Increasing the engagement of youth with concurrent disorders and their families

A literature review
Increasing the engagement of youth with concurrent disorders and their families:

A literature review

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1. Executive summary

This literature review aims to inform policies and practices in the engagement of youth with concurrent disorders and their families by considering models and evidence-informed practices which have been or could be successful in a BC context.

There are only a limited number of well evaluated programs which have successfully engaged youth with concurrent disorders and their families; as a result, this review considered promising examples from other child and youth service and care contexts, including youth justice, chronic illnesses, and community service engagement. Despite the lack of available evidence about evaluated youth and family engagement programs, the literature did show that those which successfully and fully integrate mental health and substance use services and which had engagement philosophies and practices that run through the entire program can successfully and meaningfully engage even the most vulnerable youth and families.

Youth and their families face many barriers or challenges as they try to meaningfully engage in treatment and service planning and delivery. These barriers may be present at the individual, family, and/or structural levels. Addressing these barriers will be instrumental in providing effective services for youth with concurrent disorders.

A number of innovative youth and family engaged programs and services are already operating in BC, or could be adapted for BC. There are many unique and community-specific approaches, yet commonalities emerge in an openness to including youth and families in all decisions that affect them. This literature review therefore concludes with a checklist of strategies that encourage meaningful and sustained engagement in all aspects of care and support for youth with concurrent disorders. The importance of meeting youth where they are at; ensuring continuity of care; and building relationships founded upon trust, confidentiality, and respect were repeatedly highlighted.

2. Introduction

This literature review aims to identify promising practices for engaging youth experiencing concurrent disorders and their families in treatment programs, as well as in broader service development and delivery. It also aims to identify innovative approaches, programs and resources which focus on engaging and supporting youth to stay connected to their families/caregivers and communities.

Concurrent disorders refer to “any combination of mental health and substance use disorders” (Health Canada, 2002, p. 7). The mental health problems that are most common in youth are disruptive behaviour disorders, anxiety disorders, and mood disorders (Cheung, Bennett, Bullock, Soberman, & Kozloff, 2010). These would include, for example, conduct disorders, post-traumatic stress disorder (PTSD), and depression (Health Canada, 2002; Schwartz, Garland, Harrison, & Waddell, 2007). The literature that was reviewed included mental health and substance use issues that were formally diagnosed disorders as well as defined problems of varying severity or type. Therefore, a range of mental health and substance use problems are included in this discussion of concurrent disorders.
Concurrent disorders are also referred to in the literature as co-occurring disorders, comorbid disorders, or dual diagnosis (Schwartz et al., 2007).

Engagement is a multidimensional concept that is made up of a variety of components and occurs through interconnected processes (Chovil, 2009). Engagement is premised upon key factors, such as involvement, commitment, participation, connection, respect, and collaboration (Chovil, 2009). Through processes of engagement, families and youth become motivated to recognize their own needs and strengths, and begin to take an active role in their own development (Steib, 2004). Genuine engagement will help keep families and youth motivated to work towards change. Based on the definitions put forth in two previous reports (Chovil, 2009; Smith, Peled, Hoogeveen, Cotman, & the McCreary Centre Society, 2009), engagement, for the purposes of the current literature review, refers to the meaningful participation of youth and families in decisions pertaining to treatment as well as service planning and delivery.

Several reports have summarized the available research evidence for youth with concurrent disorders, including best practice guidelines. These have included relatively broad and comprehensive reviews (Adair, 2009; Cheung et al., 2010; Health Canada, 2002) and ones that are focused on specific issues such as treatment (Schwartz et al., 2007). Also available are reviews and best practice guidelines for youth with substance use problems (Health Canada, 2001), family engagement in child and youth mental health (Chovil, 2009), and consumer and family involvement in mental health (British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002a,b). It is not the intent of the current literature review to duplicate what these other reviews have already done; however, key points related to family and youth engagement are discussed where applicable.

Despite an extensive search of the literature, the current review identified a serious gap in the rigorous evidence and assessment of youth and family engagement programs for youth with concurrent disorders. Chovil (2009) pointed out a similar gap in the literature on family engagement in child and youth mental health. Of particular note is that the literature on youth with concurrent disorders often does not address engagement specifically, and youth and family engagement literature does not speak directly to those with concurrent disorders.

The current literature review discusses the benefits and challenges of engaging youth with concurrent disorders and their families before offering examples of programs that show a strong evidence base of successfully and meaningfully engaging these young people. Additionally, strategies for ensuring youth who are in treatment remain connected to their families and communities will be suggested. Based on the evidence, the review concludes with some suggested strategies for anyone looking to engage young people with concurrent disorders and their families in treatment and in service development and delivery.
3. Literature search methodology

The purpose of the search was to identify literature and promising practices for youth engagement and participation among youth with concurrent disorders. A search was performed through academic electronic databases including Medline, PubMed, PsycInfo, ERIC, and CINAHL. Articles included English language documents from 1985 onwards in peer-reviewed journals. The search also considered relevant grey literature such as government reports, program evaluation reports, conference proceedings and abstracts, and newsletters. Grey literature databases included the New York Academy of Medicine Grey Literature, Canadian Evaluation Society, American Evaluation Association, the Public Health Agency of Canada’s Canadian Best Practices Portal, and Google. Community-based programs, as well as mental health networks and databases were explored. Finally, articles were obtained through a snowballing procedure whereby reference lists of relevant literature were explored for related material.

Search terms included substance, substance use, substance abuse, treatment, adolescent, teen, youth, concurrent, co-occurring, co-morbid, dual diagnosis, service development, service delivery, youth engagement, and family engagement. It should be noted that specific substances (e.g., alcohol, marijuana, cocaine, etc.) or mental health problems (e.g., depression, anxiety, etc.) were not used as search terms.

Examples of youth engagement and participation strategies were taken from other parts of Canada, the United States, Republic of Ireland, the UK, and Australia when it was felt that they could be adapted or applied in British Columbia.
4. Prevalence of concurrent disorders among BC youth

There is considerable variability in the prevalence estimates for concurrent disorders in youth. Part of the variability stems from different survey items and thus how substance use and mental health problems or disorders are defined. Different estimates are also obtained depending on the constitution of the sample involved, for example, whether the general population of youth is considered or whether clinical samples are used (Greenbaum, Foster-Johnson, & Petrila, 1996).

Data from the 2002 Canadian Community Health Survey indicates that 4% of Canadian youth aged 15 to 24 had concurrent mental disorders and substance use problems (Rush et al., 2008). Furthermore, the 12-month prevalence rate of concurrent disorders was highest among young people, and British Columbia had higher rates (for all age groups combined) than the other Canadian provinces (Rush et al., 2008). On the other hand, the Ontario Student Drug Use and Health Survey data shows that 11% of Ontario students aged 12 to 18 self-reported symptoms indicative of concurrent disorder (Cheung et al., 2010). In their review of population and clinical studies in the United States, Greenbaum et al. (1996) found that about half of youth who were receiving mental health services also had a concurrent substance use disorder.

The 2008 BC Adolescent Health Survey of youth aged 12 to 19 in mainstream public schools across British Columbia found that 3% of youth self-reported that they had a serious mental or emotional health condition and that they had any problematic substance use in the past year (e.g., damaged property or got into trouble with police as a result of their use, etc.) (McCreary Centre Society, 2008). However, the prevalence of concurrent disorders in clinical populations may be much higher. For example, data from youth in two addiction treatment programs in British Columbia indicates that 53% of youth had at least one mental health problem or diagnosis such as ADHD or depression (McCreary Centre Society, 2012).

Youth who may be at greater risk for concurrent disorders include females; rural youth, homeless youth; those who have been abused or victimized; lesbian, gay, or bisexual youth; Aboriginal youth; and those in government care and the justice system (Cheung et al., 2010; Hussey, Drinkard, Falletta, & Flannery, 2008; McCreary Centre Society, 2008). For example, results from the BC Adolescent Health Survey indicate that youth in rural areas were more likely than those in urban areas to report both mental health and substance use concerns (McCreary Centre Society, 2008). Specifically, 4% of rural youth indicated that they had been diagnosed with a mental or emotional health condition, compared to 3% of urban youth. Four percent of rural youth reported that they had needed help either for their alcohol or drug use in the past year, twice the rate of their urban peers.

A recent report on the experiences of homeless youth in Ontario found that about 4 in 10 homeless youth had concurrent mental health problems and problem alcohol use while about half had concurrent mental health and drug use problems (Goldstein et al., 2011). In British Columbia, a self-report survey of street youth indicated that 23% of youth reported they had a mental or emotional condition and that they had ever received, been refused, or wanted treatment for their substance use (McCreary Centre Society, 2006).
With respect to youth involved with the criminal justice system, young people in conflict with the law are often experiencing multiple and interconnected problems, including mental health challenges (Belenko & Dembo, 2003). In one study from the United States, 62% of young offenders also met the criteria for an alcohol or other drug use disorder (Aarons, Brown, Hough, Garland, & Wood, 2001). In British Columbia, a study of youth in custody found that 73% were accessing drug and alcohol programs and 69% accessing mental health programs (Murphy, Chittenden, & the McCreary Centre Society, 2005).

