Pathy Family Foundation

Effectively supporting Montreal youth on the margins: an analysis of key issues and community assets

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Executive Summary

Vulnerable and marginalised youth in Montreal face a complex interconnectivity of barriers to accessing crucial health-promotion tools, including: mental health services, housing, and education and employment options as they transition to adulthood. Through a combination of interviews with stakeholders in the youth-serving nonprofit sector, and contextual research into social determinants of health and institutional exclusion for Canadian youth, this report analyzes three Key Issues and their impacts on the immediate and long-term well-being of youth in Montreal. The Key Issues are:

1. Access to mental health support
2. Access to harm reduction for youth who use drugs
3. Youth aging out of youth protection systems.

The study found that existing community sector services in the city are chronically underfunded and, as a result, are restricted by a lack of integrated tools required to effectively support marginalised groups: LGBTQ2IAP+, racialized and Indigenous groups, homeless youth, and those leaving the youth protection system.

Mental health support

Mental health needs of marginalised youth in Montreal are vast, particularly given their higher rate of experiences of trauma in childhood and adolescence. Despite need, the report found that access to mental health support for youth in Montreal is severely compromised due to chronic underfunding, long wait lists for therapy, an inordinately complex bureaucratic system, the inaccessibility of private therapeutic resources, and a lack of diversity in backgrounds and expertise of mental healthcare providers overall. The community sector is working to fill major service gaps through diverse and low-cost mental health resources: subsidized counseling and therapy; peer support initiatives; and providing for basic unmet needs like food, in order to offset chronic stress that compounds mental health struggles. However these offerings need to be bolstered through increased funding, which will also work towards preventing burnout of workers in this area.

Harm reduction for youth who use drugs

Drug use amongst marginalised youth carries significant risks of harm when inadequately handled by institutions and community organizations. Health risks associated with drug use include Sexually Transmitted and Blood-Borne Infections (STBBIs), chronic illness, and overdose death. The latter is at a greater risk with the rise of street drugs laced with Fentanyl. The intersections of mental health and harmful drug use behaviours are particularly salient for youth from marginalised communities, as harmful drug use behaviours can emerge as a coping response to unprocessed trauma to which they are more vulnerable to. Research overwhelmingly demonstrates that programs, policies and practices that promote abstinence from drugs among youth are ineffective at decreasing drug use and promoting safe behaviours. Harm reduction is a powerful alternative for working with youth who use drugs, as it emphasizes non-judgmental attitudes that foster trust-building and open communication: with that trust built, youth workers promote safety and connect youth with other resources that can support their growth and well-being. Barriers to delivering harm reduction approaches with youth in Montreal include: stigmatizing attitudes among institutional staff, provincial bureaucratic complexity in the provision of resources, and a lack of funding for harm reduction interventions.

Youth aging out of youth protection systems

Youth who grow up in and through the youth protection system face enormous challenges as they reach the age of 18 and are released from foster care and group homes. Indigenous and racialized youth are severely overrepresented in the youth protection system due to implicit bias of case workers who investigate youth protection inquiries. As a result of disparities in accessing supportive networks and resources after age 18, a large proportion of youth from care encounter homelessness and street-involvement, lack of educational attainment, mental health issues and criminalization. Unlike their same-age peers, these youth do not have families and networks to support them through the process of graduated independence towards a thriving adulthood. In Montreal, there is a drastic lack of tailored services for care-leavers in accessing housing, employment, and education. Some community organizations and grassroots movements are mobilizing to offer identity-specific support to assist these young people in promoting a successful transition to adulthood, but are facing barriers in their efforts.

Recommendations

The report proposes a series of issue-specific and guiding recommendations to inform PFF's funding priorities in supporting vulnerable and oppressed groups of Montreal youth. The conclusions of this study found that across all Key Issues, the most urgent areas in need of financial investment are:

- Diverse housing options to assist youth that transitions out of care;
- Youth caseworkers, street workers and mental health workers within community organizations who are important lifelines for youth left unserved by institutions;
- Youth-specific harm reduction education and health promotion services;
- Peer support programming;

Finally, across all Key Issues there is a rooted trend of disempowerment whereby systems and institutions devalue youth voices in decisions about policies and services that impact them directly. Thus, in all philanthropic efforts to remedy structural inequities affecting young people, **youth must be actively involved in the decision-making concerning programming**, and treated as experts in their own needs.

Introduction and Methodology

Introduction

Youth in Montreal face a host of challenges as they age into adulthood. These challenges are amplified for marginalised youth whose identities sit at the intersections of "disprivilege", including: LGBTQ2IAP+[1] youth (transgender and nonbinary youth in particular); racialized[2] youth; newcomer and migrant youth; Indigenous[3] youth; homeless and street-involved youth; and youth aging through youth protection[4]. Youth that fall within some—or many—of these identity categories face systemic discrimination, poverty, homelessness and street involvement, mental health issues, and harms associated with drug use. Institutional exclusion, social exclusion, sexual exploitation, and inaccessible public sector resources often serve to perpetuate and reproduce these challenges. It is therefore the function of community organizations to stay rooted in the needs and strengths of youth they serve, in order to offset the risks of structural and systematic oppression (Schonert-Reichl, 2000).

The Pathy Family Foundation (PFF) has always worked to support Montreal by investing in its nonprofit and community sector, specifically youth-serving organisations. This study has been commissioned in order to help PFF better understand the Key Issues which threaten the health and well-being of marginalised youth in Montreal today, in order to better support the long-term well-being of young people and the community at large.

The Key Issues identified for inquiry in this study are:

1. Access to mental health support
2. Access to harm reduction for youth who use drugs
3. Youth aging out of youth protection

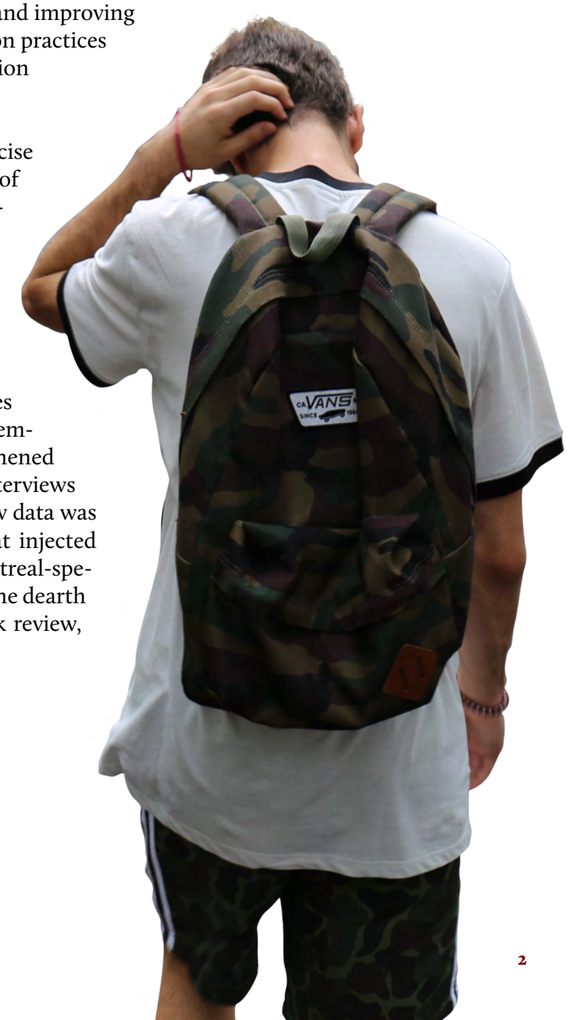
These topics have been selected because they all disproportionately affect youth on the margins, impact multiple social determinants of health, and represent areas where financial investment in the community sector will be impactful.

Methodology

The objective of the study is to analyze and contextualize the main key issues and trends that currently put different youth at risk in Montreal, in order to draw out recommendations that will inform PFF's funding strategy.

To address this, the study was guided by the following research questions:

1. What are the key barriers to youth seeking mental health services, harm-reduction support, and for youth who are aging out of the youth protection system?
2. What unique factors affect LGBTQ2IAP+ youth, Indigenous, racialized and newcomer youth specifically for each of the issues of focus?
3. What resources are available in the community sector to support youth in each of the issues of focus? Accordingly, what are service gaps and areas in need of further support?
4. What are the best practices in the areas of mental health access, harm reduction and youth aging out of the youth protection system?
5. How can foundations most effectively support the community sector in working with marginalised youth and improving mental health, implementing harm reduction practices and supporting youth leaving youth protection systems?



For each of the specified issues of inquiry, a precise search string was developed; a desk review scan of community reporting, academic literature, and relevant media was conducted. The lead researcher also attended a 4-day conference at École Nationale D'Administration Publique on supporting youth aging out of care. Subsequently, 7 key stakeholders (selected for their expertise with the issues of focus and target populations) were interviewed. The majority of the selected interviewees were also able to speak from lived experience as members of marginalised identity groups, which strengthened the research findings considerably[5]. Stakeholder interviews were recorded, and a thematic analysis of interview data was conducted in order to identify overt patterns that injected the report with stronger and more accurate Montreal-specific content. This particularly helped account for the dearth of Montreal-specific research collected in the desk review, which is a significant limitation in the literature.

[1] LGBTQ2IAP+ refers to lesbian, gay, bisexual, transgender, queer, 2-spirit, intersex, agender/asexual, pansexual and the + is a nod to the multiplicity of queer identities not captured in categorical acronyms. The shorthand "queer and trans" is often used to refer to this group and these terms are used interchangeably in the report.

[2] Racialized refers to ethnic and racial minority individuals, and often in Montreal the acronym BIPOC (black, Indigenous, people of colour) is also used alongside this term.

[3] Indigenous refers to First Nations, Inuit, and Métis communities of Canada.

[4] The commonly used terms for this community are "Youth in Care" and "aging out" is a commonly used expression which refers to the moment a youth reaches the age of majority (18 in Quebec) and is no longer entitled to housing and social services from the youth protection system.

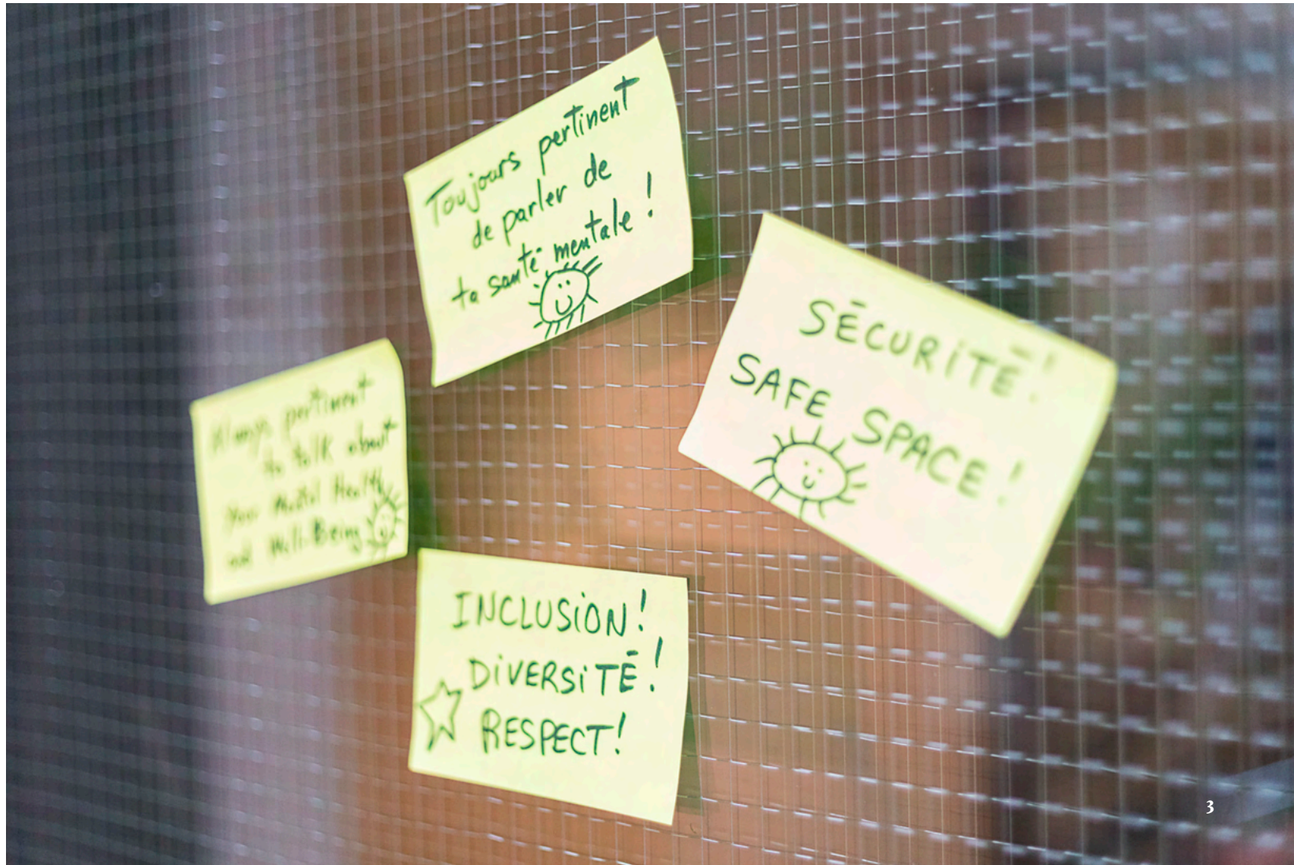
[5] See Appendix 1 for a list of stakeholders.

