RESEARCH REVIEW OF BEST PRACTICES FOR PROVISION OF YOUTH SERVICES

Prepared by:

Collaborative Community Health Research Centre

University of Victoria

for

Youth Services
Child & Youth Mental Health and Youth Justice Division
Ministry of Children and Family Development

October 2002

TABLE OF CONTENTS

Summary of Report

This report identifies elements of "best practice" in service delivery for high-risk youth. "Best practices" are based on the results of a review of current literature related to evidence of program model's effectiveness. The report also addresses barriers to service delivery affecting the high-risk youth population.

In order to provide a context for examining effective approaches for high-risk youth, the report describes characteristics of specialized population groups, such as:

- Runaway
- Homeless
- Street Involved
- Suicidal
- Substance Misuse
- LBGTQ
- Sexually Exploited
- Drop-Outs

The report also examines effective approaches within program/service areas, such as:

- Outreach
- Independent Living
- Emergency Shelters
- Transitional Housing
- Youth and Peer Mentoring
- System Development
- Youth-Family Mediation
- Reunification
- School-Based Services
- Youth Addiction Services
- Aboriginal Services
- Youth Development Approach

The main findings of this review on effective service delivery for high-risk youth is that services need to aim to achieve appropriate cognitive, interpersonal, social and physical competencies that protect youth exposed to high risk by integrating a combination of targeted individual and system focused services which reach-out into the daily circumstances of the youth through some strategic alliances between school, family, community that are implemented and sustained in a local context.

The results of this review support characteristics of services for high risk youth and should provide:

- Positive youth development approach
- Screening of vulnerable, at risk, school and street youth
- Early proactive and comprehensive (integrated) interventions for family, school and street youth
- Close linkages with an integrated array of services, now all financed by segregated ministries
- Opportunities for grass-root development and tailoring to local circumstance using local assets (public, private, voluntary and partnerships)

In addition, empirical evidence supports the view that:

- The most effective services engage youth and coordinate screening/ assessment, early intervention, and corrective services within and between education, health, and social services

- All facets of a youth's life (income, personal resources, environmental supports, cultural/beliefs) that determine well-being and physical health are defined as the youth's capacity to respond to their situation
- Are located on site (school, community centre or street)
- Are closely linked with parents/families and community resources
- Are intensive and enduring enough to produce needed changes
- Focus on skill development and competencies
- Use meaningful youth involvement and peer influence

This report is organized into two main sections. **Section I** provides an introduction and background to the project, including project definitions, parameters and limitations. **Section II** provides the results of the review, including summary and discussion of best practices and effective interventions for high-risk youth. Each sub-section is organized by topic area and an in-depth annotated bibliography of the literature is provided in Appendix A.

Section I: Project Background and Description

1. Introduction

This project pertains to "best practices" related to service delivery for high-risk youth and was initiated by Mental Health and Youth Programs and Services Branch of the Ministry of Children and Family Development.

2. Project Objectives

The objectives of this project is to:

- Inform the provision of Youth Services within the Province by providing current information on evidence-based "best practices" in the delivery of services to high-risk youth.
- Support the redevelopment of Youth Services in accordance with the new fiscal realities and the shift to community governance.
- Define evidence-based "best practices", key components and supports in delivering services to high-risk youth.

2.1. Topic Areas

The report describes characteristics of specialized population groups, such as:

- Runaway
- Homeless and Street Involved
- Suicidal
- Substance Misuse
- LBGTQ
- Sexually Exploited
- Drop-Outs

The report also examines effective approaches within program/service areas, such as:

- Outreach
- Independent Living
- Emergency Shelters and Transitional Housing
- Youth and Peer Mentoring
- System Development
- Youth-Family Mediation
- Reunification
- School-Based Services
- Youth Addiction Services
- Aboriginal Services
- Youth Development Approach

3. Review of Literature

3.1. Literature Search Strategy

The purpose of this literature review has been to determine if there is documented evidence demonstrating how youth service resources are utilized, developed, and managed to affect the outcomes of community based services for children and youth. To this end an extensive literature review was conducted, involving on-line database keyword searches, additional searches for other studies, screening of abstracts, assessing the methodological strength of the studies and integrating the findings.

The literature search process included the following major steps:

- Development of keywords and search strategies;
- Review of the references sections of articles in possession to identify potentially useful studies;
- On-line searches of databases for potentially relevant articles;
- Review of government departments and NGO websites and related links for additional studies and/or unpublished documents;
- Screening of the abstracts to identify studies for further review; and,
- Canvassing of selected academic experts, organizations and government departments for additional studies and/or unpublished documents.

3.2. Search Terms

The search terms originally developed were refined during the course of the on-line searches to reflect the terms and keywords used by various on-line services and authors. Searches were conducted on the following databases:

- PubMed;
- Social Sciences Index;
- Web of Science;
- Social Work Abstract;
- Academic Elite – EBSCO Host
- Humanities and Social Sciences
- PsycInfo
- Sociological Abstracts
- ERIC
- Health Canada resources; and,
- National and international health research and/or child/youth service web sites.

Database: PUBMED

Search	Results
Literature review + youth services	3 of 23
Literature review + youth at risk	4 of 58
Literature review + adolescent mental health services	17 of 120
Youth at risk + interventions	50 of 322
Youth at risk + interventions + literature review	1 of 7

Youth at risk + interventions + sexually exploited youth	0
Youth at risk + interventions + adolescent services	9 of 229
Youth at risk + definition	12 of 158
Human services + effectiveness + youth services	15 of 110
Human services + effectiveness + gay + lesbian youths	9 of 105
Social service + youth at risk	8 of 60

Database: Social Science Index

Search	Results
Youth services	16 of 57
Adolescent + depression	17 or 68
Sexual orientation + adolescent	1
Substance abuse + adolescent	10 – 176
Substance abuse + adolescent + interventions	1
Substance abuse + treatment	2 of 385
Service delivery	3 of 176
Effectiveness	3 of 1955
Interventions	4 of 675
Evidence based	6 of 46
FAS	3 of 13
ADHD	370
Independent living + youth	3 of 86
Sexually exploited	2
Youth prostitution	1
Peer + mentoring	1
Shelters + homeless	1 of 8
Ethnic differences	3 of 1268
Transitional housing	2 of 5
Foster children + adjustment	1 of 15
Homeless + persons + services	3 of 76
Evaluation + research + social + programs	6 of 489
Meta-analysis + youth + services	1 of 1
Mentors + in + education	2 of 33
Mentors	6 of 131
Social + networks + youth	2 of 27
Peer + Counselling	2 of 41
Runaway	3 of 91
Adolescent + psychology	5 of 2421
Outreach + programs + social work	3 of 67
Drugs + gay	1 of 9
Youth + suicides	1 of 5
Best practices	1 of 31
Performance + evaluation	3 of 371
School based	4 of 140
School violence	2 of 41
Youth + depression	1 of 4
High risk youth	2 of 9
Evidence based	2 of 48

Database: Web of Science

Search	Results
Homeless + adolescent	5 of 83
Adolescent + depression	2 of 12
Sexual orientation + adolescent	1 6
Substance abuse + adolescent	0 of 1
Youth + risk factors	3 of 791
Service delivery	2 of 221
Effectiveness	3 of 1955
Interventions	4 of 675
Evidence based	3 of 25
Prostitution + youth	0
Independent living + youth	3 of 10
Sexually exploited	2
Peer + mentoring	0
Mentoring	3 of 86
Evidence based	2 of 40
Mediation	3 of 33

Database: Social Work Abstract

Search	Results
Youth at risk	10
Homeless + adolescent	3 of 79
Sexual orientation + adolescent	3 of 141
Substance abuse + adolescent	3 of 42
Service delivery	4 of 887
Prostitution + youth	0
Sexually exploited	1 of 3
Meta-analysis + youth + services	2 of 63
Evidence based	1 of 25
Mentoring	2 of 98
Mediation	4 of 56
Effectiveness + service deliver	3 of 4

4. Project Limitations

The literature review provides an additional perspective on the topic areas defined in the study (Section 2.). It does not provide a detailed overview of youth mental health or youth justice issues, characteristics and approaches. While some information is provided, (e.g. on factors associated with adolescent depression), this information is provided only as context for the report.

The review revealed a number of gaps in the literature for high-risk youth, particularly in relation to:

- Barriers to treatment engagement
- Street outreach
- Peer mentoring
- LBGTQ
- Sexual exploitation
- Ethno-cultural minority and Aboriginal

There was also a lack of empirically based research linking specific approaches and methods with outcomes and effect.

5. Determining Program Effectiveness

5.1. Scientific Standards

The scientific community agrees on three standards for evaluating effectiveness: rigorous experimental design, evidence of significant deterrent effects, and replication of these effects at multiple sites. Most researchers want evaluations to meet one or more of these three scientific standards for assessing effectiveness.

Rigorous experimental design includes, at a minimum, random assignment to treatment and control groups (Andrews, 1994; Center for Substance Abuse Prevention, 2000; Chamberlain & Mihalic, 1998; Howell et al., 1995; Lipsey, 1992; Lonigan et al., 1998). A less stringent, but acceptable, study design is quasi-experimental, in which equivalent comparison and control groups are established but assignment of study participants to the groups is not random (Center for Substance Abuse Prevention, 2000; Howell et al., 1995; Lipsey, 1992b; Sherman et al., 1997; Tolan & Guerra, 1994).

Well-designed studies should also have low rates of participant attrition, adequate measurement, and appropriate analyses (Andrews, 1994; Center for Substance Abuse Prevention, 2000; Chamberlain & Mihalic, 1998). High attrition can undermine the equivalence of experimental and control groups. It can also signal problems in program implementation. Adequate measurement implies that the study measures, including the outcome measure, are reliable and valid indicators of the intended outcomes and that they are applied with quality, consistency, and appropriate timing (Tolan & Guerra, 1994).

In clinical trials, replication means conducting both efficacy and effectiveness trials (Lonigan et al., 1998). Efficacy trials test for benefits to participants in a controlled,

experimental setting, and effectiveness trials test for benefits in a natural, applied setting. In practice, this distinction is often blurred, but the principle of independent replication at multiple sites is well established. Replication is an important element of program evaluation because it establishes that a program and its effects can be exported to new sites and implemented by new teams under different conditions. A program that is demonstrated to be effective at more than one site is likely to be effective at other sites as well.

Statistical significance is based on the level of confidence with which one can conclude that a difference between two or more groups (generally a treatment and a control group) results from the treatment delivered and not, for example, from the selection process or chance. A probability value of .05 is widely accepted as the threshold for statistical significance; a probability below this threshold ($p < .05$) indicates that a difference of this magnitude could happen by chance less than 5 percent of the time.

High-quality evaluations of youth programs/services should be designed to demonstrate with this degree of confidence that a program is reducing the onset or prevalence of negative behaviour (Andrews, 1994; Tolan & Guerra, 1994).

A less widely accepted but nevertheless important standard for demonstrating effectiveness is long-term sustainability of effects (Elliott & Tolan, 1999). Although this criterion may not be required to establish effectiveness in other disciplines, it is very important in evaluating youth programs/services because beneficial effects can diminish quickly after youth leave a service setting or program to return to their usual environment. Effective programs produce long-term changes in individual competencies, environmental conditions, and patterns of behaviour.

High standards should be set for programs that are promoted and disseminated at a provincial level. Before a program is best, it is important to show clearly that it has a significant, sustained deterrent effect and that it can be expected to have positive results in a wide range of community settings (as long as it is implemented correctly and with the appropriate population).

5.2. Levels of Evidence-Based Practices

A typology has been created to organize youth services research into a hierarchy scheme. The lower levels **(Levels 1 and 2)** are not considered scientifically defensible but may show some empirical promise ("Promising Practices"). The higher levels **(Levels 3, 4, and 5)** are considered scientifically defensible and demonstrate a more sophisticated level of scientific rigor ("Best Practices").

Evidence-based **"Best Practices"** refers to those strategies, activities, or approaches that have been shown through research and evaluation to be effective. **"Promising Practices,"** on the other hand, are programs for which the level of certainty from available evidence is too low to support generalizable conclusions, but for which there is some empirical basis for predicting that further research could support such conclusions.

This literature review will primarily include services that are **Level 3, 4, and 5,** labelled **"best practices."** The following is an overview of the five types of scientific review processes:

Level 1: *The program/principle has been identified or recognized publicly, and has received awards, honors, or mentions.*

This level of recognition is alone insufficient to ensure that principles derived from the strategy, or the model itself, are effective.

Level 2: *The program/principle has appeared in a nonrefereed professional publication or journal. It is important to distinguish between articles found in professional publications and those found in journals.*

The distinction between a non-refereed and refereed journal is important. Information published in a non-refereed journal is similar to information in other professional publications and newsletters – it is suggestive, but without substantiation. Refereed journals require that an expert/peer consensus be reached regarding the merit of the work.

Level 3: *The program's source documents have undergone thorough scrutiny in a expert/peer consensus process for the quality of implementation and evaluation methods, or a paper has appeared in a peer-reviewed journal.*

All information and data collection processes are detailed; all analyses are presented for review. Reviewers, experienced in the field and trained as evaluators, code both the implementation variables and activities, as well as the finding. The project is rated for producing credible information regarding principles and potential of the program model.

Level 4: *The programs/principles have undergone either a quantitative analysis or an expert/peer consensus process in the form of a qualitative analysis.*

Here, multiple studies are reviewed and coded, generally first for the quality of the methodological rigor and then for findings. Analysis takes place across programs, and principles are identified. Because these principles receive support across a broad array of program intervention and evaluation strategies, we gain confidence that the principles are real and solidly defensible. Similarly, because strategies are consistently linked to positive outcomes, we gain confidence that they relate causally to the observed effects.

Level 5: *Replications of program/principle have appeared in several refereed professional journals.*

The **best evidence** of a program model's effectiveness is that it can be replicated across venues and populations, demonstrating credibility, utility, and generalizability. Programs can be replicated exactly or principles derived from programs can be replicated conceptually. Exact replications simply apply the original program to a new population or in a new venue. Conceptual replications adapt the program, maintaining its key principles but modifying specific activities. Both add to the certainty about the scientific basis of the program. Evidence of replication should be found in refereed journal articles. The scientific basis of a program is not strengthened when the same data are published in three different journals, or when different authors all cite the same original study.

Best Practices

6. Homeless and Street Youth

Numbers of homeless youth are extremely difficult to estimate, as is the case with any transient and ill-defined population (Smollar, 1999). Estimates for North America are as high as 2 million (Janus et al., 1987), and the estimated number of street youth living in large urban centres such as Toronto is thought to be between ten and twenty thousand annually (Carey, 1990; Kelly, 1989). The family histories of most street youth are troubled, often consisting of disrupted home environments, extreme family conflicts, psychological, physical and sexual abuse, and neglect. These negative home experiences are associated with a host of other problems. Poor performance in school and conflict with teachers are common (Hagan and McCarthy, 1997), and many report a history of conduct problems and depression (Rotheram-Borus, 1993). The results of these experiences for most street youth is a life on the street (Maclean et al., 1999), either as runaways, or having been thrown out as is the case with an estimated one-fifth to one-half of street youth (Ringwalt et al., 1998).

6.1. Summary of Best Practices for Homeless and Street Youth

A summary of best practices for Street Youth and Homelessness has been explicated from the following **eight** studies that were selected from a total of **sixteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Homeless and Street Youth	**Rating**
Kidd (2002) combined an extensive review of literature (42 research papers) that examined issues pertinent to interventions among street youth along with a qualitative analysis of semi-structured interviews with 80 street youth from Vancouver and Toronto	5
Swets (2000) examined services and models that aid youth in attaining and/or productively residing in a safe place of housing	3
Robertson & Toro (1998) provided a profile of homeless youth in the United States by addressing this population's diversity and their service needs, describing a variety of intervention approaches, identifying applicable social policy, and posing recommendations for future research	4
Kurtz et al. (2000) examined how runaway and homeless adolescents navigate the troubled waters of adolescence to make successful developmental transition into their young adulthood	4
Morse (1999) examined Case Management (CM) considering conceptual issues, describing and critiquing various models and approaches to CM, reviewing empirical literature on CM and homelessness, identifying gaps in CM knowledge, and recommending exemplary practices for homeless people with strong implications for homeless youth	4

Baron (1999) examined the role that various background, labour market, and street lifestyle factors play in street youths' drug and alcohol misuse	4
Unger et al. (1998) examined over 245 young homeless and street youth (aged 12-15) in Los Angeles and San Diego, California, USA as part of the AIDS Evaluation Street Outreach Project (AESOP). Youth were examined for demographic and lifestyle characteristics, peer group identification, history of homelessness, sources of shelter and money and health status	4
Yoder et al. (1999) interviewed 602 homeless and runaway youth from four Midwestern states in the USA, in shelters, on the streets and in drop-in centers. Interviews focused on their first run away time and duration on the street, and subsequent runs	4

Best practices include the following:

Assessment and Screening

- A critical aspect of providing initial care for homeless and street youth is assessment and screening of:
  - ✓ Readiness of youth to receive help and their perception of staff as trustworthy (Kurtz et al., 2000)
  - ✓ Medical needs in order to implement interventions and prevention as early as possible, ideally within two-weeks, as youth are most in danger in their first year on the streets (Yates et al. 1991; Klein et al., 2000)
  - ✓ Drug use and determining the underlying causes for substance misuse as this differs greatly depending on the youth (Adlaf et al., 1996; Baron, 1999; Schissel, 1997; Sibthorpe et al., 1995). Researchers caution that too heavy a focus on drug use alone is ineffective and that drug use is likely a symptom of other problems that need to be addressed just as urgently (Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999).
  - ✓ Mental health problems i.e. suicidality (has been found to be a major problem among street youth with suicide attempt rates between 20 and 40%), depression, and histories of maltreatment and abuse (Feitel et al., 1992; Greene & Ringwalt, 1996; McCarthy & Hagan, 1992; Molnar et al., 1998; Ringwalt et al., 1998; Rotheram-Borus, 1993; Stiffman, 1989; Yoder, 1999; Buckner & Bassuk, 1997; Whitbeck, Hoyt & Bao, 2000; Robertson & Toro 1998)
  - ✓ Reasons for running away or leaving home to determine if reunification with family is in the youth's best interest (Kurtz et al. 2000)
  - ✓ Careful assessment be undertaken as to the suitability of family members or other guardians as caretakers and being open to the possibility of the youth returning home (Ringwalt et al., 1998; Kidd, 2002)
  - ✓ Assessment of youth's social networks is important (i.e. assess whether or not to break ties with friends on the street and away form being entrenched in a street lifestyle or take into consideration that some peer support from the street is potentially a powerful and necessary part of helping youth) (Whitbeck et al., 2000; Bao et al., 2000)

- ✓ It is crucial to find the underlying reasons for drug and alcohol misuse, mental health issues and their reasons for leaving home (Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998)

Basic Needs

- Ensuring that youth are provided with the basic necessities of life i.e. adequate food, shelter and attention to physical ailments (assessment of needs in this area is crucial for this group, many who suffer multiple health problems) (Cauce, Morgan, Wagner, Moore, Sy, Wurzbacher, Weeden, Tomlin & Blanchard, 1994; McCarthy & Hagan, 1992; Terrell, 1997)
- Changing the priority of services in British Columbia from on job training to first providing for basic needs, such as safe and affordable living stabilizes youth (Swets, 2000)
- Providing comprehensive health care for homeless youth due to their high risk of injuries, physical abuse, sexually transmitted infections, homicide, suicide, and emotional or psychological problems (Robertson & Toro, 1998)

Community of Origin

- Keeping youth in their community from which they came in order to stay connected with friends and family who often remain critical players for youth after they have left home (Ensign & Gittelsohn, 1998)

Targeted Prevention

- Providing prevention programs, especially to alternate schools, is needed to avert and prevent homelessness among youth in the first place (Robertson and Toro, 1998)
- Targeting youth in grades 5-8 and teaching them about services, supportive adults they can trust to help them, location of shelters and their legal rights (Unger et al., 1998; Yoder et al., 1999)
- Several researchers stress the importance of early intervention i.e. the need to act quickly with newcomers to the streets who are often the most vulnerable to victimization (Unger et al., 1998; Whitbeck et al., 1999; Whitbeck et al., 2000)

Integration of Services

- Coordinating services among providers and interagency cooperation is essential (Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991)

Case Management

- There is strong support to indicate that case management approaches are effective for helping homeless youth with mental health issues into needed services and, more importantly, into stable housing (Morse, 1999)

Cultural Sensitivity

- Providing culturally sensitive programming to meet the unique needs of Aboriginal youth (Aboriginal youth encompass a high percentage of the homeless populace) (Kidd, 2002)

Follow-up

- Work does not end when youth have left the street environment. Comprehensive aftercare involving regular re-assessment, and further intervention to prevent youth from returning to a destructive lifestyle (Greene & Ringwalt, 1996; Kidd; 2002)

Sexual Exploitation

- A maximal effort must be made with young women and youth considering or already involved in the sex trade who are particularly vulnerable (Whitbeck et al., 1999, Greene et al., 1999; Yates et al., 1991) *(refer to section on Sexually Exploited Youth page 64 for complete information)*

Supportive Housing Services (*refer to section on Emergency Housing and Transitional Housing, page 25 for complete information on supportive housing services)*

- Housing for youth should always be accompanied with supportive housing services to: (Swets, 2000; Kidd, 2002)
    - ✓ Assist youth in making the transitions from homelessness to being housed
    - ✓ Assist youth in addressing the past and current issues which led to their homelessness in the first place
    - ✓ Assist them in making a transition either back into their families and/or onto adulthood and independence
- A continuum of housing and supported housing services is needed: (Robertson & Toro, 1998; Swets, 2000; Kidd, 2002)
    - ✓ Responsive emergency housing and support services to assist youth in their decision to exit their homeless state, to meet their basic needs for shelter and support, and to stabilize into a longer term plan
    - ✓ Second stage supported housing (transitional housing) with support services to address their issues and learn the skills they need for independence
    - ✓ Longer term supports and/or transitions into adult-based services once they have secured permanent housing and have achieved an acceptable level of competence and independence, to prevent relapses back into a homeless state
- If returning to guardian is not an option, alternative living situations need to be explored i.e. independent living programs, and other options that avoid environments with overly rigid rules or poor parenting/ care-taking practices (Greene & Ringwalt, 1996)

Outreach/Engagement *(refer to Street Outreach page 20 for complete information on outreach services)*

- Providing services through youth drop-in centres is essential for reaching with very young homeless youth (12-15) who do not need health centres because they are in good health, but avoid shelters for fear of violence, robbery, sexual assault, or being reported to parents, police or sent to a foster home (Unger et al., 1998)

- Utilizing outreach and engagement approaches in aiding homeless people to make the transition from streets to services and housing (Podschun, 1993; Johnson et al., 1998); Gleghorn et al. 2000)
- Finding innovative interventions to help homeless youth is important, such as outreach conducted by peer youth. Homeless youth are extremely vulnerable and have often learned to distrust adults (Erickson and Page, 1998; Podschun, 1993; Shulman, 1999; Gleghorn et al. 2000; Johnson et al. 1998)
- Programming for runaway and homeless youth need to be youth-centered and flexible i.e., a significant theme/message from youth was that "people are more valuable than programs and that process is more important than outcomes" (Kurtz et al. 2000)

Data Collection

- Ensuring that shelters are collecting necessary data for program planning is essential for addressing the changing needs of this target population i.e. what is the youngest age children/youth become homeless; do they know about services and shelters; and, do they avoid seeking help from these and if so, why? (Kidd, 2002; Robertson & Toro, 1998; Johnson et al., 1998; Greene, Ennett, & Ringwalt, 1999)

Staff Training

- A well-trained and multi-disciplinary staff is essential given all the assessment and many domains of intervention that must take place Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991)
- Youth service workers and agencies should have a well developed network of community resources in areas such as medical, legal, and recreational services (Cauce et al., 1994; Terrell, 1997)
- Workers should take a strength approach rather than pathology perspective (Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999) and recognize that provocative acting out behavior is an indicator of maltreatment (Powers et al., 1989)
- Youth service workers need to recognize youth's independence by:
    - ✓ ensuring youth incorporate a sense of control (Holdaway & Ray, 1992; Whitbeck et al., 1999)
    - ✓ staff are flexible, non-judgemental, (Molnar et al., 1998) and provide strict confidentiality (Ensign & Gittelsohn, 1998)

6.2. Discussion of Homeless and Street Youth

Prevention programs are the first line of defence against homelessness, targeting youth in grades 5-8 and teaching them about services, supportive adults they can trust to help them, location of shelters and their legal rights. It is possible that youth and their families can receive interventions before homelessness becomes an issue. Intervening with all youth but especially young homeless youth (ages 12-15) as soon as possible is important because they are impressionable and can still be influenced by adults to give up risky behaviours (Unger et al., 1998; Yoder et al., 1999). Young youth (ages 12-15) are usually attending school, and therefore, have access to school counsellors who can persuade them to leave the street. Also, they are still connected to adult family, relatives, and friends who can provide them with food and shelter. Youth are at most risk on the street in the first year, therefore, the sooner services are provided to support leaving the street, the safer they are. These youth need an adult to show caring (unconditional acceptance and emotional support), set boundaries and hold youth accountable, and provide concrete assistance. Youth and family can receive professional intervention ranging from conversations with shelter staff to residential treatment programs (Kurtz et al., 2000; Unger et al., 1998; Yoder, 1999).

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

- Disrupted home environments
- Extreme family conflicts
- Psychological, physical, emotional and sexual abuse, and neglect (sexual abuse and neglect have been found to be particularly linked to runaways)
- High rates of substance abuse among their parents
- Families are often on social assistance
- Witness higher levels of marital discord
- Witness domestic violence
- Frequent household moves and changes of school
- Poor performance in school
- Conflicts with teachers
- History of conduct problems
- Involved in gang activity
- Higher percentages of white male youth live on the streets

(Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999; Ringwalt, Greene & Robertson, 1998; Dadds, Braddock, Cuers, Elliott, & Kelly, 1993; Buckner & Bassuk, 1997; Kufeldt & Nimmo, 1987; Feitel, Margetson, Chamas, & Lipman, 1992; Rotheram-Borus, 1993; Kidd, 2002; Robertson & Toro, 1998).

Finding it hard to secure shelter and food, homeless youth are often cold and hungry and avoid shelters because they view them as sources of stress and danger. In an effort to support themselves, street youth engage in numerous activities including:

- Attempts to find work

- Seeking money from family/friends
- Panhandling
- Prostitution and survival sex (sex for food, shelter etc.)
- Dealing drugs and theft

Meanwhile youth experience dangers and stresses on the street in the form of physical and sexual assaults, which then leads to problems with the police. Substance misuse and addiction are major problems for street youth that stems from parental drug use and the type and severity of abuse in childhood. Also other characteristics of homeless and street youth are high incidences of mental disorders such as depression; conduct disorder; and, trauma and post traumatic stress disorder. In addition, suicidality has been found to be a major problem among street youth with suicide attempt rates between 20 and 40% (Buckner, Bassuk, Weinreb, & Brooks, 1999; Hagan & McCarthy, 1997; Holdaway & Ray, 1992; Antoniades & Tarasuk, 1998; McCarthy & Hagan, 1992; Terrell, 1997; Whitbeck, Hoyt, & Ackley, 1997; Schissel, 1997; Baron, 1999; Greene & Ringwalt, 1996; MacLean et al., 1999; Adlaf, Zdanowicz, & Smart, 1996; Sibthorpe, Drinkwater, Gardner, & Bammer, 1995; Buckner & Bassuk, 1997; Feitel et al., 1992; Whitbeck, Hoyt & Bao, 2000; Ayerst, 1999; Kurtz, Kurtz & Jarvis, 1991; Rotheram-Borus, 1993; Whitbeck, Hoyt & Yoder, 1999; Buckner & Bassuk, 1997; Greene, Ennett, & Ringwalt, 1999; Feitel et al., 1992; Molnar et al., 1998; Rotheram-Borus, 1993; Stiffman, 1989; and Yoder, 1999).

Once homeless, reaching these youth as early as possible is critical (two weeks is optimal), as they usually have multiple health problems which are exacerbated by cold, hunger and the high-risk behaviours they participate in to survive (Kurtz et al., 2000; Unger et al., 1998; Yoder, 1999). In assessing these youths' needs, it is crucial to find the underlying reasons for drug and alcohol misuse, mental health issues and their reasons for leaving home. Well-trained and multi-disciplinary staff who work from a strength approach rather than dwelling on pathology, are essential as well as a developed network of community resources in areas such as medical, legal and recreational services. (Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991).

Negotiating the best care situations for these youth is likely to include keeping them in the same community and being in contact with friends and family. Reunification is also an ideal situation if intensive family intervention works in providing a safe and secure environment for youth. However, researchers warn to be very cautious about this possibility, as up to 70% of these youth have been victims of physical or sexual abuse (Kurtz et al. 2000).

If returning to legal guardians is not an option, finding an appropriate transition or independent living program without rigid rules and with good foster parenting/ supervisory practices will provide these youth with appropriate support and guidance. These comprehensive interventions must be replaced with comprehensive aftercare involving regular re-assessment, and further intervention to prevent youth from returning to a destructive lifestyle (Greene & Ringwalt, 1996)

Previously homeless youth who have become successful adults advise professionals looking after runaway and homeless youth not to feel sorry for them and not to show favouritism, but to develop personal relationships, put themselves in the youth's shoes, and to be trustworthy and listen to them (Kurtz et al., 2000).

A lack of affordable housing is seen as part of the problem in British Columbia along with the lack of additional housing options such as emergency shelters or safe houses, transitional housing and supported housing (Swets, 2000). Lack of job readiness, education or experience also contributes to youth homelessness. The vast majority of homeless youth have not completed high school. Increasing poverty is also a significant cause of youth homelessness, as is the poor economy in various parts of our Province. In rural communities, increasing numbers of young people facing economic pressure are moving to urban centres. When they arrive in these cities, youth often find themselves without resources and can easily become homeless (Kidd, 2002; Swets, 2000; Robertson & Toro, 1998).

There is growing interest in programs that offer youth a full range of housing choices linked with support programs, such as life skills and pre-employment training. For example, the Region of Peel (Toronto) has embarked on an initiative to provide a continuum of housing options, including emergency short-term shelters beds, transitional housing and independent living. This program will attempt to help youth with life skills, employment opportunities and the opportunity to address a variety of issues related to physical and mental health, substance misuse, physical and sexual abuse, and personal safety.

The data from a report for Vancouver, BC is incorporated here but could not be included in the evaluated studies as the details are confidential and only the raw data can be used to support studies or to promote further investigation. The study indicates that 25% of youth leave home for one night, 77% of these youth attributed leaving to family conflict. 77% were very young 12-15, 11% have left home an average of longer than one month, 25% did not choose to leave, 45% have left three or more times, 72% stayed with friends, 58% did not seek help. Youth surveyed from alternate school programs were much more likely to find themselves homeless than youth surveyed from regular school programs. The findings of this study indicate that the majority of youth first leaving home are very young with 77% being between the ages of 12 and 15. Therefore, prevention programs have to be in place earlier than grade six to reach these children/youth before they first leave home. The other statistic that is significant is the fact that 58% did not seek help and further research is needed to discover if this is because they do not know about shelters and services or because they are avoiding them, and if so, what are their reasons.

7. Street Outreach

The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased services. Many of the youth that outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services (Sullivan-Mintz, 1995), have had negative experiences with service-providers (McMurray-Avila, 1997), and have been victims of violence (Goodman, et al., 1995; Weinreb, et al., 1995). Further, homeless youth with children are viewed as perhaps the most vulnerable of homeless families (Bronstein, 1996).

7.1. Summary of Best Practices for Street Outreach

A summary of best practices for Street Outreach has been explicated from the following **five** studies which were selected from a total of **fifteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria)

Street Outreach	**Rating**
Erickson & Page (1998) conducted a comprehensive review of literature compiling best practices from practitioners, policy makers, and researchers	4
Podschun (1993) evaluated a youth peer-outreach street work project involving HIV prevention education	4
Shulman (1999) carried out an extensive evaluation of a teen-focused early intervention and prevention program	4
Gleghorn et al. (2000) evaluated a set of outreach interventions developed by the needs and ideas expressed by homeless and runaway street youth	4
Johnson et al. (1998) reviewed five research and development projects which examined cooperation between law enforcement agencies and runaway and homeless youth centers	4

Best practices includes the following:

Engaging Youth

- Engaging youth is the most critical aspect of outreach and this is best accomplished by:
  - ✓ Identifying and defining subgroups within the street youth population
  - ✓ Using incentives (Erickson and Page, 1998; Shulman, 1999)
  - ✓ Providing recreational activities as a recruitment strategy and initial connection (Shulman, 1999)
  - ✓ Building the trust of youth is critical for them to eventually become receptive to intermediary services, and then slowly, longer-term services
  - ✓ Using peer outreach workers who were once homeless to provide positive role models and provide support to these youth

- Providing client-centered services also enables youth to feel in control while identifying what they feel is their most pressing health needs
- Providing services that are short term in nature and non structured. Given their lack of trust of adults and the system that already has failed many of them, young people living on the street are likely to take advantage of services that are short term in nature. For example, youth access health care clinics more than other types of services because this requires less change in their immediate circumstances and keeping more control over their lives (Robertson & Toro, 1998).

Peer Outreach Workers

- Using peer outreach workers (in combination with adult support and supervision) to match peers and youth who possess the same characteristics, values, and norms results in the following: (Erickson and Page, 1998; Podschun, 1993; Shulman, 1999; Gleghorn et al. 2000; Johnson et al. 1998)
    - ✓ Changes in peer norms
    - ✓ Encouragement to seek services
    - ✓ Promotion of preventive behaviors
    - ✓ Discouragement of risky behaviors
    - ✓ Increased self-esteem and development of life skills for peer outreach workers
- Seeking the expertise of peers/formerly homeless and street youth to contribute in the development of program design, implementation, and evaluation as these youth have specialized expertise, skills, and insight that are invaluable (Erickson and Page, 1998; Podschun, 1993; Shulman, 1999; Gleghorn et al. 2000; Johnson et al. 1998)

Early Intervention

- Providing intervention as soon as possible after youth have left home is critical because youth befriend street youth and also become involved in criminal behavior making it harder for them to return home as time progresses (Johnson et al. 1998; Erickson and Page, 1998; Shulman, 1999; (Unger et al., 1998; Whitbeck et al., 1999; Whitbeck et al., 2000; Gleghorn et al. 2000; Johnson et al. 1998; Erickson and Page, 1998)

Community Partnerships

- Form partnerships/linkages among street youth serving agencies, in particular with medical outreach services, i.e., providing easy access to short term health care clinics allows these youth to seek and receive medical help while keeping control over their lives (Cauce et al., 1994; Terrell, 1997; Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991; Gleghorn et al. 2000; Johnson et al. 1998; Erickson and Page, 1998)
- Integrating with existing youth services programs i.e. basic needs of food, shelter and clothing, youth centers, medical services, STD testing or treatment, drug treatment, employment (Whitbeck et al., 1999; Kidd, 2002; Swets, 2000; Green and Ringwalt, 1996; Yates et al., 1991; Shulman, 1999; Johnson et al., 1998)

Follow-up

- Providing short term follow-up with respect to immediate tasks at hand and long term follow-up to ensure they remain in a stable situation (Shulman, 1999; Gleghorn et al., 2000)

Hiring and Training of Staff

- Hiring outreach workers who possess the following characteristics: sensitive, honest, humble and caring (Winarski, 1998; Barrow, 1988; Shulman, 1999; Erickson and Page, 1998)
- Educating and training of outreach workers in ways that support effective engagement of youth: creative, non-judgmental, flexible, realistic expectations, commitment, cultural competency, team player and good judgment and street sense (Erickson and Page, 1998; Winarski, 1998; Axelroad, 1987; Wobido, 1990; Rosnow, 1998; Morse, 1987; Sullivan-Mintz, 1995)

Assessment

- Providing a basic triage assessment to help identify and respond to potential life threatening problems (Erickson and Page, 1998; Johnson et al. 1998; Shulman, 1999)
- Conducting an assessment of youth's comprehensive, holistic needs before providing services and linkages to meet these needs through an informal process over a period of time as the relationship builds (Erickson and Page, 1998; Johnson et al. 1998; Shulman, 1999; Gleghorn et al., 2000)

Cooperation With Law Enforcement (Johnson, et al. 1998)

- Increasing cooperation between law enforcement and youth services, for example:
  - ✓ Increasing communication between
  - ✓ Improving collaboration, referrals, and services in at-risk circumstances and their families
  - ✓ Reducing unnecessary adjudication and incarceration of these youth
- Collaboratively developing resources, for example:
  - ✓ Educational videos depicting effective ways for law enforcement agencies to work with runaway and homeless youth
  - ✓ Training curriculum to help youth service providers understand law enforcements role in dealing with runaway and homeless youth
  - ✓ Sponsor training sessions to help social workers understand law enforcement procedures for handling status offenders
  - ✓ Runaway prevention curriculum for students (grade 6 to 8) letting youth know their alternatives
  - ✓ Resource card with telephone numbers for community resources and informing youth of their rights
  - ✓ Van equipped with a police radio enabling youth service workers to monitor calls and intervene when youth were involved (The project staff went out 5 nights a week and found dinner time busy with family crisis calls where they often mediated to help solve family problems or took young people to safe houses if at-risk)

7.2. Discussion for Street Outreach

In BC alone there were over 18,000 incidents of children/youth runaways registered in 2001 with the Canadian Police Information Centre. Canadian research on street youth indicates that the vast majority of these youth (79%) have left their families because of circumstances in the home such as conflict, neglect, or abuse (Caputo, Weiler, & Anderson, 1997). These researchers also noted that youth who are on the streets are often more willing to accept help offered by service providers during their first two weeks on the street, perhaps due to fearfulness and uncertainty that they can cope with the circumstances of street life. Mobile outreach activities are therefore a vital aspect of service provision to this population.

Outreach is the initial and most critical step in connecting, or reconnecting homeless youth to needed health care, mental health, recovery, social welfare, and transition into housing services. Outreach is primarily directed toward finding homeless youth who might not use services due to lack of awareness or active avoidance (McMurray-Avila, 1997; Erickson & Page, 1998). Outreach focuses on establishing rapport and eventually engaging youth in the services they need and will accept (McMurray-Avila, 1997).

Outreach programs attempt to engage homeless youth who are unserved or underserved by existing agencies (Axelroad, 1987). This distinction is significant because the outreach model was developed to meet the large service gap found among this unique population. They may be highly vulnerable and considered "difficult to serve" (Rog, D.J., 1988) often because they are estranged from family and unable to trust traditional adult service providers.

Reaching young people soon after they have left home and providing early intervention is critical if for no other reason than to prevent their re-victimization. Also, studies have shown that the longer youth are on the street, the more difficult they find it to participate in services that can help them leave the street. Youth quickly start forming strong relationships with other youth living on the street and are reluctant to leave their new families behind. Given their lack of trust of adults and the system that already has failed many of them, young people living on the street are likely to take advantage of services that are short term in nature. For example, youth access health care clinics more than other types of services because this requires less change in their immediate circumstances and keeping more control over their lives (Robertson & Toro, 1998). Services need to be client centred as youth need to feel in control and in many cases know best what their needs are. Over time as a relationship of trust builds with the outreach workers, these youth will be more receptive to intermediary services, and then can be slowly moved into longer-term services

Engagement then, is the key to outreach. Utilizing a sensitive and positive approach to building a relationship with these youth is essential, this includes providing incentives and recreational activities to initiate a connection and being humble, honest, caring i.e.,

remembering past discussions, and perhaps willing to share personal information that these youth can relate to (Erickson & Page, 1998).

Identifying the needs of different youth subcultures and other pertinent characteristics of the street community is not only important for successful engagement but also for informing program design. Developing youth subculture specific activities and promotional/educational material has enhanced youth participation and adherence to youth services (Gleghorn et al., 2000).

Outreach workers are essential in this process and certain characteristics have been identified which enhances the relationship building so essential for successful access to youth services. Characteristics include being creative, non-judgmental, flexible, realistic expectations, commitment, cultural competency, team player and having good judgment and street sense (Erickson & Page, 1998).

The use of peer outreach workers in combination with adult support and supervision to conduct street outreach to youth has proven to be a successful intervention (Erickson and Page, 1998; Podschun, 1993; Shulman, 1999; Gleghorn et al., 2000; Johnson et al., 1998). This involves matching peers to the characteristics, values, and norms of the different street youth subcultural groups (e.g., hiring youth who can serve as positive role models, who are or were homeless, formerly involved in survival sex and prostitution). This model of outreach has proven to be effective for changing peer norms and encouraging youth to seek services, promoting preventive behaviors, and discouraging risky behaviors. Also, there are benefits to the peer outreach workers that include increased self-esteem and development of life skills (Johnson et al., 1998; Schulman, 1999).

Outreach programs should actively seek out the expertise of peers/formerly homeless and street youth because they can contribute significantly in the development of program design, implementation, and evaluation. Numerous studies have demonstrated that homeless youth and formerly homeless youth have the expertise, skills, and insight that professionals who have never experienced homelessness or life on the street, lack.

This argues for enhanced street outreach through which staff can build the trust of young people, offer intermediary services, and then slowly move them into longer term services (Podschun, 1993).

Cooperation between law enforcement agencies and runaway and homeless youth centers enables police officers to utilize outreach workers to mediate between family and youth or to place youth out of the home into safe houses. Building trust and respect for each others roles with youth is key to making this work. Providing a vehicle with a police radio so that outreach workers can assist on the scene where youth are involved works well to assist with family/youth mediation or protecting youth through a safe house. Developing resources to help police staff understand youth's issues and conversely, educating social workers on the role of police officers has worked very well. A runaway prevention curriculum is another resource that targets all grades 6-8 students. (Johnson et al., 1998)

8. Emergency Shelters and Transitional Housing

The literature primarily describes emergency shelters, supported housing services, physical housing and other social supports within a "continuum of care model". This model assists in organizing and directing existing service strategies and resources to best meet the multiple needs of homeless youth.

There are three fundamental components, which work in combination with other youth services, and these are:

1) Emergency shelters or safehouses
2) Transitional housing
3) Permanent housing (which is considered in this review as part of transitional housing)

There is also a rich and separate body of literature under "independent living programs" for youth *(refer to page 35 Independent Living)*, which is highly relevant to supported housing approaches and provides guidance in youth's transition to independence and adulthood.

8.1. Summary of Best Practices for Emergency Shelters and Transitional Housing

A summary of best practices for Emergency Shelters and Transitional Housing has been explicated from the following **seven** studies that were selected from a total of **sixteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Emergency Shelters	**Rating**
Thompson et al. (2001) examined the needs of homeless youth looking at differences among runaway--homeless, throwaway, and independent youth, and looking at youth demographics, personal characteristics, and family factors predict youth's reunification	4
Greene & Ringwalt (1997) evaluated data from 160 youth emergency shelters to determine capacity, occupancy, and occupancy ratios. Analysis focused in particular on occupancy ratios by funding status, shelter size, season, and day of the week	4
Teare & Peterson (1994) provided the first and only published report of treatment activities in a short term emergency shelter program	3

Transitional Housing	**Rating**
Barrow & Zimmer (1998) reviewed the evolution of transitional housing describing various approaches/ models for homeless youth regarding physical structures and programs within a continuum of services	4
General Accounting Office (GAO) (1990) reviewed the Housing Urban Development (HUD's) Transitional Housing Program to determine whether the program was serving the targeted population with a wide range of services,	4

whether it was helping homeless people move to independent living, and what factors influenced successful transitions	
Johnson et al. (1998) Lighthouse Youth Services Agency in Cincinnati evaluated transitional housing service (since 1973), that are provided to hundreds of youth and their families in the Cincinnati area each year	4
Kroner (1999) produced the most comprehensive descriptive handbook of alternatives for transitional living describing housing options and practical issues surrounding the operation of housing programs	4

Best practices include the following:

Emergency Shelters

Screening Homeless Youth (Thompson et al., 2001; Johnson et al., 1998)

- Screening homeless youth into the following categories *Runaway*, *Throwaway* or *Independent (Refer to page 130 & 131 for definitions)* has important service implications
- Screening for youth who are likely to successfully reunify with families and are most motivated to start this reconnection requires assessment of:
    - ✓ *Runaway* homeless youth who avoid criminally-related behaviour and whose parents are not emotionally or physically abusive
    - ✓ *Throwaway* homeless youth who have less problems with school, the criminal justice system, drug use and housing
- Customizing service for *throwaway* homeless youth is needed to provide them with specific comprehensive and intensive services addressing complex needs which require a longer period of services to encourage their autonomy and competence
- *Independent* homeless youth are closer to independent living and need assistance and services which:
    - ✓ Facilitate positive attachments with adults outside the family
    - ✓ Develop interventions that incorporate individuals and organizations in the community such as job skills training, employment opportunities and education

Parent/Family Involvement (Thompson et al., 2001; Teare and Peterson, 1994)

- Encouraging informal involvement of parents if they are critical of reunification
- Providing adjunct youth-family mediation/support programs to reduce family conflict and minimize issues i.e., educating and training parents to attend to the developmental needs of their youth

Ethnic Considerations for Homeless Youth (Thompson et al., 2001)

- Assessing needs for ethnic groups should include provision of unique services that include culturally sensitive program content to facilitate greater understanding of ethnic minority families to ascertain reunification outcomes
- Documenting and prescribing levels and outcomes of treatment in emergency shelters is needed to better serve visible minorities

Follow-up (Thompson et al., 2001)

- Providing after care service support through volunteer mentors helps keep youth feeling positive and at home

Improving Youth's Perceptions of Shelters (Greene and Ringwalt, 1997)

- Determining obstacles that prevent youth from using shelters, i.e., they fear their families will be contacted by the shelter staff or fear violence against them while in the shelter
- Developing eligibility requirements (i.e., age, gender, and restrictions on youths' behaviours)
- Ensuring housing is safe and youth are protected from violence and abuse
- Determining youths' perceptions about shelters and their services, and shelter accessibility
- Increasing outreach efforts to improve youths' awareness of the availability of shelter beds and services, and to dispel inaccurate perceptions about shelters

Teaching Social Skills Through Positive Reinforcement (Teare and Peterson, 1994)

- Orientating toward active treatment rather than just offering food and a place to sleep
- Structuring program elements to characterize a safe and effective environment:
    - ✓ Provide a safe respite for youth who may be coming from chaotic or abusive family environment
    - ✓ Provide 24 hour a day caregiver support and include both individual and group counselling
    - ✓ Focus on positive behaviour to teach new skills (teaching curriculum based social skills is the primary treatment activity in the shelter i.e. following instructions, accepting criticism, solving problems, and conflict resolution skills). The recommended minimum frequency of social skill teaching for new youth is of 15 to 18 teaching interactions each day
    - ✓ Consumer orientation youth-centred approach using a points card motivational system for using skills appropriately
    - ✓ Training (caregivers receive a minimum of 80 hours of preservice training and additional 40 hours of training during first year)
    - ✓ Internal program audit and ongoing program evaluation (accountable to their funding sources, and must document prescribed levels and outcomes of treatment)
- Teaching basic or intermediate level skills i.e., following adult instructions and learning how to greet others were the two most frequently taught skills which worked well in the short time frame (2-weeks)
- Teaching skills in accepting criticism and following instructions may be most helpful to youth when they return to their caregivers because many had problems with adult relationships
- Providing continuum care of treatment which involves families in family preservation and parent-adolescent mediation aids in youth returning home after leaving the shelter
- Providing aftercare services by linking them with volunteer mentors who visit with families periodically after the youth return home

- Focusing on the whole family to avoid isolating the child as the sole recipient of services
- Evaluating shelter staff is a necessary component, i.e., youth reported generally high levels of satisfaction with:
    - ✓ How fairly the staff implemented rules and consequences
    - ✓ How concerned, pleasant, and helpful they were when helping youth work on problems
    - ✓ How well they communicated with youth
    - ✓ How the youth were not maltreated in any way during their stay in the shelter

Transitional Housing

Approaches/Models (Barrow and Zimmer, 1998; Johnson et al. 1998; General Accounting Office, 1990)

- Adding low demand transitional housing to outreach or drop-in services for homeless individuals improve their likelihood of obtaining permanent housing
- Developing a network of semi-supervised apartments that convert to subsidized permanent housing have a number of benefits:
    - ✓ Cost effective
    - ✓ Reduce time spent homeless
    - ✓ Facilitate transition to permanent housing
    - ✓ Avoid the stigma associated with single site programs
    - ✓ Use case management and community-based services to provide the support needed to maintain housing
    - ✓ Have been proven successful with landlords and community
- Developing community networks to foster acceptance of transitional housing programs and to enhance safety and stability for residents and neighbours
- Implementing transitional housing in the context of a continuum of services that includes adequate permanent housing and the supportive community-based services that can prevent returns to homelessness
- Adding outreach or drop-in services to transitional housing
- Connecting youth with employment opportunities, i.e., staff actively recruit employers that can provide entry-level positions and describe for employers the full range of educational and supportive services provided for each of the young potential employees
- Matching of youth skills and interests to employer needs and offering to intervene when workplace issues arise for program youth
- Housing facilities can vary, ranging from converted warehouses or hospitals to renovated hotels, apartment buildings and newly constructed buildings
- Providing either directly or by referral a full array of supportive services: case management, housing placement, benefits or entitlements assistance, psychological counselling, job training, medical care, child care, and guidance in life skill, as well as specialized mental health and substance abuse services

Characteristics of Successful Outcomes (Barrow and Zimmer, 1998; Johnson et al. 1998; General Accounting Office, 1990)

- Several factors attributed to successful outcomes:
  - ✓ Availability of a safe, secure, private place to live
  - ✓ Providing a case management approach which combines advocacy work, counselling, skill development and service coordination functions
  - ✓ Screening for those who were most motivated to succeed, impediments included pre-existing problems like mental illness and substance abuse
  - ✓ Providing affordable housing and employment or vocational opportunities.
  - ✓ Providing a range of supportive services, i.e., job training/placement, child care, substance abuse treatment, mental health services, and instruction in independent living skills
- Clients most likely to succeed were those who remained in the program longer and those who used more supportive services

Example of a Successful Program (Johnson et al. 1998)

- Lighthouse Youth Services (network of supervised living arrangements for "non-system" homeless youth) (*Refer to page 34 Independent Living*). After 12 years, landlords are happy to accept program youth as tenants, in fact, they often contact the agency when they have open apartments because the Lighthouse program:
  - ✓ Guarantees rent and timely payment
  - ✓ Provides a steady flow of renters
  - ✓ Has rules which are often more strict than landlord-tenant rental agreements (for example, placing limits on numbers and hours of visitors).
  - ✓ Staff are on call for crisis intervention 24 hours a day, 7 days a week, 365 days a year
  - ✓ Covers all damages to rental units and cleans units upon termination of the lease
  - ✓ Will evict if necessary
  - ✓ Staff supervise and assist youth renters
- To expand the range of employment opportunities available to Lighthouse youth, staff actively recruit employers that can provide entry-level positions and describe for employers the full range of educational and supportive services provided for each of the young potential employees
- Lighthouse matches youth skills and interests to employer needs and offers to intervene when workplace issues arise for program youth
- Lighthouse has been successful in negotiating higher starting wages for program youth and has begun to negotiate for incentives and other benefits for youth who remain in their jobs for extended periods of time

Teaching Youth Responsibility and Independence (Johnson et al., 1998)

- Contracting with youth to encourage responsibility and proactive participation, i.e., youth agree to:
  - ✓ Pay rent, based on their ability to pay
  - ✓ Contribute a percentage of their income to a savings account
  - ✓ Make a choice between attending school and finding employment

- ✓ Coordinate weekly house meetings to discuss facility upkeep, landscaping and assigning responsibilities among themselves
- ✓ Conduct an interview of new youth entering the program, and providing input to staff on acceptance decisions

- Empowering youth to make their own decisions, i.e., choosing to work versus further training or education (usually most young people come to their own decision to get further training and education and are empowered in the process)

Alternatives to Fit Youth Needs (Kroner 1999)
Providing youth with a variety of cost effective transitional housing options to suit the needs of youth and community:

- Network of semi-supervised apartments are least restrictive for youth 17 years or older with infrequent supervision (once or twice weekly)
- Supervised Apartments are usually clustered in an apartment building and have live-in adults with 24 hour care and attention
- Shared Homes are houses where several young people live and take responsibility for the house with little supervision
- Live-in Adult/Peer Roommate Apartments provide an adult mentor
- Specialized Foster Homes have foster parents specially trained to impart independent living skills, for older youth before discharge
- Host Homes are not licensed foster homes but rent rooms to youth they like, i.e., are family friends
- Boarding Homes are facilities that provide rooms where young people live individually with minimal supervision
- Transitional Group Homes are affiliated with a residential treatment center
- Subsidized Housing are chosen by youth themselves and they are given a stipend pay for rent, food and supplies
- Residential Treatment Centres serve larger groups of youth in group or institutional living arrangements.