BC Adolescent Healthy Survey results indicate that 17% of Aboriginal youth with a mental or emotional condition also indicated they needed help for their substance use (McCreary Centre Society, 2008). Furthermore, Aboriginal youth are overrepresented in marginalized groups in BC, specifically among street-involved youth, youth in custody, and youth in government care (Murphy et al., 2005; Smith et al., 2007; Smith, Stewart, Poon, Saewyc, & the McCreary Centre Society, 2011). The challenges that Aboriginal and other marginalized and disadvantaged youth face place them at greater risk for developing a wide range of social and mental health difficulties stemming from drug use and related issues. For example, chronic drug use in adolescence predicts criminal activity (Hart, O'Toole, Price-Sharps, & Shaffer, 2007; Weiner, Abraham, & Lyons., 2001), poor social adjustment (Patton, Hetrick, & McGorry, 2007), multiple drug dependency in adulthood (Degenhardt et al., 2007), poor school attendance (Engberg & Morral, 2006), and poor job quality outcomes in adulthood (Ringel, Ellickson, & Collins, 2007).

5. Model of engagement

Based on theoretical and empirical research, Brady and colleagues (Department of Health and Children, 2004) developed a model which highlights key practices and components for collaborative and engaging service for children, youth, and their families. The model posits that each individual exists within several systems. These systems do not work independently from one another, but rather dependently, and are interconnected to create the environment in which the individual exists. Additionally, there is a continuous exchange between the individual within these systems and the systems themselves. Therefore, it is important that practices in the child, youth, and family field incorporate principles of good practice at both the management level and the intervention level in order to be effective.

At the management or structural level, the philosophy as well as the aim of the service should be clearly stated in policy and procedure which illustrate to managers, staff, and service users how that service will approach service delivery issues. These services work toward achieving well-defined objectives, the outcomes of which are evaluated and analyzed to ensure that the needs of the targeted client base are being met. Feedback from staff, service users, and other interested parties should be welcomed and encouraged. They provide an environment that fosters learning and development and provides supports to its staff members in order for them to gain personal/professional growth.

The service should be committed to creating effective partnerships with families as well as other service providers and agencies. Partnership between services and families includes constant, equal communication of information as well as emotional support and assistance with practical arrangements. Means for the child and their family to contribute to the design, implementation, and evaluation of the
service should be put in place; and staff should be educated about mechanisms for engaging families. Children and their families should be consulted in order to define their needs and in providing interventions which make sense to the service users. Consultations with families and children serve to recognize their depth of experience and knowledge.

At the intervention level, principles center on providing effective, integrated services with a more holistic approach committed to healing the “whole child” or youth. Service should be provided incorporating both the young person’s current life and past experiences. The service is both easily accessed and inviting for both the youth and their family and provide willing and competent staff who make efforts to work collaboratively in order to empower the youth and their family, while remaining mindful of their culture. Strategies and approaches should continue to evolve as the stages and needs of the youth and their family develop.

This model combines management and intervention level principles into a single system centering on the needs of children, youth, and their families. The model highlights the elements within a system’s foundation which emphasize effective and respectful support for children and families.

6. Engaging in service development and delivery

6.1. Rationale, barriers, and benefits

The inclusion of consumer voice and input in service development and delivery has become increasingly recognized as a fundamental component of successful programming, and is a core component of BC’s ten year plan to address mental health and substance use in the province (British Columbia Ministry of Health Services and Ministry of Children and Family Development, 2010). The plan states: “A focus on evidence-based practice using a collaborative approach ... will ensure existing resources provide the best outcomes. By working together, entire communities will play a part in achieving positive mental health for all British Columbians” (p. 6). This tenet is consistent with the BC provincial government’s endorsement of the United Nations Convention on the Rights of the Child (UNCRC) and its commitment to include the voices of BC children and youth and their families in planning and delivery of services (British Columbia Ministry of Children and Family Development, 2007).

The promotion of children’s rights and the awareness that youth must be active participants in decisions regarding their health and well-being has seen considerable development in the last two decades (Hill, Davis, Prout, & Tisdall, 2004). In order to meaningfully engage youth, organizations need to genuinely value their input. Youth should be seen as

Fellow citizens with rights, participating members of the social groups in which they find themselves, agents of their own lives but also interdependent with others, co-constructors of knowledge, identity and culture, children who co-exist with others in society on the basis of who they are, rather than who they will become. (Moss, 2002, p. 6).
Following this vein of thinking, youth are seen as active creators and contributors to the environment in which they live. Adults have the opportunity to learn from youth, while helping youth develop their own skills, and contribute to stronger services and policies (Hill et al., 2004).

The benefits of involving service users and their families in service and policy development of mental health services are evident in the literature (Dogra, 2005; Hill et al., 2004). Consumer involvement can offer new ways of seeing issues; make policies and practices more grounded in reality and lived-experience, more relevant, and more sensitive to local needs, thereby increasing service utilization (British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002a; Hill et al., 2004). In addition, youth may develop skills and improved self-esteem and self-efficacy (Sinclair, 2004). Specifically, they may feel empowered by seeing their views reflected in new policies and practices, and child and youth friendly spaces will be increased and supported (Hill et al., 2004). Furthermore, consumers may be able to attract the attention of funders and policy makers in a way that healthcare practitioners cannot (British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002a).

The McCreary Centre Society (Smith et al., 2009) report on youth engagement in civic and community decision-making identified many benefits of meaningful youth engagement not only for the healthy development of the young people involved, but also for institutions, families, and communities. Youth learn they can be involved in their own treatment and recovery, develop skills and confidence which they can also use to play an effective and important role in community and organizational development, and are encouraged to engage and participate in other areas of their community. Meanwhile organizations and adults gain new perspectives, have access to new and creative perspectives which can be used to develop improved services for youth and also build credibility with youth. Communities also benefit from having youth in their midst who have had experience of meaningful engagement, as these youth are more likely to go on to be involved in community development and decision making when they become adults (Evans, 2007).

The literature on both mental health and substance use suggests ways that families can become engaged in service planning and development. They can work collaboratively with service providers and policy makers to evaluate the delivery of services and supports for both youth and their family, provide family-based evidence around best practices, improve how programs are designed and implemented, help to improve the overall treatment system, contribute to education and training of service providers and to educational resources for families, and be actively involved in reviewing and writing of policy (Centre for Addiction and Mental Health [CAMH], 2004; Chovil, 2009; Smith, Hornberger, et al, 2009; Nassau and Pingitore, 2011). This collaborative work might occur in the form of participation in task forces, work groups, or advisory councils (CAMH, 2004; Chovil, 2009), but could also take place more informally. The collaboration should be viewed as a partnership which includes open communication, information exchange, and an understanding that the parties have an equal depth of experience and knowledge to offer (CAMH, 2004).

The failure of service providers and policy makers to see youth and their families as partners may present a significant barrier to engagement. Feedback from families is consistent with this notion in that they have identified tokenism and unsupportive attitudes from professionals as barriers to engagement.
in policy development (Koroloff, Hunter, & Gordon, 1995). Other barriers identified by families include personal issues (e.g., lack of time, language), home life (e.g., family crises, being away from family, lack of childcare, financial cost), and system barriers (e.g., feelings of blame or stigma, vulnerability, lack of appreciation for cultural differences) (Koroloff et al., 1995).

Chovil’s (2009) review of family engagement in child and youth mental health cited several benefits with respect to service development and delivery that would be applicable to concurrent disorders. These include improved service delivery with an increased focus on family, an increased accountability and coordination of services, an expansion of the location of services outside the clinical treatment setting, increased cultural sensitivity, and provision of a unique perspective to programs and administrators.

### 6.2. Examples of engaging youth and their families in service development and delivery

Although formally evaluated programs for youth and family engagement in service planning and development were not found, several examples of evidence-informed programs that engage families were evident. In Ontario, the Centre for Addiction and Mental Health (CAMH) has implemented practices to involve families. For example, families have input and participate in strategic planning; the design, monitoring, and evaluation of services; and reviewing policies (CAMH, 2004). Much of this work is achieved through The Family Council and its involvement on CAMH advisory committees (CAMH, 2004; The Family Council: Empowerment for Families in Addictions and Mental Health, 2012).

Also, the Ontario Youth Strategy Project (2011) has developed a workbook, described in detail later, that provides guidelines for organizations to engage youth in meaningful ways in service planning and evaluation. Inherent in these guidelines are the guiding principles that:

- For involvement to be meaningful, it must include more than just a token person on a board or planning committee. The organization must genuinely value youth’s opinions and perspectives, and identify ways to ensure their voices are heard in discussions and debates about managing the organization, developing programs and delivering services. Significant changes should be discussed with youth.

- Youth should be asked about the type of involvement that would be meaningful for them and the aspects of the organization that they would like to influence. They should also be consulted about ways to engage other youth and the potential for youth-to-youth involvement.

- Many organizations face challenges identifying effective ways to involve youth on an ongoing basis and designing consultation and engagement processes that involve youth. The “science” of youth engagement is an evolving field of practice, and so organizations should be actively seeking and sharing effective strategies. (p. 34)

In the United States, Smith, Hornberger, and colleagues (2009) describe how several states received grants from the Substance Abuse and Mental Health Services Administration’s Centre for Substance Abuse Treatment with the goal of developing more effective and affordable adolescent substance abuse treatment that would be easily accessible for both adolescents and their families. During the first two
years following the distribution of grants, several states have implemented various promising practices. In North Carolina, a collaborative partnership between families and professionals has led to the creation of curriculum designed to assist families and adolescents in choosing the best service provider. South Carolina has created a state-wide Family Advocacy Board, while Arizona has published a roadmap for families to navigate through the substance abuse treatment system.

In British Columbia, one organization that has been a leader in family engagement in youth mental health is The Families Organized for Care Recognition and Equality (The FORCE) Society for Kids Mental Health (Chovil, 2009). The Kelty Mental Health Centre in BC works with the FORCE Society for Kids Mental Health to provide Family Advocates who work with service providers to create ways to address unmet needs of families; advocate for individual families and for fair and responsive policies that affect all families; sit on policy-making, planning, and oversight boards; and partner with professionals in service delivery (Chovil, 2009).

