Marie-Claire Bélisle
BELM21568300

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Final Project Report:

What are the characteristics of an effective youth drop-in center, in view of facilitating access to community-based health services for a multi-cultural population?

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RAPID REVIEW

ACRONYMS AND ABBREVIATIONS

AFQuATs	Adolescent-Friendly Qualitative Assessment Tools
CADTH	Canadian Agency for Drugs and Technology Health
CASP	Critical Appraisal Skill Program
CIHR	Canadian Institute of Health Research
CIUSSS	Center Intégré Universitaire de Santé et Service Social (Integrated, University Affiliated, Health and Social Services Center)
CHEO	Children's Hospital of Eastern Ontario
CSSS	Centre de Santé et de Service Social (Health and Social Services Institute)
CYS	Children and Youth Service
ER	Emergency room
FEPP	First Episode of Psychosis Program
FNQLHSSC	First Nations of Quebec and Labrador Health and Local Services Commission
GP	General Practitioner
HEADSS	Home, Education and employment, Activities, Drugs, Sexuality, Suicide/Depression
HSE	Health Service Executive (Ireland)
LGBTIQ	Lesbian Gay Bisexual Transsexual Intersex Queer
MSSS	Minister for Health and Social Services
RR	Rapid Review
TELUQ	TÉLÉ-université Université du Québec (On-line University of Quebec)
WHO	World Health Organisation
YHS	Youth health services
YP	Young person, youth

EXECUTIVE SUMMARY

Introduction

In Quebec, Canada, access to health care for youths is an increasing concern as the number of youths suffering from and diagnosed with mental illness is growing[(1)]. Innovative, youth-friendly service access pathways are needed to facilitate access.

Research Questions

What are the characteristics (organisational and clinical) of an effective youth drop-in center, in view of facilitating access to community-based health services for a multi-cultural population?

Methods

Articles for a rapid review were looked for using Medline, CINHAL, PsychInfo and Google Scholar during the time period 2000-2015. Grey Literature was also looked into as per CADTH recommendations. The search criteria were: 14-25 years old attending youth centers. Outcomes of interest are referral rates to 1st line health services, attendance rates to youth center, referral rates to mental health services, referral rates to other resources, self-reported appreciation/satisfaction with youth center, and self-reported impact of youth center on quality of life. The selection, quality assessment and data extraction processes were done by one researcher. The quality of the articles was assessed using tools appropriate for the type of study designs found.

Results

1252 articles were found; only 11 were kept after the selection process. After a critical evaluation process, most were determine to be of mediocre quality. This leads us to question the quality of the results in terms of validity, generalizability and transferability. Four descriptive clinical themes and nine organisational themes were found. The analytical themes answered the questions of who operates the center (clinical, administrative, youths involvement), what it offers (activities, partnerships, research activities), its accessibility (tangible and virtual), and the organisational practices used as its framework.

Discussion

Deliberations on the definition of efficiency and outcomes of interest, on the reach of the center, on the impact of this technology on health services were considered. Implementation issues, procedural issues and ethical issues were discussed. The generalizability and transferability of findings were explored. Finally, study limitations and knowledge gap were identified.

Observations

Final observations reflect these themes from a general point of view; more local/targeted observations were not within the scope of this review.
The observations found to achieve best clinical practice are:

a. Choosing the right staff
b. Allowing for "borrowed staff" or for attendees to have privileged access to partner organisations
c. Optimising work conditions
d. Building clinical activity programming based on present needs of decision-makers and of youth health concerns
e. Building non-clinical activity programming to reflect youth's needs and desires to the extent that the building design and location can allow, and with the available local partnerships