8.2. Discussion of Emergency Shelters and Transitional Housing

Runaway youth are a heterogeneous group and require services that consider their unique needs and characteristics. Runaway homeless youth and throwaway youth are likely to reunify with their families if parent-youth mediation and a variety of services are available to lessen family conflict and minimize issues within the family. Independent homeless youth are unlikely to reunify with family but are nearer independent living, i.e., ready for education or job training and more likely to link with an adult other than family (Thompson et al., 2001; Johnson et al., 1998).

Ethnic minority youth may require unique services that include culturally sensitive program content to facilitate greater understanding of ethnic minority families, to improve reunification outcomes (Thompson et al., 2001).

Homeless youth benefit from programs that meet immediate needs first, and then help them address other aspects of their lives. Programs that minimize institutional demands and offer a range of services have had success in helping homeless youth regain stability. Educational outreach programs, assistance in locating job training and employment, transitional living programs, and health care especially designed for and directed at homeless youth are also needed. In the long term, homeless youth would benefit from many of the same measures that are needed to fight poverty and homelessness in the adult population, including the provision of affordable housing and employment that pays a living wage. In addition to these basic supports, the child welfare system must make every effort to prevent children from ending up on the streets (Tere and Peterson, 1994; Thomspons et al., 2001; Barrow and Zimmer, 1998; Greene and Ringwalt, 1997).

Future research needs to examine the barriers to adolescents' use of youth shelter services in our Province. It may be that these adolescents avoid shelters for fear that their families will be notified or that the rules and restrictions of shelters are as restrictive and inflexible as the homes from which they ran. Shelters also need to increase their outreach efforts to improve awareness of the availability of shelter beds and services and dispel inaccurate perceptions concerning shelters. A central database needs to be implemented in our Province to capture accurate information on usage and trends of youth utilizing emergency shelters. This information is invaluable in shaping provincial policy and programs. Also, systematic studies based on more representative samples, however, are still needed to obtain reliable estimates of the composition of adolescents who are living on the street or in other dangerous living situations and are not making use of shelter services. In addition, longitudinal studies are needed to assess the long-term effect of youth returning to parental homes.

Regarding shelters, the literature shows it is possible to provide safe, harm-free environments for youth in short-term emergency shelters. It is also possible to operate a short-term emergency shelter in which youth are satisfied with their stay and it is possible to operate a treatment-oriented emergency shelter program. Regardless of the treatment orientation of the program, research has shown that a well-integrated system of care is essential (Miller, 2000). Use of a well-articulated model of child-care, having a strong

client orientation, focusing on positive behaviour, and spending resources on staff training and administrative consultation with staff members works well.

As resources become increasingly scarce, programs that can document that they are providing effective and harm-free treatment programs for youth in crisis may have better success in obtaining funding. More fundamentally, however, we have an obligation to youth using shelter care to document and ensure the programs' safety and effectiveness.

Transitional housing programs are working well as descriptive surveys tell us that a substantial number (over 50%) of the individuals and families that enter these programs go on to permanent housing. Among those who remain in the transitional programs until graduation, a much higher proportion obtains housing Thompson et al., 2001).

It is re-assuring to find well-designed studies (evidence based), which prove the effectiveness of transitional housing for homeless youth, individuals and families. The scattered site models of Gateway Apartments (Lighthouse Youth Services in Cincinnati) that provide transitional and living services for youth, which eventually converts units from transitional to permanent housing has been very successful (Johnson et al., 1998). This approach has been shown effective even with multi-problem, hard-to-serve youth. The model not only seems to work; it does so at lower cost than single-site alternatives while also addressing critics' concerns that transitional housing is stigmatizing, disrupts stability by requiring multiple moves, and siphons resources away from permanent housing development.

A report for Vancouver, BC which is not available publicly but raw data can be utilized for further investigation, indicates that of youth aged 12-18, 25% had left home for at least one night, 77% said it was due to family conflict. 77% were very young 12-15, 11% have left home an average of longer than one month, 25% did not choose to leave, 45% have left three or more times, 72% stayed with friends, 58% did not seek help, only 5% had accessed an emergency shelter. Further investigation might be to find out:

- if youth know about emergency shelters
- their reasons for using them/not using them
- whether targeted programs/services to reduce family conflict, increase family/youth mediation help keep these youth home.

9. Independent Living

Adolescents aging out of the child welfare system are particularly vulnerable to poor health, under education, unemployment, and homelessness (Collins, 2001). Most graduates need help in making transition from a dependency status to self-directed community living. At a minimum, transitional assistance includes help in finding a place to live, getting a job, maintaining employment, gaining access to health/dental care, and budgeting and managing money (Mech, 1995). The majority of youth who emancipate from the system and who are expected to assume responsibility for their lives require tangible assistance.

9.1. Summary of Best Practices for Independent Living

A summary of best practices for Independent Living has been explicated from the following **five** studies which were selected from a total of **sixteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Independent Living	**Rating**
Loman (2000) provided an extensive review of reviews of independent living programs	4
Collins (2001) provided an extensive review of reviews of independent living programs	4
Johnson et al. (1998) report by the U.S. department of Health & Human Services (1998**)** called a "Compendium of Critical Issues and Innovative Approaches in Youth Services" which evaluates and describes the *Lighthouse Youth Services Program* which includes transitional and independent living services for Cincinnati non-system youth	4
Muskie et al. **(2000)** who looked extensively throughout the U.S. for Promising Practices: Supporting Transition of Youth Served by the Foster Care	5
Mech et al. (1995) who visited and studied 29 mentoring programs across the United States that served adolescents in foster care	4

Best practices include the following:

Nurturing Connections with Kin and Foster Parents and Caring Adult (Loman, 2000; Collins, 2001; Johnson et al., 1998; Muskie et al., 2000; Westat, 1998)

- Assisting youth in identifying a mentor, relative, or staff member who can provide on-going support after discharge
- Assisting youth in establishing/re-establishing or working through redefining their relationships with family of origin prior to discharge
- Exploring resources of families and relatives for all youth in long-term care even in cases where reunification is no longer considered a case goal, for example
    - ✓ Living with family or extended family upon discharge
    - ✓ Monthly contact with family and relatives

- ✓ Families providing emotional support, advising youth on problems, giving them monetary support

Supporting Educational Achievement (Loman, 2000; Collins, 2001; Johnson et al., 1998; Muskie et al., 2000)

- Providing youth who are struggling educationally and who do not plan to pursue post-secondary education with the educational support necessary to complete a high school diploma
- Placing youth in less-restrictive settings while in foster care such as foster homes and transitional apartments results in higher educational achievement
- Programs that promote educational stability and approach education in a comprehensive, integrated manner are most likely to promote the completion of high school and encourage enrollment in post-secondary education

Life Skills Training (Loman, 2000; Collins, 2001; Johnson et al., 1998; Muskie et al., 2000)

- Providing training in the following:
  - ✓ Daily living skills, including maintaining a residence; home management; shopping; money management; utilization of community services; utilization of leisure time; and personal care, hygiene, and safety
  - ✓ Personal decision-making and communication skills
  - ✓ Evaluating personal educational needs
  - ✓ Planning for a job or career
  - ✓ Securing and maintaining employment
  - ✓ Securing a residence
  - ✓ Planning for health care needs
  - ✓ Building a positive self-image and self-esteem
- Training programs should provide real-world practice experiences where youth have the opportunity to internalize and personalize what they have learned about a skill and feel confident in the ability to use this skill in the future

Employment Training (Loman, 2000; Collins , 2001; Johnson et al., 1998; Muskie et al., 2000)

- Assisting youth to change mentality, attitude or outlook on life is a critical element in becoming continually employed (DeJesus, 1998) and participating in the following activities brings about this change:
  - ✓ Activities that engage and expose young adults with successful role models
  - ✓ Activities that build self-confidence and self-esteem
  - ✓ Activities that teach interpersonal and communication skills
  - ✓ Activities in which young adults feel support and genuine concern
  - ✓ Activities that help young adults realize their educational objectives
  - ✓ Activities that allow young adults to be of service in the larger community

Transition Housing (Loman, 2000; Collins , 2001; Johnson et al., 1998; Muskie et al., 2000) (Refer to Transitional Housing pg 29)

- Providing scattered site semi-supervised housing can be very successful if the underlying assumptions are:
    - ✓ The personal space provided is central to empowering youth by giving them control over their lives
    - ✓ Youth will be happier and progress more quickly if they can choose the neighborhood and actual location that best meets their educational, employment and family needs
    - ✓ When living alone youth learn best by actually doing, making their own decisions and experiencing responsibility for day-to day-activities
    - ✓ Youth learn that their ideas have to be self-generated, not a response to the presence of a caregiver or enforcer
    - ✓ Youth will experience a smoother transition to self-reliance through a program model that allows them to keep the apartment, furnishings and security deposit after they leave the program
    - ✓ The organizations energies and resources are best diverted to youth, not the purchase and maintenance of properties
    - ✓ The size of the program should be flexible, depending on the need of youth and this model allows for easy expansion or decrease in number of apartments

Peer Support (Loman, 2000; Collins , 2001; Johnson et al., 1998; Muskie et al., 2000)

- Reducing the sense of isolation and the stigma of being in out-of-home care by providing opportunities for youth in independent living programs to meet other young people in similar situations through such activities as seminars, camps, conferences, reunions

Mentorship Programs (Mech et al., 1995; Collins, 2001; Johnson, 1998; Loman, 2000)

- Mentorship programs link youth with an adult who understands their needs and models positive life skills. Different mentorship programs include:
    - ✓ Transitional life-skills mentor is the most common and provides social support, friendship and a role model in making the transition from foster care to independent living
    - ✓ Cultural-empowerment mentors are from the same cultural or ethnic group as the youth
    - ✓ Corporate-business mentors come from the business community and provide jobs, monitor work experience, and offer career development to adolescents in foster care who are motivated to participate
    - ✓ Mentors for young mothers are experienced mothers matched with a young pregnant female
    - ✓ Mentor homes model involves four to six adolescents placed with an adult mentor who guides youth in relation to education, employment, community services and so on

9.2. Discussion of Independent Living

The tasks required of youth transitioning from foster care to independent living are ominous, and include: daily living skills, maintaining a residence; home management; shopping; money management; utilization of community services; utilization of leisure time; and personal care, hygiene, and safety; personal decision making and communication skills; evaluating personal educational needs; planning for a job or career; securing and maintaining employment; securing a residence; and planning for health care needs (Loman, 2000).

There are numerous stressors that young people transitioning out of care are likely to be dealing with, namely, long-standing historical stressors (e.g., dealing with the pain of loss or maltreatment), system-induced stressors (e.g., numerous placements), maturational development, the transition out of care (and all the transitions associated with it), and normal (e.g., arguments with friends, transportation problems) or individually unique stressors (Unger et al. 1998; Loman, 2000). In addition, these youth encounter many problems once out of foster care, which include: difficulty learning and thus graduating from high school, trouble accessing health care, problems finding a job which pays enough to support them, this leads to difficulty finding housing food and clothing, involvement in alcohol and drug misuse and often eventually, being apprehended by the law, (Collins, 2000).

Independent Living programs do have a positive effect on the outcomes of these youth and can be separated into the following life skills, education, and employment training components: assisting youth in identifying a mentor, relative, or staff member who can provide on-going support after discharge; assisting youth in establishing/re-establishing or working through redefining their relationships with family of origin prior to discharge; operationalizing a youth development philosophy in agencies and programs; providing greater focus on vocational training, computer training and driver's education; providing youth who are struggling educationally and who do not plan to pursue post-secondary education with the educational support necessary to complete a high school degree or GED; completing and reviewing life skill assessments with youth; and providing "real world" opportunities for youth to practice life skills(Muskie et al., 2000).

In addition, Collins (2000) suggests that social opportunities and social policy can play a key role in supporting or inhibiting successful transition. He also suggests longer and more flexible periods of support are needed as well as concrete assistance in attaining important ends such as college education and stable housing. He also reiterates the importance of parental support financially and emotionally.

Youth made it very clear that one of the most important things to them prior to discharge is that they have a relationship with a caring person that they can rely on after they have been discharged from a program or from care (Muskie et al., 2000). The importance of a few caring adults in these youths' lives at this time cannot be overstated. The support these youth need is monetary, emotional and social and can come from, immediate and extended family members, foster families, mentors, and the many staff encountered

through training, counselling and service roles. These adults provide the supports upon which these youth build the skills and independence to become self-sufficient; The amount of adult support various with each youth, but generally these youth prefer and do better in less restrictive settings where they can make many of their own decisions. Living in foster homes and transitional apartments works best to build independent living skills and achieve higher education and training (Mech & Che-Man Fung, 1997; Loman, 2000). However, in those times when youth are having difficulty coping with tough situations (some of which may become life-threatening), the proper intervening support by a caring adult to advocate on their behalf or link him/her with the necessary service provider is essential (Muskie et al., 2000).

In the U.S., the Foster Care Independence Act provides for the extension of Medicaid coverage, and some states are supplying financial support to help foster care youth achieve higher education. Positive educational outcomes can be achieved through programs which provide student placement/advocacy, tutoring/coaching, career counselling, college preparatory activities and school to work programs, as well as training school personnel to better understand foster care issues (Loman, 2000). For those for whom further education is not an option supporting them in completing their high school will enable them to improve their salary earning which the research shows is presently $10,000.00 (U.S.) per year for full-time work (Mech et al., 1994). Assisting youth to change mentality, attitude or outlook on life is a critical element in becoming continually employed (DeJesus, 1998; Loman, 2000), and they do best when they participate in activities which: engage and expose them with successful role models; build self-confidence and self-esteem; teach interpersonal and communication skills; make them feel supported and genuinely cared about, they realize their educational objectives; and they are of service in the larger community.

Universal, rather than targeted, programming and policy approaches require additional consideration. Collins (2000) says that David Hamburg and Ruby Takanishi (1996) provide evidence that the transition to adulthood can be difficult for many adolescents, not just those exiting from the child welfare system, and they emphasize the need for comprehensive and general youth-development activities such as community-based programs aimed at health, recreation, and job training that reach large segments of the population. As with other universal approaches, the suggested activities serve a wide array of youth, thus limiting any sense of stigmatization.

To improve referrals, funding, and collaborative efforts, data collection and evaluation needs to become a priority and there needs to be communication with provincial and local child welfare agencies about what is happening within independent living programs. Muskie et al. (2000) provide specific recommendations to improve program effectiveness through evaluation and tracking. They suggest:

- Building provincial capacity in collecting and analyzing outcome data through training and technical assistance to identify ways to track youth over time
- Developing guidelines for annual collection of a select and well-defined group of outcomes that reflect mastery of skills, education, employment, housing attainment and other indicators of self-sufficiency

- Tracking and reporting the progress of youth in meeting goals specified in their individual needs assessments and case plans related to independent living
- Supporting longitudinal studies by external evaluators to provide needed insight into the effectiveness of various ILP services and their long-term impact on youth self-sufficiency
- Conducting additional research to assess ILP staffing issues, understand causes and consequences of ILP Coordinator turnover, and develop a list of appropriate ILP staff competencies
- Looking at existing evaluation tools
- Assisting programs in developing and using a standardized reporting tool that measures short-term and long-term outcomes for youth (Muskie et al. 2000).

There needs to be an inter-agency approach to training of staff as well as involving administrators, caseworkers, foster parents, and all outside service providers, such as child welfare and other public agency staff, juvenile corrections/probation staff, school counselors and community volunteers. Training topics may include:

- Skills for success
- Separation, attachment and bonding
- Handling grief and loss issues

Training needs to be ongoing so new skills are developed and the community needs to be educated about the IL programs (Muskie et al. 2000).

Aftercare service provides the necessary support to see these youth through to adulthood. The components include assistance in providing basic needs such as housing and daily living activities, financial assistance, health care coverage, employment services and supports. Other important aftercare components are community connections, social service support systems especially youth sharing experiences with each other and crisis counseling, a continuum of housing options, and an open-door policy (Muskie et al. 2000). Providing these services gives youth something to fall back on in times of need and is more likely to result in their successful transition to adulthood.

Mentorship programs can have a positive effect on youth transitioning from foster care as these youth can be linked with an adult who understands their needs and models positive life skills. Mech et al. (1994) defined six mentorship programs which are: transitional life-skills mentors which is the most common and provides social support, friendship and a role model in making the transition from foster care to independent living; cultural-empowerment mentors from the same cultural or ethnic group as the youth; corporate-business mentors come from the business community and provide jobs, monitor work experience, and offer career development to adolescents in foster care who are motivated to participate; mentors for young mothers are experienced mothers matched with a young pregnant female; mentor homes model involves four to six adolescents placed with an adult mentor who guides youth in relation to education, employment, community services and so on.

10. Youth/Family Mediation and Reunification

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

10.1. Summary of Youth/Family Mediation and Reunification

A summary of best practices for Youth/Family Mediation and Reunification has been explicated from the following **five** studies which were selected from a total of **twelve** based on their evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Youth/Family Mediation and Reunification	Rating
Thompson et al. (2001) completed an extensive review of literature pertaining to differences among runaway-homeless, throwaway, and independent youth, and what youth demographics, personal characteristics, and family factors predict youth's reunification	4
Hogue and Liddle (1999) examined a family-based, developmental ecological preventive intervention for high-risk adolescents	4
Alexander et al. (2000) who reviewed FBEST programs (Family-Based, Empirically Supported Treatments) with respect to intervention with older more seriously at-risk youth	4
Scales (1997) examined the training levels of family support workers and recommended ways to improve family services	4
Kumpfer (1999) examined exemplary parenting and family strategies for delinquency prevention	3

Best practices include the following:

Recruitment of Parents

- Many programs establish affiliation with local schools to anchor outreach and recruitment facilitating access to populations by providing (a) information for contacting families (phone numbers and mailing addresses), (b) direct referrals of some children exhibiting academic and behavior problems, and (c) an initial level of

credibility with most parents (Dadds, Spence, Holland, Barrett, & Laurens, 1997; Dishion & Andrews, 1995)
- Maintaining close working ties with local community leaders and organizations offers a higher degree of community visibility and acceptability (Dusenbury & Diaz, 1995; Peterson, 1995),
- Featuring culturally congruent interventions and employing staff with ties to the community increases acceptability by parents (Springer, Wright, & McCall, 1997)
- Employing former participants and other parents to advocate for the program (Laudeman, 1984)
- Providing specialized training to staff regarding recruitment of parents and devoting a significant portion of time to this arduous task is necessary (Prinz & Miller, 1996; Hogue & Liddle, 1999)
- Providing participation incentives and provision of funds to counteract barriers to participation (e.g., transportation fees, on-site child care) are indispensable catalysts for reliable participation (Prinz & Miller, 1996; Hogue & Liddle, 1999)
- Developing caseworker and agency behaviors which build a working relationship with parents by communicating in a non-punitive and supportive manner through clear and concrete behaviors between the caseworker and client, such as: setting of mutually satisfactory goals, providing services that clients find helpful, focusing on client skills rather than insights, and spending sufficient time with clients to demonstrate skills and provide necessary resources

Multidimensional Family Prevention Model

- Utilizing a Multidimensional Family Prevention model helps the adolescent achieve a redefined interdependent attachment bond to parents and the family, and forge durable connections with prosocial institutions such as schools, recreational programs, and religious institutions (Liddle & Hogue, 1999)
- Encouraging academic success and investment in school (Steinberg, Elmen & Mounts, 1989), involvement in recreation activities (Mahoney & Cairns, 1997) and association with prosocial peers (Parker, Rubin, Price, & DeRosier, 1995) all insulate adolescents against behavioral problems
- Utilizing MDFP should be restricted to adolescents exhibiting the highest risk profiles because sessions occur with single families directly in their home and the counselor is highly trained with a masters degree and preferably two years post-graduate experience and does all the face-to face meetings with various agencies for the family over 3-6 months, with a total of 10-25 sessions which take place in person, or occasionally by phone 30-90 minutes
- Providing continued attachment and connection to their adolescent children, especially young adolescents ages 10 to 15, is necessary for parents, albeit with renegotiated definitions about freedom and self-regulation (Grotevant & Cooper 1985; Henry 1994; Scales 1991; Small & Eastman 1991)

Family-Based Empirically Supported Treatments

- Brief strategic Structural Family Therapy (BSFT) is a treatment which has resulted in Significant reductions in youth behavior problems improved family functioning over time (Szapocznik et al. 1989; Alexander at al., 2000)

- Various FBESTs studied produced significantly higher rate of treatment engagement and drug use reduction than non-family therapies (Stanton & Shadish, 1997; Alexander at al., 2000)
- Family based Multisystemic Therapy (MST) results in greater family cohesion and reduction in youth arrest incarceration and institutionalization. It is considered a "Blueprint" for effective intervention in "Blueprints for Violence Prevention" (Delbert & Elliott, 1998; Alexander at al., 2000)
- Functional Family Therapy (FFT) saw significant reductions in arrest rates 6-18 moth follow-up. Also lengthy follow-up rates – 5 years (Gordon, Graves & Arbuthnot, 1995). Manuals and training protocols created (Sexton, Alexander, & Harrison, 1998; Alexander at al., 2000).
- Multidimensional Family Therapy (MFT) resulted in a 55% reduction in drug use (Parker et al. Under review; Alexander at al., 2000)

Asset Building

- Building external and internal assets assists youth as follows (Benson 1997, 1993; Benson et al. 1995; Alexander at al., 2000):

  External Assets (relationships and opportunities provided to youth)
  - ✓ Support (e.g., care and communication provided by parents and other family members)
  - ✓ Empowerment (e.g., youth given useful roles; feel safe and valued)
  - ✓ Boundaries and expectations (e.g., parental monitoring and discipline; parents and teachers set high expectations)
  - ✓ Constructive use of time (e.g., family influence on after-school activities and religious involvement)

  Internal Assets (values and skills developed by youth)
  - ✓ Commitment to learning (e.g., doing homework and being motivated to achieve);
  - ✓ Positive values (e.g., helping others and delaying sexual activity)
  - ✓ Social competencies (e.g., planning and decision-making skills)
  - ✓ Positive identity (e.g., personal power; sense of purpose)

In Relation to Youth Shelters

- Reunifying with family after a shelter stay results in more positive outcomes in school, employment, self-esteem, criminal behavior, and family relationships than adolescents discharged to other locations (Thompson, Pollio, & Bitner, 2000)
- Completing services offered through community shelters is a salient factor in predicting youth returning home across all subgroups of youth (Thompson et al., 2001)

Community Partnerships/Collaboration

- Creating stronger partnerships with youth development organizations that have as their focus not just preventing problems and risky behaviors, but promoting positive youth development by building youths' developmental assets, i.e., the YMCA of the U.S.A., for example, is a traditional youth-serving organization that recently commissioned a two-year study of how it could strengthen and justify its youth

programming and its accountability by more intentionally focusing on building youths' assets (Leffert et al. 1996; Scales, 1997)

- Implementing Search Institute's "Healthy Communities Healthy Youth" initiative. Over 200 communities across the country are now involved. This initiative seeks to motivate and equip communities to nurture competent, caring, and responsible children and adolescents by helping individuals and organizations to collaborate across sectors and take both formal and informal (personal) actions to build youths' and communities' assets (Benson 1997; Alexander et al., 2000).

10.2. Discussion of Youth/Family Mediation and Reunification

The reported incidence of serious parent-adolescent conflict may be as high as 15-20% and the research shows that elevated levels of conflict and negative family communication have been associated with a number of adolescent problem behaviors including drug use, higher rates of school drop out, running away from home, suicide, and delinquency (Bachman, Green & Wirtanen,1971; Gotlieb & Chafetz, 1977; Montmayor,1983). High degrees of parent conflict also have been associated with adolescents who have conduct disorder (Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998), oppositional defiance disorder (Robin, Koepke & Moye,1990) and attention deficit/hyperactivity disorder (Barkley, Guevremont, Anastopolous, & Fletcher,1992).

Providing intervention family-based services to get homeless youth back with the family as soon as possible is key, however, the first and most difficult task facing family support workers is recruiting and engaging high-risk parents. Reasons for this may include poverty and family homelessness. Family poverty leads to youth violence and delinquency (Aber, Seidman, Allen, Mitchell, & Garfinkel, 1992; Gonzales, Cauce, Friedman, and Mason, 1996) and successful mobilization of outside resources to meet the family's identified priorities helps to overcome the family's hopelessness, resistance, and distrust of professional helpers" (Gaudin, 1993; Alexander et al., 2000). It may be necessary to provide housing for high-risk families in order for them to participate in family-based services.

Other factors affecting high-risk youth delinquency and involvement in risk behaviors is lack of supervision and monitoring which appears to be particularly salient as a cause of violent offences (Kumpfer, 1999). Violent crimes peak just after the close of school at about 3:00 p.m. (Snyder & Sickmund, 1995; Kumpfer, 1999) suggesting lack of parental supervision and latch key status. The Carnegie Council on Adolescent Development (1994) study found that about 40 percent of adolescent's non-sleeping time is spent alone, with peers without adult supervision, or with adults who might negatively influence their behavior.

There are a myriad of intervention and youth/family mediation programs offered in many communities (refer to Review of Literature in this section p. _), however, high-risk families also need community agencies to collaborate resources and create partnerships so their needs can be addressed more easily. Families need to be dealt with respectfully and non-punitively as well as given concrete actions to work on improving their communication and interaction skills. In addition, specially trained family support workers are needed to recruit high-risk parents into accessing these services and a significant amount of time as well as incentives need to be utilized for recruiting and engaging high-risk parents (Dawson & Berry, 1999; Hogue & Liddle, 1999; Scales, 1997).

For younger siblings of high-risk youth there are numerous prevention programs aimed at ages 7-12 that help build internal and external assets and teach skills to experience a more positive supportive family environment and avoid deviant peers and risky behaviors. There are also peer mediation programs at school to help reduce conflict for high-risk youth and gain confidence and self esteem in the peer mediators themselves (Silver & Vermander, 2000, Alexander et al., 2000).

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

11. School-Based Services

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

11.1. Summary of Best Practices for School-Based Services

A summary of best practices for School-Based Services has been explicated from the following **seven** studies which were selected from a total of **fourteen** based on their evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

School-Based Services	Rating
Fothergill and Ballard (1998) looked at the benefits of School-linked Health Centers (SLHCs) for adolescents	4
Greenberg et al. (1999) reviewed scores of primary prevention programs to identify preventive interventions that had been found to reduce symptoms of aggression, depression or anxiety	4
Dishion & Kavanaugh (in press) presented the Adolescent Transitions Program	4
Rossi (1996) evaluated school dropout demonstration assistance programs for the U.S. Dept. of Education	4
Prevatt (1998) did an extensive literature review on school dropouts	4
Webster Stratton & Taylor (2001) identified numerous empirically supported prevention programs	4
The Ontario Public Health Research Education and Development Program (1999) reviewed a number of studies many of which were based on Social Learning Theory	4

Best practices include the following:

Prevention Requires Early Intervention

- Screening for antisocial and/or aggressive behavior in children/youth (ideally before age eight when this behavior crystallizes), which can be caused by: an absence of nurturing parents; having been a victim of child abuse; disengagement from school; involvement with a negative peer group; depression; residence in disadvantaged neighborhoods (Taylor & Dryfoos, 1998). These youth come from high-risk families who ideally need intervention services in elementary years if risk antecedents are severe

- Intervening in the lives of youth before problems start, or when they are in their early phases, may help alter their life trajectories toward success (Durak & Wells,1997 and Lorion, et al.1994; Webster & Stratton, 2001)

Prevention Programs

- Short-term preventive interventions produce time-limited benefits, at best, with at-risk groups whereas multi-year programs are more likely to foster enduring benefits (Greenberg et al. 1999)
- Developing programs which are developmentally focused and take a skill enhancing perspective (Webster & Stratton, 2001)
- Developing program content which is broad-based and includes cognitive, behavioral, and affective components (Webster & Stratton, 2001)
- Utilizing programs which use performance training methods, e.g., videos, live modeling, role-playing practice exercise, weekly home practice sessions (Webster & Stratton, 2001)
- Providing knowledge in an experiential manner so that adolescents are able to address developmental and social norms and social reinforcement by using skills necessary to assess risk and avoid/resist the behaviors (Ontario Public Health Research Education and Development Program, 1999)
- Including a one-year follow-up program which acts as a booster and reinforces positive behavior change (Ontario Public Health Research Education and Development Program, 1999)
- Beginning prevention programs in grade 6 or 7 works best, with booster programs in one year (Ontario Public Health Research Education and Development Program, 1999)
- Providing ongoing intervention starting in the preschool and early elementary years may be necessary for children with serious conduct problems who may be more resistant to treatment (Greenberg et al. 1999; Tashman et al., 2000))
- Providing a coordinated set of programs targeting multiple negative outcomes is possible through preventive interventions directed at risk and protective factors rather than at categorical problem behaviors. (Greenberg et al. 1999)
- Providing a package of coordinated, collaborative strategies and programs is required in each community as there is no single program component that can prevent multiple high-risk behaviors, and for school-aged children, the school ecology should be a central focus of intervention (Greenberg et al. 1999)

Services Linking Child/Youth, Families and School

- Screening to identify at-risk families is effective if multilevel intervention services are available, especially which link teachers, parents and children/youth (Dishion & Kavanagh, 2000)
- Incorporating a multi level family centred prevention program within a school context is essential to reach high risk parents (Dishion et al., 1995)
- Ensuring program length is greater than 20 hours for children and families at elevated risk of developing problems (Webster & Stratton, 2001)
- Developing prevention programs which educate the child and also instil positive changes across both the school and home environments, improves the child's

behavior, as well as the teacher's and family's behavior, building a better relationship between the home and school (Greenberg et al. 1999)
- Ensuring prevention programs focus on parents and teachers strengths (Webster & Stratton, 2001)
- Utilizing programs which use performance training methods, e.g., videos, live modeling, role-playing practice exercise, weekly home practice sessions (Webster & Stratton, 2001)
- Ensuring children/youth have the care, concern and advocacy of a supportive adult increases their desire to learn and improves their academic performance, as well as increases attendance (Rossi, 1996; Masten et al, 1990; & Comer, 1984)
- Utilizing programs which are sensitive to barriers of low socio-economic families and are culturally sensitive (Webster & Stratton, 2001)

Preventing Dropping Out of School
- Integrating classroom support or coordinating separate studies with regular classroom is much more successful than pulling students out of class (Rossi, 1996)
- Tutoring at-risk students is much preferable to making them repeat a year as they are four times more likely to drop out of school if they are held back from same age youth (Vitaro, Brengden, & Tremblay, 1999; Rossi, 1996)
- Keeping students engaged in school through the use of external incentives works at all ages: elementary aged children received help in homework; middle school youth received counseling; high school youth preferred paid work (Prevatt, 1998; Rossi, 1996)
- Developing or finding community partnerships, involving parents, and using better tracking management information systems all assist in preventing these at-risk youth from dropping out (Prevatt, 1998)
- Offering multiple coordinated services worked best (Rossi, 1996)
- Engaging students through vocational educational components leads to improvement of overall performance (B.J. Haywood, 1995)

Linking to Community Services
- Integrating prevention programs with other community care systems of treatment helps create sustainability for prevention. (Greenberg et al. 1999)
- Developing School-Linked Health Centers (SLHCs) provides access to adolescents both in and out of the school system and programming on issues not allowed within the school system, such as sexual health (Fothergill & Ballard, 1998)
- Utilizing programs which emphasize the clinical skills of the intervention staff (Webster & Stratton, 2001)
- (Donovan, Jessor, & Costa, 1988; Dryfoos, 1990; Elliott, Huizinga & Menard, 1989; Jessor, Donovan & Costa, 1991)

11.2. Discussion of School-Based Services

Characteristics of High-Risk Children/Youth

High-risk youth heavily involved in behaviors that have potentially damaging consequences share many common characteristics. These often include: early "acting out"; evidence of an absence of nurturing parents; having been a victim of child abuse; disengagement from school; involvement with a negative peer group; depression; residence in disadvantaged neighborhoods; and little exposure to the work world (Taylor & Dryfoos, 1998). These youth come from high-risk families who ideally need intervention services in elementary years if risk antecedents are severe (before antisocial, aggressive behavior crystallize at age eight).

Recruiting High-Risk Parents Within the School Context

Recruiting parents of these children/youth is crucial and often the most difficult aspect of assisting these youth and their families Dishion et al. (1995) believe providing a multi level family centered prevention program within the school context works best in order to reach high risk parents and provide them with the services they need. Multilevel refers to types of program interventions offered, these are: **universal** programs available for all students and families, **selected** programs which are general targeted programs for students and families identified or seeking help; and **indicated** family interventions specifically designed for children/youth and their families identified as at-risk (Dishion et al., 1995).

Global and Targeted Prevention Programs

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

Improving Parenting Practice

Dishion & Kavanagh (2000) comment that early adolescence is an optimal developmental vantage point for targeting parenting practices to reduce adolescent problem behavior. Dishion et al., (1991) and Patterson et al., (1992) state that antisocial behavior in childhood appears to provide a basis for accumulative risk associated with peer rejection, poor academic skills and eventual involvement in a deviant peer group. They feel that, given the right support, parents can have a major role in preventing their child from engaging in high-risk activities. Parent supervision in particular, may protect

youth from escalating patterns of problem behavior in high-risk neighborhoods Dishion & McMahon, 1998. Likewise, Sampson & Laub (1994) found parenting practices can serve a protective function within a disrupted community.

Improving School Success

Research shows that in providing early intervention to potential and at-risk students in elementary and middle school, the most key element to success in school at all ages is care, concern and advocacy by a supportive adult. Attachment and identification with a meaningful adult motivates or reinforces a child's desire to learn, resulting in improved academic performance and increased attendance (Rossi, 1996; Masten et al, 1990; and Comer, 1984). It was found that pulling students out of class was not effective but integrated classroom support or coordinating separate studies with regular classroom was most successful. Vitaro, Brengden, & Tremblay (1999) found that the risk of kids dropping out was four times higher for a student held back a year. They suggested academic tutoring. Prevatt (1998) cites key points that help keep kids in school: keeping students engaged in school; developing or finding community partnerships; involving parents; using better tracking management information systems. Rossi (1996) found external incentives work at all ages, elementary it was help in homework, middle school it was counseling, high school it was paid work. Offering multiple coordinated services worked best. B.J. Haywood (1995) found vocational educational components worked well to engage students and leads to improvement of overall performance.

School-Linked Health Centers

School Linked Health Centers (SLHCs) provide easy access to adolescents in school and are also able to reach dropouts, homeless, runaway youth, those in detention centers, shelters and other social service programs (Fothergill and Ballard, 1998). SLHCs are free to determine services offered based on needs of the adolescents within their population without being affected by school control which is often restrictive, e.g., regarding sexual health.

Research shows that adolescents underuse the healthcare system, the major reason being that they fear others learning of their health issues. A second major reason for avoiding health services is a problem with being able to access these services. In order to better meet adolescence health service needs many communities have established school based and school-linked health centers (SLHC) giving adolescents an entry point into the health care system and gaining their trust through assured confidentiality.

12. Youth Mentoring

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

12.1. Summary of Best Practices for Youth Mentoring

A summary of best practices for Youth and Peer Mentoring has been explicated from the following **seven** studies which were selected from a total of **fourteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria)

Youth Mentoring	**Rating**
Mech et al. (1995) collected information on 29 mentorship programs in the U.S	4
Novotney et al. (1998) examined the Juvenile Mentoring Program (JUMP) program which provides one-to-one mentoring for youth at risk of delinquency, gang involvement, educational failure, or dropping out of school	4
Tierney, Grossman and Resch (1995) who evaluated the **Big Brothers/Big Sisters** mentoring program. The study addressed nine positive youth development constructs, including social, emotional, cognitive and behavioral competencies, positive identity, bonding, resiliency, self-efficacy, and social norms	5
Rogers & Taylor (1997) evaluated intergenerational mentoring, linking elders (over 60) who were disadvantaged youth themselves and partnering them with high risk youth	3
De Anda (2001) qualitatively evaluated the first year of a mentorship program called Project RESCUE (Reaching Each Students Capacity Utilizing Education) sponsored through a collaboration between a community agency providing youth services and the local fire department	4
LoSciuto et al. (1996) evaluated a substance abuse prevention program called Across Ages that targets sixth-grade students. The program combines community service, a life-skills curriculum and parent workshops with one-on-one mentoring by older adults	4
Sipe (1996) provided an extensive review of literature examining research in the area of mentoring from 1988-1995	4

Best practices include the following:

Program Design (Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996; LoSciuto et al., 1996; Rogers & Taylor, 1997; De Anda, 2001)

- Types of mentorship programs fall into one of five categories (Mech at al., 1995):
    1. *Transitional life skills mentors* - 80% of programs use this model which is open to recruitment of mentors irrespective of age, sex religion, race or socio-economic status and matching is done by youth's showing an interest in a mentor
    2. *Cultural empowerment mentors* - matches youth from a minority cultural or ethnic group with an adult from the same group
    3. *Corporate/business mentors* - matches older foster adolescents with interested businesses, and social agencies serve as the brokers attempting to bring together motivated adolescents and mentors
    4. *Mentors for young parents* - is difficult to find mentoring mothers because this is such a diverse population, local newspaper can run a human interest article showing photos of the teens and their babies and asking for volunteer mothers to mentor these young women
    5. *Mentor homes* places four to six foster adolescents in a home with one adult mentor who guides youth involvement in terms of education, employment, community involvement, etc., these mentors are usually college students who go to school themselves and receive a small salary and free room and board
- Developing and implementing practice standards for mentor volunteers and youth i.e. screening, training, matching, meeting requirements, and supervision is essential
- The longer matches lasted, the more positive effects mentoring had (as relationships continue the youth are more open to receiving a larger array of support, advice and guidance from the mentor)
- Setting up tasks is important for mentors and students to have something to do or work on together. Tasks can absorb initial nervous energy, and provide a basis for conversation between partners.

Recruitment and Screening (Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996; De Anda, 2001)

- Screening provides programs with an opportunity to select those adults most likely to be successful as mentors by looking for volunteers who can realistically keep their commitment and who understand the need to earn the trust of their mentee
- Finding adults who want to volunteer because they enjoy spending time with young people, rather than because they feel compelled to save youth seem to make the greatest strides
- Common ethnic and racial ties are an advantage in connecting with youth. These ties mitigate barriers to trust and provide youth with role models that look like them
- Common class backgrounds are an advantage in connecting with youth. Studies of mentoring programs have concluded that the most successful mentors are those who grew up in the same way as the youth, often coming from the same neighborhood and able to talk to them in their own language

Training and Competencies (Mech et al., 1995; Tierney, Grossman and Resch, 1995; Sipe, 1996)

- Orientation and training ensure that youth and mentors share a common understanding of the adult's role and help mentors develop realistic expectations of what they can accomplish. While mentoring is a familiar concept in the adult world, it is often a foreign concept to underserved adolescents. Working to avoid misconceptions and training young people to make the most of the experience is an important step. Most practitioners agree that some kind of orientation/training for adult mentors is needed i.e. adolescence development, an urban environment, and poverty, etc.

Relationship Building (Mech et al., 1995; Sipe, 1996; Novotney, 1999)

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

12.2. Discussion of Youth Mentoring

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

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

Commonalities of Youth and Mentors
Studies of mentoring programs for high-risk youth have concluded that the most successful mentors are those who grew up in the same way as the youth, often coming from the same neighborhood, who have been involved in the same behavior these youth are involved in or contemplating becoming involved in, who have made a successful transition away from risk behavior and perhaps making positive life choices, and are able to talk to them in their own language (Mech at al., 1995).

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

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

who provide empathy and support for youth who are dealing with their homosexual or bisexual orientation

(Mech et al., 1995; Novotney, 1999; Johnson et al., 2001; De Anda, 2001; Hritz & Gabow 1997; Rogers & Taylor, 1997); Sipe, 1996)

Outcomes of Mentoring Programs

Research shows there are many benefits to adult mentoring programs and these include:

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

(Mech et al., 1995; Novotney, 1999; Jonhson et al., 2001; De Anda, 2001; Hritz & Gabow 1997; Rogers & Taylor, 1997; Tierney, Grossman and Resch, 1995; LoSciuto et al., 1996; Sipe, 1996)

Not all the mentorship programs experienced significant improvements in adolescent behavior, for instance, the peer teen outreach for youth on the street to become aware of HIV/AIDS prevention did not significantly change the high-risk sexual behavior of the at-risk youth, even after learning about the risks and protective factors (Johnson et al., 1999).

Mentors Provide a Caring Adult for High-Risk Youth

A recurring theme throughout the research with high-risk youth is the importance of being able to rely on a caring adult in their lives. When interviewed about the type of mentor characteristics which matter the most, youth reiterated that mentors who have a genuine caring for and enjoy being with youth make more of an impact than those who feel a sense of responsibility but cannot relate well to this age group (Mech et al., 1995; Tierney, Grossman and Resch, 1995; LoSciuto et al., 1996; Sipe, 1996).

Considerations for Successful Mentorship Programs

Providing orientations for both youth and the mentors prior to the matchmaking process helps avoid misconceptions and shows them how to make the most of the experience. Time needed to spend together can vary from occasional meetings to present middle-class role models to youth, to a minimum of one interaction per week for at least a few hours in order to establish a significant relationship between the mentor and youth. Finding the

right task that interest both parties is key to developing a good rapport and environment that is comfortable. Programs should also include time for the mentors to get together to provide each other with emotional support, share experiences, and develop solutions to common difficulties (Mech et al., 1995; Tierney, Grossman and Resch, 1995; LoSciuto et al., 1996; Sipe, 1996).

13. Substance Misuse

Substance use is just one of many problems faced by street youth. For these youth, substance use differs in that it serves more as a way of coping with negative experiences (both before and after going to the street) and has less of a recreational purpose. Injection drug use is prevalent among street youth. A Montreal study (1998) found the percentage of injection drug users among a sample of close to 1,000 street youth to be very high (36%) (Roy et al., 1998). Injection drug use and the practice of sharing needles place youth at risk of infection with HIV and other bloodborne viruses such as hepatitis C. In the Montreal study, needle sharing was common and seemed to occur soon after initiation of injection drug use. In a BC study of young offenders, injection drug use was a strong predictor of other high-risk behaviours such as trading sex for money or drugs and sex with other injection drug users (Rothon et al., 1997).

13.1. Summary of Best Practices for Substance Misuse

A summary of best practices for Substance Misuse has been explicated from the following **three** studies which were selected from a total of **eighteen** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Substance Misuse	**Rating**
Currie (2001) surveyed thirty three key experts from most provinces and territories (with the exception of Prince Edward Island and Yukon)	4
Muck (2001) examined four modalities of treatment regimes for substance misuse by adolescents, in terms of etiology, maintenance and resolution	4
Autry (2000) examined best practices described by key experts relating to the outreach, contact and engagement of youth in treatment, protective factors and resilience	4

Best practices include the following:

Identifying Specific Groups of Youth and Barriers
Identifying specific groups of youth and the program-related or structural barriers these youth experience is helpful in identifying where present practices need to change in order to become best practices. These groups and barriers are:

- ***Street Involved, Homeless and Marginalized Youth*** are heavily involved in substance misuse with 25%-50% reporting frequent heavy drinking, 66% to 88% using cannabis, and 18% to 64% using cocaine (Canadian Center on Substance Abuse and Center for Addiction and Mental Health, 1999). Barriers included (Currie, 2001):
  - ✓ A lack of immediate accessibility to (24-hour) services including access to safe detoxification services

- ✓ Restrictive treatment entry requirements which may be difficult for street-involved youth to meet
- ✓ A lack of adjunctive services, such as safe and secure housing, which are prerequisites to effective treatment utilization

- ***Youth with Concurrent Substance Use and Mental Health Disorders*** found that a substantial level of concurrent substance use and mental disorders was reported in all studies reviewed, conduct disorder and depression being the most frequent mental health disorders identified (Greenbaum et al., 1996). The main barrier being:
  - ✓ Poor integration and coordination between the mental health and substance misuse treatment systems
- ***Youth Who Inject Drugs and/or are Living With HIV/AIDS, Hepatitis B and Hepatitis C*** used to be low as of 1997 with 0.8% to 1.5% of youth injecting non-medical drugs. This may be increasing with the lowering of drug costs on the street (Roy, 1999). Barriers included:
  - ✓ The isolation and general marginalization of youth who inject drugs and distance (emotional/physical) from mainstream systems
  - ✓ A high level of distrust and hostility toward the mainstream system which makes disclosure of problems difficult and makes youth who inject drugs reluctant to participate in treatment
  - ✓ The lack of accessible and effective methadone maintenance programs for older youth and for those who require or qualify for this form of treatment
  - ✓ The lack of specialized services which recognize the distinctive needs of youth who inject drugs and/or those living with HIV/AIDS
- ***Aboriginal Youth*** (Canadian Center on Substance Abuse and Center for Addiction and Mental Health, 1997, 1999) are:
  - ✓ Two to six times more likely to develop every alcohol-related problem than the general youth population
  - ✓ More frequent users of solvents than other Canadian youth (one in five Aboriginal youth use solvents, with more than half beginning use before age 11)
  - ✓ More likely to use all types of illicit drugs (First Nations and Métis youth) than non-Indigenous youth)
  - ✓ Using substances (tobacco, solvents, alcohol and cannabis) at a much earlier age than non-Aboriginal youth
  - ✓ Over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations

  Barriers included incorporating elements of cultural appropriateness such as:
  - ✓ Appropriate language
  - ✓ Inclusion of a spiritual component (beliefs and practices) in treatment
  - ✓ Aboriginal staffing
  - ✓ Culturally appropriate outreach
  - ✓ Connection of Aboriginal youth to Aboriginal social service systems and support

- ***Youth Involved in the Criminal Justice System*** there is a strong correlation between substance misuse and involvement in the justice system (Smart and Ogborne, 1994) found that:
    - ✓ 48% of street youth (already identified as having high percentages of substance misuse) and 36% of non-street youth were on probation/parole/bail or awaiting trial
    - ✓ 30% of street youth and 16% of non-street youth had been in a correctional establishment in the past six months
    - ✓ 23.3% of youth in correctional facilities were affected by FAS or related disorders (Fast et al., 1999).who resist treatment because:
        - o Multiple (socio-economic/psychological/behavioural) problems
        - o Chaotic social backgrounds with limited education and family support (Kosky et al. cited in Spooner et al., 1996)
        - o Low motivation or ambivalence toward treatment, if treatment is mandated
        - o Problems with violence which may make treatment participation difficult

  Barriers included:
    - ✓ A lack of treatment available in either the justice or substance misuse treatment systems. The correctional system typically does not provide treatment and the substance misuse system may not make treatment accessible to juvenile offenders, particularly if legal issues are unresolved
    - ✓ Correctional workers may lack knowledge and understanding of treatment options and not make referrals to appropriate community-based programs
    - ✓ The "closed culture" of juvenile offenders which makes group treatment difficult

Four Treatment Modalities

Current approaches to the treatment of adolescent substance misuse fall into the following four main modalities: ***12 step, behavioral or cognitive behavioral, family based,* and *therapeutic communities***. Each of these models views the problem of adolescent substance use—its etiology, maintenance, and resolution—from a slightly different angle (Bukstein, 1995;Winters, Latimer, & Stinchfield, 1999, Muck, 2001).

- the **12-step model** views "chemical dependency" as a disease that must be managed throughout one's life with abstinence as a goal (Winters et al., 2000). Winters, Stinchfield, et al. (1999) and Winters et al. (2000) found completers' outcomes to be far superior to non completers' at the 12-month follow-up. However, Alford et al. (1991) reported that abstinent/essentially abstinent rates fell sharply for boys and slightly for girls at 1-year post-treatment. There was no significant difference between completers and noncompleters by 2 years post-treatment
- **Behavior therapy, cognitive therapy, or cognitive-behavioral therapy (CBT)** all view substance misuse as a learned behavior that is susceptible to alteration through the application of behavior modification interventions (Miller & Hester, 1989). Specific skills vary by program but may include drug and alcohol refusal skills, resisting peer pressure to use drugs and alcohol, communication skills (nonverbal

communication, assertiveness training, and negotiation and conflict resolution skills), problem-solving skills, anger management, relaxation training, social network development, and leisure time management. New behaviors are tried out in low-risk situations (e.g., during group therapy role-plays and individually with a counselor) and eventually are applied in more difficult, real-life situations. Homework assignments, such as trying out a new behavior or collecting problem situations to discuss during therapy, are common. Staff members and parents are encouraged to provide positive reinforcement for the use of new behaviors. At the 3-month follow-up, adolescents who were in the CBT treatment significantly reduced the severity of their substance use. At the 15-month follow-up, no treatment group differences were observed on severity measures of alcohol use; drug use; psychiatric problems; problems with peers, family, or school; and legal problems (Kaminer & Burleson, 1999; Kaminer et al., 1998)

- **The Family-Based Treatment Approach** focuses on the manner in which adolescent functioning is related to parental, sibling, and extended-family functioning, as well as to patterns of communication and interaction within and between various family subsystems" (Ozechowski & Liddle, 2000, p. 270). Greater reduction in drug use at immediate post-treatment using the family-based therapy model reported at 6-month (Liddle et al., 1999) and 12-month follow-ups (Liddle et al., 1999; Liddle & Hogue, in press). Liddle et al. (1999) found no significant differences between groups for problem behavior (poor anger control, interpersonal problems, impulsivity, mood swings, and antisocial, aggressive, and sexual acting out) or grade point average. However, adolescents receiving Multi-Dimensional Family Therapy (MDFT) showed greater improvements in grade point average (Liddle et al., 1999; Liddle & Hogue, in press) and behavioral ratings of family competence (Liddle & Hogue, in press) at follow-up
- **The Therapeutic Community Treatment Approach** consists of therapeutic communities (TCs) which are long-term residential programs reserved for adolescents with the most severe substance misuse and related problems. The traditional duration of stay is at least 15 months, although some TCs have adopted shorter lengths of stay based on progress (6 to 12 months). The philosophy behind the TC is that substance abuse is a disorder of the entire person resulting from an interruption in normal personality development and deficits in interpersonal skills and goal attainment. In a study of 6 TCs by Jainchill (1997) about 44% of adolescents completed their treatment programs. At 6 months post-treatment, significant reductions were observed for inhalant, hallucinogen, and methamphetamine use

Contact and Engagement

- Location and physical accessibility of treatment includes going to where these youth are such as malls, schools, street, mental health centers, clubs, recreational facilities and a strong liaison with and presence within schools was emphasized
- Program approach and philosophy needs to include:
  - ✓ An accepting, respectful and non-judgmental approach to youth
  - ✓ Familiarity with youth reality and language
  - ✓ Treatment goals and purpose to be determined by youth and youth needs (client centered)

- ✓ The importance of establishing a physically and emotionally secure environment for treatment (where youth feel protected, comfortable and where their basic needs are met)

- Program outreach strategies needs to include:
  - ✓ Training other professionals who are the first point of contact with youth such as school teachers and counsellors, mental health workers, street workers
  - ✓ Maintaining supportive/collaborative relationships with these workers
  - ✓ Incorporating strategies to facilitate access to supportive family members even prior to contact with youth
- Program structure and content needs to include:
  - ✓ Provision of diverse recreational activities which are enjoyable and non-threatening and which establish trust and positive client-staff relationships
  - ✓ The importance of developing and supporting school-based or community prevention activities as a less threatening "window" through which youth can enter treatment

13.2. Discussion of Substance Misuse

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

The most serious substance misuse problems are found within Aboriginal youth who begin illicit substance use at a very early age (sniffing solvents before age 11); are up to six times more at- risk for every alcohol-related problem than other Canadian youth; and who are over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations. Implicit within the Aboriginal culture is a reluctance to seek treatment for these youth because a number of parents are dealing with substance misuse problems in their own lives. Effective treatment needs to incorporate cultural elements into services such as appropriate language, inclusion of a spiritual component (beliefs and practices), aboriginal staffing of adults who provide positive role models, culturally appropriate outreach which make a very big difference in engaging these youth, and connection of Aboriginal youth to Aboriginal social service systems and support (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1997, 1999).