BC Provincial Family Council for Child & Mental Health, British Columbia, Canada
The Provincial Family Council for Child and Youth Mental Health (PFC) was created in 2010 to formally integrate BC families’ perspectives into child and youth mental health care in BC (Davidson, Wiens, & Anderson, 2010). Davidson and colleagues describe the PFC, including the initiative to form the council, the process of establishing the PFC, and the working group’s assessment of the process. A brief summary is provided here.

The impetus for forming the council came from a partnership involving The FORCE Society for Kid’s Mental Health, the government, and service stakeholders. The PFC is endorsed by BC government and key provincial committees and became an affiliate of the National Institute of Families Foundation for Child and Youth Mental Health in order to promote the model of the council in other provinces and territories in Canada.

The PFC is represented on several provincial committees that deal with policy, planning, and service delivery (e.g., the Child and Youth Mental Health and Substance Use Strategic Coordinating Committee; the BC Children’s Hospital Child and Adolescent Mental Health and Addiction Programs Community Advisory Committee; and the Provincial Child and Youth Mental Health and Substance Use Care Advisory Network). The PFC addresses several key issues including:

- Innovative ways of addressing problems and issues that will support improvements.
- Key issues/priorities/opportunities that are meaningful to children, youth, families and communities of care.
- Ways in which policies and practices in service delivery can be enhanced to improve family experiences and outcomes.
- Training and evaluation practices.
- Approaches to improving family engagement.
- Evaluation of the influence of PFC on systems. (Davidson et al., 2010, p. 173)
The success of the PFC in engaging youth, family, and service providers in its development was noted by Davidson and colleagues and included the diversity of representation involved, the equality of youth and adult stakeholders, the support for youth to participate (including practical supports such as transportation, coaching, access to internet) and the extended timeframe over which the working group developed the PFC as this allowed time to build system linkages, share vision and goals of the PFC with others in the mental health system and ensure support from across the system.

7. Engaging in treatment

7.1. Engaging youth in treatment: Rationale, barriers, and benefits

Including youth in decisions that impact their health and well-being may increase service utilization, as well as its likelihood of success (Dogra, 2005; Hill et al., 2004; Sinclair, 2004). Improving treatment access, compliance, and success may be particularly important for youth with concurrent disorders as they can contribute to a range of outcomes later in life, such as physical health problems, financial hardships, unemployment, and legal difficulties (Ballon, Kirst, & Smith, 2004; Waddell, 2012). Moreover, individuals who receive treatment within the first 10 years of their substance use have a greater likelihood of sustaining substance abstinence than those who do not (Dennis, Ives, White, & Muck, 2008), yet there are low rates of treatment utilization among youth (Cheung et al, 2010). Acknowledging and addressing barriers to treatment provides a basis for making evidence-informed improvements to treatment (Ballon et al., 2004).

Canadians with concurrent disorders have a greater perceived unmet need for services for mental health and/or substance use problems than those with either disorder alone (Urbanoski, Cairney, Bassani, & Rush, 2008). Furthermore, Schwartz and colleagues (2007) cite evidence in their review that indicates youth with concurrent disorders have poorer treatment compliance and outcomes than youth without concurrent problems. This is exacerbated by the intersections at which youth with concurrent disorders exist; their mental health experiences present a constellation of challenges for healthcare practitioners and the healthcare system, as they often fall between services and require specialized care (Slesnick, Meyers, Meade, & Segelken, 2000). In addition, fragmentation within the healthcare system and a lack of continuity of care contributes to poor treatment outcomes and compliance (Waddell, McEwan, Shepherd, Offord, & Hua, 2005).

In Canada, data indicate that more than half of youth with concurrent disorders did not access any health care services (Cheung et al., 2010). Identifying and understanding the potential barriers that can prevent young people from accessing treatment is crucial for developing programs that can engage youth. For example, a common reason Canadian youth with concurrent disorders reported for not accessing services was that they wanted to handle the problem themselves (Cheung et al., 2010). This may relate to a lack of perceived need which is one of the most cited reasons for a deficiency in treatment utilization (Simmons et al., 2008). Youth may feel that their problem is not serious enough to require treatment, or if they lack information and education they may not be aware of symptoms and signs of mental health problems and/or problematic substance use. Believing that the problem will go away is another major barrier towards youth seeking treatment for their mental health problems.
Among the 18% of female youth and 7% of male youth in mainstream BC public schools who felt that they needed mental health services but did not access them, 56% cited hoping that the problem would go away as a reason (Smith, Poon, et al., 2011).

Youth with concurrent disorders also cited being afraid that others might find out as a reason for not utilizing services (Cheung et al., 2010). This may relate to the stigma around mental health and substance use problems. Youth may be embarrassed to tell their friends or family that they are experiencing a concurrent disorder, as well as be afraid of social exclusion. This finding is supported by BC data which found that 43% of youth who did not access needed mental health services avoided them because they did not want their parents to know about their problems (Smith, Poon, et al., 2011). Fear of stigma may be even greater for rural youth as 28% of rural youth were more likely to have not accessed mental health services because they were afraid someone they knew might see them, compared to 22% of urban youth (McCreary Centre Society, 2008).

<table>
<thead>
<tr>
<th>Reasons for not accessing mental health services (among youth who needed them)</th>
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<tbody>
<tr>
<td>Thought/hoped the problem will go away</td>
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<tr>
<td>Didn’t want parents to know</td>
</tr>
<tr>
<td>Didn’t know where to go</td>
</tr>
<tr>
<td>Afraid someone I know might see me</td>
</tr>
<tr>
<td>Afraid of what a Dr. would say/do</td>
</tr>
<tr>
<td>I didn’t think I could afford it</td>
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<tr>
<td>Had no transportation</td>
</tr>
<tr>
<td>Parent/guardian would not take me</td>
</tr>
<tr>
<td>I am not treated with respect there</td>
</tr>
<tr>
<td>I couldn’t go when it was open</td>
</tr>
</tbody>
</table>


Expert perspectives from Health Canada’s (2001) best practices report on youth with substance use problems as well as studies of youth in both Canada (e.g., Ballon et al, 2004) and the United States (e.g., Simmons et al., 2008) provide examples of additional barriers which are also applicable to youth with concurrent disorders. These include personal barriers (e.g., denial, minimization, fear, financial cost, transportation, lack of knowledge about available programs), family- and peer-related barriers (e.g., unsupportive attitudes, family conflict, family responsibilities, family history of substance abuse), and program or structural barriers (e.g., lack of youth-specific services, long waitlists). In addition, Denby, Brinson, and Ayala (2011) write, “To effectively intervene with youths who suffer co-occurring disorders, the presence of a workforce that is able to detect mental health and substance use disorders and deliver commensurate treatment is paramount” (p. 57). Furthermore, experts identified “poor integration and coordination between the mental health and substance abuse treatment systems,” as a key impediment to the treatment of concurrent disorders (Health Canada, 2001, p. 20).
The difficulties associated with systemic issues related to poor integration are highlighted in cases which involve trauma. The high rates of trauma experienced by youth presenting concurrent disorders require attention (Dennis & Stevens, 2003; Grella & Joshi, 2003). Grella and Joshi’s (2003) study on the needs of adolescents with a history of abuse in a substance abuse treatment program found that “abused and non-abused youth in drug treatment programs presented significantly different profiles on treatment entry…. A history of abuse was associated with more severe substance use (i.e., dependence and more frequent use) at treatment admission and higher rates of having a co-morbid mental disorder” (Grella & Joshi, 2003, p. 15). In some cases, experiences of abuse and trauma can lead to Post Traumatic Stress Disorder (Hopper, Bassuk & Olivet, 2010).

Because traumatic stress can have severe and long-lasting consequences, the incorporation of trauma-informed care into treatment services for youth with concurrent disorders can help prevent long-term mental health challenges (Hopper et al., 2010). Trauma-informed care is “a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper et al., 2010, p. 82). For youth with concurrent disorders who have experienced trauma, the inclusion of trauma-informed care in treatment services can mean that they will experience heightened feelings of safety and support (Hopper et al., 2010). Additionally, self-efficacy, feelings of empowerment, and resiliency can be increased through the use of trauma-informed care (Hopper et al., 2010).

Much intersection will occur between youth who have experienced trauma and other categories of vulnerable youth, such as homeless youth and youth living in poverty. Results from key experts indicated that although these vulnerable youth face the same barriers as youth generally, specific considerations apply to vulnerable groups (Health Canada, 2001). For example, the experts noted that street youth are likely not to self-refer, distrust the mainstream system, lack support from family, and feel outreach programs and service flexibility are lacking. Immigrant and Aboriginal youth, on the other hand, may have families that are reluctant to engage with services which are not culturally-sensitive. Furthermore, immigrant youth may face additional cultural barriers related to denial and stigma of substance use and mental health problems. Finally, the experts noted that youth involved in the criminal justice system may be most resistant to treatment, lack support from family, lack services within the correctional system, and have difficulty accessing community programs.

