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Best Practices

Early Intervention, Outreach and
Community Linkages for Youth
with Substance Use Problems



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Executive Summary

The purpose of this project was to develop guidelines for best practices related to early intervention, outreach and community linkages for youth with substance use problems. The intention is to provide a wide range of health and community professionals with updated information about specific challenges in these areas and encourage further best practice research.

The final report is organized into five main sections:

- **Project background and description:** A summary of methodology and research activities.
- **Literature review:** A critical analysis of relevant research.
- **Interviews with key experts:** A summary of key insights from experts across Canadian provincial and territorial jurisdictions representing academia, managers and clinical professionals.
- **Focus groups with youth:** The perspectives of youth who are or have been in need of early intervention, outreach or community linkage services to address problem substance use.
- **Best practice statements:** Guidelines related to early intervention, outreach and community linkages for youth with substance use problems. The sections of the document that support each best practice statement are cited in Appendix B.

Youth with Substance Use Problems

Statistics Canada estimated that youth 15 to 24 years of age represented approximately 13.6% of the population in 2005. The most frequently used substances by youth are alcohol and cannabis. Early initiation of substance use has been predictive of longer-term problem substance use for both males and females. For most substances, research indicates that male youth are more likely than female youth to use substances at problematic levels, however female youth have a lower threshold to the effects of alcohol and drug consumption than males.

Youth with problem substance use have diverse life experiences, circumstances and concerns that extend beyond their problem substance use. Assisting them requires sensitivity to and understanding of their current life situations and the development of responsive strategies.

Early Intervention

Early intervention refers to specific measures undertaken for populations identified as being at risk for or already engaged in harmful behaviours or practices. With respect to youth with problem substance use, the challenge for families, clinicians and policy makers is to prevent or stop use before it becomes persistent or more difficult to change. Theorists assert that early intervention is important for decreasing the psychosocial consequences that accompany problem substance use and disrupt the educational, occupational and social development of youth.

Outreach

Outreach refers to services that actively “reach out” and provide help to those who would not otherwise look for support in the community. Providing outreach services is critical for reducing the problems associated with substance use for youth who are not connected to mainstream services or supports.

Community Linkages

Creating positive community linkages for youth is critical for their positive growth and development. Community linkages refer to community-based services that are sources of social support and interaction and have the potential to act as protective factors to prevent and reduce the consequences associated with problem substance use. These include family and peer interactions, and attachments to

school and community. Community linkages need to be accessible, responsive and valuable for youth early on in their addiction behaviour.

Best Practice Statements

The best practice statements reflect current research, key expert interviews with service providers, and focus group sessions with youth who have had substance use problems. As research continues, these statements will need to be reviewed and modified to reflect new knowledge. Sections of the document that support each best practice statement are cited in Appendix B.

Strengthening Service Delivery Orientations

Readiness to Change Model

Prochaska and DiClemente’s Stages of Change model is a practical framework for understanding and assessing readiness to change. This model supports the creation of collaborative interactions with youth who are at varying levels of readiness to pursue change, and is applied in conjunction with brief interventions and motivational interviewing strategies.

Strength-Based Methods

Strength-based approaches are designed to promote positive change through recognizing and engaging the strengths of youths, their respective families and communities.

Strength-based methods are also beneficial for engaging and intervening with high-risk youth populations.

Youth Perspectives

The perspectives of youth should be elicited and their leadership skills utilized when organizing and delivering community-based youth-focused services and programs. Feedback from non-users, as well as those at risk for problem substance use should be taken into consideration.

Youth-Specific Services

In some jurisdictions, only adult-focused interventions are available to youth. Service providers should strive to adopt outreach and early intervention services that are responsive to the developmental needs of youth. When youth request assistance or communicate a readiness to pursue change, service providers should act upon this “window of opportunity” and provide youth specific-services in a timely manner.

Inclusive vs. Exclusionary Policies

Inclusive policies that focus on relationship development and incorporate the influence of positive adult or peer roles will foster youths’ sense of belonging and attachment to school and community. Exclusionary policies and sanctions alone are regarded as ineffective for motivating positive changes in youth with substance use problems or in linking them with needed intervention services.

Client-Focused Considerations

Histories of Abuse and Trauma

Histories of sexual, physical abuse and trauma have been positively associated with the early initiation and development of problem patterns of substance use among youth. Counselling services should be made accessible to youth and family members as appropriate, to avert the emergence or escalation of substance use problems.

Basic Needs

Early intervention services, especially for street and homeless youth, should be accompanied by adequate supports and resources to address basic living concerns, including shelter, clothing, food and transitional housing. Without these services intervention efforts will likely be impeded and problem substance use continue.

Peer Influences

Lower levels of substance use by peers may decrease availability of substances, provide less social reinforcement for using substances, and provide models for healthier behaviours. Although forming new peer connections is challenging, providing opportunities for youth to engage in social activities with non-using peers is important for them to adopt healthier choices in daily living routines.

Concurrent Mental Health Disorders

Current evidence indicates that effective interventions for youth must provide an integrative approach to co-morbid mental health and substance use problems. These interventions require the development of a single point of entry for assessment and a coordinated service response with a focus on including family members when appropriate.

Cultural Sensitivity

Barriers to intervening with ethnoculturally diverse youth include stigma associated with disclosing problem substance use, lack of openness to involve external service providers, and language barriers. Recommendations for addressing these barriers include undertaking outreach efforts to youth and their families, providing services in the language of the client, and increasing sensitivity of service providers to the values and culture of specific ethnic groups.

Aboriginal Youth

In delivering problem substance use interventions to Aboriginal youth, it is important to assess the importance of spiritual values and traditions for the target population to ensure cultural congruence. Early interventions can incorporate traditions and cultural practices (legends, storytelling), bringing together positive family and community role models in the planning process, and integrating crafts and recreational activities to present and reinforce positive directions for change.

Youth in Conflict with the Law

Early intervention activities should be implemented at the “front end” of the justice system when youth first become involved with legal authorities. At this point, screening and assessment should be undertaken to identify substance use or mental health problems as part of cautioning, diversion or community-based sentencing.

Screening Processes

Role of Community-Based Service Providers

Emergency department personnel, health specialists and other community service providers are in unique positions to identify problematic patterns of use in youth. Questions about substance use should be incorporated as part of health and rehabilitation screening protocols.

Areas of Inquiry for Screening

Screening approaches should not be limited to exploring patterns of substance use. Other information related to aspects of the youth’s life can be critical to understanding the dynamics underlying current problem substance use. Areas for investigation include family functioning, peer influences, school performance, areas of stress and coping, as well as readiness to change.

Early Intervention

Early Intervention with Young Adolescents

Early intervention efforts should be targeted at middle and junior high schools. Times of transition from middle/junior high to high school are often accompanied by increased exposure to older youth who use substances and to decreased supervision by school personnel and parents.

Brief Interventions

Recent research lends support for the use of brief intervention approaches for working with adolescents with substance use problems. These methods are generally defined as having a limited number of helping sessions and incorporate cognitive-behavioural approaches, motivational interviewing concepts and a focus on clients' areas of ability and strength.

Group Interventions

Group-based early interventions are enhanced by incorporating culturally based activities, applying discussion-oriented approaches and using incentives (free food or snacks) or other socially acceptable reasons for program attendance. Although small group approaches involving youth peers have been described as beneficial for reducing problem substance use, some research suggests that peer associations also have the potential to counter such efforts. Caution needs to be used when grouping youth with high-risk behaviours because unstructured time may reinforce existing problem substance use patterns.

Outreach

Outreach Locations and Times

Outreach should focus on meeting youth in their natural settings and community contexts where they spend time on a regular basis with their peers. Points of contact include street corners, coffee shops, drop-in agencies, parks, shelters, hospitals, custody settings, school-based activities and programs. A mobile service (e.g. van) that makes contacts in a variety of places can reach youth in rural or more isolated areas. Outreach is most effective when times can be flexible and include both evenings and weekends, and when it provides opportunities for multiple contacts.

Outreach Worker Competencies

Outreach workers must be able to communicate effectively with the target youth population and demonstrate an understanding of developmental milestones. It can be advantageous for outreach workers to have personal experience in the targeted outreach context and specialized training in addictions, mental health and motivational interviewing.

Preliminary Outreach Activities

Preliminary outreach activities should focus on building trust and fostering positive interactions between youth and outreach workers. Initial contacts with youth should be non-threatening, respectful and include brief informal conversations over frequent encounters.

Follow-Up Outreach and Intervention Activities

As relationships are developed with youth, interactions may then begin to incorporate a wider range of early intervention efforts, including focussing on increasing awareness of the risks of ongoing substance use; screening for concurrent mental health and substance use problems; linking youth with basic need services, such as shelter, food and clothing; health care; and identifying community supports to help sustain small positive changes.

Relevant Community-Based Supports

Youth-Focused Agencies

Community-based non-profit agencies and service clubs that focus on youth and family engagement have a central role to play in reaching out to youth. Outreach and early intervention activities can be implemented in conjunction with community agencies where youth are already receiving services.

Housing Options and Policies

Many jurisdictions do not have access to emergency shelter programs or longer-term residential options designed to meet the needs of youth. Conditions of available rooming houses are often unregulated and potentially unsafe for youth. Substance use problems may often be more frequent in these locations, placing youth at increased risk for development of addictions and associated problems. Service providers and community leaders must

collaborate to address policies and service gaps related to safe and regulated housing options for youth.

Family Collaboration

Early intervention activities should engage family support when appropriate to address problem substance use with youth. Approaches for helping families include providing methods for effective communication, education on adolescent patterns, signs and basic features of substance use, stages of change and problem solving. Family members can provide assistance by providing transportation to appointments, ensuring basic needs are met, and supervision for younger adolescents. Access to counselling services for youth and family members should be offered in a timely manner.

School-Based Strategies

School-based strategies to address youth substance use should consist of multiple components, including staff and student team members, individual counselling, small-group interventions, as well as policies and procedures for student assessment, referral and support.

Youth Mentorship

Mentorship programs for youth have been associated with increases in school participation, reduced involvement with negative peer associations and enhanced skills to refuse substance use. Key areas to consider when establishing mentorship relationships include creating a safe and comfortable environment for both the youth and adult, finding common interests and having mechanisms for problem solving difficulties or challenges.

Recreational and Leisure Activities

Recreational activities provide structured opportunities for building rapport with youth and contribute to expanding and strengthening youths' confidence and interests in community-based activities and relationships that can be sustained over time.

Coordinating and Integrating Community Approaches

School-Based Service Collaboration

School sites may be used for delivering coordinated services for youth and their families. School-based services might include support from local police, mental health services, addiction counsellors and other service providers representing a range of health and social programs.

School Engagement Strategies

Re-engaging youth in school following substance use problems is an important consideration in strengthening their links to the community and addressing their learning needs. Motivation to return to and stay in school is facilitated by providing individual academic assistance, mentorship, hands-on learning activities, basic life skills instruction, and opportunities to participate in apprenticeship (e.g. trades) or co-op learning experiences in the community.

Information Exchanges

Information exchanges among service providers help to increase the awareness of potential service delivery capacity and opportunities for developing coordinated and collaborative service delivery approaches in the community. They may include developing regional resource directories outlining youth and family-focused services, organizing community fairs and open houses where service providers can promote their services, and implementing community-wide planning sessions to address policy gaps or concerns.

Case Management Practices

Case management strategies have been applied to reduce barriers associated with service accessibility, and to encourage the development of positive community linkages. Case managers should ensure that community plans are coordinated and tailored to meet the unique needs and circumstances of the youth.

Coordinated and Collaborative Service Delivery Approaches

Coordinated and collaborative service delivery practices can reduce duplication of services and provide opportunities for integrating interventions. Services should develop protocols for common intake, assessment and referral; interagency consultation; communication and case-planning; memorandums of understanding to support consistent service delivery; cooperation among agency personnel; and co-locating and co-facilitating front-line services.

Consultation and Community Awareness

Addiction personnel should be available to consult with other service providers who routinely encounter youth at risk for problem substance use. Consultation may include organized professional development sessions or individual consultations on a range of topics, including substance use patterns among youth, screening methods and co-morbid mental health. Educating service providers and other community members is important in community-based outreach and early intervention activities to reduce stereotypes and foster greater readiness for community members to reach out to youth.

Evaluation

Early intervention and outreach programs should be reviewed regularly to ensure the extent to which they are efficient and effective.

Future Research

The outcomes of this project pointed to specific gaps in research and knowledge related to early intervention, outreach and community linkages for youth with substance use problems. The following summarizes these areas:

Youth and Sexual/Gender Orientation

An estimated 10% of the population may comprise individuals who are lesbian, gay, bisexual, transsexual, transgendered or questioning (LGBT/TQ) (CCSA, 2006). Minimal research has focused on the needs of youth in these populations or on effective approaches for addressing the needs of those with problem substance use (Noell and Ochs, 2001).

Internet-Based Early Intervention Approaches

Some theorists have stressed the potential benefits of integrating motivational enhancement content with Internet-based approaches for intervening early with youth. More research is needed to further explore the potential efficacy of early intervention approaches that use Internet-based applications.

Introduction

The purpose of this project was to develop guidelines for best practices related to outreach, early intervention and community linkages for youth with substance use problems, to provide health and community professionals with updated information around the specific challenges in these areas, and to encourage further best practice research.

Health Canada initiated this project as part of the research agenda developed by the Alcohol and Drug Treatment and Rehabilitation Federal/Provincial/Territorial Working Group (ADTR Working Group). Part of the mandate of the working group is to oversee the development and implementation of research studies that contribute to effective and innovative substance abuse treatment and rehabilitation programs by identifying best practices, evaluating model treatment and rehabilitation programs, identifying emerging issues and disseminating the knowledge across the country.

This project builds on a series of best practice publications, including *Best Practices – Substance Abuse Treatment and Rehabilitation* (Health Canada, 1999); *Best Practices – Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2001a); *Best Practices – Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During*

Pregnancy (Health Canada, 2001b); *Best Practices – Treatment and Rehabilitation for Women with Substance Use Problems* (Health Canada, 2001c); *Best Practices – Treatment and Rehabilitation for Youth with Substance Use Problems* (Health Canada, 2001d); *Best Practices – Methadone Maintenance Treatment* (Health Canada, 2002a); *Best Practices – Treatment and Rehabilitation for Seniors with Substance Use Problems* (Health Canada, 2002b); *Best Practices – Treatment and Rehabilitation for Driving While Impaired Offenders* (Health Canada, 2004); and *Best Practices – Early Intervention, Outreach and Community Linkages for Women with Substance Use Problems* (Health Canada, 2006a).

The goal is to make best practice guidelines available to service providers, program planners and policy makers who are involved in delivering substance abuse programs or services to youth. As well, this publication will be a resource to clients of these services, their families and communities. The best practice guidelines were identified by reviewing recent literature, interviewing key informants on current and recommended practice, and interviewing youth who have had or are now having problems with substance use.

This report is organized into five main sections:

- Project background and description: A summary of the methodology and research activities.
- Literature review: A critical analysis of relevant research.
- Interviews with key experts: A summary of key insights from experts across Canadian provincial and territorial jurisdictions representing academia, managers and clinical professionals.
- Focus groups with youth: The perspectives of youth who are or have been in need of early intervention, outreach or community linkage services to address problem substance use.
- Best practice statements: Guidelines related to early intervention, outreach and community linkages for youth with substance use problems. The sections of the document that support each best practice statement are cited in Appendix B.

1.1 Methodology

Literature Review

The literature review provided a critical analysis of the key issues related to early intervention, outreach and community linkages for youth with substance use problems. Documents were drawn from Canadian and international sources of published information and articles in recognized publications, as well as from recent unpublished reviews by key experts. The scope of this search was limited to relevant documents published or written between 2000 and 2006, including:

- professionally reviewed or expert-juried research documents;
- summary and literature review articles;
- comparison studies of different approaches or methods;
- controlled trials or quasi-experimental investigations;
- program evaluation reports;

- theoretical literature related to best practice research;
- pre-2000 publications where warranted by unique research.

The following databases were consulted:

- Medline (medical studies);
- CINAHL (nursing and allied health literature);
- Canadian Centre on Substance Abuse (CCSA) Addictions Databases;
- EBM Reviews – Cochrane Central Register of Controlled Trials; Cochrane Database of Systematic Reviews;
- ETOH (National Institute on Alcohol Abuse and Alcoholism);
- SAMHSA (Substance Abuse and Mental Health Services Administration – U.S. Department of Health and Human Services);
- PsycInfo (psychological studies).

Key Experts

In consultation with members of the ADTR Working Group, key experts working in early intervention and outreach services or facilitating community linkages for youth with substance use problems were identified throughout Canada (see Table 4). The 18 key experts who participated held various roles and had diverse backgrounds (Tables 5 and 6). All respondents were given time and opportunity to provide detailed information for each question. Interviews were conducted over the phone in either English or French, given the preference of the interviewee.

Focus Groups

Eight focus group sessions were conducted across four Canadian regions. Initial contact with participants was done in collaboration with local and regional youth service agencies. Forty-six youth participated in the sessions (see Table 7).

Definition of Best Practice

The concept of “best” or “better” practices related to program delivery in the health and community sectors has been approached with varying degrees of rigour (Association of Ontario Health Centres [AOHC], 1999; Health Canada, 2002b). Recent approaches have emphasized the importance of systematically analyzing the convergence of published literature and lessons learned from practitioners, policy makers and recipients of services. The outcomes are subsequently used to formulate statements that serve as guidelines for program managers and practitioners involved in developing community-based service delivery systems (AOHC, 1999; Murnaghan, 2006).

For this project, best practices are emerging guidelines, gleaned from client and key expert perspectives and the literature. Consistent with other Health Canada documents, the best practice guidelines outlined in this report should be regularly reviewed as research in this area continues.

1.2 Scope and Limitations

The focus of this report is on early intervention, outreach and community linkages for youth with substance use problems. Youth were defined as adolescents and young adults between the ages of 12 and 24. Research related to adults or to children under age 12 was considered to be beyond the scope of this project. The term “substance” is used to describe alcohol, solvents, prescription medication and illicit drugs.

Efforts were made throughout each phase of the project to investigate gender-based differences among youth. Where specific differences are indicated, descriptions of those are noted. As well, risk and protective factors are addressed throughout the document.

2.1 Patterns of Youth Substance Use

KEY POINTS

- Statistics Canada estimated that youth 15 to 24 years of age represented approximately 13.6% of the population in 2005.
- The most frequently used substances are alcohol and cannabis. Initiation rates for illicit substance use tend to peak during adolescence.
- Early initiation of substance use is associated with longer-term problem substance use for both males and females.
- Higher rates of injection drug use are evident among homeless and street youth.

2.1.1 General Prevalence

Statistics Canada estimated that there were approximately 4.4 million youth 15 to 24 years of age, or 13.6% of the population, in 2005 (ages 15–19: 6.6%; ages 20–24: 7.0%). The group aged 10 to 14 years comprise another 6.5% (Statistics Canada, 2006a). Research over the past several decades indicates that between the late 1970s and the early 1990s, substance use among youth declined. However, more recently there has been an increase in problem substance use to the high levels of the early and mid-1970s (Canadian Centre on Substance Abuse [CCSA], n.d.(b)); Health Canada, 2001f). The most frequently used substances by youth are alcohol and cannabis (Health Canada, 2001d). Self-report on past-year use shows that approximately two-thirds have experimented with alcohol and one-third with cannabis (CCSA, n.d.(b)).

The Canadian Addiction Survey (2004) (Adlaf, Begin and Sawka, 2005) (for individuals 15 years and over) indicates there have been significant increases in alcohol and cannabis use since 1994, with people under age 25 accounting for most of the increase (Adlaf et al., 2005). Past-year drinking is highest (90%) among youth aged 18 to 24 years (Adlaf et al.,

2005). Past-year cannabis use is 30% for 15- to 17-year-olds and 47% for 18- to 19-year-olds; however, use drops substantially after age 24 (Adlaf et al., 2005). Estimates of illicit drug use are low (at least one of cocaine; speed; ecstasy; hallucinogens; heroin) (3%) for the general population, but higher for 18- to 19-year-olds (18%) and 20- to 24-year-olds (12%) (Adlaf et al., 2005). The Canadian Community Health Survey: Mental Health and Well-being (2002) shows that prevalence of past-year heavy drinking and illicit drug use peaks during the early twenties (60% and 47%, respectively), and frequent episodes (at least monthly) of heavy drinking are common among those aged 20 to 24 (Tjepkema, 2004).

Initiation rates for illicit substances tend to peak during adolescence (Clark, 2004). For many youth, problem substance use decreases or discontinues in young adulthood (American Academy of Child and Adolescent Psychiatry [AACAP], 2005). Longitudinal observations reveal that most youth who start using substances often begin with alcohol. From this point, some progress to using marijuana, with a smaller portion subsequently moving on to harder drugs (AACAP, 2005; Brown and D'Amico, 2001; Health Canada, 2001f). Chronic substance use usually involves multiple substances (Deas, Riggs, Langenbucher, Goldman and Brown, 2000). Several Canadian provinces reported that multiple and concurrent substance use increased during the 1990s (Health Canada, 2001f). In particular, adolescent males have been reported to use a broader array of drugs than their adult counterparts (Deas et al., 2000).

The 2004 Canadian Campus Survey, of full-time undergraduates, indicated that 77% reported using alcohol within the past 30 days. Almost one-third also reported heavy drinking (five or more drinks per episode); this was more common among students living away from home. Cannabis was the next most frequently used substance. Thirty-two percent indicated using cannabis during the past year, and 17% during the past month. Following cannabis, hallucinogen use was reported by 6% of undergraduates during the past year, and opiate use was indicated by 5% (CAMH, 2005).

Survey results of substance use from various territorial and provincial government documents are summarized in Tables 1 and 2. Prevalence estimates of past-year alcohol use varied from 49% in Prince Edward Island to 69% in Quebec (Table 1). Rates of heavy use or binge drinking over the last month ranged between 23% in Ontario and 31% in Alberta (Table 1). Cannabis was the second most reported substance used by youth, with estimates of past-year use varying from 24% in Prince Edward Island to 39% in Quebec. Daily cannabis use was also noted in various reports, ranging from 3% of Ontario students (Grades 7–12) to 9% of Yukon students (Grades 8–12) (Table 1).

Substances less frequently reported by youth included LSD, psilocybin (mushrooms), mescaline, inhalants and cocaine. Survey results showed that use of hallucinogens averaged nearly 10%, while rates for the remaining substances were typically below 6% (Table 2). One limitation to student drug use surveys is that they have limited capacity to show prevalence for youth “out-of-the-mainstream” (Health Canada, 1996, 2001f).