The observations found to achieve organisational best practice are:

a. Putting in place a governance board
b. Putting in place a youth committee with decisional power and a defined mandate
c. Having a clear statement about youth participation options
d. Having a clear statement about type and level of health care being offered at the center
e. Establishing local partnerships
f. Allowing for flexibility within clinical activities
g. Allowing for flexibility in programming for non-clinical activities
h. Allowing creativity and spontaneity in programming to maximise motivation and interest of staff and youths

i. Having dedicated days/times for drop-in time, for clinical meetings and for group activities
j. Having at least 1 day open until evening hours
k. Minimising the number of steps and the time to access the needed or appropriate service
l. Developing the intake process in view of youths' and decision-makers' needs
m. Having appropriate on-site equipment for staff and for youths
n. Developing youth-friendly and optimally youth-based marketing strategies, including social media and on-line forums
o. Developing a social media presence using logo/brand
p. Having easy access to information about center's programming and other useful information such as staff descriptions or health information
q. Developing youth-friendly research activities

Conclusion

This review provides managers with some key observations that allow them to reflect on what should the new standard of care for this target population. Moreover, further research is needed to look into adequate communications between present service pathways and the youth center to optimise service access.

SOMMAIRE EXECUTIF

Introduction

Au Québec, Canada, l'accès aux soins de santé pour les jeunes est une préoccupation grandissante. Ceci est d'autant plus important puisque le nombre de jeunes souffrant et diagnostiqués avec un trouble de santé mentale est croissant[(1)]. Des pratiques innovantes et plus attrayantes pour les jeunes sont nécessaires pour faciliter l'accès aux soins et services de santé.

Question de recherche

Quelles sont les caractéristiques (cliniques et organisationnelles) d'un centre pour jeunes efficace, dans le but de faciliter l'accès aux soins?

Méthodes

Les articles ont été cherchés dans Méline, CINHAL, PsychInfo et Google Scholar pour la période 2000-2015. Les critères de recherches sont: jeunes de 14-25 ans, qui se présentent à un centre pour jeunes. Les résultats regardés sont: le taux de références aux soins de 1^{iere} ligne, le taux de présence, le taux de références aux soins de santé mentale ou à d'autres ressources/services, l'appréciation/satisfaction auto-déclarée par les jeunes du centre, l'impact du centre sur la qualité de vie. Les processus de sélection, d'évaluation des articles et d'extraction de données sont faits par un chercheur. Le processus d'évaluation de la qualité a été fait en utilisant des grilles d'évaluation pertinentes pour le type d'étude trouvées.

Résultats

1252 articles ont été trouvés, seulement 11 ont été retenus après le processus de sélection. Après le processus d'évaluation, la majorité des articles sont jugés de qualité médiocre. Ceci vient nuancer la valeur des résultats en terme de validité, généralisibilité et transférabilité.

Quatre thèmes descriptifs cliniques et neuf thèmes organisationnels ont été trouvés. Les thèmes analytiques répondent aux questions : qui fait fonctionner le centre (personnel clinique, administratif, participation des jeunes), ce qui est offert au centre (activités, partenariat, activités de recherche), l'accessibilité du centre (tangible et virtuel) et les pratiques organisationnelles qui constituent son cadre organisationnel.

Discussion

Des délibérations sur la définition de l'efficience, les résultats recherchés, la capacité d'influence et l'impact de cette technologie sur les services de santé ont été considérés. Des questions concernant l'implantation, les procédures et l'aspect éthique ont été discutés. La généralisabilité et la transférabilité des résultats ont été explorées. Les limites de cette étude ont été expliquées. Finalement, l'absence de données sur certains aspects concernant ce sujet a été documentée.

Observations

Les observations finales sont des reflets de ces thèmes d'un point de vue général, les observations plus spécifiques, pour le niveau local, ne faisant pas parties de l'envergure de cette revue.
Les observations trouvées pour atteindre les meilleures pratiques cliniques sont:

a. Avoir les bons employés
b. Avoir la possibilité d'avoir des "employés invites" ou avoir des corridors de service privilégiés avoir les institutions partenaires
c. Optimiser les conditions de travail
d. Développer la programmation des activités clinique en fonction des besoins des décideurs et en fonction des inquiétudes des jeunes
e. Développer la programmation des activités non-clinique comme reflet des besoins et désir des jeunes, en prenant en considération la capacité et de l'emplacement du bâtiment où se retrouve le centre, et les partenariats possibles.