Guiding Frameworks: Social Determinants of Health and Systematic Exclusion

The three Key Issues have been identified by PFF and the researcher as urgent areas in need of support. They each represent threats to youth health and well-being, both immediately and over the life course. In order to best explicate how these threats play out for youth, it is important to contextualize them within the **social determinants of health (SDH)** framework. This framework situates health and well-being as outcomes of complex intersecting social factors: defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age (WHO, 2008)." These conditions are shaped by the distribution of resources, power and privilege and by the opportunities families and communities are able to access accordingly. They are strongly correlated with individual and community health and well-being. The key social determinants affecting health and well-being globally for adolescents aged 10-24 have been identified as: access to education; national wealth; income inequality; supportive peers; and safe and supportive families (Viner et al, 2012). Additionally, **stigma** and **minority stress** have emerged as powerful social determinants of health in the literature addressing SDH for youth who are marginalised by societal and institutional discrimination against their racial and social identities, particularly LGBTQIA+ youth (Gary, 2005) and ethnic minorities and Indigenous youth (Hatzenbuehler & Pachankis, 2016).

The concept of **minority stress** captures the ways in which sexual and gender minority individuals experience compounding stress in multiple social areas due to stigma and discriminatory experiences (Meyer & Frost, 2013), and has also been used to capture experiences of ethnic and racial minority youth in educational institutions (Cokley, McClain, Enciso, & Martinez, 2013). The issues of focus in this inquiry can all, in various ways, be situated through the historical discrimination against Indigenous, racialized, and LGBTQ2IAP+ identities that is built into the fabric of institutions. Schools, healthcare systems and social protection agencies often serve as sites of exclusion for marginalised groups because their concerns, needs and experiences are not represented in the governing bodies who dictate policy at this level. This exclusion and erasure impacts health and well-being for marginalised youth by restricting access to resources, compounding stress during crucial developmental periods, and fracturing community connections among affected groups, especially those who are situated within multiple oppressed subject identity groups, i.e racialized queer youth.

In the interviews conducted with community workers and stakeholders for this report, most interviewees frequently referenced "the system" as a designation for provincial and federal institutions which oppress marginalised communities through this process of exclusion and erasure. The research findings of this report clearly demonstrate that community organizations are mobilizing to fill gaps in "the system" that they are not appropriately resourced to fill. However, **anti-oppressive**[6] values, such as the drive to combat racism and institutional exclusion of marginalised groups, are common in community organizations and compel them to support groups that "the system" does not. Foundations can play an important role in supporting this work by developing their understandings of these exclusionary processes, recognizing the work of community actors and building supportive relationships with the community sector. This report seeks to help PFF deepen their awareness of and engagement with the community organizations working to support marginalised youth in Montreal in key areas impacting SDH and related outcomes, and enable them to do justice through their supportive relationships with these actors.



[6] Anti-oppressive practice (AOP) is an approach originating in social work praxis that works to remedy socioeconomic oppression. It entails a critical analysis of power imbalances present in organizational structures due to sociocultural and political historical contexts and works to promote practices that foster an equitable society free from oppression, racism, and other forms of discrimination (Strier, 2007).

Issue 1: Mental Health Support

The majority of long-term mental health issues emerge in adolescence and young adulthood (Mental Health Commission of Canada, 2017). Approximately 14% of Quebec youth under 18 are affected by mental illness, a statistic that is cautionary given the stigma and underreporting of mental illness overall (Lesage & Emond, 2013). Outcomes of poor mental health and mental illness for youth include homelessness, unemployment, low academic achievement, sexual exploitation, substance use and addiction, and suicide (Kirby & Keon, 2004).

Suicide is a serious risk for youth overall, the number one cause of death for youth 18-22 in Quebec (Ministère de la Santé et des Services Sociaux, 2016). Suicide risk is extreme in the case of LGBTQ2IAP+ and particularly transgender youth, who are significantly more likely to commit suicide than heterosexual and cisgender peers (Rutherford, McIntyre, Daley, & Ross, 2012). A recent study found that Canadian transgender youth 19–25 year olds had almost 8 times the risk of serious suicidal thoughts in the past year than their cisgender peers, and over 16 times the risk of a suicide attempt in the past year (Veale, Watson, Peter, & Saewyc, 2017). Death by suicide is also far more likely for First Nations and Inuit youth at 4 and 11 times higher than national averages, respectively (McQuaid, 2017).

Mental Health Care in Quebec

Heightened mental health risks for marginalised youth can largely be explained as bi-products of **trauma**[7] and **adverse childhood experiences (ACE)**[8]. Marginalised youth are disproportionately affected by ACE-related stressors in childhood and adolescence, creating a significant effect on long-term mental health for LGBTQIA+ youth (Ghabrial, 2016), racialized and newcomer or refugee youth (Beiser & Hou, 2016), youth involved with youth protection (Farand, Chagnon, Renaud, & Rivard, 2004) and particularly Indigenous youth, for whom the adverse health effects of **intergenerational trauma**[9] are well-documented (Phillips-Beck et al., 2019). Mental illness disproportionately affects youth affected by such childhood stressors, particularly as compounded with prejudicial treatment and discrimination (McQuaid, 2017).

The exacerbated mental health risks posed by ACEs and subsequent trauma indicate that marginalised youth need amplified preventative and intervention-based mental health support, but unfortunately the conditions of access to mental health services in Montreal are severely compromised. Research investigating access to mental health service utilization in Quebec is limited, however a recent study found that among Quebec adolescent suicide victims, only 9.9% had received psychiatric care in the year preceeding their death (Farand, Chagnon, Renaud, & Rivard, 2004).

[7] **Trauma** is defined as the "lasting emotional response that often results from living through a distressing event (Canadian Association of Mental Health, 2013)."

[8] **Adverse childhood experiences (ACEs)** refer to the distressing events themselves that generate trauma, including experiencing or witnessing sexual, emotional or physical abuse, having an incarcerated or mentally ill household member, experiencing emotional or physical neglect, parental separation, or household substance abuse (Merrick et al., 2017).

[9] **Intergenerational Trauma Theory** refers to the cumulative effects of long-term mass trauma (i.e colonialism) on the rates of disease, psychological issues and maladaptive coping behaviours among affected populations across generations (Roy, 2014).

Mental health services that are available to youth in Montreal include: counseling, art therapy, peer counseling, support groups, psychotherapy, psychology and psychiatry. Of these, only psychiatry and psychology are subsidized provincially for young people. In cases where youth are diagnosed with or been diagnosed with a psychiatric condition or psychological disorder, referrals are most often made to public psychology and psychiatry services, which are covered by provincial health coverage until age 18. In cases where youth arrive in emergency services due to severe suicidal ideation or attempt, they may be referred to inpatient or outpatient psychiatric services.

Chronic underfunding of the mental health system in Quebec has created a dire situation in which wait lists for public mental health services are unacceptably long and free or sliding-scale therapy is extremely rare (Lesage & Edmond, 2013). This situation contributes to mental health disparities in the sense that wealthier, privileged youth can afford to access private psychotherapy when they need it, while youth who do not have the financial means to access these costly resources are left with few options when mental health needs are present. The bureaucratic networks of public sector resources are also inaccessible in their lack of clarity. Many interview respondents indicated that the youth they serve report confusion and overwhelm when attempting to access services due to the complexity of the system, a lack of awareness of what services they are entitled to, and uncertainty as to which services even exist (i.e: for youth under 18, who are entitled to free psychiatric services). For refugee and newcomer youth specifically, cultural stigma towards mental health is an additional barrier to access (Whitley, Kirmayer, & Groleau, 2006).

The shortage of available mental health resources extends from the public sector to university campuses, where demand for mental health services among young people has increased steadily over the past 5 years without a concurrent increase in available on-campus resources (Mahoney, 2017). In both the public sector and on university and college campuses in Montreal, a crisis-based model prevails in which resources are largely available for emergency and crisis situations: first-time psychosis or suicidality in emergency rooms, rather than preventative and ongoing accessible mental health resources (Salois, 2012).

Mental Health & Marginalization

When marginalised young people do seek to access mental health services, they often encounter barriers to meaningful and helpful care due to a lack of awareness of their lived experiences and a lack of diverse mental healthcare providers who can relate and empathize with them effectively on the basis of sexuality, ethnicity, gender, and race (Perez, Genest, Ramnanan, & Savanna, 2018).

Mental health care providers in Quebec are not diverse in their gender, sexual and racial backgrounds (Patel, 2018). This contributes to re-traumatization in which youth are forced to explain rather than process their experiences of oppression to mental healthcare providers, fracturing relationship-building and, in many cases, triggering rather than ameliorating mental health issues. Indigenous youth in particular encounter this barrier due to virtually nonexistent recognition of traditional cultural practices. The exception to this case is Indigenous youth with registered[10] **status** recognition who can access trauma-informed free mental healthcare through provincial funding for survivors of **residential schools.**[11] However many Indigenous youth do not not have or want status recognition due to complex emotional and structural issues with status identification that are beyond the scope of this inquiry.

In the case of transgender and gender nonbinary youth, a lack of diversity and sensitivity in service provision poses a serious threat: a psychologist's diagnosis of **gender dysphoria**[12] is a requirement to accessing **gender-affirming**[13] surgery, but untrained psychologists, or those with pre-existing prejudice, cannot work with transgender youth effectively and may even block them from accessing the care and services they need (Abramovich & Cleverly, 2018). Cases of discriminatory treatment based on provider bias are a significant source of mental health disparities (McGuire & Miranda, 2008), and a lack of diversity and cultural competency among care providers presents a serious barrier for marginalised youth's ability to access effective mental healthcare in Montreal.

When youth do access mental health services in Montreal despite the barriers described above, they encounter a biomedical model that places priority on diagnosis over holistic assessment and intervention (MHCC, 2016). This model focuses on standard diagnostic criteria rather than real, basic issues that negatively affect mental health, such as housing, food security and family support. This biomedical model situated within an overburdened mental healthcare system also contributes to a climate in which doctors in Quebec prescribe antipsychotic medications more regularly than in other provinces, a solution many mental health advocates see as a "band aid solution" rather than providing more nuanced and accessible therapeutic services (McInnis, 2017). In youth's own voices, this tendency towards medication to replace inaccessible therapy services is problematic—a relevant study found youth predominantly prefer talk therapy to prescription medications (Bradley, McGrath, Brannen, & Bagnell, 2010). In stakeholder interviews, a strong recurrent theme was the need for nuanced one-on-one mental health support that extends beyond diagnosis and treatment models put forth in dominant biomedical practice.