While it is a significant concern that less than half of Canadian youth with concurrent disorders access treatment; data also indicate that among those who do seek services, only half completed treatment (Cheung et al., 2010). Evidence from the substance use literature identifies reasons for early drop-out of treatment centres. For example, a New Zealand study of youth, 48% of whom had a concurrent disorder, found that disengaging from treatment was linked to both individual and treatment factors (Schroder, Sellman, Frampton, & Deering, 2009). Individual factors which led to youth disengaging included a loss of motivation which resulted from a feeling that the treatment would not contribute to changes in their life. Treatment factors that youth reported in this study are directly relevant to the ability to meaningfully engage youth in their treatment. Specifically, if youth felt they had not set clear
goals, had not been included in the development of treatment goals and felt unable to express themselves openly and honestly with staff, they were more likely to dropout. Furthermore, other treatment factors included less positive experiences with the treatment centre staff, such as a lack of support, safety and comfort (Schroder et al., 2009). These findings are reflective of the McCreary Centre Society report, “A Seat at the Table” which identified similar reasons for youth disengaging from roles in civic decision making (Smith, Peled, et al., 2009).

According to Foote et al. (1994), “the issues of engagement and retention must assume prominence in the development of new treatment approaches” (cited in Slesnick et al., 2000, p. 217). A framework to implement evidence-informed practice to engage youth is required if the needs of youth with concurrent disorders are to be met. Engagement of youth in treatment services is critical for addressing concurrent disorders. By engaging youth in all aspects of their health care and the health services they access, it is possible to address some of the underlying factors that often prevent and prohibit recovery. Results from the BC Adolescent Health Survey (Smith, Stewart, Poon, & the McCreary Centre Society, 2011b) indicate that youth with a mental health condition and a perceived need for substance use services were less likely than youth without these issues, to feel engaged in their activities. Furthermore, meaningful youth engagement was associated with reduced substance use and reductions in mental health problems.

The meaningful engagement of youth in treatment and other services that affect them can be challenging, especially when services seek to address complex issues, such as mental health and substance use. Yet not only is this now a requirement of countries that signed up to the UNRC but is also critical for the success of treatment services, and the overall improvement of health outcomes. As Aldgate and Statham (2001) wrote,

“If children were allowed to design the nature of meetings, communications might improve considerably. If children had a hand in designing forms that record their lives as looked after children, we might see more changes in how best to safeguard them and promote their welfare” (p. 95).

7.2. Engaging family in treatment: Rationale, barriers, and benefits

Bringing a child for mental health or substance use treatment can be a very stressful experience for parents and caregivers, and it is vital for service providers to engage with families and empower them within their child’s treatment process (Nassau and Pingitore, 2011). As Tannenbaum (2001, cited in Chovil, 2009) emphasized, “Parents facilitate the interaction between the child and the service system, and as such, represent the ‘central dimension’ of the system of care” (p. 1). They bring knowledge about the young person and their culture from a perspective that the health care provider cannot possibly have.

In addition, a family history of substance use or mental health problems as well as family conflict or dysfunction are risk factors for conduct disorders in youth (Adair, 2009). Inclusion of family in treatment in order to address these issues is therefore important. For example, family involvement may help to improve family relationships and contribute to treatment outcomes with respect to supervision,
motivation, and support of the adolescent (Esposito-Smythers & Goldston, 2008; Schwartz et al., 2007). Furthermore, parents who have their own mental health and substance use conditions may need to be educated about how their conditions impact their child’s condition and treatment, especially if the parent’s condition is undiagnosed or untreated (Esposito-Smythers & Goldston, 2008). BC’s practices for mental health reform suggest families be involved in treatment, discharge, and rehabilitation planning (British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002b).

With respect to treatment, a family-centered approach is the most common way of engaging families. As Bukstein and Horner (2010) point out, several different approaches have been used in the treatment of adolescents with concurrent disorders, however, they have in common a focus on the important role of contextual or ecological factors including parents and family, engagement, communication, and change in both adolescent and family.

Previous reviews have identified family-centered care as a best practice approach for the treatment of substance use and mental health problems (CAMH, 2004; Chovil, 2009). The approach acknowledges the crucial role that families play in treatment, emphasizes the needs of both client and family, and therefore encourages family engagement. Based on these reviews, some key principles and benefits of family centered care are that families are experts on their own and their youth’s abilities, needs, and strengths. Also, families are treated with respect and are considered equal partners and work collaboratively with service providers to make informed decisions about treatment.

Hoagwood (2005, as cited in Chovil, 2009) noted that there were few studies that provided evidence that family-based care improved youth clinical outcomes. However, research cited in the CAMH (2004) and Chovil (2009) reviews demonstrates that engaging families through a family-centered approach is associated with increased treatment compliance and retention; greater client, family, and service provider satisfaction with care; faster recovery from mental health and substance use problems; reduced relapse rates; improved family functioning; earlier intervention; and improved cost-effectiveness. Furthermore, the earlier families are engaged in a youth’s treatment the more likely they are to remain actively engaged. For example, phone calls and letters prior to a youth’s initial appointment can increase the chances that the family will attend (Chovil, 2009), as well as reduce families’ feelings of blame and stigma.

Despite these benefits, however, as was the case with family engagement in service development and delivery, barriers exist in meaningfully engaging families in treatment. A number of authors have identified these barriers, including a review of family engagement in child and youth mental health (Chovil, 2009; Berger & Umaschi, 2011). The barriers include family beliefs and attitudes (e.g., not being ready to engage because they do not feel the need, feeling unable to engage because they are dealing with their own problems, not knowing how to engage, stigma), practical barriers (e.g., finances, childcare, transportation, scheduling), service provider and structural barriers (e.g., negative attitudes about family involvement, discrepancy between family and provider attitudes, lack of open communication, lack of opportunity, lack of sensitivity to cultural issues). Berger and Umaschi (2011) noted that attempts to simply address practical barriers by providing childcare or transportation have
not yielded sufficient gains in enrolment rates because they did not adequately address the psychological and contextual challenges facing families.

Some of these barriers may be intensified for families who live in rural and remote areas. In their study of rural communities of Ontario, Boydel and colleagues (2006) studied the barriers faced by families seeking mental health services for their children (aged 3 to 17) who had emotional and behavioural disorders. Parents felt that stigma and confidentiality were significant barriers as the smaller population size in rural communities meant that there was a greater chance that news of a family seeking mental health services for their child would be discovered by other members of the community and thus more susceptible to being labelled. Parents also highlighted the fact that there was a general unawareness or knowledge on the types of and access to services. Limited financial means, having to take time off work, and transportation issues also prevented families from being able to travel to distant locations to access mental health services. With regards to systemic barriers, parents discussed their frustration with the lack of human resource professionals in their communities. This barrier often meant long wait times for their child to see a professional and having to look outside their community into urban settings for help. Hall et al. (2008) also identified cultural values as possible barriers to treatment in rural communities, including a wish to be self-sufficient and deal with problems themselves or with the help of family and friends, as well as the belief that their communities are “insulated from urban problems” (p. 110).

7.3. Examples of engaging youth and families in treatment
Supporting youth and family engagement in treatment programs for concurrent disorders requires dynamic, community-based, and integrated services. The following section highlights evidence-informed practices that demonstrate how youth and their families can be engaged in formal treatment settings and community-based programs.

**Ontario Youth Strategy Project Workbook for Organizations that Serve Youth**
The Ontario Youth Strategy Project (2011) developed “Best Practices in Treating Youth with Substance Use Problems: A Workbook for Organizations that Serve Youth”. This workbook is based on a Health Canada (2001) document on best practices for treatment for youth with substance use problems. The workbook aims to aid organizations in practically implementing recommendations by reflecting on and evaluating their existing policies and practices and developing plans to improve.

The workbook suggests organizations reflect on three areas of best practice: orientation to client, approach to practice, and appreciating the context. Within these three areas, sub-topics are discussed:

- **Orientation to Client**
  1. Be individualized, client centred and client directed
  2. Trust and respect the youth’s inherent motivation for treatment
  3. Involve the family, as defined by the youth
  4. Consider youth within their system of relationships, including peers, family, community and others
Approach to Practice
5. Have an explicit framework that directs practice and leads to demonstrable outcomes
6. Use a holistic, biopsychosocial approach
7. Use a harm reduction approach
8. Be strength based and experiential, and focus on skill building

Appreciating the Context
9. Provide safe, respectful service
10. Involve youth in meaningful ways in developing, delivering and evaluating services
11. Recognize that youth are not a homogeneous group
12. Manage tension among clients’ needs, clients’ choices and program resources

(Ontario Youth Strategy Project, 2011, p. iv)

The workbook provides specific practice guidelines within each of these topics. For example, with regards to orientation to the client, organizations should

- provide programs that are accessible and flexible in order to engage youth (e.g., have flexible hours, locations that are youth-friendly and accessible, different modes of contact (i.e., telephone, in-person, Internet))
- have youth evaluate the “youth-friendliness” of the organization on an annual basis
- have waiting rooms, offices, and clinical staff that are sensitive to the diversity of youth
- ensure youth are informed of their choices and are given youth-friendly information regarding their rights and policies and procedures
- have treatment goals that are client-driven and written in client’s language
- develop reports in collaboration with clients

Finally, suggestions are made about how organizations can use the workbook to guide work in different contexts including guiding discussions about best practices in staff meetings, aiding program development and strategic planning, developing client satisfaction surveys, and identifying areas for training and professional development.