The highest rates of substance misuse are among street involved, homeless and marginalized youth who require 24 hour access to safe detoxification services as well as less restrictive treatment entry requirements and safe and secure housing (Currie, 2001).

The research repeatedly purports that youth experience concurrent substance misuse and mental health disorders, conduct disorder and depression being the most frequent mental health disorders identified. Barriers to proper services include poor integration and coordination between the mental health and substance misuse treatment systems (Greenbaum et al., 1996). It has been found that adolescents presenting for treatment typically demonstrate a higher degree of co-occurring psychopathology, which frequently precedes the onset of problem substance use and often does not remit with abstinence (Kandel et al., 1997; Riggs, Baker, Mikulich, Young, & Crowley, 1995; Rohde, Lewinsohn, & Seeley, 1996).

The numbers of youth who inject drugs and/or are living with HIV/AIDS, Hepatitis B and Hepatitis C tends to be low but the barriers to receiving effective treatment are great. These youth experience great isolation and because of racial minority, sexual exploitation, or differing sexual orientations, see very few options for themselves. In the few places where effective methadone maintenance programs do exist, these youth lack access to these services (Currie, 2001).

There is a strong correlation between substance misuse and involvement in the justice system (Smart and Ogborne, 1994). Many youth were either on probation/parole/bail or awaiting trial; had been in a correctional establishment in the past six months; and were affected by FAS or related disorders (Fast et al., 1999) resulting in behaviors which make treatment participation difficult. Barriers include a lack of treatment available in either the justice or substance misuse treatment systems; correctional workers who lack knowledge and understanding of treatment options and do not make referrals to appropriate community-based programs; and the "closed culture" of juvenile offenders which makes group treatment difficult (Currie, 2001).

Four treatment modalities for substance misuse were examined (Muck, 2000), these included: a 12-step program approach which views "chemical dependency" as a disease that must be managed throughout one's life with abstinence as a goal (Winters et al., 2000); the Behavioral Treatment Approach which views substance misuse as a learned behavior that is susceptible to alteration through the application of behavior modification interventions (Miller & Hester, 1989); the Family-Based Treatment approach focuses on the manner in which adolescent functioning is related to parental, sibling, and extended-family functioning, as well as to patterns of communication and interaction within and between various family subsystems (Ozechowski & Liddle, 2000); and the Therapeutic Communities Treatment approach which provides long-term residential programs reserved for adolescents with the most severe substance misuse and related problems, requiring a 6 month to fifteen month stay at a facility.

All treatments showed improvement in reduced substance misuse at 6-month and one year follow-ups. However, in all treatment approaches (except therapeutic communities which did not perform a follow-up past one year), longer-term follow-ups show no difference between treatment groups and control groups. The Multidimensional Family-based Treatment resulted in additional positive changes including improved behavioral ratings of family and improved grade scores (Liddle & Hogue, in press). The implication from these findings suggests there is a need for further treatment at one year post-treatment with follow-up studies to determine effectiveness. It also suggests MDFT out performs other treatments areas of improving family dynamics and school grades.

Focusing on contact and engagement is an essential part of substance misuse treatment. Developing and supporting school-based or a community prevention activity provides a less threatening "window" through which youth can enter treatment. Other contact and engagement strategies include: training professionals who are first point contact with youth such as school teachers, counselors and mental health workers and maintaining a collaborative relationship with these workers; incorporating strategies to facilitate access to supportive family members, even prior to contact with youth; locating treatment programs close to youth such as malls, schools, the street, mental health centers, clubs, and recreational facilities; and providing diverse recreational activities which are enjoyable and non-threatening helps establish trust and positive client-staff relationships. (Autry, 2000)

Treatment programs need to ensure youth feel physically and emotionally secure, protected and comfortable and are treated in a respectful, non-judgmental way. Youth need to make sense of information given to them and feel they can relate to staff, as well as be part of developing program goals and identifying youth needs. The research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device (Hawkins et al., 1992; Mrazek & Haggerty, 1994). Among resilient children, protective factors appear to balance and buffer the negative impact of existing risk factors (Anthony & Cohler, 1987; Hawkins et al., 1992; Mrazek & Haggerty, 1994; Wolin & Wolin, 1995). From a substance misuse prevention perspective, protective factors function as mediating variables that can be targeted to prevent, postpone, or reduce the impact of use. Taken together, the concepts of risk and resilience enhance understanding of how and why youth initiate or refrain from substance misuse (Autry, 2000).

14. Sexual Exploitation

There is a dearth of empirical research pertaining to sexually exploited youth. Over the last 10 years a number of studies have provided theoretical constructs for how and why youth become involved in prostitution (i.e. constructed profiles of youth from a medical, psychological, and sociological perspective). Some of this literature contains suggested approaches to addressing the problem of youth sexual exploitation, but these suggestions are usually brief and very broad in nature. There is little evidence in the literature of systematic evaluation of existing programs to address youth sexual exploitation in terms of prevention, intervention or exiting. Brief references in the literature confirm the existence of ongoing programs. However, even those that have been in operation for a lengthy period of time do not appear to have been examined independently or systematically.

14.1. Summary of Best Practices for Sexual Exploitation

A summary of best practices for youth with issues of sexually exploitation has been explicated from the following **eight** studies which were selected from a total of **fourteen** based on their evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Sexually Exploitation	**Rating**
Schissel (1999) examined Social Services data on four hundred young offenders from the cities of Saskatoon and Regina and they investigated the connections between abusive childhoods, personal and educational success and involvement in the youth sex trade	4
Kinglsey and Mark (2000) conducted an extensive consultation with more than 150 commercially sexually exploited Aboriginal children and youth across Canada	3
Johnson et al., (1998), Family and Youth Service Bureau - FYSB (U.S. Department of Health and Human Services) evaluated a community-grant approach that awarded fifty-nine service agencies a 1 year grant (up to $100,000) to provide related services to support homeless and sexually exploited youth	4
National Strategy on Community Safety and Crime Prevention – Prevention and Early Intervention of Sexually Exploited Children and Youth, Victoria, BC (2002) over a three-year period the *Capital Region Action Team on Sexually Exploited Youth* will be implementing and evaluating approaches to identifying children and youth involved in the sex trade and supporting them in exiting and remaining away from the sex trade. This project has not been completed nor published and is seen as a **promising practice**	
Tyler et al. (2001) examined the effect of high-risk environments on the sexual victimization of 311 homeless and runaway youth from the Seattle Homeless Adolescent Research and Education Project (SHARE)	4
Tyler et al. (2001) examined the impact of sexual abuse on children who runaway to the streets in terms of sexual exploitation later in life	4

Benoit & Millar (2001) created a research document called "Dispelling Myths and Understanding Realities: Working Conditions, Health Status, and Exiting Experiences Of Sex Workers"	4
The Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999 examined sexual exploitation of youth in BC	4

Best practices include the following:

Data Collection

- Establishing a data base system to monitor homeless youth that enter shelters in order to determine factors that lead to involvement in commercial sexually exploitation, along with trends and programming implications for homeless youth (Johnson et al., 1998; Schissel, 1999)

Comprehensive Approach

- Types of caring intervention need to include not only safe houses where street youth can find sanctuary but also attendant counselling programs that deal with issues of health and safety, personal trauma, family problems, and financial and educational opportunity. Educational and employment programs are needed to obviate the need to prostitute (Schissel, 1999; Tyler, 2001; Benoit and Millar, 2001)
- Develop collaborations with other service provider agencies to ensure services coordination and availability. These collaborations will enhance services to young people, particularly those who are the survivors of commercial sexual exploitation (Johnson et al., 1998; Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999)
- FYSB purports that to stem the tide of sexual abuse and exploitation requires a two-pronged approach that includes providing services and creating a strong community commitment to ending the violence (youth advocates and those on the front lines of the rape crisis and battered women's movements can begin building community consensus around ending the denial of child sexual abuse) (Johnson et al., 1998)
- Given that this activity is not one of choice but of coercion and victimization, an immediate, non-legalistic, non-condemnatory intervention strategy is crucial, not only for the welfare of youth involved but also for the integrity of a society that so far has failed to stop adult predators of children and youth (Schissel, 1999; Benoit and Millar, 2001)
- Increasing funding for shelters, drop-in centres, counsellors, and especially street-based outreach workers who can locate these youth and provide them with necessary services is needed (Tyler, 2001, Johnson, 1998; Kingsley and Mark, 2000)
- Providing interventions that address the broader matrix of problems that these young people present and face will be the most successful (Cauce et al., 1998; Tyler; 2001)

Accessible Resources

- Provide ready access to safe, stable, and affordable housing (Benoit & Millar, 2001)

- Provide ready access to appropriate and sensitive health and social service providers who are knowledgeable about the needs of sexually exploited youth (Benoit & Millar, 2001)

Outreach Services

- Outreach services for sexually exploited youth must be provided from a "youth development approach" i.e. youth need to be involved in the design, operation, and evaluation of the program (Johnson et al., 1998; Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999)
- Over the last twenty years of providing street outreach for youth the FYSB have become international experts in this area. The numerous community street outreach grant projects have further demonstrated the value of street outreach to prevent the exploitation of runaway and homeless youth. Decades of experience have found that: (Johnson et al., 1998)
    - ✓ Early intervention with youth in troubled circumstances is critical
    - ✓ The longer young people are on the streets, the harder it is to bring them into appropriate services
    - ✓ Street outreach grants have significantly strengthened each program's ability to provide a consistent presence in the community, and have engaged more street youth to take advantage of the services and opportunities available to them

Public Education

- Government policy needs to make it easier for destitute and disaffiliated youth to access financial and physical resources (Schissel, 1999)
- Educate the public about the reality of sex workers' lives (Benoit & Millar, 2001; Kingsley and Mark, 2000)

Peer-support Workers

- Peer-support workers need to be carefully selected for their own emotional readiness to support others, and be given the training they need to supplement existing knowledge and skills and prepare them for such work (Johnson et al., 1998; Tyler, 2001; Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999)

Early Intervention and Keeping Youth in School

- The high rates of sexual victimization experienced by these youth, particularly females, suggest the need for early interception and intervention (Tyler, 2001)
- Providing early intervention and counselling to these sexually abused children so that they have strong self concepts and develop social skills that enable them to relate better to their peers and avoid social isolation (Tyler, 2001)
- Schools need to provide flexible education models that account for the remedial needs of street youth, and a non-punitive, non-authoritarian model of learning and development in which the opinions of street youth are considered in school policy development (when these youth are re-enrolled in school, the vast majority - 93%

stop prostitution, suggesting that education is a major deterrence to sexual exploitation) (Johnson et al., 1998; Schissel, 1999; Tyler et al., 2001)

- Providing early intervention to these youth might prevent them from engaging in prostitution for the sole purpose of getting someone to pay attention to them (Raychaba, 1998) (schools with at-risk children and youth may, for example, address the issues directly by bringing in ex-prostitutes who are able to tell youth the reality and dangers of street life and not a glamorized portrait of riches and money (Schissel, 1999)
- Prevention strategies such as: (The Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999)
    - ✓ Awareness programs at both the school and community levels
    - ✓ A range of youth services and community activities that address the underlying factors that place youth at risk of sexual exploitation

Special Considerations for Aboriginal Youth

- Outreach, intervention, programs and services must be culturally significant especially in cities where the majority of children and youth in the sex trade are of aboriginal ancestry (as stated in the 1996 Royal Commission on Aboriginal Peoples, aboriginal street youth look for aboriginal faces in helping agencies. In light of research from this study and the Royal Commission report, more trusting and effective helping relationships occur when services and programs are culturally relevant (Schissel, 1999; Kingsley and Mark, 2000)
- Sexually aboriginal youth are more vulnerable to stranger violence and sexual exploitation than are non-aboriginal counterparts (Badgley, 1984; Lowman, 1987; McCarthy, 1996; Mayor's Task Force 1996; Schissel, 1999)
- Providing community friendship centres with flexible and late-night hours is a central component to preventing child and youth sexual exploitation (having a place that feels safe and offers support, shelter, and activities, to enable youth to find alternatives to a life on the street) (Lowman, 1987; McCarthy, 1996; Mayor's Task Force 1996; Schissel, 1999; Kingsley and Mark, 2000)
- Youth Recommendations for Prevention: (Kingsley and Mark, 2000)
    - ✓ Awareness-raising through education and discussion
    - ✓ A safe, non-judgmental place to go
    - ✓ Cultural connection
    - ✓ Raising self-esteem
    - ✓ Service providers who have experience in the trade
    - ✓ Viable economic alternatives
- Youth Recommendations for Crisis Intervention and Harm Reduction: (Kingsley and Mark, 2000)
    - ✓ 24 hour drop-in centers
    - ✓ Safe housing
    - ✓ Crisis lines
    - ✓ Experiential youth and counselors to staff all of the above
    - ✓ Education about existing resources
- Youth Recommendations for Exiting and Healing: (Kingsley and Mark, 2000)

- ✓ Specific services/agencies for the unique needs of Aboriginal youth sex workers
- ✓ Services and support for those who do not wish to exit the sex trade
- ✓ Longer term services
- ✓ Experiential counselors
- ✓ Decreasing obstacles youth face in accessing services
- ✓ Education
- ✓ Self-confidence building
- ✓ Building trust with agencies, outreach workers and counselors
- ✓ Basic life skills training
- ✓ Social skills training

- Youth Recommendations on Youth Participation: (Kingsley and Mark, 2000):
  - ✓ Using their own experience to help and benefit other youth
  - ✓ Training experiential counselors to help others out of their situation
  - ✓ Connecting with others who have successfully exited the trade
  - ✓ Having a central role in providing outreach, support, public education, advocacy, and mentoring for others in the trade
- Creating peer support groups
  - ✓ Staffing crisis hotlines
  - ✓ Creating and running drop-in centers
  - ✓ Creating and staffing non-judgmental support networks
  - ✓ Educating the larger community about their experiences
  - ✓ Creating, developing, and delivering specific programs for commercially sexually exploited Aboriginal youth

Collaboration with Law Enforcement

- Police need to assume the mandate of frontline social workers as well as peace and crime control officers (street youth need to trust police officers as guardians and protectors) (inner-city police officers understand street life and the inherent dangers and they are on the front lines) (Schissel, 1999)
- Police officer and youth service worker collaborating as a street outreach team to work exclusively sexually exploited youth has proven to be successful (Johnson et al., 1998; Benoit and Millar, 2001; Schissel, 1999)
- Changing the mandate and training of the police, allowing them to create and work in an atmosphere of trust by street children and youth (It is certainly within the realm of possibility for officers to be advocates for children and youth involved in the sex trade) (Schissel, 1999).
- Make available better education and training for police and other criminal justice personnel to encourage them to be more sensitive understanding of the dynamics of sex work across all venues (Benoit & Millar, 2001)

14.2. Discussion for Sexually Exploitation

The research indicates that the present welfare and law enforcement system are having difficulty assisting these youth to avoid or get away from sexual exploitation. The majority of sexually exploited youth (60-80%) have been in government care and they do not want to seek out social services nor police help (McCreary Centre Society, 1999 & 2001; Weisberg, 1985; Raychaba 1998; Martin & Palmer, 1997; Snell, 1995).

Why Youth Become Involved in Sexual Exploitation

The direct causal link between childhood physical and sexual abuse and the decision to enter the sex trade has been well documented (McMullen 1987; Seng 1989; Simons and Whitbeck 1991; Chesney-Lind and Shelden 1992; Van Brunschot 1995; Boritch 1997). Approximately 90% of youth on the streets have runaway to escape from abusive situations (McCreary Centre Society, 1999). Over 18,000 incidents of runaways are reported annually in BC and many of these youth are defined as throwaways (kicked out by their parents) rather than defined as runaway. The majority of street youth have, at some point, been in government care and are homeless. (McCreary Centre Society, 1999 & 2001). Weisberg 1985, also determined that around 60-80% of youth being sexually exploited have had some kind of involvement with social services. Research has further suggested that significant involvement in the child welfare system can lead to homelessness and living on the street (Raychaba 1998). Studies in Canada, Britain and the United States have found that young people from the child welfare system are over-represented in studies of the homeless (Martin and Palmer 1997). Raychaba (1998) suggested that problems with transience, high staff turnover, and general impersonal nature in the system could contribute to a youths' drift into the sex trade. He cited one youth's rationale for becoming involved in prostitution as "someone was actually paying attention to me". Also, Snell (1995), found that the social services were the second least sought out service among a list of community supports-only the police were requested less. Fifty-six percent suggested that they would not even use street shelters. These youth view service providers and shelters with distrust, fearing violence, robbery and sexual assault in shelters and disbelieving the unrealistic attitudes of many service providers who believe that if they get off the streets, off drugs, and back into school, they will integrate into "normal" teen culture.

For these youth, childhood abuse damages self-perception that would normally allow children and youth to resist exploitation and they do not fit in with youth brought up without this abuse. When youth have been sexually abused by family members in the past, they are more likely to believe that strangers can use and abuse them also. They tend to be antisocial, promiscuous and are rejected by their peers. They also develop patterns of behaviour that exposes them to dangerous individuals and events, often associating with deviant antisocial peers and boyfriends who get them involved in prostitution. (McMullen 1987; Seng 1989; Simons and Whitbeck 1991; Chesney-Lind and Shelden 1992; Van Brunschot 1995; Boritch 1997, Schissel, 1998; Tyler et al. 2001; Benoit & Millar, 2001). The reasoning is that abusive families normalize abusive treatment in the minds of victimized youth. Youth will often hold a "distorted image of

their own bodies" which may "lead them to expect that their worth will only be acknowledged when they permit sexual access" (Boyer and James 1982; Chesney-Lind and Shelden 1992; Simons and Whitbeck, 1991). They also purport that childhood abuse damages self-perception that would normally allow children and youth to resist exploitation and it patterns behaviour that exposes them to dangerous individuals and events. In effect, youth may see themselves as commodities that can be bought and sold at the whim of those who have the financial capital (Simons and Whitbeck 1991; Boyer and James 1982).

Aboriginal Youth

Because of socio-cultural factors, all commercially exploited youth may not experience the level of abuse and its damaging effects equally. For example, Lowman states that First Nations girls face many of the same problems that other sexually exploited youth experience, but they encounter them in a heightened form. Not only do they enter into the sex trade at younger ages, they are also "more likely to be the victims of both family violence and trick or pimp violence" (Lowman, 1986; Tyler, et al., 2001; Schissel, 1999). Schissel, 2002 also found evidence to suggest that although prostitution predisposes all youth to self-injury, it does so especially for non-aboriginal youth. The study reported that aboriginal youth involved in prostitution are more vulnerable to stranger violence than are non-aboriginal youth. These conclusions are offered in a context in which First Nations and Metis youth are more vulnerable to sexual exploitation on the streets than their non-aboriginal counterparts (Lowman 1987, McCarthy 1996)

Education

Since many of the youth who are involved in the sex trade have less than adequate educational backgrounds, their access to the job market is restricted, often positioning prostitution as the only logical way by which runaways have the ability to secure an income (Badgley, 1984; Gibson-Ainyette, Templer, and Brown, 1988; Seng, 1989; Boritch, 1997). Poor educational achievement is due primarily to the fact that these youth have dropped out of school at an early age (before the end of grade ten) and they tend to have negative attitudes toward school and low self esteem and self-efficacy because of their perceived “failure” (Badgley 1984; Sullivan 1987). Their youth and their lack of education prevent their escape from the street because they have no means to obtain the marketable skills that will secure employment. Conversely, Schissel, 1999 found that youth returning to school are less likely to be sexually exploited for both non-aboriginal and aboriginal youth (95.8% and 93.3% non-involvement respectively). This finding suggests that keeping these youth in school assists these youth in keeping them off the streets and gets them involved in something that can better their life.

Youth Involvement and Peer Support

A common theme in youths’ accounts of their experience with service agencies is that they have felt misunderstood, distrusted and controlled. Moreover, youth have indicated that programs based on peer support, provided by youth who have a personal understanding of the circumstances and experiences of sexually exploited youth, are more likely to be accessed by youth. Peer-support workers need to be carefully selected for their own emotional readiness to support others, and be given the training they need to

supplement existing knowledge and skills and prepare them for such work. For example, peer support is a basic principle of a program in Victoria, BC, operated by PEERS (Prostitutes Empowerment, Education and Resource Society) that provides crisis intervention, ongoing support and advocacy. The services provided by PEERS have not been systematically evaluated

Where and How Sexual Exploitation Occurs

An implication for service providers is the question of where youth commercial sexual exploitation occurs. While sexually exploited youth appear to be most often exploited on the street, other venues have also been reported. Information on the location of youth sexual exploitation will assist in developing services that will most effectively reach the broad population of sexually exploited youth.

The Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth (1999) found that sexual exploitation occurs at nightclubs, massage parlors, karaoke bars and apartments, hitch-hiking, at truck stops and through a specific business. For example, kids work through cab drivers taking the kids to the tricks, or several girls might be set up in a room, or sometimes one guy will pick a girl up, then the trick will drive her to the next date. In smaller communities, youth sexual exploitation was less visible and sometimes completely invisible to all but those directly involved and well-informed professionals. A wide range of venues was reported, including private homes, public docks, back alleys, parks, truck stops and fishing boats.

In some communities the majority of youth were reported to become involved through their family, community or lifestyle, and intergenerational involvement in the sex trade was reported to be common. Increasingly, older girls were also luring young girls into the trade. Also, distinct subcultures in the sex trade are emerging in the urban areas, including the trafficking of Vietnamese girls in the Vietnamese community in Vancouver, the trafficking of Sikh girls between Vancouver-area locations, and a trafficking circuit among cities in western U.S. and Canada (The Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 1999).

The Capital Region District (Victoria, BC) (1997) study was one of the few to provide detailed information on the locations where youth sexual exploitation takes place. While the street was found to be the most common location for two-thirds of youth interviewed, youth reported trading sex in a variety of indoor venues including bars, escort agencies and the youth's home, or by working as an independent escort. An unexpected finding was that almost all youth who worked out of an escort agency also traded sex on the street.

Overall, the literature provides mixed conclusions about the situations in which youth sexual exploitation takes place, highlighting the need for better information to ensure that services reach all sexually exploited youth.

Exiting

Another area of knowledge importance for programming is to understand what motivates and supports youth who successfully exit commercial sex work. Researchers and youth themselves have proposed numerous interventions at the structural and individual levels to support those who are seeking to exit. However, as noted by Shaw and Butler (1998) there is an absence of longitudinal studies that would provide knowledge of how long youth remain involved. While the reasons for entering prostitution provide some guidance for policy and practice, the academic literature provides little insight into why and how young people leave prostitution.

Targeted Prevention

Targeted prevention programs within a school setting, especially in inner city neighbourhoods could address issues directly by bringing in ex-prostitutes who are able to tell youth the reality and dangers of street life. As mentioned in the Outreach section of this document, outreach interventions, services should be culturally relevant especially in cities where the majority of children and youth in the sex trade are of Aboriginal ancestry. As stated in the 1996 Royal Commission on Aboriginal Peoples, aboriginal street youth look for aboriginal faces in helping agencies (Canada 1996).

The Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth , 1999 call for structural changes to legal reform, saying the cost of services over 20 years for many of these youth is enormous, "millions per baby". These authors state that redirecting resources to prevention and early intervention rather than always reacting, would cost less.

The Role Of Law Enforcement

Lastly, and probably most importantly, the police need to assume the mandate of frontline social workers as well as peace and crime control officers. Inner-city police officers understand street life and the inherent dangers and they are on the front lines. It is certainly within the realm of possibility for officers to be advocates for children and youth involved in the sex trade to create an atmosphere of trust. Outreach models developed by the Family and Youth Service Bureau show promising results pertaining to collaborations between police and youth commercial sexual exploitation and homeless youth. Also deserving of mention is the collaborative approach between *Capital Region Action Team on Sexually Exploited Youth and the Victoria Police Department* – a police officer and youth service worker collaborate as a street outreach team to work exclusively sexually exploited youth. Another example is collaboration between MCFD and the Vancouver Police Department called Yankee 177. This initiative focuses on high-risk youth in the Downtown Eastside of Vancouver and involves one Vancouver police officer and one youth service worker teaming up to conduct street checks, and where appropriate, to take charge of youth who are found to be in circumstances that place their health or safety in immediate danger.

15. LGBTQ Youth

Although the empirical evidence varies by type of problem, LGBTQ youth appear to be at greater risk of depression, suicide, runaway behavior, and chemical dependency than their heterosexual peers (Durby, 1994; Gonsiorek 1988; Mallon, 1997; Morrison & L'Heureux, 2001). Of these problems, suicide has been the most studied. Studies have consistently shown extremely high suicide attempt rates among gay and lesbian youth (D'Augelli and Hershberger, 1993; Proctor and Groze, 1994; Schneider et al., 1989). Several authors have urged youth service agencies to become more responsive to the needs of their gay, lesbian, and bisexual clients (Child Welfare League of America, 1991; McMillen, 1991; Mallon, 1997). There is a dearth of evidence-based best practices for this population of youth with most of the literature discussing both the dilemmas faced by LBGTQ youth seeking services and obstacles facing agencies attempting to serve them.

15.1. Summary of Best Practices for LGBTQ Youth

A summary of best practices for LGBTQ Youth has been explicated from the following **five** studies that were selected from a total of **twelve** articles based on their high evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

LGBTQ Youth	**Rating**
Noell and Ochs (2001) explored the relationship of sexual orientation and gender to factors related to family history, incarceration, substance use and depression and suicide using a sample of homeless adolescents (216 females and 316 males – total of 532) recruited in the Portland, Oregon	4
Dempsey (1994) provided an extensive review of professional literature regarding social and health issues of adolescent homosexuality and presented implications for practitioners in providing culturally appropriate services	3
Morrison and Heureux (2001) examined the incidence rates and specific risks for suicide in LBGTQ adolescent population. An ecological model of suicide risk assessment for LBGTQ youth is presented based on Bronfenbrenner's model of human development	4
Phillips and McMillen (1997) studied relevant information pertaining to the needs and obstacles that LBGTQ youth face with youth serving agencies and provided recommendations on how administrators and practitioners can make changes in agencies that are not adequately serving sexual minority youth	3
Mallon (1997) examined a youth development perspective for working with LBGTQ youth and recommended principles that promote youth development along with ways in which youth practitioners can incorporate guiding principles of youth development. The author presents a model for creating an environment to meet the personal and social need of LGBTQ youth	3

Best practices include the following:

Program Design

- Youth service agencies need to become more responsive to the needs of their gay, lesbian, and bisexual clients (Child Welfare League of America, 1991; Mallon 1992, McMillen 1991; Phillips and McMillen, 1997)
- Sensitivity toward gay and lesbian youth need to be embedded in programs designed to increase employees' understanding of the social realities of varying client groups (i.e. ethnic, religious, cultural, and socio-economic) (Phillips and McMillen, 1997)
- Implementing diverse comprehensive programs need to include:
  - ✓ In-service training
  - ✓ Non-discrimination policies
  - ✓ Participation in culturally specific celebrations and holidays
  - ✓ Advocacy
  - ✓ Employment strategies
  - ✓ Client and staff groups that explore diversity
  - ✓ Efforts to create a climate that welcomes all people (Sue 1991)

Supporting Youth With Gender Issues

- Implementing group-based after-school services for at-risk youth to provide a historical perspective of human rights charters in Canada as an effort to increase youth empowerment, self-esteem, and respect for varying cultures (i.e. such a program could include key events and figures in the human rights movements for women, Aboriginal, and gays and lesbians) (Phillips and McMillen, 1997)
- Support gay youth NGOs that provide LBGTQ youth opportunities to learn and practice social skills, share and exchange information, develop friendships, obtain peer support, explore the meaning of their sexual identity, and find positive role models (Gonsiorek, 1988) (such groups decrease emotional and social isolation, help members clarify values, and encourage responsible decision making) (Remafedi, 1990; Dempsey, 1994)

Anti-harassment Policy

- Youth-serving agencies need to demonstrate a commitment to the safety of all clients by providing zero tolerance policies against violence, emotional maltreatment, and direct or inadvertent mistreatment. Providing policies with a strong stance against physical aggression and verbal harassment sends important messages regarding gay and lesbian youth (Phillips and McMillen, 1997)

Assessing and Addressing High Risk

- Services and treatment need to be based on sexual behaviors, not sexual orientation (complete sexual histories should be taken to provide the necessary information pertaining to treatment and services) (Sanford, 1989)
- LBGTQ youth need to be identified and assessed for suicidal risks, substance abuse, home and school problems that may precipitate running away or dropping out of school, and emotional problems (Remafedi, 1990; Sanford, 1989; Dempsey, 1994)

- Providing mental health services to deal with the high rates of depression and suicidal ideation is essential for LBGTQ adolescents (Noell and Ochs, 2001; Morrison and Heureux, 2001)
- Service providers need to become aware of community resources and make referrals as needed (Remafedi, 1990; Sanford, 1989; Dempsey, 1994)
- All LBGTQ youth need comprehensive HIV prevention education (information should be presented in ways that show respect for youth regardless of sexual orientation (Sanford, 1989; Dempsey, 1994)

Female Gender Specific

- Providing substance misuse interventions particularly dealing with injection drug use among females who identify as lesbian/bisexual is critical (Noell and Ochs, 2001)
- Providing interventions that are female gender specific (i.e. the proportion of homeless female adolescents identifying as lesbian or bisexual is very high) (Noell and Ochs, 2001)

Hiring Staff

- Hiring staff who demonstrate a commitment to providing services that foster self-esteem and acceptance of LBGTQ youth (agencies must strive to hire open-minded, and supportive employees). Three strategies to achieve this end are:
    - ✓ Communication of anti-discrimination policies
    - ✓ Recruitment and employment of gay and lesbian staff members
    - ✓ Assessment of attitudes during interviews (Phillips and McMillen, 2001)
- Hiring staff members who reflect the client population is important (i.e. including different ethnic groups, religious affiliations, and sexual orientations) (Phillips and McMillen, 2001)

In-service Training

- To guarantee adequate coverage of sexual minority matters, the following strategies for in-service training need to be incorporated: (Phillips and McMillen, 2001)
    - ✓ Gay and lesbian concerns are incorporated into all training sessions
    - ✓ General information is presented at seminars about gay and lesbian youth issues
    - ✓ Role-plays are used to develop appropriate language usage
    - ✓ Experiential exercises are used to develop natural, appropriate responses
- Sensitivity to gay and lesbian concerns need to be incorporated into all training sessions (i.e. staff education regarding youth suicide would not be complete without discussing elevated levels of attempted suicide among sexual minority adolescents and the reasons for this (Proctor & Groze, 1994; (Phillips and McMillen, 2001)
- Staff need to practice using gender-neutral language and intervening when hurtful, homophobic language is used. Appropriate language usage has repeatedly been emphasized as crucial to successful interventions with sexual minority youth (Herdt 1989; McMillen 1991; Morrow 1993; (Phillips and McMillen, 2001)
- Agencies need to develop diligence in training and approaches to practice. For an agency to be consistently sensitive to the needs of its clients, efforts to welcome

sexual minority youth and to understand their social realities should be institutionalized (Phillips and McMillen, 2001)

- To serve gay and lesbian youth better, agencies need to be guided by philosophies that embrace diversity and translate these into concrete actions (Phillips and McMillen, 2001)
- It is essential for service providers to understand the meaning and experience of being gay and a teenager in order to provide competent and sensitive services (Remafedi, 1987; Sanford, 1989; Dempsey, 1994)
- Service providers also need to promote therapeutic goals that promote physical, social, and emotional development in order to facilitate a healthy transition to adulthood (Remafedi, 1990; Dempsey, 1994)

Suicide Prevention (Morrison and Heureux, 2001)

- Prevention of LBGTQ youth suicide needs to include treating the environments that interface with LBGTQ youth in addition to treating the adolescent themselves
- Practitioner need to assess *individual, micro, and macro system* risk factors of suicide for LBGTQ youth
- The following *individual* factors for increased risk of suicide need to be assessed (Garland and Ziglar, 1993; Morrison and Heureux, 2001): regarding the following factors:
    - ✓ Psychiatric history
    - ✓ Family history of suicide
    - ✓ Substance abuse
    - ✓ Availability of a lethal method.
- In addition to the above individual risk factors (common for all sexual orientations), LBGTQ youth are more at risk for suicide and need to be additionally assessed regarding the following if they: (Morrison and Heureux, 2001**)**
    - ✓ Acknowledge their sexual orientation at an early age (Remafedi et al., 1991)
    - ✓ Report a sexual abuse and/or familial abuse history (Gibson, 1994)
    - ✓ Do not disclose their sexual orientation to anyone (Remafedi et al., 1994)
    - ✓ Self-present with high levels of gender non-conformity (Remafedi et al., 1991)
    - ✓ Report high levels of intrapsychic conflict regarding their sexual orientation (Savin-Williams, 1990).
    - ✓ Are "double minority" (i.e. lack of acceptance from their racial/ethnic community) (Savin-Williams and Rodriquez, 1993)
- The *micro system* risk factors (individuals environment) needs to be assessed i.e. youth's positive or negative interface with teachers, parents, counselors, friends, religious communities, neighborhoods and youth serving agencies needs to assessed (Bronfenbrenner, 1997; Morrison and Heureux, 2001)
    - ✓ Lack of tolerance due to homophobic attitudes in teacher, peers, and family members increases suicide risk of LBGTQ youth
    - ✓ Negative experiences with practitioners (i.e. mental health and youth care providers) could further isolate a LBGTQ youth and put them over the edge in terms of suicidal (Morrison, 2000)

- ✓ Lack of information regarding LBGTQ youth isolation and oppression in mental health care providers may contribute to misdiagnosis and a lack of preventative care for potentially suicidal LBGTQ youth
- ✓ Families with rigid role structures and an inability to accept change have increased rates of suicide in family members (Richman, 1986). Thus a family that is unwilling to support, accept, and affirm a child that is questioning their sexual orientation or coming out may contribute to an increased risk for suicidal ideation and attempts
- ✓ Lack of informed support networks in the LBGTQ youth's immediate environment may increase risk for suicide attempts and completions (access to programs that affirm all sexual orientations and decrease isolation for LBGTQ youth may decrease all forms of self-destructive behavior, including suicide risk)

- The *macrosystem* risk factors (e.g. human rights law/legislation, profession ethical guidelines for psychologists, counselors and teacher, mass media, school, provincial and federal policies and prevalent cultural values) may indirectly influence suicide risk for LBGTQ youth (Morrison and Heureux, 2001)
  - ✓ When LBGTQ issues are prominent in the press, anti-gay violence often escalates, and threats, harassment and violence may put youth at increased risk for self-injurious behaviors (D'Augelli, 1992)
  - ✓ A second macrosystem factor in suicide risk assessment for LBGTQ youth is the presence or absence of school policies that set expectations for educators to neither tolerate nor participate in homophobic and/or anti-gay rhetoric (e.g., in performing a suicide risk assessment for a particular LBGTQ youth, if the young person attends school at an institution with (1) a non-discrimination policy which includes sexual orientation; (2) diversity training for staff and teachers on issues; and (3) diversity training for other students which includes LBGTQ issues, that student is less likely to face harassment and homophobia in school and therefore may be less likely to engage in self-injurious behaviors
  - ✓ Pressure can come from racial, ethnic, religious, national, and/or community cultural values

Positive Youth Development Approach (Mallon, 1997) (Refer to Section II 16. for further information on Positive Youth Development Approach)

- Incorporate the following five premises (model by Pitman & Zeldin, 1995) for building positive youth services and supports for LBGTQ youth:

  Premise One -Possibilities and Preparation:
  - ✓ Programs that are tailored to meet clients' needs and interests as opposed to programs that have a "one-size-fits-all" approach, are better equipped to meet the needs not only of gay, lesbian, and bisexual youth and their families but of all youth and their families
  - ✓ Programs are designed by a youth and adult planning group that recognizes from the outset that the goal of the project was not simply problem reduction, but the enhancement of supports and opportunities for gay, lesbian, and bisexual youth

- ✓ Young people were involved in brainstorming ideas for the funding proposal

Premise Two - Participation:

- ✓ Effective youth development only occurs when young people are engaged and immersed in program activities. Utilizing principals of meaningful youth participation will empower youth

Premise Three - People:

- ✓ Relationship building ("people") is perhaps the most important premise underlying effective youth development practice (attention on the part of professionals and other adults to the establishment of respectful, supportive relationships that enable youth to fully engage in programs and services)
- ✓ Adult members need expertise in working with gay, lesbian, and bisexual youth and ability to establish caring relationships with youth and families of diverse backgrounds

Premise Four - Place and Pluralism:

- ✓ Organizations need to create an environment that signal safety and acceptance while allowing youth to take healthy risks, make real choices, contributions and form lasting relationships
- ✓ Providing a safe place for youth to be themselves and promoting an organizational culture that supports and recognizes cultural strengths and differences in clients populations are essential

Premise Five – Partnerships:

- ✓ Working from a positive youth developmental perspective means recognizing that development occurs within multiple contexts and therefore requires partnerships among key players, including youth's family, service providers, and community. (community stakeholders are an excellent resource and need to be included as significant partners in all the phases of program development)

15.2. Discussion of LBGTQ Youth

There is a dearth of evidence-based best practices for this population of youth. In those few places where support services are available to youth and their families, there has been some success in linking these youth with others who can understand their confusion and depression and help them accept their sexuality and know they are not alone. There has been some success in educating family so they are more tolerant and accepting. In other cases it is just better for the youth to leave the family environment to be in a place where they can feel a sense of belonging and reassurance.

Studies have noted high rates of suicide in association with drug abuse among LBGTQ youth (Hetrick and Martin, 1988; Garents and Kimmel, 1991; D'Augelli and Hershberger, 1993; Gibson, 1994). To quantify this phenomenon specifically in the LBGTQ population, anywhere from 19 per cent to 42 percent of LBGTQ youth surveyed report attempting suicide unsuccessfully (Gibson, 1994; D'Augelli and Hershberger, 1993). One early study (Remafedi et al. 1991) that reviewed psychosocial characteristics of gay adolescents who attempted suicide found a high degree of illicit drug use (85 percent) by LBGTQ youth. Other more recent studies have found similar findings along with reporting high rates of depression, runaway behavior, prostitution, multiple arrests, and alcohol use (Mallon, 1997; Morrison & L'Heureux, 2001). In addition, one study reviewed found that more that 50 percent of gay adolescent males in their sample reported multiple suicide attempts (Rotherman-Borus et al., 1994). Explanations for the association between depression, suicide, and substance abuse in this population are many. One reason directs attention to the turmoil over the "coming out" process, especially with youth's disclosure to parents. Additionally, suicide and substance abuse in this population appear to be aggravated by societal discrimination, violence, loss of friendship (isolation), and current attitudes towards homosexuality.

Kruks (1991) found that gay and bisexual male youth appear to be at increased risk both for homelessness and suicide. 80% of gay street youth receiving services at the Youth Services Department of the Gay and Lesbian Community Service Center in Los Angeles reported that homophobia and prejudice are one of the main reasons that gay youth seem to end up on the streets in such disproportionate numbers. These youth come to large urban areas in search of acceptance and nurturing but instead experience exploitation and homelessness. Kruks (1991) quotes Children's Hospital In Los Angeles which provided medical services to 620 street youth and found that 72% of males involved in survival sex identified themselves as gay or bisexual. The gay youth often ends up in "sugar daddy" relationships which they hope is love but after 1 or 2 months find out is only about sex, and they often become extremely suicidal at the end of each cycle (Kruks (1991).

An ecological model of suicide risk assessment of LBGTQ youth, based on Bronfenbrenner's model of human development, suggests that individual, micro, and macro levels of assessment are needed to increase accuracy in determining level of risk of LBGTQ youth (Morrison & L'Heureux).

It is impossible to help LBGTQ youth without dealing with the fundamental sexual orientation issues. Youth services workers need training in order to understand and to deal positively with sexual orientation issues. There is extreme isolation that LBGTQ youth experience that is by and large unique. The gay youth is usually totally alone with his or her gay/lesbian feelings, whether it is a secret or not, and is unable to get support from anyone. It is often on the streets that many of these youth find for the first time, peer acceptance and support.

Successful support programs for LBGTQ youth provide flexibility, are centrally located as well as offer outreach education, assessment, and group treatment in schools and drop-in centres. These programs also recognize that LBGTQ youth often lack parental and peer support in dealing with issues (i.e. recovery, depression, suicide ideation) therefore, these youth are often paired with sponsors who are gay or lesbian to help them maintain a healthier lifestyle.

16. Youth Development Approach

Recently, there has been a renewed interest in the youth development approach, which offers youth a continuum of opportunities and services on the basis of individual need and circumstance. The youth development approach asks not what youth should avoid but rather what they might become and how the community can help them realize their full potential Johnson et al., 2001). Our changing society and decreasing sense of community have reduced opportunities for many young people to receive the support necessary to move to self-sufficiency. Programs with a youth development focus offer young people the skills and knowledge they will need to function effectively as adults in an increasingly competitive world (Benson and Saito, 2000). Some core components of a youth development approach are (Johnson et al., 1998):

- ✓ Viewing youth and families as partners rather than as clients, and involving them in designing and delivering programs and services
- ✓ Giving youth access both to prevention and intervention services and to programs that meet their developmental needs
- ✓ Offering youth opportunities to develop relationships with caring, supportive adults

16.1. Summary of Best Practices for Youth Development Approach

A summary of best practices for Positive Youth Development Approach has been explicated from the following **four** studies which were selected from a total of **twelve** based on their evaluation rating of empirically sound best practices (refer to Section 1. 5.2 page 8 for evaluation criteria).

Positive Youth Development Approach	**Rating**
Johnson et al. (1998) - Family and Youth Service Branch (FYSB), U.S. Department of Health and Human Services have extensively evaluated and integrated youth development principles into all of the programs that they administer	4
Social Development Research Group (University of Washington) (1997), conducted an extensive review and evaluation of twenty-five positive youth development programs	5
Benson and Saito (2000) examined the status of youth development research and provided an extensive overview of current literature	4
Batavick (1997) examined key elements and relative success of family support and youth development practices	3

Best practices include the following:

Youth Development Approach in Shelters and Transitional/Independent Living Programs

- Requiring youth shelters to actively involve youth in the ongoing planning and delivery of services
- Inviting youth to serve on youth shelter's boards of directors or providing opportunities for them to serve as peer counsellors/mentors
- Establishing mechanisms for obtaining feedback from youth assisted by the shelter about the quality of services
- Developing performance standards that require shelters to provide youth with developmental opportunities by scheduling leisure-time activities that help them discover new skills and interests
- Designing program performance standards to ensure that emergency shelters and drop-in centres provide high-quality care. The standards provide agencies with operational guidelines in areas, such as providing counselling and aftercare, ensuring that youth participate in designing and delivering services, and maintaining confidentiality
- Designing transitional living programs for older homeless youth specifically designed to meet developmental needs. It is essential for transitional living programs to build competencies that youth need to move to independent living, such as basic life skills, interpersonal skills, job preparation and attainment, and physical and mental health
- Developing performance standards that ensure youth have opportunities within transitional living to build significant relationships by living and learning in a supportive, structured environment in which adults are available to advise and assist them. In addition, each youth works with staff to establish individual goals and action steps. This process helps them gain decision making skills and a sense of control over their future

(Johnson et al., 1998; Social Development Research Group, 1997; Benson and Saito, 2000; Batavick, 1997; Scales and Leffert, 1999; Zeldin, 1995)

Positive Youth Development Approach

- Effective programs addressed a range of positive youth development objectives yet shared common themes. All sought to strengthen social, emotional, cognitive and/or behavioural competencies, self-efficacy, and family and community standards for healthy social and personal behaviour
- Positive youth development programs need to involve the community in utilizing it's many resources to enhance the other youth, family, and school strategies.
- Target community involvement and factors more broadly, through influencing local city or neighbourhood policies for youth, or through the use of mass media
- Implement youth competency strategies by targeting youth directly with skills training sessions, to peer tutoring conducted by at-risk youth, to staff training that resulted in better classroom management and instruction
- Develop program guidelines or manuals (curricula) that help those delivering the program to implement it consistently from group to group, or from site to site
- Allow sufficient time (nine months) for evidence of behaviour change to occur, and to be measured within the programs
- Increase healthy bonding with adults, peers and younger children

- Combine resources of the family, the community, and the community's schools
- Supporting local collaborations in offering youth people constructive after school activities that are based on a youth development model
- Requiring agencies to develop a common vision for meeting the needs of youth and for promoting relationships between youth and caring adults
- Fostering meaningful youth participation in program design and delivery and offer a range programs and develop linkages with other community agencies to ensure that young people have access to services and chances for academic, social, and personal growth
- Youth development requires collaboration. No single community organization can provide the range of developmental, preventive, and intervention programs and services required to give young people the experiences they need to mature into successful adults. Rather, creation of such programs requires collaborative planning by a community's youth-serving agencies, other social service and educational institutions, policymakers, community leaders, and young people
- Shifting to the youth development approach requires educating service providers, policymakers, families, and communities. Youth service professionals interested in shifting their organizational focus to youth development will need to educate families and the community about adolescent development
- Youth development requires creating a shared vision for youth and community. Youth service providers, in conjunction with their professional collaborative partners, youth, and community members, should develop not only a shared language that includes definitions of adolescent ages and developmental stages, but also a shared understanding of what that language means. They must decide what youth need to develop into healthy, self-sufficient, and involved adults and how those needs can best be met by the larger community. Through that collaborative process, they can begin discussing the youth development framework and how it might translate into a vision for young people within their community.
- Implementing a youth development approach may require organizational change. The youth development approach is based on the paradigm that youth and communities are partners in developing and delivering services and opportunities for young people and in strengthening communities. Many youth agencies believe in involving youth and communities. Putting that belief system into practice to its fullest extent, though, often requires that organizations re-examine their missions, structures, and decision-making procedures.
- Evaluation indicators of youth development must be designed. Before discussing how to move to a youth development approach, agencies need to define the goals of such an approach for the young people served. On the basis of these goals, they can develop measurable outcomes that are clearly linked to youth development programming.
- Agency staff, accompanied by an experienced evaluator, might begin by discussing behavioral changes that indicate positive development among young people. These might include, for example, improved interpersonal skills or goal development. Agencies also can include young people and families in the design of outcome measures by conducting focus groups, individual interviews, or surveys, for example.

- Advocating for all young people demands that youth agencies pay considerable attention to creating positive images of youth in the media and the community. Media images and societal attitudes profoundly affect both the resources that are dedicated to young people and the way that services and programs are designed. Too often, media messages convey negative images of unintended pregnancies, drug use, crime, and violence.

(Johnson et al., 1998; Social Development Research Group, 1997; Benson and Saito, 2000; Batavick, 1997; Scales and Leffert, 1999; Zeldin, 1995)

Building Youths' Strengths and Competencies

- Encourage youth to take an active role in shaping and building their family and their community
- Implementing development programs that encourage competency development through youth-adult partnerships, enabling youth to plan artistic or community organizing projects and creating opportunities for youth to care for younger or elderly persons in their community
- Award and nurture youth leaders, recognize youths' strengths, encourage independent decision making, and create opportunities for youth to belong to a valued group
- Focus on how the environment affects youth development (youth development theory and practice are not rooted in descriptions of problems) i.e. impact of the youth's family and neighborhood on differences in developmental pathways, expectations of the youths' role within their culture and community, and the way that youth see themselves (Chalk & Phillips 1996)
- Involving youth in planning and decision making is central to the youth development movement
- Providing an asset/strengths-based programming approach - the focus shifts from providing services that respond to consumer problems to providing supports and opportunities that enable personal growth. Zeldin (1995) defines opportunities and supports for youth development
- Providing empowerment rather than treatment - traditionally, social and mental health services have been designed to reduce deficits through treatment-based behavioral, psychodynamic, or case management models. Staff need to act as catalysts to consumer empowerment by providing supports and opportunities for families and youth to contribute to their own development and to be involved in programs. Preparing staff to play this critical role requires significant investment in training and support by program managers and administrators.
- Insuring consumer involvement in planning and community development - is central to both the family support and youth development approaches. Research in youth development has shown that "when young people have ongoing chances to have a voice, to make decisions, to contribute, to make choices, then they are more likely to achieve positive outcomes" (Zeldin 1995). This is true for three reasons: participation allows youth to develop skills, enables them to take ownership of the program or activity, and ensures that the program or activity reflects youths' strengths, interests, and needs.
- Use of systems theory and the ecological perspective – the ecological perspective views all people in the context of their social, cultural, and physical environment. It

recognizes that interdependence is more realistic than independence and healthier than dependence. Both family support and youth development practice aim to work with children, youth, parents, and other community members with respect and appreciation for their racial and cultural identity and the family and community structures that support them. The role family support and youth development practice is to work with and seek to strengthen these systems, rather than to supplant them. Systems theory asserts that each member of a system contributes to its structure. This can be interpreted to mean that each member holds the power to change the structure of the family and community in which they live (Melaville et al. 1993; Zeldin 1995).

- Recognizing the resources of both youth and parents - A collaborative program that involves families and youth can thrive by using the strengths of both. Parents can mentor, tutor, and provide other supports for youth, while youth can care for younger children, create murals and theatre productions, or improve the physical environment. Both parents and youth can work together in planning and organizing programs and community activities. The community would benefit from their knowledge and ideas and a new generation of leaders would be able to learn from their elders.

(Johnson et al., 1998; Social Development Research Group, 1997; Benson and Saito, 2000; Batavick, 1997; Scales and Leffert, 1999; Zeldin, 1995)

Family Support Approach

- Social service staff members are trained in cultural competence: respect for people from different racial and cultural backgrounds, knowledge about the norms and customs of different cultures, and celebration of this diversity
- Staff members take on roles that resemble extended family and are committed to altering the structure of the agency and the social service system to create this atmosphere (Riley 1995).
- Family support works best in agencies where staff members are enabled to transform client involvement and input into policy and administration, making the entire system more effective and responsive than agencies that operate in a typically hierarchical fashion
- Family support programs always start with the community as a source of ideas and knowledge, have home visiting or at least create a homelike program environment, and demonstrate flexibility through drop-in child care and service options
- Focus remains on the family as a unit, celebrating its strengths and striving to retain its integrity and enhance its functioning.
- Efforts to strengthen community ties and natural helping networks follow readily (Dunst 1995)
- While social workers usually make up the core staff of a family support program, the use of community members as paraprofessionals can help a program be more responsive and feel more comfortable to participants [Zigler & Black 1989].
- Understanding the Population - to begin a family support program, planners and professionals must have an understanding of the community's structure and an appreciation of its strengths. Spending time in the community and speaking with those who live there help greatly
- Family Involvement and Empowerment - the parents suggest that organizers support and encourage parents' talents, keep in mind that the community belongs to the

parents, create stipends or paid positions to encourage a feeling of partnership, be role models, be open to letting parents experiment and express their views, avoid belittling language, and never come with their own agenda

- Involve and engage families in positive youth development programs through:
  - ✓ Parent skills training
  - ✓ Using strategies that involve parents in program implementation
  - ✓ Strategies that involve parents in program design and planning
- Encouraging parent participation sends a message to parents that they have the skills and the knowledge to know what is best for their children and their communities. Parents who are involved in programming that affects their children are more likely to be more involved in the lives of their children (Batavick, 1997)

16.2. Discussion of Youth Development Approach

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

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

- Interpersonal skills
- Quality of peer and adult relationships
- Self-control
- Problem solving
- Cognitive competencies
- Self-efficacy
- Commitment to schooling, and academic achievement

Effective programs showed significant improvements in problem behaviors, including:

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

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

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

17. Self-Regulating Service Delivery System

Implementing a self-regulating model for the delivery of youth services has major implications and benefits for provincial governments that would shift focus more to consumer and population outcomes and away from the process (Junek and Thompson, 1999).