Les observations trouvées pour atteindre les meilleures pratiques organisationnelles sont:

a. Mettre en place un comité de gouvernance
b. Mettre en place un comité de jeunes avec un pouvoir décisionnel et un mandat défini
c. Définir clairement les options qu'ont les jeunes pour s'impliquer dans le centre
d. Définir clairement les options de soins en santé et les services sociaux offerts
e. Établir des partenariats avec les organisations locales
f. Accepter la flexibilité par rapport aux activités cliniques

g. Accepter la flexibilité par rapport à la programmation des activités non-cliniques
h. Accepter la créativité et la spontanéité par rapport à la programmation pour maximiser la motivation et l'intérêt des jeunes et des employés
i. Avoir des temps/des jours spécifiques pour le sans-rendez-vous, pour les réunions cliniques et pour les activités de groupes
j. Avoir au minimum 1 jour pendant lequel le centre ferme en soirée
k. Minimiser le nombre d'étape et le temps d'attente pour avoir accès aux soins requis or le plus approprié
l. Développer le processus d'accueil en prenant en considération les besoins des jeunes et des décideurs
m. Avoir le matériel approprié pour les jeunes et les employés
n. Développer des stratégies de commercialisation pour jeunes et optimalement par les jeunes, en incluant les réseaux sociaux et les forums de discussion enligne
o. Développer une présence sur les réseaux sociaux en utilisant le logo/la marque du center
p. Avoir facilement accès à la programmation du center et à d'autre information utile tel que la description du staff ou de l'information sur la santé
q. Développer des activités de recherches pour les jeunes

Conclusion

Cette revue transmet aux gestionnaires des observations clés, ce qui leur permet d'entamer un processus de réflexion sur ce qui pourrait être une meilleur pratique en soins pour cette population cible. Également, plus d'études sont nécessaires pour évaluer les communications entre les présentes portes d'accès et cette nouvelle porte d'accès aux soins et services de santé.

BACKGROUND

Description of the context

Due to their developmental stage, youths, 14-25 years old, are at higher risks to develop family dynamic issues, sexual identity/orientation difficulties, drugs and/or alcohol use, dropping out of school, and other psychological stress[2]. In 2013, Statistics Canada published the "Canadian community health survey on mental health, 2012"[3] reports showing that "10% of people of 15 years or more have reported symptoms consistent with at least 1 of 6 mental health diagnosis or substance abuse disorder, in the past 12 months". Already in 2006, Statistics Canada found that "70% of mental health problems have their onset during childhood or adolescence"[4] and that "young people aged 15 to 24 are more likely to experience mental illness and/or substance use disorders than any other age group"[5]. And of that 2.8 million people, Statistics Canada approximates that only 67% received adequate help [3]. We also have found some studies showing that youths find accessing health care services a challenge [5, 6, and 7]. This may be one of the factors leading to the children's hospital of eastern Ontario's (CHEO) observation that there has been a "50% increase in mental health crisis visits to CHEO emergency department over the last two years, 146% increase over the past five years in mental health admissions to CHEO as a result of emergency department visits and 60% increase in outpatient referrals to CHEO clinics between 2010 and 2011" [1].

In Parc-Extension, the neighbourhood of Montreal, Quebec that we are targeting in this review, there is also the added challenge of multi-ethnicity, language barriers and low socio-economic situations[17]. This makes the youth of this neighbourhood even more vulnerable to develop mental health problems[86].

Description of current practice

With the predicted budget-cuts in the healthcare sector, institutions need to look at how to do more with less. This means that usual service access pathways may not be optimal anymore to handle the new constraints (growing needs, fewer resources). The first usual service pathway in our context is one's family doctor. However, in our context's health care system, there is a shortage and/or difficulty of access to a family doctor. Twenty-five percent of people in the province of Quebec do not have access to a family doctor [9], and the average waiting time for a routine appointment can be up to 24 days [10]. The other usual gateway to services is via the ER of a hospital. Using the CTAS scale (the Canadian triage and acuity scale [11]), we can see that mental health care is low on the priority scale. In our context of Montreal, Canada, the usual waiting time for this type of priority can be up to 12 hours [12]. We can understand that this pathway is not very appealing for a youth/family in distress.