Multidimensional Family Therapy
Multidimensional Family Therapy (MDFT) is an internationally used integrated therapy approach that engages youth with problematic substance use and their parents individually, as well as supporting the building of the relationship between them. MDFT has been applied in clients’ homes, community-based clinics, residential treatment centers, and correctional facilities (Rowe, 2012). It has also been applied in the case of trauma where an intervention was developed for youth who were victims of Hurricane Katrina (Rowe and Liddle, 2008). In MDFT, adolescent drug abuse is viewed as a complex phenomenon in which personal issues, interpersonal relationships, overall family functioning, and extrafamilial systems (e.g., schools, social services) must all be addressed to effect enduring change (Rowe, 2010).
Sessions with youth aim to establish meaningful therapeutic goals, foster motivation, and help adolescents develop concrete strategies to solve problems and find alternatives to drug taking and criminal behaviour. Family sessions involve discussions of family problems and introduce methods that build family strengths, improve communication, and reduce conflict, including family management and parenting skills. These sessions also provide opportunities to provide emotional support (Liddle, 2010). Dr. Liddle notes, "We connect with parents in a way that recognizes their stress and the anger, hopelessness, and even despair they may feel about their child. Then we help parents reconnect emotionally to their child. This renewed caring is instrumental in changing parenting practices" (Sherman, 2010, p. 13).

Research studies on treatments for adolescent drug use “have shown clinically significant effects of MDFT on youths’ drug use and related problems in comparison with other state-of-the-art, well-articulated, and carefully monitored treatments” (Rowe, 2012, p. 224). Studies have also demonstrated higher retention rates compared to comparison programs and sustained effects at one-year follow-up (Rowe, 2010). Many of the studies that have examined MDFT include youth with concurrent disorders. For example, one study involved 83 youth (predominantly male, Hispanic or African-American, low-income), many of whom had a comorbid disorder (39% conduct disorder, 29% ADHD, 9% depressive disorder) (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). In fact, evidence suggests that MDFT had better outcomes than comparison therapies in treating those with more severe substance use and more concurrent diagnoses (Henderson, Greenbaum, Dakof, & Liddle, 2010). Studies of MDFT have not only demonstrated effects with respect to reducing substance use and criminal behavior, but also improved school and family functioning and reduced internalized distress such as depression (Rowe, 2010).

**Multisystemic Therapy**

Multisystemic Therapy (MST) is an intensive family-and community-based treatment program that focuses on restructuring and addressing youth’s environment (Rowe, 2012). MST has shown impressive impacts on youth delinquency and drug use (Rowe, 2012). It employs an ecological approach that works with youth in their homes and also works intensively with families, schools, teachers, and friends of the youth; it aims to blend clinical treatments with community, school and family engagement (Rowe, 2012). MST has been well evaluated for its use with young offenders in the UK and shown to improve parenting capacity, increase young people’s engagement with education and training, reduce their offending behaviour, and reduce mental health and substance use problems (Baruch & Butler, 2007).

For example, in a study of 118 12- to 17-year old substance-abusing or dependent juvenile offenders, MST was compared to usual services in a randomized controlled trial in South Carolina, USA (Henggeler, Pickrel, & Brondino, 1999). Seventy-nine percent of the participants were male, 50% were African American and 47% were Caucasian. In addition, 56% were diagnosed with substance abuse and the remainder as substance dependent, while 72% met DSM-III-R criteria for other mental health concerns, including 35% for conduct disorder, 19% for social phobia, 16% for simple phobia, and 12% for oppositional defiant disorder, among others. Results indicated no significant treatment effects and modest effects with the MST condition showing decreased alcohol, marijuana, and other drug use at post-treatment but not at 6-month follow-up. However, youth in the MST condition experienced 50%
fewer out-of-home placements (incarceration, psychiatric hospitalization, residential placements) than those in the usual services condition during the study. The authors attribute their modest findings to difficulties in transportability. Nevertheless, in a four-year follow up study of 80 of the participants (Henggeler, Clingempeel, Brondino, & Pickrel, 2002), treatment effects were found for aggressive criminal activity and marijuana abstinence, but not psychiatric symptoms.

In another study, Trupin and his colleagues (2011) studied the efficacy of a family-based intervention for youths with concurrent disorders who were transitioning out of the juvenile justice system in Washington state. The sample consisted of 274 participants who were mostly male and Caucasian. The Family Integrated Transitions (FIT) program consisted of multisystemic therapy, dialectical behaviour therapy and motivational enhancement, plus a parent skills training module. The treatment program occurred over a period of 2 to 3 months while in custody and for 4 to 6 months after release. Those in the FIT program as opposed to usual services reported reduced felony recidivism but not overall, violent, or misdemeanor recidivism. Substance use was not assessed.

**Integrated Co-occurring Treatment**
The Integrated Co-occurring Treatment (ICT) model for youth is an integrated treatment program specifically focusing on adolescents with concurrent disorders and their families (Cleminshaw, Shepler, & Newman, 2005). The model incorporates a system of care philosophy with home-based service delivery with its guiding principles centered on providing intensive but flexible time-limited treatment, while establishing a strength-based and supportive relationship with the youth and their family through the implementation of necessary therapeutic approaches and case management services. This model focuses on meeting the client’s, their family, and their community’s readiness and stage of change. ICT highlights the importance of involving the family along with the community in both the client’s treatment process and their ongoing recovery process. Treatment makes an effort to address the client’s individual needs with the goal of decreasing symptoms and substance use while developing the client’s skill set. The family and the community are encouraged to become involved in the process and are provided assistance in order to establish a healthy recovery environment for the client to maintain their treatment gains.

A preliminary evaluation of the ICT model was implemented in a children’s mental health agency on 56 male and female youth between the ages of 13 and 18 diagnosed with concurrent disorders. Every youth served was involved with the juvenile justice system. After being discharged from the program, “14 of the 56 youth (25%) served in ICT were either committed, recommitted, and/or recidivated back to the Department of Youth Services” (Cleminshaw et al., 2005, p. 91). The researchers acknowledged that although the results looked encouraging, they were only preliminary findings and further empirical research must be conducted on the efficacy of the ICT model.

**Uptake of family-driven, youth-guided care**
A study conducted by Brown and colleagues (2010) examined the uptake of family-driven, youth-guided care in residential facilities. Family-driven, youth-guided care involves the family as an advocate to ensure the youth receives the best care and through policy and procedure, ensure all youth in residential treatment receive the best care. The youth are encouraged to become active participants in
their treatment planning and provision. The study surveyed 293 residential mental health treatment providers across the United States to assess the extent to which residential treatment facilities have implemented the family-driven youth-guided philosophy in their care model.

The results of the survey indicated that residential treatment providers had implemented several practices based off the family-driven youth-guided philosophy which consisted of “strength-based individualized treatment planning, collaboration with community-based providers to develop treatment plans, and the provision of various forms of support to families” (p. 150). A large portion of residential treatment facilities reported developing individualized treatment plans which reflected the feedback received from both the youth and their families. Many of the treatment plans include working with families and other service providers outside of the treatment facility. While a large majority of treatment providers reported using a team-based approach to treatment planning, less than two thirds incorporated the youth and their family’s input into selecting treatment team members. Eighty-nine percent of treatment facilities included youth and families as participants on the treatment team, while two-thirds of facilities reported having youth and their families contribute to the development of the treatment plan. Seventeen percent of facilities did report to having limited to no input from the youth or their family in the formation of the treatment plan. A significant proportion of facilities had reported that their staff “had never heard of family-driven principles, had heard of them but had not received training or needed additional training to apply them” (p. 154).

HELP!!! Simulation Workshop
In order to help health professionals understand the barriers that youth face, HELP!!! was developed as “an interactive, experiential simulation of the health care system that youth with concurrent mental health and addiction issues need to access for help” (Ballon & Chaim, 2006, p. 603). Ballon & Chaim describe the details of the simulation as well as data on the perceptions of a total of 547 participants across 16 workshops, each of which involved 30 to 50 participants. Participants, or learners as the authors describe them, include professionals, both front-line service providers and agency/program managers, from a wide range of disciplines including social work, nursing, youth work, addictions, family medicine, and psychiatry.

The simulation exercise takes about 60 minutes and involves learners in the roles of youth with concurrent disorders, family, and service providers and staff representing various agencies such as education, mental health, addictions, housing, juvenile justice, medical health and youth programs. In addition, the simulation includes “Joe’s coffee shop” which is a place for youth to go when not engaging with the system. The facilitators of the workshop act in the role of health ministers or other funders.

Results indicated that the learners found the simulation to be innovative and educational, motivated discussion about enacting change in the system, helped them understand system gaps, and helped them experience the feelings youth might experience in navigating the system and thereby feeling empathy for youth.
Delaware Youth Project Campbell River, BC, Canada
Although not yet independently evaluated, a local example of a community based project which is engaging youth with concurrent disorders in a community setting is the ‘Delaware – We are always there’ project launched by The John Howard Society of North Island (2011). The project initially aimed to address the needs of school age youth with mental health and substance use challenges who were not attending school and who were either treatment resistant or had been denied service.

Delaware is a youth-driven collaborative project drawing together various community groups and youth aged 13 to 24. It aims to provide youth with a safe and supportive space that gives them a sense of belonging, a place to express their voices and explore issues relevant to their lives. In response to the needs of youth in the community, Delaware provides an internet café, a nutritious breakfast program free of charge, field trips, information on community programs and support for youth to reengage with education. Delaware also has a youth council that meets regularly to discuss fundraising and directions for the centre. In addition, as most of the youth attending Delaware are Aboriginal, connections have been forged with elders and cultural specialists who have worked with youth on cedar weaving, bark harvesting and river cleansing.