17.1. Best Practices for a Self-Regulating Service Delivery System

A summary of best practices for a Self-Regulating Service Delivery System has been explicated from the following study:

Self-Regulating Service Delivery System	Rating
Junek and Thompson (1999) presented a conceptual model applicable for delivering services for youth at risk	3

Self-Regulating Service Delivery System (Junek and Thompson, 1999)

- Developing a mission and desired purpose for the system of care is established for youth. Developing a clear mission, goals, indicators, and outcome measures for the consumer and population domains is essential
- Developing outcome measurements that reflect high-risk youth issues in services and the population
- Collecting measurements at regular intervals is important. Progress report of the wellbeing of youth and families, are provided regularly to organizations, regional authorities, government, and the public. The executives of organizations use the outcome indicators to evaluate progress toward the goals and purpose. Their own internal process indicators will help them decide which actions to take to lead to improved outcomes in the subsequent years. The executives also will note that some important indicators cannot be achieved without co-operative action with others in the system of care
- Developing a powerful motivational and incentive structure to accompany the desired outcomes is essential to create positive changes in youth services and motivate provider behaviour. Rewards for specific achievements are given to regions, communities, organizations, or individuals who reach or exceed their goals. Not only will the system flounder without strong rewards for achievement, but the nature and importance of these rewards will reflect the importance of youth in society
- Providing an accountability process for service delivery organizations that emphasize clear outcomes
- Evaluating the consumer and population outcomes
- Providing communities with increased freedom and creative opportunities to manage their service delivery; reduce overlap and duplication, and induce more co-operation

17.2. Discussion of Self-Regulating Service Delivery System

Many long-standing and fundamental difficulties with service delivery for high-risk youth can be addressed by self-regulating systems (Junek, 1999). A self-regulating service delivery system places a major emphasis on regular measurements of outcome in two domains:

- Consumers of services
- General population

It depends on the development and regular use of powerful incentives focused on the outcome indicators to drive a system of constantly improving outcomes. It suggests that a number of other features naturally evolve from it or are induced by it: (Junek, 1999)

- Better quality
- Interorganizational cooperation
- Less duplication
- Stronger community support
- High staff morale
- Efficiency, and better use of resources

This model would shift focus more to consumer and population outcomes of service delivery and away from the process. By developing a powerful motivational and incentive structure to accompany the outcomes, changes would be made in a variety of services for youth. The province would have an accountability process for service delivery organizations that emphasized the most important product--better outcomes. Services for youth would be evaluated on the consumer and population outcomes leading to a singular and joint focus on them. Communities would have increased freedom and creative opportunities to manage their service delivery; overlap and duplication would be reduced, while more cooperation would be induced. Turf and mandate disagreements or boundaries would become less important in the cooperative effort to seek the common outcomes and rewards. Overall, the effect would be to liberate their creativity in options for action but to confine the focus of action on outcomes.

Implications extend into the research community. The development and selection of key indicators for the most beneficial results, and the choice and implications of incentives for better outcomes, are underdeveloped areas and need to be researched. There is a dearth of research in both areas.

Two key research observations explain some of the dissatisfaction with the present methodology of service delivery. First, the problems of children do not come as neatly divided as do government departments; that is, children's needs frequently cut across government ministries/departments (Lerman, 1984; Rutter, 1979; Thompson, 1988). Second, the actual number of children/youth at risk far exceeds the capacity of consumer-centered service delivery (Offord et al., 1987; Rae-Grant, 1989). This suggests that the service delivery system needs to extend beyond any single branch and to extend its reach, via prevention and population health approaches, to children and youth who are not yet

registered clients but who are at risk. The self-regulating service delivery system is designed for these additional requirements.

The most important potential benefit of a self-regulating service delivery system is improved outcomes for child and youth. Other potential benefits and effects are:

- Decisions and actions in the system of care will focus on the mission (desired purpose) with reduced influence from distracting or competing purposes
- As a system, and as a model, it lends itself to new approaches to strategic planning. Strategic interventions and priorities arise that might not have been recognized without the overall model. For instance, the importance of regular Progress Reports on the Well-Being of Children and Youth and the examination and attachment of incentives for beneficial outcomes becomes clearer
- The system concerns itself with the measures and counts of a product that is truly important--beneficial outcomes for children--rather than a process of production as is frequently done
- The rational self-interest of the system is such that it induces, as opposed to demands or pleads for, cooperative planning and actions inside a region. This leaves regions and communities more in control of their organizations and system of care. While shifts of authority among various levels of government and administration can help or hinder total system functioning, the overall direction of the system continues to evolve in the direction of improved outcomes for all children and youth
- Communities and regions are free to be creative in whatever partnerships with each other they can develop in the pursuit of better outcomes for children
- The data obtained provide useful information for decisions and action. The system makes it easier to link costs and outcomes. It enables better priority setting and action through choices of indicators and attached incentives. It makes it easier to determine the best balance of resource allocation among clinical, preventive, and promotional activities for a region
- The system can accommodate a variety of conditions regardless of whether these are produced by external factors (e.g., high unemployment levels, difficult socio-economic circumstances) or internal factors (e.g., resource limitations for service organizations)
- The shift to using outcome indicators with appropriate incentives for the population as a whole becomes a means of both evaluating and managing managed care. The outcomes for children and youth in different groups (various managed care arrangements) provide governments with the needed information for policy development and funding decisions that will allow them to focus on bringing the best benefits to their total populations
- The system introduces basic principles of business in a perspective useful to service delivery--product (better functioning youth and adults), profit (rewards, awards, and other incentives), quality (both in choice of and measured standards of the functioning of children), competition (in a friendly win-win manner, as children always will gain), and efficiency (organizations will seek to maximize their outcomes with their available resources)

- The system is compatible with other management tools such as total quality management and continuous improvement systems.
- The system allows attention to specific problem areas (chronicity and complexity) by choice of indicators
- Powerful incentives focus the efforts of organizations on improved outcomes. The data gained will be useful for the organizations, governments, and the public in understanding youth's issues and advocating for solutions.
- Incentives such as individual awards and public recognition of the importance of their work can boost morale of frontline workers
- Politicians supporting the development of and continued participation in this system are placed in a win-win situation because children benefit and politicians bring positive action in support of communities and families
- The overall government role is simplified to setting the rules, allocating resources equitably, measuring and monitoring indicators, applying and monitoring incentives, and celebrating successes
- While most service delivery has arisen out of historical precedent and ad hoc solutions, as a model, this system is subject to the testing of hypotheses including those associated with the potential benefits.
- This system is self-regulating and self-perpetuating.

Appendix A

Annotated Bibliography

Appendix A

Annotated Bibliography

6.3. Homeless and Street Youth

The reviewed literature pertaining to the topic of street youth and homelessness included sixteen collected articles, eight of which met the evaluation criteria and are included in this section. These studies and reviews all received **four or five** out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Street Youth

The first of our best practice studies is by **Kidd, 2002** and the study received an evidence-based rating of **five** out of five. This study combined an extensive review of literature (42 research papers) that examined issues pertinent to interventions among street youth along with a qualitative analysis of semi-structured interviews with 80 street youth of the cities of Vancouver and Toronto.

An extensive review of literature determined the following characteristics of street youth:

- Family histories of most street youth are troubled, often consisting of disrupted home environments, extreme family conflicts, psychological, physical and sexual abuse, and neglect (Kidd, 2002)
- High rates of substance abuse are found among the parents of street youth (Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999)
- High percentage of street youth's families are on social assistance (Ringwalt, Greene & Robertson, 1998
- Higher levels of marital discord in the homes of street youth (Dadds, Braddock, Cuers, Elliott, & Kelly, 1993), and they are more likely to have witnessed domestic violence (Buckner & Bassuk, 1997)
- Families of street youth show evidence of frequent household moves and changes of school (Buckner & Bassuk, 1997)
- In addition to physical and sexual abuse, high levels of emotional abuse (Ringwalt et al., 1998) and neglect (Dadds et al., 1993; Kufeldt & Nimmo, 1987) are also reported among street youth
- Poor performance in school and conflict with teachers are common (Hagan & McCarthy, 1997), and many report a history of conduct problems (Feitel, Margetson, Chamas, & Lipman, 1992; Rotheram-Borus, 1993)

The result of these experiences for most street youth is a life on the street (Adams, Gullotta, & Clancy, 1985; Maclean et al., 1999), either as runaways, or having been thrown out as is the case with an estimated one-fifth to one-half of street youth (Ringwalt et al., 1998).

Challenges to homeless youth on the street are:

- When leaving home, they are immediately faced with the problem of finding shelter and food
- While socially supported agencies are potential sources of assistance, they are often viewed negatively by street youth, perceived as sources of stress and danger (Buckner, Bassuk, Weinreb, & Brooks, 1999; Hagan & McCarthy, 1997; Holdaway & Ray, 1992)
- In an effort to support themselves, street youth engage in numerous activities (Greene, Ennett, & Ringwalt, 1999; Hagan & McCarthy, 1997) including:
    - ✓ attempts to find work
    - ✓ seeking money from family/friends
    - ✓ panhandling
    - ✓ prostitution
    - ✓ survival sex (sex for food, shelter etc.)
    - ✓ dealing drugs, and theft
- The difficulty of supporting oneself is highlighted by the large number of street youth who regularly lack shelter and go hungry (Antoniades & Tarasuk, 1998; McCarthy & Hagan, 1992)
- Street life presents numerous dangers and stresses in the form of physical and sexual assaults on the street (Terrell, 1997; Whitbeck, Hoyt, & Ackley, 1997)
- Associated with the above mentioned activities are frequent problems with the police (McCarthy & Hagan, 1992; Schissel, 1997)
- Drug abuse and addiction are major problems for street youth (Baron, 1999; Greene & Ringwalt, 1996; MacLean et al., 1999; McCarthy & Hagan, 1992)
- Drug abuse has been found to be a function of parental drug use and the type and severity of abuse in childhood (Adlaf, Zdanowicz, & Smart, 1996; Baron, 1999; Schissel, 1997; Sibthorpe, Drinkwater, Gardner, & Bammer, 1995)
- Related to the extremely negative backgrounds common to many street youth and the subsequent stressors they face on the street are high incidences of mental disorders (Buckner & Bassuk, 1997; Feitel et al., 1992; Whitbeck, Hoyt & Bao, 2000) including:
    - ✓ Depression appears most frequently (Ayerst, 1999; Kurtz & Jarvis, 1991; MacLean et al., 1999; Rotheram-Borus, 1993; Whitbeck, Hoyt & Yoder, 1999)
    - ✓ Conduct disorder, (Buckner & Bassuk, 1997; Feitel et al., 1992)
    - ✓ Trauma and post traumatic stress disorder (Feitel et al., 1992)
- Suicidality has been found to be a major problem among street youth with suicide attempt rates between 20 and 40% (Feitel et al., 1992; Greene & Ringwalt, 1996; McCarthy & Hagan, 1992; Molnar et al., 1998; Ringwalt et al., 1998; Rotheram-Borus, 1993; Stiffman, 1989; Yoder, 1999)

Workers and agencies should have a well-developed network of community resources in areas such as medical, legal, and recreational services (Cauce et al., 1994; Terrell, 1997)

The following best practices were identified:

- First priority is to ensure that the youths are provided with the basic necessities of life i.e. adequate food, shelter and attention to physical ailments (assessment of needs in this area is crucial for this group, many who suffer multiple health problems) (Cauce, Morgan, Wagner, Moore, Sy, Wurzbacher, Weeden, Tomlin & Blanchard, 1994; McCarthy & Hagan, 1992; Terrell, 1997)
- Assess medical needs and implement interventions and prevention as early as possible (Yates et al. 1991)
- Assessment of drug use is an important element in an intervention program (Baron, 1999; Greene & Ringwalt, 1996; MacLean et al., 1999; McCarthy & Hagan, 1992)
- Recognize that the mechanics underlying substance abuse may differ greatly from youth to youth (Adlaf et al., 1996; Baron, 1999; Schissel, 1997; Sibthorpe et al., 1995)
- Researchers caution that too heavy a focus on drug use alone is ineffective and that drug use is likely a symptom of other problems that need to be addressed just as urgently (Hagan & McCarthy, 1997; Maclean, Embry & Cauce, 1999)
- Researchers stressed the importance of careful screening for symptoms of mental health problems i.e. specifically screen for suicidality, depression, and histories of maltreatment and abuse (Baron, 1999; Ayerst, 1999; Kurtz & Jarvis, 1991; MacLean et al., 1999; Rotheram-Borus, 1993; Whitbeck, Hoyt & Yoder, 1999)
- Be cautious when considering reunification with legal guardian (for many youth leaving home was an escape from abuse, neglect and in some cases situations far more threatening than street life) (Kidd, 2002)
- Careful assessment be undertaken as to the suitability of family members or other guardians as caretakers and being open to the possibility of the youth returning home (Kidd, 2002)
- Intensive family work will be necessary if a mutual agreement has been made for youth to return (Kidd, 2002; Green et al., 1998)
- If returning to guardian is not an option, alternative living situations need to be explored i.e. independent living programs (Kidd, 2002; Ringwalt et al., 1998; Greene et al., 1998)
- In recommending alternative living options avoid environments which are similar to those of youth's former guardians such as those with overly rigid rules or poor parenting/care-taking practices (Kidd, 2002; Ringwalt et al., 1998; Greene et al., 1998)
- It is important for the youths to try and stay in the community from which they came (some family support may still exist, however limited that support might be) (Ensign & Gittelsohn, 1998)
- Assessment of youth's social networks is important (i.e. assess whether or not to break ties with friends on the street and away form being entrenched in a street lifestyle or take into consideration that some peer support from the street is potentially a powerful and necessary part of helping youth) (Whitbeck et al., 2000; Bao et al., 2000)
- A well trained and multi-disciplinary staff is essential given all the assessment and many domains of intervention that must take place (Green and Ringwalt, 1996; Yates et al., 1991)

- Workers and agencies should have a well developed network of community resources in areas such as medical, legal, and recreational services (Cauce et al., 1994; Terrell, 1997)
- Workers should take a strength approach rather than pathology perspective (Ensign & Gittelsohn, 1998; Molnar et al., 1998; Whitbeck et al., 1999) and recognize that provocative acting out behavior is an indicator of maltreatment (Powers et al., 1989)
- Core elements in any such work should include a recognition of the youth's independence and incorporate a sense of control on their part (Holdaway & Ray, 1992; Whitbeck et al., 1999), include a flexible, non-judgemental approach (Molnar et al., 1998) and strict confidentiality (Ensign & Gittelsohn, 1998)
- Throughout their efforts to teach the youth better coping skills, the worker must be able to let the youth try, fail, and try again (Kurtz et al., 1991)
- Work with these young people does not end when they have left the street environment. Comprehensive intervention must be replaced with comprehensive aftercare involving regular re-assessment, and further intervention to prevent the youth from returning to a destructive lifestyle (Greene & Ringwalt, 1996)
- Several researchers stress the importance of early intervention i.e. the need to act quickly with newcomers to the streets who are often the most vulnerable to victimization (Unger et al., 1998; Whitbeck et al., 1999; Whitbeck et al., 2000)
- A maximal effort must be made with young women and youth considering or already involved in the sex trade who are particularly vulnerable (Whitbeck et al., 1999, Greene et al., 1999; Yates et al., 1991)

Services and Models

The second of our best practice studies is by **Swets, 2000** and the study received an evidence-based rating of **three** out of five. This literature review examines information regarding topics and options of housing for high-risk youth. Youth is defined in this paper as a person between sixteen and twenty-four years old, although homelessness frequently emerges in a person's life before age sixteen. This paper provides a summary of the literature and research on youth housing and examines services and models that aid youth in attaining and/or productively residing in a safe place of housing.

Little research directly addresses youth homelessness, although it is often considered as a component of other youth issues, such as youth with addictions, et cetera. The United Nations (as cited in Swets, 2000) differentiates between two categories of homelessness - 'absolute homelessness' with no reliable physical shelter, and 'relative homelessness', that is, living in unsafe, substandard housing. The homeless youth population includes those both in absolute and relative homelessness.

Homeless youth frequently face multiple concerns. "Homeless youth are a high risk, heterogeneous special needs housing population possessing multiple needs and issues that require resolution" (p. 1). Issues include insufficient financial support, children-in-care, women escaping violence, disorderly offenders, et cetera. Therefore, assessing youth homelessness entails more than supplying temporary housing or 'putting a roof over their heads'.

Youth homelessness is considered in the literature and a number of service implications were determined:

- Curb, Curbside and Runaway Youth
  - ✓ Youth retain a home connection
  - ✓ The first two weeks a youth is on the street is a crucial point in time for intervention
- Street-Entrenched Youth
  - ✓ Services in BC focus on job training or youth support despite the fact that this counters literature and research that suggests basic needs, such as safe and affordable housing, must first be met
- Sexually Exploited Youth
  - ✓ Although it cannot be assumed that homeless youth are certainly caught up in the sex trade, many youth report they become prostitutes to survive and escape physical, sexual and emotional abuse in their homes and schools
- Lesbian, Gay, Bi-Sexual, Transgender, and Questioning Youth (LGBTQ)
  - ✓ There is always a correlation found in the research on LGBTQ youth and running away behaviours
- Aboriginal Youth
  - ✓ Encompass a high percentage of the homeless populace
- Youth in Care
  - ✓ Connections between housing policy and the child welfare system are needed as a means of decreasing the possibility of youth becoming homeless
- Substance Use and Misuses Experiences
  - ✓ Family substance abuse and misuse is one of the main reasons that youth leave home
- Health, Mental Health, and Suicide
  - ✓ Mental health illness may either predispose youth to homelessness or be caused by homelessness

Housing for youth should always be accompanied with ‘supportive housing services” to:

- Assist youth in making the transitions from homelessness to being housed
- Assist youth in addressing the past and current issues which led to their homelessness in the first place
- Assist them in making a transition either back into their families and/or onto adulthood and independence

A continuum of housing and supported housing services needs to have available:

- Responsive emergency housing and support services to assist youth in their decision to exit their homeless state, to meet their basic needs for shelter and support, and to stabilize into a longer term plan
- Second stage supported housing with support services to address their issues and learn the skills they need for independence
- Longer term supports and/or transitions into adult-based services once they have secured permanent housing and have achieved an acceptable level of competence and independence, to prevent relapses back into a homeless state

Literature and research specific to BC indicates a critical lack of housing for youth which has longer term social and financial costs for youth and the Province

Addressing Long and Short-term Needs

The third of our best practice studies is by **Robertson & Toro, 1998** and the study received an evidence-based rating of **four** out of five. The authors' paper offers a profile of homeless youth in the United States by addressing this population's diversity and their service needs. The authors explain their definition of homeless youth in this research as minors, those between twelve and seventeen years old, who have spent at least one night on "the streets" or in an emergency shelter. The authors also describe a variety of intervention approaches, identify applicable social policy, and pose recommendations for future research.

The authors find rigorous research on homeless youth to be sparse despite the fact that American homeless youth constitute an estimated yearly prevalence of at least five percent (or more than one million youth in a given year). Given such statistics, adolescents may be at a greater risk for actual homelessness than adults. This disturbingly frequent percentage composes a diverse and large group. In lacking credible research, Robertson & Toro recommend that research with this special population would likely benefit from more input by service providers, policy makers, and the youth themselves.

Recent literature identifies that homeless youth are comprised of a diverse and large group. There is no typical homeless youth, and there is no single cause for youth homelessness. However, many youth have compounding issues including:

- Emotional, mental, and medical problems
- Substance abuse
- Family conflict
- Gang activity
- Neglect
- Physical and sexual abuse

In attempting to survive on the streets, many youth engage in illegal activities such as dealing drugs or prostitution as a means of survival. Many youth who live on the streets are also further victimized by physical or sexual assault.

The following best practices were identified:

- Addressing long and short-term needs of homeless youth i.e. in the short-term, transitional and emergency services are required
- Providing tailored and comprehensive services
- Ensuring co-ordination among providers and interagency co-operation
- Providing access to other services including treatment and screening for mental health, health, and substance problems, reconciling family strife, and vocational or educational training, as well as basic needs
- Preventing homelessness through the following basic approaches:

- ✓ Targeting youth early on in their homeless careers prevent repeated homelessness
- ✓ Implementing primary prevention interventions that attempt to prevent homelessness and other harmful outcomes among adolescents in the general population
- ✓ Implementing residential options such as transition or independent living services are needed
- ✓ Protecting youth while in foster and group home placement through advocacy and addressing legal issues
- ✓ Planning for discharge and aftercare are essential for youth leaving institutions

In conclusion, Robertson & Toro address program evaluation and comment:

- There is a paucity of research evidence about best practices for meeting the needs of homeless youth
- We need research around the effectiveness of case management, primary care, mental health and substance abuse services much in the same way that we have research for the adult systems
- We need research in knowing not only what works, but under what conditions, for which groups, and at what cost

The Role of Formal and Informal Helpers

The fourth of our best practice studies is by **Kurtz et al., 2000** and the study received an evidence-based rating of **four** out of five. The majority of adolescents progress from adolescence to young adulthood with success. "However, runaway and homeless youth experience formidable obstacles in their paths and engage in dangerous behaviours that threaten their well being and long-term prospects". In this study, the authors examined how runaway and homeless adolescents navigated the troubled waters of adolescence to make successful developmental transition into their young adulthood.

The authors used qualitative design, in depth interviews with twelve formerly runaway and homeless young people, comparative methodology in analysis, and a strength-based versus problem-based perspective in their research. This research was vital because little was known about how homeless youth successfully progress into adulthood. Youth perceptions are importance in program planning. Therefore, this study asked runaway and homeless youth what types of help they received from formal and informal sources that they believe assisted them resolve difficulties.

The research reported that adolescents felt isolated and were disinclined to trust formal aid agencies. However, all of the participants identified that help from others was critical in being able to resolve difficult problems. The following four categories were identified by the youth as types of help they received:

- Caring (unconditional acceptance and emotional support)
- Setting boundaries and holding youth accountable
- Concrete assistance (i.e. sheltered living)

- Professional intervention (ranging from conversations with shelter staff to residential treatment programs).

The youth explained that those who provided them with help included family members (parents, relatives, and foster parents), friends, and professionals when friends and families were unable or unwilling to help. The youth also admitted they did not always take advantage of their families, friends, and professionals offers to help them. Youth indicated that two conditions had to be present in order for them to utilize such help:

- Youth had to perceive the helper as trustworthy
- Youth had to be ready to accept help

The youth offered the following advice to professionals assisting runaway and homeless youth:

- First and foremost, youth need helpers to be trustworthy, to be there for them, and listen to them
- Staff should not show favouritism to selected youth
- Youth needed an adult they could constantly rely on, even after being discharged from a program
- Youth recommended helpers put themselves in the youth's shoes
- Youth found staff were more helpful when they developed personal relationships versus rigid helper-client boundaries
- Staff should not feel sorry for youth.

In contrast to participants' advice regarding how youth want to be treated in their relationships with helpers, no clear themes emerged regarding recommendations for program development. Youth overall found caring, stable relationships most beneficial.

The following best practices were identified:

- Programming for runaway and homeless youth need to be youth-centered and flexible i.e., a significant theme/message from youth was that "people are more valuable than programs and that process is more important than outcomes"
- Supporting relationships are critical to success i.e. friends and family often remain critical players for these youth after they have left the home. The overarching message was that young people need to want to make their own decisions, but they also need others support.

Case Management Approach

The fifth of our best practice studies is by **Morse, 1999** and the study received an evidence-based rating of **four** out of five. Case management (CM) has been used extensively over the past twenty years as a service approach for homeless people. However, questions have surfaced regarding the clarity and meaning of the term CM, as well as its effectiveness for helping individuals. This research report considers conceptual issues, describes and critiques various models and approaches to CM, reviews empirical literature on CM and homelessness, identifies gaps in CM knowledge, and

recommends exemplary practices for homeless people with strong implications for homeless youth.

"CM has become in practice one of the most common services to people who are homeless" (Morse, 1999). However, confusion about the concept of CM has risen due to a lack of definitional specificity. Research in the past decade has addressed this issue. There are also a number of different approaches to providing CM that vary in functional characteristics (what they do) and operational or process characteristics (how the service operates).

Morse, 1999 reviews seven CM models. Most published literature addresses CM approaches for individuals with mental health issues; thus, reviews of models reflect this development, and, unfortunately, lack of development in other areas. For example, *intensive case management (ICM)* approaches are widely used with a variety of homeless subpopulations including youth, *assertive community treatment (ACT)* approaches are also commonly used with homeless individuals with mental health issues. Morse also identifies that there are relatively few CM approaches for dually diagnosed homeless individuals. Consideration of CM for homeless people as a strategy for supplementing primary health care services, as well as for homeless youth and families, is needed as literature and innovation is limited in these areas.

The following best practices were identified:

- Although more effectiveness research needs to be conducted, there is strong support to indicate that some CM approaches are effective for helping homeless people with severe mental illness into needed services and, more importantly, into stable housing
- *ACT* has the most extensive body of supportive research; results consistently indicate its effectiveness for assisting homeless clients with severe mental illness to achieve stable housing and to maintain needed services. There is also some but less research to indicate that *ACT* is effective in a few other client outcome domains, including for reducing psychiatric symptoms
- A very small set of studies suggest that *ICM* can be effective for helping clients to achieve stable housing
- Frequent service contact tends to be an important critical ingredient leading to positive treatment retention and housing outcomes
- CM services tend to be less effective with certain clients: men, persons with more psychotic symptoms, persons with longer homeless histories, and people with co-occurring substance abuse disorders
- CM working with homeless and possibly mentally ill clients possess a thorough knowledge and skill base to work with this population
- CM models used are consistent with research findings
- CM is guided by core service principles, such as having small case loads for CM staff
- Organizational practices empower CM's and give them authority to access needed client resources

Morse recommends that government should avidly pursue two broad courses of action:

- Promote the acceptance of existing exemplary practice through knowledge dissemination, advocacy, and financing
- Encourage and foster the development of new knowledge through additional research.

Access to Health Care

The sixth of our best practice studies is by **Klein et al., 2000** and the study received an evidence-based rating of **four** out of five. Little is known of runaway or homeless youths' access to health care. The authors in this research examined the use of health services and self-reported contact to emergency and regular health care by street youth and homeless adolescents. The need for health care within this population is significant because runaway and homeless adolescents are at high risk for injuries, physical abuse, sexually transmitted infections, homicide, suicide, and emotional or psychological problems. "Despite runaway and homeless youths' high level of risk and increased need for health services, many factors may influence their decision not to seek care" including cost, lack of follow-up, and fear of legal intervention or social services notification (Klein, 2000).

Interviewer-administered surveys addressed use of health services, types of care sources used, availability of sources of care for emergencies, and serious health history problems. All participants were between twelve and twenty-one years old. An abbreviated style of the questionnaire used with youth in shelters was used for street youth. Interviews occurred in 1992 that encompassed a nationally representative sample within the United States inclusive of 640 sheltered youth and an intended sample of 600 street youth.

The authors found results that identified 36% of sheltered youth and half of street youth did not have a customary source of health care. However, a remarkable percentage of shelter and street youth did report a source of routine care. 18% of sheltered youth and one-fourth of street youth reported serious health difficulties in the past year. "Street youth were more likely than sheltered youth to have used emergency treatment and alcohol- or drug-related emergency treatment". However, sheltered youth with a consistent source of health care were more likely to employ nonemergency sources than youth without a site of primary care. Youth who had a consistent centre of health care had a greater degree of continuity between emergency and routine care. Few street or sheltered youth viewed clinics for runaway youth, shelter clinics, or free youth clinics to be available to suit their emergency needs.

The following best practices were identified:

- The significance of connecting health services to programs attempting to meet the needs of homeless youth
- This integration may advance access to health care for youth without a regular source of care and provide greater continuity for high-risk youth
- The authors also suggested that suitable service connections may aid at-risk youth in their exit from the street.

Street Youths and Substance Misuse

The seventh of our best practice studies is by **Baron, 1999** and the study received an evidence-based rating of **four** out of five. This study explicates "the role that various background, labour market, and street lifestyle factors play in street youths' drug and alcohol use". Little is known about which aspects of the street and of homelessness account for street youths' alcohol and drug usage.

The current research attempts to explore some of the conditions and experiences of street life and their relationship to drug and alcohol use. In particular, it focuses on the role of the street lifestyle and the influence that homelessness, peers, and criminal behaviour have on drug and alcohol use. Further, it examines the role of economic factors, including income and unemployment, and how reactions to labour market problems may be linked to drug and alcohol use on the street. Finally, the current research examines whether prior family experiences play a role in street youths' drug and alcohol use.

Baron, 1999 reviewed extensive literature surrounding issues of street lifestyle, unemployment, and substance use. For example, research suggested physical and sexual abuse played a role in adolescent self-derogation and drug usage was at times used to counter these feelings. Physically or sexually abused youth were therefore more likely to use alcohol, drugs, or both.

This research transcended traditional studies that explored youths' alcohol and drug use by focusing on a population often ignored from traditional data sources. This study explored experiences, conditions, and details of life on the street that could lead to alcohol and drug use. The research population included interviews of 200 males, 24 years old or younger who had left or finished school, and were on the street or in a mall a minimum of three hours a day, three days a week. Data identified the average respondent was a full-time street youth, homeless approximately four months in the previous year. Respondents were questioned on topics including drug and alcohol use, length of homelessness, job histories, parental drug and alcohol use.

The following implications were identified:

- Homeless youth came to the streets with backgrounds that encouraged alcohol and drug use. Although, once they were on the street, their risk for alcohol and drug use was intensified by their street experiences
- Experience with parental substance abuse increased street youths' risk of hard-drug and alcohol use (however, correlation was identified between parental usage and street youths' use of hard drugs and drinking but not soft drug use)
- Neither a history of physical or sexual abuse had a major impact on the youths' alcohol or hard-drugs use. Yet, the data identified youths who had been physically abused were more likely to use psychedelic drugs
- Long-term homelessness influenced hard-drug use, whereas alcohol- and drug-using peers influenced the use of alcohol, psychedelic drugs, and marijuana
- Involvement in property crime augmented street youths' use of all varieties of drugs and alcohol. However, not all criminal behaviour was related to alcohol and drug use
- Drug distribution was found to be linked to greater soft-drug use

- Beyond the street lifestyle, labour market histories and responses to unemployment were important factors in understanding alcohol and drug usage
- Respondents were more likely to use alcohol if they had limited job experience, experienced depression about their unemployment, or did not accept blame for their unemployment. However, youth who described not feeling depressed about their unemployment tended to use hard drugs

In conclusion, Baron, 1999 found that homeless youths came to the streets with backgrounds that endorsed drug and alcohol use.

Very Young Homeless Youth

The seventh study is by **Unger et al., 1998** and received an evidence-based rating of **four** out of five. The authors examined 2,476 very young homeless and street youth (aged 12-15) in Los Angeles and San Diego, California, as part of the AIDS Evaluation Street Outreach Project (AESOP). The youth were examined for demographic and lifestyle characteristics, peer group identification, history of homelessness, sources of shelter and money and health status.

One child in eight will run away from home before the age of eighteen. Although not all remain homeless, the estimated population is 250,000 to one million (Robertson, 1992). Many of these youth are out of school, unemployed, and/or involved with gangs, drug dealing and prostitution. Homeless and street youth report high rates of psychological disorders including depressive symptoms, low self esteem, attention deficit/hyperactivity disorder, suicidality, and self-injurious behaviour (Unger at al., 1997). Many engage in high-risk behaviours leading to HIV (Kipke, O'Connor, Palmer & Mackenzie, 1995).

Approximately 10% of homeless youth are 15 years of age or younger (if statistics are correct, this could represent more than 10,000 youth in the U.S.). This younger group tends to have more females, more Latinos and more heterosexuals than older groups of adolescent homeless youths. They were more likely to have attended school in the past month. Early adolescents have typically less sophisticated decision-making skills (Schvanaveldt & Adams, 1983; Steinberg & Cauffman, 1996) and they are less able to use techniques of abstract reasoning, hypothetical thinking, and formal logic (Peterson & Leffert, 1995). Early adolescence is also characterized by increasing conformity to the social norms of peers and decreasing conformity to the wishes of parents and authority figures (Harris, 1995; Youniss & Haynie, 1992).

Early adolescents desire the approval of peers and on the street may seek out older street youth as surrogate families (Corsaro & Elder, 1990). Consequently, they may engage in risky behaviours (such as drug dealing, unprotected sex, or crime) in an attempt to form attachments with older runaway/homeless adolescents. These young homeless youth are at greater risk of victimization because of their physical and psychological immaturity (Kipke et al., 1997) and experience sexual and physical assault and recruitment into gangs (because they are prosecuted as minors for committing crimes) more often than older adolescents (Vitaro et al., 1997). Early onset of delinquency or antisocial behaviour

has been shown to be associated with increased subsequent delinquency (Tolan & Thomas, 1995) and criminal conviction (Farrington & Hawkins, 1991).)

34% of these young homeless youth identified with "gang members", followed by 20% "druggies", 20% "alternatives" (Generation X) and 13% "punkers"

34% had been homeless for one month or less. 40% had participated in illegal subsistence activities, 70 % rated their health as good, 29% said their health had become worse and 14% felt their health had become better. They depend more on other people in their social networks for shelter and money

These youth avoid shelters because of fear of violence robbery or sexual assault, being reported to the police or parents, and turned over to foster care. In some cases they were turned away from shelters because they did not have a driver's licence.

Factors which protect early adolescent homeless youth psychologically or physically:

- Have more connections to adult social networks, i.e., received money or shelter from friends or relatives and have attended school recently, which connects them with school personnel who can help them leave the streets
- They reported less affiliation with the punker group (20%) which use hard drugs, share needles and have unprotected sex and sex with needle users so are at greater risk of getting HIV

Factors that put early adolescent homeless youth at increased risk psychologically or physically:

- Affiliation with gang members (34%) puts these youth at high risk of becoming involved in criminal activities
- Because their health is excellent or good they do not access free health clinics

Best practices:

- Providing services where these youth are likely be located such as youth use drop-in centres

More Characteristics of Homeless Youth

The last of our best practice studies is by **Yoder et al., 2001** and received an evidence-based rating of **four** out of five. The authors interviewed 602 homeless and runaway adolescents from four Midwestern states, in shelters, on the streets and in drop-in centres. Interviews lasted 1.5 hours and the adolescents received a snack and a $15.00 participation fee.

The authors found that:

- White males were more likely to spend time on the streets and efforts to keep youths off the street should be especially targeted to these youth
- Unstable family environments characterized by neglect and sexual abuses led to youths running away from home, therefore, providing prevention and intervention programs for these youth is needed

- Neglect was viewed by youth as enough to warrant running away more than physical maltreatment (Gauthier et al. 1996)
- The newer to the street the more risk of harm, i.e., under one year

7.3. Street Outreach

There is a dearth of empirical literature pertaining to the topic of outreach, however, in our literature search, fifteen articles were collected, **eleven** of which met the minimal criteria, and from this body of pertinent work, **five** studies met the evaluation criteria. These studies and reviews all received three to four typology ratings out of five, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Many of the youth that outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services (Sullivan-Mintz, 1995), have had negative experiences with service-providers (McMurray-Avila, 1997), and have been victims of violence (Goodman, et al., 1995; Weinreb, et al., 1995). Further, homeless youth with children are viewed as perhaps the most vulnerable of homeless families (Bronstein, 1996).

Engagement is a crucial process for successful outreach. It is described as the process by which a trusting relationship between worker and client is established, which then can provide a context for assessing needs, defining service goals and agreeing on a plan for delivering these services (Barrow, 1988, Winarski, 1994).

Engagement is the Key to Successful Outreach

The first of our best practice studies is by **Erickson & Page, 1998** which received an evidence-based rating of **four** out of five. These authors consider engagement to be the key to outreach. They state that "the goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased services". Erickson & Page (1998) conducted a comprehensive review of literature compiling best practices from practitioners, policy makers, and researchers. The following best practices were identified:

- Engaging is the key to outreach. Some strategies are:
    - ✓ Treating youth with positive regard, remembering past encounters and discussions, being humble, honest and sharing information about themselves when appropriate
    - ✓ Providing incentive items and services i.e. food, drinks, condoms, cigarettes, vitamins, toiletries, interest items such as - art, books, hobbies or collections
    - ✓ Letting clients set the pace
    - ✓ Communicating at the clients level i.e. if the client is sitting on the curb join him/her
    - ✓ Being creative i.e. an outreach dog can be used as a great ice breaker or using the arts to reach out and engage
- Connecting to these youth as early as possible in order to prevent acclimation to street life

- Starting with the client's perceived goals where these homeless youth are regarded as the experts in their life
- Utilizing a peer model approach where youth outreach workers can act as peers for other homeless youth and become a bridge between street life and the world of adult professionals who they tend to mistrust
- Utilizing the experiences of peers/formerly homeless youth in the development of program design and implementation
- Hiring effective outreach workers with the following qualities:
    - ✓ Good judgment, intuition and street sense: this includes safety for themselves and the client, being observant and vigilant, as well as using good common sense. Strategies include going out with a partner, avoiding closed, remote or dangerous areas, developing a relationship with local police (Winarski, 1998), carrying a cellular phone, dressing appropriately, and assessing situations before acting.
    - ✓ Non-judgmental attitude (Winarski, 1998): Regardless of the worker's personal beliefs, no behavior on the part of the client is morally judged.
    - ✓ Team player: Workers must know when to ask for help, from getting backup on the streets to a second opinion in clinical assessments. Outreach staff must have a strong commitment to the "team" approach to service delivery (Axelroad, 1987; Wobido, 1990).
    - ✓ Flexibility (Rosnow, 1988): Outreach workers are flexible in reassessing daily work priorities, in setting work schedules, and in the treatment planning process (Morse, 1987), and content.
    - ✓ Realistic expectations: Workers have an "expectation of non-results." They understand that they will not be able to "cure" or "save" clients (Axelroad, 1987), and at the same time continue to persevere.
    - ✓ Commitment: Outreach workers are both consistent and persistent in their dealings with clients (Axelroad, 1987; Wobido, 1990). They do what they say they are going to do to create trust (Sullivan-Mintz, 1995)
    - ✓ Cultural competency: Workers demonstrate competence across ethnicity, gender, transgender, lifestyle, and age spectrums.
- Conducting an assessment of youth's comprehensive, holistic needs before providing services and linkages to meet these needs through an informal process over a period of time as the relationship builds
- Providing a basic triage assessment to help identify and respond to potential life threatening problems
- Providing short term follow-up with respect to immediate tasks at hand and long term follow-up to ensure they remain in a stable situation

Training Youth as Peer Outreach Workers

The second of our best practice studies is by **Podschun, 1993** which received an evidence based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The author evaluated a youth peer outreach-street work project designed to train youth specifically as peer outreach workers to provide HIV prevention education to some 1000

homeless adolescents who were living on the street. These peer educators were matched with adult outreach staff. The following best practices were identified:

- Integrating with existing youth services programs i.e. basic needs of food, shelter and clothing, youth centres, medical services, STD testing or treatment, drug treatment, employment.
- Developing appropriate educational materials for this low literacy target population.
- Utilizing youth peers to facilitate structured focus groups contributing to concept development, project development, i.e., creating and disseminating posters to advertise outreach services, and evaluation of draft products
- Implementing a youth peer outreach model in combination with adult outreach workers

Community Outreach Model

The third of our best practice studies is by **Shulman, 1999** which received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). This author also carried out an extensive evaluation of a teen-focused early intervention and prevention program called the "Teen Outreach and Primary Services (TOPS)" for youth at-risk (ages 15-24) for, or living with HIV. Shulman utilized an innovative community outreach model to improve access to a local consortium of 25 agencies. More than 2000 hard-to-reach adolescents at-risk for HIV/AIDS were involved in this study and were referred to and participated in case management sessions, counseling and therapy, HIV testing, drug treatment, family planning, and STD services. The following best practices were identified:

- Hiring adult outreach workers who are ethnically sensitive to the target population and experienced with street culture
- Hiring part-time peer educators complements the outreach team to build a better bridge of trust among community youth
- Developing on-site recreational activities as a recruitment strategy
- Developing an incentive program to enhance adherence to the program
- Developing services in response to assessment of client needs i.e. in this study - an adolescent-specific clinic with major emphasis on HIV; an HIV Counseling and Testing program on-site at TOPS to provide greater confidentiality than at the Health Department program which was avoided by adolescents.
- Defining overall objectives of the program i.e. in this study:
    - ✓ Refine peer counseling program
    - ✓ Provide outreach and assessment service to 500 hard-to-reach youth per year for potential admission to the program
    - ✓ Provide individual and group harm reduction services to 175 youth at risk for HIV infection
    - ✓ Provide age-appropriate HIV counseling and testing to a minimum of 200 youth
    - ✓ Provide training and consultation on HIV service and intervention needs of collaborating agencies
    - ✓ Improve the availability and coordination of local services for underserved youth with HIV/AIDS or at high risk for HIV infection

- ✓ Disseminate the model of care and promote replication of the model in other sites
- ✓ Integrating with existing youth services programs i.e. basic needs of food, shelter and clothing, youth centres, medical services, STD testing or treatment, drug treatment, employment.
- ✓ Developing appropriate educational materials for this low literacy target population

- Developing educational resources i.e. in this study a video and instruction manual for professionals was created about the issues and techniques of establishing a peer educator program model, focusing on:
  - ✓ Street youth culture
  - ✓ Issues about HIV/AIDS prevention and services
  - ✓ Primary and subsequent pregnancy prevention
  - ✓ Substance abuse
  - ✓ Education and methods for enhancing adolescent self-esteem

Elements of an Intensive Outreach Program for Homeless and Runaway Street Youth

The fourth of our best practice studies is by **Gleghorn et al., 2000** which received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). Over a two-year period, the author evaluated a set of outreach interventions developed by the needs and ideas expressed by homeless and runaway street youth. The interventions increased high-risk youth contact with outreach and prevention services. The following best practices were identified:

- Developing a comprehensive street outreach program involving a combination community adult outreach worker and peer educators
- Developing an innovative youth centre to provide prevention services
- Creating youth subculture-specific prevention activities and educational materials
- Identifying and defining subgroups within the street youth population i.e. this study identified two subgroups *hippie/deadhead* and *punk/squatter* that had distinctive value systems such as norms of appearance, artistic and musical preferences and acceptance of different types of drug use
- Engaging youth in a context they can relate to i.e. in this study a variety of products were produced for each subculture and great efforts were made to engage youth in a context they could relate to:
  - ✓ The Grateful Dead band cooperated in the production of a video and condom cover for *hippie/deadhead* youth
  - ✓ Posters were developed from focus groups of youth from each subculture
  - ✓ *Punk/squatter* youth developed an underground magazine (topics ranged from prostitution to safer shooting techniques) and a referral card to orientate their peers to youth outreach services
- Utilizing the following seven step to engage youth in developing outreach activities and subculture-specific interventions:
  1. Gain an understanding of the community
  2. Focus on a subculture

3. Organize a core group from the subculture
4. Support the core group's development and production of activities or materials
5. Supply the core group with necessary resources
6. Evaluate the finished product
7. Develop new products

Building Cooperation Between Law Enforcement Agencies and Runaway and Homeless Youth Centers

The last of our best practice studies is by **Johnson et al., 1998** which received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The authors created a Compendium of Critical Issues and Innovative Approaches in Youth Services for the U.S. department of Health & Human Services**.** This study examined fourteen sites participating in five research and development projects that operated over a two-year period and looked at cooperation between law enforcement agencies and runaway and homeless youth centres. The goals of the projects were: 1) increasing communication between the two groups, 2) improving collaboration, referrals and services for youth in at-risk circumstances, and 3) reducing unnecessary adjudication and incarceration of these youth.

Tumbleweed Phoenix

Gaining Trust and Respect Initial involvement was 8 hour shifts on Friday Saturday and Sunday nights. This later expanded to five nights a week and dinnertime was often a peek time as police saw how much the Tumbleweed staff helped the youth and families. Staff respecting the police roll was most significant in gaining the officers trust and they received in-service training on working with police in crisis situations. Most staff worked well with the police and any that did not were partnered with more experienced Tumbleweed staff. They had weekly project meetings to discuss how calls went and ways to improve things.

The Role of the Outreach Team. The staff had a van equipped with a police radio, enabling them to monitor calls to police regarding young people. Police also alerted staff when they came across youth they felt needed help. Project staff responded to:

- Domestic violence calls in which young people were at risk and needed safe houses so they would not run away and become homeless. More than half the projects caseload were young victims
- Cases where youth were experiencing family difficulties that were getting them into trouble e.g., having to miss school to baby-sit younger siblings, project staff mediated by helping them identify the problems triggering the crisis and assisted the family in solving the problem, in this case, finding daycare

Evaluation. The project staff thought police would most appreciate the time-saving aspects of their help but in fact, many police really cared about the outcomes of individual youth and would follow-up with staff to find out this information.

Surveys were mailed to the police, youth and parents to solicit feedback. The police had a high response rate (66%) and had a positive reaction to the team. There was a low response rate from youth and families (17%) but these were mostly positive.

Open Inn Network of Community Projects in Tucson

This project was comprised of a transportation service and "holdover program" for youth in at-risk circumstances coming into contact with the law. The service was provided for children/youth aged up to 18. Transportation aides who resided in four local communities were responsible for transporting young people from law enforcement or other referring agencies to the center, where they would receive temporary housing and other services… The project was able to offer individual, group, and family counseling, shelter care and after care.

Transportation Aides. Transportation aides had to be 21, hold a valid drivers licence, possess a high school diploma,, drive their own vehicles and maintain liability insurance. Aides were paid an hourly wage and reimbursed mileage. Protocols were developed which stated they only transport youth the same gender as them, unless an adult of the same gender as the youth was brought along, they could also refuse to transport youth who were suicidal, physically aggressive, under the influence of drugs or alcohol, or who had an arson offense history. Project staff located referrals for these youth.

Role of the Children's Center. Once at the center, staff notified legal guardians, arranged transportation home for out-of-state runaways, and advocated with child protective service agencies for placements when young people could not return home.

Impact Suicide Prevention Centre in Tempe

Project staff worked most closely with police sergants who then scheduled them in for 20-minute presentations at roll call to talk about Empact's services and how Empact staff could be a help to the police officers. They played a dual role in educating police staff and mediating crisis situations, they also freed up police while they dealt with difficult family situations.

Project LEARN

Law Enforcement and Runaway and Homeless Youth Network was implemented in Metropolitan Dade County Department of Justice Assistance in Miami, Florida. To support the project the Department of Justice Assistance appointed an ad hoc advisory committee and sought members from the 20 municipal police departments and received a response from 86 youth agencies. This ad hoc committee advised project staff:

- To make educational videos for law personnel to watch during roll call, resulting in development of two videos on effective ways for law enforcement to work with runaway and homeless youth called "Please Somebody Help Me" and "Are You Listening?"
- To create a training curriculum called "Working With the Police" to help youth service providers understand law enforcements role in dealing with runaway and homeless youth
- To put on a six-project-sponsored training events to help social workers understand law enforcement procedures for handling status offenders
- To develop a runaway prevention curriculum for students in grade 6 to 8 called "the Third Option" letting youth know their alternatives
- To develop a resource card with telephone numbers for community resources and informing youth of their rights

As a result of the positive interaction between law enforcement and youth service professionals, a new legal procedure was adopted by Dade county whereby runaway and homeless youth no longer automatically taken home by police, but were taken for an assessment to determine if they should be taken home.

Rainbow Youth Services

Serves a large rural area of fourteen counties in Michigan and experienced immediate success because the key liaison officer was a former police officer. There was no need to do training at roll call as the liaison officer dropped by the various stations to talk about the project. Trust, respect and access was easily established because the police knew their roles with youth were clearly understood.

8.3. Emergency Shelters and Transitional Housing

Emergency Shelters

The reviewed literature pertaining to the topic of emergency shelters included **nine** collected articles, **three** of which met the evaluation criteria and are included in this section. These studies and reviews all received three to four out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

The research defines emergency shelters as larger facilities offering less privacy. Shelter services address basic needs (food, clothing, a place to sleep), along with limited short-term services and referrals, with few expectations placed on youth. Length of stay tends to be short in duration, i.e., less than thirty days.

Defining Runaway Youth and Prediction of Reunification

The first of our best practice studies is by **Thompson et al., 2001** and the study received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The author states that youth community-based emergency shelters represent the primary method of intervention for runaway youths and are often mandated to reunify youths with their families. Thompson et al. (2001) examined the needs of homeless youth asking two questions: (1) what are the differences among runaway--homeless, throwaway, and independent youths? (2) What youth demographics, personal characteristics, and family factors predict youth's reunification? A sample of 17,790 youths using shelter services during 1997 was collected from The Runaway Homeless Youth Management Information System (RHYMIS), a comprehensive, automated information system developed to assist federally funded youth shelters nationwide in the United States. Chi-square and logistic regression demonstrated that the three groups differed significantly on a variety of characteristics.

Researchers divided runaway youths into three categories based on research confirming the distinct differences in these subgroups (Bass, 1992; Ringwalt, Green, & Robertson, 1998; Zide & Cherry, 1992), which are:

Runaway-homeless youths--stay away from home without the permission or knowledge of their parents or guardians.

This group predominately lives with parents, has more runaway episodes, and uses drugs more than the other groups. They appear to be acting out but are still in close contact with parents and are more likely to reunify with their families if they avoid behaviour related to criminality and have parents who are not emotionally or physically abusive. These youths experience conflicting parent-child relationships but are more likely to remain connected with their families and engage in less severe problem behaviours. These youths often have a variety of problems, such as school failure, substance abuse, criminality, and unprotected sexual activity. They frequently report high levels of family conflict, including parental abuse, criminality, and substance abuse (Kipke, Palmer, LaFrance, & O'Connor, 1997; Sfiffman, 1989; Whitbeck et al., 1997; Greene, 1997). In

addition, their families have histories of unstable housing situations and often are characterized as emotionally unavailable and lacking effective parenting skills. Because runaway adolescents typically lack the skills and education necessary to obtain and maintain gainful employment, they often are forced into prostitution, drug dealing, and other criminal behaviour to survive. Life on the street also can have "deadly consequences" because these adolescents are at significantly increased risk of serious health problems such as malnutrition, sexually transmitted diseases, and premature death resulting from suicide, murder, and drug overdose (Powers, Eckenrode, & Jaklitsch, 1990; Greene, 1997).

Throwaway youths--leave home because their parents have encouraged them to leave or have locked them out of the house

Thompson et al. (2001) state that this group includes a larger percentage of youths who had been living in correctional facilities or with an adult other than their parents, identifies their guardian as a child welfare or juvenile justice organization, and had dropped out or been expelled from school. These youths had more juvenile delinquency problems (selling and using drugs) than the other two groups and less contact with parents because they have especially conflictual and strained family relationships, marked by forced eviction from home. Thompson et al. (2001) also indicate that some throwaway youth from various ethnic minority groups appear to be at greater risk of not unifying with their families. For example, African American and Asian/Pacific Islander throwaway youths are less likely to return home than white youths.