Sector Snapshot

The community sector in Montreal is mobilizing to fill the gaps in public sector service provision by providing individualized, whole-person and identity-specific support services and programming. Some intervention areas that are well-covered include: phone and online crisis support through hotlines like **Interligne, Tel-Jeunes**, and **Suicide Action Montreal** and care services for family and caregivers of those with mental health issues such as those provided through **AMI Quebec**. Despite these existing services, the mental health needs of marginalised youth are significant, and community workers

[10] **Status** refers to "a legal recognition of a person's First Nations heritage, which affords certain rights such as the right to live on reserve land" (Henderson, 2018).

[11] **Residential schools** were developed by Christian churches and the Canadian government in order to assimilate Indigenous youth into colonial Canadian society. The violent practice severely disrupted Indigenous lives and communities, causing long-term issues and suffering. The last residential school closed in 1996 (Miller, 2012).

[12] **Gender Dysphoria** "involves a conflict between a person's physical or assigned gender and the gender with which they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender (Parekh, 2016)."

[13] **Gender-affirming** care is an approach to working with trans and nonbinary individuals that emphasizes the importance of validating and recognizing an individual's asserted gender identity rather than trying to question, change or compel them to prove this identity in order to access services and resources (Reisner, Radix, & Deutsch, 2016).

often find themselves overwhelmed and under-resourced. Research investigating access to mental health service utilization in Quebec is limited, however a recent study found that among Quebec adolescent suicide victims, only 9.9% had received psychiatric care in the year preceding their death. Community organizations such as **DESTA**, **Head & Hands** and **Native Montreal** provide free or low-cost counselling and support for diverse youth with lived experiences of trauma and institutional exclusion. Others, like **Dans la Rue** and **Ometz** have subsidized licensed psychologists on staff, who receive training in working with the groups of youth who these organizations cater to. However, this type of resource mobilization, while direly needed, is infrequent and still has access limitations. For example, DLR and Ometz are only able to provide their free psychology services to homeless and Jewish youth, respectively, and the subsidized trauma-informed psychology services for Indigenous youth at Native Montreal are only offered part of the year, in accordance with budgetary constraints.

While the fact that these resources are often identity-specific in catering to the membership is a strength, it is also limiting when individualized services do not exist for all groups. In lieu of subsidized licensed mental health professionals, youth case workers and street workers can provide important relationships that improve mental health, however many interview respondents lamented that lack of resources and funding prevented them from providing as many positions in this area as could meet the demands of youth they serve. Because these workers are often underpaid and overextended, burnout and job turnover is high in these positions. Many interview respondents wished these workers, who are often community members themselves with their own mental health needs, had more time, support, and security of funding to meet the existing need.

Organizations that provide food security, housing support, *and* crisis intervention under the same umbrella bridge access gaps by making sure that once youth come through the door, they are connected with acute stabilizing resources. This service provision promotes autonomy and capacity-building; a crucial component of promoting mental health over the long term. When youth have places they know are safe and reliable sites where they can get their basic needs met, they are able to build upon those resources, to share them with one another, and establish trust in themselves and their communities in order to thrive. For example, trans and nonbinary youth at Head and Hands often access the health clinic for hormone therapy and sexual health services, from where they are often referred to counseling if they need mental health support, and often also to the legal program for name change and other procedural guidance. As a hub for resources in this respect, the trans community represented at Head & Hands has grown steadily.

Community organizations also play a crucial role in mental health promotion of youth by identifying individual identity-specific needs and employing micropractices that address them. For example, Montreal's **Aboriginal Youth Center** provides access to traditional game meats that help youth reconnect to a sense of cultural identity that has been compromised by the ongoing violence of colonialism. At the **South Asian Women's Center**, community workers help newcomer and refugee mothers learn how to cook with unfamiliar ingredients, which helps their children thrive and boosts their own self-esteem and mental health. At **Project 10**, trans and nonbinary youth can try on samples of gender affirming gear such as **binders**[14] in a safe space, and order them directly through the center at a subsidized rate. These micropractices have ripple effects not captured in crisis or biomedical frameworks, because they help youth access what they need in order to live comfortably in their cultural and social identities. Interview respondent Harleen Boghal, of South Asian Women's **Community Centre, put it perfectly, saying, "Institutions aren't set up to provide holistic support that is individualized, but small community organizations and actors can. You can't standardize mental health."**

Finally, community organizations promote youth mental health by acting as a key site for **peer support programming**. Peer support bridges isolation and empowers youth as actors in their own mental health promotion. Identity-specific peer support groups and community suppers, like those for queer and trans youth found at **Project 10**, **ATQ**, **ASTTEQ**, and **Gender Creative Kids**, can be an important lifeline for youth whose identities and lived experiences are not represented in mainstream health promotion and education frameworks. Peer support is especially effective when it incorporates art, storytelling and activity-based programming that promotes self-esteem through self-expression and capacity-building. Examples of such projects can be found at Head & Hands' satellite program **Jeunesse 2000**, where youth of colour are invited in to make and record music together; **Unraveling in Rhymes** poetry workshops at South Asian Women's Center; the **arts circle** projects at Native Montreal; and the **NoBadSound** music recording project at **Maison des Jeunes de Côte-des-Neiges**. This type of programming allows otherwise isolated youth to build connections and find support, but it is resource and labour intensive for organizations to build and maintain.

Foundations can play an important role in supporting community actors in the aforementioned efforts. Some foundations in Montreal are also partnering with provincial funders in supporting research implementation initiatives that work to improve mental health service provision and promote preventative models. Examples of such efforts include creative projects like **ACCESS Open Minds** and **Projet AIRE Ouvert** (Abdel-Baki et al., 2019). These initiatives were developed in order to remedy some of the main service gaps in the mental health sector by implementing online rapid triage assessment systems combined with peer-led mental health spaces and outreach to vulnerable youth through collaboration with community organizations. Another such initiative is the **Rossy Foundation Student Wellness Hub** that is intervening to remodel access to mental health in post-secondary institutions in Montreal. Other key funders in youth mental health in Montreal include: Barry F Lorenzetti Foundation; Echo foundation; Centraide; Fondation Jeunes en Tête; and Graham Boeckh Foundation. While the funding landscape is heavily focused on research and preventative wellness promotion, community organizations that provide holistic services that meet basic needs and employ anti-oppressive models to reach vulnerable youth require additional and sustained financial support.

[14] Binders are used by some trans and nonbinary individuals to flatten and reduce the appearance of breasts in order to live comfortably in their gender identities.

Best Practices in Supporting Youth Access to Mental Health Support

- ✓ **Personalize and contextualize mental health within a system of needs**—Assessments and interventions should account for complex life experiences, and use diagnostic criteria and treatment protocols as tools in a larger landscape of personalized mental health support.

- ✓ **Move beyond crisis models to preventative care**—Non-urgent mental healthcare promotes healthier coping patterns throughout the life course, which prevents long-term, more complex and more serious mental health issues which are more difficult to manage and require more resources.

- ✓ **Provide trauma-informed and culturally sensitive care**—Trauma-informed care that is provided by diverse, culturally competent mental health workers provides an important lever to offsetting the impact of lived violence of marginalization.

- ✓ **Promote alternative therapies**—Arts, drama and creative therapies and programming (both groups and individual) have demonstrated to be transformative in their impact on youth mental health (Fancourt et al, 2019).

- ✓ **Promote peer-support and youth-led mental health initiatives**—Engage youth themselves in caring for each other and bridge isolation, crucial for mental health during developmental periods (Mental Health Commission of Canada, 2010)

- ✓ **Incorporate new technologies**—This is an under-utilized asset in mental health service provision, but represents an important opportunity to reach marginalised youth who are less likely to reach out in person. Examples of such innovations include chat and text counseling, e-counseling via video web platforms and mental health promotion apps.

Issue 2: Harm Reduction

National trends demonstrate that drug use among youth is widespread and harmful: 60% of illicit drug users in Canada are between the ages of 16-24 (Cotter, Greenland, & Haram, 2013), and youth in Canada are four times more likely than adults over 25 to report harm from drug use (McQuaid, 2017). Research indicates that drug use (including opioid use, methamphetamine and other nonprescription and injection drug use) is more common among the younger homeless population than older cohorts (Kidd, Gaetz, & O'Grady, 2017). Youth engaged in injection drug use in Montreal have been shown to be more likely to encounter illness, and these risks are higher for youth identifying as female and/or bisexual (Bamvita, Zunzunegui, & Machouf, 2013). Opioid-associated health risks have steadily risen over the past decade for Canadian youth, particularly marginalised youth—rates of opioid-related hospitalizations rose by 53% in the last decade, and are up to 7 times higher among Indigenous youth and 5 times higher for low-income youth (Statistics Canada, 2018). Taken together, such findings illustrate how drug-related health risks (including STBBI contraction, overdose, chronic illness, etc) are higher for youth and especially for youth who are oppressed due to their identities, which indicates that youth-specific interventions should be incorporated into health promotion programming.

The intersections of mental health and harmful drug use behaviours are particularly salient for youth from marginalised communities in association with trauma and chronic stress. As discussed previously, marginalised youth are disproportionately affected by ACE-related stressors in childhood and adolescence. Such traumatic experiences have lasting impacts on the mental health of young people as they grow and develop. While experimentation with substances can be a standard component of adolescent development, the emergence of harmful substance use behaviours often represents a coping response to unprocessed trauma (Garland, Pettus-David, & Howard, 2012). Youth who have experienced childhood abuse, for example, are more likely to initiate injection opioid drug use (Kerr, Marshall, & Strathdee, 2009).

Opioids are a particularly dangerous class of drugs that are linked to rising mortality trends in Canada. Injection use of prescription opioids is rising among street-involved youth in Montreal (Roy, Arruda, & Bourgois, 2011), and harms associated with opioid use are significantly higher among LGBTQIA+ youth and Indigenous youth (Dell et al., 2012; Shrager et al., 2014). Mortality associated with opioid use is rising in large part due to the proportion of street drugs that are laced with Fentanyl, a painkiller that is 50 to 100 times stronger than morphine (Fischer, Vojtila, & Rehm, 2018). It is very often the case that those who consume products laced with Fentanyl are unaware of its presence, however suppliers continue to add this substance into their products to cut costs, increasing the risk of overdose death. Apart from the rising risk of overdose deaths associated with injection opioid use, youth who inject opioids are also at serious risk of contracting HIV, Hepatitis B and Hepatitis C (Roy et al., 2011). Unfortunately, a limitation of this report is the lack of reliable current data on risk and mortality trends associated with injection drug and opioid use in Montreal among youth and a limited scope in which to analyze the data available. Data collection on drug-related overdose is particularly unreliable in Quebec compared with other provinces such as BC and Alberta (CBC, 2019). Nevertheless, the harms and health outcomes associated with youth drug use, particularly injection and opioid use behaviours, indicate a need for youth-targeted interventions.

Increasingly, **harm reduction** has emerged as a powerful tool for working with youth in particular, in order to offset the harms associated with drug use and target the root underlying causes of harmful substance use behaviours. Harm reduction is an approach that works to destigmatize practices themselves, including drug use but also sexual health and other behavioural patterns, which have been labeled as wrong or immoral in public and historical discourse. Harm reduction proposes that behaviours themselves are not wrong, bad or shameful and uses a nonjudgmental blanket attitude to open up dialogue about how an individual's behaviours may or may not be serving their best interests (Bierness, 2008). Harm reduction can be especially effective in helping care workers support young people who are engaging in problematic drug use patterns as a means of coping with unresolved trauma because removing judgment from the behaviour itself opens the door for conversations that create space for youth to explain what they are coping *with*, thus getting at the root of the issue rather than targeting the behaviour on the surface.

Utilizing a Harm Reductive Approach

Drug use intervention has traditionally prioritized abstinence-based programming, however **harm reduction** approaches are increasingly being turned to as effective methods for managing health and mortality risks associated with drug use (Moore, 2013). Harm reduction recognizes that drug use is happening and will continue to happen, and seeks to help promote safety in this process: the model promotes non-judgmental attitudes towards traditionally stigmatized behaviours like drug use, and through education and service provision help individuals develop safer practices (Merkinaite, Grund, & Frimpong, 2010). Comprehensive harm-reductive service provision includes supervised injection sites, needle and syringe programs, opioid substitution therapy, educational workshops and activities for drug users and their sexual partners, HIV and STI testing and counseling (Krug, Hildebrand, & Sun, 2015).