Table 1: Prevalence (%) of Alcohol and Cannabis Use by Students

Province	Alcohol			Cannabis		
	Past year ^A	Heavy use ^B	Drunkenness ^C	Past year ^A	Monthly or more	Every day
N.L. 2003 ¹	58		36	35	21	5
N.S. 2002 ²	52	29	28	37	16	5
P.E.I. 2002 ³	49			24		
N.B. 2002 ⁴	53			35		
Que. 2002 ⁵	69			39	25	4
Ont. 2005 ⁶	62	23	22	27		3
Man. 2004 ⁷	59	25		33	11	4
Alta 2005 ⁸	63	31		27		
B.C. 2003 ⁹	57*	26		37*		
Y.T. 2001 ¹⁰					17	9

Table 2: Prevalence (%) of Other Drug Use in the Past Year by Students

Province	LSD	Tranquillizers	Hallucinogens**	Inhalants	Amphetamine	Ecstasy	Cocaine	Heroin
N.L. 2003 ¹	5	3	8	6	5	2	4	1
N.S. 2002 ²	6		12	5	9	4	4	2
P.E.I. 2002 ³	4	4	7	6		4	2	2
N.B. 2002 ⁴	5	5	12	5	11	4	4	2
Que. 2002 ⁵			13	2			5	1
Ont. 2005 ⁶	2	2	7	5	2	5	4	1
Man. 2004 ⁷				3	3	3		
Alta 2005 ⁸	2	2	9	3		6	4	1
B.C. 2003 ⁹			13*	4*	4*		5*	1*
Y.T. 2001 ¹⁰	5*		24*	4*		7*	5*	

^A Students reporting use in the past year

^B Defined as binge drinking or consuming five or more drinks in one episode in the past month

^C Drank to the point of drunkenness in the last month

* Prevalence based on “ever” having used the substance

** Hallucinogens usually included psilocybin (mushrooms) and mescaline

¹ Poulin, Martin and Murray. (2005). Newfoundland and Labrador (Island Portion Only) Student Drug Use Survey 2003 Summary Report.

² Poulin. (2002). Nova Scotia Student Drug Use 2002 Technical Report. Province of Nova Scotia.

³ Van Til and Poulin. (2002). Prince Edward Island Student Drug Use Survey 2002 Highlights Report.

⁴ Liu, Jones, Grobe, Balram and Poulin. (2002). New Brunswick Student Drug Use Survey 2002 Highlights Report.

⁵ Perron and Loiselle. (2003). Portrait of the Situation in 2002 and Main Comparisons with 2000, Quebec Survey of Tobacco Use in High School Students, 2002 (Summary Results), Québec, Institut de la statistique du Québec.

⁶ Adlaf and Paglia-Boak. (2005). Ontario Student Drug Use Survey Highlights: Drug Use Among Ontario Students—1977–2005. Centre for Addiction and Mental Health.

⁷ Patton, Mackay and Broszeit. (2005). Alcohol and Other Drug Use by Manitoba Students. Manitoba High School Survey 2004. Addictions Foundation of Manitoba.

⁸ AADAC. (2006). The Alberta Youth Experience Survey (TAYES) 2005 Summary Report.

⁹ McCreary Centre Society. (2004). Healthy Youth Development: Highlights from the 2003 Adolescent Health Survey III.

¹⁰ Government of Yukon Women’s Directorate and the Department of Education. (2002). A Capella North 2 (ACN2) 2001. Bulletin 5 Alcohol and Drugs.

2.1.2 Gender-Specific Considerations

Female youth often have a lower threshold than males to the effects of alcohol (Health Canada, 2001f). In addition, female youth tend to experience symptoms of dependence more quickly and are often more susceptible than males to health problems related to alcohol and drug consumption (Poole and Dell, 2005).

Histories of sexual and physical abuse are positively associated with increased substance use and are more frequent among female than male youth (Ballon et al., 2001; Poole and Dell, 2005). Research suggests that some female youth use substances to ameliorate mood, increase confidence, cope with problems, loosen inhibitions, lose weight or enhance sexual experiences (Poole and Dell, 2005).

For most substances, research indicates that male youth are more likely than female youth to use substances at problematic levels (Poole and Dell, 2005). Student drug use surveys reveal that males' substance use is higher for most drugs investigated. Exceptions to this pattern include non-medical stimulants such as diet pills (Health Canada, 2001f). In an Australian study investigating hospital emergency room visits, alcohol use was more prevalent among male than among female youth, whereas prescription medications were more often used by females (Hulse, Robertson and Tait, 2001).

Studies on injection drug use among street youth have revealed conflicting findings, with some reporting higher rates among females than among males, and others reporting lower rates (Health Canada, 2001f; Montgomery et al., 2002). In one study, it was noted that young

women were more apt to use protective behaviours such as accessing needle exchange and carrying clean needles. The authors suggested that young women might be more open to receiving interventions to reduce both their own risks and those of their social networks (Montgomery et al., 2002).

2.1.3 Age of Initiation

Early initiation of substance use has been predictive of longer-term problem substance use for both males and females (D'Amico et al., 2001; Health Canada, 2001f; Manning et al., 2001; Simkin, 2002; Sung, Erkanli, Angold and Costello, 2004; Usher, Jackson and O'Brien, 2005). Early onset and a rapid escalation of substance use patterns have also been identified as risk factors for subsequent addictions (AACAP, 2005). In a community sample of youth interviewed at age 12 and again several times before the age of 30, those who drank at an earlier age were more likely to develop alcohol use problems. Heavy first-time use was predictive of greater problems with alcohol (Warner and White, 2003).

Early drinkers are also more likely to develop problems with alcohol and other drugs (Brown and D'Amico, 2001; Grant, Stinson and Harford, 2001; Stueve and O'Donnell, 2005). Studies suggest that early initiation of drug use (before the age of 14) is associated with greater risk for subsequent alcohol and poly-drug use as well as injection drug use (Ellickson, Tucker, Klein and Saner, 2004; Grant et al., 2001; Storr, Westergaard and Anthony, 2005; Sung et al., 2004). One longitudinal study indicated that when onset of alcohol use was delayed, there was a corresponding reduction in alcohol

dependence (Grant et al., 2001). Deferred initiation of cannabis and tobacco use also decreased the likelihood of developing subsequent problem substance use (Ellickson and Morton, 1999; Gil, Wagner and Tubman, 2004; Grant et al., 2001).

2.1.4 Alcohol

Alcohol is often the first and the most frequently used substance by Canadian youth (Government of Yukon, 2002; Health Canada, 2001f; Stice, Myers and Brown, 1998).

Approximately two thirds of middle and high school students report consuming alcohol at least once in the past year (Health Canada, 2001f). Males were more likely than females to use alcohol (Adlaf and Paglia, 2003). Research suggests that use of alcohol may disinhibit youth and encourage experimentation with other substances (Stice et al., 1998).

In an American sample, initial alcohol use was noted to be more likely to occur in the context of family gatherings. Youth who initiated use outside of family situations were at greater risk of developing later alcohol use problems. Feeling “drunk” upon initial use was also reported to be an important predictor of future problem drinking (Warner and White, 2003).

Levels of use among peers have also been positively associated with alcohol use escalation as well as reduction rates. When peers use, many youth are more inclined to use because of increased accessibility of substances and social acceptance. In contrast, lower levels of use among peers decrease availability, involve less social reinforcement and model more appropriate coping strategies and lifestyles (Stice et al., 1998). Escalation of alcohol use

has also been associated with low parental support, negative affect (e.g. anxiety and depression) and internalizing symptoms (e.g. withdrawn behaviours, somatic complaints) (Stice et al., 1998).

Binge or heavy episodic drinking, usually defined as five or more drinks on one occasion for males and four or more for females, has been identified as a common pattern among many adolescents. In a high school sample from California, half were characterized as having been binge drinkers at some point (D’Amico et al., 2001). Researchers have noted that for many youth, binge drinking is a transitory pattern, with youth moving into and out of binge patterns of consumption within a few years (Baer, Kivlahan, Blume, McKnight and Marlatt, 2001; D’Amico et al., 2001).

Binge drinking among high school students has been linked with poorer academic performance and histories of engaging in other risk-taking behaviours (D’Amico et al., 2001). One longitudinal study in Australia indicated that binge drinking in adolescents was a strong predictor of subsequent problems with alcohol use in adulthood (Masterman and Kelly, 2003).

Among adults, alcohol use disorders are sometimes linked with performance decrements in visuo-spatial, locomotor, executive functioning (inhibiting actions, restraining and delaying responses, attending selectively, planning, organizing) and memory functioning (Brown, Tapert, Granholm and Delis, 2000). In particular, executive functioning was observed to have slow recovery from central nervous system exposure to alcohol. In one study of adolescents 15 to 16 years of age,

alcohol-dependent youth exhibited neuro-cognitive deficits in visuo-spatial aspects and in retention of recently acquired information. The researchers commented that such deficits exacerbate academic problems that in turn enhance risk for social problems (Brown et al., 2000).

2.1.5 Cannabis

Among provincial Canadian student drug use surveys, reports of past-year cannabis use varied from 24% in Prince Edward Island to 39% in British Columbia (see Table 1). For many, cannabis use is initiated during later middle school or at the beginning of the secondary level (AADAC, 2006; Patton, Mackay and Broszeit, 2005; von Sydow et al., 2001). In one longitudinal investigation, approximately half of all cannabis users had spontaneously ceased their use by their early twenties; however, cannabis use was linked with the initiation of other illicit substances (von Sydow et al., 2001).

The psychoactive effects of smoking or ingesting cannabis include a sense of well-being, a decrease in inhibitions, difficulty with concentration, and an increase in the perceived intensity of sensations (Roberts, 2003). Some individuals experience anxiety, depression or paranoia. At high doses, panic attacks and hallucinations may occur (Roberts, 2003). Factors predicting initial cannabis use include:

- accessibility;
- male gender;
- low socio-economic status;
- adverse life events;
- concurrent mental health disorders;
- low parental attachment and conflicting family relationships;

- parental substance use problems (von Sydow et al., 2002b);
- poor academic performance (Ellickson et al., 2004).

Research indicates that approximately 66% of 14- to 16-year-olds who are offered cannabis will use it. For those who have ever used, approximately 34% will proceed to regular use (Manning et al., 2001). Higher rates of cannabis use have been noted among street or homeless youth (66% to 88%) (CCSA, n.d.(a)). Factors predicting progression to cannabis abuse and dependence include male gender, younger age, other substance abuse or dependence and early parental loss (von Sydow et al., 2002b).

2.1.6 Volatile Substances/Inhalants

Problematic substance use includes inhaling fumes or vapours from solvents and other volatile substances, such as paint thinner, glue, gasoline, paint, correcting fluid, felt-tip markers and aerosol sprays with gas propellants. Vapours can be inhaled by sniffing from a container, breathing through soaked materials or inhaling concentrated fumes from a bag placed over the mouth. Psychoactive effects include light-headedness, hallucinations, impulsiveness and a brief high. Higher rates of inhalant use have been observed among street youth, inner-city youth and some First Nations and Inuit youth residing in rural and remote areas. Surveys in Canadian secondary schools indicate that most who use volatile substances are between the ages of 10 and 17, with use peaking between 12 and 15 years of age (Dell and Beauchamp, 2006).

Inhalants are often first used during the pre-adolescent years (Health Canada, 2001f). In a British study of youth aged 14 to 16, approximately 44% of those who were offered solvents subsequently initiated use (Manning et al., 2001). Some research indicates that inhalant use is more common among males than among females (MacLean and d'Abbs, 2002).

The Ontario Student Drug Use Survey reported that between 1977 and 2001, prevalence of solvent abuse during a 12-month period for students in Grades 7 to 13 was on average 2.5% (Dell and Garabedian, 2003). The 1998–99 National Longitudinal Survey of Children and Youth asked 12- and 13-year-olds whether their friends had experimented with glue or solvents. Approximately 90% indicated that none of their peers or friends had used solvents; the remaining 10% reported that a few, most, or all their friends had tried solvents (Dell and Garabedian, 2003). Although concerns have been raised in the media about solvent abuse among Canadian Aboriginal peoples, current prevalence is unknown. In a survey of First Nations and Inuit communities, approximately half of all participants who had abused solvents had begun to use them when they were 11 years of age or younger. Approximately 43% of the respondents described themselves as experimental users, 38% referred to themselves as social users and 19% considered themselves chronic users. Approximately 76% of those who used solvents also used alcohol (Dell and Garabedian, 2003).

2.1.7 Non-Medical Use of Prescription and Over-the-Counter Drugs

Surveys of student drug use in Grades 7 to 12 indicate that approximately 7% of females and 5% of males in Ontario reported the non-medical use of stimulants, such as diet pills, during the past year (Adlaf and Paglia, 2003). Non-medical use of amphetamines and/or methylphenidate (Ritalin) was reported by 2% of Alberta youth (AADAC, 2006), 3% of males and females in Ontario (Adlaf and Paglia, 2003) and 12% of females and 14% of males in Nova Scotia students in Grades 7, 9, 10 and 12 (Poulin, 2002). In Manitoba, surveys of students revealed that the prevalence of using other people's prescriptions increased from Grade 7 through to Senior 4, from 2% to 8% for females and from 2% to 5% for males (Patton et al., 2005).

2.1.8 Ecstasy and Other Amphetamines

Youth who use ecstasy and other amphetamines tend to be poly-drug users and often have co-morbid mental health issues (Saskatchewan Health, n.d; von Sydow et al., 2002a). The chronic use of methamphetamine generally involves a "binge and crash" pattern of behaviour that is accompanied with higher doses and higher frequency of use (Deguire, 2005). Possible long-term effects of methamphetamine include memory loss, difficulty completing complex tasks, inflammation of the heart lining, dental health problems and persistent psychotic symptoms (Deguire, 2005; Saskatchewan Health, n.d.).

Epidemiological reviews indicate that the prevalence of ecstasy use was around 1% among Ontario high school students in 1996 (Smart

and Ogborne, 2000). A 1999 Ontario student drug use survey indicated that experimentation with ecstasy among students ranged from less than 1% in Grade 7 to approximately 10% in Grade 11 (Health Canada, 2001f). Surveys conducted in 2001 in Manitoba and in 2003 in Ontario indicated that approximately 3% of senior school students (Manitoba) and 3% of students in Grades 7 through 12 (Ontario) reported using methamphetamine during the past year (Adlaf and Paglia, 2003; Patton, Brown, Broszeit and Dhaliwal, 2001). More recent surveys in Alberta, Manitoba and Ontario reported past-year student rates of methamphetamine use in the range of 2% to 3% (AADAC, 2006; Adlaf and Paglia-Boak, 2005; Patton et al., 2005).

Investigations undertaken with homeless or street youth often report higher prevalence of methamphetamine. In a Vancouver study, 71% of a non-random sample of street youth and young adults (aged 14–30) reported using methamphetamines. Similarly, a Toronto study indicated that 37% of homeless youth used methamphetamine at least once a month (Deguire, 2005). In a recent survey of street youth living in Winnipeg, 41% of males and 33% of females reported using methamphetamine monthly or more often. Daily methamphetamine use was reported by 18% of male and 21% of female youth (Bodnarchuk, Patton and Rieck, 2006).

Regional reports from some Canadian jurisdictions suggest increases in the use of amphetamines among youth. Many provinces have published provincial plans for addressing the problem use of crystal meth and other amphetamines. These strategies have identified target populations of special concern, including

street youth, those who attend “rave” dances and youth using methamphetamine to control weight (AADAC, 2004; B.C. Ministry of Health Services, Mental Health and Addictions, 2004; Saskatchewan Health, n.d.).

2.1.9 Opiate, Cocaine and Injection Drug Use

A great proportion of injection drug users is located in large urban centres; however, regional addiction reports suggest increases in opiate use, especially among youth, in rural settings (Ploem, 2000). Opiate use includes heroin, morphine, codeine, methadone, Dilaudid, Demerol and OxyContin. Most of those who use opiates are injection drug users. Opiate users frequently also inject cocaine/crack, amphetamines or other stimulants, and smaller percentages inject steroids, hallucinogens and other substances (Health Canada, 2001e; Ploem, 2000).

Although recent student surveys indicate that a small percentage of youth inject opiates, cocaine or other substances, current data-gathering efforts do not effectively reach those who are not connected with formalized community systems or services. Prevalence of past year injection drug use for in-school students is approximately 1% (Liu et al., 2002; McCreary Centre Society, 2004; Poulin, 2002; Poulin et al., 2005). Individual studies involving street and homeless youth generally report higher rates (Bodnarchuk et al., 2006; Health Canada, 1996, 2001f). Findings from the 2003 Enhanced Surveillance of Canadian Street Youth indicated that lifetime prevalence of injection drug use among street youth was 22% (Public Health Agency of Canada, 2006). A survey of Winnipeg street youth showed lifetime prevalence as 35%

for females and 37% for males (Bodnarchuk et al., 2006). The substances most commonly injected included methamphetamine, cocaine, the opiates heroin and morphine, speedball (a mix of cocaine and opiates, usually heroin) and hallucinogens (Bodnarchuk et al., 2006; Public Health Agency of Canada, 2006).

2.1.10 Alcohol Abuse and Dependence

Approximately 8% of young people aged 15 to 24 and 3% of adults aged 25 to 44 experience substance dependence (Statistics Canada, 2003a). Diagnostic decisions pertaining to substance “abuse” and “dependence” are generally formulated according to the adult guidelines/criteria outlined in the DSM-IV and DSM-IV-TR (American Psychiatric Association [APA], 1994; 2001). “Abuse” criteria reflect a maladaptive pattern of substance use that results in significant impairment in functioning (APA, 1994; 2001). Indicators include role impairment, physically hazardous use, and recurrent substance-related legal, social and interpersonal problems (Clark, 2004). Of these areas, symptoms of abuse are most commonly present in the hazardous use and interpersonal domains (Clark, 2004). “Dependence” criteria include continued substance use despite significant substance-related problems, and include features such as blackouts, withdrawal, tolerance and loss of control over intended use (APA, 1994; 2001).

Concerns have been raised about the applicability of DSM criteria to adolescents (American Academy of Child and Adolescent Psychiatry [AACAP], 2005; Brown and D’Amico, 2001; Lopez, Turner and Saavedra, 2005). Some researchers note that in contrast to

adults who generally demonstrate a progression from abuse to dependence, adolescent abuse symptoms do not always precede dependence symptoms (Bonomo, Bowes, Coffey, Carlin and Patton, 2004; Brown and D’Amico, 2001; Clark, 2004). Adolescents exhibiting clinically significant problems with alcohol may not qualify for an alcohol use disorder diagnosis.

Symptoms of alcohol withdrawal tend to be experienced less frequently in adolescents until late in their alcohol use disorder (Clark, 2004). Tolerance is a predictor of dependency in adults, but has less applicability for youth (Bonomo et al., 2004; Brown and D’Amico, 2001). Their presentation of tolerance may be different from that of adults (Brown and D’Amico, 2001). Health complications are often chronic in nature and are more frequently experienced by adults than by adolescents (Bonomo et al., 2004). However, youth often experience significant impairment in family functioning and interpersonal relationships, as well as disruptions in school attendance and academic performance (AACAP, 2005).

2.2 Client-Related Characteristics

KEY POINTS

- Early intervention services for pregnant youth are critical for decreasing the psychosocial and physiological effects of problem substance use for both the youth and the developing child.
- Injection drug use has been associated with many potential high-risk situations and behaviours, including drug dependence, accidental overdose, unsafe injection and sexual practices, prostitution and transmission of blood-borne pathogens.
- Effective interventions for youth must provide an integrative approach to addressing both problem substance use and co-morbid mental health issues.
- Cultural sensitivity is identified as important when working with youth and their families from diverse ethnic backgrounds.

Youth with substance use problems are a diverse group, with varying concerns and characteristics that extend beyond their problem substance use. The following section will describe important features of Canadian youth in need of services for problematic substance use. Understanding of and sensitivity to this diversity is required when developing responsive strategies for early intervention, outreach and community linkages. Profiles are included for:

- pregnant or parenting youth;
- youth and sexual/gender orientation;
- poly-substance–using youth;
- youth living with or at risk for blood-borne pathogens;
- homeless and transient youth;
- youth with concurrent mental health disorders;
- Aboriginal youth;
- youth who use inhalants or volatile substances;
- youth in conflict with the law;
- diverse ethnicity and culture;
- rural youth.

2.2.1 Pregnant or Parenting Youth

Early intervention services for pregnant youth are seen as critical for decreasing the psychosocial and physiological effects of problem substance use for both the youth and the developing fetus/child (B.C. Ministry of Children and Families, 2005). Pregnancy provides an opportunity to reach out to the youth, given the youth's concern for the health and well-being of the unborn child (Zilberman, Tavares, Blume and El-Guebaly, 2002). Pregnant and parenting youth with problem substance use face many challenges associated with their own treatment needs, as well as concerns related to family care and responsibilities. They may defer their decisions to engage services due to the absence of necessary supports or financial means for child care (Health Canada, 2001b).

A study examining substance use and sexual risk-taking behaviour among females found a quarter of those in substance use treatment reported being pregnant during adolescence.

These higher pregnancy rates persisted into young adulthood, with many indicating a lack of stable and supportive relationships in their current circumstances (Tapert, Aarons, Sedlar and Brown, 2001).

2.2.2 Youth and Sexual/Gender Orientation

It is estimated that 10% of the population is made up of individuals who are lesbian, gay, bisexual, transsexual, transgendered or questioning (LGBTQ) (CCSA, 2006). Marginalization and discrimination of LGBTQs are widespread and take a range of forms, from insensitivity to violence. These experiences may put them at increased risk for using substances. This is of particular concern for youth who are dealing with their emerging sexual orientation and the challenges associated with sharing their concerns with family members and friends. The use of support groups, assistance from support agencies, the provision of accurate health information and the promotion of positive community linkages are effective for reaching out to these youth (CCSA, 2006; Gleghorn, Clements and Sabin, 1998; Noell and Ochs, 2001; Woods et al., 2002).

A study by Noell and Ochs (2001) examining sexual orientation in a sample of 141 homeless adolescents found that lesbian and bisexual females were more likely than heterosexual counterparts to have used injection drugs, amphetamines, marijuana and LSD. As well, depression and suicidal ideation were associated with homeless gay, lesbian or bisexual youth. More research is warranted to understand the needs of these youth and key approaches for addressing their problems with substance use (Noell and Ochs, 2001).

2.2.3 Poly-Substance Using Youth

Poly-substance and injection drug use are associated with many adverse outcomes, including drug dependence, accidental overdose, unsafe injection, unsafe sexual practices, prostitution and disruption of educational advancement. Young poly-drug users often have psychiatric co-morbidity and engage in anti-social behaviours (Hopfer, Khuri, Crowley and Hooks, 2002; Mills, Teeson, Darke, Ross and Lynskey, 2004; Tait, Hulse, Robertson and Spirvulis, 2002).