Independent youths--feel that they have no home to return to because of irreconcilable conflicts with their families, have lost contact with their families, or have families that are homeless.

Fewer of this group have lived with parents before coming to the shelter and more were employed. Independent youths had few personal and family factors that predicted their reunification and were closer to being able to live independently.

Reunifying with Family or Living Independently

Thompson et al (2001) point out that community-based youth shelters provide a variety of crisis and custodial services and have a stated mission to reunify youths with their families or to teach them the skills to live independently and reduce the likelihood of involvement in high-risk behaviours. Once discharged from youth shelters, more than one-half (53 percent) of the runaway youths return to their parent's home and although youths report difficulties in their homes, recent studies have shown that those who reunify with their families have more positive outcomes than those finding housing in other locations leaving the shelter. The following best practices were identified:

- Returning to their parental home results in more positive outcomes in:
  - ✓ School
  - ✓ Employment
  - ✓ Self-esteem
  - ✓ Reduced criminal behaviour
  - ✓ Decreased hopelessness
  - ✓ Decreased suicidal thoughts and behaviours
  - ✓ Less family problems

    - ✓ More optimistic view of the future
- Facilitating family reunification through individual and family counselling
- Completing services has a great impact on reunification

Runaway Homeless

- Reconnecting *runaway* homeless youth with family so they engage in less severe problem behaviours requires assessment of:
    - ✓ Avoidance of criminally-related behaviour
    - ✓ Ensuring parents are not emotionally or physically abusive

Throwaway Homeless

- Reconnecting *throwaway* homeless youth with family so they engage in less severe problem behaviours requires assessment of fewer problems with:
    - ✓ School
    - ✓ The criminal justice system
    - ✓ Drug use
    - ✓ Housing
- Customizing service for *throwaway* homeless youth is needed to provide them with more comprehensive and intensive services over a protracted period to encourage their autonomy and competence

Independent Homeless

- Assessing and servicing *independent* homeless youth is easier because they are closer to independent living and should include:
    - ✓ Facilitating positive attachments with adults outside the family
    - ✓ Developing interventions that incorporate individuals and organizations in the community such as job skills training, employment opportunities and education

Parent/Family Involvement

- Encouraging informal involvement of parents because youths with greater exposure to their families and who lived with them previously are more likely to return home
- Providing adjunct youth-family mediation/support programs to reduce family conflict and minimize issues i.e., educating and training parents to:
    - ✓ Learn ways to attend to the developmental needs of their youth
    - ✓ Learn new management skills such as effective monitoring and discipline

Ethnic Considerations for Homeless Youth

- Assessing needs for ethnic groups should include provision of unique services that include culturally sensitive program content to facilitate greater understanding of ethnic minority families to ascertain reunification outcomes
- Documenting and prescribing levels and outcomes of treatment in emergency shelters is needed to better serve these youth
- Providing after care service support through volunteer mentors helps keep youth feeling positive and at home

Utilization of Emergency Shelters

The second of our best practice studies is by **Greene & Ringwalt, 1997** and the study received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). After evaluating data from 160 youth emergency shelters the authors

found that many street youths perceive youth shelters as dangerous places and think that shelters provide no help for them.
The authors view runaway and homeless youths as one of the most vulnerable populations in the nation today and certainly one of the most elusive and difficult to serve. Youth shelters provide the primary means of meeting the complex needs of this population and the following best practices were identified:

- Determining obstacles that prevent youth from using shelters, i.e., they fear their families will be contacted by the shelter staff or fear violence against them while in the shelter
- Developing eligibility requirements (i.e., age, gender, and restrictions on youths' behaviors)
- Determining youths' perceptions about shelters and their services, and shelter accessibility
- Increasing outreach efforts to improve youths' awareness of the availability of shelter beds and services, and to dispel inaccurate perceptions about shelters
- Ensuring housing is safe and youth are protected from violence and abuse
- Providing counselling and other intervention services in order to stabilize youth and assist them to exit from the street
- Reuniting youths with their families, or helping them develop the skills necessary to live independently
- Preventing or reducing participation in high-risk behaviours (e.g., substance use and unprotected sex
- Increasing shelter utilization through development of research, policy and service communities

Treatment Implications

The third of our best practice studies is by **Teare & Peterson, 1994** receiving an evidence-based rating of **three** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). Although this is an older study, the authors provide the first and only, published report of treatment activities in a short-term emergency shelter program and examine treatment implications from data collected from 100 youths admitted consecutively. The purpose of the study was to determine how frequently social skills teaching was taking place and which skills were being taught most often. They also examined other, more indirect indicators of program implementation and safety, such as the youths' satisfaction with the program, and how often negative events occurred within the shelter. The following best practices were identified:

- Orientating toward active treatment rather than just offering food and a place to sleep
- Structuring program elements to characterize a safe and effective environment:
    - ✓ Provide a safe respite for youths who may be coming from chaotic or abusive family environment
    - ✓ Provide 24 hour a day caregiver support and include both individual and group counselling
    - ✓ Focus on positive behaviour to teach new skills (teaching curriculum based social skills is the primary treatment activity in the shelter i.e. following instructions, accepting criticism, solving problems, and conflict resolution

skills). The recommended minimum frequency of social skill teaching for new youths is of 15 to 18 teaching interactions each day

- ✓ Consumer orientation youth-centred approach using a points card motivational system for using skills appropriately
- ✓ Training (caregivers receive a minimum of 80 hours of preservice training and additional 40 hours of training during first year)
- ✓ Internal program audit and ongoing program evaluation (accountable to their funding sources, and must document prescribed levels and outcomes of treatment)

Social Skill Development

Social skills were taught through planned behavioural rehearsals (role-plays), or spontaneously as opportunities arose. During teaching, youth were told of the specific skill and its components, they were given several rationales for the importance of the skill, and given the opportunity to role-play the skill and receive feedback from staff members, earning positive points on a card that s/he carried. After learning the skill, should the youth not engage in the skill appropriately during the day, s/he would earn negative points. The following best practices were identified:

- Providing a very active and positive treatment environment for the youths i.e., for every one corrective interaction there were 15 positive teaching interactions emphasizing reinforcement of positive behaviours.
- Teaching basic or intermediate level skills i.e., following adult instructions and learning how to greet others were the two most frequently taught skills which worked well in the short time frame (2-weeks)
- Teaching skills in accepting criticism and following instructions may be most helpful to the youths when they return to their caregivers because many had problems with adult relationships
- 70% of the youths return home after leaving the shelter because family are included in the youths' continuum of care treatment, i.e. family preservation, parent-adolescent mediation, and parent
- Providing aftercare services by linking them with volunteer mentors who visited with the families periodically after the youths returned home
- Focusing on the whole family helps avoid isolating the child as the sole recipient of services
- Evaluating the shelter staff, i.e., youth reported generally high levels of satisfaction with:
  - ✓ How fairly the staff implemented rules and consequences
  - ✓ How concerned, pleasant, and helpful they were when helping the youths work on problems
  - ✓ How well they communicated with the youths
  - ✓ How the youth were not maltreated in any way during their stay in the shelter

Transitional Housing

The reviewed literature pertaining to the topic of transitional housing included **seven** collected articles, **four** of which met the evaluation criteria and are included in this section. These studies and reviews all received four out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Defining Transitional Housing

Swets (2000) states that transitional housing assists individuals in moving from emergency shelters toward permanent housing. It allows an individual to begin to address their life situation in a safe, secure and comfortable place to live. Access to supported housing services and supports such as personal counselling, job training, job placement and other independent living programs are often offered in the transitional housing stage.

In the context of a continuum of responses to homelessness, transitional housing occupies an intermediate position. It consists of relatively private accommodations provided on a temporary basis along with intensive services intended to facilitate the transition to permanent housing. The distinctions between transitional housing and other types of temporary and/or service-enriched accommodations for homeless people are not hard and fast: what one locality labels as "transitional" may look a lot like the "shelters" in another setting. Despite this overlap, however, we can clarify core features by examining how transitional housing contrasts with emergency shelter, residential treatment programs, and permanent supportive housing.

Transitional housing vs. emergency shelters – transitional housing usually differs from emergency shelter in offering smaller facilities, more privacy, and more intensive services with greater expectations for participation. While shelter services address basic needs (food, clothing, a place to sleep), the services in transitional programs almost invariably extend beyond meeting survival needs. They tend to be coordinated by case managers and are geared toward helping residents define goals and achieve greater independence. Finally, transitional housing is almost always time limited, with lengths of stay usually capped somewhere between three months and two years.

Approaches/Models for Transitional Housing

The first of our best practice studies is by **Barrow & Zimmer, 1998** and the study received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The authors reviewed the evolution of transitional housing and describe various approaches/models for homeless youth regarding physical structures and programs within a continuum of services. The following best practices were identified:

- Adding low demand transitional housing to outreach or drop-in services for homeless individuals improve their likelihood of obtaining permanent housing
- Developing scattered-site models that convert to subsidized permanent housing have a number of benefits:

- ✓ Cost effective
- ✓ Reduce time spent homeless
- ✓ Facilitate transition to permanent housing
- ✓ Avoid the stigma associated with single site programs
- ✓ Use case management and community-based services to provide the support needed to maintain housing

- Developing community networks to foster acceptance of transitional housing programs and to enhance safety and stability for residents and neighbors
- Transitional housing can only be effectively implemented in the context of a continuum of services that includes adequate permanent housing and the supportive community-based services that can prevent returns to homelessness.

Factors Influencing Successful Transitions

The second of our best practice studies is by the **General Accounting Office (GAO), 1990** receiving an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The authors reviewed the Housing Urban Development (HUD's) Transitional Housing Program and set out to determine whether the program was serving the targeted population with a wide range of services, whether it was helping homeless people move to independent living, and what factors influenced successful transitions. The GAO conducted a telephone survey of program directors of 360 (94%) of funded projects and visited 32 of the project sites.

The following best practices were identified:

- Housing facilities can vary, ranging from converted warehouses or hospitals to renovated hotels, apartment buildings and newly constructed buildings
- Lengths of stay can vary enormously, with maximum duration ranging from one month to 24 months, the limit set by HUD
- Providing—either directly or by referral—a full array of supportive services: case management, housing placement, benefits or entitlements assistance, psychological counselling, job training, medical care, child care, and guidance in life skill, as well as specialized mental health and substance abuse services
- 56 percent of the individuals served by transitional programs succeeded in obtaining mostly unsubsidized stable housing without services and a source of income upon leaving the program
- Several factors attributed to successful outcomes:
  - ✓ Availability of a safe, secure, private place to live
  - ✓ Providing a case management approach which combines advocacy work, counselling, skill development and service coordination functions
  - ✓ Screening for those who were most motivated to succeed, impediments included pre-existing problems like mental illness and substance abuse
  - ✓ Providing affordable housing and employment or vocational opportunities.
  - ✓ Providing a range of supportive services, i.e., job training/placement, child care, substance abuse treatment, mental health services, and instruction in independent living skills
- Clients most likely to succeed were those who remained in the program longer and those who used more supportive services.

Transitioning to Self-Independence

The third of our best practice studies is by **Johnson et al., 1998** which received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The authors created a Compendium of Critical Issues and Innovative Approaches in Youth Services for the U.S. department of Health & Human Services and the specific program examined was **The Lighthouse Youth Services Agency in Cincinnati (1998).** Beginning as a small emergency shelter for runaway youth in 1973, the project is now providing one of the most comprehensive services to hundreds of youth and their families in the Cincinnati area each year. Their program Gateway Apartments is a network of supervised living arrangements for "non-system" homeless youth that is built on a foundation of values, namely, youth independence and responsibility.

Gateway Apartments is funded in part by Family and Youth Service Bureau FYSB's Transitional Living Planning TLP. The TLP supports comprehensive services within a supervised living arrangement for periods of up to 18 months. It is designed to meet the needs of homeless youth ages 16–21 who are not under the protection of the child welfare or juvenile justice systems.

The following best practices were identified:

- As conditions for entering and remaining in the program, for example, youth must agree to do the following:
  - ✓ Pay rent, based on their ability to pay
  - ✓ Contribute a percentage of their income to a savings account
  - ✓ Make a choice between attending school and finding employment
  - ✓ Youth also are responsible for participating in maintaining the program, by conducting activities such as the following:
  - ✓ Coordinating the weekly house meetings to discuss facility upkeep and landscaping and assigning responsibilities among themselves
  - ✓ Conducting the third interview of new youth entering the program, and providing input to staff on acceptance decisions
- Youth make their own decisions and are not guided by the staff, i.e., if the youth are not interested in their education the staff members help them look for a job, usually most young people come to their own decision to get further training and education and are empowered in the process
- After 12 years, landlords are happy to accept program youth as tenants, in fact, they often contact the agency when they have open apartments because the Lighthouse program:
  - ✓ Guarantees rent and timely payment
  - ✓ Provides a steady flow of renters
  - ✓ Has rules which are often more strict than landlord-tenant rental agreements (for example, placing limits on numbers and hours of visitors).
  - ✓ Staff are on call for crisis intervention 24 hours a day, 7 days a week, 365 days a year
  - ✓ Covers all damages to rental units and cleans units upon termination of the lease

- ✓ Will evict if necessary
- ✓ Staff supervise and assist youth renters

- To expand the range of employment opportunities available to Gateway youth, staff actively recruit employers that can provide entry-level positions and describe for employers the full range of educational and supportive services provided for each of the young potential employees
- Lighthouse matches youth skills and interests to employer needs and offers to intervene when workplace issues arise for program youth
- Lighthouse has been successful in negotiating higher starting wages for program youth and has begun to negotiate for incentives and other benefits for youth who remain in their jobs for extended periods of time

Alternatives for Transitional Living

The fourth of our best practice studies is by **Kroner, 1999** and the study received an evidence-based rating of **four** out of five (refer to Section 1. 5.2 page 8 for evaluation criteria). The author produced the most comprehensive descriptive handbook of alternatives for transitional living and describes housing options and practical issues surrounding the operation of housing programs. Kroner presents eleven types of programs that are the basis of the following descriptions. The types vary from least to most restrictive. Kroner emphasizes the value of learning by doing in an environment with real-world consequences. The greater the freedom afforded to the youth, the higher the probability that necessary skills will be acquired and practiced. On the other hand, it is also true that the greater the freedom, the greater the likelihood that problems will develop.

In each of the following arrangements, subsidies were provided to the young people. When they were living in private arrangements, this included rent. In these and in several other types of housing, youths received subsidies for food and personal items as well.

1. Scattered-Site Apartments are least restrictive, individual apartments for youth 17 years or older. Usually private landlords, supervision daily for one week, then once or twice a week. Rent paid for, stipends for food and personal items, youth take over payments after emancipation and usually take over apartment lease.
2. Supervised Apartments are usually clustered in an apartment building owned by the agency, live-in or overnight staff supervision, daily attention, supervision counselling and youth can assume most responsibilities.
3. Shared Homes are houses where several young people live and take responsibility for the house. May be minimally supervised or there maybe live-in adults.
4. Live-in Adult/Peer Roommate Apartments are rented or owned by the agency, are shared between a young person and an adult or older youth who may be a student who acts as a mentor or role model
5. Specialized Foster Homes have foster parents specially trained to impart independent living skills, for older youth before discharge, they may stay with foster parents after discharge and continue to participate in family life, or may come back periodically.

6. Host Homes are not licensed foster homes but rent rooms to youths, may be family friends, former foster parents, neighbours, or others who have a natural bond with the youth.
7. Boarding Homes are facilities that provide rooms where young people live individually with minimal supervision, good for short-term living needs, some facilities maybe shared.
8. Transitional Group Homes are affiliated with a residential treatment centre, where youths move from the centre to the group home to begin assuming greater personal responsibility and are given greater freedom.
9. Subsidized Housing is chosen by the youths themselves and they are given a stipend pay for rent, food and supplies.
10. Residential Treatment Centres serve larger groups of youths in group or institutional living arrangements. Some may have on-site programs that are less restrictive. In others, they may place youth in scattered site apartments after.

9.3. Independent Living

The reviewed literature pertaining to the topic of independent living included **sixteen** collected articles, **five** of which met the evaluation criteria and are included in this section. These studies and reviews all received four out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8 for evaluation criteria).

Factors Affecting Youth Transitioning from Foster Care to Independent Living
The first study of our best practices is by **Loman, 2000** who did an extensive review of reviews of independent living programs. The study received an evidence-based rating of **four** out of five.

Nurturing Relationships with Kin or Foster Care Parents
Outcomes for high-risk youth after leaving foster care are better when they have strong concrete or emotional support networks which include family members (comprehensive 10 year long study by Westat; 1991). Thee research indicates that being able to rely on kin may be a critical predictor of successfully negotiating early emancipation. Contact with fathers enabled youth to find help and resources on their own Inglehart (1994). Kinship care at last placement enabled successful exit from out-of-home care leading to reunification with family or kin, adoption, or emancipation to independent living Courtney and Barth (1996). A high percentage of those leaving a foster home arrangement keep in frequent contact with their last foster family (87%) (Festinger, 1995).

Ties often remain with families, including extended family members, even when relationships are judged to be so poor that placement permanency goals have been changed from reunification to adoption or independent living.

The following best best practices have been identified:
- Valuing any nurturing relationships with relatives which is supported by outcomes associated with kinship care arrangements
- Exploring resources of families and relatives for all youths in long-term care even in cases where reunification is no longer considered a case goal

Support from family takes the form of:
- Living with family or extended family upon discharge, (38 percent were still living in this situation 2.5 to 4 years later, Westat, 1998)
- Monthly contact with family and relatives
- Families providing emotional support, advising the youth on problems, giving them monetary support

Promoting Education

Finishing high school before emancipation or aging out of foster care is critical. The research shows strong evidence that individuals who have not completed high school before discharge will drop out after discharge, i.e., one study reviewed found 12 to 18 months after discharge from the foster care system, 37% of youth had not yet completed their high school education. The following best practices were identified:

- Valuing programs that promote the education of youths in out-of-home care
- Providing services in the following four core service components saw gains of 3.2 months academic growth for each month of tutoring, earning of more academic credits, higher rates of graduation, reduced dropout rates and maladaptive behavior:
    - ✓ School placement/student advocacy
    - ✓ Tutoring
    - ✓ Counseling
    - ✓ Employment readiness
- Bringing back youths who have dropped out into alternative schools or GED preparation programs
- Providing services that may contribute to the youth's positive educational outcomes including:
    - ✓ Liaisons (consistent contact person for managing educational information)
    - ✓ Tutors/coaches,
    - ✓ College preparation
    - ✓ school personnel regarding foster care issues
- Placing youth in less-restrictive settings while in foster care such as foster homes and transitional apartments results in higher educational achievement (Mech & Che-Man Fung, 1997)

Life Skills Training

The following are examples of specific life skills services currently required in Ohio's state regulations and which are provided to each child in substitute care who has attained the age of 16 years. They can be provided in a variety of ways—through mentors, public agency workers, private agency workers, community agencies, organizations or schools.

- Services are to include:
    - ✓ Daily living skills, including maintaining a residence; home management; shopping; money management; utilization of community services; utilization of leisure time; and personal care, hygiene, and safety
    - ✓ Personal decision-making and communication skills
    - ✓ Evaluating personal educational needs
    - ✓ Planning for a job or career
    - ✓ Securing and maintaining employment
    - ✓ Securing a residence
    - ✓ Planning for health care needs
    - ✓ Building a positive self-image and self-esteem
- Coordinating training in smaller communities requires that this occur across several areas and between different agencies, i.e., The JTPA (Job Training Partnership Act) summer youth employment program run in three rural counties weekly group seminars that emphasized the development of hard skills, such as:
    - ✓ Money management

- ✓ Meal preparation
- ✓ Apartment hunting
- ✓ Interpersonal skills, such as living with a roommate and making decisions

- Reducing the sense of isolation and the stigma of being in out-of-home care by providing opportunities for foster youths in independent living programs to meet other young people in similar situations through such activities as:
  - ✓ Seminars
  - ✓ Camps
  - ✓ Conferences
  - ✓ Reunions--. Such shared experiences may, in fact, be one of the major benefits of life-skills training classes.

Intensive Relationship-Based Services

- Providing smaller caseloads and intensive relationship-based services managed by master IL social workers results in:

Services	Benefits to Youth
• home visits	• more likely to graduate from high school
• work with the families and peers	• have a history of employment
• meet with the youth at least 2x/mth	• be living on their own
• coordination of services	• be self-supportive/employed at case close
• individual services -life-skills instruction and practice, counseling, advocacy, and resource referral	

Employment Training

- Assisting youth to change mentality, attitude or outlook on life is a critical element in becoming continually employed (DeJesus, 1998) and participating in the following activities brings about this change:
  - ✓ Activities that engage and expose young adults with successful role models;
  - ✓ Activities that build self-confidence and self-esteem;
  - ✓ Activities that teach interpersonal and communication skills;
  - ✓ Activities in which young adults feel support and genuine concern;
  - ✓ Activities that help young adults realize their educational objectives; and,
  - ✓ Activities that allow young adults to be of service in the larger community

- Providing the following necessary elements of an effective employment component:
  - ✓ Job search training
  - ✓ Job skills training
  - ✓ Job development
  - ✓ Job placement
  - ✓ Job coaching
  - ✓ Career exploration

Independent Living Skills Training

The second study of our best practices is by **Collins, 2001** who also did an extensive review of reviews of independent living programs. The study received an evidence-based rating of **four** out of five.

Outcomes for youth leaving foster care tend to be poor. The research shows these youth:

- Are more likely to be involved in the criminal justice system (Rogers & Leunes, 1979; Courtney *et al.*, 1998; Berridge and Cleaver, 1987).
- Are at higher risk of teen pregnancy and parenting (Stock, *et al.*, 1997; Boyer& Fine, 1992).
- Have lower reading and math skills and high school graduation rates (Barth, 1990; Cook, *et al*., 1991; Cook, 1994; Fanshel, Finch & Grundy, 1990; Fanshel & Shinn, 1978; Festinger, 1983; Fox & Arcuri, 1980; Jones & Moses, 1984; North, Mallabar & Desrochers, 1988; Zimmerman, 1982).
- Have disproportionately high rates of physical, developmental, and mental health problems (AAP, 2000; Rest & Watson, 1984).
- Are more likely to experience homelessness (Stone, 1987; Cook *et al.*, 1991; Courtney *et al.*, 1998).
- Have higher rates of alcohol and other drug abuse (Stock *et al*., 1997; Boyer & Fine, 1992).
- Have higher rates of unemployment and likelihood of dependence on public assistance (Cook, 1989; Cook, 1994; Triseliotis & Russell, 1984; Courtney *et al.*, 1998).

Preparing to live independently is a difficult transition for any youth but for youth transitioning out of foster care becoming self-sufficient must be overwhelming. Collins (2001) states that in order to prepare for living self-sufficiently, these youth must develop an understanding of, and build skills needed to:

- Pursue or complete their education or vocational training
- Obtain and maintain employment (e.g., learn how to prepare a resume, conduct a successful interview, develop on-the-job skills, communicate effectively with supervisors)
- Locate and maintain affordable housing (e.g., learn where to look for an apartment and how to complete a lease)
- Manage their money and keep a budget
- Cook meals, keep house, and perform other "daily living" routines
- Access health care and community services.

A study by Westat (1988) remains the most comprehensive research analyzing the effects of independent living services using regression models. The study lacks a comparison group and findings were somewhat limited in terms of best practice concluding that adolescents aging out of the foster care system, in general, have poor outcomes and that those involved in independent living programs have slightly better outcomes.

The study examined the impact of the independent living skills on such core areas as money, credit, consumer skills, education, employment, socialization, health, family

planning, locating housing, and home management. Positive effects were found in employment, health care, cost to the community, overall satisfaction with life, and a composite measure of self-sufficiency. The likelihood of achieving better outcomes occurred when clients received training in more of these five core areas. The following best practices were identified from the Loman study:

- Services work best when a set of particular services are targeted to meet specific goals (Westat, 1988)
- Independent living programs result in program participants being more likely to live independently or pay all of their housing expenses 1-3 years after leaving care (Lindsey and Ahmed, 1999)
- Consistent training in five core areas listed below has positive consequences in the lives of youths (Westat, 1991):
    - ✓ Ability to maintain a job at least one year
    - ✓ Ability to access health care when needed
    - ✓ Whether the youth was a cost to the community (on welfare, in jail, or on Medicaid
    - ✓ Presence of a social network
    - ✓ Overall success as measured by the sum of the previous outcomes

    (three outcomes did not have significant outcomes, these were: high school graduation, young parenthood and satisfaction with life)
- Providing universal, rather than targeted, programming and policy approaches reduces stigmatization of these youth

Scattered-Site Semi-Supervised Apartments

The third study of our best practices is by **Johnson et al., 1998** who created a report for the U.S. department of Health & Human Services called a 'Compendium of Critical Issues and Innovative Approaches in Youth Services'. This report received an evidence-based rating of **four** out of five.

The report evaluates and describes the Lighthouse Youth Services program that includes transitional and independent living services for Cincinatti youth. One aspect is the Gateway apartments component, a network of supervised living arrangements for "nonsystem" homeless youth (elaborated upon in the 'Shelters & Transitional section), and the other aspect is the Lighthouse independent living component which is made up of scattered site semi-supervised apartments. Lighthouse is responsible for paying rents, providing a steady flow of renters, enforcing strict rules on number and hours of visitors, providing staff on-call 24hours, 7 days a week, 365 days of the year, covering damage and cleaning units at end of lease, evicting youth renters if needed, and supervising and assisting renters. Lighthouse developed a comprehensive risk-management strategy that has resulted in a 10-year program track record free of litigation. The underlying assumptions of the scattered site approach are:

- The personal space provided is central to empowering youths by giving them control over their lives
- Youth will be happier and progress more quickly if they can choose the neighborhood and actual location that best meets their educational, employment and family needs

- When living alone youth learn best by actually doing, making their own decisions and experiencing responsibility for day-to day-activities
- Youth learn that their ideas have to be self-generated, not a response to the presence of a caregiver or enforcer
- Youth will experience a smoother transition to self-reliance through a program model that allows them to keep the apartment, furnishings and security deposit after they leave the program
- The organizations energies and resources are best diverted to youth, not the purchase and maintenance of properties
- The size of the program should be flexible, depending on the need of youth and this model allows for easy expansion or decrease in number of apartments
- Incorporating public/private partnerships into the program enhances goodwill and support, landlords were willing to rent to Lighthouse as rent and strict rules for youth was guaranteed

Promising Practices: Supporting Transition of Youth Served by the Foster Care

The fourth of our best practice studies is by **Muskie et al**., **2000** who looked extensively throughout the U.S. for Promising Practices: Supporting Transition of Youth Served by the Foster Care and the study received an evidence-based rating of **five** out of five. The author surveyed 98 independent living programs.

For youth in out-of-home care, life skills instruction efforts need to be both specific and intentional because most have not had consistent parenting or education and will not be able to gradually assume responsibility for themselves as they move into their mid-20's. For these youth, "childhood" will abruptly end at age 18 or 21. When programs have a clearly defined life skills instruction component, it is more likely that essential life skills will not be overlooked.

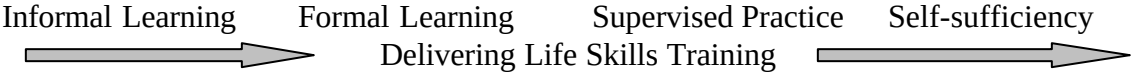
The following best practices were identified:

- Over 90 percent of programs surveyed indicated they directly deliver services in the following life skills areas:
    - ✓ Employment skills
    - ✓ Money management
    - ✓ Communication
    - ✓ Decision-making
    - ✓ Locating housing
- When programs provide real-world practice experiences, youth have the opportunity to internalize and personalize what they have learned about a skill and feel confident in the ability to use this skill in the future
- Programs that promote educational stability and approach education in a comprehensive, integrated manner are most likely to promote the completion of high school and encourage enrollment in post-secondary education
- Programs should include educational supports aimed at helping youth achieve:
    - ✓ Access to necessary educational resources, e.g., educational advocate
    - ✓ Increased literacy
    - ✓ Selection of a career field or sectors of interest

  - ✓ Participation in an educational/vocational program
  - ✓ Completion of an educational/vocational program
- Support for post-secondary education are only happening in states that support youth through age 21 or in programs with private endowments. 70 percent or more (71%-87%) of the programs provide the following educational supports:
  - ✓ help youth access necessary educational resources
  - ✓ provide assistance with financial aid forms
  - ✓ help selecting careers
  - ✓ provide assistance in beginning an educational/vocational program
- One-third to more than one-half of programs (36%-57%)provide:
  - ✓ assistance in completing an educational/vocational program
  - ✓ tutors to assist with education;
  - ✓ educational advocates;
  - ✓ provide postsecondary education/counseling;
  - ✓ financial aid or assistance; and,
  - ✓ services to increase literacy.

Tangible and Intangible Life Skills

Dorothy Ansell describes a four-stage continuum that enables youth in Independent Living Programs to move through a series of phases to acquire tangible and intangible skills.



throughout the four-stage continuum gives youth the flexibility to move through the continuum based on their own developmental needs and individualized independent living goals

Caliber Associates reported that between 1987 and 1996, state Independent Living Programs provided services that addressed both tangible and intangible skills.

Tangible Skills

- educational
- vocational
- Money management
- Home management
- Use of community resources

Intangible Skills

- decision making
- Problem solving
- Communication
- Time management
- Conflict resolution
- Social skills

Programming/ Services

- Assisting youth in identifying a mentor, relative, or staff member who can provide on-going support after discharge
- Assisting youth in establishing/re-establishing or working through redefining their relationships with family of origin prior to discharge

- Assisting programs in operationalizing the youth development philosophy in agencies and programs
- Expanding life skills training to provide greater focus on vocational training, computer training and driver's education
- Providing youth who are struggling educationally and who do not plan to pursue post-secondary education with the educational support necessary to complete a high school degree or GED
- Completing and review life skill assessments with youth
- Provide "real world" opportunities for youth to practice life skills

Evaluation and Data Collection/Reporting

- Muskie et al. (2000) surveyed 98 independent Living programs and all indicated an interest in measuring and evaluating youth outcomes: The following evaluation practices were identified:
  - ✓ Affiliated with and evaluated by Boys Town
  - ✓ Alumni Study (two programs)
  - ✓ One evaluation of last four years of work aimed at doing a long-term evaluation
  - ✓ Employment is tracked to comply with HUD requirements
  - ✓ Evaluate strengths/weaknesses of youth's program experience
  - ✓ Evaluate progress of teens through mentor progress reports
  - ✓ National level which is difficult to apply or utilize in our office
  - ✓ Tracking of program indicators monthly

Improving Program Effectiveness

- Improving program effectiveness and youth outcomes reporting (Caliber Associates) can be achieved by:
  - ✓ Building provincial capacity in collecting and analyzing outcome data through training and technical assistance to identify ways to track youth over time
  - ✓ ? ? Developing guidelines for annual collection of a select and well defined group of outcomes that reflect mastery of skills, education, employment, housing attainment and other indicators of self-sufficiency
  - ✓ Encouraging states to track and report the progress of youth in meeting goals specified in their individual needs assessments and case plans related to independent living
  - ✓ Supporting longitudinal studies by external evaluators to provide needed insight into the effectiveness of various ILP services and their long-term impact on youth self-sufficiency
  - ✓ Conduct additional research to assess ILP staffing issues, understand causes and consequences of ILP Coordinator turnover, and develop a list of appropriate ILP staff
  - ✓ Competencies
  - ✓ Encouraging programs to document their activities
  - ✓ Assisting programs in identifying and utilizing those data collection and evaluation tools that do exist
  - ✓ Developing a common language to define the services provided and create uniformity of reporting

- ✓ Assisting programs in developing and using a standardized reporting tool that measures short-term and long-term outcomes for youth

Training of Staff

- Inter-agency training needs to encompass all involved parties including administrators, caseworkers, foster parents, and all outside service providers. Some states also reported training child welfare and other public agency staff, juvenile corrections/probation staff, school counselors and community volunteers. Among the training topics reported were examples such as:
  - ✓ Youth Assessments - practice and procedures
  - ✓ Skills for success
  - ✓ Separation, attachment and bonding
  - ✓ Handling grief and loss issues
- Programs should include an on-going training component that:
  - ✓ Orients new staff & care providers to IL/ YD philosophy
  - ✓ Provides continuing education for experienced staff & care providers
  - ✓ Encourages staff & care providers to develop new knowledge and skills
  - ✓ Educates the community, e.g. schools, employers, about the needs of youth while in transition.

After Care Services

- Important aftercare components include assistance in providing basic needs such as housing, financial assistance, and employment services and supports. Other important aftercare components are community connections, social service support systems, a continuum of housing options, and an open-door policy:
  - ✓ Providing Temporary medical coverage/health care
  - ✓ Providing temporary financial assistance for the first few months setting-up expenses
  - ✓ Providing temporary housing as many youth experience at least one period of homelessness
  - ✓ Providing help in establishing and maintaining own living arrangements until sufficiently skilled to maintain their living arrangement without assistance
  - ✓ Providing opportunities for youth to talk to others about the difficulty of trying to live on their own on minimum wage
  - ✓ Providing crisis counseling enables youth to get help when they are having difficulty coping with situations which may become serious/life-threatening
  - ✓ Providing information and referral allows youth to know where to go to get the help he/she needs. With the right information, he/she can handle a situation alone
  - ✓ Sharing their life lessons with current program participants can be therapeutic for the young adult and the younger youth who is listening
  - ✓ Providing support for youth during the transition to permanency with someone who knows them and cares about them is important This person is the young adult's lifeline as they go about making new friends and re-establishing family connections

Mentors Assist Youth in Becoming Independent

The fifth study of our best practices is by the Mech et al. (1995) who visited and studied 29 mentoring programs across the United States that served adolescents in foster care. The study received an evidence-based rating of four out of five (refer to Section 1. 5.2 page 8 for evaluation criteria).

Support programs which assist youth in foster care to graduate is critical as about a third to two-thirds of youths in foster care do not graduate (Fanshel et al. 1990; Mech, 1996; Festinger, 1995; Barth, 1994). In addition, assisting these youth in training for higher paid jobs is essential as many work close to full-time (38-70% in the various studies) for an annual salary of $10,000.00, far below the poverty level (Barth, 1994; Cook, 1993). Reducing the number of young parents is important because overall, the chance of public aid use by former foster wards is 40%-50% with females being more of a cost to the community because 43%-65% are young parents (Festinger, 1995; Barth, 1994).

Five mentoring program models emerged from this research and are best practices identified from this study:

- *Transitional life-skills mentors* provide young people with social support, friendship and serve as role models in making the transition from foster care to independent living. The mentors are recruited from a wide variety of community organizations and settings. They are typically older than 21 years of age and are matched with receptive youths in foster care. This was the most common type of mentoring
- *Cultural-empowerment mentors* are recruited from the same cultural or ethnic group as the youths. The fundamental idea is to offer each youth a positive role model from her or her minority group and a means of overcoming the negative messages about the group from the general society. These mentors are found in specific target populations and cannot be recruited through general advertising in the community.
- *Corporate-business mentors* come from the business community and provide jobs, monitor work experience, and offer career development to adolescents in foster care who are motivated to participate. Businesses are recruited that in turn offer the mentors to the youths. The social agency acts as intermediary facilitating the relationship.
- *Mentors for young people* are experienced mothers matched with a young pregnant female. The mentors under this model endeavor first to assist, instruct, and encourage the girls regarding child rearing and then to guide them toward self-sufficiency. The goal is to help the girls avoid abusing or neglecting their own children in the future. Recruitment in the Akron, Ohio program was a problem at first and was accomplished via a human interest newspaper story on the program published on Mother's Day, that resulted in a flood of volunteers.
- *Mentor homes* are four to six adolescents placed with an adult mentor. The program works with at-risk youth, and the mentor is responsible for guiding the youths in relation to education, employment, community services and so on. The mentors are usually college students who live in the homes. Beside teaching basic living skills they serve as positive models to the youths of behaviors in which the youths themselves are usually engaged, such as getting to school and work on time and studying for classes.

10.3. Youth/Family Mediation & Reunification

The reviewed literature pertaining to the topic of Youth/Family Mediation and Reunification included **twelve** collected articles, **five** of which met the evaluation criteria and are included in this section. These studies received three -four out of five for typology rating, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8 for evaluation criteria).

Differences among homeless Youth and Factors Affecting Reunification

The first of our best practices study is by **Thompson et al., 2001** who examined the differences among runaway--homeless, throwaway, and independent youths and the demographics, personal characteristics, and family factors which predict youth's reunification with family. The study received an evidence-based rating of **four** out of five.

Thompson et al. (2001) cite Finkelhor et al. (1990) who suggest that in the U.S. up to one million youth runaway or are forced to leave their parental home each year. In order to set the context of why youth /family interventions are needed, a study by Thompson et al. (2001) is briefly reiterated here and has been examined in more depth in the section of this document called *Emergency Shelters and Transition Housing.*

Homeless Youth Reunifying with Family Do Better

Thompson et al. (2001) state that a number of these youth find themselves in community-based youth shelters which offer the primary method of intervention for runaway youths and are mandated to reunify youths with their families. Once discharged from youth shelters, Bass, (1992) found that more than one-half (53 percent) of the runaway youths return to their parent's home. Although youths report difficulties in their homes, recent studies have shown that those who reunify with their families have more positive outcomes than those finding housing in other locations leaving the shelter. In an exploratory study of homeless or runaway youths in a large Midwestern city, researchers found that youths who returned to their parental homes after a shelter stay reported more positive outcomes in school, employment, self-esteem, criminal behavior, and family relationships than adolescents discharged to other locations (Thompson, Pollio, & Bitner, 2000). Similarly, other research has demonstrated that youths who failed to reunify with their families had longer shelter stays, increased hopelessness, and suicidal thoughts and behaviors; reported more family problems; and had a more pessimistic view of the future than those who returned to their families (Teare, Furst, Peterson, & Authier, 1992; Teare et al., 1994).

Risks to Homeless Youth

Because runaway adolescents typically lack the skills and education necessary to obtain and maintain gainful employment, they often are forced into prostitution, drug dealing, and other criminal behavior to survive (Greene et al., 1997). Life on the street also can have "deadly consequences" because these adolescents are at significantly increased risk of serious health problems such as malnutrition, sexually transmitted diseases, and

premature death resulting from suicide, murder, and drug overdose (Powers, Eckenrode, & Jaklitsch, 1990).

Tyler et al.(2001) state that the high rate of victimization experienced by homeless and runaway youth, especially females, suggest the need for early interception and intervention. Tyler et al.(2001) quote Hagan & McCarthy(1997) as saying that due to the small number of options available, many homeless youths engage in criminal activity when they lack food or money or when trying to find shelter. Interventions that will be successful are those that address the broader matrix of problems that these young people present and face (Cauce et al., 1998). Whatever the interventions, it is still best to connect with these youth as quickly as possible, as the longer they are away from home, the less likely they are to be able to reintegrate into family life.

Shelters Have Mandate to Reunify Youth with Families

Community-based youth shelters are the primary method of intervention designed to meet the complex needs of adolescents who leave home before possessing skills to live autonomously. These shelters provide a variety of crisis and custodial services and have a stated mission to reunify youths with their families or to teach them the skills to live independently and reduce the likelihood of involvement in high-risk behaviors (Johnson, Farquhar, & Sussman, 1996; Shane, 1989). Thompson et al. (2001) states that one of the most salient factors that predicted youths returning home across all subgroups of youths was completion of services. This reflects the focus of shelters' mission to reunify families and suggests service effectiveness..

Reducing Family Conflict and Increasing Family Preservation

Reducing family conflict is one way to try to keep these youth at home as long as possible. For every year delayed in getting involved in substance abuse and leaving home, there is a 10% increased chance of transitioning safely to adulthood. Long & Adams (2001) quote Montemayor (1983) as saying that the reported incidence of serious parent-adolescent conflict may be as high as 15-20%. Elevated levels of conflict and negative family communication have been associated with a number of adolescent problem behaviors including drug use, higher rates of school drop out, running away from home, suicide, and delinquency (Bachman, Green & Wirtanen, 1971;Gotlieb & Chafetz, 1977;Montmayor,1983). High degrees of parent conflict also have been associated with adolescents who have conduct disorder (Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998, oppositional defiance disorder (Robin, Koepke & Moye, 1990) and attention deficit/hyperactivity disorder (Barkley, Guevremont, Anastopolous, & Fletcher,1992).

Preservation of families and intervention treatments to mediate parent/youth conflict have been a focus in the U.S. since the 1970s. There has been a reluctance for family support workers and agencies to place children outside of the home, even in desperate situations. Corcoran (2000) finds the reason for this in a quote by Nelson,Landsman, & Deutelbaum (1990), namely, it is because of “the human cost involved in child placement because of the centrality of the parent-child attachment bond in terms of trauma, loss and stigmatization”. Family preservation is at the heart of most interactions between service

providers and high-risk families and family-based prevention and intervention programs have been the focus of helping these at-risk youth.

Family-Based Prevention

The second of our best practices study is by **Hogue & Liddle, 1999** who examined a family-based, developmental ecological preventive intervention for high-risk adolescents and received an evidence-based rating of **four** out of five. The authors state that family-based prevention is beginning to achieve widespread recognition as a necessary component of comprehensive prevention planning (Hogue & Liddle, 1999; Kumpfer & Alvarado, 1995). However, enthusiasm for including parents in prevention efforts has been considerably dampened by the numerous recruitment obstacles and modest recruitment successes encountered by most programs (Durlak, 1997). The biggest dilemma facing those involved in providing services to high-risk families is the difficulty in recruiting parents into prevention and intervention programs. Hogue et al. (1999) state that although many programs covet parental participation, few have demonstrated the ability to outreach, recruit, and engage parents in a meaningful way.

Recruitment of High Risk Parents

Recruitment of high-risk parents has become a major focus in time and resources, easily as much as the intervention and prevention programs themselves. Despite such deterrents in recruiting these parents, family-based programs have persevered in their struggles to recruit parents and families, and they have featured diverse outreach strategies. Many programs establish affiliation with local schools to anchor outreach and recruitment (e.g., Dadds, Spence, Holland, Barrett, & Laurens, 1997; Dishion & Andrews, 1995). This facilitates access to populations by providing (a) information for contacting families (phone numbers and mailing addresses), (b) direct referrals of some children exhibiting academic and behavior problems, and (c) an initial level of credibility with most parents. Other programs develop outreach operations within community organizations--churches, adolescent recreational centers, and social clubs frequented by parents (e.g., St. Pierre & Kaltreider, 1997). Still other programs rely on third-party referrals from medical institutions or social welfare agencies (e.g., Beardslee et al., 1993).

Various prevention sources have nominated the following strategies for recruiting families in an effective manner. First, programs and organizations that maintain close working ties with local community leaders tremendously enhance recruitment efforts (Dusenbury & Diaz, 1995; Peterson, 1995), as this offers a higher degree of community visibility and acceptability. Second, acceptability is also boosted by featuring culturally congruent interventions and by employing staff with ties to the community (Springer, Wright, & McCall, 1997) as well as employing former participants and other parents to advocate for the program (Laudeman, 1984). Third, recruitment staff should be specially trained for, and devote a significant portion of their time to, the arduous task of recruitment (Prinz & Miller, 1996). Fourth, participation incentives and provision of funds to counteract barriers to participation (e.g., transportation fees, on-site child care) are indispensable catalysts for reliable participation (Prinz & Miller, 1996).

1. The parent identifies worrisome behavior by the child such as academic deficiencies or oppositional conduct. In these instances, the recruiter elicits specific details about these problems and builds intensity by validating the parent's concerns and interest in the child's well-being. The recruiter then attempts to personalize the program by matching specific program services to identified problems (e.g., "Here is how we might address that problem together in our program"). Recruiters should avoid talking in non-informative generalizations about the problem or the program.
2. The parent presents no current problems with the child but does express concern about problems or challenges that may develop as the child gets older. Again, the recruiter attempts to elicit specific details about the nature of these concerns and avoids making assumptions about what the misgivings may be. When more specific details are voiced by the parent, the recruiter proceeds with validating these concerns, discussing concretely how the program might address them, and pointing out how increased knowledge about normative adolescent development (a key ingredient in prevention programs of all kinds) can alleviate some of the uncertainties parents face when raising children.
3. The parent presents no immediate problems or concerns and is extremely confident in his/her ability to handle parenting challenges as they arise. In this case the recruiter begins by acknowledging the parent's capacity to navigate various developmental transitions that children and families experience. Recruiters then stress that the program is not meant for "bad kids" or "parents in crisis." Instead, the program works with successful families to provide extra support and review parenting strategies during a time when kids face mounting pressures and negative influences of many kinds. The program is presented as an opportunity to solidify existing family strengths in order to protect against negative influences and ensure the child will stay on track.

Family-based prevention has emerged as a promising intervention modality for addressing the complex web of ecological influences that give rise to the initiation of severe behavior problems (Hogue and Liddle, 1999). The impact of family-related factors on the development of antisocial behavior is now well documented. Disruptions in family management practices (Patterson, 1986), high rates of conflict and low rates of communication and involvement (Baumrind, 1991), and lack of parental investment in and attachment to their children (Brook, Nomura, and Cohen, 1989) all create vulnerability to various problems in youth. In contrast, positive parenting practices such as supportiveness and behavioral monitoring foster psychological well-being and insulate children against negative environmental influences (Steinberg, 1990).

Multidimensional Family Prevention
Liddle and Hogue (2000) go on to say that family-based intervention models have considerable empirical support for treating existing childhood disruptive and antisocial behavior(Center for Substance abuse Prevention[CSAP], 1996) and adolescence substance abuse (Liddle & Dakof, 1995) and preventive interventions have also demonstrated success in preventing adolescent drug use (Bry, Catalano, Kumpfer,Lochman, & Szapocznik, (1998) and violence (Borduin et al., 1995).

Liddle and Hogue (2000) introduce Multidimensional Family prevention (MDFP) a family-based intervention designed to prevent the on-set of drug-use and delinquency in

high-risk adolescents. The theoretical premises, conceptual framework, and intervention principles of MDFP are derived from multidimensional family therapy (MDFT; Liddle, 2000), an empirically supported treatment for adolescent drug abusers. MDFP combines the curriculum-based and protection focused methods of standard prevention with the assessment-based and symptom-focused methods of psychotherapy.

Liddle and Hogue (2000) cite Hawkins et al., (1992) who have reviewed the empirical research on risk and protection and found that bonding to family and bonding to prosocial factors are pivotal for protecting youth from antisocial outcomes. MDFP sets out to achieve two fundamental prevention goals for every family: 1) helping the adolescent achieve a redefined interdependent attachment bond to parents and the family, and 2) helping the adolescent forge durable connections with prosocial institutions such as schools, recreational programs, and religious institutions. Academic success and investment in school (Steinberg, Elmen & Mounts, 1989), involvement in recreation activities (Mahoney & Cairns, 1997) and association with prosocial peers (Parker, Rubin, Price, & DeRosier, 1995) all insulate adolescents against behavioral problems.

MDFP is very intensive and costly because sessions occur with single families directly in their home and the counselor is highly trained with a master's degree and preferably two years post-graduate experience and does all the face-to face meetings with various agencies for the family. The services take from 3-6 months, each family receives 10-25 sessions which take place in person, or occasionally by phone 30-90 minutes. Liddle and Hogue propose that MDFP should only be used with adolescents exhibiting the highest risk profiles to substantiate costs. The MDFP program follows the following steps: assessing risk and protection domains and setting an individualized prevention agenda; looking at family relationships, school involvement, prosocial activities, peer relationships, drug issues, cultural themes, adolescent health and sexuality. The most difficult task is to recruit the parents. The counselor coaches the parents and adolescent to communicate more effectively with each other, this is practiced during individual sessions and then "played out" in a rehearsed communication session. The counselor is highly trained and able to pinpoint areas of need by assessing five modules:

- "Adolescent module" looks at their interests and developing an inventory of personal assets
- "Parent module" is very broad and an ecological view of parenting is essential for developing sensitivity to the life circumstances of parents (Luster & Okagaki, 1993); the counselor needs to identify the stressors in the parents lives, determine how the adolescent and children can be shielded from the effects of these stressors, and help parents access various resources for themselves and their family,
- "Interactive module" looks at developing motivation, skills and experience to modify interpersonal bonds and interact in more adaptive ways,
- "Extended family module" looks at relationships possibilities with siblings, estranged parents or adult relatives
- "Extra familial module" looks at ways to help parents be involved in their adolescents lives at school, extracurricular lives, getting to know friend, friends parents, etc..

Effective Engagement of Families in Child Welfare Services
Dawson & Berry (2002) looked at ways to better engage families in child welfare services. Drop-out and non-compliance rates in child welfare services are high and lead to high removal of children from their families and to eventual termination of parental rights. The authors looked at effective engagement strategies including service components and caseworker qualities and behaviors. They quote Gaudin (1993) as saying that "successful mobilization of outside resources to meet the family's identified priorities helps to overcome the family's hopelessness, resistance, and distrust of professional helpers". The authors found that caseworker and agency behaviors, rather qualities, appear to be the most important in engagement of clients in child welfare services. Although empathy and respect are certainly important in building a working relationship, these qualities are best communicated in a non-punitive and supportive manner through clear and concrete behaviors between the caseworker and client, such as: setting of mutually satisfactory goals, providing services that clients find helpful, focusing on client skills rather than insights, and spending sufficient time with clients to demonstrate skills and provide necessary resources.

Family Based Empirically Supported Treatments
Our third best practices study is by **Alexander et al. , 2000** who reviewed FBEST programs (Family-Based, Empirically Supported Treatments) with respect to intervention with older more seriously at-risk youth and received an evidence-based rating of **four** out of five. Treatment programs that effectively change maladaptive behavior, represent a class of interventions that share common factors of working with family units (no matter how dysfunctional) as a unit and as it exists in the community. They reviewed and rated the following FBEST programs:

FBEST	RESULTS of REVIEW
• Brief strategic Structural Family Therapy (BSFT)	Significant reductions in youth behavior problems improved family functioning over time (Szapocznik et al. 1989)
• Various FBESTs studied	Produced significantly higher rate of treatment engagement and drug use reduction than non-family therapies (Stanton & Shadish, 1997)
• Family based Multisystemic Therapy (MST)	Family cohesion and reduction in youth arrest incarceration and institutionalization. It is considered a "Blueprint" for effective intervention in "Blueprints for Violence Prevention" (Delbert & Elliott, 1998).
• Functional Family Therapy (FFT)	Significant reductions in arrest rates 6-18 moth follow-up. Also lengthy follow-up rates – 5 years (Gordon, Graves & Arbuthnot, 1995). Manuals and training protocols created (Sexton, Alexander, & Harrison, 1998).

• Multidimensional Family Therapy (MFT)	55% reduction in drug use (Parker et al. Under review)

Scales (1997), points out that parents play important, continuing roles as sources of support, caring, control, and values for youths (Rice & Mulkeen, 1995; Steinberg et al., 1991). Rather than needing to break away from their parents, adolescents, especially young adolescents ages 10 to 15, need continued attachment and connection to their parents, albeit with renegotiated definitions about freedom and self-regulation (Grotevant & Cooper, 1985; Henry, 1994; Scales, 1991; Small & Eastman, 1991). The significant physical, cognitive, and socio-emotional changes young adolescents experience as they go through puberty present for parents and those who work with adolescents numerous potentially issues such as the nature of appropriate authority and discipline, adolescent demands for privacy, the implications of adolescent sexual maturation, and differences in parent/adult-adolescent values and expectations (Feldman & Elliott, 1990).