In the CSSS de la Montagne, health institution appointed to provide healthcare services for Park-Extension, the entrée points are the medical walk-in clinic or the psychosocial walk-in clinic of the CLSC. According to Broadhurst (2015), having direct access to mental health services is not possible, and the wait times to have access can vary between a few weeks to a few months.

Description of a youth drop-in center

Community centers are public places where members of a designated community or group can gather for group activities, social support, and where the members can have a sense of belonging [84]. For youths, it can become a place they go to instead of hanging out on the street after school or during weekends; where they can have access to animators and mentors to help guide them when dealing with some difficult situations such as: family problems, school/bullying issues, anxiety/depression or sexual identity and/or orientation [84].

Description of the new service

One of the difficulties youths have in accessing health care services is understanding how the system works, when to ask, where to go, who to talk to[7, 8] to receive help; and the waiting time for the appropriate service to be available.

Having a community center within the service plan of a health institution would create a service bridge between the community center staff and the health care staff[85]. This would in turn decrease the number of times one would repeat the difficulties they're going through and the time it takes to have the appropriate help. Access to care would then be less complicated/less daunting, faster and most importantly, more humane.

Another benefit of this service bridge would be to decrease the stigma associated with asking for mental health services. The creation of a safe place within the center would facilitate the development of a trusting relationship between the youth/client and the workers. This would allow youths that would not have asked for help otherwise to come forward and access needed services [85].

Finally, the youth center would then be another place where screening for youths in need would be possible. Depending on cognitive and emotional development, some youths have difficulties articulating or even recognising their needs. The staff would be able to direct them to services if they chose to accept help [85].

Why it is important to do this review

First, in 2005, the ministry of health and social services (MSSS) published their strategic plan[13] for 2005-2010. This document describes the priorities set by the MSSS for the health care institutions. In this document, we find the following priorities: 'facilitating access to 1st line services' and 'adequate delay for services', with emphasis on vulnerable populations (including mental health and pediatric populations) [13]. The concept of 'reaching out' in preventative care describes a way that health care is being provided. It can be different depending on the setting, but the goal is to use non-traditional models to provide care for vulnerable populations that would not be able to receive care otherwise. Usually, this is done by having the workers go towards the population in need rather than have the population go to the clinic or hospital [14]. 'Reaching out' is used to facilitate access to services to a population that hasn't received the help it needs via usual pathways to care. In this review, the concept of a 'youth center' is part of the reaching out strategy that the managers at CSSS De La Montagne have chosen.

In 2015, the MSSS wrote a new strategic plan for 2015-2020, in which it describes 9 measures specifically targeting increase in quantity and quality of services for young people [15].

Another important concept to take into account is the change in our society's perceptions about what being an adult means; specifically at what age one becomes an adult. In 2012, Leopold describes the ages when youths leave their parents' house based on cultural belonging [16]. In the context of the decision-makers requesting this review, there are a growing number of immigrant families. In fact, Park-Extension, one of the Montreal neighbourhoods from which the youths attending the center would be from, is a very multi-cultural neighbourhoods in Canada, with 57% of the population being from a visible minority [17]. It is therefore important to take in consideration the fact that, within certain cultures, the age of 18 is not the age at which one becomes an independent adult[16].

Health services in Quebec, Canada, are divided using the medical practice of pediatric care (less than 18 years old), and adult care (18-100 years old). Although the term young adult (18-30 years old) is becoming commonly used in practice, there aren't any mental health/social service programs targeted at this population. The health needs of the young adult population may be called the same as the needs of the rest of the adults, but the severity and chronicity of those needs have not set in, and so the approach to treating them should be different.