Young people beginning to use heroin or other opiates tend to be poly-substance users. They quickly progress to problematic use and at faster rates than adults. Thus, there is a narrow window of opportunity for early intervention (Hopfer et al., 2002; Mills et al., 2004). Poly-substance use contributes to toxicity and biochemical interactions, resulting in additional use of hospital facilities and resources (Tait et al., 2002). In an investigation of repeat hospital visits by youth, poly-substance users accounted for a large proportion of the multiple visits (Tait et al., 2002).

Many youth identified as poly-substance users have experimented with or used drugs that are often administered by injection (e.g. cocaine, amphetamines, opiates) (Ellickson and Morton, 1999). A review of descriptive studies of heroin-using youth indicated that a substantial proportion were poly-substance users (Hopfer et al., 2002). The decision by youth to initiate administering substances by injection has been viewed as qualitatively different from the decision to use substances such as alcohol and cannabis. In contrast to the substantial number of youth who experiment with marijuana,

alcohol and cigarettes, those who decide to administer substances by injection disregard the health, safety and legal risks that are generally avoided by most other adolescents (Ellickson and Morton, 1999).

2.2.4 Youth Living with or at Risk for Blood-Borne Pathogens

Injection drug users, sex-trade workers and homeless youth are younger cohorts at risk for transmission of blood-borne pathogens such as HIV and hepatitis B and C (Boivin, Roy, Haley and Galbaud du Fort, 2005; Health Canada, 2001e). Research has suggested that one in four individuals injecting drugs may be under the age of 20 (Health Canada, 2001e). Youth who share drug use paraphernalia, such as syringes, rinse water, intranasal straws and pipes, are at risk of infection. Personal items that are shared (e.g. razor blades, toothbrushes) carry a risk of transmission. Tattooing and body-piercing practices that do not adhere to recommended guidelines also pose health risks (Health Canada, 2001e).

Youth who use cocaine may be at greater risk of contacting blood-borne pathogens because of the high number of drug administrations per day. Demands on drug use paraphernalia (injection or inhalation) increase the tendency to share supplies among users (Health Canada, 2001e).

A study by Mills et al. (2004) examining the patterns of heroin use reported that youth (aged 18 to 24) on average first initiated heroin use at age 16 and subsequently injected at age 17. Forty-one percent of this cohort had overdosed in their lifetime, with 24% overdosing within the past 12 months. Approximately one in five

had borrowed used needles, while another third indicated they had given needles to others. Females were twice as likely as males to have borrowed used needles (Mills et al., 2004).

As part of an enhanced surveillance of Canadian street youth, nearly 30% of youth who injected drugs reported that they had not always used clean injection equipment. Approximately 31% reported they had borrowed used equipment from someone else at least once (Public Health Agency of Canada, 2006).

In a description of health and risk behaviours among youth living with HIV attending a residential care program, participants receiving services improved their nutrition and hygiene practices, but did not improve their sexual and substance use risk behaviours. The researchers suggested that youth living with HIV could benefit from longer-term problem substance use treatment, but may have difficulty accessing services or remaining engaged through the treatment process. For these youth, concurrent mental health problems and behavioural patterns often contribute to early program termination (Rotheram-Borus, Murphy, Kennedy, Stanton and Kuklinski, 2001).

Intervention approaches for youth who inject drugs should include flexible policies and low-threshold programs designed to engage and retain youth in needed support and treatment options (Health Canada, 2002a; Public Health Agency of Canada, 2006). Efforts should also include additional services that address specific basic need, health and support services. Outreach is often a critical component in initiating early intervention approaches (Health Canada, 2002a).

Outreach and support strategies have been identified as critical for engaging youth living with or at risk for contracting blood-borne pathogens. Some initiatives include street clinics, needle exchange programs and other services that also provide basic need services (food, shelter, clothing). In addition, specialized training for service providers and information on health-related concerns associated with blood-borne pathogens may be important for reaching this client group (Martinez et al., 2003; Woods et al., 2002).

2.2.5 Homeless and Transient Youth

Adolescent populations considered homeless or at risk of homelessness include those who do not have a permanent residence and those who frequently move from one living situation to another (e.g. living with friends or family members, staying in shelters or residing in other accessible short-term housing) (Kurtz, Lindsey, Jarvis and Nackerud, 2000). DeMatteo et al. (1999) estimated that approximately 150,000 youth are living on the streets in Canada. A recent synthesis of 52 epidemiological studies of homeless youth in industrialized countries indicated that mental health problems were more common than for those with a stable residence. Similarly, increased levels of assault and abuse, more frequent pregnancies and increased prevalence of blood-borne infections were evident among homeless youth (McMorris, Tyler, Whitbeck and Hoyt, 2001). Many homeless youth have long histories of out-of-home placements and involvement with child protection services (system youth). In one study, approximately half of the substance-abusing shelter youth had previous involvement with child protection

services. These youth indicated they used prescription medication for mental health issues more often than non-system youth (Slesnick and Meade, 2001).

Rates of alcohol and problem substance use are significantly higher among adolescents than among the general population (Bodnarchuk et al., 2006; McMorris et al., 2001). Youth who are homeless have often left their homes and communities because of abuse and victimization (Bodnarchuk et al., 2006; McMorris et al., 2001). They use substances to cope with feelings of isolation, loneliness and past negative life events (Bodnarchuk et al., 2006; McMorris et al., 2001). Street youth often develop strong bonds to a peer “family” on the streets and may adopt risky behaviours to fit in with the group (Bodnarchuk et al., 2006). For homeless youth, problem substance use that is left untreated often contributes to chemical dependency and a continuation of homelessness into adulthood (McMorris et al., 2001).

A one-day U.S. survey by van Leeuwen et al. (2004) investigated the problem substance use behaviours of 168 homeless youth (aged 16 to 25) in an urban centre. Their reported rates of past nine-months use included alcohol 69%, marijuana 75%, hallucinogens 30% and ecstasy 25%. Rates for cocaine, methamphetamine and heroin were 19%, 18% and 12%, respectively. Approximately 11% of the sample reported trading sex for drugs or money, whereas 13% reported sharing needles. The researchers suggested that shelters for these youth should include comprehensive substance use and health screening in addition to follow-up intervention or treatment services (van Leeuwen et al., 2004).

Many homeless adolescents are reluctant to seek services from traditional treatment and community agencies; therefore, outreach is considered critical. Outreach workers should convey unconditional acceptance and a willingness to listen, and provide genuine feedback about their circumstances, behaviours and potential options for accessing needed services or supports. Outreach may also include offering concrete assistance, such as temporary shelter, food or transportation (Kurtz et al., 2000).

The living situations of youth need to be stabilized in conjunction with early intervention services. Individual supports and counselling should address a wide range of issues in addition to problem substance use, including feelings of rejection, anger management and issues of trust (McMorris et al., 2001).

2.2.6 Youth with Concurrent Mental Health Disorders

Youth with problem substance use often experience concurrent mental health problems (Martinez et al., 2003; Mills et al., 2004). Childhood mental health disorders may predict subsequent problems with substance use and can intensify existing emotional and behavioural conditions (Armstrong and Costello, 2002; Chung and Martin, 2001; Kuperman et al., 2001; Zimmermann et al., 2003). Compared to youth without concurrent problems, those with co-existing substance and mental health issues tend to have a history of earlier onset, greater frequency and more chronic substance use (Rowe, Liddle, Greenbaum and Henderson, 2004).

Mental health conditions most frequently co-occurring with substance use problems include conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD), major depression, anxiety disorders and adjustment disorder (Brown and D'Amico, 2001; Crome and Bloor, 2005; Simkin, 2002; Turner, Muck, Muck, Stephens and Sukumar, 2004; Zimmermann et al., 2003). Problem substance use has also been identified with post-traumatic stress disorder (PTSD). Prevalence of PTSD co-morbidity ranges from 25% for males to 75% for females (Turner et al., 2004). A recent study of youth aged 18 to 23 examining co-morbid anxiety and problem substance use disorders found that increased risk was largely attributable to PTSD (Lopez et al., 2005).

The use of cannabis has been associated with episodes of anxiety, depression and psychosis (Raphael, Wooding, Stevens and Connor, 2005). Problem alcohol use combined with major depression has been identified as a risk factor related to suicidal ideation in youth (Kelly, Cornelius and Clark, 2004). With respect to gender, variations in mental health correlations with substance use patterns were investigated for an American sample of adolescents. In this cohort, internalizing emotional features (e.g. emotional problems associated with withdrawn behaviours, somatic complaints, anxiety and depression) were more frequently associated with female participants with problem substance use. In contrast, externalizing behavioural symptoms (e.g. overt behaviour problems in aggressive or delinquent

domains) were linked with substance use for both males and females (Wu, Schlenger and Galvin, 2003).

Youth with both internalizing and externalizing mental health features often experience higher levels of problems related to poly-drug use, and as a result may not enter or complete treatment. In contrast, some theorists believe that the onset of substance use disorders can be deferred with early effective treatment of mental health problems (Turner et al., 2004). A recent meta-analysis on the treatment of ADHD reported that early treatment with stimulants reduced the risk of subsequent problem substance use (Crome and Bloor, 2005).

Current empirical evidence and clinical perspectives indicate that effective interventions for concurrent mental health and substance use in youth require an integrated approach where services are coordinated and involve both the youth and the family members (Rowe, Liddle, Greenbaum and Henderson, 2004). Integrative approaches can involve a single point of entry for assessment and should have a coordinated individual community-based plan (Turner et al., 2004). Substance abuse service and mental health providers benefit from specialized training in the major aspects of concurrent conditions and strategies for engaging youth in treatment (Raphael et al., 2005).

2.2.7 Aboriginal Youth

Canada's Aboriginal population (Métis, First Nations and Inuit) comprised 3% of the total 1996 and 2001 Census counts. In 1996, 44% were under 20 years of age, comprising an estimated 5% of the total youth in Canada (Erickson and Butters, 2005; Statistics Canada,

2003b). Recent reviews and Canadian government documents report that Aboriginal youth are over-represented among several high-risk sub-populations of youth in Canada. These cohorts include those:

- experiencing problem substance use (Collaborative Community Health Research Centre, 2002; Erickson and Butters, 2005; Health Canada, 2001d);
- using illicit drugs (Collaborative Community Health Research Centre, 2002) and solvents (Erickson and Butters, 2005);
- initiating substance use at early ages (Collaborative Community Health Research Centre, 2002);
- residing in custodial settings (Erickson and Butters, 2005; Health Canada, 2001d; Statistics Canada, 2006b);
- experiencing homelessness (Health Canada, 2001d);
- at risk for contracting blood-borne pathogens (Collaborative Community Health Research Centre, 2002; Health Canada, 2001d).

Aboriginal children and youth have higher rates of health problems such as type 2 diabetes mellitus and obesity (Trumper, 2004). In addition, Aboriginal youth are more likely than non-Aboriginal youth to visit a doctor for mental health concerns. Suicide has been recognized as a significant problem among Aboriginal youth, with a rate five to six times higher than for non-Aboriginal youth (Trumper, 2004).

In delivering problem substance use interventions, many theorists and practitioners have underscored the importance of incorporating spiritual values and traditions (Stewart et al., 2005). To ensure cultural congruence with Aboriginal youth, researchers recommend emphasizing traditions and cultural practices (legends, storytelling), bringing community members and elders together in the planning process, and integrating craft and recreational activities (Hurdle, Okamoto and Miles, 2003; Stewart et al., 2005). In Canada, several Aboriginal communities have implemented innovative programs for addressing problem substance use in teens (Stewart et al., 2005). Program content includes an emphasis on life skills development and the use of symbolism to present and reinforce directions for positive change and daily living. Culturally congruent symbolism contributes to an environment where life lessons are applied in a manner that conveys respect for traditions and valued ways of life (Stewart et al., 2005).

Interventions can be strengthened by including positive role models from the immediate and extended family or the community (Hurdle et al. 2003; Waller, Okamoto, Miles and Hurdle, 2003). In a focus group study with Aboriginal middle school students, risk and protective factors associated with alcohol and drug use were explored. The study found that interactions with cousins and siblings in family kinship networks were particularly influential with respect to substance use behaviours. Therefore, positive support from same-age family peers should be seen as an important consideration when planning intervention programs for Aboriginal youth (Waller et al., 2003).

2.2.8 Youth Who Use Volatile Substances/Inhalants

Inhalant abuse in Canada is evident across many cultural groups; however, higher rates have been evident in some Aboriginal communities, especially among young males (Coleman, Charles and Collins, 2001; Landau, 1996). Inhalant use is often higher in communities that are isolated and that have greater rates of unemployment, poverty and violence. Negative emotional states, such as anger, boredom, sadness and loneliness, can be key triggers. Strong peer associations are reported among those who use inhalants (Coleman et al., 2001).

Youth who have used volatile substances for a prolonged period are less likely to stop using than those who are still early in their “sniffing” behaviour (Dell and Beauchamp, 2006; MacLean and d’Abbs, 2002). Interventions have been established in various Aboriginal communities in Canada. Components of these approaches include detoxification, assessing physiological and cognitive effects of use, building strengths (e.g. cultural awareness, social skills), resolving family issues and developing community reintegration plans (Dell and Beauchamp, 2006).

2.2.9 Youth in Conflict with the Law

Youth in conflict with the law and those in secure custodial settings often have substance use problems. This group tends to initiate substance use at earlier ages (Jenson and Potter, 2003; Murray and Belenko, 2005), use a greater variety of substances, use them more frequently, and at higher doses than their same-age peers (Erickson and Butters, 2005).

Longitudinal evidence suggests that youth who commit more serious and violent crimes have significant problem substance use histories (Molidor, Nissen and Watkins, 2002). In many instances, these youth do not recognize their substance use as problematic. Such behaviours may be regarded by their peer group as normal, and they may also receive minimal attention about exploring the consequences of substance use (N.B. Department of Public Safety, 2004).

For youth in conflict with the law, problem substance use is also often accompanied by co-morbid mental health problems (Elgar, Knight, Worrall and Sherman, 2003; Erickson and Butters, 2005; Letters and Stathis, 2004; Ulzen and Hamilton, 1998). Reported mental health problems frequently include conduct and oppositional defiant disorders, depression and anxiety (Molidor et al., 2002). Personality characteristics of delinquent or adjudicated youth include impulse control problems and sensation seeking. Mood disorders and antisocial personality traits also tend to co-occur with substance use disorders (Murray and Belenko, 2005).

Youth in conflict with the law may have minimal involvement with, or access to, organized community services or intervention options (Dembo and Walters, 2003). Barriers to intervening can include youth resistance to mandated treatment, to participation in established rehabilitation plans or to receiving family support (Health Canada, 2001d). Youth who are “on remand” to custody, and who have not yet received a disposition may experience delays in accessing timely services and supports (Health Canada, 2001d). A recent report indicates that although Canadian adult prisons

have standardized assessment and intake approaches for delivering intervention services, such approaches for youth vary by province and by institution (Erickson and Butters, 2005). Frequent shifts in residential and custodial placements interfere with their opportunities to develop positive community linkages. Youth who do not have community connections often seek support and acceptance among peer groups that are easily accessible to them, and these contacts are often with youth experiencing similar problems (N.B. Department of Public Safety, 2004).

Early intervention activities should be implemented at the “front-end” of the justice system when youth first become involved with the legal system. At this point, screening methods should be used to identify potential substance use and mental health issues. Once screening is complete, case plans should be tailored to meet the individual needs of the youth and ensure timely access to key treatment and support services (Dembo and Walters, 2003). Early intervention activities should incorporate family-oriented approaches that decrease the anxiety and conflict that contribute to patterns of behavioural misconduct and substance use (Cook, 2001). The use of strength-based and gender-specific approaches can be beneficial for engaging and intervening with youth in conflict with the law (Molidor et al., 2002). Strength-based approaches can be “facilitated by recognizing and engaging the strengths of individuals and groups rather than being defined and constricted by a pathology perspective” (Molidor et al., 2002, p. 220).

2.2.10 Diverse Ethnicity and Culture

Cultural sensitivity has been identified as key to working with youth and their families from diverse ethnic backgrounds. Service providers need to be aware of cultural differences that reflect variations in customs, beliefs and values, how these can influence early intervention and outreach efforts, and how services can be adapted to the unique needs and backgrounds of minority youth (Nissen, Hunt, Bullman, Marmo and Smith, 2004).

Barriers to seeking treatment for ethnoculturally diverse youth can include stigma associated with disclosing problem substance use, a lack of openness to involving service providers or those beyond the family, and language barriers (Health Canada, 2001d). Recommendations for addressing these barriers include undertaking outreach to youth and their families, providing services in the language of clients, and increasing the sensitivity of service providers to the values and culture of specific ethnic groups. The importance of cross-cultural training for treatment providers and community service workers has been emphasized (Health Canada, 2001d).

2.2.11 Rural Youth

In a Newfoundland and Labrador study, rural youth reported less substance use and behaviour problems than urban youth (Elgar et al., 2003). Researchers noted that compared to rural youth, urban youth likely had more opportunity to engage with substance-using peer groups (Elgar et al., 2003).

Demographic profiles differed between urban and rural street youth in British Columbia, with over 50% of rural youth being 16 years of age or younger. In addition, rural street youth had greater access to permanent housing than urban counterparts (Stockburger, Parsa-Pajouh, de Leeuw and Greenwood, 2005). Researchers have observed that most urban street youth are actually rural youth, and speculated that rural youth who become involved in street life at a young age move to urban centres when they are older (Stockburger et al., 2005).

There is often a lack of service providers who work with marginalized youth in rural areas (Anderson and Glitter, 2005; Elgar et al., 2003; Self and Peters, 2005). Fewer clients can impact the feasibility of providing specialized intervention services (Self and Peters, 2005). Youth in rural regions often face difficulty in obtaining regular transportation to needed services or support (Anderson and Glitter, 2005). Staff retention is a barrier for youth who seek to engage with services in rural settings (Stockburger et al., 2005). Researchers have suggested that the lack of resources for rural youth increases the likelihood that youth detention will be used as a first-line service (Elgar et al., 2003).

Residents often express concern that confidentiality is difficult to ensure in rural areas (Self and Peters, 2005). Stigma and the possibility of encountering someone familiar while accessing mental health and problem substance use services increase reluctance to seek out or engage needed interventions and supports (Anderson and Glitter, 2005; Self and Peters, 2005). Sex-trade workers and injection drug users may be less visible in rural areas than

in urban centres, contributing to the challenge of providing them with early intervention services (Self and Peters, 2005). Some practitioners emphasize the importance of providing outreach in rural settings as well as in urban areas. Such approaches involve meeting with clients in their natural settings and developing rapport with them through multiple contacts (Self and Peters, 2005).

2.3 Early Intervention

KEY POINTS

- Early intervention refers to specific measures or interventions undertaken for populations identified as being at risk for or already engaged in harmful behaviours or practices.
- Intervening early is essential for decreasing the psychosocial consequences that accompany problem substance use and that can ultimately disrupt the educational, occupational and social development of youth.
- Early intervention requires early identification or screening of problem substance use behaviours and co-morbid risk features.
- Brief interventions have been recognized as cost-effective and beneficial for intervening early with youth with problem substance use.
- Early intervention approaches often involve working with the influential social systems of the youth (e.g. family, school, peers) and strengthening protective or resiliency factors.

2.3.1 Introduction to Early Intervention

Early intervention for substance use problems refers to specific measures or interventions undertaken for populations at risk for or already engaged in harmful behaviours. The challenge for families, clinicians and policy makers is to arrest the development of patterns of use that can persist and become more difficult to change over time (Kendall and Kessler, 2002; Liddle, Rowe, Dakof, Ungaro and Henderson, 2004). Early intervention is a key strategy for reducing the progression and severity of substance use behaviours and decreasing or eliminating the psychosocial consequences that can disrupt the educational, occupational and social development of youth (Kirby and Keon, 2004). Early intervention may also reduce co-morbid mental health features that often accompany problem substance use (Koposov, Ruchkin, Eisemann and Sidorov, 2005).

Once a problem has been identified through screening for substances and co-morbid features (Kirby and Keon, 2004), early intervention approaches involve working within the influential social systems of youth (e.g. family, school, peers) (Liddle et al., 2004) and strengthening protective and resiliency factors.

For those involved in high-risk substance use (e.g. injection drug use), earlier intervention can increase the likelihood of reducing problematic substance use (Steensma, Boivin, Blais and Roy, 2005). Certain sub-populations of youth have been identified as having an elevated risk of poor treatment outcomes. Screening and intervening early are particularly important for these groups:

- young people with co-morbid mental health problems (Kirby and Keon, 2004; Kopolosov et al., 2005; Riggs, Rukstalis, Volpicelli, Kalmanson and Foa, 2003);
- youth who have contact with the youth justice system (Dembo and Walters, 2003; Erickson and Butters, 2005);
- homeless and street youth, who are especially vulnerable to victimization (Whitbeck, Hoyt and Bao, 2000);
- youth who use inhalants, given that those who stop using inhalants will likely do so early in their behaviour, rather than after long-term use (MacLean and d'Abbs, 2002);

- youth who inject drugs, given that rates of cessation decline as time spent injecting increases (Steensma et al., 2005);
- young heroin users, as they tend to progress to problematic use more quickly than older heroin users (Hopfer et al., 2002; Mills et al., 2004).

2.3.2 Screening for Substance Use

As a first step, early intervention services must screen for substance use problems. When adolescents are under the influence of alcohol or drugs, they are more susceptible to injury, unprotected sex or interpersonal physical altercations with others. Substance use can be a contributing factor to motor vehicle accidents, homicides and suicides. In light of the health and physical risks associated with substance-related trauma and/or overdose, emergency department personnel, health specialists and other community service providers are in unique positions to screen for problematic patterns of use (Burke, O'Sullivan and Vaughan, 2005; Maio et al., 2000). Questions about substance use should be incorporated into health and rehabilitation screening protocols (Levy, Vaughan and Knight, 2002). Medical check-ups provide an opportunity to screen for problem substance use, as does screening youth when they first become involved with justice-based rehabilitative or residential programs (Erickson and Butters, 2005).

2.3.3 Screening Formats

When alcohol or other substance use is disclosed during screening, health providers and community providers can introduce more focused questions related to the type and extent of use. These should include, but not be limited to:

- How many days a week do you drink alcohol or use drugs?
- How much do you usually drink or use?
- What's the most you have had to drink or taken (for drugs) at one time in the past three months?
- Have you ever sought help or assistance for an alcohol or drug problem? (Burke et al., 2005)

Other approaches incorporate the use of standardized assessment measures or structured interview formats. The CRAFFT is a validated screening tool designed for assessing problem alcohol or drug use in youth (Knight, Sherritt, Harris, Gates and Chang, 2003; Knight, Shrier, Bravender, Farrell, VanderBilt and Shaffer, 1999). Two or more affirmative answers to the following questions suggest a potential substance use problem:

- C** – Have you ever ridden in a **car** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** – Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
- A** – Do you ever use alcohol or drugs while you are by yourself, **alone**?