Developing External and Internal Assets in Youth
Early adolescence is a crucial period during which community resources can have a positive impact on young adolescents and their families. The middle-school years are recognized as the last best chance for communities to ensure that adolescents have the crucial assets they need for experiencing positive development and avoiding problems such as early sexual involvements, alcohol and other drug abuse, and school failure [Carnegie Council on Adolescent Development 1989, 1992; Scales 1996, 1991].

Since 1989, Search Institute has conducted studies of youth assets that have now involved more than 400,000 youths in grades six to 12 in more than 600 communities [Benson 1997, 1996, 1993; Blyth 1992]. Analyses have shown that the more of these external and internal assets that adolescents have, the fewer the risky behaviors in which they engage (e.g., substance abuse, frequent sexual intercourse, delinquent behavior) and the more likely they are to experience positive outcomes.

External and Internal Assets (Benson, 1997; Benson et al., 1995)
External Assets (relationships and opportunities provided to youths)
- Support (e.g., care and communication provided by parents and other family members)
- Empowerment (e.g., youths given useful roles; feel safe and valued)
- Boundaries and expectations (e.g., parental monitoring and discipline; parents and teachers set high expectations)
- Constructive use of time (e.g., family influence on after-school activities and religious involvement)

Internal Assets (values and skills developed by youths)
- Commitment to learning (e.g., doing homework and being motivated to achieve);
- Positive values (e.g., helping others and delaying sexual activity)
- Social competencies (e.g., planning and decision-making skills)
- Positive identity (e.g., personal power; sense of purpose)

Collaborating Resources in Communities to Strengthen Family Support
The fourth of our best practice studies is by **Scales, 1997** who looked at the training level of 659 family support workers (surveyed from a potential pool of over 6,000). The study received an evidence-based rating of **four** out of five.

In looking at the results of this survey, Scales (1997) states that it is promising that more than 75% of the family support workers surveyed said they needed to do more to meet the needs of young adolescents and their families. They especially wanted to provide more personal growth instruction services in areas such as peer counseling and communication skills, as well as more mentoring programs and community service opportunities. The family support workers did very little in the way of in-depth collaboration and two aspects of collaboration were identified as needing development:

- The first is creating stronger partnerships with youth development organizations that have as their focus not just preventing problems and risky behaviors, but promoting positive youth development by building youths' developmental assets. The YMCA of the U.S.A., for example, is a traditional youth-serving organization that recently commissioned a two-year study of how it could strengthen and justify its youth programming and its accountability by more intentionally focusing on building youths' assets [Leffert et al. 1996].
- Second, more family support programs should have the kinds of significant roles in community building that comprehensive family resource centers already have in many communities. When resources collaborate intentionally enough across all the community's sectors, success in supporting families and youths is more likely than it is in narrower efforts that work with families but do not try to mobilize the community for more systemic change [Bogenschneider 1996; Stone 1996]. Recognition of this reality is one reason why nearly 200 communities across the country are now involved in Search Institute's "Healthy Communities Healthy Youth" initiative. This initiative seeks to motivate and equip communities to nurture competent, caring, and responsible children and adolescents by helping individuals and organizations to collaborate across sectors and take both formal and informal (personal) actions to build youths' assets [Benson 1997].

Preventing Juvenile Delinquency
The fifth in our best practices studies is by **Kumpfer, 1999** who examined exemplary parenting and family strategies for delinquency prevention. The study received an evidence-based rating of **three** out of five.

Kumpfer states that although fewer crimes are being committed, the juvenile arrest rate has grown by 20% since 1991. According to the FBI about 2.7 million juveniles were arrested in 1995, which is 18% of all arrests. Additionally, in 1994 more than 1.5 million delinquency cases were processed in juvenile courts in the United States representing a 41% increase in cases since 1985 (Butts, 1996). When looking at numbers of youth involved it is only a small percentage (approximately 16% to 23%) of delinquents who are serious, chronic offenders (Shannon, 1991; Snyder, 1988), they account for about

50% to 60% of all juvenile offences and about 75% of all violent juvenile offences (Huizinga, Loeber, & Thornberry, 1995).

According to a poll of police chiefs, 85 percent of chiefs want major changes in current policies related to this area and 47 percent want to see more efforts in education, prevention, and treatment (Fox, 1996). Only 21 percent gave a higher priority to law enforcement strategies. Many prominent correctional specialists agree with prevention specialists that longer-term solutions are required to prevent the problems of delinquency.

Kumpfer points out that lack of supervision and monitoring appears to be particularly salient as a cause of violent offences. Violent crimes peak just after the close of school at about 3:00 p.m. (Snyder & Sickmund, 1995) suggesting lack of parental supervision and latch key status. The Carnegie Council on Adolescent Development (1994) study found that about 40 percent of adolescent's non-sleeping time is spent alone, with peers without adult supervision, or with adults who might negatively influence their behavior.

Recent research and theory has focused on the processes by which family poverty leads to violence and delinquency in individuals who live in public housing and lower-income neighborhoods (Aber et al., 1992; Gonzales et al., 1996).

One other interesting risk factor deals with the source of income as well as who within the family is earning the income. Increases in female income can have quite different effects on violence than increases in male income. Violence in the family is lower when the male is employed for a significant proportion of the time, while changes in female employment generally have an insignificant effect on violence, no matter what the level of income. Additionally, studies have found that children from families without an adult male in the home rely on the influence of peers and other socializing agents as their primary reference (instead of the family) at an earlier age (by age 8) than other children. This reality calls attention to the limits of the family's influence on delinquency and violence (Hawkins & Weis, 1985).

In B.C., the Centre for Conflict Resolution offers a large variety of mediation courses, one is the parent teen mediation service run out of the counseling centre at the University of British Columbia. It is free and is run by a trained mediator with training in Conflict resolution at the Justice institute of B.C. and a New Westminster Secondary Student who has had two years training and experience with Peer Mediation and Conflict Resolution.

Using Peer Mediation to Reduce Conflict at School

The last in our best practices study is by **Silver & Vermander, 2001** who looked at three organizational models of peer mediation programs in the U.S: the total school model, the elective course model, and the student club model. This study is unpublished, therefore, has not been rated but is seen as a **promising practice**.

In addition to conflict at home many youth experience conflict at school and it may well be that peer mediation at school helps to prevent some of the school stressors that might

contribute to youths choosing to runaway and/or becoming homeless. In the U.S., in excess of 10,000 schools and community groups are presently using peer mediation as a means to resolve conflicts among youths. In most middle and high schools the student club model is most widely used.

To initiate a peer mediation program, schools need to: a) Get support for a program and a coordinator from the teaching/counseling staff b) Select and train peer mediators and promote the program. The authors describe numerous peer mediation programs: Winning Against Violent Environments (WAVE) in Cleveland, Ohio is one of the oldest programs in the U.S. beginning in 1982; Resolving Conflict Creatively Program in Atlanta High Schools(RCCP) revealed a one-third reduction in in-school suspensions and a 17.2 percent reduction in out-of–school suspensions, whereas other Atlanta schools not involved in the program saw a 16.8 rise in in-school suspensions and also a s5.8 percent rise in out-of-school suspensions during this same time; Metropolitan Toronto Separate School Board implementation of peer mediation programs and found an increase in self esteem among peer mediators and 80% of parents and 88% of teachers felt peer mediation had a positive effect on the mediators and taught responsibility and gained confidence; in Manitoba a survey of 319 high school students revealed 90% success rate in disputes; Schools Teaching options for Peace at the Walt Whitman Intermediate School in Brooklyn, by the end of year four they saw the number of school suspension decrease from 27 to 15 per month; In 1992 violence prevention programs in 100 New York City schools are credited with a reduction in classroom fights by 71%; The Common Ground at Urbana middle school, in Urbana Illinois.

The Common Ground program guide sets out the following steps for the peer mediation process (which Silver and Vermander describe in detail):

- Open the session
- Gather information
- Focus on common interests
- Create options
- Write the agreement and close

11.3. School-Based Services

The reviewed literature pertaining to the topic of School-Based Services included **fourteen** collected articles, **seven** of which are included in this section. These studies and reviews received three-four out of five for typology ratings and one promising practice (see Section I. 5.2, page 8).

School Linked Health Centres

The first of our best practices study is by **Fothergill and Ballard (1998**) who looked at the benefits of school Health Linked Centres for adolescents and received an evidence-based rating of **four** out of five. The authors state that for those youth who have not received interventions by high school, School-linked Health Centres (SLHCs) provide easy access to adolescents in school and are also able to reach dropouts, homeless, runaway youth, those in detention centres, shelters and other social service programs (Fothergill and Ballard, 1998).

Fothergill and Ballard (1998) state another major benefit is that SLHCs are free to determine services offered based on needs of the adolescents within their population without being affected by school control which is often restrictive, e.g., regarding sexual health. School-Linked Health Centres have been successful in providing reproductive health care to prevent pregnancies and sexually transmitted disease among adolescence.

Adolescents have multiple and diverse needs and yet data shows this population under uses the health care system. One of the reasons for this is fear of others finding out about their health issues and in fact, adolescents report that the most important attribute in health care providers is the quality of "trust" to ensure confidentiality. A second major reason adolescents avoid using a variety of health services is a problem with being able to access these services. In order to better meet adolescence health service needs many communities have established school based and school-linked health centres (SLHC) giving adolescents an entry point into the health care system and providing comprehensive services.

The Adolescent Transitions Program (ATP)

The second study of our best practices is by **Dishion & Kavanagh (2000)** who present The Adolescent Transitions Program **(ATP)** a multilevel family-centered intervention delivered in the middle school setting (Dishion & Kavanagh, in press). The study received an evidence-based rating of **four** out of five.

Multilevel refers to **Universal**, **selected** and **indicated** family interventions. The first step is establishing a Family resource Room to establish an infrastructure of collaboration between school staff and parents. This allows for dissemination of information encouraging family management practices that promote school success to prevent the development of early-onset alcohol and drug use.

Selected interventions include summer home visits for one hour to "plan for success" of a child/youth identified as at-risk. This has worked very well and begins the year on a positive note. Also parent use of parenting videos and rating forms designed to be used in the first week of school helps parents identify observable risk factors in the context of parent-child interaction. A third intervention happens during the fall term and is a 6-week health curriculum called Success Health and Peace Curriculum. Both parents and children participate.

The Family Check-Up is an intervention program for those families indicated as needing support and which involves the initial interview, a comprehensive multi-agent multi-method assessment and a family feedback session using motivational skills to encourage maintenance of current positive practices and change of disruptive practices. They have found statistically significant improvements with this program, especially if therapist uses motivational interviewing processes.

Mental Health Interventions

The third study of our best practices is by **Greenberg et al. (2001)** who reviewed scores of primary prevention programs to identify preventive interventions that had been found to reduce symptoms of aggression, depression or anxiety and received an evidence-based rating of **four** out of five

The authors state that over 20% of youth are affected by mental health issues that apart from the personal suffering to these children and their families, has a tremendous cost to society. According to the National Advisory Mental Health Council, in 1990 mental illness cost the United States an estimated 74.9 billion dollars. Although these figures are not as high in British Columbia, Canada, they are significant

The authors believe that to reduce levels of childhood mental illness, interventions need to begin ideally, prior to the development of significant symptomology. In addition, efforts need to be increased to reach the many children that do not have access to treatment. Many children and adolescents with clinical levels of problems never receive appropriate mental health services or they receive inappropriate services (Knitzer, 1985; Tuma, 1989). Another problem with service delivery is that some children only become eligible for therapeutic services after they have entered another system such as special education or juvenile court and this is usually after their problems have begun to escalate.

Recent findings in behavioral epidemiology indicate that mental health problems, social problems, and health-risk behaviors often co-occur as an organized pattern of adolescent risk behaviors (Donovan, Jessor, and Costa, 1988; Dryfoos, 1990; Elliott, Huizinga and Menard, 1989; Jessor, Donovan & Costa, 1991; Jessor & Jessor, 1977). Thus, because risk factors may predict multiple outcomes and there is great overlap among problem behaviors, prevention efforts that focus on risk reduction of interacting risk factors may have direct effects

After a thorough review of prevention programming for high risk children and youth (Greenberg et al., 2001) the following best practices were identified:

- Short-term preventive interventions produce time-limited benefits, at best, with at-risk groups whereas multi-year programs are more likely to foster enduring benefits.
- Although preventive interventions may effectively operate throughout childhood (when developmentally-appropriate risk and protective factors are targeted) given the resistance to treatment of serious conduct problems, ongoing intervention starting in the preschool and early elementary years may be necessary to reduce morbidity.
- Preventive interventions are best directed at risk and protective factors rather than at categorical problem behaviors. With this perspective, it is both feasible and cost-effective to target multiple negative outcomes in the context of a coordinated set of programs.
- Interventions should be aimed at multiple domains, changing institutions and environments as well as individuals.
- Prevention programs that focus independently on the child are not as effective as those that simultaneously "educate" the child and instill positive changes across both the school and home environments. The success of such programs is enhanced by focusing not only on the child's behavior, but also the teacher's and family's behavior, the relationship between the home and school, and the needs of schools and neighborhoods to support healthy norms and competent behavior.
- There is no single program component that can prevent multiple high-risk behaviors. A package of coordinated, collaborative strategies and programs is required in each community. For school-aged children, the school ecology should be a central focus of intervention.
- In order to link to other community care systems and create sustainability for prevention, prevention programs will need to be integrated with systems of treatment. In this way, communities can develop common conceptual models, common language, and procedures that maximize the effectiveness of programs at each level of need. Schools, in coordination with community providers, are a potential setting for the creation of such fully integrated models. It is surprising that few comprehensive interventions have been developed and evaluated that combine school-wide primary prevention together with secondary prevention and treatment.

Tashman et al (2000), also agree that there is growing frustration with traditional forms of providing mental health services to children and there is an increasing awareness of the benefits of school-based services, creating a growth in expanded school mental health programs in the U.S. (Adelman & Taylore, 1999; Flaherty, Weist & Warner, 1996; Weist, 1997, 1999).

School Drop-Out Assistance Programs

The fourth study of our best practices is by **Rossi, 1996** who evaluated school dropout demonstration assistance programs for the U.S. Dept. of Education and received an evidence-based rating of **four** out of five. The author found these programs operated through school districts and offered services within schools, their primary goals being to improve academic performance, increase attendance and provide early intervention to potential and at-risk students in elementary and middle school. The most key element to success at all ages was care, concern and advocacy by supportive adult. Masten et al.,

1990 found a significant positive influence on outcomes of high-risk youth with the presence of a consistent stable relationship with a caring adult. Comer (1984) also found that attachment and identification with a meaningful adult motivates or reinforces a child's desire to learn.

It was found that pulling students out of class was not effective but integrated classroom support or coordinating separate studies with regular classroom was most successful. Vitaro, Brengden, & Tremblay (1999) found that the risk of kids dropping out was four times higher for a student held back a year. They suggested academic tutoring.

Keeping Kids in School

The fifth study of our best practices is by **Prevatt (1998)** who did an extensive literature review on school dropouts and received an evidence-based rating of **four** out of five. The author cites key points in his findings that help keep kids in school: keeping students engaged in school; developing or finding community partnerships; involving parents; using better tracking management information systems. Rossi (1996) found external incentives work at all ages, elementary it was help in homework, middle school it was counseling, high school it was paid work. Offering multiple coordinated services worked best. B.J. Haywood (1995) found vocational educational components worked well to engage students and leads to improvement of overall performance.

Prevention Programs

The sixth study of our best practices is by **Webster Stratton & Taylor (2001**) identified numerous empirically supported prevention programs and received an evidence-based rating of **four** out of five. The authors state that children at the greatest risk of engaging in substance abuse or delinquent acts in adolescence are those who exhibit Oppositional Defiance Disorder(ODD) and Conduct Disorder (CD). The risk of later problems is further increased if the child has any of the following risk factors: the child associates with deviant peers; the child's parents are harsh and inconsistent in their discipline and have problems monitoring their child's activities; and the child has not bonded well at school and is experiencing academic failure.

Webster and Stratton suggest it is necessary to "nip problems in the bud" before children/youth create secondary school and peer risk factors and in order to provide adequate fertilization for building the protective factors that guard against substance abuse and violent behavior". They site Eron (1990) who has studied the development of aggression for 30 years, who says, " without intervention, aggressive tendencies crystallized around 8 years of age."

Webster and Stratton (2001) identified numerous empirically supported prevention programs and have come up with key features of effective programs:

- Programs take a skill enhancing perspective
- Program content is broad-based and includes cognitive, behavioral, and affective components

- Program length is typically greater than 20 hours for children and families at elevated risk of developing problems
- Programs intervene as early as the risk factors can be clearly identified
- Programs are developmentally focused
- Programs use a collaborative focus with parents, teachers & children
- Programs focus on parents and teachers strengths
- Programs use performance training methods, e.g., videos, live modeling, role-playing practice exercise, weekly home practice sessions
- Programs promote partnerships between teachers and students
- Programs emphasize the clinical skills of the intervention staff
- Programs are sensitive to barriers of low socio-economic families and are culturally sensitive
- Programs have been empirically validated in control and comparison group studies using multiple methods and provide follow-up data.

They state that central to any of these intervention programs is the parent, teacher, school counsellor partnership model.

Programs Based on the Social Learning Theory

The last of our best practices study was by the **Ontario Public Health Research Education and Development Program (1999),** which reviewed a number of studies many of which were based on Social Learning Theory because this has positive effects on reducing adolescent risk behavior. The study received an evidence-based rating of **four** out of five.

The authors cite Bangert-Drowns, 1988; Bruvold, 1993; Rundell et al., 1988; Tobler et al., 1997 who all support interactive programs based on social learning theory because these have the largest positive effect on reducing adolescent risk behaviors. Studies show that effective prevention programs are those which provide knowledge in an experiential manner so that adolescents are able to address developmental and social norms and social reinforcement by using skills necessary to assess risk and avoid/resist the behaviors. Such programs have proved effective in reducing adolescent risk behaviors in smoking, drug use, and sexual activity and there were even better results if youth had a one-year follow-up. It was suggested that programs begin at grade 6 or 7 with boosters in later years. Delaying the onset of smoking beyond 18 years has been shown to be one of the major predictors of non-smoking. It was suggested that programs begin at grade 6 or 7 with boosters in later years. Programs that had little or no effect on reducing adolescent risk behaviors were the rational programs focusing on improving knowledge with the expectation that behavior would change accordingly. Also a study in Sexual Risk Behavior reduction found an abstinence program actually spurred males to become sexually active.

12.3. Youth Mentoring

The reviewed literature pertaining to the topic of Youth Mentoring included **fourteen** collected articles, **seven** of which are included in this section. These studies and reviews received three-five out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Mentorship Categories

The first of our best practices studies is by **Mech et al., 1995** who collected information on 29 mentorship programs The study received an evidence-based rating of **four** out of five. These programs fell into five categories:

- Transitional Life Skills Mentors, 80% of the sites used this model which was open to recruitment of mentors irrespective of age, sex religion, race or socio-economic status and matching was done by youth's showing an interest in a mentor
- Cultural Empowerment Mentors, matches youths from a minority cultural or ethnic group with an adult from the same group. The two sites using this model included an African-American group and a gay-lesbian group. Recruitment occurred as ads in local newspapers or speakers announcing this program
- Corporate/business Mentors, matches older foster adolescents with interested businesses and social agencies serve as the brokers and attempt to bring together motivated adolescents and mentors
- Mentor Homes, places four to six foster adolescents in a home with one adult mentor. The mentor guides youth involvement in terms of education, employment and community involvement. Mentors are usually college students who go to school themselves and receive a small salary and free room and board. In this study the majority of mentors were white females whereas the majority of mentees were non-white males. Mech et al.(1995) found many positive results in their review but suggest further mentor recruitment and training.

The following recommend practices were identified:

- Common ethnic and racial ties are an advantage in connecting with the youth. These ties mitigate barriers to trust and provide youth with role models that look like them. However, common ethnic and racial background is no guarantee of success
- Common class backgrounds are an advantage in connecting with youth. Studies of mentoring programs have concluded that the most successful mentors are those who grew up in the same way as the youth, often coming from the same neighborhood and able to talk to them in their own language. The life experiences of these mentors can provide more accessible and realistic models for the youth.
- The adults who become involved because they enjoy spending time with young people, rather than because they feel compelled to save youth seem to make the greatest strides.
- Preparing youth to the mentoring concept prior to matching process - while mentoring is a familiar concept in the adult world, it is often a foreign concept to underserved

adolescents. Working to avoid misconceptions and training young people to make the most of the experience is an important step

- Scheduling enough time together - there is no substitute for mentors and students spending consistent time together. If the goal of a mentoring program is to establish a significant relationship, a minimum of one interaction per week of at least a few hours in duration seems to be the standard.
- Setting up tasks - when mentors and students have something to do or work on together, it gives them more direction. Tasks can absorb initial nervous energy, and provide a basis for conversation between partners. The key is finding the right task that interests both parties.
- Supporting mentors - most practitioners agree that some kind of orientation to adolescence, an urban environment, and poverty is a good idea. In order to combat the isolation in which most mentoring is conducted, programs should provide time for the mentors to get together to provide each other with emotional support, share experiences, and develop solutions to common difficulties. Mentoring teams, where several adults share mentoring responsibilities for several youths, can also be effective and less draining on the adults.

Juvenile Mentoring Programs

The second of our best practices studies is by **Novotney et al., 1998** who examined the Juvenile Mentoring Program (JUMP) program. The study received an evidence-based rating of **four** out of five. This program provides one-to-one mentoring for youth at risk of delinquency, gang involvement, educational failure, or dropping out of school. Since the program's implementation in 1996, great strides have been made in enhancing the body of knowledge available about mentoring as a potential intervention for at-risk youth. Information has been collected through an automated JUMP management information system (MIS), intensive case studies, and extensive communication with grantee agencies. Currently, data are available for 7,515 youth, 6,163 mentors, and 6,362 matches. Both youth and mentors were quite positive when rating their mentoring experiences, which were assessed in such terms as school achievement, abstention from drugs and alcohol, and avoidance of violence. Mentoring can be used as a primary intervention to prevent delinquency or as a remedial intervention to address it.

In 1994-1995, JUMP funds competitively awarded 41 grants of up to $180,000 each for a 3-year period (cohort I) to implement mentoring projects. Another 52 agencies and organizations (cohort II) were awarded JUMP funds of up to $190,000 with combined 1996 and 1997 funds, for a total of 93 JUMP projects. In June 1999, up to $210,000 was awarded to 71 additional agencies (cohort III), bringing the total number of JUMP projects to 164 in 41 States, the District of Columbia, and the U.S. Virgin Islands.

Novotney et al. (1998) found that both youth and mentors viewed the experience as positive. Youth and mentors were asked to indicate whether they believed the mentoring relationship helped the youth a little, a lot, or not at all in regard to the following behaviors:

- Attending all classes

- Staying away from drugs
- Avoiding fights
- Getting along with family
- Not using knives or guns
- Staying away from alcohol
- Getting better grades
- Staying away from gangs
- Avoiding friends who start trouble

Both youth and mentors were very positive when rating various aspects of their mentoring experiences, although perceptions of their relationships did not correspond completely.

Other Mentorship Programs
Big Brothers Big Sisters (BBBS) of Northwest Florida, Pensacola, FL.BBBS affiliate in Southeast using corporate mentors.

City of Madison Mentoring Program, Madison, WI. Works with youth in two high-risk neighborhoods.

Community Service and Employment Training, Visalia, CA. Works primarily with migrant youth in a school-based project.

*Greater Lawrence Community Action Council (*GLCAC), Lawrence, MA. Project based in a large community action organization.

*Ohio Dominican College, Columbus***, OH.** College setting that combines one-to-one mentoring with a cluster concept.

Project RAISE, Baltimore, MD. Enrolled 90 youth in second grade and is following them until high school graduation.

St. John Baptist Church Mentoring Program, Columbia, MD. Church-based project for African American males.

*Valley Youth Foundation, San Jacinto, CA***.** Recreation center-based project.
Virginia Department of Correctional Education, Richmond, VA. Provides mentors to youth in two of Virginia's residential correctional facilities.

Big Brothers/Big Sisters Mentoring Program
The third of our best practices studies is by **Tierney, Grossman and Resch, 1995** who evaluated the Big Brothers/Big Sisters mentoring program. The study addressed nine positive youth development constructs, including social, emotional, cognitive and behavioral competencies, positive identity, bonding, resiliency, self-efficacy, and prosocial norms. The study received an evidence-based rating of **five** out of five.

The model featured positive youth development strategies that did not include a specific skills training component, but rather, targeted systemic change in the child's social domains as a function of bonding with a healthy adult. The core strategy in Big Brothers/Big Sisters is to have youth use the program structure and resources to establish a mentoring relationship with adults. The minimum time commitment required of mentors was several hours, two to four times a month for at least a year. More than 70% of matches in this study met at least three times a month for more than three hours each time, and nearly half met once a week and had an average total exposure of 11 months. The one-to-one mentoring was based on careful matching of adult mentors and children on backgrounds, preferences, and geographic proximity. Standards were implemented for volunteer and youth screening, training, matching, meeting requirements, and supervision.

Evaluation results of this intervention identified the following compared to the control group:

- 46 percent less likely than their control group counterparts to initiate drug use
- 27 percent less likely to initiate alcohol
- Less likely to show aggression
- Skipped only half as many days of school as did control youth
- Felt more competent about their ability to do well in school and received slightly higher grades by the end of the study
- More positive relationships with their friends and their parents

The following recommend practices were identified:

- Find more positive effects among pairs who interacted more frequently, in which the mentors sought the input of the youth, and in which the mentor did not take punitive approaches with the youth
- The longer matches lasted, the more positive effects mentoring had (as relationships continue the youth are more open to receiving a larger array of support, advice and guidance from the mentor)
- Developing and implementing practice standards for volunteers and youth screening, training, matching, meeting requirements, and supervision

Elderly Mentors

The fourth of our best practices studies is by **Rogers & Taylor (1997)** who looked at intergenerational mentoring, linking elders (over 60) who were disadvantaged youth themselves and partnering them with high-risk youth. The study received an evidence-based rating of **three** out of five. Results were most favorable for those receiving mentoring and program interventions in the areas of attitudes towards school, future and elders, feelings of well being, frequency of drug use, and reactions to stress and anxiety. School attendance really improved. Rogers & Taylor, 1997 also found:

- Enhancement in youth’s knowledge and refusal skills regarding alcohol, tobacco and other drugs,

- Increasing youth's sense of self worth, promoting feelings of well-being, and reducing feelings of sadness and loneliness.

Low-income Urban Setting

The fifth of our best practices studies is by **De Anda, 2001** who qualitatively evaluated the first year of a mentorship program called Project RESCUE (Reaching Each Students Capacity Utilizing Education) sponsored through a collaboration between a community agency providing youth services and the local fire department. The study received an evidence-based rating of **four** out of five.

Fire fighters served as mentors to at-risk high school students in a one to one relationship. These youth lived in a low-income urban setting with high rates of youth and violent crime. Pre and posttest data were collected employing a standardized set of open-ended questions regarding the program and the mentees relationship with the mentors. Most were overwhelmingly positive about the program, developed a valued relationship with their mentors, and secured concrete benefits as well (e.g., employment and greater academic achievement).

One-On-One Mentoring

The sixth in our best practices studies is by **LoSciuto et al., 1996** evaluated a substance abuse prevention program called Across Ages that targets sixth-grade students. The program combines community service, a life-skills curriculum and parent workshops with one-on-one mentoring by older adults. The study received an evidence-based rating of **four** out of five.

The evaluation compared outcomes for students who participated in all components of the program with those who participated in all components except mentoring and with students who did not participate in the program at all. Finding demonstrated that student who had mentors had:

- Better attitudes toward school
- Better attitudes toward the future
- Better attitudes toward elders
- Used substances less frequently
- Somewhat better school attendance

The following best practice were identified:

- Mentors need to be highly involved with their youth
- Ongoing supervision and support of matches by staff is critical
- Ensuring that pairs meet regularly over a substantial period is important for developing positive relationships

Program Practices

The seventh in our best practices studies is by **Sipe, 1996** provided an extensive review of literature examining research in the area of mentoring from 1988-1995. The study

received an evidence-based rating of **four** out of five. The author found that successful programs had the following program practices:

- Screening – provides programs with an opportunity to select those adults most likely to be successful as mentors by looking for volunteers who can realistically keep their commitment and who understand the need to earn the trust of their mentee
- Orientation and training – ensure that youth and mentors share a common understanding of the adult's role and help mentors develop realistic expectations of what they can accomplish
- Support and supervision – helps negotiate problems in the relationship

Sipe, 1996 found that programs incorporating the three key elements created solid relationships that created:

- Improved attitudes to school and future
- Improved academic performance
- Decreased antisocial behaviors (i.e. drug and alcohol use)

Mentoring programs missing one or more of the three elements had more difficulty establishing good relationships and did not produce the positive effects of mentoring.

The following best practices were identified for being an effective mentor:

- Mentors need to maintain a steady and involved presence in the lives of the youth
- They need to respect the youth's views and desires
- Pay attention to the youths' need for fun
- They need to become acquainted, but not overly involved, with the mentees' families
- They need to seek and use advice and support from program staff

13.3. Substance Misuse

In our literature search for substance misuse, eighteen articles were collected, eleven of which met the minimal criteria, and from this body of pertinent work, **three** studies met the high evaluation criteria. These studies and reviews all received four typology ratings out of five, categorizing them as empirically sound with strong evidence to support best practices (see Section I.5.2, page 8).

Barriers Experienced by Specific Groups

The first of our best practice studies is by **Currie, 2001** who surveyed thirty three key experts from most provinces and territories (with the exception of Prince Edward Island and Yukon) regarding barriers specific groups of youth experience (program-related or structural barriers received the most emphasis) and received an evidence-based rating of **four** out of five.

Specific population groups of youth involved in substance misuse can be identified as follows:

Street Involved, Homeless and Marginalized Youth. According to the Monitoring the Future Study (Johnston, O'Malley, & Bachman, 2001), adolescent drug use started increasing in the early 1990s and continued to do so until 1997. From 1992 to 1998, the number of adolescent substance abuse treatment admissions grew by 53% (from 96,787 to 147,899) (Dennis, Noursi, Muck, & McDermeit, in press). At the same time, fewer than 10% of adolescents reporting past-year substance use disorder symptoms have ever received treatment (Dennis & McGeary, 1999).

In addition to the alarming trends in adolescent drug use and lack of treatment, the age at which adolescents are introduced to drug use appears to be decreasing. For instance, the age of first marijuana use has decreased from older than 18 in the 1960s, to 15 to 17 years of age in the late 1970s and early 1980s, to younger than 15 in the late 1980s and 1990s (Johnston et al., 2001). This trend is of particular concern because most adolescents who begin using marijuana on a regular basis at an early age have consistently been found to continue their use and/or increase their frequency and amount of use as well as show an increase in related problems over time (Perkonigg et al., 1999).

The most recent *Canadian Profile: Alcohol, Tobacco and Other Drugs, 1999* (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) indicated that between a quarter and a half of street youth report frequent heavy drinking. In terms of other drug use, the percentage using cannabis ranges from 66% to 88%, and for cocaine from 18% to 64%. Street youth also have a much broader range of problems associated with heavy substance use, including employment, legal, psychosocial, educational and health problems (Smart and Ogborne, 1994).

HIV infection is a serious risk for street youth because of drug use, needle sharing, unsafe sex practices, poor hygiene and lack of program resources. Rates of lifetime injection drug use among Canadian street youth range from approximately 11% in a national

sample to 48% of males and 32% of females among Vancouver street youth (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999).

Youth with Concurrent Substance Use and Mental Health Disorders. Although there are gaps in youth epidemiological research and problems with assessment of mental disorders, research clearly substantiates a high prevalence of concurrent substance use and mental disorders among youth. In a review of population studies, clinical studies and studies of youth with psychiatric or substance use disorders in in-patient settings, Greenbaum et al. (1996) found that a substantial level of concurrent substance use and mental disorders was reported in *all* studies reviewed, conduct disorder and depression being the most frequent mental health disorders identified.

Youth Who Inject Drugs and/or are Living With HIV/AIDS, Hepatitis B and Hepatitis C
The biannual Ontario Student Drug Use Survey has reported on use of drugs by injection (Adlaf, et al., 1997). Between 1991 and 1997, the percentage of students injecting non-medical drugs during 12 months prior to the survey for the years 1991 to 1997 ranged from a high of 1.5% in 1995 to a low of 0.8% in 1997. The percentage who reported sharing needles in the previous year remained below 0.5% for all years. Rates of injecting and needle sharing are higher among street youth. A recent study in Montreal found that 36.1% had injected drugs in their lifetime, and of these 58% had shared needles (Roy, 1999).

In Canada, AIDS is rare among youth. As of December 31, 1999, 0.4% of reported AIDS cases were adolescents (10 – 19 years) and 15.7% were diagnosed in young adults (20 – 29 years); given the length of time between initial infection and diagnosis of AIDS, the latter group may well have been infected as teenagers (Health Canada, 2000). Among younger adolescents (10 – 19 years), AIDS is almost entirely associated with exposure to infected blood or blood products. However, among those in the 15- to 19-years-old age group, 4% was attributed to injection drug use and a further 4% to men having sex with men/injection drug use. The same pattern also holds true for HIV (Health Canada, 2000).
Aboriginal Youth. According to *Canadian Profile 1997* and *1999* (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1997, 1999), Aboriginal youth:

- Are at two to six times greater risk for every alcohol-related problem than their counterparts in the general population
- Use solvents more frequently than other Canadian youth. One in five Aboriginal youth has used solvents; one third of all users are under 15 and more than half of all solvent users began use before age 11
- Are more likely to use all types of illicit drugs (First Nations and Métis youth) than non-Indigenous youth
- Begin using substances (tobacco, solvents, alcohol and cannabis) at a much earlier age than non-Aboriginal youth

Aboriginal youth are also over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations.

Youth Involved in the Criminal Justice System. There appears to be a strong relationship between youth substance misuse and direct involvement in the criminal justice system, although the nature of this relationship is not clear. In a study of 847 youth from 11 substance misuse programs in Ontario, Smart and Ogborne (1994) found that:

- 48% of street youth and 36% of non-street youth were on probation/parole/bail or awaiting trial
- 30% of street youth and 16% of non-street youth had been in a correctional establishment in the past six months

A review of 121 youth referred for individual and group out-patient addiction counseling in Toronto (83% of all referrals in a six-month period) found that 50% of the sample had been involved, at some level, with the justice system, with 18% of the sample mandated to treatment by the courts (Ogborne, 1997).

Many youth involved in the criminal justice system are affected by Fetal Alcohol Syndrome (FAS) and other alcohol-related effects. A study of 287 youth in British Columbia referred for a forensic psychiatric/psychological assessment in the juvenile justice system (1995 – 1996) found that 23.3% were affected by FAS or related disorders (Fast et al., 1999).

Youth with substance misuse disorders who are also involved in the justice system often manifest:

- Multiple (socio-economic/psychological/behavioral) problems;
- Chaotic social backgrounds, with limited education and family support (Kosky et al. cited in Spooner et al., 1996);
- Low motivation or ambivalence toward treatment, if treatment is mandated;
- Problems with violence which may make treatment participation difficult.

Currie (2001) surveyed thirty-three key experts from most provinces and territories (with the exception of Prince Edward Island and Yukon), asking them to identify barriers related to groups with specialized needs. In most cases, program-related or structural barriers received the most emphasis and these included:

Barriers Street-Involved, Homeless and Marginalized Youth

Key experts noted that street-involved, homeless youth and marginalized youth experience all the barriers identified for youth in general but in a more intensive form. Homeless or street-involved youth do not traditionally self-refer to programs and are unlikely to be familiar with access points or the process of referral. Highly stressful living conditions (e.g. poverty, lack of adequate housing) and concurrent substance misuse and mental health disorders also make self-referral problematic. Street-involved/homeless youth also have a higher degree of distrust and hostility toward mainstream institutions and typically lack family support to assist with treatment access, costs or planning.

On a program/structural level, key experts identified the following factors as barriers to this group:

- A lack of immediate accessibility to (24-hour) services including access to safe detoxication services;
- Restrictive treatment entry requirements which may be difficult for street-involved youth to meet;
- A lack of adjunctive services, such as safe and secure housing, which are prerequisites to effective treatment utilization.

Barriers Youth with Concurrent Substance Use and Mental Health Disorders
Key experts identified structural/program barriers, specifically poor integration and coordination between the mental health and substance abuse treatment systems, as the most significant barrier for this group. This lack of integration is related to differences in each system's philosophy, role definitions and approach.

Barriers Youth Who Inject Drugs
Key experts described many barriers to treatment experienced by youth who inject drugs and those living with HIV/AIDS. Two primary personal barriers were emphasized:
- The isolation and general marginalization of youth who inject drugs and distance(emotional/physical) from mainstream systems;
- A high level of distrust and hostility toward the mainstream system which makes disclosure of problems difficult and makes youth who inject drugs reluctant to participate in treatment.

No familial/community barriers were noted. However, a number of program/structural barriers were identified. These centred on two themes:
- The lack of accessible and effective methadone maintenance programs for older youth and for those who require or qualify for this form of treatment;
- The lack of specialized services which recognize the distinctive needs of youth who inject drugs and/or those living with HIV/AIDS.

Respondents noted that youth who inject drugs are characterized by multiple problems and a sense of "apartness" strengthened by behaviors sometimes seen as ritualistic. HIV/AIDS victims are more severely marginalized and have little in common with other youth in treatment. Programs need to be able to meet practical needs (e.g. to supply clean needles) initially without putting too many restrictions or "conditions" on early stage treatment access or assistance.

Barriers Aboriginal Youth
Key experts identified familial/community and program/structural barriers for Aboriginal youth. Language barriers were identified by a number of key experts. Language problems may be particularly acute for parents, thus preventing them from participating in their child's recovery. Many Aboriginal youth were also described as coming from a more problematic substance "misuse" environment. Responding to alcohol misuse may be more difficult within certain Aboriginal communities.

- Key experts also mentioned that youth treatment programs are often not supported in the Aboriginal community and that parents often do not request assistance due both to

community factors and their own history of misuse or family breakdown. There was strong consensus that treatment programs are often alienating or not culturally appropriate for Aboriginal youth. Elements of cultural appropriateness were identified by some respondents. Elements include:

- ✓ Appropriate language
- ✓ Inclusion of a spiritual component (beliefs and practices) in treatment
- ✓ Aboriginal staffing
- ✓ Culturally appropriate outreach
- ✓ Connection of Aboriginal youth to Aboriginal social service systems and support

Barriers Youth Involved with the Criminal Justice System

Key experts described youth involved in the criminal justice system as the group most likely to be resistant to treatment (which is often mandated), due to lack motivation5, and as having little or no support from family. Structural barriers identified by key experts include the following:

- A lack of treatment available in either the justice or substance abuse treatment systems. The correctional system typically does not provide treatment and the substance abuse system may not make treatment accessible to juvenile offenders, particularly if legal issues are unresolved.
- Correctional workers may lack knowledge and understanding of treatment options and not make referrals to appropriate community-based programs.
- The "closed culture" of juvenile offenders which makes group treatment difficult. This culture is characterized by secrecy and group loyalty.

The literature review by Currie (2001) also supports findings of key experts opinions on barriers to treatment and factors influencing treatment outcome e.g. the co-occurrence of psychiatric disorders and risk factors (Bukstein et al., 1989; Weinberg et al., 1998;) association of peer influence (Spooner et al., 1996) and presence of childhood victimization (Blood and Cornwell, 1996).

Best Practices - Adolescent Treatment Models

The second of our best practice studies is by **Muck, 2001** who examined four modalities of treatment regimes for substance misuse by adolescents, in terms of etiology, maintenance and resolution and received an evidence-based rating of **four** out of five.

In 1998, most adolescents receiving treatment for substance misuse did so in an outpatient setting. Out of 147,899 adolescents in treatment, 69% were in outpatient programs, 11% in intensive outpatient programs, 6% in short-term residential programs, 9% in long-term residential programs, and 6% in other treatment settings (detoxification hospital inpatient, detoxification free standing, detoxification ambulatory, and hospital-based inpatient) (Dennis et al., in press). Whereas most treatment regimes incorporate a number of methods, current approaches to the treatment of adolescent substance misuse fall into the following four main modalities: 12 step, behavioral or cognitive behavioral, family based, and therapeutic communities. Each of these models views the problem of

adolescent substance use—its etiology, maintenance, and resolution—from a slightly different angle (Bukstein, 1995;Winters, Latimer, & Stinchfield, 1999).

The 12-Step Treatment Approach

Basic model. The 12-step approach, also known as the Minnesota Model or the Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) approach, is the most widely used model in the treatment of adolescent drug abusers. Based on the tenets of AA and basic psychotherapy, the 12-step model views "chemical dependency" as a disease that must be managed throughout one's life with abstinence as a goal (Winters et al., 2000). The backbone of 12-step treatment is step work, a series of treatment and lifestyle goals that are worked in groups and individually. Step work provides the basis structure for treatment and recovery. Counselors in 12-step programs are often recovering substance users and serve as powerful role models for living a drug-free life. Although once available only in residential settings, 12-step treatment is now widely offered in both residential and outpatient settings.

Effectiveness. Studies examining the effectiveness of 12-step programs typically focus on comparisons between program completers and noncompleters rather than comparisons to other treatment models. Studies show that at 6-month follow-up, program completers had a significantly higher abstinence rate than non completers (Alford, Koehler, & Leonard, 1991; Brown, Myers, Mott, & Vik, 1994; Winters, Stinchfield, Opland, & Weller, 1999; Winters et al., 2000). Results at 1- and 2-year follow-ups, however, are mixed. Both studies by Winters, Stinchfield, et al. (1999) and Winters et al. (2000) found completers' outcomes to be far superior to non completers' at the 12-month follow-up. However, Alford et al. (1991) reported that abstinent/essentially abstinent rates fell sharply for boys and slightly for girls at 1-year posttreatment. There was no significant difference between completers and noncompleters by 2 years posttreatment.

Results for behavioral functioning show a similar pattern. Alford et al. (1991) reported that 45% of treatment completers were abstinent/essentially abstinent and successfully functioning in school or a job and in family-social activities, whereas this was true for only 25% of noncompleters. At 1-year posttreatment, this difference narrowed to 29% versus 18% for completers and noncompleters, respectively, and further narrowed to 27% versus 23% at 2 years posttreatment.

In addition to comparisons with noncompleters, Winters et al. (2000) also compared outcomes of program completers to those for a wait-listed group of adolescents. Results show that program completers reported superior outcomes to adolescents in waiting list groups, who in turn did not differ significantly from the noncompleter group. This finding was consistent for both categorical (abstinence/minor relapse rates) and continuous (standardized drug use frequency scores) variable analyses.

The Behavioral Treatment Approach

Basic model. Behavioral approaches focus on the underlying cognitive processes, beliefs, and environmental cues associated with the adolescent's use of drugs and alcohol and teach the adolescent coping skills to help him or her remain drug free. Whether called

behavior therapy, cognitive therapy, or cognitive-behavioral therapy (CBT), all behavioral approaches view substance abuse as a learned behavior that is susceptible to alteration through the application of behavior modification interventions (Miller & Hester, 1989). The goal of behavioral approaches is to teach adolescents to unlearn the use of drugs and to learn alternative, prosocial ways to cope with their lives. Thus, "treatment focuses on the factors that precipitate and maintain episodes of substance use" (Kaminer, Burleson, Blitz, Sussman, & Rounsaville, 1998, p. 684). In particular, cognitive-behavioral techniques attempt to alter thinking as a way to change behavior. Behavioral techniques are used in residential and outpatient settings as part of group or individual therapies.

A commonly used behavioral intervention focuses on the development of coping skills. Particular skills to be taught are introduced and modeled. Using examples from the adolescents' lives is crucial to help engage them and convince them of their practical utility. Specific skills vary by program but may include drug and alcohol refusal skills, resisting peer pressure to use drugs and alcohol, communication skills (nonverbal communication, assertiveness training, and negotiation and conflict resolution skills), problem-solving skills, anger management, relaxation training, social network development, and leisure time management. New behaviors are tried out in low-risk situations (e.g., during group therapy role-plays and individually with a counselor) and eventually are applied in more difficult, real-life situations. Homework assignments, such as trying out a new behavior or collecting problem situations to discuss during therapy, are common. Staff members and parents are encouraged to provide positive reinforcement for the use of new behaviors.

Behavioral contracting is another technique used in behavioral approaches. The adolescent and counselor agree on a set of behaviors to be changed and develop weekly incremental goals for the adolescent. As each goal is reached, the adolescent is highly praised or otherwise reinforced. Behaviors are explicitly defined on the contract, with criteria and time limitations noted.

Effectiveness. To date published studies examining the effectiveness of behavioral programs focus on the comparison of behavioral models to other treatment methods. For instance, Azrin and colleagues (Azrin, Donohue, Besalel, Kogan, & Acierno, 1994; Azrin, McMahon, et al., 1994) compared the effectiveness of a behavioral outpatient treatment program to that of a supportive counseling program. In the behavioral program, the number of adolescents using drugs by the end of treatment decreased by 73% compared with a decrease of only 9% of those receiving the comparison treatment. Drug use was measured in three ways at each session—adolescent selfreport, parent report, and urinalysis—and all three methods of measuring drug use showed substantial decreases during the course of the behavioral treatment. These measures showed only slight decreases during the nonbehavioral treatment, and the average number of days per month of drug use actually increased. For the behavioral program, reported alcohol use decreased by about 50%, whereas the comparison treatment showed an increase of 50%.

Looking at other measures of improvement for the behavioral program, the percentage attendance at school or work increased significantly, and a large decrease in average scores on the depression measure was observed. Parent satisfaction with the youth increased from a prebaseline rate of 42% to 72% overall satisfaction. Youth satisfaction with the parent increased from a prebaseline rate of 69% to 85%, although the difference was marginally significant. For the comparison, non-behavioral program, the percentage attendance at school or work decreased only slightly as did the average scores on the depression measure. Parent satisfaction with youth and youth satisfaction with the parent remained unchanged at 50% and 63%, respectively. Substance use data and related measures were not collected posttreatment.

In their studies, Kaminer, Burleson, and colleagues (Kaminer & Burleson, 1999; Kaminer et al., 1998) compared CBT to interactional treatment (IT)—an insight-oriented outpatient group approach—to determine which treatment would provide improved outcomes for adolescent substance abusers that also were diagnosed with a psychiatric condition. The overall treatment completion rate was 47% (8 in the CBT group and 7 in the IT group). At the 3-month follow-up, adolescents who were in the CBT treatment significantly reduced the severity of their substance use compared with those assigned to IT. At the 15-month follow-up, no treatment group differences were observed on severity measures of alcohol use; drug use; psychiatric problems; problems with peers, family, or school; and legal problems.

Finally, in a study similar to the one described earlier, Kaminer, Burleson, and Jadamec (1999) compared CBT to psychoeducational treatment (PET) to determine which of the two treatments would provide improved outcomes for adolescent substance abusers. The CBT was administered similarly to the previous study; however, the program in this study was slightly shorter, lasting 8 weeks instead of 12. The PET addressed the dangers of using drugs and alcohol through a didactic process.

Kaminer et al. (1999) reported an overall treatment completion rate of 86%. At the 3-month follow-up, adolescents who completed CBT treatment and follow-up measures significantly improved on the severity of their peer problems as compared with those assigned to PET. In addition, a trend toward improvement on the drug and alcohol severity measures was observed for adolescents treated in CBT relative to those in PET.

The Family-Based Treatment Approach

Basic model. Family-based approaches acknowledge the critical influence of the adolescent's family system in the development and maintenance of substance misuse problems. Most techniques are based on four family therapy models—structural, strategic, functional, and behavioral—alone or by combining effective parts of a number of models. "A family systems view of adolescent drug misuse focuses on the manner in which adolescent functioning is related to parental, sibling, and extended-family functioning, as well as to patterns of communication and interaction within and between various family subsystems" (Ozechowski & Liddle, 2000). The family, then, is viewed as a collection of subsystems (e.g., parents and children), each with a variety of roles. Ideally, boundaries between subsystems are permeable enough for, say, an adolescent to

feel comfortable seeking input from a parent on an important issue but not so permeable that the boundaries between parent and child roles are blurred. Problems arise when boundaries and roles are not clear or are inappropriate for a given family subsystem.

Effectiveness. Studies examining the effectiveness of family-based programs also focus on the comparison of this model to other modes of treatment. Several studies have compared family-based models to education models of treatment (Joanning, Quinn, Thomas,&Mullen, 1992; Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle et al., 1999; Liddle & Hogue, in press). Lewis et al. (1990) reported that adolescents in a family-based therapy model showed a significant decrease in ratings of seriousness of drugs used from pre- to posttreatment, whereas adolescents in a family drug education program did not show similar decreases. Studies examining the amount of drug use (Joanning et al., 1992; Liddle et al., 1999) report greater reduction in drug use at immediate posttreatment using the family-based therapy model. Similar results are reported at 6-month (Liddle et al., 1999) and 12-month (Liddle et al., 1999; Liddle & Hogue, in press) follow-up.

Looking at factors related to substance use, Liddle and Hogue (in press) reported that multidimensional family therapy (MDFT) showed superior improvement in behavioral ratings of family competence and adolescent's grade point average from pretreatment to 12-month follow-up. Joanning et al. (1992) also reported that at the 6-month follow-up, adolescents in all treatment groups perceived that their communication with their parents had improved significantly. The adolescents' parents, however, did not share this perception.

Similar results were found when comparing family-based models to adolescent group therapy. Family systems therapy (Joanning et al., 1992) and MDFT (Liddle, Dakof, & Diamond, 1991; Liddle et al., 1999) resulted in greater improvement in reduction of drug use at immediate post treatment than the adolescent group therapy model. This difference remained at 6- and 12-month follow-ups for the MDFT studies (Liddle et al., 1991, 1999; Liddle & Hogue, in press).

Looking at pre- to posttreatment differences in related factors, Liddle et al. (1999) found no significant differences between groups for problem behavior (poor anger control, interpersonal problems, impulsivity, mood swings, and antisocial, aggressive, and sexual acting out) or grade point average. However, adolescents receiving MDFT showed greater improvements in grade point average (Liddle et al., 1999; Liddle & Hogue, in press) and behavioral ratings of family competence (Liddle & Hogue, in press) at follow-up. No significant difference between groups was found for problem behaviors at follow-up (Liddle et al., 1999).

Finally, Szapocznik, Kurtines, Foote, Perez-Vidal, and Hervis (1983, 1986) compared conjoint family therapy (CFT; therapy with the entire family present for most sessions) to one-person family therapy (OPFT; therapy with only one family member present for most sessions). At immediate post treatment, adolescents in both conditions showed significant improvement in clinical status (including drug abuse, impulse control, behavioral

disturbance, and subjective distress), behavior problems (including conduct problems, delinquency, personality problems, and inadequate development), and family functioning. At follow-up (6 to 12 months posttreatment), adolescents in both groups continued to show improvements in clinical status and family functioning; however, adolescents in OPFT showed significantly more reduction in problem behavior and drug abuse than adolescents in CFT.

Clearly, family-based treatment of adolescent substance abuse has received much attention in the research literature. In their review of family-based therapy for adolescent drug abuse, Ozechowski and Liddle (2000) concluded that this model's efficacy in addressing adolescent drug abuse and externalizing and internalizing behavioral problems and symptoms of psychiatric comorbidity has received solid empirical support. They further concluded that related factors, such as improved family functioning, involvement in school, and reductions in peer-associated delinquent behavior, have also been shown to be significantly improved through family-based therapy.

The Therapeutic Community Treatment Approach

Basic model. Therapeutic communities (TCs) are long-term residential programs reserved for adolescents with the most severe substance abuse and related problems. The traditional duration of stay is at least 15 months, although some TCs have adopted shorter lengths of stay based on progress (6 to 12 months). The philosophy behind the TC is that substance abuse is a disorder of the entire person resulting from an interruption in normal personality development and deficits in interpersonal skills and goal attainment. Thus, the purpose of the TC is to provide a psychologically and physically safe, nurturing, and structured environment in which the adolescent can develop more adaptive personal and social behaviors, attitudes, and beliefs (Jainchill, 1997). The social organization of the TC serves as a family surrogate for the adolescent and provides a therapeutic, supportive environment for the adolescent to mature and grow.