RESEARCH QUESTION

According to Granados et al.[87], performing an HTA assessment can require assessments of multiple aspects: technical performance, safety, clinical efficacy and effectiveness, cost, cost-effectiveness, organisational implications, social consequences, and legal and ethical considerations. Therefore, assessments are composed of a 'Policy question' aimed to support the decision-making process, and 'Research questions' specifically targeting which aspects to assess (see Assessment Process Schematic, Annexe 2). According to Busse[88], the research questions "specify the target group, the condition, and the aspects of the technology that are going to be assessed". Just as the policy question is discussed with the decision-maker, the choice of aspects to assess is decided with the decision-maker, and reflects the financial context, the time limits, the scope of the review, and the level of details required.

In this review, the Policy Question is the following:
What is best practise when implementing a youth drop-in center for the 14-25 years old population in an urban, multi-cultural setting, in view of facilitation access to 1st line health care services?

At this time, the decision-makers prioritized the organizational aspect, but may request other aspects to be assessed at a later time, such as the psychological/social/ethical aspect, or the economical aspect.

After preliminary results of the literature review were presented to the decision-makers, the aspects of 'urban' and 'multi-cultural' were identified as facets to be analysed as themes after data extraction rather than having the absence of these be considered as exclusion criteria when performing the search. Therefore, when constructing our research equations for the chosen databases, the notions of 'urban' and 'multi-cultural' remained in the equation as optional variables rather then non-optional. As such, within the institution's archives, although the research question implies the notions of multi-culturalism and geographical relevance, it is understood that the research results include articles that do not necessarily refer to these aspects in their analyses.

The Research Question that is being addressed is the following:
What are the characteristics (organisational and clinical) of effective youth drop-in centers, in view of facilitating access 1st line services for a multi-cultural population?

METHODS

1. PICOS

Our target population was youths between the ages of 14 to 25, males and females.
As there isn't an intervention itself to assess, the performance or utilisation of this type of center is what we used as a basis for our search. As such, the setting description becomes an important inclusion factor.
As no 'golden standard' for a youth drop-in center exist, we used the following definition (annexe 1): "A safe meeting place where young people can hang out with their friends, chat, drink coffee or soft drinks, watch TV or movies, or surf the Internet. Also, it can have a variety of recreational and educational activities, chosen by the young people themselves, plus information on State and local services of interest to young people. The activities or programmes in this kind of café are usually developmental and/or community-focused. It can as well include a range of specific services, directly designed for young people. These might include, for example, education and training, healthcare information (both physical and emotional) and direct targeted assistance"[45].
As our comparator, we used the 'usual pathway to care'.
The primary outcome we looked for in the articles we searched for is: referral rates to 1st line health services as we seek to determine which determinants of performance have an impact on this outcome. The secondary outcomes we looked for are: referral rates to mental health services, referral rates to other resources as these can be substitute for the primary outcome. We also looked for: attendance rates to youth center, self-reported appreciation/satisfaction with youth center, self-reported impact of youth center on quality of life, as these outcomes can reflect utilisation of the youth center.

2. Literature search

The following databases were used for this review: PubMed, CINAHL, PsychInfo and Google Scholar.

We searched using MeSH terms and/or key words to reflect the different elements of our research question and of the PICO.

For the Population, we used the following key words to describe the 3 sub-concepts which describe our target population. The first key word is: <youth of 14-25 years of age>; this is a mandatory concept. The concepts of <immigrant> and <urban> are not mandatory, the absence of these will not be seen as an exclusionary element.

The concept of Intervention also needed to be broken up into 3 sub-concepts: the organizational practices, the clinical practices, and the center in itself. Therefore, we used the following key words: <intervention>, <activities>, <best practices>, <clinical best practices>, <good practices>, <health care services>, <social services>, <psycho*>, <management>, <administration>, <organization>, <services>, <implementation>, <partnership > and <active participation of youths in center-programming decisions>, <youth center> and <youth services>.

Finally, for the Outcomes, we used key words that reflect 2 sub-concepts: the efficiency of the center and the efficiency of the center in view of facilitating access to

health care. The key words used are: <referral rates to services>, <referral rates to health care>, <attendance at the center>, <access>, <efficiency>, and <effectiveness>.