F – Do you ever **forget** things you did while using alcohol or drugs?

F – Do your family or **friends** ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten into **trouble** while you were using alcohol or drugs?

Recent standard criterion validation studies of the CRAFFT compared its outcomes concurrently with the Substance Use/Abuse Scale of the Problem Oriented Screening Instrument for Teenagers (POSIT), the Adolescent Diagnostic Interview (ADI), the Alcohol Use Disorders Identification Test (AUDIT) and the CAGE questions. The participants for this validity study were adolescents 14 to 18 years of age who attended routine health care appointments. The outcomes provided support for the CRAFFT as a valid instrument for screening adolescents with substance-related problems (Knight et al., 2003; Knight, Sherritt, Shrier, Harris and Chang, 2002).

Various screening approaches include questions that invite clients to list the types of substances consumed during the past 30 days and describe the frequency of use. Screening approaches should not be limited solely to exploring patterns of substance use. Other data related to the client's life and circumstances can be critical to understand the dynamics underlying the substance use. Areas for investigation should include family functioning, peer influences, school performance and areas of stress and coping (Wagner, Brown, Monti, Myers and Waldron, 1999).

Some approaches advocate undertaking screening without the presence of parents or guardians. These methods endorse the need to ensure patient–client confidentiality and create a comfortable environment that facilitates open and frank discussions with primary care professionals about problem substance use patterns. Other formats point to the benefits of including the adolescents’ parents or caregivers. These strategies emphasize the need to obtain youth consent and feedback on how to inform parents or guardians about specific substance use problems. Regardless of the format used, youth who disclose alcohol or substance use during screening processes should be given positive reinforcement for acknowledging their patterns of use and pursuing change (Burke et al., 2005).

A U.S. study investigated the adolescent alcohol screening practices of over 1,800 health professionals from a national stratified sample of pediatricians and family practitioners. Most indicated they were currently using screening approaches with adolescent clients, but younger teens were not as likely as older teens to receive screening services. This outcome was noted as an area of concern because many youth begin

experimenting with alcohol early in their adolescent years. In general, physicians who demonstrated higher rates of screening and counselling also reported the availability of resources to address alcohol management problems. The study suggests that adopting standard approaches to screening is necessary. As well, core competencies to administer baseline assessments should be included in basic curriculum health training programs and in continuing education sessions for practising health professionals (Millstein and Marcell, 2003).

2.3.4 Screening for Stages of Use and Readiness to Change

Additional areas of inquiry include exploring “stages of use” and “readiness to change” (Levy et al., 2002). Knight et al. (1999) provided a model for looking at stages of use: abstinence, experimentation and regular use, problem use and abuse, and dependence patterns.

Identifying the stage of use as part of the screening process can help structure subsequent interventions. Table 3 provides a summary of the given stage of use and the corresponding intervention approach.

Table 3: Stages of Use and Corresponding Intervention

Stage of Use	Intervention
Abstinence	Positive reinforcement
Experimentation/Regular use	Risk reduction
Problem use/Abuse	Brief intervention
Dependence	Motivational interviewing, referral to treatment specialist

A widely used model for understanding and assessing treatment readiness was developed by Prochaska and DiClemente (1986). They conceptualized a sequence of stages of change through which clients progress when working through their substance use problems.

Pre-contemplation Stage: At this stage, youth may not regard their substance use patterns as problematic or in need of change. Therefore, preliminary intervention approaches focus on increasing youth awareness of the risks and consequences associated with continued substance use (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

Contemplation Stage: During the contemplation stage, clients experience a sense of ambivalence. At this point, they begin to question the reasons for and against reducing substance use. Interventions include weighing the risks and benefits, acknowledging ambivalence, and evoking reasons to change (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

Preparation Stage: During this stage, youth begin to identify specific steps for pursuing positive change. Interventions include developing plans, specifying goals and identifying resources needed to support subsequent actions (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

Action Stage: This stage involves the execution of specific steps directed at changing substance use patterns. Interventions involve providing the necessary support and encouragement to

assist youth in moving forward (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

Maintenance: During this stage, actions are taken to sustain the positive efforts initiated by youth. Interventions include relapse prevention and positive reinforcement strategies (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

Relapse: This stage involves renewing the processes of contemplation, preparation and action. Corresponding interventions include avoiding demoralization, enhancing movement back to actions and identifying lessons learned (Burke et al., 2005; O’Leary Tevyaw and Monti, 2004).

This model is seen as beneficial because it does not require those seeking help to admit or acknowledge at the outset that they have a substance use problem; thus, interventions can be structured to address youths’ level of readiness to change (O’Leary Tevyaw and Monti, 2004).

2.3.5 Brief Interventions

Brief interventions have been recognized as cost-effective and beneficial for intervening early with youth. Brief interventions often use approximately one to five helping sessions or encounters administered over brief time periods (O’Leary Tevyaw and Monti, 2004) and may incorporate cognitive behavioural approaches, motivational interviewing concepts and a focus on the client’s strengths. They often include a set of common elements: assessment and direct feedback, negotiation and goal setting, behaviour modification techniques,

self-help–directed biblio-therapy, follow-up and reinforcement (Levy et al., 2002). They have also been regarded as flexible and applicable in various settings, including:

- emergency departments (Monti et al., 1999);
- physicians’ offices (O’Leary Tevyaw and Monti, 2004);
- correctional residential settings (O’Leary Tevyaw and Monti, 2004);
- counselling offices (O’Leary Tevyaw and Monti, 2004);
- school-based programs (D’Amico, McCarthy, Metrik and Brown, 2004);
- part-time or full-time work settings (Wu, Schlenger and Galvin, 2003).

Youth may seek help from any of these agencies to address problems resulting from alcohol or substance use, and these points of contact may serve as “teachable moments” for intervening early (Monti et al., 1999).

2.3.6 Aspects of Brief Intervention

Brief interventions can be organized according to the FRAMES model. This model describes six phases: Feedback, Responsibility, Advice, Menu, Empathy and Self-Efficacy (O’Leary Tevyaw and Monti, 2004).

Feedback: This approach involves conveying concern to youth about their current problem substance use without using professional jargon. Included is feedback on the immediate causes and effects of substance use in terms that are relevant to them (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

Responsibility: This entails communicating messages that emphasize clients’ personal “responsibility for change.” Encouraging responsibility may also include providing self-help resources and instructing clients on how to use them independently (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

Advice: This entails providing succinct recommendations that highlight the potential benefits of not continuing with current use patterns. Suggestions are often combined with expressions of concern or caring (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

Menu: This involves offering youth a range of options for pursuing positive change, highlighting the most therapeutically beneficial ones first. If the youth resists selecting and trying an option, service providers should encourage him or her to think about the various options before the next meeting together. This invitation to “reflect on the options” is viewed as a strategy for moving youth from the pre-contemplation to the contemplation stage of readiness (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

Empathy: Expressions of empathy should be used at various points in the conversation and be evident in the service provider’s overall manner. This conveys unconditional acceptance and a sincere desire on the part of the helper to understand the client from the person’s frame of reference (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

Self-Efficacy: This involves increasing the client’s optimism for pursuing change through exploring strengths or resources available.

Resources can include strengths or competencies within the youth, or external sources of support from peers, family or the community (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004).

2.3.7 Motivational Interviewing

Motivational interviewing (MI) is a brief counselling approach that has been identified as promising for working with adolescents. This client-centred intervention entails using collaborative decision-making processes, applying strategies to increase awareness of problem substance use, and implementing motivational strategies to facilitate client commitment toward action to decrease and eliminate substance use. Key assumptions implicit in MI are:

- Motivation is not an innate character trait.
- Motivation is the result of interpersonal interactions.
- Ambivalence to change is normal and acceptable (Burke et al., 2005).

For adolescents, the task of developing autonomy involves questioning and challenging authority figures. Given that MI embraces client choice, ambivalence and resistance, this approach offers youth workers and counsellors a respectful and caring means for engaging adolescents (Baer and Peterson, 2002). For youth, ambivalence is the experience of grappling with mixed feelings regarding change. In the context of MI, youth are invited to openly discuss feelings of ambivalence. The service provider conveys respect for the autonomy and free will of the youth. The

helper’s central task is to facilitate the exploration of the benefits and consequences—the intent is to move youth toward an “acceptable resolution that triggers change” (Burke et al., 2005, p. 775). Staff who use MI are trained in strength-based approaches, able to address questions youth might have about substance use, and interact in a non-judgmental way. Other helper characteristics for MI include “rolling with resistance,” supporting self-efficacy and promoting problem-solving skills (Nyamathi et al. 2005; O’Leary Tevyaw and Monti, 2004). Such self-directed approaches may facilitate connections with aloof or oppositional youth (O’Leary Tevyaw and Monti, 2004). Key helper skills associated with MI include:

- reflective listening;
- open-ended questioning;
- summarizing reflection;
- identifying discrepancies between personal goals and behaviours;
- affirming strengths;
- encouraging small-step plans and behaviours (Burke et al., 2005; Dunn, Deroo and Rivara, 2001).

Motivational interviewing has been seen as particularly beneficial for use with adolescents who show a strong identification with problem substance or alcohol use and resistance to adults who try to direct or influence their behaviour (Dunn et al., 2001; Masterman and Kelly, 2003). The advantages of using MI are:

- MI does not rely on acknowledging substance use problems.
- MI can be applied within a range of readiness to change.
- MI avoids argument and hostile confrontation.
- MI fosters an environment of self-directed change (O’Leary Tevyaw and Monti, 2004).

Some theorists have questioned the benefit of using MI approaches with younger teens. Concern has been noted about the developmental readiness of some youth to meaningfully grasp the connection between their substance use and their current circumstances. Some younger adolescents may be inappropriate candidates for MI techniques that rely solely on abstract reasoning tasks, such as planning how to integrate feedback or imagining future consequences of substance use (Levy et al., 2002; O’Leary Tevyaw and Monti, 2004). When applying MI with younger cohorts, the following should be considered:

- Youth workers need to be sensitive to the youth’s doubt about the value of meeting a counsellor or helper. Concerns should be shared openly with the intent of establishing a common goal for the session.

- Some youth may find open-ended questioning and reflective listening techniques to be demanding for their level of verbal communication skills. Closed-ended questions may at times be more useful for orienting discussion.
- Structuring the interaction at the outset may facilitate initial interactions with some youth. This is done by describing the goal of the interview, the expected length of the session and the intent to understand their perceptions and perspectives.
- Youth workers must make a concerted effort to use language that does not infer criticism or judgment. In the place of words such as “problems or issues” early in the conversation, talking to youth about “choices or behaviours” is more advantageous.
- Interactions should address the personal goals of the youth. Clinical goals may vary substantially depending on the concerns of the youth (Baer and Peterson, 2002).

2.3.8 Evidence for Brief Interventions and Motivational Interviewing

Over the past several years, there has been growing evidence to support the use of brief intervention strategies for problem alcohol and substance use in adults. Fewer studies have investigated the potential usefulness of these approaches with younger cohorts; however, recent investigations do suggest that they may also be beneficial for working with youth (Levy et al., 2002). The following provides a summary of recent investigations:

Single-session brief intervention over a four-year period

A single-session brief intervention undertaken with first-year heavy drinking college students was investigated over a four-year period. Subjects who reported histories of heavy drinking were randomly assigned to treatment (n=145) or high-risk control (n=143) groups. Follow-up over four years was completed with 84% of the sample. It was found that participants receiving brief intervention had greater reductions in negative consequences than high-risk controls. However, frequency and quantity of drinking did not decline over four years for either group. The authors speculated that the feedback and advice inherent in brief interventions were successful in reducing problems associated with drinking, even taking into account maturational trends of drinking reductions throughout an individual's college years (Baer et al., 2001).

Brief intervention in an emergency department, treatment referral and attendance

In this study, 127 adolescents (aged 12–19) presenting with alcohol- or drug-related issues at emergency departments were randomly assigned to brief intervention (n=60) and control (n=67) groups. A normative group involving 122 non-users was included for comparison. This brief intervention involved identifying barriers to treatment referral and attendance and identifying avenues of support to facilitate attendance at a given treatment service. A 4-month follow-up revealed that a significantly greater proportion of daily and occasional substance users from the brief

intervention group had attended subsequent treatment services. In addition, whether they attended treatment or not, the intervention group demonstrated greater improvement on a general health status measure than controls. The investigators concluded that brief intervention is useful for encouraging adolescents to attend treatment appointments and that some health benefits might be realized as a result of brief interventions, even if more formalized treatment is not pursued (Tait, Hulse and Robertson, 2004).

Brief intervention in emergency department client perceptions of helpfulness and alcohol consumption

In an investigation designed to evaluate an emergency department brief intervention, approximately 2,000 college-age students were screened for problem alcohol use. Of those, 54% were identified as positive for experiencing alcohol problems. Ninety-six percent of students who screened positive agreed to receive the brief intervention session as part of their visit. At three-month follow-up, three quarters of participants indicated that the brief intervention session had been beneficial, and that they had reduced their alcohol consumption (Helmkamp et al., 2003).

Brief intervention, youth satisfaction and alcohol consumption

In another study, college students reporting drinking five or more drinks on two or more occasions in the past month were randomly assigned to brief intervention (n=29) and control groups (n=31). Participants in the brief intervention group reported high levels of satisfaction with

the content of the session and indicated that they would recommend such services to their peers. Follow-up was completed after six weeks, with the brief intervention group exhibiting decreases in alcohol use (from 18 to 11 drinks per week) and the control group showing less reduction (from 19 to 16 drinks per week). Neither group exhibited decreases in alcohol-related problems. The investigators speculated that lack of reduction in associated problems may be attributed to the short time span of the study and that realizing potential differences may require participants to make longer-term lifestyle changes. There were comparable reductions in drinking for both male and female participants in the brief intervention group (Borsari and Carey, 2000).

Motivational interviewing and alcohol-related problems

A brief motivational interview was used to reduce the problems associated with alcohol use among urban adolescents 18 to 19 years of age accessing emergency department services after an alcohol-related event. Participants were randomly assigned to a two-group design, with 52 participants receiving an intervention and 42 receiving standard emergency care. Both groups significantly reduced their alcohol use, especially during the first three months. Compared to standard care recipients, youth who received the intervention reported greater reductions in drinking-related problems with dates, friends, parents, police and at school, and were also less likely to experience an injury related to alcohol or to have a motor vehicle violation six months after the visit to the emergency department (Monti et al., 1999).

Motivational interviewing, alcohol and substance use, and deterioration of effects

In a study from Great Britain, college staff identified students who were willing to recruit their peers into the research project. Peer interviewers recruited 200 students aged 16 to 20, who were then randomly allocated to a motivational interview (n=105) or a non-intervention group (n=95). All youth in this study reported involvement with illicit substance use (cannabis or stimulant use). For the intervention, individual motivational interviews were conducted with participants to identify substance use problems and to encourage reflection on options for change. Of the 200 participants at baseline, 179 were available at three-months for follow-up. At this point, intervention group participants, compared to the control group members, were more likely to have reduced or discontinued alcohol and cannabis use (McCambridge and Strang, 2004).

In a follow-up study of the same participants, 158 were available for follow-up after 12 months. At this point, the differences between youth in the motivational interview intervention group and the control group had deteriorated. More specifically, the intervention group did not maintain significant reductions in alcohol and cannabis use, and the control group reversed their initial increases in consumption. The researchers discussed the possibility of an unintended “Hawthorne effect,” where the three-month follow-up assessment may have exerted a beneficial effect for the control group. They also suggested that motivational interview booster sessions may be important for sustaining the effect of brief interventions (McCambridge and Strang, 2005).

Brief interventions and accelerated maturational process

Recent literature summaries on brief interventions with youth provide support for their use with youth. Even though young persons often “mature out” of hazardous alcohol and substance use, motivational and brief intervention strategies may “accelerate this maturational process” (O’Leary Tevyaw and Monti, 2004).

2.3.9 Group Interventions

In a study investigating the intervention preferences among secondary school students, youth identified as heavy drinkers indicated that they would be most open to interventions involving a small group format with other adolescents. Key characteristics of this intervention include:

- confidentiality;
- convenient meeting times;
- absence of a long-term commitment;
- involvement of a leader/facilitator with whom they could relate (D’Amico et al., 2004).

Students who drank more heavily also reported a willingness to be involved in school-based interventions that used a small group discussion format with school counsellors. In addition, the findings suggested that the use of incentives such as free food or snacks provides adolescents with a “socially acceptable reason” for program attendance. The investigators underscored the importance of adopting a group format that is socially acceptable to youth and reduced the potential stigma of seeking assistance for “personal problems” (D’Amico et al., 2004).

Small group early intervention activities may blend a range of different modalities, including:

- educational or discussion approaches (D’Amico et al., 2004);
- brief intervention and motivational perspectives (Bailey, Baker, Webster and Lewin, 2004);
- cognitive behavioural strategies (Bailey et al., 2004);
- skill-based decision-making methods (Sussman, Dent and Stacy, 2002);
- social and interpersonal skill development (Friedman, Terras and Glassman, 2002);
- culturally relevant content (Stewart et al., 2005).

Small group brief intervention, alcohol consumption and readiness to change

In an Australian study designed to measure the effectiveness of a small group brief intervention for problem alcohol use, youth aged 12 to 19 were randomly assigned to a treatment (n=17) and a non-treatment group (n=17). Participants were recruited from a youth centre in a region identified as having a higher risk for problems related to alcohol consumption. The intervention involved the delivery of four small group sessions, applying both cognitive behavioural therapy and motivational interviewing. Most treatment participants (76.5%) attended three or four sessions. Data were collected pre- and post-program, and at one- and two-month follow-up intervals following the intervention. At the post-program

and first follow-up assessments, the treatment group participants had reduced their frequency of drinking and increased their readiness to reduce alcohol consumption. In contrast, the control group participants reported an increase in frequency of hazardous and binge drinking at the second follow-up. The authors concluded that this intervention had been particularly beneficial in addressing the needs of youth who were ambivalent regarding their alcohol use and had increased their readiness to embrace positive change (Bailey et al., 2004).

Residential group sessions with youth in conflict with the law

Another early intervention small group investigation evaluated the effectiveness of a social learning program for court-adjudicated males aged 13 to 18 years in a residential treatment centre. Youth were randomly assigned to either the intervention or control conditions. Both groups received the basic residential treatment program, which provided access to educational facilities, social workers, psychological assessment and recreational activities. Participants in the intervention group attended on average 34 of the 55 scheduled classroom sessions that included three aspects: a cognitive-behavioural social learning model for understanding substance use and learning to control behaviour, a social learning model to redirect tendencies toward violence along socially and personally acceptable lines, and a values clarification procedure for clarifying, exploring, developing and identifying with prosocial values. Six months after discharge from their residential treatment program, 84% (n=201) of the original sample were available for follow-up, including 110 in the intervention

group and 91 in the control group. Outcomes indicated that compared to the control group, the intervention group reported a greater degree of reduction in drug use and in selling drugs. A similar non-significant trend was also noted with respect to alcohol use and illicit behaviours (Friedman et al., 2002).

Culturally relevant group approaches

In an early intervention group designed for Aboriginal youth aged 13 to 19, native symbolism and traditions (e.g. canoe journey, medicine wheel) were integrated into an eight-session life-skills curriculum. Group participants were surveyed about their alcohol use at baseline (n=122) and at three-month (n=50) and six-month (n=21) intervals following the program. When baseline measures were compared to averaged follow-up scores, outcomes showed reductions in alcohol and marijuana use and problems associated with alcohol use (Stewart et al., 2005).

Cautions associated with peer-based group interventions

Although small group approaches involving youth peers have been described as beneficial for reducing problem substance use behaviour, some research has suggested that peer associations can counter such efforts. In a nine-month study investigating patterns of use among a community sample of adolescents (n=390) aged 16 to 19, peer substance use predicted escalation of use. The authors speculated that exposure to peer substance use may promote use because it reinforces perceptions regarding the “acceptability of use” and facilitates greater access to substances (Stice

et al., 1998). In contrast, evidence of less peer pressure may provide less social reinforcement and limit access to substances (Stice et al., 1998). In a study investigating the perspectives of over 4,000 young adolescents aged 12 to 14, positive associations were found between alcohol use and social interaction with problem-behaving friends (Simons-Morton, Haynie, Crump, Eitel and Saylor, 2001). Various theorists assert that peer approaches can inadvertently facilitate “deviance training” and contribute to increased problem substance use. Deviance training is defined as “contingent positive reactions to rule-breaking discussions” among peers (Dishion, McCord and Poulin, 1999, p. 776). Thus, caution should be demonstrated when grouping youth with high-risk behaviours in unstructured contexts in which “laughter, social attention and interest” reinforce existing problem substance use patterns (Dishion et al., 1999).

2.3.10 Parent/Guardian and Family-Focused Intervention Efforts

Family influences may either encourage or discourage problem substance use for youth. Increases in adolescent alcohol use have been linked to increased family conflict and greater adolescent autonomy (i.e. separation, independence or detachment) (Bray, Adams, Getz and Baer, 2001). In an examination of family environmental risk factors, exposure to parental substance use problems was found to predict substance use disorders among offspring (Biederman, Faraone, Monuteaux and Feighner, 2000). Other contributing family interaction factors have included low levels of communication between parents and children, lack of supervision, inadequately defined and

communicated expectations, and inconsistent and harsh discipline. A recent study examining the perceptions of 4,263 students in Grades 6 to 8 found that high levels of parent involvement, high parent expectations, and perceptions of being respected and held in high regard were protective against alcohol use. The outcomes of this study were consistent with the hypothesis that authoritative parenting behaviours that include frequent, open communication and an attitude of acceptance of the teen can provide a protective role against alcohol use among younger adolescents (Simons-Morton et al., 2001).

Other approaches have advocated a family focus. In an effectiveness trial, 80 adolescents aged 11 to 15 from low-income and ethnically diverse backgrounds were randomly assigned to either multidimensional family therapy or peer group therapy. All participants had been referred to outpatient treatment for a substance use problem. Youth were reassessed after six weeks in the program and again at discharge. The family therapy was developed specifically for youth and targeted change across four life areas—individual, family, peers and school—and was aimed at increasing family cohesion and communication, and improving parenting skills. Peer-based group therapy focused on the individual and peer aspect with the rationale that pro-social peers may protect young adolescents from substance use problems and that peer groups offer a safe setting for expressing feelings and learning new social skills. Results indicated that adolescents in the family therapy group demonstrated improvement more rapidly across the four life areas than those receiving peer-based group

therapy, and also decreased their substance use more than the peer-based group (Liddle et al., 2004).