Delaware’s youth engagement strategies include:

- Meeting the needs of vulnerable and “high risk” youth in the community
- Initiating and supporting activities that have been identified by youth as of interest
- Providing a safe, supportive and relaxed environment where youth can feel comfortable
- Addressing substance use and mental health challenges by providing a space where youth feel safe, and can develop trusting and supportive peer and adult relationships

In an internal reflection on the Delaware Project, youth involved with the program said,

- “It’s somewhere youth can go chill and hang out sober.”
- “Helps me get up in the morning”
- “Safer here than outside”
- “Freedom to express”

Hartford Youth Project, Hartford, Connecticut, USA
The Hartford Youth Project (HYP) sought to reach and provide a continuum of substance abuse treatment services for youth in one of the United States’ most ethnically diverse and economically challenged cities (Simmons et al., 2008). The project was developed as a part of the American Substance Abuse and Mental Health Administration’s (SAMSHA) Strengthening Communities for Youth (SCY) Initiative. The project has not yet been externally evaluated, but “exceeded its service objectives in both the number served and in improving treatment discharge outcomes from historical state levels” (Simmons et al., 2008, p. 53).

The project sought to engage youth before they became entrenched within a cycle of substance use. Of the 190 participants, about 70% reported symptoms of an internalizing (e.g., depression) or externalizing (e.g., conduct disorder) mental health problem. The guiding principles of the HYP were
relationship-building, collaboration, needs assessment and individualized family-focused treatment. Although not externally evaluated, this service model was considered to be culturally appropriate through its use of community-based organizations and culturally relevant practices.

The HYP was a partnership between Connecticut Department of Children and Families and established community groups which worked collaboratively to develop engagement and outreach strategies. They also developed relationships with agencies that had regular access to the youth population that they were trying to reach. The partnerships between the diverse range of community agencies and local government department provided the project with valuable links into communities and were identified as crucial to its success.

Community Engagement Specialists were hired for the project to act as a link between community groups and treatment providers, as well as support engagement of youth and their families. The treatment program exceeded its service objectives and improved treatment discharge outcomes. HYP also provided help and support with the social determinants of health. They linked youth and their families to assistance with housing, medical care, vocational training, legal support, and child care. The researchers write, “these support services were considered to be as important to treatment success as the treatment services themselves” (Simmons et al., 2008, p. 44).

Although this is an American example, it contains many elements which could be adapted for a BC setting. These include:

- Partnerships with pre-established community groups
- Addressing the social context in which youth live and the social determinants of health
- Utilization of a model of family focused and community centered care
- Encouragement of cultural safety and sensitivity

8. Engaging vulnerable populations

As stated earlier, certain populations of youth are more vulnerable to concurrent disorders, and may also be harder to reach and engage in treatment. Research in the United States has found that minority cultures or ethnic groups may be hesitant to engage in mainstream treatment programs presented by the dominant culture (Simmons et al., 2008). Cavaleri et al. (2006) noted that certain family characteristics, such as poverty, low socio-economic status, and minority status, contribute to the underutilization of mental health services. Thus, treatment programs need to incorporate a holistic and integrated approach. Dr. Michael Marmot on the World Health Organization commission for the Social Determinants of Health writes, “Treating existing disease is urgent and will always receive high priority but should not be to the exclusion of taking action on the underlying social determinants of health” (2005, p. 1103).

Brady and colleagues (Department of Health and Children, 2004) suggest that there are some critical components which can assist in engaging hard to reach and vulnerable youth in treatment programs and community based services. These include having youth take the initiative in identifying actions and
solutions, emphasize prevention and early intervention, have service providers who have knowledge about and are skilled in working with youth needs, and engaging families. Brady and colleagues also suggest that there are no universal or simple strategies for working with at-risk youth. Rather each situation presents its own challenges and opportunities, and will require customized engagement and response strategies. They also point out that it is critical to include evaluation and research in program development so engagement levels and effectiveness can be monitored.

8.1. Homeless and Street-involved Youth

For street-involved youth to be meaningfully engaged in treatment and other services, it is important for service providers to consider facts beyond their presenting concurrent disorder and housing situation. This may mean an acknowledgement of the exclusion and social isolation they may have faced in the past, as well as histories of trauma, physical and/or sexual abuse (Murphy, Poon, Weigel, & the McCreary Centre Society, 2001). In their recent report, “Youth on the Street and youth involved with child welfare,” Goldstein and colleagues (2011) write,

> Given the prevalence of mental health symptoms and substance use among the sample of youth who are homeless, a collaborative, youth-centered outreach approach maybe be most accessible and may increase engagement in treatment...Building a continuum of care for youth who are homeless is a challenging but necessary task. (p. 25).

They also suggest that services should focus on outreach and unconventional approaches.

Engagement of reluctant substance-abusing runaway youth and their families, New Mexico, USA

Engaging runaway youth in treatment is difficult and there is little evidence of treatment evaluation for this population (Slesnick, 2001). Based on their research with runaway youth using substances in the United States, Slesnick et al. (2000) present a four-stage model for engaging homeless and street-involved youth in treatment programs and services.

1. **Contact.** This may be the most critical stage of engagement as youth may not stay engaged if this phase is unsuccessful. Their research suggests that therapists or healthcare providers should utilize language from the youth’s culture, as well as adopt their demeanor to meet the needs of youth. In addition, the initial space of contact should be relaxed and accepting. It is important that health care providers are trained in how to interact and support youth, and how to reduce feelings of intimidation and alienation among youth.

2. **Presentation.** This stage of engagement is meant to present the treatment program in a manner that youth find appealing and non-threatening which is youth-friendly and accessible. At this stage, service providers inform youth of the confidentiality of treatment services, as well as the length or treatment and range of services.

3. **Evaluation.** It is critical that youth feel they are understood and heard at this stage. Here, the service provider’s role is to identify points that may serve to motivate youth into treatment, as well as reinforce positive social behaviors. Alliances are established between youth and service providers, and a safe context for therapy to occur in is established.
4. **Negotiation.** It may be necessary for healthcare providers to work with youth to develop suitable treatment programs. It is critical that providers meet youth where they are at here. Youth may be reluctant to give up substance use, or leave communities of friends. If youth are pushed into meeting criteria for acceptance into treatment, then they may resist and the opportunity for engagement will be lost. Here, flexibility, acceptance and respect should be utilized.

The key youth engagement components of this program include having:

- Highly trained, capable and youth-friendly staff
- Accessible and open spaces
- A careful and deliberate approach to treatment that responds to the needs of youth, as well as recognizes their history and social context
- Flexible, patient and accepting practices that encourage and support youth in their treatment process – this may mean that service providers have to surrender their own agenda

**Intensive Mobile Youth Outreach Service, Melbourne, Australia**

The Intensive Mobile Youth Outreach Service (IMYOS) is a program of the Orygen Youth Health Centre, Australia’s largest youth mental health focused organization (Orygen Youth Health, 2012; Ryall et al., 2008). The project was developed to meet the needs of youth at significant risk of homelessness, suicide, drug abuse and unemployment, and works on a referral system from healthcare providers within the healthcare system. IMYOS deliberately seeks to reach youth who have had difficulty engaging in the mainstream service system. The youth engaged in IMYOS are often experiencing family conflict, may be in crisis, have a history of involvement with Child Protection Services and may not be attending school.

The IMYOS team is multidisciplinary and draws on the theoretical framework of Multisystemic Therapy (MST). Additionally, the IMYOS program has adapted the MST model to be flexible and meet the needs of a hard to reach youth population. Interventions occur at three levels: individual, family, and systems (which means including all the other people involved in providing care to a young person). It operates on a case-management system to ensure that young people receive the individualized care that they require.

Recognition of the vulnerability of the youth that IMYOS works with has lead to a focus on establishing a sense of personal safety for all clients. Strategies such as validation, collaboration, and consistency, as well as the development of personal safety plans, help strengthen therapeutic relationships and increase the sense of safety for clients.

Another key component of IMYOS is its involvement with families and systems in which youth live. The IMYOS model suggests having a team member specifically work with families to educate them about the program, explain theoretical and behavioral models, help in the development of a safety plan and consider strategies for intervention. IMYOS states that, “Clear, supportive, and improved family relationships are of central importance in the reparatory experience for the individual” (Ryall, et al., 2008, p. 164).
Key practices of IMYOS that foster collaboration and engagement are:

- Transparency – Youth are actively involved and included in their assessment and treatment. Concerns are openly shared with youth, and safe and respectful spaces where youth, their families, and healthcare providers can come together are facilitated.
- Flexibility and creativity of approaches – Interventions are youth- and family-friendly, non-blaming and respectful. In addition, youth and their families are able to guide interventions with the help of clinicians clearly outlining possibilities and support services.
- Joint participation – Invitations are extended to youth and their families to participate in dialogue surrounding the youth’s situation, challenges and health concerns. These discussions inform interventions and can be re-negotiated.

This project includes many key elements of youth engagement which can be adopted in a BC setting. These include:

- Intensive outreach which incorporate multifaceted interventions and approaches
- A multidisciplinary team with training and knowledge of youth behaviours and needs
- An emphasis upon family involvement and engagement
- The creation of spaces for dialogue where youth voice are heard and valued
- Ensuring that youth have a key role in designing their own treatment programs, while providing clear safety plans and supports, and also operating in a transparent and accessible manner

8.2. Immigrant Youth

Immigrant youth may be marginalized by language barriers, as well as unfamiliarity with the healthcare system. Keleher and Armstrong (2005) suggest that any program which aims to work with immigrant youth needs to be knowledgeable, sensitive, and respectful of culture and practices; partner with local refugee and cultural centres and community leaders and ensure community engagement with all stakeholders; establish social arenas that build connection and trust in multicultural contexts; and become sustainable by ensuring processes for skills development, establishing ongoing support mechanisms, changing community attitudes and creating connections that did not previously exist.

When the McCreary Centre Society looked at factors that promote positive mental health among BC youth, they found some differences between immigrant youth and those born in Canada. For example, immigrant youth who had been in Canada two years or less were the most likely to seek out professional help, and were also more likely to find the help useful, which highlights the need to build rapport early and establish early prevention projects with new Canadians (Smith, Stewart, Poon, & the McCreary Centre Society, 2011a).