Youth are not often the target of these services, and the use of harm reduction with youth remains a contentious issue in institutional spaces, particularly schools and public health settings. However, the small pool of research into existing programs that use harm-reduction with young people has indicated success in reducing harms associated with drug use and promoting safer attitudes towards substance use in general (Jenkins, Slemon, & Haines-Saah, 2017). Harm reduction works well with youth because, in addition to promoting safety when they do engage in drug use behaviours, it invites a non-judgmental dialogue that builds trust, brings youth in the door, and helps youth workers connect them with other services and resources that can help them thrive.

This is particularly helpful when youth are using harmful drug use behaviours as a coping mechanism to deal with experiences of trauma, because once they have built trust they can open up about these experiences and can be referred to mental health resources accordingly. On the other hand, research into the effects of abstinence-based programming for preventing incidence and harms of youth drug use has found very limited effectiveness (McMaster, Holleran, & Chaffi, 2005; Poulin & Nicholson, 2005; Pelan, 2015).

It takes significant resources and mobilization to set up and deliver harm reduction services and supervised drug use sites. For example, Andrea Clarke of Head & Hands pointed out that just the effort to access **Naloxone**[15] kits took months of dedicated efforts and networking by staff that are already overextended responding to their clients' needs. This is not a unique experience in Montreal, where access to such resources is compromised though overdose trends indicate a need for such materials to more readily available (CBC, 2017). Barriers to accessing Naloxone derive from a lack of provincial efficacy in comprehensive distribution across neighborhoods, at pharmacies and to organizations due to a slow mobilization of resources that reflects the fact that the province has not declared a state of emergency (as has been done in Ontario or British Columbia). This slow mobilization has dire consequences, making it harder for organizations to deliver harm reduction services that keep people safe. As Andrea said: "We are standing on train tracks, watching a train move from west to east, asking ourselves what might happen when that train gets to us. Rather than getting off the tracks, we are sitting down and waiting to see what happens." An example of the impact this lack of mobilization has for individuals is the fact that clients seeking to access Naloxone at pharmacies and clinics report geographic inaccessibility, discriminatory attitudes and lack of knowledge as major barriers. Due to the prevailing health and social service sector focus on stigmatizing drug use and promoting abstinence-based models, particularly in relation to youth, the majority of harm reduction initiatives originate in grassroots movements and underfunded community organizations, who often are not adequately supported in their efforts.

Harm Reduction vs. Abstinence in Montreal

The distinction between harm reduction and abstinence-based approaches is important to delineate in a landscape where abstinence-based models prevail and drug use, particularly among youth, is heavily stigmatized. While abstinence-based *education* has been shown to be largely ineffective in reducing harmful drug use behaviours among youth, abstinence-based services such as drug detoxes and rehabilitation programs can play an important role in service provision once an individual has been supported in making informed choices in the context of non-judgmental harm-reductive care (MacMaster & Holleran, 2005). Some organisations use abstinence based models in order to support youth who have decided that drug use cannot be moderated and is having a negative impact on their lives, and need support in detoxing and eliminating their use altogether. This includes detox programs where individuals can be medically supervised during withdrawal from substances, long-term inpatient rehab facilities that include mental health support and group activities, as well as outpatient rehab programs where individuals can get semi-structured support in staying sober while also continuing to work and live independently. These abstinence-based services are important components in a landscape of support, however it becomes harmful when they are the only offerings available. When youth who use drugs are told at every turn that their behaviours and choices are exclusively harmful and must be eliminated altogether, it becomes very difficult to build open and trusting relationships that are necessary in effective youth work. Thus, a variety of services can balance out these two realities and provide youth with appropriate options. Interview respondent Wayne Robinson of Native Montreal also raised the important point that a variety of service offerings is particularly important for Indigenous youth, who need access to some spaces that disrupt the prevailing narrative of Indigenous individuals as addicts and alcoholics. As a result, the **Native Friendship Centres** of Montreal have split their two spaces so that one space is abstinence-focused and the other is harm-reductive. This illustrates how a robust and diverse continuum of services can give youth autonomy in managing their own needs while including identity-specific considerations.

The fact that abstinence-based models receive the bulk of government and private funding in Montreal, particularly in schools and the public health sector, presents a great challenge to organizations seeking to practice harm-reduction with youth. Interview respondent Liz Singh of Head & Hands, a seasoned street worker with significant harm reduction expertise, expressed frustration at "feeling like a small ant fighting against a big system machine," and described the challenges to delivering harm reduction for youth when "their ecosystem is working against you." Prohibition-era attitudes stigmatize drug use, resulting in parents, teachers, and healthcare providers working from an assumption that individuals who use drugs somehow *deserve* the harms associated with drug use practices. Harm reduction workers in Montreal understand and advocate for individuals who use drugs, recognizing that people make choices available to them in the conditions in which they live for all different reasons, and believe their roles are not to judge but rather to support, care, and promote safe behaviours. For example, Harleen Bhogal of the Southasian Women's Community Centre (SAWCC) described a case in which a teacher referred a student to her because she knew the student had been struggling in school and suspected drug use might be involved, but recognized that she herself was not able to utilize a harm reduction approach with the student due to the confines of her role in the school. Harleen, on the other hand, was able to work with the young person with a non-judgmental attitude to openly discuss her behaviours and they worked together to offset the impact this was having on her school performance. This example demonstrates the effectiveness of the approach beautifully: when youth can speak openly and honestly, they can build trust with the individuals who are working to help them grow and thrive.

This attitude of non-judgment helps bring youth in the door: when they feel safe to share their experiences and know they won't be punished, a dialogue begins in which youth workers can build relationships that keep their clients safe. Community organizations seeking to offer such harm reduction resources require more financial support and investment in these efforts than are currently available, as harm reduction does not appear to be a priority for private funding. Foundations and groups that prioritize youth drug use include Fondation Jean Lapointe, Fondation Bon Départ, and

[15] Medication used to block the effects of opioids, reducing the risk of fatality in the case of an overdose.

Fondation Robert Piche, however the bulk of private financial investment remains wedded to abstinence-based models.

Although the majority of provincial funding goes towards abstinence-focused intervention initiatives, harm-reduction focused organisations increasingly also depend on provincial funding as a significant contributor. While this may sound antithetical, the desperation for solutions in response to the recent upsurgence in fentanyl-related drug overdoses and the demonstrated successes of harm-reduction interventions in BC have spurred other provincial governments to think beyond abstinence models. In BC, a recent study found that harm reduction services prevented 3,000 deaths in the year following the declaration of a public health emergency (Baker, 2019). While the fact that government actors are beginning to support harm reduction services is positive, their implementation of funding expectations can be problematic for community workers in this area. Several interviewees pointed out that a drive for quantitative statistical "proof" of effectiveness from funding bodies can be a challenge for organizations delivering these services: the successes of harm reduction—the trusting relationships, the increased client engagement due to nonjudgmental attitudes—often take time to manifest into statistical outcomes and are thus hard to immediately capture and report. Building up a more robust network of harm reduction services geared at youth will require concerted investment and prioritization by well-resourced and motivated actors beyond the provincial health authorities who recognize the value of qualitative assessment and reporting in addition to statistics and immediate outcomes.

Sector Snapshot

While a balanced provision of both harm reductive and abstinence-focused frameworks is necessary to address the risks facing youth who use drugs, this is not the prevailing model in Montreal: abstinence-based programming represents the bulk of service offerings despite the breadth of evidence supporting harm-reduction's effectiveness.

Additionally, the majority of services for drug users in Montreal are not geared towards youth. Existing services for youth include safe injection sites at **CACTUS**, **Dopamine**, **Spectre de Rue**, and **L'Anonyme**, which receive private and provincial funding (Laframboise & D'amours, 2017). The majority of harm reduction services in Montreal are centralized in French-speaking organizations or neighbourhoods, creating an additional barrier for anglophone and allophone youth. Youth-specific organisations that are guided by harm reduction include **Head & Hands**, **Dans la Rue**, **GIAP**, and **Médecins du Monde**.

Best Practices for Harm Reduction with Youth

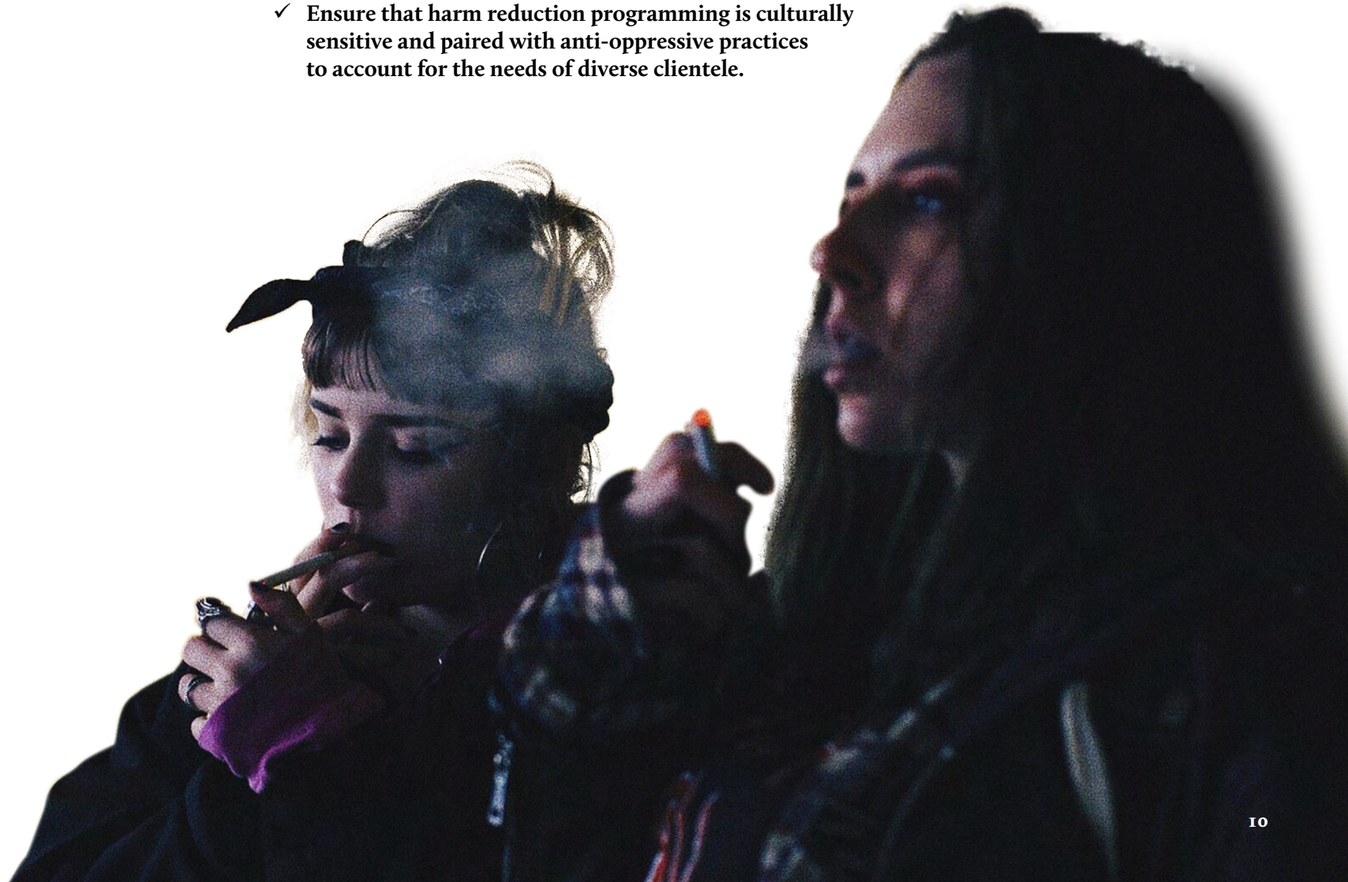
- ✓ **Destigmatize and decriminalize drug use**—Promote non-judgmental attitudes that build trust and promote dialogue with youth and within their ecosystems, including schools and healthcare settings.