2.3.11 Student Assistance Programs

As a parallel to adult-oriented employee assistance programs, student assistance programs (SAP) were developed in school systems across the United States. These programs consist of multiple components, including staff and student team members, individual and small group interventions/counselling, as well as policy and established procedures for student assessment, referral and support for problem alcohol and substance use. Although these programs are implemented in various contexts, minimal research has been undertaken to evaluate their impact or to identify the specific components that contribute to reductions in problem substance use. One study examined the feedback of 144 high school students following completion of a SAP initiative. The key components of this intervention group program included a wide range of topics and skill areas: substance use education; recognition and acknowledgement of substance use problems; self-monitoring and commitment to reduction/cessation; identification of high-risk situations; development of alternatives to substance use and coping methods; relationship-building and family conflict resolution; relapse prevention and practising refusal; and social support. The outcomes showed significant decreases in alcohol, cannabis and other drug use, and most participants reported the program to be a positive experience. The investigators of this study stressed the need for continued research of SAP

programs and emphasized the importance of including comparison or control groups in subsequent evaluations (Wagner et al., 1999).

2.3.12 Internet-Based Interventions

Internet-based strategies are a promising approach to early intervention and have the potential for wider reach to youth. Researchers noted that the Internet has facilitated access to information and formation of online support groups and listservs, but also cautioned about the lack of qualifications of individuals providing information, especially with respect to substance use interventions (Monahan and Colthurst, 2001).

A recent survey reported that 90% of adolescent participants indicated a willingness to use the Internet to gain information about substance use. In this investigation, over three quarters of participants stated that they had direct access to the Internet through the school, home or community (Skinner, Maley, Smith, Chirrey and Morrison, 2001).

Some theorists have stressed the potential benefits of integrating motivational enhancement content with Internet-based approaches for intervening early with youth. More research is needed to explore further the potential efficacy of early intervention approaches that use Internet-based applications (O’Leary Tevyaw and Monti, 2004).

2.4 Outreach

KEY POINTS

- Outreach services must actively “reach out” to provide help to those who would not otherwise receive or access such support in the community. The provision of outreach services is critical for reducing problem substance use for youth who are not connected with mainstream services or supports.
- Outreach should focus on meeting youth in their natural settings and community contexts.
- Outreach workers must be able to connect and communicate effectively with the target population.
- Initial outreach contacts may be very brief and involve multiple time-limited conversations. As relationships are developed with youth, interactions may then be elaborated to incorporate a wider range of early intervention efforts.
- Interactions undertaken as part of outreach services should be “client-centred” and engage youth as the main participants in identifying needs and making decisions about plans for action or change.
- Outreach programs should be reviewed regularly to ensure the extent to which they are efficient and effective.

2.4.1 Introduction to Outreach

Outreach implies that services must actively “reach out” to help those who would not otherwise receive or access community support (Rhodes, 1996; Self and Peters, 2005).

Outreach is described as a method of health education and service provision that aims to:

- increase awareness of risks to health;
- encourage changes in behaviour;
- sustain positive lifestyle changes (Rhodes, 1996).

The provision of outreach services is critical for reducing problem substance use for youth who are not connected with mainstream services or supports. In a study of initial contacts with at-risk youth, those reached through outreach (vs. through community health centres or hospitals) were described as particularly vulnerable, with more homeless and runaway youths, and with greater involvement with the mental health system (Woods et al., 2002). Many youth who would benefit from outreach services are reluctant to seek assistance from community agencies as a result of previous negative experiences with service providers or from being victims of violence or abuse. Therefore, preliminary efforts should be to build trust and foster positive interactions between youth and outreach workers (Collaborative Community Health Research Centre, 2002; Health Canada, 1996).

Outreach should focus on meeting youth in their natural settings and community contexts. Points of contact can include street corners, coffee shops, drop-in agencies, parks, shelters,

hospitals, custody settings, school-based activities and programs, or any place where youth gather (Collaborative Community Health Research Centre, 2002; Gleghorn et al., 1998; Rhodes, 1996). Outreach can be implemented in conjunction with community agencies where youth are already receiving services (Rhodes, 1996). Outreach can also use mobile services (e.g. a van) to make contacts in a variety of places or reach youth in rural or more isolated areas (Health Canada, 1996; Self and Peters, 2005).

Initial contacts with youth may be very brief and involve multiple time-limited conversations. Preliminary worker–youth interactions can include making introductions, asking how the youth is doing, giving information about local services (e.g. services available at a “youth centre” or needle exchange location) and distributing materials such as condoms or bleach kits (Gleghorn et al., 1998; Rhodes, 1996). As relationships are developed, interactions can incorporate a wider range of early intervention efforts (Rhodes, 1996). These can include focusing on increasing awareness of risks associated with ongoing substance use, exploring options for reducing use, and identifying supports to help sustain small-step positive changes (Rhodes, 1996). Interactions should be “client-centred” and engage youth as the main participant in identifying needs and making decisions around plans for action or change (Collaborative Community Health Research Centre, 2002). Outreach services include providing direct support as needed to help youth access social supports and health services; thus, they need to maintain linkages and collaborative alliances with other community-based service agencies (Health Canada, 1996; Rhodes, 1996).

In most instances, outreach activities involve agencies’ extending their traditional program boundaries to engage youth who would not usually engage their services. Outreach should not be seen as a replacement or duplication of existing intervention services, but as an essential and complementary activity to assist other community-based health and treatment programs (Rhodes, 1996).

2.4.2 Assessing the Need and Targeting Outreach Services

When developing preliminary plans for outreach services, two fundamental levels of needs assessment should be done. The first involves investigating concerns related to the extent and nature of the problem substance use. The second deals with the extent and nature of services accessible to users. Sources of information to address both areas should include:

Quantitative data on substance use problems: surveillance data gathered by health and law enforcement departments; epidemiological research that describes the extent and nature of local problem substance use (Rhodes, 1996).

Quantitative data on service use: monitoring data gathered by community agencies, treatment facilities and youth services that describe the extent and types of services accessed by users (Rhodes, 1996).

Observational data on problem substance use and services accessed: information provided by informants on drug use patterns and help-seeking behaviours. Informants include users, service providers in contact with local users, police, health care professionals and addiction researchers (Rhodes, 1996).

Needs assessments should provide the data necessary to effectively organize and implement outreach operations and identify:

- youth populations that are not being reached by services;
- key changes in local patterns of problem substance use;
- locations where users meet and socialize;
- locations where substances are exchanged or purchased;
- availability and organization of current service delivery programs and support options;
- areas in most need of service (Rhodes, 1996).

2.4.3 Outreach Staff and Activities

Outreach workers must be able to connect and communicate effectively with the target youth population (Gleghorn et al., 1998; Rhodes, 1996). Characteristics of effective outreach workers include:

- being credible to youth (Rhodes, 1996);
- exhibiting genuine and accepting attitudes (Collaborative Community Health Research Centre, 2002);
- demonstrating a non-judgmental approach to drug use norms, culture and behaviours (Collaborative Community Health Research Centre, 2002; Health Canada, 1996; Rhodes, 1996; Self and Peters, 2005);
- having a real-life understanding of the social context of use for youth (e.g. street sense) (Self and Peters, 2005);
- adopting a flexible approach with realistic expectations (Collaborative Community Health Research Centre, 2002).

Training and supervision of outreach workers should be included in the design and development of outreach services. Induction programs can vary from a single week to several weeks of training, and content should include, but not be limited to:

- generating outreach contacts;
- communication skills;
- advising and counselling competencies;
- knowledge of problem substance use, health, legal and social welfare issues;
- program delivery policies and reporting protocols;
- referral and follow-up procedures;
- methods for working collaboratively with other service providers;
- stress management and self-care skills;
- ethics, confidentiality and obligations to disclose information;
- professional boundaries (Health Canada, 1996; Rhodes, 1996).

In addition to making initial connection with youth, outreach workers may be involved in a wide range of related activities, such as:

Making contacts as early as possible: It is critical that outreach services connect early on with youth who are “unserved or underserved” by community agencies, especially those who are new on the “streets” or who have left home and are without a permanent place to live (Collaborative Community Health Research Centre, 2002). Initial contacts often involve “engaging in small talk” with no formal “agenda.” Early contacts are focused on developing trust and conveying a non-judgmental attitude (Self and Peters, 2005). Making initial contacts may include

cold contacts (initiating conversations with individuals not met before), natural contacts (those that emerge naturally because of sufficient time spent in a location) and snowball contacts (introductions to new contacts made with individuals reached through previous outreach efforts) (Rhodes, 1996).

Reaching out and being present in locations where youth assemble: Outreach efforts should be directed toward locations where youth gather and spend time. These include a wide variety of locations in the community, such as parks, malls or recreational facilities. Outreach workers should also strive to maintain strong linkages with schools and have a presence during lunch or other break times (Collaborative Community Health Research Centre, 2002; Gleghorn et al., 1998; Self and Peters, 2005).

Organizing engagement activities: Outreach programs should assist in connecting with and fostering collaborative working relationships with youth. Engagement strategies include organizing recreational activities to meet and become acquainted with youth (Collaborative Community Health Research Centre, 2002), sharing common interest areas, incorporating music and artistic interest areas, offering incentives (e.g. pizza) (Gleghorn et al., 1998), discussing the lessons presented in short video presentations (Gleghorn et al., 1998), employing young outreach workers, and providing short-term services that use an informal format (Collaborative Community Health Research Centre, 2002).

Carrying out screening assessments: Outreach workers are in a unique position to carry out screening interviews to assess problem substance use, as well as other health and basic needs. Often a flexible and informal meeting format over several individual contacts is needed. This can be beneficial for identifying potential life-threatening situations that should receive immediate attention and action (Collaborative Community Health Research Centre, 2002; Health Canada 1996).

Addressing concurrent needs: In addition to problem substance use, youth may have an array of other basic needs to address. These can include mental health or health care issues, inadequate financial support, and the need for emergency shelter, food or transitional housing. In many instances, these must be addressed first or in conjunction with treatment services if a reduction in substance use is to be realized. Therefore, outreach services that provide early intervention for problem substance use should take into account the range of life circumstances and needs faced by youth (Collaborative Community Health Research Centre, 2002; Gleghorn et al., 1998; Martinez et al., 2003).

Increasing awareness of services and supports: Outreach workers should also be knowledgeable about key support services that may be beneficial for youth, and how they are accessed (Collaborative Community Health Research Centre, 2002; Self and Peters, 2005). “Resource cards” with telephone numbers or contact information for specific youth-focused services should be given to youth during informal conversations or outreach contacts (Collaborative Community Health Research Centre, 2002; Gleghorn et al., 1998).

Building cooperative alliances with youth-centred agencies and enforcement authorities:

Outreach workers can help youth link with basic and essential services.

Developing collaborative alliances between outreach programs and community agencies is essential for implementing coordinated case plans and ensuring timely access to services (Collaborative Community Health Research Centre, 2002; Rhodes, 1996; Self and Peters, 2005). Efforts should be made to establish positive working relationships with law enforcement. Local police and justice officials should be informed of proposed outreach activities before implementing them, and their feedback should be sought and incorporated into preliminary plans. This collaboration is critical for ensuring that outreach work does not interfere with police routines and that enforcement personnel support the goals and activities of the outreach program (Rhodes, 1996).

Educating community members: Outreach activities should include educating service providers and other community members about the needs and circumstances of youth with problem substance use. This can reduce potential stereotypes or stigmas attached to the youth and foster a greater readiness of community members to reach out to them (Health Canada, 1996).

Initiating follow-up contacts: As youth make initial steps to address their problem substance use and other needs, it is important for outreach to provide follow-up. These contacts should focus on monitoring progress and helping them sustain the positive gains they have made (Collaborative Community Health

Research Centre, 2002; Martinez et al., 2003). The need for follow-up outreach services may vary substantially depending on the needs and circumstances of the individual. In one study, the number of outreach contacts required to help youth make transitions to specific supports or treatment ranged from as few as five to as many as 55 (Martinez et al., 2003).

Respecting safety protocols: Some outreach programs have specific guidelines to ensure the safety of workers. These include restricting contacts with youth who are involved in drug transactions, violence, deliberations with the police or any other situation that is perceived by workers as uncomfortable or unsafe (Gleghorn et al., 1998).

2.4.4 Peer Helpers in Outreach Activities

Outreach services may invite former clients to work alongside outreach staff or accompany workers as peer educators or helpers (Health Canada, 1996; Rhodes, 1996). The benefits of using former clients or peers with similar histories have been generally well recognized (Gleghorn et al., 1998; Health Canada, 1996; Rhodes, 1996; Woods et al., 2002). Using peers has several potential advantages:

- Peers can often address barriers associated with distrust of adults or professional service providers (Collaborative Community Health Research Centre, 2002).
- Peers often have knowledge of existing youth networks and social norms (Rhodes, 1996).
- Peers with street knowledge may be more easily accepted by youth who are homeless or out-of-the-mainstream (Health Canada, 1996).

- Peers may have innovative insights about the design and implementation of outreach activities and operations (Collaborative Community Health Research Centre, 2002).

One concern is the potential for the former client to reinitiate problem substance use. This possibility may be heightened when they are exposed to situations that make them feel vulnerable (Imagine Canada, 2006; Rhodes, 1996). Peers may also delay transition into mainstream community life if they are engaged as peer helpers (Health Canada, 1996). Outreach initiatives that incorporate peer workers or volunteers should ensure that ongoing support and supervision are available to them as part of regular program operations. This is essential for ensuring an effective peer helper service and reducing the risks of relapse for peers (Health Canada, 1996; Imagine Canada, 2006; Rhodes, 1996; UNAIDS, 1999).

In addition to peers, community members who have had previous positive involvement with youth may be points of connection for reaching out to youth. They can be important sources of encouragement to youth in both accessing and becoming connected with community supports or treatment (Nissen et al., 2004).

2.4.5 Evaluation of Outreach Programs

Outreach programs should be reviewed regularly to ensure the extent to which they are efficient and effective. Three types of program evaluations may be considered: program monitoring, process evaluations and outcome evaluations.

Program monitoring: This approach to evaluation involves reviewing the internal functioning associated with daily operations and staff routines. These reviews are based on data gathered from daily activity records completed by program personnel, such as initial contacts, re-contacts and the type of outreach activities implemented, together with their outcomes (Rhodes, 1996).

Process evaluation: Similar to program monitoring, process evaluation is focused on the extent to which the program is being effectively implemented and consistent with the established intent and design of the initiative. Process evaluations often involve data-gathering procedures that extend beyond the review of daily activity records. Data collection methods should include, but not be limited to, management observations and interviews, as well as interviews with clients who were reached or not reached by the outreach program (Rhodes, 1996).

Outcome evaluation: Outcome evaluations focus on measuring the actual impact of the outreach program on client behaviours and circumstances. These types of evaluations often require substantial financial resources and expertise to carry out, and involve pre- and post-program designs. Measuring impact may include follow-up with clients on a range of behaviours and personal status variables, such as problem substance use patterns and associated problems, physical and mental health functioning, and participation in treatment activities initiated as a result of outreach efforts (Rhodes, 1996).

2.5 Community Linkages

KEY POINTS

- Community linkages consist of sources of social support and interaction that have potential as protective factors to prevent and reduce problem substance use.
- Early assessment and screening provided by community-based agencies should facilitate timely referrals to essential services for youth.
- Community-based case planning should be structured to reflect the developmental stages of youth and incorporate the use of strength-based methods.
- Areas of community connectedness for youth include having a safe place to live, receiving support from family or other community members, being involved in an educational or career-related program, and participating in recreational activities.
- Creating service delivery alliances among mental health and addiction services providers involves developing a multidisciplinary perspective and coordinating programs across agencies to ensure a planned continuum of care.

2.5.1 Introduction to Community Linkages

Community linkages for youth contribute to positive growth and development, and can be protective against problem substance use. Positive linkages are a source of social support, be it with family, peers or school (Murray and Belenko, 2005). Community linkages also refer to community-based services that are accessible and responsive to youth early on in their addiction behaviour (Dembo and Walters, 2003).

Positive community linkages for youth should focus on:

- strengthening youths' attachment to pro-social relationships, activities, agencies and programs;
- reducing exposure and bonds to anti-social groups and norms;
- enhancing school attendance and academic performance;
- increasing opportunities to learn and practise skills that facilitate achievement of personal educational and career goals;
- engaging youth and family members in planning;
- encouraging collaborative responses among health providers, community members and police in addressing specific substance use problems in the community;

- creating service networks among agencies that effectively address the needs of youth at risk (Collaborative Community Health Research Centre, 2002; Murray and Belenko, 2005).

2.5.2 Essential Community Linkages

Early intervention efforts are strengthened when youth are meaningfully connected to a variety of community activities and relationships. Without these linkages, efforts to reduce problem substance use may be significantly impeded (MacLean and d'Abbs, 2002). Areas of community connectedness include having a safe place to live, receiving support from family or other community members, being involved in an educational or career-related program, and participating in recreational services.

Residential options

Many jurisdictions do not have emergency shelter programs or longer-term residential options designed to meet the needs of youth. Rooming houses are often unregulated and potentially unsafe for youth. Substance use is often more frequent in these locations, placing youth at increased risk for developing problematic use. It is critical that service providers and community leaders collaborate to address gaps in basic services in conjunction with substance use interventions (Collaborative Community Health Research Centre, 2002; Human Resources Development Canada, 2006; Nyamathi et al., 2005).

School connectedness

Schools are a potential location for providing early intervention supports for youth substance use problems (Kirby and Keon, 2004; Welsh, Domitrovich, Bierman and Lang, 2003). Early intervention efforts should emphasize academic achievement and incorporate strategies for strengthening youth participation in educational and career-readiness activities (Collaborative Community Health Research Centre, 2002). Strategies can include academic support services, establishing school transition programs and providing in-school mental health and addiction-related supports. School sites can be central locations for delivering coordinated services for youth and their families, supported by local police, mental health services, addiction counsellors and other providers representing a range of health and social programs (Welsh et al., 2003).

Recreational activities

Recreational activities provide youth with an opportunity to develop positive peer associations and increase their sense of belonging in the community. Intervention strategies that incorporate time-limited wrap-around services need to emphasize youth involvement in sustainable recreational programming (Eckstein, 2005; N.B. Department of Public Safety, 2000). Participation in structured community-based recreational activities can have a protective effect against substance abuse by students (AADAC, 2003).

Family and social supports

Intervention plans and outcomes are enhanced when positive family and community supports are elicited to encourage youth to pursue and sustain positive changes in their lives. Support is particularly crucial for youth in transition to the community from residential treatment or custodial settings. Organizing community support entails inviting family and community members to fulfill key roles that communicate to youth that they will “be there” for them as they experience challenges and successes associated with reducing problem substance use (Boyd-Ball, 2003).

Community support may also include youth mentorship programs where youth are linked with an adult who understands their needs and models positive life skills. Mentors provide social support and friendship. Mentorship programs have been found to have a positive influence, especially where youth are matched with mentors who have experienced similar issues and have a genuine respect for youth. Research on these programs has shown increased school participation, reduced involvement with negative peer associations, and enhanced skills to refuse alcohol and substance use. Of particular importance is the matching of adult mentors to youth. Key areas for consideration in mentoring relationships include creating a comfortable environment for youth and adults, finding common interests, and developing approaches to address areas of difficulty or challenge (Collaborative Community Health Research Centre, 2002).

2.5.3 Barriers to Community Linkages

In some instances, youth experience difficulty establishing meaningful attachments or accessing supports. Barriers can include:

- rigid and inflexible program protocols and/or admission requirements that impede participation in essential support services;
- previous negative experience with formalized services, leading to reluctance to engage in structured community programs;
- conflicting mandates and competition among agencies that inadvertently create barriers to service coordination;
- lack of transportation, which interferes with access to services (Caputo, Weiler and Green, 1996; Nissen et al., 2004).

In addition, when youth are faced with long wait times they may lose the motivation to pursue change and hence continue with problem substance use and illicit activities. Early assessment and screening provided by community-based agencies should facilitate timely referrals to essential services (Dembo and Walters, 2003).

2.5.4 Case Management

Case management strategies are used to reduce obstacles associated with service accessibility and to facilitate the development of community linkages. This approach requires assigning a youth worker or professional to assess, in conjunction with the youth and/or family, areas of need/concern, and to access services and supports. Case managers need to ensure that treatment plans are coordinated and tailored to meet the unique needs of the youth (Murray

and Belenko, 2005). Throughout the planning process, case managers should encourage youth to explore and evaluate alternatives, set goals, and project the consequences of their actions. They should be comfortable with motivational interviewing approaches, knowledgeable about cultural backgrounds and able to discuss the “pros and cons” of behaviours in a respectful and caring manner (Nyamathi et al., 2005).

Case planning should be structured to reflect the developmental stages of youth and incorporate the use of strength-based methods (Nissen et al., 2004). Case management involves:

- meeting individually with youth and family members to engage them in the case planning process;
- arranging meetings between the youth, parents and key service providers;
- organizing case conferences among community service agencies and professionals to ensure coordination of essential services (Murray and Belenko, 2005).

Case management can be closely linked or integrated with outreach programs to enhance youths’ positive connections in the community and support their subsequent access to needed services (Martinez et al., 2003). Family members are often included as key participants in the case management process. They play an important role by identifying barriers that may impede the youth’s efforts to reduce problem substance use, and can be a key source of support and motivation for youth. Case planning may also incorporate culturally relevant traditions or practices that strengthen or support early intervention (Boyd-Ball, 2003).

2.5.5 Step Care Methods

Case management can include Step Care approaches as part of the community planning process. This entails a graduated approach to intervention intensity that is matched to the youth’s needs and level of readiness to pursue change. The preliminary step involves inviting the youth to reduce substance use without providing external supports or treatment. If self-initiated change does not take place, then a “stepped-up” response might include engaging the youth in a motivational interviewing session to enhance commitment to action or to seek supports from others. If this is not successful, then administration of a more intense alternative, such as eliciting the youth’s participation in a self-help or pre-treatment group, may be required. The strengths of the Step Care approach is that it can be tailored to address the needs of the individual and uses existing resources cost-effectively. From a community planning perspective, this approach is valuable for targeting and using community service linkages to execute early intervention strategies (Hawkins, Cummins and Marlatt, 2004).

2.5.6 Coordinating Mental Health and Problem Substance Use Services

Community-based interventions must often address both problem substance use and mental health issues (Collaborative Community Health Research Centre, 2002). Some key challenges associated with providing concurrent mental health and problem substance use services include:

- fragmented and uncoordinated service delivery approaches;

- lengthy wait times for services;
- lack of services designed especially for youth;
- the need for helping professionals to be trained in both addictions and mental health issues (Kirby and Keon, 2004).