Substance abuse program for African Canadian and Caribbean youth (SAPACCY), Toronto, Canada

SAPACCY is based out of the Canadian Centre for Addiction and Mental Health in Toronto (Centre for Addiction and Mental Health, 2010). The program seeks to meet the needs of Canadian African, Caribbean, and Continental African youth. Although not formally evaluated, SAPACCY was highlighted in a 2008 United Nations’ Report on Good Practices for Community Based Treatments for Drug Dependency (www.unodc.org/treatnet).
The program provides community-based outreach services to substance-abusing youth and their families. It uses a holistic, equitable and culturally sensitive model using the key principles of having staff that are representative of the communities in which they work, as well as providing flexibility to meet the needs of their clients. In addition, part of SAPACCY’s mandate is to focus on the social determinants of health. The centre staff may therefore work with youth to secure housing, food, or stable income before they begin to address substance use in the youth’s life.

The manager of SAPACCY, Lew Golding, suggests that one of the organization’s strengths is its continuous community visibility and presence. The organization is visible in schools and community events so that when youth feel that they need help they are aware of SAPACCY. Additionally, he suggests that culturally competency and earning the trust of participants is crucial for the success of programs.

**8.3. Aboriginal Youth**
Within British Columbia, the legacy of colonialism combined with experiences of discrimination and fears of being stigmatized have resulted in Aboriginal youth experiencing mistrust and wariness towards services that are not based within their local community and are not culturally sensitive. For example, among Aboriginal youth in mainstream schools, 24% of females and 10% of males had not accessed mental health services that they felt they needed within the past 12 months, and this rate rose to more than half among those with a mental or emotional health condition (Tsuruda et al., 2012).

International research has acknowledged that Aboriginal groups require increased mental health support and services to address the negative legacies of colonialism (Westerman, 2004). However, there is a dearth of services to meet the pressing needs of Aboriginal youth mental health concerns. Westerman (2004) suggests that this is exacerbated by a lack of evaluated and evidence-informed practices on therapeutic programs and interventions with Aboriginal people. A Meadow Lake Tribal Council Administrator highlights the need for community-based services in saying, “Finding our way to wellness among diverse communities of children and families requires many pathways. No one approach, no one program model, will reach or work for everyone” (Ball, 2006, “Cultural safety is respectful engagement that supports and protects many paths to well-being,” ¶1).

Programs that seek to meet the needs of Aboriginal youth and their families must be premised upon the concept of cultural safety. Cultural safety refers to “the outcome of interactions where individuals experience their cultural identity and way of being as having been respected or, at least, not challenged or harmed” (Ball, 2006, “Indicators of cultural un-safety,” ¶5). Cultural safety is an outcome determined by the recipients of services. It is predicated upon respectful relationships and equitable partnerships in which all parties have the right to influence the terms of engagement.

White and Jodoin (1998, 2007) concluded that in order to provide a community-based, culturally sensitive intervention, programs for Aboriginal youth must reach a consensus as to the focus of the program; involve elders, youth, and families; involve community agencies and be knowledgeable about the local community and understand community assets; recognize that developing a successful program takes time; and prepare and deliver key evaluation questions.
The White Stone Project, Calgary, Alberta
The White Stone Project (Centre for Suicide Prevention, n.d.) utilizes community sensitivity and capacity building to provide training for Aboriginal and Inuit Youth leaders in the area of suicide prevention. The name draws upon the Ojibwa concept referring to “one who teaches others to grow old” (Centre for Suicide Prevention, n.d., Home page, ¶2). The White Stone project has been presented to over 400 youth across Canada.

The project addresses a pressing need in Aboriginal and Inuit communities and aims to be culturally sensitive, and engages community members and works with youth community leaders to develop community capacity and strength. The project builds upon this capacity and provides youth with training to be leaders in their communities. The model highlights the importance of working with communities to develop sustainable strategies for meeting their needs, especially in rural and remote areas. It also presents a cost-effective model through which youth can be trained as peer-educators and supporters. In addition, the training is flexible and can respond to the needs of the participants.

White Stone is an evidence-informed project based on youth focus groups and participant feedback in addition to a review of current literature and programs in Canada, the United States and Australia. Program delivery is continually improved through feedback from participants, trainers, communities, and organizers. The website indicates that the program has been evaluated and the results were reported in 'White Stone Viewed Through a Cultural Lens' which was released in 2005. Unfortunately, this report was not available for the current literature review.

Aboriginal Next Steps, McCreary Centre Society, British Columbia, Canada
Given the risk factors in the lives of Aboriginal youth in BC, it is essential that more be done to promote their engagement in community programs and treatment services. The Aboriginal Next Steps aims to bolster and sustain Aboriginal youth protective factors and to minimize risk factors, through constructive community activities that empower youth, motivate them to achieve their goals, and facilitate a healthy transition to adulthood (Smith, Simon, Hoogeveen, & the McCreary Centre Society, 2010). It is known that Aboriginal youths’ involvement in extracurricular activities is associated with a wide range of positive outcomes, including reduced rates of substance use and mental health problems (e.g., Tsuruda et al., 2012).

Between 2007 and 2009, the Aboriginal Next Steps program targeted 132 youth aged 13 to 19 with mental health and substance use problems in 10 Aboriginal communities across BC. Youth participated in workshops where they learned about the risk and protective factors associated with substance use and mental and physical health, they then worked with adult mentors to develop skills in multi-media and facilitation to share what they had learned with peers and adults in their community before developing and delivering a sustainable youth-led project which addressed substance use in their community.

An evaluation of the project (Peled & Smith, 2010) included pre and post surveys of youth’s health risk behaviours and showed improvements in overall mood; self-esteem; substance use; criminal activity; suicidal ideation; self-harm; as well as in peer, school, and community connectedness.
Youth participants’ self report survey data was corroborated by caregiver interviews where many noted that the project helped to foster their children’s self-esteem and confidence in their abilities and to improve their coping skills and emotion regulation. As one parent reported in the evaluation,

[She] was an angry youth … but then she got involved with the program and she’s been able to handle her emotions, her behaviour, she’s able to have more self control on tight issues and she’s more focused when it comes to her education or any other major life changing decisions that she has to make.” (p. 41)

**Diabetes screening in remote First Nations’ communities, Northern Coast, British Columbia, Canada**

An example of a medical program which successfully engaged Aboriginal youth and their families can also offer some lessons for those planning services for youth with concurrent disorders.

A diabetes screening program was undertaken by UBC’s Department of Pediatrics in three communities in the Tsimshian nation on the northern coast of British Columbia (Panaglotopoulos, Rozmus, Gagnon, & Macnab, 2007). It was able to engage 100% of families and establish and retain community support by ensuring appropriate dialogue, care, and respect and planning to overcome the sociological, ethical, and practical challenges. Because the study was initially requested by the community, there was initially a strong desire for success of the screening program.

Ethics and confidentiality issues posed challenges. For example, as many community members had a limited understanding of the need for and complexity of the screening (for example, to ensure children would fast before blood samples were taken), it was important to educate the community so they could make an informed decision, and to ultimately understand the results. Furthermore, a history of having data and blood samples taken from Aboriginal Canadians without their consent, and the cultural issues regarding children providing assent/consent was an ethical challenge. As the Elders are responsible for the welfare of the children, the concept of having the children providing informed assent/consent was new in the community.

The personnel from the Department of Pediatrics had a pre-existing relationship with the community in the context of an oral health program that had been running there for the past three years. They also hosted an open meeting to ensure buy-in and understanding from the community. The parents and children were scheduled to meet the team at the health clinic for an opportunity to ask questions in confidence before signing consent forms. The pre-existing relationship between the researchers and community was also an important factor, as without it, the sheer invasiveness of the procedures and the appearance of an externally-imposed medicine would have been seen as violation of community and culture.

Cultural context was also important to consider. The community had a history of paternalistic western medicine being forced on the people, ignoring traditional medicine. Animosity toward outsiders was also strong, due to ongoing conflict over land rights. However, the remoteness and isolation of the community contributed to the ease with which information about the program was able to travel quickly and effectively. Finally, it took time to establish community involvement and support for the
program. It was important to work with the schedules of a remote community which operated at a different pace.

9. **Keeping youth engaged with their families and communities during and after residential treatment**

When youth obtain substance use and/or mental health treatment through residential programs, they are removed from their family and community life. Given the previous evidence presented regarding family-centered care and the importance of treating youth within an ecological context, residential treatment programs may pose a challenge to youth who want to stay connected to their families and communities. Re-engaging with their families and communities is also pertinent following discharge from residential programs.

This idea of staying connected or re-connecting is supported from evaluation work carried out by the McCreary Centre Society of treatment programs offered by an agency based in the Lower Mainland of British Columbia (Peled, Smith, & the McCreary Centre Society, in press). One suggestion from youth in residential programs for young people with addictions and mental health challenges was to have more unsupervised home visits while youth were still in the program. They felt that these visits would allow them to build stronger relationships with their families and feel less anxious about returning home after leaving the program. One participant noted that an integration worker helps youth plan for the transition back to the community, and other youth emphasized how the plan might help to keep them occupied in healthy ways in the community.

Further support is provided by a study which involved 68 youth with substance use disorders who were discharged from a residential treatment facility (Wei, Heckman, Gay, & Weeks, 2011). The results indicated the importance of strong social networks which provide a sense of acceptance and an environment that supports youth in their recovery process. Establishing strong social supports and integration could increase their motivation to avoid using substances as they reintegrate back into their homes and communities.