- ✓ **Recognize the successes of a continuum of services**—It is crucial to offer a diversity of services and models, that include abstinence-based services, to reach the broadest range of vulnerable youth.

- ✓ **Operationalize harm reduction**—Utilize harm reduction as a theoretical tool in client interactions, in conjunction with trauma-informed approaches that account for the role that trauma, discrimination and chronic stress play in problematic substance use, sexual health and STBBI prevention.

- ✓ **Encourage community collaboration**—Redefining the role of enforcement agencies and first responders to build "public safety-public health" partnerships. Provide trainings in harm reduction for educational professionals, healthcare workers, and law enforcement as well as providing opportunities for interdisciplinary conversations among these stakeholders to promote shared community understandings and robust networks.

- ✓ **Ensure that harm reduction programming is culturally sensitive and paired with anti-oppressive practices to account for the needs of diverse clientele.**



Issue 3: Youth Aging Out of Youth Protection

Youth who grow up in and through the youth protection system face enormous challenges as they reach the age of 18 and are released from **group homes** and **foster homes**. An estimated 1200 youth age out of foster care every year in Montreal (CBC, 2016). Among these youth, 40-50% will go on to become homeless (Gaetz et al, 2013). As youth from care frequently end up in cycles of poverty, chronic homelessness and street involvement, they are also more likely to be criminalized and incarcerated (Nichols, 2013). Unlike their same-age peers, when they leave care, these youth do not have families and networks to support them through a process of graduated independence until they are ready and stable enough to thrive in adulthood. Young people today often live with parents or independently with familial financial support from ages 20-29 as they pursue higher education, work to build independent living and career skills, and establish support networks outside their families. Youth from care, who are forced to leave their foster and group homes at 18 without material support or savings, do not have the same opportunities to grow and thrive, and this has dire consequences for their long-term well-being.

Current research has come to identify ages of 18-29 as a key developmental period known as "emerging adulthood," during which there is heightened instability in relationships, employment, housing and activities (Arnett, Žukauskienė, & Sugimura, 2014). For youth leaving care, who have few supports during this crucial developmental stage, this time of instability is most often chaotic and disruptive to their developmental trajectories (Marion, Paulsen, & Goyette, 2017), contributing to the significantly increased risk for homelessness (Gaetz, 2014), lack of educational attainment, sexual exploitation, criminalization and poor health outcomes (Kovarikova, 2017). In response to the disparities faced by youth from care, many organizers and advocates have lobbied for extending support to youth from care up to age 25 and developing a process of graduated support systems to help them transition to independent adult life, however no provinces have implemented such reforms to date (Sherlock & Culbert, 2015). While some provinces have made changes to the age of majority for youth leaving care, at 19 in British Columbia and 21 in Ontario (Anderson, 2016), Quebec has lagged behind. This lack of action may be due in part to the fact that Quebec, unlike other provinces, has no designated public office for youth services, and houses this role under the umbrella of its Commission on Human and Youth Rights (HRI, 2018).

Indigenous and racialized youth are severely overrepresented in the youth protection system, due to the implicit biases and discriminatory attitudes of many case workers who investigate reports of youth neglect (referred to as "*signalements*"), conduct interventions and make decisions about removal procedures (Bernard & McAll, 2009; Blackstock, Trocmé, & Bennett, 2004). Beginning with the "*signalement*," underfunding has severely compromised the process of investigating youth domestic safety: there are not enough resources allocated to investigate claims thoroughly, and the bureaucratic push for efficiency detracts from the process (Stevenson & Abboud, 2019). The Directorate

of Youth Protection in Quebec is composed of the Departement de Protection de la Jeunesse (DPJ) for francophone populations, and Batshaw Youth and Family Centers, for anglophone populations (Simpson, Fast, Wegner-Lohin, & Trocmé, 2014). Staff and caseworkers at DPJ and Batshaw are not trained in anti-oppression and cultural sensitivity. As a result of this knowledge gap, caseworkers exercise bias towards immigrant, Indigenous and racialized families—particularly socio-economic circumstances, languages, and cultural standpoints—rather than working with families to promote healing and familial stability (Bousquet Saint-Laurent, 2014).

Racialized youth (in particular Black, Haitian, and Indigenous), are more likely to be reported for neglect, and two to three times more likely to be removed from their families and placed permanently into group and foster homes than their white peers (Dufour, Lavergne, Gaudet, & Couture, 2016). The overrepresentation of racialized and Indigenous youth in the youth protection system is not purely a result of their socio-economic status but rather is a product of the biases that frontline workers within the system hold (Hassan & Rousseau, 2007).

Identity Disruption & Peer Support

When youth are removed from their families, they are placed into group and foster homes where their sense of continuity, belonging and identity is severely disrupted; creating the potential for negative long-term effects on self-esteem and mental health. As interview respondent Marcelle Partouche Guttierez of Care Jeunesse put it, "These [youth] are survivors of genuine social catastrophes." The disconnection from family networks itself creates a rootlessness of identity that is typical for many youth in foster care. Informally, youth are able to recreate these networks through "chosen family" structures and friendships with peers who share their experiences. Peer support can be an important protective factor for seeking support in navigating the specific challenges of care-leavers (Marion, Paulsen & Goyette, 2017). Research indicates that social networks and relationships can be an important lifeline for youth from care, who have often had many fractured and unstable relationships compromise their mental health and stability (Goyette, 2012).

This disconnection from identity and family is particularly salient for Indigenous youth, who are frequently removed from their families and placed in non-Indigenous households where the languages, cultural practices, food and attitudes are unfamiliar and destabilizing. At private and institutional levels, there is little effort made to remedy this disruption, with multiple documented cases in which youth are forbidden from or punished for speaking their native languages (MacLellan, 2018), a stark parallel to the colonialist trauma of **residential schools** (Blackstock, 2007). Indigenous self-governance over child neglect inquiries has the potential to disrupt this traumatic process (Guay & Grammond, 2012) and has found success in Atikamekw, which recently became the first First Nations community to take control of their youth protection services (Fennario & Miller, 2019).

Housing & Employment

When asked about the most significant challenges facing youth leaving care, interview respondents unanimously situated housing as the primary barrier to successful transition. All expressed a sense of severe urgency for their clients from care who they consider are "aging out into homelessness." Access to housing is limited by discriminatory tenant practices which prevent youth from being able to sign a lease. As mentioned, youth without a network of support are unable to identify an older and "more credible" person to cosign for them. Additionally, many youth from care report being denied access to housing on the basis of their identities as care leavers (Serge et al., 2002) but have no recourse to pursue legal action due to a lack of resources and the fact that they are not specifically designated as a protected class under the Canadian Charter of Human Rights and Freedoms. The current housing market in Montreal exacerbates these issues, as the housing vacancy rate has been dropping steadily since 2010, contributing to rising rental costs and spurring discriminatory practices (Labrèche, 2019). Subsidized housing in Montreal is also drastically inadequate to meet the needs of population: 23,000 people were on wait lists for subsidized housing in 2018 for the city's 62,000 housing units (McInis, 2018). Beyond the physical accommodation of space in which to live, youth leaving care need varying degrees of support with respect to housing. Some youth leaving care feel ready to build independent living skills and crave freedom from rigidity, rules and structures that constricted them during their time in care. However, many youth from care have not had the opportunities to build independent living skills gradually and require additional supportive services, such as mentorship, capacity-building and subsidized rental support, in order to thrive in independent living. A diversity of housing options for care leavers is necessary to support this community in thriving into adulthood, however all interview respondents emphasized that this type of support is woefully absent from the landscape in Montreal.

Other significant issues for youth leaving care are access to employment and education (Mann-Feder & Goyette, 2019). Under the aforementioned housing instability facing many youth, it is extremely difficult to mobilize oneself to find stable work and organize educational goals. Increasingly, higher education is a necessary component of career attainment and job security in Quebec (Belzile & Moreau, 2017), but youth leaving care are not encouraged to attend CEGEP and university; they are pushed by caseworkers towards more immediately lucrative and available low-skilled labour and/or professional programs. This emphasis on survival in the short-term over success in the long-term through visioning and self-discovery that happens in higher education is a gross injustice to these young people, who deserve to be supported in entering the job market just as their same-age peers are by family and friends.

Sector Snapshot

Montreal's Native Friendship Centre has found success in reducing the incidence of Indigenous youth removed from their families by liaising with the DPJ and Batshaw case workers on behalf of their clients and promoting shared cultural understandings. Interview respondents working with newcomer communities echoed this tactic and

pointed to youth worker advocacy and translation with DPJ authorities at the South Asian Women's Center as an important lifeline for their clients. Similarly, the **African Canadian Development and Prevention Network** plays this role for Black and racialized families being investigated and intervened with by DPJ. These are important assets in preventing youth from being placed in a system that disrupts their identity development in ways that become increasingly dire as they age out of care and are forced to rely on themselves to survive the transition to adulthood with little support or resources.

Organizations such as **Dans la Rue** provide some housing for homeless and street-involved youth, though not exclusively for youth who have aged out of care. Apart from shelters, there are no preventative options to keep youth aging out of care out of homelessness. One notable exception to this is **ASPIRE**, a residential facility for youth from care which incorporates mentorship and skill-building. However, resources such as this one need support in order to expand and offer a diverse array of options to youth leaving care, as the current landscape is inadequate to account for the housing needs of this community. Additionally, the development of housing availabilities should promote youth autonomy and self-determination by providing flexible entry and exit qualifications, rather than asserting rigid categories that exclude youth who are underemployed or undereducated from having access to these resources.

Job placement and career counseling services are available through organizations like **YES Montreal**, **Emploi Jeunesse** and **Ometz**. These types of resources are well-funded provincially, but such programs are often rigid and not flexible or responsive to the unstable experiences of youth exiting care. Youth from care require sensitive, adaptive job counselling and training resources that can adequately support them and their experiences, and this represents a significant gap in service provision in the current landscape.

In the Montreal community sector there are a small number of grassroots, youth-led peer support organizations that are mobilizing to support youth leaving care. These include **MYCASA**, a peer support network for care alumni in post-secondary institutions; Care Jeunesse, a working board of care alumni who work to provide resource referrals and peer mentorship to youth in and leaving care, as well as a scholarship program. Both of these organizations are currently struggling to maintain and expand their visions for service provision due to a lack of resources—though Care Jeunesse is a working board, they are all unpaid volunteer members. Notably, a research initiative called **Projet Porte-Voix** has brought together a group of youth in and from care through storytelling and co-creation in order to heal collectively as well as raise awareness and visibility and promote systemic change. However, interview respondents indicated that the lack of the identity-specific resources for youth from care is a significant gap in the community sector. Peer-led resources support youth network-building and promote self-esteem, however they are far too limited in their reach due to lack of funding and organizational capacity. Those few resources that exist require financial support to expand their reach and create a sense of permanency to respond to the pressing needs of this community.