Some theorists have noted the potential benefits of establishing centralized intake facilities that screen and assess youth for co-morbid mental health and substance use problems (Dembo and Walters, 2003). This involves the collaborative efforts of various community and government-based agencies that represent justice, mental health, social services and addictions. The purpose is to facilitate access to key services for youth and ensure that interventions are coordinated and implemented in a timely fashion (Dembo and Walters, 2003; Jenson and Potter, 2003; Kirby and Keon, 2004), especially for high-risk youth, such as those who are homeless or at risk of homelessness. A one-stop multi-service setting can include a range of primary health care services in addition to mental health and addiction services (Nyamathi et al., 2005).

Community-based cross-system mental health and addiction services may be particularly beneficial for youth involved in the justice system. One U.S. study examined the effects of a coordinated mental health and substance use intervention strategy for 154 youth involved with the justice system. During their detention, these youth participated in a psychoeducational group on co-occurring mental health and substance use problems. They also met with a child psychiatrist and with case managers to plan for post-program coordinated mental

health and addiction-related support in the community. Individualized case planning services were continued for three months after their release. Of the original sample, 69% were located for follow-up. At six months, youth reported significant reductions in severity of mental health symptoms, decreased use of alcohol, cannabis, hallucinogens and cocaine, and reductions in property, person and drug-related offending behaviour. Although these outcomes provide some evidence for the efficacy of an integrative mental health and addiction intervention approach, the authors cautioned that their outcomes may be influenced to some extent by the exclusion of youth who were not located at the time of follow-up (Jenson and Potter, 2003).

Creating service delivery alliances among mental health and addiction services providers involves developing a multidisciplinary perspective and coordinating programs across agencies to ensure a planned continuum of care. This requires mutual understanding, an appreciation of cross-sectoral approaches, and a willingness to collaborate with others (Letters and Stathis, 2004).

2.5.7 Creating Linkages Among Service Providers

Service providers must have adequate knowledge of the range of available programs and resources in the community to intervene effectively with youth exhibiting substance use problems. Strategies for enhancing service providers' awareness of existing community capacity include:

- developing regional or community resource directories outlining youth and family-focused services;
- organizing community fairs and open houses where providers may promote their services and exchange program information;
- implementing community-wide planning sessions to strengthen collaborative efforts and develop strategies that address policy gaps or concerns (Gleghorn et al., 1998; Murray and Belenko, 2005).

Other actions may also be undertaken to develop coordinated and collaborative service delivery approaches in the community. These include implementing common intake, assessment and referral protocols, developing complementary service delivery policies among service providers, and creating mechanisms to address gaps in policy and service accessibility barriers (Nissen et al., 2004). Ideally, developing coordinated service delivery care networks for youth reduces duplication of services and provides opportunities for integrating complementary intervention efforts (Woods, et al., 2002).

2.5.8 Implementing Community-Wide Approaches

Establishing community linkages contribute to creating community-wide plans or strategies for addressing problem substance use. Approaches are often broad-based and aimed at addressing a wide range of family- and community-level risk factors. One example, the Community Empowerment Method, uses social awareness and promotional strategies to increase knowledge and change norms related to problem substance use among youth. The direct involvement of community leaders, role models and decision makers is central to implementing this approach (Hawkins et al., 2004).

In addressing community-wide approaches, some theorists assert the importance of assessing the community's readiness to change. The Community Readiness Model provides a beneficial framework for community leaders in planning regional strategies to reduce problem substance use and its consequences among youth. This model serves as a guide for evaluating the level of community readiness to embrace and sustain early intervention programs for youth. The underlying theory postulates that unless the community "is ready" to initiate a program, it is conceivable that it will not happen or succeed. The underlying principles of this model are:

- Communities are at various stages of readiness with respect to specific issues or problems.
- The stage of readiness can be assessed and documented.

- Communities can proceed through a series of stages to formulate, implement and sustain positive changes in health and behaviour.
- It is essential to structure specific intervention approaches based on the community's level of readiness (Edwards et al., 2000).

The Community Readiness Model includes a nine-stage awareness process (Edwards et al., 2000; Hawkins et al., 2004). The following provides an adapted summary of the community-readiness stages:

1. No awareness: Community members or leaders do not recognize the issue as a problem. Community climate may inadvertently encourage problematic behaviour among certain groups.

2. Denial: There is some recognition of a problem; however, there is minimal confidence in local capacity to address identified areas of concern.

3. Vague awareness: There is a general consensus regarding areas of concern; however, a lack of leadership or motivation impedes the development of strategies to move toward actions.

4. Pre-planning: There is a clear recognition of the local issue or problem. There are also identified community leaders or working groups that acknowledge the necessity of addressing the area of concern.

5. Preparation: During this phase, planning is ongoing and details for taking action are worked through.

6. Initiation: Adequate information has been gathered to justify implementing key actions or responses.

7. Stabilization: One or two initiatives are implemented and supported by local community and service providers.

8. Confirmation expansion: Actions are evaluated and lessons learned are used to modify existing approaches. Innovative and expanded efforts are implemented.

9. Professionalization: Implemented actions may include both community-wide approaches and specific intervention efforts targeted at reducing specific risk factors. Services are coordinated by trained personnel, involve participation of community members, and are routinely evaluated to ensure that evidence-based practices are implemented.

Interventions designed to facilitate communities' move along the readiness continuum may be developed in conjunction with this theoretical framework. Appendix A provides a summary of example strategies that match each stage of the community-readiness process. Further research is required to document the effectiveness of such community-wide interventions and to understand accurately the most beneficial aspects of these programs.

Key Informant Interviews

3.1 Selection of Key Experts

Key experts were identified in consultation with the members of the Health Canada ADTR Working Group. The list included those who had expertise in providing outreach and early intervention services or facilitating community linkages for youth with problem substance use.

Participants interviewed had on average 15 years of direct work or clinical experience in the area of youth or broader-based addictions. Tables 4, 5 and 6, respectively, provide the locations, the professional roles and the academic backgrounds of the interviewees.

Table 4: Geographic Distribution of Key Experts

Geographic Location (number)	Number of Key Experts
North Yukon (1)	1
West British Columbia (4)	4
Prairies Alberta (2) Saskatchewan (2) Manitoba (2)	6
Central Ontario (3) Quebec (1)	4
East Newfoundland and Labrador (2) Nova Scotia (1)	3

Table 5: Professional Roles of Key Experts

Professional Roles	Number of Key Experts
Service delivery managers and/or clinicians	11
Senior departmental or agency directors	4
Researchers	3

Table 6: Educational Backgrounds of Key Experts

Educational Backgrounds	Number of Key Experts*
Psychology, Counselling, Psychiatric Nursing	7
Social Work	5
Philosophy, Sociology, Criminology	3
Public Policy, Administration, Leadership	3
The Trades/Community College	1

* Some key experts had a background in more than one field.

3.2 Key Expert Interview Process

The key experts, representing each province and territory in Canada, were contacted in summer and fall 2006. Eighteen interviews were carried out across the country. The major areas of focus included:

- circumstances faced by youth with substance use problems;
- key actions for working with youth with substance use problems;
- important considerations for specific youth populations;
- early intervention and outreach approaches;
- roles for individuals in supporting early intervention and outreach;
- evaluation of early intervention and outreach strategies;
- community linkages.

The data gathered from the 18 interviews were merged to provide a unified data set. Content analysis was used to identify emergent theme categories. Specific theme categories were included based on endorsement of a minimum of three informants. The major findings for each area of inquiry are presented in the following sections.

3.3 Key Client Considerations

3.3.1 Circumstances Faced by Youth with Substance Use Problems

Initially, participants were asked to describe the unique circumstances facing youth with problem substance use. They outlined a range of key challenges and need areas related to the current life situations of many youth. These included:

Complex family problems

Various long-standing family problems were highlighted, including exposure to violence, traumatic events, physical and/or sexual abuse, parental discord, inconsistent or harsh discipline, lack of positive parent–youth communication, introduction of new or changes in adult figures in the home.

Instability in living conditions

Many youth with substance use problems were reported to have experienced frequent moves or changes in primary care relationships. These shifts often precipitated significant changes in both home and school routines, as well as loss in continuity of support or needed services.

Concurrent mental health issues

Many youth with problem substance use often have concurrent mental health issues. Areas of concern included depression, anxiety and grief related to loss or pain regarding family circumstances or relationships.

Lack of positive community attachments or connections

Youth with substance use problems were described as having limited or no involvement in structured community-based activities. Participants reported that many were not actively engaged in school, leisure or work. Lack of positive community connections was viewed as increasing the likelihood of developing negative peer associations, potential conflict with the law and continued substance use problems.

Minimal educational success

Participants indicated that problem substance use often impedes youths' successful functioning in school. Inconsistent attendance, poor academic performance and early school leaving were identified as consequences associated with prolonged substance use.

Basic need concerns

For some youth, lack of basic needs was associated with developing problem substance use behaviours. Areas of concern included the need for shelter, long-term stable housing, food and clothing.

Program policies that exclude youth

In some jurisdictions, age restrictions of some support programs or resources may limit youth access to essential support services, including residential options, financial assistance or alternate options for academic advancement.

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

Participants were also asked to identify important considerations for working with youth to address concerns about problem substance use. They identified a range of key actions that service providers should consider in their outreach or early intervention approaches:

Recognize that the motivations for substance use may vary

Experts underscored that youths' experimentation with substances may reflect their curiosity, an expression of their autonomy or even their resistance to rules identified by adults. Such motivations were noted to be consistent with developmental stages related to emergence of autonomy and the identity formation of adolescents. Others noted that substance use may be linked to social interactions with other youth or a way to deal with difficult personal or family-related circumstances. Participants stressed the importance of listening to youth and eliciting their perceptions about their current needs, situations and substance use.

Convey understanding and acceptance

The use of a non-judgmental approach and expression of acceptance of youth were viewed as critical for establishing a strong relationship. In contrast, the use of labels or professional "jargon" and "telling approaches" were identified as ineffective for engaging youth.

Engage youth as collaborators

Although many youth are dependent on adult, family or specific community supports for meeting basic needs, service providers should be cognizant of youths' need for autonomy and strive to engage them as collaborators in developing and implementing community-based activities.

Be flexible and creative in meeting and planning activities

Participants stressed that case plan activities should be developmentally appropriate, flexible in terms of meeting places and approach, include content related to interests and strengths of youth, and be tailored to meet their individual needs.

Incorporate and build upon positive family or community connections

Working in the context of the family and using positive sources of support from family or community members were viewed as important for strengthening and sustaining intervention efforts in the community.

Express concern regarding youths' health and well-being

Along with delivery of needed services or support, the importance of conveying an attitude of concern and expressions of caring were seen as critical for building and maintaining rapport with youth.

Maintain a positive connection during the process of change

The importance of remaining open to youth, even when they push away relationships or make decisions that impede their positive functioning in the community, was identified as a critical protective factor and a means for sustaining positive sources of influence in their lives. Continued openness to youth during and following such periods provides increased opportunities to re-engage them in activities that could ultimately reduce continued substance use and contribute to their positive growth and development.

Reach out using youth-focused media formats

Participants highlighted the potential benefits associated with using current media strategies for reaching out to youth (music, websites, online chat forums/bulletin boards). Such formats may be advantageous for creating awareness of substance use problems and facilitating engagement in early intervention services.

Select developmentally appropriate approaches

Informants noted that intervention strategies should be designed to match the developmental needs and circumstances of youth. For example, activity-based approaches may be useful for all adolescent ages, but particularly important for younger age groups.

Address family relationship concerns as part of early intervention efforts

Interviewees stressed the importance of addressing family relationship issues or areas of concern when intervening with youth with substance use problems. This may include working with parents/guardians and extended family, or others who act as role models to the youth. Efforts should emphasize development of collaborative interactions with family members and build on their areas of identified strengths and coping capacities.

Increase service provider awareness of barriers to youths' access

Participants emphasized the importance of service providers being sensitive to program operations or approaches that impede youths' access to or continued participation in needed support services. Barriers might include lengthy referral processes, lack of transportation, risk of stigmatization or lack of positive support from adults in their lives.

Include recreation activities as part of outreach and early intervention activities

Key experts stressed the importance of including fun and recreational components in outreach and intervention activities. These activities provide structured opportunities for building rapport with youth and also contribute to expanding and strengthening youths' interests in community-based activities and relationships that may be sustained over time.

3.3.3 Important Considerations for Specific Youth Populations

Key experts were asked to identify the major considerations that should be taken into account in providing early intervention and outreach services. They also provided insights about enhancing community linkages for youth with problem substance use. Sufficient data were gleaned from participants to identify key implications for eight specific youth populations.

Early adolescent substance users

Participants emphasized the importance of collaborating with parents/guardians, family members and school personnel in identifying and addressing areas of concern related to young adolescents at risk for problem substance use. Key aspects of effective approaches in working with younger youth included involving counsellors trained in child and youth care methods, incorporating youths' strengths and interests, avoiding technical language or jargon, and creating a comfortable, less formal environment.

Aboriginal youth

Problem substance use was widely recognized as a concern for many Aboriginal communities. Experts stressed the importance of community members being engaged in developing their own solutions for addressing areas related to problem substance use among youth. When implementing problem substance use awareness or intervention services, they also stressed that approaches should be culturally sensitive and may benefit from including specific content or activities that reflect community values or

traditions. The influence and participation of immediate and extended family members, as well as community elders may be important considerations for planning and executing outreach or early intervention activities.

Homeless and transient youth

Participants reported that homeless and transient youth have often experienced significant losses, including home and community attachments. These youth often form strong bonds with other peers who have experienced similar circumstances. They also indicated that higher prevalence of substance use is evident among this population. In addition to substance use, these youth face a wide range of concerns, including the need for shelter, food, clothing, safety and transitional housing. It was also asserted that outreach and early intervention services for these youth should be accompanied by adequate supports or resources to address their basic needs; otherwise, intervention efforts will likely be impeded and problem substance use will continue.

Youth with concurrent mental health problems

Participants indicated that youth with problem substance use may also exhibit concurrent mental health issues. Some informants noted that substance use by youth may also intensify existing mental health conditions. Screening for both substance use and mental health problems was therefore regarded as important in providing early intervention for youth. Collaborative efforts among youth-focused service providers, including school, mental health and addictions personnel, were seen as

critical for providing early intervention. Other informants stressed the importance of providing service providers with training opportunities to gain increased knowledge and understanding of substance use and mental health problems in youth.

Youth who inject drugs

Participants emphasized that youth who inject drugs are not a homogeneous group, and that service providers should expect variations in age, culture, geography of origin and socio-economic status. Focusing on small-step successes were recommended strategies for engaging and working with these youth. Other informants identified the need to increase youths' awareness and knowledge about the risks associated with intravenous drug use, including transmission of blood-borne pathogens. It was also noted that youth who inject drugs may be inappropriate participants in group-based intervention sessions with peers who had never initiated injection practices.

Youth in conflict with the law

Participants indicated that most youth involved with the justice system have also experimented with or regularly used substances. Many are estranged from both structured school and community-based programs, and have formed peer associations that are linked with substance use and criminal activity. When youth first come into conflict with the law, it is imperative that screening for substance use be done as part of cautioning, diversion or community-based sentencing. Many youth in conflict with the law have long-standing histories of behavioural

and academic difficulties that become evident during early school years. Providing early intervention services in the school may also address identified risk factors associated with problem substance use and strengthen youths' attachment to school.

Rural youth

Many youth residing in rural areas may not have access to problem substance use intervention services. Outreach and transportation were identified as important for connecting with youth in more remote locations. Participants highlighted the potential benefits of working with regional educational authorities and schools in providing early intervention efforts.

Youth in care

Participants indicated that many youth in care experience frequent changes in their living circumstances and relationships. Their past often includes trauma, significant loss, attachment difficulties and complex family-related issues. For those with problem substance use, participants placed importance on ensuring that early intervention substance use services are implemented in conjunction with residential placements and mental health counselling services.

3.4 Early Intervention and Outreach Approaches

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

Participants were asked to identify the theoretical orientations that provide the basis for organizing and delivering early intervention and outreach services for youth with problem substance use. Most informants highlighted the potential benefits of applying motivational interviewing concepts in conjunction with Prochaska and DiClemente's model of stages of change. Motivational interviewing practices were identified as easily adaptable to the various stages of readiness to change. Positive features associated with this framework included:

- an empathic and respectful approach for engaging youth;
- a small-step approach for addressing positive change;
- a strength-based focus designed to increase youths' desire for change.

In conjunction with brief intervention strategies such as motivational interviewing, experts stressed the importance of developing positive interactions with youth. Youth should actively participate in the development of their own goals and plans related to problem substance use. The use of active listening and approaches that focus on solutions, in contrast to more directive or "lecture/telling" methods, is imperative for increasing youths' willingness to become involved in intervention activities with community-based or professional helpers. Relationship-based approaches should also take into account youths' developmental level and the potential benefits of designing activities tailored to their interests and need for active involvement.

Participants also emphasized systemic approaches that include creating collaborative alliances with significant and influential adults in the lives of the youth from the home, school and community. Identifying and using the capacity of family members, school personnel and members of the wider community is important when developing wrap-around services to meet the comprehensive needs of some youth.

3.4.2 Structuring Early Intervention Approaches

Key experts stressed that early intervention approaches should be informal, comfortable and inviting. Ideally, early intervention approaches should be designed to provide youth with interactive opportunities to:

- examine key issues and their perceptions and reasons for reducing or not reducing substance use;
- share their perspectives and areas of personal concern/stressors related to the family, school or community;
- explore strategies for sustaining and enhancing school connectedness;
- formulate specific approaches or strategies to address identified personal needs;
- identify and engage sources of positive peer supports in their current school or community settings.

Early intervention was described in terms of individually focused or small group approaches carried out in settings where youth spend time with peers. Particular emphasis was placed on undertaking efforts in conjunction with youth-serving agencies or contexts such as schools, recreational facilities, boys and girls clubs and community youth groups. Other locations to implement early intervention initiatives included drop-in centres, outreach clinics and other street settings where youth congregate or meet one another.

When designing and implementing early intervention programs, participants emphasized the importance of collaborating with community service providers, agency managers and community volunteers. For youth already involved with government-based support services such as justice, child protection services or mental health, early intervention activities should be coordinated in conjunction with existing case plans. Although collaboration with specific professionals and community agencies may be required when developing early intervention approaches, delivering such activities should be done by people who have the qualities and skills to engage youth effectively in conversation and build rapport with them. Participants asserted that early intervention workers should possess knowledge and competencies in child and youth care methods or social work practices, and be skilled in designing interactive approaches for engaging youth at a wide range of developmental levels. Participants also spoke about benefits of offering training opportunities for community service providers and youth workers on problem substance use and early intervention practices.

3.4.3 Implementing Early Intervention Screening and Assessment Approaches

Problem substance screening processes were identified as a key aspect of early intervention activities. According to participants, screening processes were beneficial for:

- engaging youth in conversation and establishing rapport;
- defining problem substance use patterns or risk factors;
- exploring other areas of need or concern related to family, school or peer relationships and routines;
- exploring the strengths, interests and preferences of youth;
- identifying potential support networks and coping strategies;
- matching needs with available resources or sources of support.

Informal approaches to screening were described as being a semi-structured format that elicited information from youth through a conversational interview style. Screening activities can also be done with others who have direct knowledge of youth functioning, such as parents/guardians, counsellors or other service providers. Participants emphasized that interactions must be undertaken in a non-judgmental manner and convey respect to the youth or adult interviewees.

Participants also identified key areas of inquiry that might be included in screening protocols. These included:

- substance use history (drugs used, quantity and frequency, routes of administration, age of first use, any negative experiences);
- youths' perception of substance use patterns and impact on major life areas;
- family members' perspectives on substance use;
- existing mental health status and past history;
- suicide risk and self-harm history;
- other service providers involved with the youth or family;
- school performance, educational level and vocational interests;
- nature of family relationships, interactions and potential stressors;
- peer associations and influences;
- areas of community involvement;
- youth and family strengths, significant relationships and sources of support.

Ideally, screening should provide a comprehensive profile of youths' current functioning, as well as priority areas that should be targeted by subsequent intervention activities.

3.4.4 Internet-Based Intervention Support Materials

In-person approaches may be supplemented by written or Internet-based early intervention resources. Participants stressed that youth are comfortable with emerging technology and that websites provide opportunities to engage them through use of youth-friendly language and presentation styles.

Internet resources may provide the catalyst for conversations with youth or be used as discussion starters for small group interventions. Participants stressed that web-based formats should be appealing to youth and incorporate visual or graphic material that catches their attention and effectively conveys the intended intervention messages. They also emphasized that youth should be directed to sites hosted by reputable agencies that have web security features to ensure user safety.

Limitations associated with online approaches were also noted. These included:

- the lack of information reliability on some websites;
- the time required to supervise and guide youth in identifying credible and useful Internet sites;
- the literacy level of some website content and the challenges it may pose to youth with reading lags or disabilities;
- specific risks of unsecured online discussions or forums.

Participants stressed that the Internet as a stand-alone approach for early intervention is inadequate for effectively addressing problem substance use among youth; however, this medium is strengthened when applied in the context of establishing positive alliances between youth and early intervention workers.

3.4.5 Outreach Approaches

Partnerships

Participants indicated that community partnerships are important when planning and delivering outreach services. Organized exchanges among community agencies provide valuable opportunities to increase providers' understanding of the complex needs of youth at risk, and the range of available youth-focused services in the community.

Community-based non-profit agencies and service clubs that focus on youth and family engagement may play a central role in organizing effective methods for reaching out to youth. Youth may have regular or more frequent contact with these types of agencies than with health-related services that require set appointment times. Participants highlighted the value of addiction services personnel providing specialized training to community-based agency staff to enhance their knowledge and skills for working with youth with problem substance use.

Settings and delivery times

Participants stressed that outreach services should strive to reach youth in their “own space”— places where they regularly spend time with their peers. Locations may include formal or structured settings where youth are engaged

in activities, such as schools, recreation facilities, after-school programs or community activities, or informal places frequent, such as street meeting locations, parks, shelters, drop-in centres and malls. A third type of outreach included the use of mobile services that have the capacity to reach out to multiple locations and often involve the delivery of basic need or health services along with early intervention efforts.

Experts emphasized that outreach sites, in contrast to formal office-based settings, should be in the youths' social environment and conducive to rapport building. Initial contacts with youth should be non-threatening, respectful and include brief informal conversations over frequent encounters. In structured settings, outreach services must adapt to set program times. In contrast, outreach in informal settings is most effective when meeting times are flexible and provide opportunities for multiple contacts with youth. Hours of operation for outreach activities should include both evenings and weekends.