Life in a TC is highly structured, with days scheduled from early morning through the evening. Days are filled with school classes and tutoring, peer group and individual therapy, recreation, jobs, and occupational training. Management of the TC is the responsibility of the residents, and all adolescents are assigned a job. Through progress and productivity, adolescents rise through the job hierarchy to positions of management or coordination. Participation by a family member is often a part of the TC experience. As in 12-step programs, counselors and primary staff members at TCs are often ex-clients who have been successfully rehabilitated in TCs.

Effectiveness. The Center for Therapeutic Community Research led an investigation of six TC treatment programs across nine sites (Jainchill, 1997; Jainchill, Bhattacharya,&Yagelka, 1995). Although programs varied on factors such as setting (urban vs. rural), planned duration of stay (6 to 18 months), and the size of their staff, all shared the basic features of a TC. Halfway through their planned stay of duration, 45% of adolescents were still in treatment, and significant positive changes were observed on most indicators of psychological status, such as self-esteem and behavioral indicators (trouble controlling violent behavior and serious thoughts of suicide in the past 30 days).

About 44% of adolescents completed their treatment programs. At 6 months post treatment, significant reductions were observed for inhalant, hallucinogen, and methamphetamine use. In addition, more than 66% of the adolescents reported that their alcohol use was either greatly reduced or at an abstinent level.

Based on learning from the evaluation of treatment models and the Juvenile Justice Treatment Network, two new community-based interventions have been developed. First, the Robert Wood Johnson Foundation is set to launch a new initiative, Reclaiming Futures (Robert Wood Johnson Foundation, 2001), to build more seamless systems of care and further the learning about how systems interventions can improve outcomes for justice-involved adolescents. Second, CSAT will fund three to five communities to develop a continuum of care—early identification, referral, treatment, and continuing care/aftercare—to provide a seamless service system for youth in need of substance abuse interventions .

As communities begin to adopt best practices and develop systems of care for adolescents in need of substance abuse treatment, they are likely to converge in some localities with ongoing restorative justice programs. Given the preponderance of justice-involved youth in the treatment system, it is extremely important that these two fields communicate and maximize their service delivery. The state of evidence about the effectiveness of adolescent substance abuse treatment provides many opportunities for enhancements to assist in improving relapse and treatment retention rates. The potential for integration of existing treatment models with restorative justice principals may provide additional advancements to the field. Community-based treatment that involves establishing or supplementing a continuum of seamless care is a natural nexus for application of adolescent substance abuse treatment and restorative justice practices.

Contact and Engagement

The last of our best practice studies is by **Autry, 2000** who examined best practices described by key experts relating to the outreach, contact and engagement of youth in treatment, protective factors and resilience, and received an evidence-based rating of **four** out of five.

Key expert comments were categorized into four general areas:

1. Location and physical accessibility of treatment
    - Identified the importance of direct staff outreach to all community locations where youth assemble (malls, schools, street, mental health centers, clubs, recreational facilities). A strong liaison with and presence within schools was emphasized
2. Program approach and philosophy
    - An accepting, respectful and non-judgmental approach to youth
    - Familiarity with youth reality and language
    - Treatment goals and purpose to be determined by youth and youth needs (client centered)

- The importance of establishing a physically and emotionally secure environment for treatment (where youth feel protected, comfortable and where their basic needs are met)

3. Program outreach strategies

   Many other professionals (school teachers and counsellors, mental health workers, street workers) are the first point of contact with youth. Key experts stressed the need for program staff to provide training and maintain supportive/collaborative relationships with these workers in order to facilitate treatment access. Key experts also identified a need for programs to incorporate strategies to facilitate access to supportive family members, even prior to contact with youth

4. Program structure and content
   - The importance of immediately engaging youth through the provision of diverse recreational activities which are enjoyable and non-threatening and which establish trust and positive client-staff relationships
   - The importance of developing and supporting school-based or community prevention activities as a less threatening "window" through which youth can enter treatment

Protective factors, such as solid family bonds and the capacity to succeed in school, help safeguard youth from substance use. Research has also demonstrated that exposure to even a substantial number of risk factors in a child's life does not necessarily mean that substance use or other problem behaviors will inevitably follow. Many children and youth growing up in presumably high-risk families and environments emerge relatively problem-free. The reason for this, according to many researchers, is the presence of protective factors that reduce the likelihood that a substance misuse disorder will develop (Hawkins et al., 1992; Mrazek & Haggerty, 1994). The research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device. Among these resilient children, protective factors appear to balance and buffer the negative impact of existing risk factors (Anthony & Cohler, 1987; Hawkins et al., 1992; Mrazek & Haggerty, 1994; Wolin & Wolin, 1995). From a substance abuse prevention perspective, protective factors function as mediating variables that can be targeted to prevent, postpone, or reduce the impact of use. Taken together, the concepts of risk and resilience enhance understanding of how and why youth initiate or refrain from substance misuse. Although not all risk and protective factors are amenable to change—genetic susceptibility to substance use, for example—research demonstrates that their influence can often be assuaged or enhanced.

Adolescent substance abusers are different from adult substance abusers in a number of important ways, including drug use patterns and developmental and social factors (Winters, Stinchfield, Opland, Weller, & Latimer, 2000). Adolescents may be more susceptible than adults to the development of substance dependence syndromes, even in the absence of physiological withdrawal. The progression from casual use to dependence can also be more rapid in adolescents than in adults (Winters, 1999). Adolescents presenting for treatment typically demonstrate a higher degree of co-occurring

psychopathology, which frequently precedes the onset of problem substance use and often does not remit with abstinence (Kandel et al., 1997; Riggs, Baker, Mikulich, Young, & Crowley, 1995; Rohde, Lewinsohn, & Seeley, 1996).

Motivation for treatment is a key factor in addressing adolescent substance use because adolescents presenting for treatment almost never enter as a self-referral. Instead, they are typically referred by a parent, juvenile justice system official (judge or probation or parole officer), school official, child welfare worker, or representative of some other community institution. State-of-the-art substance abuse treatment must also take into account what we know about how people change. Important research on how people change addictive behaviors (Prochaska, DiClemente, & Norcross, 1992)—later applied to a wide variety of other behavioral problems—has shown that people move through stages in the change process. The stages of change model has been applied to adolescents (Pallonen, 1998) and young adults (Pallonen, Murray, Schmid, Pirie, & Luepker, 1990). The stages were the same in these populations, although there were differences in distribution, speed of movement through stages, and tendency to relapse.

The consensus of clinical practitioners is that for a given degree of severity or functional impairment, adolescents require greater intensity of treatment than adults. This is often reflected by a greater tendency to place adolescents in more intensive levels of care (Mee-Lee, Shulman, Fishman, & Gastfriend, 2001) and in part indicates the need for strategies that are not so much rehabilitative as habilitative.

14.3. Sexually Exploited Youth

The reviewed literature pertaining to the topic of sexually exploited youth included **fourteen** collected articles, **eight** of which are included in this section. These studies and reviews received **three-four** out of five for typology ratings and one promising practice (see Section I. 5.2, page 8).

As mentioned there is a dearth of research on sexually exploited youth as well as government policies and services. Nominal information has been published in the literature about services and innovations with little to no evaluation in most areas of practice.

Aboriginal Youth

The first study of our best practices is by **Schissel (1999)** using Social Services data on four hundred young offenders from the cities of Saskatoon and Regina, they investigated the connections between abusive childhoods, personal and educational success and involvement in the youth sex trade. The study further examined the associations between involvement in prostitution and psychological, physical and emotional safety with respect to Aboriginal and Non-Aboriginal youth. The study received an evidence-based rating of **four** out of five.

The following characteristics were identified:

- Youth are involved in prostitution partly because their early lives were characterized by neglect and abuse. (i.e. such damage/trauma prevent them from coping in a conventional world, and/or such damage normalizes abuse and sexual exploitation in the minds of these young victims)
- Evidence suggests that a child's self-concept and affective abilities, likely associated with early sexual and/or physical abuse, determine involvement in the sex trade
- Childhood abuse damages self-perception that normally allows children and youth to resist exploitation and it patterns behaviour that exposes individuals to dangerous individuals and events (Finkelhor, 1987; Finkelhor and Browne, 1988; Simons and Whitbeck, 1991)
- Teenage prostitution is enhanced by acute sexual and physical victimization and the sex trade is related to predispositions to self-destructive behaviour
- Prostitution creates a context in which those youth who are involved will run a high risk of being damaged by a predator or by themselves -- either directly through assault and self-injury or indirectly through high-risk behaviour (these findings are offered in a street context, in which subcultural norms for protection are absent and in which children and youth are coerced and trapped in the sex trade and are not there by choice) (Chesney-Lind and Shelden, 1992; Campagna and Poffenberger, 1988).
- Evidence suggests that although prostitution predisposes all youth to self-injury, it does so especially for the non-aboriginal youth
- Young aboriginal prostitutes are more vulnerable to stranger violence than are non-aboriginal youth prostitutes

- First Nations and Metis youth are more vulnerable to sexual exploitation on the streets than their non-aboriginal counterparts (Badgley, 1984; Lowman, 1987; McCarthy, 1996; Mayor's Task Force, 1996)

The following best practices were identified:

- Given that this activity is not one of choice but of coercion and victimization, an immediate, non-legalistic, non-condemnatory intervention strategy is crucial, not only for the welfare of the youth involved but also for the integrity of a society that so far has failed to stop adult predators of children and youth
- Types of caring intervention need to include not only safe houses where street youth can find sanctuary but also attendant counselling programs which deal with issues of health and safety, personal trauma, family problems, and financial and educational opportunity
- Educational and employment programs are needed to obviate the need to prostitute
- Government policy needs to make it easier for destitute and disaffiliated youth to access financial and physical resources
- Schools need to provide flexible education models that account for the remedial needs of street youth, physical spaces in which marginalized youth feel safe and secure, and a non-punitive, non-authoritarian model of learning and development in which the wishes and opinions of street youth are considered in school policy
- Schools with at-risk children and youth may, for example, address the issues directly by bringing in ex-prostitutes who are able to tell youths the reality and dangers of street life and not a glamorized portrait of riches and money
- Outreach, intervention, programs and services must be culturally significant especially in cities where the majority of children and youth in the sex trade are of aboriginal ancestry (as stated in the 1996 Royal Commission on Aboriginal Peoples, aboriginal street youth look for aboriginal faces in helping agencies. In light of research from this study and the Royal Commission report, more trusting and effective helping relationships occur when services and programs are culturally relevant)
- Police need to assume the mandate of frontline social workers as well as peace and crime control officers (street youths need to trust police officers as guardians and protectors) (inner-city police officers understand street life and the inherent dangers and they are on the front lines)
- It is certainly within the realm of possibility for officers to be advocates for children and youth involved in the sex trade. This, however, would involve changing the mandate and training of the police, allowing them to create and work in an atmosphere of trust of and by street children and youth.

Aboriginal Youth Continued

The second study of our best practices is by **Kingsley and Mark, 2000** - Sacred Lives: Canadian Aboriginal Children and Youth Speak Out About Sexual Exploitation –Report for Save the Children Canada. The study received an evidence-based rating of **three** out of five.

Over a period of five months, consultations with more than 150 commercially sexually exploited Aboriginal children and youth took place in 22 communities across Canada, consisting of major cities, smaller communities, and more rural areas. The youth consultation was recorded, and for those unable or unwilling to attend, written questionnaires were distributed and collected at the end of each visit. The tapes and questionnaires were then transcribed, and form the basis of the report.

Youth across the country, on reserve and off, in large communities and rural areas told their stories which had common themes. In every community, youth discussed the following needs:

- Drop-in centers
- Emergency shelters
- Support groups
- Community friendship centers with flexible and late-night hours as a central component to preventing child and youth sexual exploitation
- Having a place that feels safe and offers support, shelter, and activities, to enable youth to find alternatives to a life on the street.

The following best practices were identified:

- Youth Recommendations for Prevention
  - ✓ Awareness-raising through education and discussion
  - ✓ A safe, non-judgmental place to go
  - ✓ Cultural connection
  - ✓ Raising self-esteem
  - ✓ Service providers who have experience in the trade
  - ✓ Viable economic alternatives

- Youth Recommendations for Crisis Intervention and Harm Reduction
  - ✓ 24 hour drop-in centers
  - ✓ Safe housing
  - ✓ Crisis lines
  - ✓ Experiential youth and counselors to staff all of the above
  - ✓ Education about existing resources

- Youth Recommendations for Exiting and Healing
  - ✓ Specific services/agencies for the unique needs of Aboriginal youth sex workers
  - ✓ Services and support for those who do not wish to exit the sex trade
  - ✓ Longer term services
  - ✓ Experiential counselors
  - ✓ Decreasing obstacles youth face in accessing services
  - ✓ Education
  - ✓ Self-confidence building
  - ✓ Building trust with agencies, outreach workers and counselors
  - ✓ Basic life skills training
  - ✓ Social skills training

- Youth Recommendations on Youth Participation
  - ✓ Using their own experience to help and benefit other youth
  - ✓ Training experiential counselors to help others out of their situation
  - ✓ Connecting with others who have successfully exited the trade
    Having a central role in providing outreach, support, public education, advocacy, and mentoring for others in the trade
    Establishing peer support groups
  - ✓ Staffing crisis hotlines
  - ✓ Creating and running drop-in centers
  - ✓ Creating and staffing non-judgmental support networks
  - ✓ Educating the larger community about their experiences
  - ✓ Creating, developing, and delivering specific programs for commercially sexually exploited Aboriginal youth

Community Approach

The third study of our best practices is by **Johnson et al., 1998** - Family and Youth Service Bureau - FYSB (U.S. Department of Health and Human Services). The study received an evidence-based rating of **three** out of five.

In 1999, the FYSB issued an invitation to it's over 100 Runaway and Homeless Youth Program grantees to apply for Street Outreach Programs grants. This community approach awarded fifty-nine 1 year grants of up to $100,000 to provide related services, such as survival aid, individual assessment, treatment and counselling, prevention and education activities, information and referral, crisis intervention, and follow-up support for homeless and sexually exploited youth. The FYSB limited the competition to agencies providing shelter to youth since the purpose of all street outreach is to build relationships with young people to move them off the streets and into service. FYSB also required that applicants for the new grant program offer services on the street during the hours youth tend to be out. The programs also must use staff whose genders, ethnicities, and life experiences are similar to those of the young people to be served. Further, given the intensity of the street and the difficulty reaching sexually exploited youth, FYSB required applicants to provide staff with supportive training on issues relevant to street life. They also must provide staff with street-based supervision, including guidance on the boundaries of their job responsibilities and strategies for helping youth who are survivors of commercial sexual exploitation.

The following best practices were identified:

- Outreach services for sexually exploited youth must be provided from a “youth development approach” i.e. youth need to be involved in the design, operation, and evaluation of the program
- Develop collaborations with other service provider agencies to ensure services coordination and availability. These collaborations will enhance services to young people, particularly those who are the survivors of commercial sexual exploitation; they also will refocus the discussion of exploitation.

- FYSB purports that to stem the tide of sexual abuse and exploitation requires a two-pronged approach that includes providing services and creating a strong community commitment to ending the violence (youth advocates and those on the front lines of the rape crisis and battered women's movements can begin building community consensus around ending the denial of child sexual abuse)

Over the last twenty years of providing street outreach for youth the FYSB have become international experts in this area. The numerous community street outreach grant projects have further demonstrating the value of street outreach to prevent the exploitation of runaway and homeless youth. Decades of experience have found that:

- Early intervention with youth in troubled circumstances is critical
- The longer young people are on the streets, the harder it is to bring them into appropriate services
- Street outreach grants have significantly strengthened each program's ability to provide a consistent presence in the community, and have engaged more street youth to take advantage of the services and opportunities available to them.

An example of one of the street outreach initiatives demonstrated that youth are responding well to a multi-disciplinary approach where health and youth workers have successfully piloted a peer health education/safer sex project. This pilot project 'Safer on the Streets' has involved outreach workers giving strong support to a group of 10 young women who have themselves been involved in prostitution and are also drug users. The group, in turn, have been able to support each other and to share their awareness of health and related issues with other street workers.

Exiting the Sex Trade

The fourth study of our best practices is the **National Strategy on Community Safety and Crime Prevention – Prevention and Early Intervention of Sexually Exploited Children and Youth, Victoria, BC, 2002**. Due to the infancy of this project and the fact that no evaluation has been completed, it is has not been rated but is seen as a **promising practice**.

In June 1998 the Government of Canada launched Phase II of its 'National Strategy on Community Safety and Crime Prevention'. Administered by the National Crime Prevention Centre (NCPC), the National Strategy supports an early intervention, community-based approach to preventing crime and victimization, with a particular emphasis on children and youth, Aboriginal people and women. The Government has committed $32 million annually to assist communities across Canada as they develop programs and partnerships that will help prevent crime.

Just recently, the NCPC provided $489,825 over a three-year period to the 'Capital Region Action Team on Sexually Exploited Youth'. This money will contribute to the establishment and testing of an integrated, seamless model to identify children and youth who want to leave the sex trade and provide them with the immediate and long-term support they require to exit and stay away from the sex trade.

This project will evaluate an approach to identifying children and youth involved in the sex trade and supporting them in exiting and remaining away from the sex trade through integrated procedures and delivery of services. A multi-agency service delivery team will be supported by three front-line teams/individuals. These include:

- A Street Outreach Team, consisting of a police officer and a youth worker, will work exclusively with sexually exploited youth to establish a necessary first step for further interventions. The team will identify opportunities when youth are open to leave the sex trade and immediately offer them a coordinated range of services through a single contact person. The primary objective is to encourage youth to leave and establish an immediate sense of safety. Resources to provide the basic necessities, including secure, safe housing, clothing, food, personal supplies and transportation, for youth exiting the trade will be available immediately.
- A liaison worker will be assigned and will be responsible for the immediate and long-term needs of the exiting youth. The worker will provide support and brief counselling to the youth; engage in case planning to coordinate the delivery of all required needs and services such as housing, income assistance, drug and alcohol treatment, counselling, repatriation with parents or guardians; and ongoing follow-up to ensure these needs are being met.
- A dedicated court worker will be assigned to support exiting youth who are involved in criminal proceedings (i.e., witnesses against their pimp); act in an outreach and referral capacity with the youth's peers who may be involved in or watching the proceedings to encourage them to exit the sex trade; and, monitor Youth Court proceedings for other cases involving sexually exploited youth to encourage them to exit and provide immediate referrals to a comprehensive range of services.

This project will also establish a database of children and youth involved in, or leaving, the sex trade. Ages, places, travel patterns and methods of recruitment will be tracked and conveyed to police departments, service delivery organizations and prevention programs across the country.

High Risk Environments

The fifth study of our best practices is by **Tyler et al., 2001** who examined the effect of high-risk environments on the sexual victimization of 311 homeless and runaway youth from the Seattle Homeless Adolescent Research and Education Project (SHARE). This longitudinal study received an evidence-based rating of **four** out of five.

Many homeless adolescents engage in high-risk behaviour, often as a means of survival which increases their exposure to offenders, thus resulting in an increased risk for victimization (Hagan & McCarthy, 1997; Whitbeck & Hoyt, 1999). Hagan and McCarthy (1997) found that runaway youth were more likely to engage in criminal activity when they lacked food or money or when trying to find shelter. Many runaways become involved in trading sex because they are hungry and need money (Silber & Pines, 1982; Weisberg, 1985). Engaging in risky sexual behaviours is linked to victimization among homeless adolescents (Whitbeck et al., 1999). Homeless youth who engage in

deviant subsistence strategies, have high rates of drug use and engage in survival sex are more likely to be sexually victimized (Tyler et al. 2001)

This study identified the following characteristics:

- The likelihood of being a victim is a combination of engaging in certain behaviours and having certain attributes that art considered of value by the offender. This suggests that being victimized is not simply a matter of being on the street but who you are and what you are doing also matters (Hoyt et al. 1999; Tyler et al. 2001)
- The more kept the appearance of youth, the more likely they are to be victimized
- Relative to males, females were more likely to be sexually victimized as their us of hard drugs increased
- Females experience higher rates of victimization as their drug use increased whereas among males, increasing drug use did not affect level of sexual victimization
- Younger aged youth experienced the lowest levels of sexual victimization when their participation in deviant subsistence strategies was low. In contrast, 19 year-old youths experienced the highest rates of sexual victimization when participation in deviant subsistence strategies was lowest. Thus, the association between involvement in deviant subsistent strategies and increase risk of sexual victimization appears to be present only among the younger adolescents. It is possible that younger people are new to the streets and have little experience with street life. This inexperience, coupled with the fact that they engage in deviant subsistence strategies, increase their chances on interacting with potential offenders thereby increasing their risk for sexual victimization (Miethe & Meier, 1994; Finkelhor & Asdiagian, 1996; Tyler et al., 2001)
- Engaging in survival sex was strongly associated with sexual victimization (Weisberg, 1985; Whitbeck & Simons, 1990, 1993; Tyler et al. 2001)
- Due to small number of options available, many homeless youth engage in criminal activity when they lack food or money or when trying to find shelter (Hagan & McCarthy, 1997; Tyler et al. 2001)

The following best practices were identified:

- The high rates of sexual victimization experienced by these youth, particularly females, suggest the need for early interception and intervention
- Increasing funding for shelters, drop-in centers, counsellors, and especially street-based outreach workers who can locate these youth and provide them with necessary services is needed
- Providing interventions that address the broader matrix of problems that these young people present and face will be the most successful (Cauce et al., 1998; Tyler; 2001)

Impact of Early Sexual Abuse

- The sixth study of our best practices is by Tyler et al. (2001) and examines the impact of childhood sexual abuse on later sexual victimization among runaway youth. The study received an evidence-based rating of three out of five.

- The authors conducted an interview by outreach workers of 372 homeless and runaway youth on the streets and in shelters in Seattle. Characteristics identified were:
- Females were at much greater risk than males for victimization on the street
- There was an indirect link to sexual abuse because they tend to be on the street earlier and longer, participating in deviant subsistence strategies such as survival sex
- Female children are sexually abused three times more often than males and the average age of females becoming victims of sexual abuse is between eight and twelve years old
- When they get old enough, they often runaway, sometimes returning periodically out of desperation, but they inevitably run away again because life at home is intolerable
- The number of children who experience childhood sexual abuse has doubled in the U.S. according to the third national incidence study of child abuse and neglect in 1993
- Finkelhor and Dziuba-Leatherman, 1994 found rates of abuse as high as 25% among their sample of 10- to 16-year-olds. Studies on homeless and runaway youth have found rates of sexual abuse that exceed 50% (Janus, McCormack, Burgess, and Hartman, 1987; Silbert and Pines, 1981). In this study 20% of the females interviewed had experienced
- The negative training these children receive from abusive families is anti-social and when these children model this behavior at school, their peers reject them. They are ostracized from children their own age and experience loneliness at school until they run away from their abusive families
- Once on the streets, the combination of antisocial behavior and rejection by conventional peers leads adolescents to form ties with deviant peer groups, which are important for explaining adolescents' subsequent involvement in risky, deviant behaviors (Whitbeck et al., 1997a; Whitbeck et al., 1999)
- Knowing the life histories of these adolescents makes it easier to understand the choices they make while on the streets. When resources are few and choices are extremely limited, the social context of street life--in which the end result for many of these homeless adolescents is often victimization--can be overwhelming."

The best practice that can be gleaned from this study is:

- Providing early intervention and counselling to these sexually abused children so that they have strong self concepts and develop social skills that would enable them to relate better to their peers

Suggestions from Ex Sex Trade Workers

The seventh study of our best practices is by **Benoit & Millar, 2001** interviewed 160 female, 36 male and 5 transgendered currently active sex workers residing in Victoria, BC and the surrounding area. The study received an evidence-based rating of **four** out of five.

Ex sex-trade workers were trained as research assistants and became involved in activities ranging from recruiting respondents, interviewing them, inputting questionnaire data into the computer program, and transcribing the tape-recorded interviews.

Characteristics and most of the findings of this study paralleled other studies although only a minority of respondents escape from their situations through the use of illicit addictive substances, with use slightly higher for those currently working as sex workers than those who have exited. Mental health issues are a major problem and even those respondents who have exited the trade for 2 or more years continue to struggle post-retirement with mental health and related problems that do not end simply by their leaving the sex trade life behind.

The following best suggestions were identified:

- Educate the public about the reality of sex workers' lives
- Campaign for changes in policy and legislation to make sex work safer
- Make available better education and training for police and other criminal justice personnel to encourage them to be more sensitive understanding of the dynamics of sex work across all venues
- Provide ready access to safe, stable, and affordable housing
- Provide ready access to appropriate and sensitive health and social service providers who are knowledgeable about the needs

Sexual Exploitation of Youth in British Columbia

The last study of our best practices is by the **Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth (1999)** and examines *Sexual Exploitation of Youth in British Columbia.* The study received an evidence-based rating of **four** out of five.

The following characteristics were identified:

- Youth leaving home at an early age with little education, namely, they are at risk of living on the street and, through economic need and association with other street youth, may turn to prostitution as a means of survival
- Youth become immersed in a subculture in which drug misuse is common. For many, drug dependency and the means to obtain drugs through trading sex become reasons for remaining involved in prostitution, and prevent them from being able to genuinely consider an alternative future
- A pattern of truancy from school is common before youth quit school completely
- Few commercially sexually exploited youth have completed high school, dropping out about grade ten. Many have not completed elementary school
- The majority of youth were reported to become involved through their family, community or lifestyle, and intergenerational involvement in the sex trade was reported to be common
- Older girls were also luring young girls into the trade
- A small proportion of youth, primarily in urban settings, were controlled by a pimp
- Pimp-related recruitment occurred in both unsupervised and supervised settings, i.e., anywhere youth tended to gather i.e., food courts in the malls, fast food restaurants and bus stops; but also supervised locations including community centres, youth drop-in programs, schools, group homes, juvenile detention centres, youth shelters and treatment centres.

Where Sexual Exploitation Happens

- Nightclubs, massage parlors, karaoke bars and apartments, hitch-hiking, at truck stops and through specific business.
- Kids can work through cab drivers taking the them to the tricks, or several girls might be set up in a room, or sometimes one guy will pick a girl up, then the trick will drive her to the next date
- In smaller communities, youth sexual exploitation was less visible and sometimes completely invisible to all but those directly involved and well-informed professionals. A wide range of venues was reported, including private homes, public docks, back alleys, parks, truck stops and fishing boats

Subcultures Emerging in Urban Areas

- Distinct subcultures in the sex trade are emerging in the urban areas
- Trafficking of Vietnamese girls in the Vietnamese community in Vancouver
- Trafficking of Sikh girls between Vancouver-area locations
- Trafficking circuit among cities in western U.S. and Canada

Sexual Exploitation of Aboriginal children and Youth

- Aboriginal sexually exploited youth in B.C. ranged from 14%-60% depending on the community consulted
- Are over-represented in the sexually exploited youth population
- The average age of becoming a victim of sexual exploitation was 15, although most also noted that the age at entry is getting younger and as young as 11 in some communities the vast majority of youth are female
- Exploited aboriginal youth come from reserves, rural communities and urban areas
- Many were attracted to the big city as an escape from family dysfunction at home and drawn by unfulfilled hopes of employment
- The resulting isolation, culture shock and poverty, together with substance addiction on the street, left them especially vulnerable to sexual exploitation
- In the same Aboriginal community, many of the Elder women had been involved in the sex trade when they were young, but historically they did not speak about it

Prevention-related resources and services for Aboriginal youth varied widely across communities, and most services were crisis oriented. These ranged from no services for older youth to:

- Life skills programs
- Detox services
- Peer counseling
- Recreation programs

Services were needed for programs that address:

- The risk factors and underlying problems leading to Aboriginal youth sexual exploitation
- Providing a comprehensive support network for youth who are already sexually exploited
- Emphasizing cultural reconnection and renewal
- Education and skill development

- Peer support
- Inter-service collaboration.

Suggestions for Services and Practices
These authors offer some suggestions gleaned from consultations with Canadian sexually exploited youth who indicate that in order to consider and initiate a successfully exit from the streets and prostitution, youth want and have need of:
- A wide range of supports and services
- Long-term practical and emotional support

The study revealed information which may be useful in finding out why efforts to assist these youth in the past *has not* worked, i.e.,
- There is widespread reluctance to use existing services, because of past negative experiences with service providers and fear of harassment and judgment. "Anyone needs emotional and physical safety in order to risk change. These kids have never experienced a trusting or healthy relationship, so why would they risk change?"
- The role of the "pimp in youth sexual exploitation is significant because many youth are lured into prostitution by pimps (often referred to as a "boyfriend") and are forced to stay in the sex trade because of drug dependency and/or retaliation from a pimp

Information provided by sexually exploited youth and in the literature provides some guidance in terms of recommended approaches to the provision of services for sexually exploited youth. The following suggestions by youth for best practices were identified:
- Increased outreach staff
- Youth addiction treatment services
- Residential mental health facilities
- Safe housing for sexually exploited youth
- Services that are designed for youth, to meet their particular needs and circumstances
- A multiservice agency approach
- Youth involvement in program development
- Peer support
- A continuum of services to meet the needs of sexually exploited youth during involvement and through the process of exiting and reintegration
- Public-private partnerships
- Recognition of community-wide responsibility
- Prevention strategies such as:
  - ✓ Awareness programs at both the school and community levels
  - ✓ A range of youth services and community activities that address the underlying factors that place youth at risk of sexual exploitation

Long range strategies must incorporate:
- Gender analysis
- Resiliency models
- The concept of healing
- Realistic expectations of change

- Abolishment of co-ed group homes, co-ed residential treatment and negative environments

Lastly, the authors call for structural changes to *legal reform*, saying the cost of services over 20 years for many of these youth is enormous, millions per youth. "By redirecting resources to prevention and early intervention rather than always reacting, we could do more and it would cost less."

15.3. LGBTQ Youth

The reviewed literature pertaining to the topic of LGBTQ Youth included **twelve** collected articles, **five** of which are included in this section. These studies and reviews received three-four out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Homeless LBGTQ Youth

The first of our best practice studies is by **Noell and Ochs, 2001** who explored the relationship of sexual orientation and gender to the following factors:

- Family history
- Incarceration
- Substance use
- Depression and suicide

Using a sample of homeless adolescents (216 females and 316 males – total of 532) recruited in the Portland, Oregon the authors assessed this group of youth using semi-structured interviews at baseline, three and six months. Sexual orientation and other variables (heterosexual n=391 and non-heterosexual youth n=141) were compared on all factors using logistic regressions. The study received an evidence-based rating of **four** out of five.

Homeless adolescents have been characterized as engaging in a wide variety of risky behaviours (Baily et al., 1998; Kipke et al., 1993) as have LGBTQ adolescents, particularly in terms of sexual behaviours, substance use, and suicide risk (Faulkner & Cranston, 1998; Rotheram-Borus et al., 1994). Relatively little is known about adolescents who are both homeless and LBGTQ. This study provided a prospective examination of a homeless youth population, comparing homeless LBGTQ youths and homeless heterosexual youths.

The following characteristics of homeless LBGTQ were identified:

- 44.9% of females identified as lesbian or bisexual, while only 13.9% of males identified as gay or bisexual
- LBGTQ youth are less likely to have been in foster care, but more likely to have spent time in a locked mental health treatment facility
- Sexual orientation was not significantly related to the family history variables of physical abuse, sexual abuse or who initiated departure from home or origin
- Regarding incarceration variables, LBGTQ youth were less likely to have been arrested
- LBGTQ status was significantly associated with several of the lifetime drug use variables for females, but not for males
- Lesbian-bisexual females were significantly more likely to have used injection drugs, amphetamines, marijuana and LSD than heterosexual females
- LBGTQ status was associated with greater likelihood of amphetamine use and injection drug use for both males and females

- LBGTQ status was associated with high rates of depression and suicidal ideation

The following best practices were identified:
- Providing substance misuse interventions particularly dealing with injection drug use among females who identify as lesbian/bisexual is critical
- Providing interventions that are female gender specific (i.e. the proportion of homeless female adolescents identifying as lesbian or bisexual is very high)
- Providing mental health services to deal with the high rates of depression and suicidal ideation is essential for LBGTQ adolescents

Risk Factors

The second study of our best practices is by **Dempsey, 1994** who provides an extensive review of professional literature regarding social and health issues of adolescent homosexuality and present implications for practitioners in providing culturally appropriate services. The study received an evidence-based rating of **three** out of five.

The following characteristics of LBGTQ youth were identified:
- 10% of our population is believed to be gay, lesbian or bisexual (Sanford, 1989)
- Schools fail to support gay youth out of legitimized fears of being accused of sexual exploitation or abuse and of promoting homosexuality (Sanford, 1989; Martin & Hetrick, 1988; Whitlock, 1989)
- Social isolation for these gay youth facilitates poor self-esteem, self-hatred, and self-abusive behaviors (Remafedi, 1990)
- Negative attitudes attached to homosexuality challenge the adolescent's fragile self-concept of masculinity or femininity and can induce internalized homophobia (Remafedi,1990), which may present itself as feelings of inferiority, being evil, lacking self worth and social value (Gonsiorek,1988), guilt, shame, depression, self defeating behaviors, and self destructiveness (remafedi,1990).
- The socialization process of gay adolescence involves learning to hide; in other words, they attempt to pass as heterosexuals (Uribe &Harbeck, 1992)
- LBGTQ youth are significantly at risk for:
    - ✓ Psychological dysfunction
    - ✓ Suicide
    - ✓ Substance abuse (58% in a non-clinical study reported they regularly used substances)
    - ✓ Homelessness (48% in a non-clinical study reported running away from home)
    - ✓ Dropping out of school
    - ✓ Prostitution
    - ✓ Being a victim of violence (40% suffered violence, 49% of this was from family members and sexual abuse (also rape is a common form of violence in group shelters (Martin & Herrick, 1988)
    - ✓ Acquiring sexually transmitted diseases
- Dempsey cites Whitlock (1989) who points out that whereas 1 in 10 heterosexual teens attempts suicide, 2 or 3 out of every 10 gay teens attempt suicide. The mean

age of the first attempt was 15, which was also the year 30% of these youth found out they were gay, lesbian or bisexual, although the primary precipitating cause was family problems

The following best practices were identified:

- It is essential for service providers to understand the meaning and experience of being gay and a teenager in order to provide competent and sensitive services (Remafedi, 1987; Sanford, 1989)
- Service providers need to promote therapeutic goals that promote physical, social, and emotional development in order to facilitate a healthy transition to adulthood (Remafedi, 1990)
- Services and treatment need to be based on sexual behaviors, not sexual orientation (complete sexual histories should be taken to provide the necessary information pertaining to treatment and services) (Sanford, 1989)
- LBGTQ youth need to be identified and assessed for suicidal risks, substance abuse, home and school problems that may precipitate running away or dropping out of school, and emotional problems (Remafedi, 1990; Sanford, 1989)
- Service providers need to become aware of community resources and make referrals as needed
- Support gay youth NGOs that provide LBGTQ youth opportunities to learn and practice social skills, share and exchange information, develop friendships, obtain peer support, explore the meaning of their sexual identity, and find positive role models (Gonsiorek, 1988) (such groups decrease emotional and social isolation, help members clarify values, and encourage responsible decision making) (Remafedi, 1990)
- All LBGTQ youth need comprehensive HIV prevention education (information should be presented in ways that show respect for youth regardless of sexual orientation (Sanford, 1989)

Suicide Prevention

The third study of our best practices is by **Morrison and Heureux, 2001** who examine the incidence rates and specific risks for suicide in LBGTQ adolescent population. An ecological model of suicide risk assessment for LBGTQ youth is presented based on Bronfenbrenner's model of human development. The model argues for individual, micro, and macro levels of assessment to increase clinical judgement and accuracy in determining high risk GLBQ adolescents. The model also delineates both primary and secondary intervention strategies that could be utilized to prevent GLBQ youth suicide. The study received an evidence-based rating of **four** out of five.

The authors stated that the State of Massachusetts has been a leader in analyzing state data with specific regard to suicide risk in GLBQ youth. In 1995, the Massachusetts Department of Education reported that students who described themselves as LBGTQ /or students who have had same-sex sexual contact reported being significantly more likely than their heterosexual peers to face threats, attempt suicide, and abuse drugs and alcohol. More specifically, the GLBQ youth were:

- Four times more likely to have attempted suicide
- Five times more likely to have used cocaine
- Five times more likely to miss school because of feeling unsafe (Massachusets Department of Education, 1995)

Similar results have been reported in the states of Washington (Seattle YRBS, 1995; Washington Safe Schools Anti Violence Project, 1995), and Vermont (Vermont Department of Health, 1995).

The following best practices were identified:

- Prevention of LBGTQ youth suicide needs to include treating the environments that interface with LBGTQ youth in addition to treating the adolescent themselves
- Practitioner need to assess **individual, micro, and macro system** risk factors of suicide for LBGTQ youth
- The following **individual** factors for increased risk of suicide need to be assessed (Garland and Ziglar, 1993): regarding the following factors:
  - ✓ Psychiatric history
  - ✓ Family history of suicide
  - ✓ Substance abuse
  - ✓ Availability of a lethal method.

  In addition to the above individual risk factors (common for all sexual orientations), LBGTQ youth are more at risk for suicide and need to be additionally assessed regarding the following if they:
  - ✓ Acknowledge their sexual orientation at an early age (Remafedi et al., 1991)
  - ✓ Report a sexual abuse and/or familial abuse history (Gibson, 1994)
  - ✓ Do not disclose their sexual orientation to anyone (Remafedi et al., 1994)
  - ✓ Self-present with high levels of gender non-conformity (Remafedi et al., 1991)
  - ✓ Report high levels of intrapsychic conflict regarding their sexual orientation (Savin-Williams, 1990).
  - ✓ Are "double minority" (i.e. lack of acceptance from their racial/ethnic community) (Savin-Williams and Rodriquez, 1993)
- The **microsystem** risk factors (individuals environment) needs to be assessed i.e. youth's positive or negative interface with teachers, parents, counselors, friends, religious communities, neighborhoods and youth serving agencies needs to assessed (Bronfenbrenner, 1997):
  - ✓ Lack of tolerance due to homophobic attitudes in teacher, peers, and family members increases suicide risk of LBGTQ youth
  - ✓ Negative experiences with practitioners (i.e. mental health and youth care providers) could further isolate a LBGTQ youth and put them over the edge in terms of suicidal (Morrison, 2000)
  - ✓ Lack of information regarding LBGTQ youth isolation and oppression in mental health care providers may contribute to misdiagnosis and a lack of preventative care for potentially suicidal LBGTQ youth
  - ✓ Families with rigid role structures and an inability to accept change have increased rates of suicide in family members (Richman, 1986). Thus a family that is unwilling to support, accept, and affirm a child that is questioning their

sexual orientation or coming out may contribute to an increased risk for suicidal ideation and attempts
    - ✓ Lack of informed support networks in the LBGTQ youth's immediate environment may increase risk for suicide attempts and completions (access to programs that affirm all sexual orientations and decrease isolation for LBGTQ youth may decrease all forms of self-destructive behavior, including suicide risk)
- The **macrosystem** risk factors (e.g. human rights law/legislation, profession ethical guidelines for psychologists, counselors and teacher, mass media, school, provincial and federal policies and prevalent cultural values) may indirectly influence suicide risk for LBGTQ youth:
    - ✓ When LBGTQ issues are prominent in the press, anti-gay violence often escalates, and threats, harassment and violence may put youth at increased risk for self-injurious behaviors (D'Augelli, 1992)
    - ✓ A second macrosystem factor in suicide risk assessment for LBGTQ youth is the presence or absence of school policies that set expectations for educators to neither tolerate nor participate in homophobic and/or anti-gay rhetoric (e.g., in performing a suicide risk assessment for a particular LBGTQ youth, if the young person attends school at an institution with (1) a non-discrimination policy which includes sexual orientation; (2) diversity training for staff and teachers on issues; and (3) diversity training for other students which includes LBGTQ issues, that student is less likely to face harassment and homophobia in school and therefore may be less likely to engage in self-injurious behaviors
    - ✓ Pressure can come from racial, ethnic, religious, national, and/or community cultural values

Obstacles

The fourth study of our best practices is by **Phillips and McMillen, 1997** who have explicated relevant information pertaining to the needs and obstacles that LBGTQ youth face with youth serving agencies and recommend how administrators and practitioners can make changes in agencies that are not adequately serving sexual minority youths. The authors worked with two agencies that have developed model programs to support the needs of gay and lesbian youth. They are located in metropolitan areas of the mid-west U.S. and provide a continuum of shelter care, out-client counseling, and community outreach services. The study received an evidence-based rating of **three** out of five.

The following characteristic of LBGTQ youth were identified:

- LBGTQ youth face numerous obstacles from service agencies attempting to serve them [Durby 1994; Gonsiorek 1988; Hetrick & Martin 1987; [Mallon 1992; Sullivan 1994]
- LBGTQ youths appear to be at greater risk of depression, suicide, and chemical dependency than their heterosexual peers (see Durby [1994] and Gonsiorek [1988]
- Studies have consistently shown extremely high suicide attempt rates among gay and lesbian youths [D'Augelli & Hershberger 1993; Proctor & Groze 1994; Schneider et al. 1989]

The following best practices were identified:

- Youth service agencies need to become more responsive to the needs of their gay, lesbian, and bisexual clients [Child Welfare League of America 1991; Mallon 1992a, 1992b; McMillen 1991
- Sensitivity toward gay and lesbian youths need to be embedded in programs designed to increase employees' understanding of the social realities of varying client groups (i.e. ethnic, religious, cultural, and socioeconomic)
- Comprehensive diversity programs need to include:
  - ✓ In-service training
  - ✓ Non-discrimination policies
  - ✓ Participation in culturally specific celebrations and holidays
  - ✓ Advocacy
  - ✓ Employment strategies
  - ✓ Client and staff groups that explore diversity
  - ✓ Efforts to create a climate that welcomes all people (Sue 1991)
- Implementing group-based after-school services for at-risk youths to provide a historical perspective of human rights charters in Canada as an effort to increase youth empowerment, self-esteem, and respect for varying cultures (i.e. such a program could include key events and figures in the human rights movements for women, Aboriginal, and gays and lesbians)
- Youth-serving agencies need to demonstrate a commitment to the safety of all clients by providing zero tolerance policies against violence, emotional maltreatment, and direct or inadvertent mistreatment
- Providing policies with a strong stance against physical aggression and verbal harassment sends important messages regarding gay and lesbian youths

Hiring Staff

- Hiring staff who demonstrate a commitment to providing services that foster self-esteem and acceptance of LBGTQ youth (agencies must strive to hire open-minded, and supportive employees) Three strategies to achieve this end are:
  - ✓ Communication of anti-discrimination policies
  - ✓ Recruitment and employment of gay and lesbian staff members
  - ✓ Assessment of attitudes during interviews (Phillips & McMillen, 2001)
- Hiring staff members who reflect the client population is important (i.e. including different ethnic groups, religious affiliations, and sexual orientations)

Inservice Training

- To guarantee adequate coverage of sexual minority matters, the following strategies for inservice training need to be incorporated:
  - ✓ gay and lesbian concerns are incorporated into all training sessions
  - ✓ general information is presented at seminars about gay and lesbian youth issues
  - ✓ role-plays are used to develop appropriate language usage
  - ✓ experiential exercises are used to develop natural, appropriate responses

- Sensitivity to gay and lesbian concerns need to be incorporated into all training sessions (i.e. staff education regarding youth suicide would not be complete without discussing elevated levels of attempted suicide among sexual minority adolescents and the reasons for this (Proctor & Groze,1994)
- Staff must practice using gender neutral language and intervening when hurtful, homophobic language is used. Appropriate language usage has repeatedly been emphasized as crucial to successful interventions with sexual minority youths (Herdt 1989; McMillen 1991; Morrow 1993)
- Agencies must develop diligence in training and approaches to practice. For an agency to be consistently sensitive to the needs of its clients, efforts to welcome sexual minority youths and to understand their social realities should be institutionalized
- To serve gay and lesbian youths better, agencies need to be guided by philosophies that embrace diversity and translate these into concrete actions

Youth Development

The fifth study of our best practices is by **Mallon, 1997** who examined a youth development perspective for working with LBGTQ youth including:

- Principles that promote youth development
- Ways in which youth practitioners should incorporate the guiding principles of youth development
- Presentation of a model for creating an environment to meet the personal and social need of LGBTQ youth

The study received an evidence-based rating of **three** out of five.

The author purports that gay, lesbian and bisexual youths in out-of-home care should receive supports and services using principles and practices of a positive youth approach rather than focusing on control and treatment. The goal of a youth development approach is to provide the supports and opportunities that will best promote young people's competence and their connectedness to families and communities. Basic needs critical to survival and healthy development are set forth by Pittman and Cahill (1991) and include:

- Safety and structure
- Belonging and membership
- Self-worth and an ability to contribute to society
- Independence and control over one's life
- Closeness and several good relationships
- Competence and mastery
- Self-awareness.

The study evaluated a program called the Triangle Tribe based at the Green Chimneys Children's Services on Manhatten's East Side in New York City. The Triangle Tribe utilizes a positive development approach to guide their working philosophy vs. a treatment service approach. This successful program is based on a model by Pittman & Zeldin, 1995 incorporating five premises to use in working towards positive youth services and supports (The following best practices were identified):

- Premise One -Possibilities and Preparation:

- ✓ Programs that are tailored to meet clients' needs and interests as opposed to programs that have a "one-size-fits-all" approach, are better equipped to meet the needs not only of gay, lesbian, and bisexual youths and their families but of all youths and their families
- ✓ Programs are designed by a youth and adult planning group that recognizes from the outset that the goal of the project was not simply problem reduction, but the enhancement of supports and opportunities for gay, lesbian, and bisexual youths
- ✓ Young people were involved in brainstorming ideas for the funding proposal

- Premise Two - Participation:
  - ✓ Development only occurs, note Pittman and Zeldin, 1995 when young people are engaged and immersed in program activities
- Premise Three - People:
  - ✓ Relationship building ("people") is perhaps the most important premise underlying effective youth development practice (attention on the part of professionals and other adults to the establishment of respectful, supportive relationships enables young people to fully engage in programs and services)
  - ✓ Adult members of the Tribe were selected for their expertise in working with gay, lesbian, and bisexual youths and their ability to establish caring relationships with these young people and families of diverse backgrounds
- Premise Four - Place and Pluralism:
  - ✓ Organizations need to create an environment that signal safety and acceptance while allowing youth to take healthy risks, make real choices, contributions and form lasting relationships
  - ✓ Providing a safe place for youths to be themselves and promoting an organizational culture that supports and recognizes cultural strengths and differences in clients populations are essential
- Premise Five - Partnerships
  - ✓ Working from a positive developmental perspective means recognizing that development occurs within multiple contexts and therefore requires partnerships among key players, including youths, family, service providers, and community. (The Tribe has always viewed these community stakeholders as resources and has included them as significant partners in all phases of program development)

16.3. Youth Development Approach

The reviewed literature pertaining to the topic of Youth Development Approach included **twelve** collected articles, **four** which are included in this section. These studies and reviews received three-five out of five for typology ratings, categorizing them as empirically sound with strong evidence to support best practices (see Section I. 5.2, page 8).

Youth Development Approach

The first study of our best practices is by **Johnson et al., 1998** - Family and Youth Service Branch (FYSB), U.S. Department of Health and Human Services who have evaluated and integrated youth development principles into all of the programs that they administer. The study received an evidence-based rating of **four** out of five.

Over the last twenty years the FYSB maintained a youth development approach and have a long history of supporting local efforts in accessing youth development approach.

FYSB have identified four factors that allow most young people to stay out of trouble:

- A sense of competence
- A sense of usefulness
- A sense of belonging
- A sense of power

FYSB has maintained a focus on a youth development approach for several reasons:

- Programs with a youth development focus offer young people the skills and knowledge they will need to function effectively as adults in an increasingly competitive world
- FYSB recognizes that it is crucial that positive developmental opportunities be available during adolescence, a time of rapid growth and change. Adolescents need opportunities to fulfill developmental needs in the physical, intellectual, psychological, social, moral, and ethical areas. They benefit from experiential learning, need to belong to a group while maintaining there individuality, and want adult support and interest. They also need opportunities to express opinions, challenge adult assumptions, and develop the ability to make appropriate choices, and learn and use new skills.
- FYSB understands that developmental programs are needed now more than ever because of increasing poverty, violence, and hopelessness in many neighborhoods. In such communities, developmental opportunities for young people are limited by crime and violence, which affect young people's ability to move about their neighbourhoods safely to participate in after school activities. Dehumanizing living conditions affect their ability to see themselves as valuable and important contributors to society who have a range of choices regarding careers, beliefs, and lifestyles. Inadequate educational opportunities discourage learning, preventing young people from developing the ability to reason and solve problems. In such environments, a commitment by communities to creating programs and services that meet young people's developmental needs is critical.

FYSB has integrated youth development principles into all of the programs that it administers. The following best practices have been identified:

- Viewing young people and families as partners rather than as clients, and involving them in designing and delivering programs and services
- Giving all youth access both to prevention and intervention services and to programs that meet their developmental needs
- Directing programs and services to at-risk and high-risk youth, rather than targeting only those in high-risk situations
- Offering youth opportunities to develop relationships with caring, supportive adults
- Require youth emergency shelters to actively involve youth in the ongoing planning and delivery of services
- Shelters can invite young people to serve on their boards of directors or provide opportunities for them to serve as peer counsellors/mentors
- Establish mechanisms for obtaining feedback from young people assisted by the shelter about the quality of services
- Develop performance standards that require shelters to provide young people with developmental opportunities by scheduling leisure-time activities that help them discover new skills and interests
- Designed program performance standards to ensure that emergency shelters and drop-in centres provide high quality care. The standards provide agencies with operational guidelines in areas, such as providing counseling and aftercare, ensuring that youth participate in designing and delivering services, and maintaining confidentiality
- Design Transitional Living Programs (TLP) for older homeless youth specifically designed to meet the developmental needs of homeless young people. The TLP builds competencies that youth need to move to independent living, such as basic life skills, interpersonal skills, job preparation and attainment, and physical and mental health
- Develop performance standards that ensure youth have opportunities within TLP to build significant relationships by living and learning in a supportive, structured environment in which adults are available to advise and assist them. In addition, each TLP youth works with staff to establish individual goals and action steps. This process helps them gain decision making skills and a sense of control over their future
- Support local collaborations in offering youth people constructive afterschool activities that are based on a youth development model
- Agencies are required to develop a common vision for meeting the needs of youth and for promoting relationships between youth and caring adults
- Fostered meaningful youth participation in program design and delivery and offer a range programs and develop linkages with other community agencies to ensure that young people have access to services and chances for academic, social, and personal growth
- Youth development requires collaboration. No single community organization can provide the range of developmental, preventive, and intervention programs and services required to give young people the experiences they need to mature into successful adults. Rather, creation of such programs requires collaborative planning by a community's youth-serving agencies, other social service and educational institutions, policymakers, community leaders, and young people

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

Youth Development Approach (cont'n)

The second of our best practices is by the **Social Development Research Group (University of Washington), 1997**, conducted an extensive review of twenty-five positive youth development programs. The programs reviewed for this study all sought to achieve one or more of these positive youth development objectives with youths aged 6-20. Programs were not included if their activities represented treatment of, or a response to a diagnosed disorder or behaviour problem. All evaluations of these programs were considered against the usual standard in the field-research designs

employing control or at least strong comparison groups and all measured youth behavioural outcomes. The study received an evidence-based rating of **five** out of five.