Best Practices to Support Youth Leaving Care

- **Involve youth in decision-making—Involve youth in the creation of programming targeted towards them, provide a sense of control that has been denied in their experiences in the authority-based structure of youth protection.**

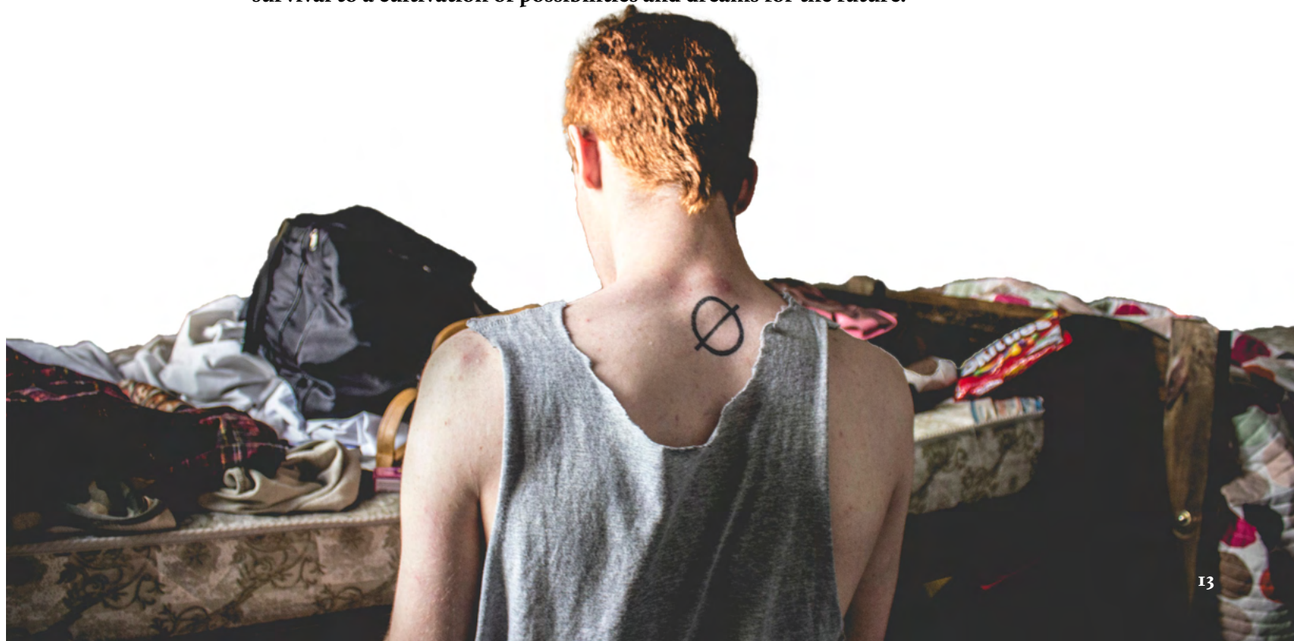
- **Address the institutionalized racism inherent in youth protection—Hold institutions and staff accountable to processes of learning, working to incorporate cultural sensitivity in case worker practices. Support self-determination efforts of Indigenous communities in youth protection processes.**

- **Invest in post-care system continuum of care—Recognize the period of emerging adulthood as a critical developmental period in which youth need support to achieve independence and advocate for change to age of majority policy in DPJ Quebec.**

- **Support peer support—Whether housed at a registered not-for-profit or grassroots based initiatives, support opportunities for youth from care to connect through peer networks and build horizontal and mentorship relationships. Add skills and autonomy-building praxis within this model.**

- **Encourage legal literacy and address discrimination—Youth from care need support in advocating for themselves to fight against experiences of housing and employment discrimination. Legal literacy workshops and outreach for care leavers play an important role in promoting this resiliency.**

- **Promote attitudinal shifts—Amongst workers engaging with youth who are in care and aging out of care, it is necessary to shift focus from an emphasis on survival to a cultivation of possibilities and dreams for the future.**



Recommendations on Supporting Montreal Youth as Private Foundations & Community Members

Mental Health

- ★ Engage youth with lived experience of mental health challenges in the development of new, or expansion of existing, mental health services and programming.
- ★ Increase availability of free and/or sliding scale therapy in the community sector by subsidizing psychologists, counselors, and psychiatrists in community organizations. Ensure that there is a breadth of professionals from all educational backgrounds to address varying targeted needs of potential clients.
- ★ Fund street workers and caseworkers at community organizations, whose main objectives are to seek out and work with youth outside of institutional spaces, engaging them "where they already are." Ensure these positions are well-resourced (financially and through a strong network of support) to reduce burnout and staff turnover.
- ★ Fund trauma-informed training for community workers and healthcare professionals.
- ★ Invest in initiatives to improve mental health service provision at a structural level, including: advocacy and research groups, youth-led initiatives and peer support spaces, and institutional mental health (specifically in schools).

Youth Protection System

- ★ Support youth-led grassroots peer support organizations working to strengthen networks of care leavers.
- ★ Provide community organizations with discretionary emergency stipends for housing and basic needs. Invest in the expansion of accessible housing projects to help expand their reach. Both low-cost independent housing is needed as well as structured residential programs with opt-in-based mentorship and skill-building components.
- ★ Enhance access to legal counselling for youth from the protection system, equipping them with skills necessary to combat housing and employment discrimination, with the ultimate goal of gaining autonomy as they leave care.
- ★ Invest in capacity-building and employment counselling services that are sensitive to lived experiences of youth from care, and that operate flexible implementation rather than rigid or rules-driven that reproduce the care system's structure.
- ★ Fund scholarship and/or bursary programs for youth from care that are not bureaucratically complex to promote educational attainment.

Harm Reduction

- ★ Build partnerships with community organizations that use harm reduction as a *guiding philosophy* for working with youth in community sector, amidst a continuum of services. Harm reduction is often spoken of only in relationship to sexual health and drug practices, but when employed as a guiding philosophy in all activities, the attitudes of non-judgment and autonomy promotion have significant effect on youth engagement and relationship-building with these organizations.
- ★ Invest in projects that provide harm reduction services specifically for youth who use drugs, including supervised injection sites and needle exchange programs.
- ★ Provide funding for harm-reduction trainings for youth workers in all partner organizations.
- ★ Promote community education projects in schools, healthcare institutions and social services that work to dispel stigmatizing attitudes towards drug use.
- ★ Increase funding for street workers in community organizations who bring harm reduction practices to youth through neighborhood outreach relationship-building.

General Structural Recommendations

The following recommendations represent actions that cut across all the Key Issues analyzed in this report. Incorporating these recommendations into a youth funding strategy will ensure that the fundamental systemic problems and related solutions for all Key Issues analyzed in this study are addressed appropriately and ensure sustainable change.

- ★ **Invest in safe and supportive housing projects for youth**, and specialized housing for youth leaving care. In particular, focus on a solid continuum of housing, from structured to semi-structured to independent, in order to meet diverse needs of different groups of youth.

- ★ Prioritize funding for organizations with **holistic approaches to service provision**. These organizations provide support for multiple acute basic needs, as well as giving long-term care, and are more effective at catching youth falling through the cracks. They also promote an individualized and "whole-person" approach that increases youth autonomy, rather than a hyper-standardized system.

- ★ **Encourage flexibility among funders** working with youth-serving organizations, allowing those organizations **to set diverse agendas for the communities of youth they serve** and respond to individual needs through micropractices that are internally prioritized rather than funder-driven.

- ★ Meaningfully **involve youth with lived experiences of oppression** in all levels of decision-making. Move beyond simply asking for youth feedback to act on youth suggestions and involve them in leadership positions.

- ★ **Encourage capacity-building in the sector**, supporting small and grassroots community-led projects access non-profit and registered charity status. Foundations are well-positioned to assist growth in professionalization and formalization of grassroots movements by providing guidance based on their experiences with partner organizations, and providing financial support in the process to individual actors seeking to formalize through honorariums not wedded to organizational status.

- ★ **Support actors lobbying for systemic change**. All of the Key Issues require reconfiguration of institutions, which cannot be reached without concerted effort. Community organizations are often spread too thin to effectively engage in lobbying while supporting their clients, and want to avoid fracturing relationships with institutions and harm potential or existing clients in the process. Focus in particular on supporting the Tables de Concertations around Montreal and advocacy networks. [16]

- ★ Foundations must **take a more hands-on approach to relationship building** that is not just evaluative, but that grounds them in the realities of the work they are funding. Foundation staff should participate in trainings around anti-oppression and the issues they are funding, building relationships with community actors, and allow funding to be flexible and responsive to changing needs.

- ★ **Provide long-term renewable funding**. Building direct programming and a sense of trust with youth clients is a slow process, requiring sustainable funding. Once youth ownership over a project is established, the loss of that project due to one-time funding or instability is traumatizing for participants.

[16] Eg: (See annex 3): Urban aboriginal strategies network; TOMS: Table des organismes Montréalais de lutte contre le Sida; Tables de Concertations Jeunesse; Coalition for Access to Psychotherapy.

Research Specifics

Gabriela Kassel Gomez holds a Masters in Educational Psychology from McGill University. She works as the Research Coordinator at the Meraki Health Centre and currently oversees its participation in the Trans Youth CAN study, a national inquiry into the health and social outcomes of youth who access gender-affirming healthcare. She is also a youth counselor at Head & Hands. In 2017 she participated in the Pathy Family Foundation's OceanPath Fellowship, where she collaborated with trans and nobinary artists and youth in building an art-based peer support storytelling program.

This study was conducted for the Pathy Family Foundation between May 1 - July 15, 2019. There were 7 stakeholders interviewed from various community organizations in Montreal, many of which are highlighted in this document. A special thank you to all of those who participated for offering their expertise and professional perspectives on the issues facing vulnerable youth in Montreal.

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Glossary

- **Adverse childhood experiences (ACEs):** Distressing events themselves that generate trauma, including experiencing or witnessing sexual, emotional or physical abuse, having an incarcerated or mentally ill household member, experiencing emotional or physical neglect, parental separation, or household substance abuse (Merrick et al., 2017).

- **Anti-oppression:** Anti-oppressive practice (AOP) is an approach originating in social work praxis that works to remedy socioeconomic oppression. It entails a critical analysis of power imbalances present in organizational structures due to sociocultural and political historical contexts and works to promote practices that foster an equitable society free from oppression, racism, and other forms of discrimination (Strier, 2007).

- **Binder:** Binders are used by some trans and nonbinary individuals to flatten and reduce the appearance of breasts in order to live comfortably in their gender identities.

- **Cisgender:** Refers to individuals whose sense of personal identity and gender identity correspond with the biological sex they were assigned at birth.

- **Community sector:** This term refers to community-based organizations, institutions, and initiatives, usually but not exclusively run as nonprofits or charities, as opposed to those operated by provincial government, national or international groups, or large corporations.

- **Gender-affirming care:** An approach to working with trans and nonbinary individuals that emphasizes the importance of validating and recognizing an individual's asserted gender identity rather than trying to question, change or compel them to prove this identity in order to access services and resources (Reisner, Radix, & Deutsch, 2016)

- **Gender dysphoria:** "Involves a conflict between a person's physical or assigned gender and the gender with which they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender (Parekh, 2016)."

- **Harm reduction:** Refers to policies, attitudes and practices that work to reduce negative physical, socioeconomic, social and legal impacts related with drug use, sexual health practices and other socially stigmatized behaviours. Harm reduction centres on communicating and working with individuals in promoting positive changes they want for themselves without judgment, discrimination, or coercion.

- **Intergenerational trauma theory:** Refers to the cumulative effects of long-term mass trauma (i.e colonialism) on the rates of disease, psychological issues and maladaptive coping behaviours among affected populations across generations (Roy, 2014).

- **LGBTQ2IAP+:** Lesbian, gay, bisexual, transgender, queer, 2-spirit, intersex, asexual, pansexual. The + represents all other non cishetero-normative identity categories not explicitly written in the acronym. For example: non-binary, genderqueer/genderfluid.

- **Naloxone:** Medication used to block the effects of opioids, temporarily reducing the risk of fatality in the case of an overdose.

- **Non-binary:** Refers to individuals who do not identify as male or female but rather situate themselves within, among or outside of the gender binary. Other terms sometimes used to overlap or intersect with nobinary experience include **genderqueer**, **agender**, **bigender**, **gender bender**, and others.

- **Private funding:** The private funding landscape includes individual donors, foundations and corporate trusts and entities.

- **Queer:** A generalized term referring to either individuals within the LGBTQ2IAP+ umbrella, or the community at large. May also refer to those who know they are not heterosexual and/or cisgender, but do not wish to define themselves within the acronym. "Queer" began to be reclaimed in the 1990s through the creation of academic "queer theory", born from women's and gender studies scholars.

- **Racialized:** Refers to individuals who are visual or non-visible racial minorities.

- **Residential Schools:** These were developed by Christian churches and the Canadian government in order to assimilate Indigenous youth into colonial Canadian society. The violent practice severely disrupted Indigenous lives and communities, causing long-term issues and suffering. The last residential school closed in 1996 (Miller, 2012).

- **Status Recognition:** Refers to "a legal recognition of a person's First Nations heritage, which affords certain rights such as the right to live on reserve land (Henderson, 2018)."