3.4.6 Outreach Workers

Qualities of outreach workers

Participants indicated that outreach workers should demonstrate a non-judgmental attitude in responding to youths' perspectives and choices, enjoy working with youth, and have an understanding of developmental milestones and attachment issues. With respect to professional competencies, youth outreach workers should have the capacity to:

- establish and sustain rapport with youth who mistrust or challenge authority;

- actively listen and elicit youth perspectives;
- set personal limits and seek consultation when necessary;
- collaborate with other service providers without comprising their alliance with the youth;
- deal effectively with stressful events and de-escalate potential conflict situations;
- identify and incorporate youths' strengths in intervention activities.

Areas of academic training for outreach workers included child and youth care, psychology, education, social work and counselling. Specialized training in addictions, mental health and motivational interviewing was also viewed as important. In addition to training and education, participants stressed the importance of having outreach workers who have substantial personal experience in the targeted outreach group.

Activities and tasks

The first task of outreach workers is to establish a point of connection with youth that facilitates dialogue and potential intervention.

Participants highlighted a range of key activities that can be undertaken by outreach workers, including:

- meeting and conversing with youth in their settings;
- educating youth on specific health risks associated with substance use and sexual practices;

- screening for potential problem substance use and mental health concerns;
- linking youth with services that address basic needs, such as shelter, food and clothing or health care;
- assisting youth in navigating the system and understanding referral processes;
- collaborating with youth to plan specific action steps to address problem substance use or concurrent needs;
- referring youth to treatment or rehabilitation services;
- accompanying youth to preliminary appointments with health care providers;
- re-engaging youth with positive sources of family and community support;
- providing supportive counselling services.

Participants also emphasized the importance of worker accountability and supervision. Being part of a staff team provides opportunities for debriefing, ongoing professional development and use of feedback to enhance ongoing practices.

3.4.7 Supporting Early Intervention and Outreach

Key informants described possible roles for various individuals in supporting early intervention and outreach to youth. They provided comments on potential contributions of family members, school personnel, community service providers, and addictions and mental health personnel.

Family members

Participants emphasized that family members have a crucial role to play in supporting early intervention efforts; however, assistance may be needed to help families develop and implement effective strategies for addressing concerns related to youth problem substance use. Approaches for helping families include providing education on adolescent experimentation patterns, signs or basic features of drug use, stages of readiness to change, brief intervention approaches, and methods for effective communication and problem solving. Referrals to family counselling agencies can be made. In some cases, problem substance use is not limited to the youth, but can involve other family members; therefore, ways to pursue change or to engage in collaborative family actions may vary. Family members can often assist youth by providing transportation to appointments or ensuring that basic needs are met. For younger adolescents, family members should have increased involvement in supervising and structuring youths' daily activities and monitoring their peer associations.

School personnel

School personnel are in a unique position to identify early experimentation and problem substance use patterns. Participants emphasized that school personnel must know how to engage youth and link them with appropriate early intervention services. School personnel should work collaboratively with other youth-focused agencies, including mental health, addiction services and justice. Outreach efforts should also attempt to elicit the support of family members in intervention activities. Ideally, outreach and early intervention efforts should not only address problem substance use, but also strengthen the youth's connectedness at school and support successful educational and career advancement.

Community service providers

Community service providers are also in a position to identify early patterns of problem substance use among youth. Participants emphasized the possible benefits associated with training service providers in problem substance use screening and early intervention approaches. Community service providers may also refer youth and families to basic need or treatment services.

Addictions and mental health personnel

Addictions and mental health personnel are in a position to act as consultants for other service providers who routinely encounter youth at risk for potential problem substance use. Consultation may include organized professional development sessions or individual consultations on a range of topics, including substance use patterns, screening methods,

co-morbid mental health concerns, protocols for accessing community mental health and addiction services, motivational interviewing approaches, and stages of readiness to change.

3.4.8 Evaluation of Early Intervention and Outreach Strategies

Participants stressed that evaluation processes should be developed as part of the initial planning and design of outreach and early intervention services. Evaluation plans should take into account both process and outcome approaches to program review. Process components focus on evaluating how the program is implemented. Outcome evaluation measures the extent to which the program has had a positive impact on client functioning or other areas targeted for change. The creation of logic models was cited as useful to guide program design, implementation and subsequent evaluation.

Carrying out pilot projects evaluations was cited as beneficial. These were considered useful for providing constructive and practical information for refining intervention programs. In designing program evaluations, participants indicated the importance of:

- pre-post intervention measures;
- control group comparisons;
- longer-term follow-up data collection;
- quantitative and qualitative data;
- participatory approaches that include personnel, youth and family feedback/perspectives;

- indicators for youth functioning in school, family or community;
- indicators for reduction in substance use problems.

Participants indicated that program reviews should include daily or regular operational reporting requirements. Accountability indicators should include a range of outputs,

such as number of contacts, assigned caseloads, referral patterns, attendance at meetings, type of outreach or intervention activities implemented. Participants emphasized the importance of valuing the youth perspectives in the evaluation process. They recommended that youth be given “a voice” in determining the focus of evaluation activities and identifying indicators of success.

3.5 Essential Community Linkages

3.5.1 Essential Community-Based Services and Supports

Key informants were asked to identify the kinds of community services or programs that should support early intervention approaches for youth with substance use problems. Important community linkages for youth include schools, recreation activities, mentorship programs, basic need supports and youth and family-focused counselling. Participants stressed the value of inviting youth to participate in designing and evaluating community-based services and supports.

Participation in structured community youth programs

Youth-focused recreation programs or clubs were identified as forums in which youth may engage in wellness-oriented activities with positive peer and adult supports. Participation in these programs was viewed as beneficial for fostering both skill development and lifelong interest in meaningful pastime activities. For

some youth, providing financial support or bursaries may be required to support long-term participation in some community-based programming.

Enhanced school connectedness

Participants stressed the importance of strengthening youth attachment to their school and their commitment to educational advancement. Strategies for enhancing connectedness included peer mentorship programs, participation in organized school-based physical or social activities, on-site early intervention activities and counselling, involvement in drama/music/arts programs, academic assistance, and opportunities for vocation or supervised work experiences.

Involvement in mentorship programs

Participants highlighted the importance of organizing mentorship opportunities for youth with positive adult role models in the

community. Such relationships were identified as providing youth with sources of support that could be sustained over the long term.

Provision of basic need supports

For some youth, basic needs must be addressed in conjunction with early intervention approaches. This may require collaboration between community-based and government agencies, developing coordinated case plans and accessing income supports or transitional housing.

Access to youth- and family-focused counselling services

Timely access to counselling services for youth and their families should be offered by counsellors who are comfortable addressing a wide range of issues related to family stressors, mental health concerns and problem substance use.

3.5.2 Service Delivery Challenges

Participants were asked to identify challenges that impede the efforts of community service providers to work collaboratively to deliver services for youth with problem substance use. Key barriers were identified as:

- competition for limited resources;
- differences in service delivery orientations;
- waiting lists and complex intake processes;
- large case loads and time constraints;
- lack of established protocols for information exchange and communication among service departments or agencies;

- inflexible program mandates and policies;
- inadequate service options in rural or remote areas.

Many of the service delivery challenges could be addressed through strengthened collaboration and interagency consultation among service providers; however, commitment from agency leaders and directors was viewed as important for developing and realizing long term solutions.

3.5.3 Policy and Service Gaps

Participants indicated that in some jurisdictions significant policy and service gaps exist for youth between 16 and 18 years of age related to the lack of housing and basic need services. Other concerns related to practices and policies included the lack of effective school-based strategies for re-engaging youth with substance use problems who no longer attend school, waiting lists for addictions and mental health services for youth, and the lack of coordination or integration of services among addiction and mental health services. In addressing policy or service gaps, participants emphasized the importance of remaining youth focused rather than program driven.

3.5.4 Coordinated and Integrative Service Delivery Approaches

Youth with problem substance use often face a range of concurrent psycho-social needs. Providing early intervention efforts often requires implementing a multifaceted community plan involving the participation of a variety of community service providers. Participants highlighted the benefits associated

with developing integrative service delivery approaches that build on shared resources and capacities of existing community-based agencies. Key actions that support the development of interagency collaboration include:

- eliciting support for service delivery cooperation from senior administrative and operational managers;
- enhancing understanding among front-line workers regarding their respective mandates and referral protocols;
- developing mechanisms for timely information exchange;
- offering interagency and multidisciplinary training opportunities, including workshops and conferences to share better practices;
- establishing protocols for interagency consultation, communication and case planning activities;
- implementing memorandums of understanding to support consistent service delivery cooperation among agency personnel;
- co-locating and co-facilitating front-line services.

Participants noted the potential advantages of having specific mechanisms in place to identify gaps in policy and practice that may emerge as services are coordinated or integrated. Identifying these issues could result in implementing more timely responses to support interagency cooperation and improved outcomes. Evaluation of integrative service delivery efforts was viewed as challenging. Participants indicated the value of eliciting feedback from clients and service providers when evaluating regional or pilot projects. The use of key informant interviews, focus groups or distributed surveys were suggested for documenting perspectives of key stakeholders.

Focus Groups

4.1 Introduction

The purpose of the focus groups was to elicit the perspectives of youth who had previous experiences with problem substance use. Data gathering was completed across northern, western, central and eastern Canada. In each region, one focus group was conducted with females and another with males. Initial contact with potential participants was done in collaboration with local and regionally based treatment service providers to explain the sessions and to ask for their input.

Each focus group used a semi-structured format for discussion. Participants were also given an opportunity to review their responses at the close of each session and to highlight specific themes they viewed as most crucial. Four key areas of inquiry were addressed:

- What key challenges face youth with substance use problems?
- What services or supports might make a difference for youth early on in the development of substance use problems?

- How might services in your community more effectively reach out and connect with youth who have or who are at risk for problem substance use?
- What community services would be most needed or helpful for youth with problem substance use?

Descriptive session notes provided the basis from which to write a summary for each focus group exercise. At the end of the eight sessions, individual summaries were merged to provide a unified data set. Content analysis was applied to identify major themes and trends arising from the data. Clustering of key themes subsequently provided the basis to develop categories for the various areas of inquiry. Theme categories were included based on endorsement of at least two focus groups. Unless otherwise indicated, the themes that are summarized reflect contributions from groups of both male and female youth. The major findings for each area of inquiry are presented in the following sections.

4.2 Participant Demographics

A total of 46 youth participated in the focus groups, with an average attendance of six. Youth ranged in age from 16 to 28 years, with

an average age of 18 for both males and females. Demographic data gathered from participants are presented in Table 7.

Table 7: Focus Group Participant Demographics

Participant Variable	Percentage of Sample (%)
Gender	
Male	54
Female	46
Residence	
Urban	59
Small urban	21
Rural	20
Ethnicity	
Caucasian	37
First Nation	30
Black	15
Latino	11
Not specified	7

4.3 Challenges Faced by Youth with Substance Use Problems

“It happens so fast.”

“...to leave drugs you must abandon friends.”

“... no job...no hope for a job because there is no education...no place to live.”

“Selling, whatever you have, all you have, for drugs.”

“Stealing from them...it hurts families and ruins trust.”

“It hurts on the inside.”

Participants were initially asked to describe the challenges faced by youth with substance use problems, and which issues were of greatest concern. The following indicates the challenges and the number of focus groups that endorsed the given theme:

- feelings of desperation and loss of control (8);
- peer influences (8);
- history of abuse, trauma and complex family issues (6);
- disengagement from school or work activities (5);
- exposure to substance use by family members or older individuals (4);
- decreased hope and self-esteem (4);
- gender-based stigma (2).

4.3.1 Feelings of Desperation and Loss of Control

Focus group participants indicated that problems with substance use patterns were characterized by “chasing that first high” and focusing on the next chance to use. Motivations linked with problem substance use often reflected attempts to escape from negative emotions, dissatisfaction with self, or other stressors related to complex family problems, basic need issues or other social factors. “Having money” was often regarded as a reason to sustain substance use patterns, whereas “not having money” was associated with a sense of desperation and a willingness to “doing anything” to obtain substances. Stealing from friends, family and others, selling drugs and prostitution were cited as typical means used by youth to obtain money to support use. The consequences of such behaviours often culminated in loss of personal support from others, and rejection and estrangement from friends and family members.

4.3.2 Peer Influences

Influence from peers was regarded as a major challenge facing youth trying to reduce substance use. Participants stressed that substance use is a lifestyle shared by friends and that adopting patterns of decreased use or no use requires disassociation from current peers. The decision to decline use was often associated with peer rejection or even threats from others to their personal safety. Forming connections with non-using peers was regarded as a major challenge, but recognized as an important step in adopting other lifestyles and choices.

4.3.3 History of Abuse, Trauma and Complex Family Issues

Participants disclosed that many youth who have substance use problems have experienced physical, emotional or sexual abuse. Trauma, significant loss and grief were cited as factors contributing to initiation of substance use and development of problems with using. In many instances, traumatic experiences were related to or exacerbated by a range of complex, stressful family relationships.

4.3.4 Disengagement from School or Work Activities

Participants noted that intoxication and substance use often impeded the ability to be successful in academic and work-related activities. Prolonged substance use can interfere with attendance in structured daily routines and subsequently result in withdrawal from school or work or being asked to leave by educational authorities or employers. Re-engaging in school following problems with substance use was viewed as particularly challenging.

4.3.5 Exposure to Substance Use by Family Members or Older Individuals

Participants reported that youth are often influenced by older individuals, including siblings, parents and other youth. Times of transition from middle/junior high school to high school often are accompanied by increased exposure to older youth who use substances as well as decreased supervision by school personnel and parents.

4.3.6 Decreased Hope and Self-Esteem

As a result of the complexity of issues facing those with substance use problems, participants stressed that many youth lack hope that positive changes are possible in their current life situations. This sense of hopelessness is often accompanied by both depressive feelings and a sense of diminished self-worth and self-respect.

4.3.7 Gender-Based Stigma

Some participating young women reported that there was greater stigma attached to substance use for females than for males. They cited experiences when they had encountered disrespect from legal and health care professionals toward female youth. They stressed that judgments and presumptions made about them or their peers were often not justified or made without cause.

4.4 Early Intervention

“There is nothing for kids to do during the day, after school or evenings. It’s so boring that they pick up drugs, and the young ones follow the older ones.”

“Introduce new activities, try new stuff. Expand youths’ experiences beyond the (drug-using) community.”

“We need flexible rules and space to move.”

“The people I trusted, that I hung out with, said that I was doing too much.”

“Delay onset of use. Get them early on.”

“Find out what they are good at. Even though they use, they have a talent. Just find it. Point out what they are doing right. Notice what is good.”

“Strength is an anti-drug...using strengths as a natural high.”

Participants were asked to identify key services, supports or actions that might assist in intervening earlier with youth and averting the development of long-standing problem substance use. The following summarizes the key themes and the number of focus groups that endorsed each theme:

- provide opportunities for open and supportive interactions about substance use (6);
- engage youth in high-interest recreation and leisure activities (6);

- ensure access to positive sources of social support (5);
- intervene with younger adolescents (5);
- focus on youths’ strengths (4).

4.4.1 Provide Opportunities for Open and Supportive Interactions About Substance Use

Participants emphasized the value of honest information exchanges with educators and family members about the consequences of substance use. Use of “scare tactics” and “punitive measures” were regarded as ineffective for engaging youth in dialogue and were often viewed as contributing to increased tension and alienation in youth and adult relationships. Participants also stressed that such interactions should include opportunities for youth perspectives to be heard and respected, despite their current choices or behaviours.

4.4.2 Engage Youth in High-Interest Recreation and Leisure Activities

Boredom and lack of interesting recreational or leisure activities were cited as factors contributing to both the initiation and continuance of substance use among youth. Participants highlighted activities in which youth could engage, including camping, wilderness adventures, organized outdoor sports, indoor activities such as pool and ping pong, artistic and music activities, as well as community excursions or volunteer opportunities. Youth participation in structured

social activities with other youth was identified as beneficial for providing positive social support and promoting pro-social behaviours.

4.4.3 Ensure Access to Positive Sources of Social Support

In preventing or reducing the development of problem substance use, participants highlighted the importance of having access to positive social support. For female youth, emphasis was placed on having positive points of connection in the immediate or extended family. In addition, having caring adults in the school or community setting was seen as beneficial for supporting positive changes in behaviour or lifestyle. Such relationships were also identified as trusted sources of feedback and advice.

4.4.4 Intervene with Younger Adolescents

Participants stressed the importance of intervening earlier among youth, especially among adolescents who had started experimenting with substance use at the middle or junior high school level. Exclusionary policies and consequences were regarded as ineffective for motivating positive changes in youth substance use behaviours. Participants underscored the value of taking time to listen, communicate and establish rapport with youth.

4.4.5 Focus on Youths' Strengths

Early intervention with youth should focus on identifying and using areas of competency. This may entail exploring youths' preferences, interests, strengths and aspirations. Participants stressed that focusing on strengths facilitates the development of positive interactions with youth and serves to enhance their confidence and self-esteem.

4.5 Outreach Approaches

“Staff need to be real to help us. The staff here are real people: they owned our shoes... they get on the same level to talk.”

“The legal approach is all wrong. Don’t go by the book. Police should talk to us instead of charging us.”

“It takes a lot of time to build trust in someone and get used to them.”

“Talk to me, be interested in what I have to say.”

“They don’t put pressure on you...when you are ready then they will be there.”

Participants were asked to describe effective ways of reaching out or connecting with youth with substance use problems. The following summarizes the key responses and indicates the number of focus groups in which each theme was discussed.

- convey a genuine interest (7);
- sustain supportive and problem-solving interactions (6);
- take time to build a relationship (5);
- provide timely assistance to youth (5);
- avoid use of sanctions alone (3);
- go where youth are (2).

4.5.1 Convey a Genuine Interest

Participants emphasized that youth are generally receptive to approaches in which they perceive outreach workers to be sincere. In particular, genuineness was viewed as a central ingredient in initially developing trust with youth. They also indicated that outreach personnel who have lived in similar circumstances are regarded as more credible, and are more readily accepted by youth.

4.5.2 Sustain Supportive and Problem-Solving Interactions

Participants underscored the importance of youth having access to sources of social support and understanding during times when they re-initiate or increase substance use. Having individuals with whom they could interact during difficult times was seen as beneficial for problem-solving.

4.5.3 Take Time to Build a Relationship

Participants stressed that building relationships with youth takes time. Developing trust may require frequent encounters with youth over extended time periods. The nature of such interactions should be based on mutual respect and caring.

4.5.4 Provide Timely Assistance to Youth

Participants indicated that community service providers should be responsive to youth needs, especially when youth ask for assistance or communicate a readiness to pursue change. Providers should act upon the “window of opportunity” to support youth in making positive changes.

4.5.5 Avoid Use of Sanctions Alone

The use of sanctions alone to address substance use problems was regarded as ineffective for engaging youth in making changes. Participants stressed that school personnel, police and community service providers should adopt approaches that foster the development of personal and positive interactions with youth.

4.5.6 Go Where Youth Are

The importance of getting to know youth in their “own spaces” and meeting places in the community was highlighted.

4.6 Community Services and Linkages

“Community frowns upon drugs—you feel like the black sheep. Makes you feel guilty.”

“Look at me like you want to know me, like you care. Hear what I am saying. I am not a monster, I’m just like you.”

“We all make mistakes and all need help—we all need people around us.”

“Go to youth for their ideas.”

“It needs to be a safe place....Somewhere to spend time.”

Participants were asked to identify specific community services and supports that should be available to youth with substance use problems. They highlighted a range of key actions that could strengthen youth linkages in their communities.

- provide safe and positive meeting places for youth (7);
- ensure practical and meaningful educational experiences (5);
- build positive peer support networks (5);
- ensure youth focused-transition support and treatment options (4);
- increase community members’ understanding and appreciation of youth (4).

4.6.1 Provide Safe and Positive Meeting Places for Youth

Concern was expressed about the lack of access to local recreational or youth centres, especially for those living in rural areas. Participants indicated that facilities in urban centres often have policies and rules that do not permit youth to hang out or congregate. To be responsive to youth needs, they stressed the importance of eliciting youths' perspectives and leadership in organizing and delivering community-based recreational activity programs. These program sites should offer activities during the day and evening, and be characterized as safe places for all youth.

4.6.2 Ensure Practical and Meaningful Educational Experiences

Participants stressed the importance of providing youth with educational experiences that encourage them to stay in school. Academic programs should include individual academic assistance, hands-on learning activities, basic life skill instruction and opportunities to participate in apprenticeship programs (e.g. trades) or co-op learning experiences. Ideally, they should be tailored to meet the individual needs of youth, and be geared to building upon areas of interest and strength.

4.6.3 Build Positive Peer Support Networks

In sustaining positive changes in behaviour, participants recognized the importance of youth having meaningful relationships with non-using peers. The sense of "not being alone" and having friends with common interests were important considerations.

4.6.4 Ensure Youth-Focused Transition Support and Treatment Options

Participants cited examples of youth with problem substance use who had attended community or residential rehabilitation programs designed for adults. They stressed the importance of developing youth-specific programming for problem substance use and related concerns, such as detoxification programs, residential treatment services, shelters and transitional housing options.

4.6.5 Increase Community Members' Understanding and Appreciation of Youth

Some participants stressed that youth with substance use problems often feel judged and misunderstood by members of the wider community. They asserted the need for community members to value youth and to foster their potential to be successful and to make positive contributions to others.

Best Practice Statements

This section will present the best practice statements associated with providing early intervention, outreach and community linkages for youth with substance use problems. These statements reflect the convergence of major insights from the research and from either key expert interviews with service providers or focus group sessions with youth who have had substance use problems. As research continues, these statements will need to be reviewed and modified to reflect new knowledge. Sections of the document that support each best practice statement are cited in Appendix B. The best practice statements are categorized according to the following service delivery issues:

- Strengthening Service Delivery Orientations;
- Client-Focused Considerations;
- Screening Processes;
- Early Intervention;
- Outreach;
- Relevant Community-Based Supports;
- Coordinating and Integrating Community Approaches.

5.1 Strengthening Service Delivery Orientations

5.1.1 Readiness to Change Model

Prochaska and DiClemente's Stages of Change model is a practical framework for understanding and assessing readiness to change. This model supports the creation of collaborative interactions with youth who are at varying levels of readiness to pursue change, and is applied in conjunction with brief interventions and motivational interviewing strategies.

5.1.2 Strength-Based Methods

Strength-based approaches are designed to promote positive change through recognizing and engaging the strengths of youths, their respective families and communities. Strength-based methods are also beneficial for engaging and intervening with high-risk youth populations.

