation |  
- Data Collection |
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<td>Pulaarvik Kablu Friendship Centre, Rankin Inlet</td>
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Network Development | Capacity Building | Screening Implementation | Data Collection
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- Green circle indicates activity has been completed.
- Red circle indicates activity is planned.
- Blue circle indicates activity is in progress.
- Yellow circle indicates data collection has been completed.
Appendix F: Process Summary

National Project Summary

- Total number of agencies (Standard Implementation Networks): 42
- Total number of services (Standard Implementation Networks): 82
- Total number of agencies (Adapted Implementation Networks): 27
- Total number of service providers trained: 553
- Total number of GAIN SS received to date: 1,305
- Total number of sectors represented: 9

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<th>Number of people trained</th>
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<td>43</td>
<td>2 mos</td>
</tr>
<tr>
<td>Nunavut*</td>
<td>Capacity &amp; Network</td>
<td>3*</td>
<td>NA</td>
<td>0</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>Pictou County, Cumberland County, and Guysborough/ Antigonish/ Strait Region</td>
<td>All</td>
<td>9</td>
<td>18</td>
<td>0</td>
<td>88</td>
<td>7 mos</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>All</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>107</td>
<td>3 mos</td>
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<tr>
<td>Prince George, BC</td>
<td>All</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>19</td>
<td>11 mos</td>
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<tr>
<td>St. John’s, NF</td>
<td>All</td>
<td>4</td>
<td>15</td>
<td>1</td>
<td>72</td>
<td>9 mos</td>
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<tr>
<td>Thompson, MB</td>
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<td>9</td>
<td>9</td>
<td>1</td>
<td>43</td>
<td>7 mos</td>
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<tr>
<td>Yellowknife, NWT*</td>
<td>Capacity &amp; Network</td>
<td>24*</td>
<td>NA</td>
<td>1</td>
<td>37</td>
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</table>

*Adapted Implementation Networks participated in network development and capacity building only.
## Appendix G: Project Timeline

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
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<tbody>
<tr>
<td>Networking: Introduce project to potential participating agencies</td>
<td>Apr-Jul</td>
<td>Apr-Jul</td>
<td>Apr-Jul</td>
<td>Apr-Jul</td>
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<tr>
<td>Evidence-based training for participating agencies</td>
<td>Jul-Dec</td>
<td>Jul-Dec</td>
<td>Jul-Dec</td>
<td>Jul-Dec</td>
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<tr>
<td>Data collection launch</td>
<td>Jan-Mar</td>
<td>Jan-Mar</td>
<td>Jan-Mar</td>
<td>Jan-Mar</td>
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<tr>
<td>Data collection actively underway</td>
<td>Apr-Jun</td>
<td>Apr-Jun</td>
<td>Apr-Jun</td>
<td>Apr-Jun</td>
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<tr>
<td>Preliminary findings presented</td>
<td>Jul-Sep</td>
<td>Jul-Sep</td>
<td>Jul-Sep</td>
<td>Jul-Sep</td>
</tr>
</tbody>
</table>
Appendix H: Project Flow Chart

National Youth Screening Project: Project Flow

New youth (aged 12-24) presents for service

Youth info is recorded on Tracking Form

Youth is given Youth Package

Youth refuses to complete Package

Info is recorded on Tracking Form & regular agency service is delivered

Youth completes questionnaires & Consent to share info is provided

Questionnaire info is reviewed and used for service planning, copy of consent is provided to youth/parent

Original consent and anonymous copy of questionnaire package is submitted to Project Coordinator

Info is recorded on Tracking Form and agency service is delivered-informed by screening

Youth completes questionnaires & does not provide consent to share info

Questionnaire info is reviewed and used for service planning

Info is recorded on Tracking Form and agency service is delivered-informed by screening
Appendix I: Sample Project-Related Knowledge Exchange Activities

- 12th Canadian Collaborative Mental Health Care Conference (June 23 – 25, 2011), Halifax, Nova Scotia
  - Building Collaboration and Learning about Youth Needs through a Cross-Sectoral Network Screening Project

- Global Implementation Conference (August 15 – 17, 2011), Washington, DC, USA
  - Enhancing Evidence-Informed Treatment Practices for Youth through Cross-Sectoral Collaboration

- Issues of Substance Conference (November 6 – 9, 2011), Vancouver, British Columbia
  - National Youth Concurrent Disorders Screening Project: Collaboration in Progress

- Addiction Ontario’s 2012 Annual Addictions Conference (May 2012), Toronto, Ontario
  - Examining the Landscape of Youth Substance Use and Concurrent Disorders Services: National & Provincial Perspectives

- System Action & Evidence Exchange Network (National Webinar) (April 17, 2013)
  - National Youth Screening Project - Understanding Youth Needs and Service Provider Capacity
Appendix J: References


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