- **Transgender:** Refers to individuals whose assigned gender at birth does or did not reflect their actual genders. Transgender individuals may or may not have completed hormonal or surgical transitions.

- **Trauma** is defined as the "lasting emotional response that often results from living through a distressing event (Canadian Association of Mental Health, 2013)."

- **2-Spirit:** A specifically pan-Indigenous umbrella term used by Indigenous peoples or communities who fulfill a "third-gender", "non-gender", or "gender-variant" role. This is a relatively new term invented in the 1990s. It is crucial to note that some Indigenous nations have their own specific terms for gender variant community members, and 2-Spirit does not necessarily apply across all groups.

Appendix 1: List of Stakeholders Interviewed

Amanda Keller: Founder, Care Jeunesse / Case Manager: Youth Team, Agence Ometz

Andrea Clarke: Executive Director of Head & Hands / À Deux Mains.

Cécile Arbaud: Executive Director, Dans La Rue

Harleen Bhogal: Youth Programs Coordinator at South Asian Women's Center; Coordinator of "Uncensored Chai," former Peer Support Coordinator at the Center for Gender Advocacy.

Liz Singh: Street Worker, Head & Hands / À Deux Mains.

Marcelle Partouche Gutierrez: Board member, Care Jeunesse / youth committee researcher on youth aging out of care with École Nationale d'Administration Publique

Wayne Robinson: Human Relations Officer, Native Montreal

Appendix 2: Interview Questionnaire

Introduction:

Thank you for sitting down with me today! The Pathy Family Foundation has commissioned this study in order to better understand the key issues that threaten the health and well-being of youth in Montreal today. In conducting a scan of the research literature and community reporting around this topic, we have identified three main issues for further study, namely: lack of accessible mental health support; need for harm-reductive intervention to support youth who use drugs; and the lack of support for youth aging out of care systems. Our next step in this initiative is to hear from stakeholders who work with vulnerable youth in the community in order better understand how these issues are affecting youth in Montreal. Therefore, we need your input! Each person invited for an interview has been selected because of their experience with specific communities of youth, so please feel free to speak as much as possible to the experiences of the youth that you, your work or organization knows best—we want to understand how these issues are impacting Indigenous youth, LGBTQIA+ youth, racialized, newcomer and street-involved youth and bring diverse experiences into focus for these youth as much as possible.

A: Introductions - First, can you briefly introduce yourself, and the communities of youth you have experience working with?

B: Issue-specific Questions

<u>Mental Health Access</u>

1. What do you consider to be the main challenges for youth seeking to access mental health support services in Montreal?
    a. How are specific groups of vulnerable youth, such as LGBTQ, Indigenous and racialized youth, impacted by these obstacles?
2. How are community organizations working to offset the mental health risks posed by systemic barriers with youth on the ground, and how can foundations support this work?
    a. How is the non-profit sector involved in lobbying for systemic change in mental health access, and how can foundations best support this work? Where might financial investment be most impactful?

Harm Reduction and Drug Use:

1. Where and how are harm reductive services being delivered to benefit youth in Montreal presently? What are the successes of harm reduction that you've observed within the communities of youth you work with?

2. What are the major current challenges to delivering harm reductive services for youth in Montreal?

3. What are some trends in terms of funding allocation for initiatives supporting youth who use drugs that you have noticed?

    - What real impact do you think [x funded area] serves? How does this align with the goals of harm reduction?

    - How does this trend impact the work, successes and challenges that you've mentioned so far?

Aging out of care

1. What are the major challenges facing youth leaving group homes, foster care and the youth protection system as they transition into adulthood?

    a. (If not mentioned in the response): What specific challenges are affecting Indigenous and racialized youth who are overrepresented in this community?

2. What are service gaps where support is most needed for youth leaving care at the moment in Montreal?

    a. What are examples of community organizations and projects that are providing support to communities of youth leaving care?

    a. What about projects and organizations that are mobilizing to lobby for systemic change?

C: Synthesis

1. Reflecting on all the issues we've discussed, what are some examples of specific needs that are not being met for the communities of youth you work with?

2. What are examples of creative and innovative strategies or approaches that you've seen implemented in the community sector to target any issues we've discussed so far?

    a. (If hesitant, give examples): For example, art-based community approaches for mental health improvement / mobile safe-injection sites, peer-to-peer counselling, etc.

3. What can foundations or granting organizations do better to meet the needs you just mentioned or that we've discussed in this conversation?

4. How can youth be included in the efforts to improve these issues and their effects themselves?

    a. What should foundations look for in an organization they might be funding or seeking to fund, that indicates youth are meaningfully involved there?

5. Can you think of any resources you would recommend for us to look at or anyone else you think we should talk to in order to ensure that this inquiry does justice to the issues of focus for this study?

Appendix 3: List of Montreal Community Sector Resources, Projects and Organizations

(In order of appearance in-text)

Aboriginal Youth Center - http://ityc.nfcm.org
ACCESS Open Minds - http://accessopenminds.ca
African Canadian Development and Prevention Network - http://www.acdpn.org
AMI Quebec - https://amiquebec.org
ASPIRE Residential Services - (no website found)
ASTTEQ: Association Santé Travesti(e)s et Transexuell(e)s de Québec - http://astteq.org
ATQ: Aide au Trans du Quebec - https://atq1980.org
CACTUS - https://cactusmontreal.org/?lang=en
Care Jeunesse - https://youthincare.ca/425-2
Coalition for Access to Psychotherapy - https://capqc.ca
Dans la Rue - https://danslarue.org/en
DESTA - https://destabyn.org
Dopamine - http://www.dopamine.ca/en
Emploi Jeunesse - http://emploi-jeunesse.org
Gender Creative Kids - https://gendercreativekids.ca
GIAP: Groupe d'intervention Alternative par le Pairs - http://www.giap.ca/en
Head & Hands - https://headandhands.ca
Interligne - https://interligne.co
Jeunesse 2000 - https://headandhands.ca/programs-services/jeunesse-2000
L'Anonyme - http://www.anonyme.ca
Médecins du Monde - https://www.medecinsdumonde.ca/en/mobile-clinic-montreal
MYCASA - https://www.facebook.com/pg/mycasa.aeajpm/about
Native Friendship Centre - https://nfcm.org
NoBadSound - https://mdjcdn.wordpress.com/studio-nobadsound
Ometz - https://www.ometz.ca
Project 10 - https://p10.qc.ca
Projet Aire Ouvert - https://www.quebec.ca/sante/trouver-une-ressource/aire-ouverte
Projet Porte-Voix - https://chantier9adaj.openum.ca/jeunesse-au-carrefour/projet-porte-voix
South Asian Women's Center - https://www.sawcc-ccfsa.ca
Spectre de Rue - http://www.spectrederue.org
Suicide Action Montreal - https://suicideactionmontreal.org/en
Tables de Concertations Jeunesse - (regional) - eg: http://www.ndg.ca/en/ndg-youth-table
Tel-Jeunes - https://www.teljeunes.com
TOMS: Table des organismes Montréalais de lutte contre le Sida - http://toms-mtl.org
Unravelling in Rhymes - https://www.sawcc-ccfsa.ca/EN/unravelling-in-rhymes-kicks-off-for-2019
Urban Aboriginal Strategies Network - https://reseaumtlnetwork.com
YES Montreal - https://www.yesmontreal.ca

References

Abdel-Baki, A., Aubin, D., Morisseau-Guillot, R., Lal, S., Dupont, M. È., Bauco, P., ... & Iyer, S. N. (2019). Improving mental health services for homeless youth in downtown Montreal, Canada: Partnership between a local network and ACCESS Esprits ouverts (Open Minds), a National Services Transformation Research Initiative. *Early Intervention in Psychiatry, 13*, 20-28.

Abramovich, A., & Cleverley, K. (2018). A call to action: the urgent need for trans inclusive measures in mental health research. *The Canadian Journal of Psychiatry, 63*(8), 532-537.

Anderson, S. (2016, November 07). Alberta government improving services for youth leaving care. Retrieved from https://calgaryjournal.ca/more/city-hall/3398-child-and-youth-advocates-push-for-stronger-support-systems.html.

Arnett, J. J., Žukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. The Lancet Psychiatry, 1(7), 569-576.

Baker, R. (2019, June 5). Overdose crisis death toll would be more than double without harm reduction, study says | CBC News. Retrieved from https://www.cbc.ca/news/canada/british-columbia/bc-od-crisis-lives-saved-1.5163581.

Bamvita, J. M., Zunzunegui, M. V., & Machouf, N. (2013). Living Conditions and Illness among Injecting Drug Users in Montreal. Health Care: Current Reviews, 1-7.

Beiser, M., & Hou, F. (2016). Mental health effects of premigration trauma and postmigration discrimination on refugee youth in Canada. *The Journal of nervous and mental disease, 204*(6), 464-470.

Belzile, G., & Moreau, A. (2017). *Education in Quebec: Where Does the Money Go?*. Montreal Economic Institute.

Bernard, L., & McAll, C. (2004). La surreprésentation des jeunes Haïtiens dans le système québécois de protection de la jeunesse. *Revue Intervention, 160*, 117-124.

Bernard, L., et McAll, C. (2009). La surreprésentation des jeunes Noirs montréalais. Montréal : Centre de recherche sur les inégalités sociales, les discriminations et les pratiques alternatives de citoyenneté (CREMIS). www.cremis.ca.

Bierness, D. (2008) Harm Reduction: What's in a name? Canadian Center on Substance Abuse National Policy Working Group. Retrieved from: http://www.ccsa.ca/Resource%20Library/ccsa0115302008e.pdf.

Blackstock, C. (2007). Residential schools: Did they really close or just morph into child welfare. *Indigenous LJ*, 6, 71.

Blackstock, C., Trocmé, N., & Bennett, M. (2004). Child Maltreatment Investigations among Aboriginal and Non-Aboriginal Families in Canada, Violence Against Women, 10 (8), 901-916.

Blatterer, H. (2007). Adulthood: The contemporary redefinition of a social category. *Sociological Research Online, 12*(4), 1-11.

Bousquet Saint-Laurent, T. (2014). Analyse qualitative du contenu des signalements retenus à la protection de la jeunesse et leur évaluation pour les enfants de minorités visibles.

Canadian Association of Mental Health. (2013). Trauma. Retrieved from https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma.

CBC News (2017). Life-saving opioid overdose drug hard to find in Montreal, nurse discovers. CBC News. (2017). Retrieved from https://www.cbc.ca/news/canada/montreal/naloxone-montreal-nurse-pharmacy-1.4247538.

CBC News (2019). Fatal fentanyl overdose data lacking from across Canada, federal health minister says. Retrieved from https://www.cbc.ca/news/health/opioid-deaths-1.4088080.

Chandler, M., J and C. Lalonde, Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth. Vol. 10. 2008.

Cokley, K., McClain, S., Enciso, A., & Martinez, M. (2013). An examination of the impact of minority status stress and impostor feelings on the mental health of diverse ethnic minority college students. *Journal of Multicultural Counseling and Development, 41*(2), 82-95.

Cotter, A., Greenland, J., & Karam, M. (2015). *Drug-related offences in Canada, 2013*. Statistics Canada.

Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization, 2008.

Dell, C. A., Roberts, G., Kilty, J., Taylor, K., Daschuk, M., Hopkins, C., & Dell, D. (2012). Article Commentary: Researching Prescription Drug Misuse among First Nations in Canada: Starting from a Health Promotion Framework. *Substance abuse: research and treatment, 6*, SART-S9247.

Dufour, S., Lavergne, C., Gaudet, J., & Couture, D. (2016). Protecting visible minority children: Family–caseworker dynamics and protective authority intervention strategies. Canadian Psychology/psychologie canadienne, 57(4), 356.

Fennario, T., & Miller, S. (2019, February 19). Atikamekw Nation in Quebec inspiring others with sovereign youth protection. Retrieved from https://aptnnews.ca/2019/02/19/atikamekw-nation-in-quebec-inspiring-others-with-sovereign-youth-protection/

Farand, L., Chagnon, F., Renaud, J., & Rivard, M. (2004). Completed suicides among Quebec adolescents involved with juvenile justice and child welfare services. Suicide and Life-Threatening Behavior, 34(1), 24-35.