5.1.3 Youth Perspectives

The perspectives of youth should be elicited and their leadership skills utilized when organizing and delivering community-based youth-focused services and programs. Feedback from non-users, as well as those at risk for problem substance use should be taken into consideration.

5.1.4 Youth-Specific Services

In some jurisdictions, only adult-focused interventions are available to youth. Service providers should strive to adopt outreach and early intervention services that are responsive to the developmental needs of youth. When youth

request assistance or communicate a readiness to pursue change, service providers should act upon this “window of opportunity” and provide youth specific-services in a timely manner.

5.1.5 Inclusive vs. Exclusionary Policies

Inclusive policies that focus on relationship development and incorporate the influence of positive adult or peer roles will foster youths’ sense of belonging and attachment to school and community. Exclusionary policies and sanctions alone are regarded as ineffective for motivating positive changes in youth with substance use problems or in linking them with needed intervention services.

5.2 Client-Focused Considerations

5.2.1 Histories of Abuse and Trauma

Histories of sexual, physical abuse and trauma have been positively associated with the early initiation and development of problem patterns of substance use among youth. Counselling services should be made accessible to youth and family members as appropriate, to avert the emergence or escalation of substance use problems.

5.2.2 Basic Needs

Early intervention services, especially for street and homeless youth, should be accompanied by adequate supports and resources to address basic living concerns, including shelter, clothing, food and transitional housing.

Without these services, intervention efforts will likely be impeded and problem substance use continue.

5.2.3 Peer Influences

Lower levels of substance use by peers may decrease availability of substances, provide less social reinforcement for using substances, and provide models for healthier behaviours. Although forming new peer connections is challenging, providing opportunities for youth to engage in social activities with non-using peers is important for them to adopt healthier choices in daily living routines.

5.2.4 Concurrent Mental Health Disorders

Current evidence indicates that effective interventions for youth must provide an integrative approach to co-morbid mental health and substance use problems. These interventions require the development of a single point of entry for assessment and a coordinated service response with a focus on including family members when appropriate.

5.2.5 Cultural Sensitivity

Barriers to intervening with ethnoculturally diverse youth include stigma associated with disclosing problem substance use, lack of openness to involve external service providers, and language barriers. Recommendations for addressing these barriers include undertaking outreach efforts to youth and their families, providing services in the language of the client, and increasing sensitivity of service providers to the values and culture of specific ethnic groups.

5.2.6 Aboriginal Youth

In delivering problem substance use interventions to Aboriginal youth, it is important to assess the importance of spiritual values and traditions for the target population to ensure cultural congruence. Early interventions can incorporate traditions and cultural practices (legends, storytelling), bringing together positive family and community role models in the planning process, and integrating crafts and recreational activities to present and reinforce positive directions for change.

5.2.7 Youth in Conflict with the Law

Early intervention activities should be implemented at the “front end” of the justice system when youth first become involved with legal authorities. At this point, screening and assessment should be undertaken to identify substance use or mental health problems as part of cautioning, diversion or community-based sentencing.

5.3 Screening Processes

5.3.1 Role of Community-Based Service Providers

Emergency department personnel, health specialists and other community service providers are in unique positions to identify problematic patterns of use in youth. Questions about substance use should be incorporated as part of health and rehabilitation screening protocols.

5.3.2 Areas of Inquiry for Screening

Screening approaches should not be limited to exploring patterns of substance use. Other information related to aspects of the youth's life can be critical to understanding the dynamics underlying current problem substance use. Areas for investigation include family functioning, peer influences, school performance, areas of stress and coping, as well as readiness to change.

5.4 Early Intervention

5.4.1 Early Intervention with Young Adolescents

Early intervention efforts should be targeted at middle and junior high schools. Times of transition from middle/junior high to high school are often accompanied by increased exposure to older youth who use substances and to decreased supervision by school personnel and parents.

5.4.2 Brief Interventions

Recent research lends support for the use of brief intervention approaches for working with adolescents with substance use problems. These methods are generally defined as having a limited number of helping sessions and incorporate cognitive-behavioural approaches, motivational interviewing concepts, and a focus on clients' areas of ability and strength.

5.4.3 Group Interventions

Group-based early interventions are enhanced by incorporating culturally based activities, applying discussion-oriented approaches and using incentives (free food or snacks) or other socially acceptable reasons for program attendance. Although small group approaches involving youth peers have been described as beneficial for reducing problem substance use, some research suggests that peer associations also have the potential to counter such efforts. Caution needs to be used when grouping youth with high-risk behaviours because unstructured time may reinforce existing problem substance use patterns.

5.5 Outreach

5.5.1 Outreach Locations and Times

Outreach should focus on meeting youth in their natural settings and community contexts where they spend time on a regular basis with their peers. Points of contact include street corners, coffee shops, drop-in agencies, parks, shelters, hospitals, custody settings, school-based activities and programs. A mobile service (e.g. van) that makes contacts in a variety of places can reach youth in rural or more isolated areas. Outreach is most effective when times can be flexible and include both evenings and weekends, and when it provides opportunities for multiple contacts.

5.5.2 Outreach Worker Competencies

Outreach workers must be able to communicate effectively with the target youth population and demonstrate an understanding of developmental milestones. It can be advantageous for outreach workers to have personal experience in the targeted outreach context and specialized training in addictions, mental health and motivational interviewing.

5.5.3 Preliminary Outreach Activities

Preliminary outreach activities should focus on building trust and fostering positive interactions between youth and outreach workers. Initial contacts with youth should be non-threatening, respectful and include brief informal conversations over frequent encounters.

5.5.4 Follow-Up Outreach and Intervention Activities

As relationships are developed with youth, interactions may then begin to incorporate a wider range of early intervention efforts, including focussing on increasing awareness of the risks of ongoing substance use; screening for concurrent mental health and substance use problems; linking youth with basic need services, such as shelter, food and clothing; health care; and identifying community supports to help sustain small positive changes.

5.6 Relevant Community-Based Supports

5.6.1 Youth-Focused Agencies

Community-based non-profit agencies and service clubs that focus on youth and family engagement have a central role to play in reaching out to youth. Outreach and early intervention activities can be implemented in conjunction with community agencies where youth are already receiving services.

5.6.2 Housing Options and Policies

Many jurisdictions do not have access to emergency shelter programs or longer-term residential options designed to meet the needs of youth. Conditions of available rooming houses are often unregulated and potentially unsafe for youth. Substance use problems may often be more frequent in these locations, placing youth at increased risk for development of addictions and associated problems. Service providers and community leaders must collaborate to address policies and service gaps related to safe and regulated housing options for youth.

5.6.3 Family Collaboration

Early intervention activities should engage family support when appropriate to address problem substance use with youth. Approaches for helping families include providing methods for effective communication, education on adolescent patterns, signs and basic features of substance use, stages of change and problem solving. Family members can provide assistance by providing transportation to appointments,

ensuring basic needs are met and supervision for younger adolescents. Access to counselling services for youth and family members should be offered in a timely manner.

5.6.4 School-Based Strategies

School-based strategies to address youth substance use should consist of multiple components, including staff and student team members, individual counselling, small-group interventions, as well as policies and procedures for student assessment, referral and support.

5.6.5 Youth Mentorship

Mentorship programs for youth have been associated with increases in school participation, reduced involvement with negative peer associations and enhanced skills to refuse substance use. Key areas to consider when establishing mentorship relationships include creating a safe and comfortable environment for both the youth and adult, finding common interests and having mechanisms for problem solving difficulties or challenges.

5.6.6 Recreational and Leisure Activities

Recreational activities provide structured opportunities for building rapport with youth, and contribute to expanding and strengthening youths' confidence and interests in community-based activities and relationships that can be sustained over time.

5.7 Coordinating and Integrating Community Approaches

5.7.1 School-Based Service Collaboration

School sites may be used for delivering coordinated services for youth and their families. School-based services might include support from local police, mental health services, addiction counsellors and other service providers representing a range of health and social programs.

5.7.2 School Engagement Strategies

Re-engaging youth in school following substance use problems is an important consideration in strengthening their links to the community and addressing their learning needs. Motivation to return to and stay in school is facilitated by providing individual academic assistance, mentorship, hands-on learning activities, basic life skills instruction, and opportunities to participate in apprenticeship (e.g. trades) or co-op learning experiences in the community.

5.7.3 Information Exchanges

Information exchanges among service providers help to increase the awareness of potential service delivery capacity and opportunities for developing coordinated and collaborative service delivery approaches in the community. They may include developing regional resource directories outlining youth and family-focused services, organizing community fairs and open houses where service providers can promote their services, and implementing community-wide planning sessions to address policy gaps or concerns.

5.7.4 Case Management Practices

Case management strategies have been applied to reduce barriers associated with service accessibility, and to encourage the development of positive community linkages. Case managers should ensure that community plans are coordinated and tailored to meet the unique needs and circumstances of the youth.

5.7.5 Coordinated and Collaborative Service Delivery Approaches

Coordinated and collaborative service delivery practices can reduce duplication of services, and provide opportunities for integrating interventions. Services should develop protocols for common intake, assessment and referral; interagency consultation; communication and case-planning; memorandums of understanding to support consistent service delivery; cooperation among agency personnel; and co-locating and co-facilitating front-line services.

5.7.6 Consultation and Community Awareness

Addiction personnel should be available to consult with other service providers who routinely encounter youth at risk for problem substance use. Consultation may include organized professional development sessions or individual consultations on a range of topics, including substance use patterns among youth, screening methods and co-morbid mental health. Educating service providers and other community members is important in community-based outreach and early

intervention activities to reduce stereotypes and foster greater readiness for community members to reach out to youth.

5.7.7 Evaluation

Early intervention and outreach programs should be reviewed regularly to ensure the extent to which they are efficient and effective.

Future Research

The outcomes of this project pointed to specific gaps in research and knowledge related to early intervention, outreach and community linkages for youth with substance use problems. The following summarizes the most salient of these areas:

Youth and Sexual/Gender Orientation

An estimated 10% of the population may comprise individuals who are lesbian, gay, bisexual, transsexual, transgendered or questioning (LGBTTQ) (CCSA, 2006). Minimal research has focused on the needs of youth in these populations or on effective approaches for addressing the needs of those with problem substance use (Noell and Ochs, 2001).

Internet-Based Early Intervention Approaches

Some theorists have stressed the potential benefits of integrating motivational enhancement content with Internet-based approaches for intervening early with youth. More research is needed to further explore the potential efficacy of early intervention approaches that use Internet-based applications.

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Appendix A: Community-Readiness Strategies

from Edwards et al., 2000, pp. 302–304.

Stage 1. No Awareness

Goal: Raise Awareness of the Issue

- Visit one-on-one with community leaders and members.
- Visit existing and established small groups to inform them of the issue.
- Make one-on-one phone calls to friends and potential supporters.

Stage 2. Denial

Goal: Raise Awareness that the Problem or Issue Exists in the Community

- Continue one-on-one visits and encourage those with whom you've talked to assist.
- Discuss descriptive local incidents related to the issue.
- Approach and engage local education/health outreach programs to assist in the effort with flyers, posters or brochures.
- Begin to point out media articles that describe local critical incidents.
- Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.
- Present information to community groups.
- Sample media message: "Is child abuse somebody else's business? Domestic violence affects children."

Stage 3. Vague Awareness

Goal: Raise Awareness That the Community Can Do Something

- Present information at local community events and to unrelated community groups.
- Post flyers, posters and billboards.
- Begin to initiate your own events (pot lucks, potlatches, etc.) to present information on the issue.
- Conduct informal local surveys/interviews with community people by phone or door to door.
- Publish newspaper editorials and articles with general information, but relate information to local situation.
- Sample media message: "Our community can change their world" (with photos of children).

Stage 4. Preplanning

Goal: Raise Awareness with Concrete Ideas to Combat Condition

- Introduce information about the issue through presentations and media.
- Visit and develop support from community leaders in the cause.

- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who benefits and what the degree of success has been.
- Conduct local focus groups to discuss issues and develop strategies.
- Increase media exposure through radio and public service announcements.

Stage 5. Preparation

Goal: Gather Existing Information to Help Plan Strategies

- Conduct school drug and alcohol surveys with general violence prevalence questions.
- Conduct community surveys.
- Sponsor a community picnic to initiate the effort.
- Present in-depth local statistics.
- Determine and publicize the costs of the problem to the community.
- Conduct public forums to develop strategies.
- Use key leaders and influential people to speak to groups and to participate in local radio and television shows.

Stage 6. Initiation

Goal: Provide Community-Specific Information

- Conduct in-service training for professionals and para-professionals.
- Plan publicity efforts associated with start-up of program or activity.
- Attend meetings to provide updates on progress of the effort.
- Conduct consumer interviews to identify service gaps and improve existing services.

- Begin library or Internet search for resources and/or funding.

Stage 7. Stabilization

Goal: Stabilize Efforts/Program

- Plan community events to maintain support for the issue.
- Conduct training for community professionals.
- Conduct training for community members.
- Introduce program evaluation through training and newspaper articles.
- Conduct quarterly meetings to review progress and modify strategies.
- Hold special recognition events for local supporters or volunteers.
- Prepare and submit newspaper articles detailing progress and future plans.
- Begin networking between service providers and community systems.

Stage 8. Confirmation/Expansion

Goal: Expand and Enhance Service

- Formalize the networking with Qualified Service Agreements.
- Prepare a community risk assessment profile.
- Publish a localized program services directory.
- Maintain a comprehensive database.
- Develop a local speakers bureau.
- Begin to initiate policy change through support of local city officials.
- Conduct media outreach on specific data and trends related to the issue.

Stage 9. Professionalization

Goal: Maintain Momentum and Continue Growth

- Engage local business community and solicit financial support from them.
- Diversify funding resources.
- Continue more advanced training of professionals and para-professionals.
- Continue reassessment of issue and progress made.
- Use external evaluation and feedback for program modification.
- Track outcome data for use with future grant requests.
- Continue progress reports for benefit of community leaders and local sponsorship.

Appendix B:

Document Sections Supporting the Best Practice Statements

This appendix identifies the sections from the document that support each best practice statement.

Strengthening Service Delivery Orientations

Readiness to Change Model

Sources:

2.3.4 Screening for Stages of Use and Readiness to Change

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

Strength-Based Methods

Sources:

2.2.9 Youth in Conflict with the Law

2.3.6 Aspects of Brief Intervention

2.3.7 Motivational Interviewing

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

3.3.3 Important Considerations for Specific Youth Populations

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

3.4.3 Implementing Early Intervention Screening Approaches

3.4.6 Outreach Workers

4.4 Early Intervention

4.4.5 Focus on Youths' Strengths

4.6.2 Ensure Practical and Meaningful Educational Experiences

Youth Perspectives

Sources:

2.3.3 Screening Formats

2.4.3 Outreach Staff and Activities

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

3.4.6 Outreach Workers

- 3.4.8 Evaluation of Early Intervention and Outreach Strategies*
- 3.5.4 Coordinated and Integrative Service Delivery Approaches*
- 4.4.1 Provide Opportunities for Open and Supportive Interactions About Substance Abuse*
- 4.6.1 Provide Safe and Positive Meeting Places for Youth*

Youth-Specific Services

Sources:

- 2.4.3 Outreach Staff and Activities*
- 2.5.4 Case Management*
- 3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems*
- 3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach*
- 4.6.4 Ensure Youth-Focused Transition Support and Treatment Options*

Inclusive vs. Exclusionary Policies

Sources:

- 2.3.7 Motivational Interviewing*
- 2.3.10 Parent/Guardian and Family-Focused Intervention Efforts*
- 3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems*
- 3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach*
- 3.5.1 Essential Community-Based Services and Supports*
- 4.5.1 Convey a Genuine Interest*
- 4.5.3 Take Time to Build a Relationship*
- 4.5.5 Avoid Use of Sanctions Alone*

Client-Focused Considerations

Histories of Abuse and Trauma

Sources:

- 2.1.2 Gender-Specific Considerations*
- 2.2.9 Youth in Conflict with the Law*
- 2.3.10 Parent/Guardian and Family-Focused Intervention Efforts*
- 3.3.1 Circumstances Faced by Youth with Substance Use Problems*
- 3.3.3 Important Considerations for Specific Youth Populations*
- 3.4.7 Supporting Early Intervention and Outreach*
- 3.5.1 Essential Community-Based Services and Supports*
- 4.3.3 History of Abuse, Trauma and Complex Family Issues*

Basic Needs

Sources:

- 2.1.1 General Prevalence*
- 2.4.3 Outreach Staff and Activities*
- 2.5.2 Essential Community Linkages*
- 3.3.1 Circumstances Faced by Youth with Substance Use Problems*
- 3.3.3 Important Considerations for Specific Youth Populations*
- 3.4.6 Outreach Workers*
- 3.4.7 Supporting Early Intervention and Outreach*
- 3.5.1 Essential Community-Based Services and Supports*
- 4.3.1 Feelings of Desperation and Loss of Control*

Peer Influences

Sources:

- 2.5.2 Essential Community Linkages*
- 3.3.1 Circumstances Faced by Youth with Substance Use Problems*
- 3.4.2 Structuring Early Intervention Approaches*
- 3.5.1 Essential Community-Based Services and Supports*
- 4.3.2 Peer Influences*
- 4.6.3 Build Positive Peer Support Networks*

Concurrent Mental Health Disorders

Sources:

- 2.2.6 Youth with Concurrent Mental Health Disorders*
- 2.3.2 Screening for Substance Use*
- 2.5.2 Essential Community Linkages*
- 2.5.6 Coordinating Mental Health and Problem Substance Use Services*
- 3.4.7 Supporting Early Intervention and Outreach*
- 3.5.1 Essential Community-Based Services and Supports*

Cultural Sensitivity

Sources:

- 2.2.10 Diverse Ethnicity and Culture*
- 2.5.4 Case Management*
- 3.3.3 Important Considerations for Specific Youth Populations*

Aboriginal Youth

Sources:

2.2.7 Aboriginal Youth

3.3.3 Important Considerations for Specific Youth Populations

Youth in Conflict with the Law

Sources:

2.2.9 Youth in Conflict with the Law

3.3.3 Important Considerations for Specific Youth Populations

Screening Processes

Role of Community-based Service Providers

Sources:

2.3.2 Screening for Substance Use

2.3.3 Screening Formats

3.4.7 Supporting Early Intervention and Outreach

Areas of Inquiry for Screening

Sources:

2.3.3 Screening Formats

2.4.3 Outreach Staff and Activities

3.4.3 Implementing Early Intervention Screening Approaches

Early Intervention

Early Intervention with Young Adolescents

Sources:

2.1.4 Alcohol

2.1.5 Cannabis

3.3.3 Important Considerations for Specific Youth Populations

4.3.5 Exposure to Substance Use by Family Members or Older Individuals

4.4.4 Intervene with Younger Adolescents

Brief Interventions

Sources:

2.3.5 Brief Interventions

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

3.4.5 Outreach Approaches

Motivational Interviewing

Sources:

2.3.7 Motivational Interviewing

3.4.1 Theoretical or Applied Orientations for Early Intervention and Outreach

Group Interventions

Sources:

2.3.9 Group Interventions

2.4.4 Peer Helpers in Outreach Activities

3.3.3 Important Considerations for Specific Youth Populations

3.4.2 Structuring Early Intervention Approaches

Outreach Services

Outreach Locations and Times

Sources:

2.4.3 Outreach Staff and Activities

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

3.4.5 Outreach Approaches

4.6.1 Provide Safe and Positive Meeting Places for Youth

Outreach Worker Competencies

Sources:

2.4.3 Outreach Staff and Activities

3.4.6 Outreach Workers

Preliminary Outreach Activities

Sources:

- 2.4.1 Introduction to Outreach*
- 2.4.2 Assessing the Need and Targeting Outreach Services*
- 2.4.3 Outreach Staff and Activities*
- 3.4.5 Outreach Approaches*

Follow-Up Outreach and Intervention Activities

Sources:

- 2.4.1 Introduction to Outreach*
- 3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems*

Relevant Community-Based Supports

Youth-Focused Agencies

Sources:

- 2.4.1 Introduction to Outreach*
- 2.4.3 Outreach Staff and Activities*
- 3.4.2 Structuring Early Intervention Approaches*
- 3.4.5 Outreach Approaches*

Housing Options and Policies

Sources:

- 2.5.2 Essential Community Linkages*
- 3.3.1 Circumstances Faced by Youth with Substance Use Problems*
- 4.6.4 Ensure Youth-Focused Transition Support and Treatment Options*

Family Collaboration

Sources:

- 2.3.1 Introduction to Early Intervention*
- 2.3.10 Parent/Guardian and Family-Focused Intervention Efforts*
- 2.5.2 Essential Community Linkages*
- 3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems*
- 3.4.7 Supporting Early Intervention and Outreach*
- 3.5.1 Essential Community-Based Services and Supports*

School-Based Strategies

Sources:

2.4.3 Outreach Staff and Activities

2.5.2 Essential Community Linkages

3.4.7 Supporting Early Intervention and Outreach

Youth Mentorship

Sources:

2.5.2 Essential Community Linkages

3.5.1 Essential Community-Based Services and Supports

Recreational and Leisure Activities

Sources:

2.5.2 Essential Community Linkages

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

3.5.1 Essential Community-Based Services and Supports

4.4.2 Engage Youth in High-Interest Recreation and Leisure Activities

Coordinating and Integrating Community Approaches

School-based Service Collaboration

Sources:

2.5.2 Essential Community Linkages

3.3.3 Important Considerations for Specific Youth Populations

3.4.2 Structuring Early Intervention Approaches

3.4.7 Supporting Early Intervention and Outreach

School Engagement Strategies

Sources:

2.5.2 Essential Community Linkages

4.3.4 Disengagement from School or Work Activities

4.6.2 Ensure Practical and Meaningful Educational Experiences

Information Exchanges

Sources:

2.5.7 Creating Linkages Among Service Providers

3.4.5 Outreach Approaches

Case Management Practices

Sources:

2.5.4 Case Management

3.5.4 Coordinated and Integrative Service Delivery Approaches

Coordinated and Collaborative Service Delivery Approaches

Sources:

2.5.4 Case Management

3.5.4 Coordinated and Integrative Service Delivery Approaches

Substance Use Consultation and Community Awareness

Sources:

2.3.3 Screening Formats

2.3.7 Motivational Interviewing

2.4.3 Outreach Staff and Activities

3.3.2 Key Actions for Working with Youth Who Have Substance Use Problems

3.3.3 Important Considerations for Specific Youth Populations

3.4.5 Outreach Approaches

3.4.6 Outreach Workers

3.4.7 Supporting Early Intervention and Outreach

4.6.5 Increase Community Members' Understanding and Appreciation of Youth

Evaluation

Sources:

2.4.5 Evaluation of Outreach Programs

3.4.8 Evaluation of Early Intervention and Outreach Strategies