In another study of family-driven youth-guided practices in residential treatment, Brown et al. (2010) found that facilities across the United States provided youth and families the opportunity to remain connected while the youth is in residential treatment. Almost all facilities surveyed (n=257) allowed conference calls between youth and family members, 203 facilities hosted social events for youth and their families, and over half provided financial support towards transportation in order for family member’s to visit the facility.

**Detention to Community Program**

Detention to Community (DTC) is a reintegration program for drug-using juvenile detainees which utilizes an adapted Multidimensional Family Therapy (MDFT) approach (Liddle, Dakof, Henderson, & Rowe, 2011). It is an example of an evaluated program from the juvenile justice system which has implications for young people receiving treatment for concurrent disorders.
The MDFT-DTC program involved carrying out therapy for four months with families after release from the detention centre with an emphasis on treatment and providers to engage and retain the young people and their families. Participants’ (n=154) had an average of 2.4 psychiatric conditions including conduct, generalized anxiety, ADHD and major depressive disorder. The modified MDFT therapy was more effective than the services as usual condition in terms of treatment engagement, retention, and satisfaction. The program successfully retained 87% of its participants in treatment compared to 13% in the services as usual control group for at least three months after the youth were released from custody.

The success of the program’s retention and engagement rates were accredited to the focus on family relationships as a context of adolescent and parent change. Therapists worked with youth and their families to prepare them for meetings and appointments (e.g., with court and school hearings) as well as attending these appointments alongside family members, to support the whole family to ensure the best possible outcomes.

The MDFT-DTC program was able to target multiple outcomes of substance abuse, mental health, and risky behaviours, by starting the comprehensive services in the youth custody facility and continuing them into community- and family-based services with the same therapists.

**Gorey Youth Needs Group, Ireland**

The Gorey Youth Needs Group (GYNG) is an example of a community-based youth project that involved youth, families, schools, and communities. The GYNG project supports marginalized young people such as those with mental health and substance use challenges. The project is centered on youth participation, and an emphasis is placed upon empowering and enabling youth to take active roles in their own futures, as well as positively contributing to the communities that they are a part of (Department of Health and Children, 2004; Gorey Youth Needs Group, 2006).

The program uses a variety of avenues through which to engage and support youth and their families. It includes in-school support, community support groups, drop-in projects, and social activities. In addition, the program offers parenting courses for the families of youth involved. Support groups at GYNG focus on increasing self-esteem, providing youth with tools for managing their behaviour and exploring attitudes towards school. Counseling and specialized support is provided to any youth who express a need for it.

A key component of the program is that youth remain involved in the program on a long-term basis as they transition into adulthood. Other engagement components of the program include provision of family support and training, providing a stable supportive environment for youth, and a community-based initiative that seeks to develop community strengths, thereby contributing to its sustainability.

An evaluation of this project found its success to lie in its integrated and holistic approach (Department of Health and Children, 2004). The project was found to not only improve the mental health of young people but also to increase school attendance and retention, and increase youth uptake of educational opportunities.
The Rights and Participation Project (RAPP) (Kirby, Lanyon, Cronin, & Sinclair, 2003) is a child and youth advocacy and support centre that uses child centered care to develop effective working relationships with young people. The centre currently receives 27 referrals per month and has contact with around 3,000 young people per year. RAPP offers a range of services that support youth well-being and engagement, and provides a space where young people can develop their own ideas. They aim to strengthen services available to youth at risk of falling through cracks in the system, as well as promote child-centered practice and policy developments.

Key components of the RAPP vision and mandate are:

- To enable children and young people to participate through a range of fun, creative and challenging activities and projects
- To encourage children and young to become active citizens through campaign groups, school councils, consultation events, outreach work and city wide events
- To empower young people to put their ideas into action by working in partnership with agencies and decision makers who want to help children and young people make a difference

(Rights and Participation Project, n.d., “Youth Council Missions Statement and Vision”)

RAPP workers seek to meet youth where they are at and interact with them as allies and friends. They provide a host of services that help youth engage in skill-building exercises that draw them off of the street into a friendly and supportive environment. The RAPP program is relevant for the development of engagement programs for youth with concurrent disorders as it focuses upon meeting youth where they are at, and seeking to increase the protective factors in youth’s lives. Additionally, it presents an example of a community-based program that has successfully engaged hard to reach youth. Lessons learned from this program for engaging youth can help inform the development of programs for youth with concurrent disorders, including respecting youth ideas and voices, providing care that responds to the needs of youth in the community, advocating for and supporting youth, and having programs that are creative and fun.

10. Checklist of strategies for successfully engaging youth

- Integrate mental health and substance use services and provide comprehensive care programs that are client-centered, family-centered, and holistic with a regard for the social determinants of health and the ecological context of youth and families
- Give youth a voice, listen to them, respect their ideas and needs, and view them as partners in collaborations
- Facilitate and encourage open, safe, respectful communication
✓ Create youth-friendly, accessible spaces
✓ Meet youth where they are at by having services and providers that are supportive and accepting
✓ Establish partnerships with community organizations, agencies, and policy makers who want to empower young people to make a difference
✓ Provide incentives for youth to attend meetings (e.g. food, transport, fun activities)
✓ Develop creative, fun and engaging programs which also help youth develop skills
✓ Develop strength-based programming
✓ Ensure staff are trained, knowledgeable and aware in the areas of youth health and concurrent disorders and are able to leave their own biases and agendas behind when they work with youth
✓ Keep youth connected to their families and communities
✓ Develop services and programs that are grounded in the community, developed in partnership with communities, and develop community strengths
✓ Extend services to youth who may be marginalized or traditionally excluded (e.g., youth in care) and allow them to come together as a group (building solidarity amongst youth)
✓ Develop assertive outreach for vulnerable and hard-to-reach youth
✓ Have programs and policies that are culturally sensitive and culturally safe
✓ Recognize, acknowledge and address the histories (e.g., experiences of abuse and trauma need to be recognized and should be addressed using trauma-informed practices) and social contexts of youth

11. Checklist of strategies for successfully engaging families

✓ Adopt mental health and substance use services that are client-centered, family-centered, and holistic with a regard for the social determinants of health and the ecological context of youth and families
✓ Ensure staff are trained in the principles of meaningful family engagement and ensure all stakeholders are committed to facilitating the engagement of families, from frontline staff to policy developers
✓ View families as equal partners in the treatment of youth with concurrent disorders
✓ Ensure the environment is safe, comfortable, and non-judgmental for families to talk openly about their experiences and those of their child
✓ Encourage participation in task forces, work groups or councils that focus on the health of youth with concurrent disorders and which engage families at the institutional level so they can effect policy and programming decisions
✓ Develop a Family Advisory Council that is diverse in membership and comprises a variety of families who have experienced the treatment program or service
✓ Ensure service providers communicate with the family in a clear and honest fashion, avoiding acronyms and technical jargon, so that families can be meaningfully involved in service planning
✓ Tie care plans to the family’s beliefs, opinions and preferences
✓ Provide a role for parents as co-trainers in the education, training, and professional development of mental health professionals
Acknowledging that families may have feelings of shame, guilt, and blame related to the stigma of substance use and mental health problems, recognize and address the unique barriers that families from rural communities may face, and build on the strengths of the child and family.

12. Conclusion and future directions

Genuine investment will lead to improved health outcomes and services utilization for youth and their families, although this path will not always be straightforward or clear. Sinclair (2004) states,

The challenge for the next decade will be how to move beyond one-off or isolated consultations to a position where children’s participation is firmly embedded within organizational cultures and structures for decision-making—to offer genuine participation to children that is not an add-on but an integral part of the way adults and organizations relate to children. (p. 116)

Commonalities can be seen in youth and family engagement in service development and delivery as well as in treatment. The following evidence-informed practices should be considered in policies and programs developed to increase the engagement of youth with concurrent disorders and their families. However, each situation is unique and practices need to be adapted to fit the environment in which they are being employed.

- **Family-centered care** — Treatment methods, such as multi-dimensional family therapy (MDFT) and multi-systemic therapy (MST) engage not only youth, but also their families. The practice of family engagement has been repeatedly evaluated and been found to be an integral component of successful treatment services.

- **Youth and family input in service planning and policy development** — Research has repeatedly documented the importance of including service users and their families in all stages of service development.

- **Cultivating a supportive and respectful environment** — Youth and families repeatedly state that the presence of healthcare providers who understand and listen to their needs is essential in their involvement in treatment programs. The cultivation of respectful, supportive, and trusting relationships is crucial.

- **Assertive Outreach** — Service providers need to be able to go where youth are, especially for hard to reach populations of youth. Assertive outreach may involve travelling to remote areas of British Columbia, as well as visiting spaces that youth frequent.

- **Meeting youth where they are at** — This may mean that services need to be flexible, gradual, and accepting. If youth are given ultimatums that they are unable to meet, then they may disengage from treatment. This requires providers to be supportive and accepting.

- **Youth-friendly and knowledgeable staff** — Service providers must be trained in how to effectively work with youth. Youth require respect and support to engage with treatment.
Integration of services – Services for concurrent disorders will benefit youth and their families if treatment programs are integrated. This will help address the larger context in which youth and their families live, as well as ensure coordination of services.

This literature review has identified evidence-informed strategies and examples of programs and approaches that attempt to engage youth with concurrent disorders and their families in service development, delivery, and treatment. However, more research is needed on youth with concurrent disorders specifically to evaluate the extent and meaningfulness of youth and family engagement, and its success in effecting positive change in clinical outcomes and service development.
13. References