Program Findings:

- The 25 programs were found in community, school, and family settings. Eight approaches took place in one environment, either the community or schools. The remaining 17 programs combined their strategies in either two (typically the family and school) or three (the community combined with the family and school) environments. School components were used in 22 (88%) programs, family components in 15 (60%), and community components in 12 (48%)
- The study showed that there are at least three ways in which positive youth development programs engaged the family:
    - ✓ Through parent skills training (seven programs)
    - ✓ Through using strategies that involve parents in program implementation (nine programs)
    - ✓ Through strategies that involve parents in program design and planning (two programs). Several programs combined parent skills training with parental involvement in implementation or organizational strategies
- When positive youth development programs involved the community, they often used it's many resources to enhance the other youth, family, and school strategies. For example, one intergenerational mentoring program sent youth and their older mentors together into nursing homes to work side by side with residents of the homes, while another placed youth and their parents in neighbourhoods mobilizing for change as the whole family received communication skills training in another setting. Several programs targeted community factors more broadly, through influencing local city or neighbourhood policies for youth, or through the use of mass media
- Effective programs addressed a range of positive youth development objectives yet shared common themes. All sought to strengthen social, emotional, cognitive and/or behavioural competencies, self-efficacy, and family and community standards for healthy social and personal behaviour. Seventy-five percent also targeted healthy bonds between youth and adults, increased opportunities for youth participation in positive social activities, and recognition and reinforcement for that participation
- The youth competency strategies varied among programs from targeting youth directly with skills training sessions, to peer tutoring conducted by at-risk youth, to teacher training that resulted in better classroom management and instruction. The evidence showed an associated list of important outcomes including better school attendance, higher academic performance, healthier peer and adult interactions, improved decision-making abilities, and less substance use and risky sexual behaviour
- The study highlighted the importance of two features also generally present in effective programs. One is the importance of using structured program guidelines or manuals (curricula) that help those delivering the program to implement it consistently from group to group, or from site to site. Twenty-four (96%) programs used training manuals or other forms of structured curricula. The second aspect is that programs require sufficient time for evidence of behaviour change to occur, and to be measured. Twenty (80%) programs provided their services for nine months or more

This study concluded:

- A wide range of positive youth development approaches can result in positive youth behaviour outcomes and the prevention of youth problem behaviours
- Nineteen effective programs showed positive changes in youth behaviour, including significant improvements in interpersonal skills, quality of peer and adult relationships, self-control, problem solving, cognitive competencies, self-efficacy, commitment to schooling, and academic achievement
- Twenty-four effective programs showed significant improvements in problem behaviours, including drug and alcohol use, school misbehaviour, aggressive behaviour, violence, truancy, high risk sexual behaviours, and smoking

Themes common to success in the programs involved methods to:

- Strengthen social, emotional, behavioural, cognitive, and moral competencies; build self-efficacy; shape messages from family and community about standards for positive youth behaviour
- Increase healthy bonding with adults, peers and younger children
- Expand opportunities and recognition for youth who engage in positive behaviour and activities
- Provide structure and consistency in program delivery
- Intervene with youth for at least nine months or more
- Combine resources of the family, the community, and the community's schools

Primary Settings for Implementing Youth Development

The third of our best practices is by **Benson and Saito, 2000** who examined the status of youth development research and provided an extensive overview of current literature. The study received an evidence-based rating of **four** out of five.

The authors determined that there are four primary settings in which youth development principles are applied and in which youth development occurs. They are:

- *Programs* - these are semi-structured processes, most often led by adults and designed to address specific goals and youth outcomes. A program can be considered a youth development program when it intentionally incorporates experiences and learning's to address and advance the positive development of children and youth. This category incorporates a range of programs from those that are highly structured, often in the form of curriculum with step-by-step guide-lines, to those that may have a looser structure but incorporate a clear focus on one or more youth development activities. Schools, national voluntary youth organizations, and community-based organizations are primary, but not exclusive, delivery systems.
  Recently, the Social Development Research Group at the University of Washington completed a meta-analysis of 25 program evaluations that met specific criteria related to program content and standards (Catalano et al., 1998). The program criteria include a focus on promoting competencies and social, emotional or cognitive development; the target population is youth aged 6 to 20. Program evaluations were required to

show significant effects using a strong research design with comparison groups and to measure behavioral outcomes. Some of the outcomes these programs improved were:

- ✓ Self-control
- ✓ Assertiveness
- ✓ Problem solving
- ✓ Interpersonal skills
- ✓ Social acceptance
- ✓ School achievement
- ✓ Completion of school work
- ✓ Graduation rates
- ✓ Parental trust
- ✓ Self-efficacy
- ✓ self-esteem

At the same time, data showed a decrease in the following negative outcomes:

- ✓ Alcohol, tobacco and other drug use
- ✓ hitting, carrying weapons and vehicle theft
- ✓ school failure, skipping classes and school suspensions
- ✓ negative family events
- ✓ teen pregnancy.

- *Organizations* - this category includes "place-based" youth development opportunities, i.e., settings in which a wide variety of activities and relationships occur which are designed to improve the well-being of children and youth. Using the definition offered by Costello et al., 1998 these are "structures in which people and resources are coordinated for a definite purpose". Examples include school-based after-school recreation and co-curricular activities, parks and recreation centers and leagues, community centers, amateur sports leagues, faith based youth development opportunities, and the myriad of places and opportunities developed by community-based and national youth organizations (e.g., YMCA, YWCA, Girl Scouts, Boy Scouts). These kinds of settings can mobilize a wide range of formal and informal youth development inputs.

  In one of the more comprehensive syntheses of the scientific literature on adolescent development, Scales and Leffert (1999) include a section on studies related to constructive use of time, including participation in youth organizations. Some of the outcomes they describe are associated with involvement in youth development settings. They include:

  - ✓ Increased self-esteem, increased popularity, increased sense of personal control and enhanced identity development; public, decision-making, and increased dependability and job responsibility
  - ✓ Greater communication in the family
  - ✓ Fewer psychosocial problems, such as loneliness, shyness and hopelessness
  - ✓ Decreased involvement in risky behaviors, such as drug use, and decreased juvenile delinquency
  - ✓ Increased academic achievement
  - ✓ Increased safety

Many of the evaluations of youth development organizations focus on a particular program of curriculum, such as the evaluation of Boys & Girls Clubs of America's alcohol and other drug abuse prevention program called SMART Moves (Boys & Girls Clubs of America, 1991). This evaluation included five public housing sites, each with two control groups: one public housing site without a Boys & Girls Club and one public housing site with a Boys & Girls Club that did not use SMART Moves. Of particular interest to us as we explore the evidence of impact by youth development organizations, this study found that Boys & Girls Clubs appeared to have a positive impact on youth (and adults) in public housing sites, regardless of whether they used the SMART Moves initiative. These outcomes include a reduction in alcohol and drug use, drug-related crimes and drug trafficking (Benson and Saito, 2000).

- *Socializing systems* - youth are embedded in an important array of complex systems intended to enhance processes and outcomes consonant with youth development principles. These include schools, families, neighborhoods, religious institutions, museums and libraries. When we expand to socializing systems and community, we move from specific settings and places constructed to deliver on youth development targets to complex entities where youth development becomes an approach or philosophy designed to inform, reform or transform existing systems. Included here are schools, religious congregations, public safety and courts, neighborhoods, employers and families. There are, we will argue, a growing number of social scientists and practitioners who seek to draw youth development perspectives into these important spheres of developmental influence. For example, a number of middle school reform initiatives are premised wholly or in part on mobilizing the climate, norms and relationships of schools to better meet developmental needs (Connell, 1996; Scales, 1996). Other efforts are emerging to draw youth development principles and strategies into a wide range of other systems, including neighborhoods, park and recreation departments, city and county government, and employers (Benson and Saito, 2000).

- *Community* - this is the most general of the four categories, the most difficult to define, and perhaps the most potentially powerful source of youth development. For now, we use the concept of community to include not only the geographic place within which programs, organizations and systems intersect, but also the social norms, resources, relationships and informal settings that can dramatically inform human development, both directly and indirectly. Applications of the varied concepts of community are now common in a number of applied areas, including alcohol and other drug use prevention (Hawkins and Catalano, 1992), student learning and achievement (Comer, 1997; Epstein, 1996), and health promotion (Walberg et al., 1997). The theme running through these community-based theoretical and action formulations is the assumption that both child and adolescent well-being require the engagement and participation of multiple community forces and sectors. Recent studies have helped to define several of the dimensions of this engagement. The initial publication of the National Longitudinal Study of Adolescent Health (Resnick et al., 1997) concludes that youth's connectedness to such multiple support networks

as family, school and community serves as an important protective factor across multiple domains, including emotional health, violence, substance use and sexuality. In an analysis of the variability of violent crime in 343 Chicago neighborhoods, Sampson et al., (1997) suggest that the level of social cohesion within neighborhoods, combined with the level of shared commitment to take action, is strongly linked to rates of violence, beyond what is accounted for by demographic factors like income and residential stability. What is particularly relevant is that the definition of the common good is that the glue that unites neighbors in shared purpose and action has to do with the welfare of neighborhood children and youth (Benson and Saito, 2000).

Community-Based Family Support and Youth Development Approach

The fourth study of our best practices is by **Batavick, 1997** who examined key elements and relative success of family support and youth development practice including:

- Comparison on the family support and positive youth development approach
- How to improve family support programs
- Evaluation of family support programs
- Benefits from youth development programs
- Suggestions for integrating youth development and family support programs

The study received an evidence-based rating of **three** out of five.

The community-based family support approach has been hailed by many in the social service field as the best way to work with children and families (Batavick, 1997). On a community level, it promotes integrating existing supports to reduce fragmentation and duplication. On a family level, it uses the strengths perspective to build on family supports and strengths, as well as to empower consumers to shape their own plans and the systems that serve them.

At the same time that acceptance for the family support approach has grown, a parallel approach has gained momentum in the youth services field. Known as youth development, grounded in the philosophy of positive youth development, this movement also integrates community supports, strengthens family functioning, and empowers its consumers to shape their own plans and the programming that affects them. Both movements emphasize that involving consumers in collaborative planning creates more responsive and effective programs (Batavick, 1997).

Batavick, 1997 states that funding streams have also affected family services and community intervention. The private non-profit sector is being asked to take a large role in providing social services and is often funded by grants, many of which mandate a collaborative effort involving multiple agencies. The hope is that agencies will be able to view their efforts as contributing to overall community prosperity rather than only helping individuals. Many federal funding and foundation sources, however, are designed to serve families or youths but do not encourage agencies to serve both. The result, in these instances, is that youths participate in programs separate from their families, and that family support programs do not benefit from the resource that youths represent.

The family support and positive youth development approaches parallel each other and have the potential to complement each other. Both are asset/strengths-based, encourage consumer involvement, value empowerment more than treatment, and are consistent with an ecological perspective and systems theory.

The following best practices were identified:

- Implementing a family support approach:
  - ✓ A family support approach values families, communities, and different cultural groups for their strengths and for their diversity (Melaville et al. 1993)
  - ✓ Social service staff members are trained in cultural competence: respect for people from different racial and cultural backgrounds, knowledge about the norms and customs of different cultures, and celebration of this diversity
  - ✓ Staff members take on roles that resemble extended family and are committed to altering the structure of the agency and the social service system to create this atmosphere (Riley 1995).
  - ✓ Family support works best in agencies where staff members are enabled to transform client involvement and input into policy and administration, making the entire system more effective and responsive than agencies that operate in a typically hierarchical fashion
  - ✓ Family support programs always start with the community as a source of ideas and knowledge, have home visiting or at least create a homelike program environment, and demonstrate flexibility through drop-in child care and service options
  - ✓ Focus remains on the family as a unit, celebrating its strengths and striving to retain its integrity and enhance its functioning.
  - ✓ Efforts to strengthen community ties and natural helping networks follow readily (Dunst 1995)
  - ✓ While social workers usually make up the core staff of a family support program, the use of community members as paraprofessionals can help a program be more responsive and feel more comfortable to participants [Zigler & Black 1989].
  - ✓ Understanding the Population - to begin a family support program, planners and professionals must have an understanding of the community's structure and an appreciation of its strengths. Spending time in the community and speaking with those who live there help greatly
  - ✓ Family Involvement and Empowerment - the parents suggest that organizers support and encourage parents' talents, keep in mind that the community belongs to the parents, create stipends or paid positions to encourage a feeling of partnership, be role models, be open to letting parents experiment and express their views, avoid belittling language, and never come with their own agenda

- Implementing a positive youth development approach:
  - ✓ Focus shifts from trying only to eradicate youths' problems to helping youths prepare for adulthood. Through the youth development lens, youths are viewed as part of a family and a community and are encouraged to take an active role in shaping and building their family and their community

- ✓ Positive youth development is a value perspective as well as a set of concrete actions. It recognizes the inherent value of youths and seeks to draw on youths' strengths and build on youths' competencies. Doing so not only helps youths build a positive self-image and critical skills, but also enables the entire community to benefit from the ideas, talents, and energy that youths have to offer
- ✓ Youth development programs encourage competency development through youth-adult partnerships, enabling youths to plan artistic or community organizing projects and creating opportunities for youths to care for younger or elderly persons in their community. The programs also award and nurture youth leaders, recognize youths' strengths, encourage independent decision making, and create opportunities for youths to belong to a valued group
- ✓ While statistics highlight the importance of programs that serve youths, youth development theory and practice are not rooted in descriptions of problems. Rather, they focus on how the environment affects youth development, such as the impact of the youth's family and neighborhood on differences in developmental pathways, expectations of the youths' role within their culture and community, and the way that youths see themselves (Chalk & Phillips 1996)
- ✓ Youth involvement and empowerment - involving youths in planning and decision making is central to the youth development movement

- Providing an asset/strengths-based programming approach - the focus shifts from providing services that respond to consumer problems to providing supports and opportunities that enable personal growth. Zeldin (1995) defines opportunities and supports for youth development:

  Opportunities are the ongoing chances for young people to:
  - ✓ Be actively involved in their own learning
  - ✓ Make decisions and contributions
  - ✓ Take on challenging roles and responsibilities
  - ✓ Engage in part-time or volunteer work

  Supports are the ongoing relationships through which young people become connected to others and to community resources. Supports can be:
  - ✓ Emotional
  - ✓ Motivational
  - ✓ Strategic.
- Family support centres also emphasize providing opportunities and supports through inclusion of parents on planning groups and other parent participation strategies give parents the opportunity to support each other and to improve the program and their neighbourhood
- Insuring consumer involvement in planning and community development - is central to both the family support and youth development approaches. Research in youth development has shown that "when young people have ongoing chances to have a voice, to make decisions, to contribute, to make choices, then they are more likely to achieve positive outcomes" (Zeldin 1995). This is true for three reasons: participation allows youths to develop skills, enables them to take ownership of the program or activity, and ensures that the program or activity reflects youths' strengths, interests, and needs. Encouraging parent participation sends a message to parents that they

have the skills and the knowledge to know what is best for their children and their communities. Parents who are involved in programming that affects their children are more likely to be more involved in the lives of their children (Batavick, 1997)

- Providing empowerment rather than treatment - traditionally, social and mental health services have been designed to reduce deficits through treatment-based behavioral, psychodynamic, or case management models. Youth development and family support work focus on empowering community members to identify and build on their strengths. The goal of family support extends past short-term needs such as employment or family reunification to encompass structural change in family, community, or service systems. The youth development field uses the mantra "problem free is not fully prepared" to emphasize the importance of longer-term goals for youths (Pittman & Cahill 1991). Being fully prepared includes possessing fully developed social skills, civic and cultural competencies, positive attitudes toward community, and a strong sense of identity (Zeldin 1995).
- Staff need to act as catalysts to consumer empowerment by providing supports and opportunities for families and youths to contribute to their own development and to be involved in programs. Preparing staff to play this critical role requires significant investment in training and support by program managers and administrators.
- Use of systems theory and the ecological perspective – the ecological perspective views all people in the context of their social, cultural, and physical environment. It recognizes that interdependence is more realistic than independence and healthier than dependence. Both family support and youth development practice aim to work with children, youths, parents, and other community members with respect and appreciation for their racial and cultural identity and the family and community structures that support them. The role family support and youth development practice is to work with and seek to strengthen these systems, rather than to supplant them. Systems theory asserts that each member of a system contributes to its structure. This can be interpreted to mean that each member holds the power to change the structure of the family and community in which they live (Melaville et al. 1993; Zeldin 1995).
- Recognizing the resources of both youths and parents - A collaborative program that involves families and youths can thrive by using the strengths of both. Parents can mentor, tutor, and provide other supports for youths, while youths can care for younger children, create murals and theater productions, or improve the physical environment. Both parents and youths can work together in planning and organizing programs and community activities. The community would benefit from their knowledge and ideas and a new generation of leaders would be able to learn from their elders.

17.3. Service Delivery Systems

Self-Regulating Service Delivery System
The study is by **Junek and Thompson, 1999** who presented information on a conceptual model of service delivery applicable to children and youth at risk. The author introduced the factors that led to the development of the model including a brief overview of present service delivery in Canada, notes on some major trends in the United States, and a summary of major structural problems with present services delivery. This is followed by a description of the self-regulating model and system functioning, steps to implement the model, the role of government, evaluation, and potential benefits. The study received an evidence-based rating of **three** out of five.

The model arose to meet the challenges posed by the fundamental problems of present service delivery and attendant attempts at reform (Culbertson, 1993; Junek, 1994; Henggeler, 1994; Friedman, 1994). In both Canada and the United States, reform has taken the direction of seeking systems integration, accountability, evaluation, and cost efficiency. Thus, the author present a model that was designed to address a number of system problems in the context of these "reform" values.

This article proposes that the many long-standing and fundamental difficulties with service delivery can be addressed by self-regulating systems. A self-regulating service delivery system places a major emphasis on regular measurements of outcome in two domains: consumers of services and the general population. It depends on the development and regular use of powerful incentives focused on the outcome indicators to drive a system of constantly improving outcomes. It suggests that a number of other features naturally evolve from it or are induced by it: better quality, interorganizational cooperation, less duplication, stronger community support, high staff morale, efficiency, and better use of resources. As a system, it is driven by the pursuit of success for our youth.

The author stated the following problems with the present mode of service delivery in Canada:

- The system of care (as opposed to its separate component organizations) often exists without either a mission statement or relevant goals. In addition, there are few regular indicators of outcomes relevant to the clients or the general population that would measure some facet of goal attainment. In consequence, the system of care in most jurisdictions has problems both focusing on where it is going and determining whether it is getting there (Bickman, 1996).
- In the absence of valid indicators of child health, organizations are left open to many other influences, each of which comes with its own set of incentives and disincentives. As a result, the organizations are open to serving many more purposes than just benefiting children at risk. Competing purposes include special interests or dislikes of executive officers, board members, and politicians as well as influences

due to the media, lobbies from special interest groups, and the community's demand that the system provide employment.

- There is little to no external incentive for efficiency (surplus dollars often must be returned to central coffers rather than be reinvested locally), producing better outcomes (no one knows what the outcomes are), coherent planning, priority setting, or action.
- It is the rare case in which resources can be moved from one segment of a system to another as the need arises, and different components often seem to be unable to coordinate their services even when all parties might agree that it is a good idea to do so. The crux is that there is no mechanism that can cause the whole system of care to decide, act on, and implement coherent action.
- It is difficult to judge the best balance of resources to invest in service delivery, prevention of disorder, and promotion of well-being. Public health nurses, primary care physicians, and kindergarten teachers are known to see many of these children and, therefore, are part of the actual resource expenditure, but little is known about what they do or how to incorporate or coordinate their activities with a system of care (Offord et al., 1987)
- Provincial and territorial governments have key roles yet are themselves part of the problem. The various departments, subsections, and committees created inside government to mandate, fund, and regulate services add to the complexity of service delivery. Specific integrative efforts to date have not overcome this problem.

The following recommend practices were identified:

- Implementing a self-regulating model has major implications for provincial governments that would shift focus more to consumer and population outcomes of service delivery and away from the process
- A mission, the desired purpose, for the system of care is established for youth. Goals, indicators, outcome mearsures are developed for the consumer and population domains
- Developing outcome measurements that reflect high-risk youth issues in services and the population
- Measurements are taken at regular intervals. The results, representing a progress report of the wellbeing of youth and families, are provided regularly to organizations, regional authorities, government, and the public. The results from one cycle form the baseline for the next cycle. The executives of organizations use the outcome indicators to evaluate progress toward the goals and purpose. Their own internal process indicators will help them decide which actions to take to lead to improved outcomes in the subsequent years. The executives also will note that some important indicators cannot be achieved without cooperative action with others in the system of care.
- Developing a powerful motivational and incentive structure to accompany the desired outcomes is essential to induce positive changes in youth services and motivate provider behavior. Rewards for specific achievements are given to regions, communities, organizations, or individuals who reach or exceed their goals. The periodic and desired rewards become the incentives; for example, rewards can be attached to reduce young offender recidivism rates and others to reduced general

youth drug abuse rates to induce the decisions to develop effective preventive programs. Not only will the system flounder without strong rewards for achievement, but also the nature and importance of these rewards will reflect the importance of youth in society.

- Providing an accountability process for service delivery organizations that emphasized the most important product--better outcomes
- Evaluating the consumer and population outcomes leading to a singular and joint focus on them
- Providing communities with increased freedom and creative opportunities to manage their service delivery; reduce overlap and duplication, and induce more cooperation

Appendix B

Bibliography

REFERENCES

Aber, J.L., Brown, J.L., Chaudry, N., Jones, S.M., & Samples, F. (1996). The evaluation of there solving conflict creatively program: an overview. American Journal of Prevention Medicine, 12 (5).

Acorn, S. (1993). Emergency shelters in Vancouver, Canada. Journal of Community Health, 18 (5).

Antoniades, M. & Tarasuk, V. (1998). A survey of food problems experienced by Toronto street youth. Canadian Journal of Public Health, 87, 371-375.

Arella, L.R. (1993). Multiservice adolescent programs: Seeking institutional partnership alternatives. Journal of Youth and Adolescences, 22 (3).

Alexander, J.F., Robbins, M.S., & Sexton, T.L. (2000). Family-based interventions with older, at-risk youth: From promise to proof to practice. Journal of Primary Prevention, 21 (2).

Alexander, K.L., Entwisle, D.R., & Kabbani, N.S. (2001). The dropout process in life course perspective: Early risk factors at home and school. Teachers College Record, 103 (5), 760-822.

Bank, L., & Burraston, B. (2001). Abuse home environments as predictors of poor adjustment during adolescence and early adulthood. Journal of Community Psychology, 29 (3), 195-217.

Baron, S.W., (1999). Street youths and substance use. Youth & Society, 31(1), 3.

Barrett, D. (1998). Young people and prostitution: Perpetrators in our midst. International Review of Law, Computers & Technology, 12 (3), 475.

Barrow, S., & Zimmer, R. (1998). Transitional housing and services: A synthesis. The 1998 National Symposium o Homeless Research.

Barter, K (1999). Building community: A conceptual framework for child welfare. Journal of Child and Youth Care, 13 (1),49-72.

Barton, W.H., & Watkins, M. (1997). Youths and communities: Toward comprehensive strategies for youth development. Social Work, 76 (5), 483

Baruch, G. (2001). Mental health services in schools: The challenge of locating a psychotherapy service for troubled adolescent pupils in mainstream and special schools. Journal of Adolescent, 24, 549-570.

Batavick, L. (1997). Community-based family support and youth development: Two movements, on philosophy. Child Welfare, 76 (5), 639.

Bickman, L. (1996). A continuum of care more is not always better. American Psychological Association, 51 (7), 689-701.

Booth, R.E., Zhang, Y., & Kwiatkowski, C.F. (1999). The challenge of changing drug and sex risk behaviors of runaway and homeless adolescents. Child Abuse and Neglect, 23(12), 1295-1306.

(British Columbia) Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth. (2000). Sexual Exploitation of youth in British Columbia. Victoria: Ministry of Health.

British Columbia (1996). Community Consultation on Prostitution in British Columbia: Overview of Results. Ministry of Attorney General.

Bruner, C. (1994). Occasional paper #10 issues in developing comprehensive, community-based service systems. Child Protection Clearinghouse.

Buckner, J.C., & Bassuk, E.L. (1997). Mental disorders and service utilization among youth from homeless and low-income household families. Journal of the American Academy of Child and Adolescent Psychiatry, 36,890-900.

Burt, M.R. (1996). Why should we invest in adolescents? The Urban Institute.

Burt, M.R., Resnick, G., & Matheson, N. (1992). Comprehensive service integration programs for at-risk youth. Integrated Service Programs for At-Risk Youth.

Busen, N.H., & Beech, B. (1997). A collaborative model for community-based health care screening of homeless adolescents. Journal of Professional Nursing, 13 (5), 316-324.

Cauce, A.M., (2000). The characteristics and mental health of homeless adolescent: Age and gender differences. Journal of Emotional & Behavioral Disorders, 8(4), 230.

Cauce, A.M, Morgan, C.J., Shantinah, S.D., Wagner, V., Wurzbacher, K., Tomlin, S., & Blanchard, T. (1994a). Effectiveness of intensive case management for homeless youth: A description of a study in progress. Community Psychologist, 26 (2), 32-34.

Cauce, A.M., Morgan, C.J., Wagner, V., Moore, E., Sy, J., Wurzbacher, K., Weeden, K., Tomlin, S., & Blanchard, T. (1994). Effectiveness of intense case management for homeless adolescents: Results of a 3-month follow-up. Journal of Emotional and Behavioral Disorders, 2 (4), 219-227.

Cauce, A.M., Paradise, M., Embry, L., Morgan, C., Lohr, Y., Theofelis, J., Sy, J., & Wagner, V. (1997). Homeless youth in Seattle: Youth characteristics, mental health needs, and intensive case management. (unpublished).

Checkoway, B. (1998). Involving young people in neighborhood development. Children and Youth Services Reviews, 20, 765-795.

Chesney-Lind, Meda and Randall Shelden 1992 Girls, Delinquency and Juvenile Justice. Pacific Grove, CA: Brooks/Cole Publishing.

Collins, M.E. (2001). Transition to adulthood for vulnerable youths: A review or research and implications for policy. Social Service Review, 75 (2), 271.

Commercial sexual exploitation: Innovative ideas for working with children and youth (2002). Justice Institute of B.C., social services and community safety division justice institute of British Columbia.

Corcoran, J. (2000). Crisis intervention family preservation services. Crisis Intervention, 5 (3), 171-178.

Courtney, M.E., & Barth, R.P. (1996). Pathways of older adolescents out of foster care: Implications for independent living services. Social Work, 41 (1), 75.

CRD (1997). A Consultation with 75 Sexually Exploited Youth in the Capital Regional District (CRD) of British Columbia. Report of the Research Subgroup of the Committee for Sexually Exploited Youth in the CRD, Victoria, B.C.: City of Victoria.

Culbertson, J (1993). Clinical child psychology in the 1990s: Broadening our scope. Journal of Clinical Child Psychology; 22, 116-122.

Dalton, M.M., & Pakemenham, K.I. (2002). Adjustment of homeless adolescents to a crisis shelter: Application of a stress and coping model. Journal of Youth and Adolescence, 31 (1), 79-89.

Daly, D.L., & Dowd, T.P. (1992). Characteristics of effective, harm-free environments for children in out-of-home care. Child Welfare, 71 (6), 487.

D'Augelli, A.R. & Hershberger, S.L. (1993). Gay and bisexual youth in community settings: Personal challenges and mental health problems. American Journal of Community Psychology, 21, 421-448.

Davis, R.B., et al (1994). Intervening with high risk youth: a program model. Adolescence, 29 (1), 16, 763.

Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice, 81 (2), 293.

De Anda, D. (2001). A qualitative evaluation of a mentor program for at-risk youth: the participants perspective. Child and Adolescent Social Work Journal, 18, 2, 97-117.

Dempsey, C.L. (1994). Health and social issues of gay, lesbian, and bisexual adolescents. Families in Society. The Journal of Contemporary Human Services, 75 (3), 160.

Diego, M., Sanders, C., & Field, T. (2001) Adolescent depression and risk factors. Adolescence, 36 (143), 491.

Dishion, T.J., & Andews, D.W. (1995). Preventing escalation in problem behaviors with high-risk young adolescents: Immediate and 1-year outcomes. Journal of Counseling and Clinical Psychology, 63 (4), 538-548.

Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. American Psychologist, 54 (9), 755-764.

Dore .M.M. (1999). Emotionally and behaviorally disturbed children in the child welfare system: Points of preventive intervention. Children and Youth Services Review, 21, 7-29.

Dumont, M., & Provost, M.A. (1999). Resilience in adolescent: Protective role in social support, coping strategies, self-esteem, and social activities on experience of stress and depression. Journal of Youth and Adolescence, 28 (3).

Durlak, J.A. & Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. American Journal of Community Psychology, 25 (2).

Eddy, J.M., Dishion, T.J., & Stoolmiller, M. (1998). The analysis of Intervention change in children and families: Methodological and conceptual issues embedded in intervention studies. Journal of Abnormal Child Psychology, 26 (1).

Erickson, S., & Paige, J. (1998). To dance with grace: Outreach & engagement to persons on the street. The 1998 National Symposium on Homelessness Research.

Feitel, B., Margetson, N., Chamas, R., & Lipman, C., (1992). Psychological background and behavioral and emotional disorders of homeless and runaway youth. Hospital and Community Psychiatry, 43 (2), 155-159.

Fitzgerald, M.D. (1995). Homeless youths and the child welfare system: Implications for policy and service. Child Welfare, 74(3),717.

Fothergill, K., & Ballard, E. (1997). The school-linked health center: A promising model of community-based care for adolescents. Journal of Adolescent Health, 23, 29-38.

Freedman, M., (1993). The Kindness of Strangers: Adult Mentors, Urban Youth, and the New Volunteerism. Jossey-Bass Publishers, San Francisco (1993)

Friedman, R.M. (1994). Restructuring of systems to emphasize prevention and family support. Journal of Clinical Child Psychology, 23, 40-47.

Garnets, L. & Kimmel, D. (1991). Lesbian and gay male dimensions in the psychological study of human diversity. In Psychological Perspectives on Human Diversity in America, J. Goodchilds (Ed.). Washington, DC, American Psychological Association.

Garrison, J. (1989). Services and treatment issues. Journal of Adolescent Health Care, 10, 489-499.

Geen, R., & Duerr Berrick, J. (2001). Kinship care: An evolving service delivery option. The Urban Institute.

Gibson, S.A. (1994). Suicidal behavior and its correlates in adolescent and young adult lesbian women. (Unpublished).

Gleghorm, A.A., Clements, K.D., & Sabin, M. (2002). Elements of an intensive outreach program for homeless and runaway street youth in San Francisco. National Center for HIV, STD and TB prevention.

Glisson, G.M., & Thyer, B.A. (2001). Serving the homeless: Evaluation the effectiveness of homeless shelter services. Journal of Sociology and Social Welfare, 28 (4).

Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. The America Association of Suicidology, 31.

Greenberg, M.T., Domitrovich, C., & Bumbarger, B. (2001). The prevention of mental disorders in school-aged children: Current state of the field. Prevention & Treatment, 4 (1).

Greene, J.M., & Ringwalt, C.L. (1997). Shelters for runaway and homeless youths: Capacity and occupancy. Child Welfare, 76 (4), 549.

Grossman, J. B., & Tierney, J. P. (1998). Does mentoring work? An impact study of the Big Brothers Big Sisters program. Evaluation Review, 22, 403-426.

Grossman, J. B. & Johnson, A. W. (1998). "Assessing the Effectiveness of Mentoring Programs." Contemporary Issues in Mentoring, June, 1999. Philadelphia: Public/Private Ventures.

Grizenko, N., Pipineau, D. (1992). A comparison of the cost-effectiveness of day treatment and residential treatment for children with severe behavior problems. Can. J. Psychiatry, 37.

Guenther-Grey, C., Norian, D., Fonseka, J., & Higgins, D. (1996). Developing community networks to delver HIV prevention interventions. Public Health Reports, 110.

Hamner, K.M., & Lambert, E.W. (1997). Children's mental health in a continuum of care: Clinical outcomes at 18 months for the Fort Bragg demonstration. Journal of Mental Health Administration, 24 (4), 465.

Handwerk, M.L., Friman, P.C., et al (1998). The relationship between program restrictiveness and youth behavior problems. Journal of Emotional & Behavioral Disorders, 6 (3), 170.

Haurin, R.J., Haurin, D.R., Hendershott, P.H., & Bourassa, S. C. (1997). Home or alone: The costs of independent living for youth. Social Science Research, 26, 135-152.

Hawkins, W.E. (1998). Consequences and strategies for youth involvement. Children and Youth Services Review, 20, 753-755.

Heggeer, S.W., & Schoenwald, S.K. (1994). The contribution of treatment outcome research to the reform of children's mental health services: Multisystemic therapy as an example. Journal of Mental Health Administration, 21 (3), 229.

Heflinger, C.A., & Northrup, D.A. (1999). Community-level changes in behavioral health care following capitated contracting. U.S. Army Health Services Command.

Heneghan, A.M., & Horwitz S.M. (1997). Evaluating intense family preservation programs: A methodological review. Pediatrics, 97 (4), 535.

Hetrick, E., & Matin, A.D. (1987). Development issues and their resolution for gay and lesbian adolescents. Journal of Homosexuality, 13,25-43.

Hogue, A., Johnson-Leckrone, J., & Liddle, H.A. (1999). Recruiting high-risk families into family-based prevention and prevention research. Journal of Mental Counseling, 21 (4), 337.

Holland, R., Moretti, M.M., Verlaan, V., & Peterson, S. (1993). Attachment and conduct disorder: The response program. Can. J. Psychiatry, 38.

Hritz, S.A., & Gabow, P.A. (1997). A peer approach to high risk Hritz, S.A., & Gabow, P.A. (1997). A peer approach to high risk youth. Journal of Adolescent Health, 20, 259-260.

Huba, G.J. et al (2000). Predicting substance abuse among youth with, or at high risk for, HIV. Psychology of Addictive Behaviors, 14, 197-205.

Hyde, K.L., Burchard, J.D., & Woodworth, K. (1996). Wrapping services in an urban setting. Journal of Children and Family Studies, 5 (1), 67-82.

Jarvis, S.V., & Shear, L. (1997). Community youth development: Learning the new story. Child Welfare, 76(5), 719.

Jessor, R. (1993). Successful adolescent development among youth in high-risk settings. American Psychological, 48 (2), 117-126.

Johnson, R.L., Stanford, P.D., Douglas, W., Botwinick, G., & Marino, E. (2001). High-risk sexual behaviors among adolescents engaged through a street-based peer outreach program-(the adolescent HIV project). Journal of the National Medical Association, 93 (5).

Junek, W., & Thimpson, A.H. (1999). Self-regulating service delivery systems: A model for children and youth at risk. Journal of Behavioral Services & Research, 26 (1), 64.

Junek W. (1994). Problems Serving Children at Risk: Observations and Issues. Paper presented at annual meeting of the Child Welfare League of Canada, Halifax, Nova Scotia, June 17, 1994.

Kalafat, J., & Illback, R.J. (1998). A qualitative evaluation of school-based family resource and youth service centers. American Journal of Community Psychology, 26 (4).

Kidd, S.A., (2001). The stigmatization of street youth: Models of cultural abuse. (unpublished).

Kidd, S.A., & Kral, M.J. (2001). Suicide and prostitution among street youth: A qualitative analysis. (unpublished)

Kipke, M.D., Simon, T.R., Montgomery, S.B., Unger, J.B. & Iversen, E.F. (1997). Homeless youth and their exposure and involvement in violence while living on the streets. Journal of Adolescent Health, 20, 360-367.

Klein, J.D., Woods, A. Hall, Wilson, K.M., Prospero, M., Greene, J., & Ringwalt, C. (2000). Homeless and runaway youths' access to health care. Journal of Adolescent Health,, 27, 331.

Kline Pruett, M., Davidson, L., McMahon, T.J., Ward, N.L., & Griffith, E.E.H. (2000). Comprehensive services for at-risk urban youth: Applying lessons from the community mental health movement. Children's Services: Social Policy, Research, and Practice, 3 (2), 63-83.

Knapp, J.E., et al (1991). Variables associated with success in an adolescent drug treatment program. Adolescence, 26, 305.

Kolko, D.J., Brent, D.A., Baugher, M., Bridge, J., & Birmaher, B. (2000). Cognitive and family therapies for adolescent depression: treatment specificity, mediation, and moderation. Journal of Consulting and Clinical Psychology, 68 (4), 603-614.

Kumpfer, K.L. (1999). Strengthening America's families: Exemplary parenting and family strategies for delinquency prevention. Literature Review.

Kurks, G. (1991). Gay and lesbian homeless/street youth: Special issues and concerns. Journal of Adolescent Heath, 12, 515-518.

Kurtz, P.H., Lindsay, E.W. Jarvis, S., & Nackerud, L. (2000). How runaway and homeless youth navigate troubled waters: The role of formal and informal helpers. Child & Adolescent Social Work Journal, 17(5), 381-402.

Leslie, M.B., Stein, J.A., & Rotheram-Borus, M.J. (2002). Sex-specific predictors of suicidality among runaway youth. Journal of Clinical Child and Adolescent Psychology, 31 (1), 27-40.

Liddle, H.A., & Hogue, A. (2000). Family –based, development-ecological preventive intervention for high-risk adolescents. Journal of Marital and family Therapy, 26 (3), 265-279.

Lindsay, E.W., & Ahmed, F.U. (1999). The North Carolina independent living program: A comparison of outcomes for participants and non-participants. Children and Youth Services Review, 21 (5), 389-412.

Lochman, J.E. (1995). Screening of the child behavior problems for prevention programs at school entry. Journal of Consulting and Clinical Psychology, 63 (4), 549-559.

Loman, L.A., & Siegel, G. (2000). A review of literature on independent living of youths in foster and residential care. Institute of Applied Research.

Long, E.S., & Adams, C.D. (2001). Mediation of parent-adolescent conflict through the combination of problem-solving communication training and behavior exchange. Child & Family Behavior Therapy, 23 (3).

MacAllum, C., Kerttula, M.A., & Quinn, E. (1997). Evaluation of the transitional living program for homeless youth: Phase II report. (unpublished).

MacQueen, K.M., et al (2001). What is community? An evidence-based definition for participatory public health. American Journal of Metal Health, 91 (12), 1929.

Mallon, G.P. (1997). Basic premises, guiding principles, and competent practices for a positive youth development approach to working with gay, lesbian, and bisexual youths in out-of home care. Child Welfare, 76 (5), 591.

Martin, A, & Cohen, D.J. (2000). Adolescent depression: Window of (missed?) opportunity. Am J Psychiatry, 157 (10), 1549.

McCarthy, B., & Hagan, J. (1992). Surviving on the street: The experiences of homeless youth. Journal of Adolescent Research, 7, 412-430.
McCuller, W.J., et al (2001). Concurrent prediction of drugs use among high-risk youth. Addictive Behaviors, 26, 137-142

McMahon, T.J., et al (2000). Building full-service schools: Lessons learned in the development of interagency collaboratives. Journal of Education and Psychological Consultations, 11 (1), 65-92.

McMorris, B.J., Tyler, K.A., Whitbeck, L.B., & Hoyt, D.R. (2002). Familial and "on-the-street" risk factors associated with alcohol use among homeless and runaway adolescents. Journal of Studies on Alcohol.

Mech, E.V. (1994). Foster youths in transition: Research perspective on preparation for independent living. Child Welfare, 73 (5), 603.

Mech, E.V., Pryde, J.A., & Rycraft, J.R. (1995). Mentors for adolescents in foster care. Child and Adolescent Social Work Journal, 12 (4).

Mercier, C. (2000). An application of theory-driven evaluation to a drop-in youth center. Evaluation Review, 24 (1), 73.

Molnar, B., Shade, S.B., Kral, A.H., Booth, R.H. & Watters, J.K. (1998). Suicidal behavior and sexual/physical abuse among street youth. Child Abuse & Neglect, 22, 213-222.

Morrison, L.L., L'Hereux, J. (2001). Suicide and gay/lesbian/bisexual youth: Implications for clinicians. Journal of Adolescence, 24, 39-49.

Morse, G. (1998). A review of case management for people who are homeless: Implications for practice, policy, and research. The 1998 National Symposium on Homelessness Research.

Muck, R. et al (2001). An overview of the effectiveness of adolescent substance abuse treatment models. Youth & Society, 33 (2), 148-168.

Nelson-Simley, K. & Erickson, L. (1995). The Nebraska "network of drug-free youth" program. Journal of School Health, 65 (2), 49.

Network Training and Research Group (1996). Evaluation of the Mentoring Center and Bay Area Mentoring Efforts. First Evaluation Report, Redwood City, Calif.

Noell, J.W., & Ochs, L.M. (2000) Relationship of sexual orientation to substance use, suicidal ideation, suicide attempts, and other factors in a population of homeless adolescents. Journal of Adolescent Health, 29, 31-36.

Novotney, L.C., Mertinko, E., Lange, J., & Baker, T.K. (2000). Juvenile mentoring program: A progress review. U.S. Department of Justice.

Out from the shadows. (1998). Out from the Shadows International Summit of Sexually Exploited Youth: Final Report. Victoria: School of Child and Youth Care, University of Victoria.

PEERS (1997). Creating an Atmosphere of Hope for All Children and Youth: Teen Prostitutes Speak Up & Speak Out. Prostitutes Empowerment, Education and Recovery Society (PEERS), Victoria, B.C.

Phillips, S., & McMillen, C. (1997). Concrete strategies for sensitizing youth-serving agencies to the needs of gay, lesbian, and other sexual minority youths. Child Welfare, 76 (3), 393.

Poleg, J., Ciliska, D., Brunton, G., MacDonnell, J., & O'Brien, M. (1999). The effectiveness of school-based curriculum suicide prevention programs for adolescents. (unpublished).

Poole, D.L., 7 Colby, I.C. (2002). Do public neighborhood centers have the capacity to be instruments of change in human services? Social Work,.47 (2), 142.

Potterat, J.J., Rothenberg, R.B., Muth, S.Q., Darrow, W.W., & Phillips-Plummer, L. (1998). Pathways to prostitution: The chronology of sexual abuse milestones. Journal of Sex Research, 35 (4), 333.

Remafedi, G. (1994). The state of knowledge on gay, lesbian and bisexual youth suicide. In Death by Denial: Studies of Suicide, L.C. Whitaker and R.E. Slimak (Ed.). Boston, MA: Alyson Publications.

Ringwalt, C.L., Greene, J.M., & Robertson, M. (1998). Risk behaviors, negative familial experiences, and institutional placements among throwaway youth. Journal of Adolescence, 21, 241-252.

Rispen, J., Aleman, A., & Goudena, P.P. (1997). Prevention of child sexual abuse victimization: a meta-analysis of school programs. Child Abuse & Neglect, 21 (10), 975-987.

Roberts, R.E., Roberts, C.R., & Chen, Y.R. (1997). Ethno cultural differences in prevalence of adolescent depression. American Journal of Community Psychology, 25 (1), 95-110.

Robertson, M.J., & Toro, P.A. (1998). Homelessness youth: Research, intervention, and policy. The 1998 National Symposium on Homelessness Research.

Rogers, A.M., & Taylor, A.S. (1997), Intergenerational mentoring: A viable strategy for meeting the needs of vulnerable youth. Journal of Gerontological Social Work, 28, 125-140.

Rollin, S.A., Rubin, R.I. & Wright, J.C. The evolution of a community-based drug prevention program for youth. JADE's website: www.unomaha.edu/~health/Jade.html

Rosenblatt, J.A., Rosenblatt, A., & Biggs, E.E. (2000). Criminal behavior and emotional disorder: Comparing youth served by the mental health and juvenile justice systems. Journal of Behavioral Health Services & Research, 27 (2), 227.

Rosenblatt, A., Wyman, N., et al (1998). Managing what you measure: Creating outcome-driven systems of care for youth with serious emotional disturbances. Journal of Behavioral Health Services & Research, 25 (2), 177.

Ross, M.R., Powell, S.R., & Elias, M.J. (2002). New roles for school psychologists: addressing the social and emotional learning needs of students. School Psychology Review, 31 (1), 43.

Rossi, R.J. (1996). Dropout recovery demonstration. American Institutes for Research.

Rotheram-Borus, M.J. (1991). Serving runaway and homeless youths. Family and Community Health, 14 (3), 23-32.

Rotheram-Borus, M.J. (1993). Suicidal behavior and risk factors among runaway youths. American Journal of Psychiatry, 150 (1), 103-107.

Rotherman-Borus, M.J., Hunter, J. & Rosario, M. (1994). Sexual and substance use behaviors among homosexual and bisexual youths. Journal of Adolescent Research, 9, 498-508.

Royse, D. (1998). Mentoring high-risk minority youth: Evaluation of the brothers project. Adolescence, 33 (129), 145.

Scales, P.C. (1997). The role of family support programs in building developmental assets among young adolescents: A national survey of services and staff training needs. Child Welfare, 76 (5), 611.

Schissel, B., & Fedec, K. (1999). The selling of innocence: The gestalt of danger in the lives of youth prostitutes. Canadian Journal of Criminology, 41 (1), 33.

Sedlak, A.J., Shultz, D.J., Wiener, S., & Cohen, B., (1997). National Evaluation of runaway and homeless youth: Final report. (unpublished).

Shaw, I., & Butler, I. (1998). "Understanding young people and prostitution: A foundation for practice", British Journal of Social Work, 28, 177-196.

Sheehy, A.M., Oldham, E., Zanghi, M., Ansell, D., Correia, P., & Copeland, R. Promising Practices: Supporting transition of youth served by the foster care system. (unpublished).

Shochet, I.M., Dadds, M.R., Holland, D., Whitefield, K., Hartnett, P.H., & Osgarby, S.M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. Journal of Clinical Psychology, 30 (3), 303-315.

Silver, J., & Vermander, K. (2000). Managing school conflict: The peer mediation approach. (unpublished).

Simons, R.L., & Whitbeck, L.B. (1991). Sexual abuse as a precursor to prostitution and victimization among adolescent and adult homeless women. Journal of Family Issues, 12 (3), 361-379.

Spoth, R.L. (2001). Randomized trial of brief family interventions for journal of consulting and clinical psychology, 69, 627-642.

Springer, F.J., Wright, L.S., & McCall, G.J. (1997). Family interventions and adolescent resiliency: The southwest Texas state high-risk youth program. Journal of Community Psychology, 25 (5), 435-452.

Stiffman, A.R., et al (1997). Adolescents' and providers' perspectives on the need for and use of mental health services. Journal of Adolescent Health, 21, 335-342.

Still, C. (2000). Report for the safe shelter steering committee youth safe shelter task force survey. (unpublished).

Sullivan, T.R. (1994). Obstacles to effective child welfare service with gay and lesbian youths. Child Welfare, 73 (4), 291.

Sussman, S., Stacy, A.W., Ames, S.L. & Freedman, L.B. (1998) Self-reported high-risk locations of adolescent drug use. Addictive Behaviors, 23 (3), 405-411.

Swets, R. (2000). A roof is not enough: A literature review-housing for youth in BC. (unpublished)

Tashman, N.A., et al (2000). Toward the integration of prevention research and expanded school mental health programs. Children's Services: Social Policy, Research, and Practice, 3 (2), 97-115.

Taylor, A.S., & Dryfoos, J.G. (1999). Creating a safe passage: Elder mentors and vulnerable youth. Generations, 22 (4), 43.

Teare, J.F., Larzelere, R.E., Smith, G.L., Becker, C.Y., Castrianno, L.M., & Peterson, R.W. (1999). Placement stability following short-term residential care. Journal of Child and Family Studies, 8 (1), 59-69.

Teare, J.F., Peterson, R.W. (1994). Treatment implementation in a short-term emergency shelter program. Child Welfare, 73 (3), 271.

Teare, J.F., Smith, G.L., Osgood, D.W., Peterson, R.W., Authier, K., & Daly, D.L. (1995). Ecological influence in youth crisis shelters: Effects of social density and length of stay on youth problem behaviors. Journal of Child and Family Studies, 4 (1), 89-101.

Thomas, H., et al (1999). Effectiveness of school-based interventions in reducing adolescent risk behaviour: A systematic review of reviews. (unpublished).

Thomas, J.D. (2000). A multilevel approach to family-centered prevention in schools: Process and outcome. Addictive Behaviors, 25 (6), 899-911.

Thompson, E.A., Eggert, L.L., Faan, R.N., & Herting, J.R. (2000). Mediating effects of an indicated prevention program for reducing youth depression and suicide. Suicide and Life-Threatening Behavior,30 (3).

Thompson, S.J., Safer, A.W., & Pollio, D.E. (2001). Differences and predictors of family reunification among subgroups of runaway youths using shelter service. Social Work Research, 25 (3), 163.

Tiet, Q.Q., Bird, H.R., Dies, M., Hoven, C., Cohen, P., Jensen, P.S., & Goodman, S. (1998). Adverse life event and resilience. J. AM. Acad. Child Adolescent Psychiatry, 37, 11.

Tyler, K.A, Hoyt, D.R, & Whitbeck, L.B., (2000). The effects of early sexual abuse on later sexual victimization among female homeless and runaway adolescents. Journal of Interpersonal

Tyler, K.A., Hoyt, D.R., Whitbeck, L.B., & Cauce, A.M. (2001). The effects of a high-risk environment on the sexual victimization of homeless and runaway youth. Violence and Victims, 16 (4).

Ungar, M., & Teram, E. (2000). Drifting toward mental health high-risk adolescents and the process of empowerment. Youth & Society, 32 (2), 228-252.

Verdant. (2000). Homeless street youth in downtown south: A snapshot study. (A report prepared for: City of Vancouver, Social Planning Department).

Waxman, R.P., Weist, M.D., & Benson, D.M. (1999). Toward collaboration in the growing education-mental health interface. Clinical Psychology Review, 19 (2), 250-253.

Webster-Stratton, C., & Taylor, T. (2001). Nipping early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at youth children (0-8 years). Prevention Science, 2(3).

Weinberg, N.Z. (2001). Risk factors for adolescent's substance abuse. Journal of Learning Disabilities, 34 (4), 343.

Weisberg, D.K. (1985). Children of the night: A study of adolescent prostitution. Lexington MAL Lexington Books.

Weist, M.D. (2001). Toward a public mental health promotion and intervention system for youth. Journal of School Health, 71 (3), 101.

Whitbeck, L.B., Hoyt, D.R., Yoder,K.A., Cauce, A.M., & Paradse, M, (2001). Deviant behavior and victimization among homeless and runaway adolescents. Journal of Interpersonal Violence, 16(11), 1175-1204.

Williams, N.R., Lindsay, E.W., Kurtz, P.D., & Jarvis, S. (2001). From trauma to resiliency: Lessons from runaway and homeless youth. Journal of Youth Studies, 4(2).

Wulczyn, F.W. (2000). Federal fiscal reform in child welfare services. Children and Youth Services Review, 22 (2), 131-159.

Yeh, J., White, K.R., & Ozcan, Y.A. (1997). Efficiency evaluation of community-based youth services in Virginia. Community Mental Health Journal, 33 (6).

Yoder, K.A., Hoyt, D.R., & Whitback, L.B. (1998). Suicidal behavior among homeless and runaway adolescents. Journal of Youth and Adolescence, 27 (6).

Zlotnick, C., Robertson, M.J., & Lahiff, M. (1999). Getting off the streets: Economic resources and residential exits from homelessness. Journal of Community Psychology, 27 (2), 209-224.

_. (1999b). Youth Basics: Youth Building and Applying Strategies for Involvement in Communities. Burnaby: The Society.

_. (2000). Sacred Lives: Canadian Aboriginal Children and Youth Speak Out About Sexual Exploitation. Toronto: Save the Children Canada. http://www.savethechildren.ca/en/whatwedo/pdf/sacredlives.pdf

_. (2001). No Place to Call Home: A profile of Street Youth in British Columbia. Burnaby: The Society.