Fischer, B., L. Vojtila, and J. Rehm, The 'fentanyl epidemic' in Canada–Some cautionary observations focusing on opioid related mortality. Preventive medicine, 2018. 107: p. 109–113.

Gaetz, S. (2014). Coming of age: Reimagining the response to youth homelessness in Canada. Canadian Homelessness Research Network.

Galabuzi, G. E. (2004). Social exclusion. Social determinants of health: Canadian perspectives, 235-251.

Garland, E. L., Pettus-Davis, C., & Howard, M. O. (2013). Self-medication among traumatized youth: structural equation modeling of pathways between trauma history, substance misuse, and psychological distress. Journal of behavioral medicine, 36(2), 175-185.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in mental health nursing, 26*(10), 979-999.

Ghabrial, M. A. (2017). "Trying to figure out where we belong": Narratives of racialized sexual minorities on community, identity, discrimination, and health. Sexuality Research and Social Policy, 14(1), 42-55.

Goyette, M. (2012). Réseaux sociaux des jeunes en difficulté. *Les Cahiers Dynamiques*, (2), 39-48.

Guay, C., & Grammond, S. (2012). Les enjeux de l'application des régimes de protection de la jeunesse aux familles autochtones. *Nouvelles pratiques sociales, 24*(2), 67-83.

Hassan, G., & Rousseau, C. (2007). La protection des enfants: enjeux de l'intervention en contexte interculturel. *Association pour la recherche interculturelle, 45*, 37-50.

Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth: research evidence and clinical implications. *Pediatric Clinics, 63*(6), 985-997.

Henderson, William B.. "Indian Act". The Canadian Encyclopedia, 23 October 2018, Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/indian-act. Accessed 14 July 2019.

HRI. (2018, February 21). Blog Series: Child and Youth Advocates. Retrieved from https://hri.ca/blog-series-child-and-youth-advocates/.

Interagency Youth Working Group. (2010). Young people most at risk of HIV: a meeting report and discussion paper from the Interagency Youth Working Group, United States Agency for International Development, Joint United Nations Programme on HIV/AIDS Inter-Agency Task Team on HIV and Young People, and FHI. *Research Triangle Park, NC, USA, FHI.*

Jenkins, E. K., Slemon, A., & Haines-Saah, R. J. (2017). Developing harm reduction in the context of youth substance use: insights from a multi-site qualitative analysis of young people's harm minimization strategies. Harm reduction journal, 14(1), 53.

Kerr, T., Stoltz, J. A., Marshall, B. D., Lai, C., Strathdee, S. A., & Wood, E. (2009). Childhood trauma and injection drug use among high-risk youth. Journal of Adolescent Health, 45(3), 300-302.

Kovarikova, J. (2017). Exploring youth outcomes after aging-out of care. Toronto, Canada: Provincial Advocate for Children and Youth.

Kidd, S. A., Gaetz, S., & O'Grady, B. (2017). The 2015 national canadian homeless youth survey: Mental health and addiction findings. The Canadian Journal of Psychiatry, 62(7), 493-500.

Kirby, M. J. L., & Keon, W. J. (2004). Mental health, mental illness, and addictions: Overview of policies and programs in Canada. The Standing Senate Committee on Social Affairs.*Science and Technology. Ottawa, ON: Parliament of Canada.*

Krug, A., Hildebrand, M., & Sun, N. (2015). "We don't need services. We have no problems": exploring the experiences of young people who inject drugs in accessing harm reduction services. Journal of the International AIDS Society, 18, 19442.

Labrèche, A. (2019, April 02). Even in Montreal, It's Becoming Harder to Find an Apartment. Retrieved from https://www.vice.com/en_ca/article/nexppq/even-in-montreal-its-becoming-harder-to-find-an-apartment.

Laframboise, K., & D'Amours, M. (2017, June 26). A week after opening, Montreal's safe injections sites report success | CBC News. Retrieved from https://www.cbc.ca/news/canada/montreal/montreal-safe-injection-sites-1-week-1.4177515.

Lavergne, C., Dufour, S., Sarmiento, J., & Descôteaux, M. È. (2009). La réponse du système de protection de la jeunesse montréalais aux enfants issus des minorités visibles. *Intervention, 131*, 233-241.

Lesage, A., & Emond, V. (2013). Surveillance of mental disorders in Québec: prevalence, mortality and service utilization profile. Institut national de sante publiqué du Québec.

MacLellan, A. (2018, December 13). Indigenous youth in Quebec child protection told not to speak their own languages, sources say | CBC News. Retrieved from https://www.cbc.ca/news/canada/montreal/quebec-indigenous-nakuset-batshaw-language-1.4941393.

MacMaster, S. A., Holleran, L. K., & Chaffi, K. (2005). Empirical and theoretical support for the inclusion of non-abstinence-based perspectives in prevention services for substance using adolescents. *Journal of Evidence-Based Social Work, 2*(1-2), 91-111.

Mahoney, J. (2017, May 31). Crisis on campus: Universities struggle with students in distress. Retrieved from https://montrealgazette.com/news/local-news/mental-health-on-campus.

Mann-Feder, V. R., & Goyette, M. (Eds.). (2019). *Leaving Care and the Transition to Adulthood: International Contributions to Theory, Research, and Practice.* Oxford University Press.

Mar, M. Y., Neilson, E. K., Torchalla, I., Werker, G. R., Laing, A., & Krausz, M. (2014). Exploring e-mental health preferences of generation Y. *Journal of Technology in Human Services, 32*(4), 312-327.

Marion, É., Paulsen, V., & Goyette, M. (2017). Relationships matter: Understanding the role and impact of social networks at the edge of transition to adulthood from care. Child and Adolescent Social Work Journal, 34(6), 573-582.

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs, 27*(2), 393-403.

McQuaid, R. J. (2017, March 9). Substance Use and Suicide among Youth: Prevention and Intervention Strategies. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2017-04/suicide_prevention_webinar_march_2017_eng.pdf.

Mental Healh Commission of Canada (2017, March). Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_for_investment_eng.pdf.

Merkinaite, S., Grund, J. P., & Frimpong, A. (2010). Young people and drugs: Next generation of harm reduction. *International Journal of Drug Policy, 21*(2), 112-114.

Merrick, M. T., Ports, K. A., Ford, D. C., Afifi, T. O., Gershoff, E. T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. Child abuse & neglect, 69, 10-19.

Meyer, I. H., & Frost, D. M. (2013). Minority stress and the health of sexual minorities. *Handbook of psychology and sexual orientation,* 252-266.

Miller, J., Residential Schools in Canada (2018). In The Canadian Encyclopedia. Retrieved from https://www.thecanadianencyclopedia.ca/en/article/residential-schools.

Ministère de la Santé et des Services sociaux en collaboration avec l'Institut national de santé publique du Québec (2016). La santé de la population: portrait d'une richesse collective, [Sixième rapport national sur l'état de santé de la population du Québec].

Moore, D. (2013, June 25). Harm reduction more effective than war on drugs: Study. Retrieved from https://www.ctvnews.ca/health/health-headlines/harm-reduction-more-effective-than-war-on-drugs-study-1.1339700.

National Advisory Committee on Prescription Drug Misuse. (2013). First do no harm: Responding to Canada's prescription drug crisis. Ottawa: Canadian Centre on Substance Abuse.

Nichols, N. (2013). Nobody "Signs Out of Care." Exploring the Institutional Links Between Child Protection Services & Homelessness. Youth homelessness in Canada: Implications for policy and practice, 75-93.

O'Hagan, M., Cyr, C., McKee, H., & Priest, R. (2010). Making the case for peer support. *Calgary: Mental Health Commission of Canada*, 1-92.

Parekh, R. (2016, February). What is gender dysphoria? Retrieved from https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

Patel, A. (2018, December 19). As a person of colour, its a struggle to find therapists who look like you. Retrieved from https://globalnews.ca/news/4712491/finding-a-therapist-of-colour/.

Pelan, M. (2015). Re-visioning drug use: A shift away from criminal justice and abstinence-based approaches. *Social Work & Society, 13*(2).

Perez, A., Genest, E., Ramnanan, M., & Savanna, C. (2018, September 4). Concordia's Mental Health Services: Little Diversity and Long Wait Times | News. Retrieved from https://thelinknewspaper.ca/article/a-lack-of-diversity-and-long-wait-times.

Phillips-Beck, W., Sinclair, S., Campbell, R., Star, L., Cidro, J., Wicklow, B., ... & McGavock, J. M. (2019). Early-life origins of disparities in chronic diseases among Indigenous youth: pathways to recovering health disparities from intergenerational trauma. *Journal of developmental origins of health and disease, 10*(1), 115-122.

Poulin, C., & Nicholon, J. (2005). Should harm minimization as an approach to adolescent substance use be embraced by junior and senior high schools?: Empirical evidence from An integrated school-and community-based demonstration intervention addressing drug use among adolescents. *International Journal of Drug Policy, 16*(6), 403-414.

Reisner, S. L., Radix, A., & Deutsch, M. B. (2016). Integrated and gender-affirming transgender clinical care and research. Journal of acquired immune deficiency syndromes (1999), 72(Suppl 3), S235.

Roy, A. (2014). Intergenerational Trauma and Aboriginal Women: Implications for Mental Health during Pregnancy. *First Peoples Child & Family Review, 9*(1).

Roy, É., Arruda, N., & Bourgois, P. (2011). The growing popularity of prescription opioid injection in downtown Montreal: new challenges for harm reduction. *Substance use & misuse, 46*(9), 1142-1150.

Roy, É., Robert, M., Vaillancourt, É., Boivin, J. F., Vandermeerschen, J., & Martin, I. (2011). Residential trajectory and HIV high-risk behaviors among Montréal street youth—a reciprocal relationship. Journal of urban health, 88(4), 767.

Rutherford, K., McIntyre, J., Daley, A., & Ross, L. E. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. Medical Education, 46(9), 903-913.

Salois, R. (2012). Rapport d'appréciation de la performance du système de santé et de services sociaux 2012: pour plus d'équité et de résultats en santé mentale au Québec.

Schonert-Reichl, K. (2000, April). Children and youth at risk: Some conceptual considerations. In PECERA Symposium report: Children and youth at risk (2000, Ontario, Canadá). Canadian Education Statistics Council (pp. 9-10).

Schrager, S.M., et al., Correlates and Consequences of Opioid Misuse among High-Risk Young Adults. Journal of Addiction, 2014.

Serge, L., Eberle, M., Goldberg, M., Sullivan, S., & Dudding, P. (2002). Pilot study: The child welfare system and homelessness among Canadian youth. *Ottawa: National Homelessness Initiative.*

Simpson, M., Fast, E., Wegner-Lohin, J., & Trocmé, N. (2014). Quebec's Child Welfare System.

Statistics Canada. (2018, August 24). A portrait of Canadian youth. Retrieved from https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2018001-eng.htm.

Stevenson, V., & Abboud, E. (2019, May 04). Quebec order of social workers calls for broad inquiry into youth protection services | CBC News. Retrieved from https://www.cbc.ca/news/canada/montreal/quebec-order-of-social-workers-calls-for-inquiry-youth-protection-1.5122965.

Strier, R. (2006). Anti-oppressive research in social work: A preliminary definition. *British Journal of Social Work, 37*(5), 857-871.

Veale, J. F., Watson, R. J., Peter, T., & Saewyc, E. M. (2017). The mental health of Canadian transgender youth compared with the Canadian population. The Journal of adolescent health: official publication of the Society for Adolescent Medicine, 60(1), 44.

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The lancet, 379*(9826), 1641-1652.

Ward, H. (2011). Continuities and discontinuities: Issues concerning the establishment of a persistent sense of self amongst care leavers. *Children and Youth Services Review, 33*(12), 2512-2518.

WHO Commission on Social Determinants of Health, & World Health Organization. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. World Health Organization.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *The Canadian Journal of Psychiatry, 51*(4), 205-209.

Youth Mental Health Stats in Canada. (2018). Retrieved from https://ymhc.ngo/resources/ymh-stats/.

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