For each search strategy used in the various databases, the different concepts were combined in the same way. In view of finding all pertinent articles, all sub-concepts of each concept were combined with <OR>, and then all concepts were combined using <AND>.

We also searched for grey literature using the CADTH checklist[83]. Using the same key words and combination of concepts as previously cited, we searched through all the recommended websites expect for those deemed not pertinent or those that had been previously excluded. We did not search the websites from the sections "Health Economics", "Drug and Device Regulatory Approvals", "Advisory and Warnings", "Drug Class Reviews", "Clinical Trials" and "Canadian Drug Formularies".

See Annexe 3 for complete search strategy for each database.

3. Committee consultations

An internal orientation committee to review research protocol was created at the beginning of this review process to ensure the quality of the review, pertinence to the context and to ensure that methodological decisions reflect all stakeholders needs. On this committee, we find decision-makers, managers, librarian, and experts on this field. Mid-way through the review process, an expert consultation committee, with decision-makers present, was consulted to review and validate that youth-centers models found through literature search were similar to the one decision-makers are interested in implementing.

4. Inclusion and exclusion criteria

Amongst the articles found, we included the articles that had a target population of youths 14-25 years old who attend a youth center, and had defined attendance as being present for a minimum of one activity or a minimum of one hour of drop-in time. We excluded studies that looked at a target population of 12 years old and less or 30 years old and over. We also excluded studies in which the participants are referred to 1st line services by another health care professional or General Practitioner or hospital. Publication dates were limited to 2000-2014. The CADTH guidelines suggest limiting the time bracket to the last five years. However, the time bracket chosen for our search is based on the technological advances (smart phones, social media and on-line gaming) which may have an impact on our target population's views on health care accessibility and their health care needs[18]. Language was restricted to English and French, to capture the maximum amount of literature published and also the maximum amount of literature representing the reality of the context in which this RR is being done. Conference abstracts were excluded and clinical trial registries were not searched (as per CADTH default search limits).

5. Selection process

The articles were selected by one researcher following the search criteria. The steps of the selection process are displayed in Annexe 4 using a flow diagram based on Busse, R, et al. (2002). Best practice in undertaking and reporting health technology assessments. *International Journal of Technology Assessment in Health Care, 18(2),* 361-422.

6. Critical appraisal

The process was done by one researcher.

Historically, a systematic review is defined as a synthesis of quantitative data, provided by RCTs (randomised-control trials)[103]. This would allow the synthesis to be quite homogeneous, as all data would be coming from studies of the same design[103]. As the need to include a variety of data, such as intuition, personal experience and inferred knowledge, within systematic reviews emerged, the notion of 'hierarchy of evidence' was developed. This is used to qualify the weight or the worth of studies based on their design[104]: the highest quality or worth being RCTs, the lowest being expert opinions[104]. Consequently, the definition of 'evidence-based practice' evolved, and researchers needed to find a way to incorporate other types of study designs, such as qualitative studies, within systematic reviews methodology[103]. As the definition of systematic reviews can be interpreted in two ways, this remains a challenge[103]. On one hand, a systematic review can be seen as a defined methodology; on the other hand, it can be viewed as a framework that allows different forms of data to be synthesised into a narrative review, for instance[103]. In this review, we find ourselves using the second definition as we complied, in majority, qualitative data provided by articles of different study designs. As such, the critical appraisal step is essential. Qualitative data can be found within a large variety of study designs making appraisal of qualitative studies challenging: no tool exists that can evaluate all qualitative studies[103]. Therefore, in this review, we have chosen tools that have been validated by peers and have demonstrated their effectiveness, increasing the validity of the final synthesis.

For the qualitative article, it was done using the CASP for Qualitative Research checklist[89] to assess the quality of the studies found. Since the article was found to be of sufficient quality, it was then submitted to another evaluation process to look at the reporting format.

As there is no "gold standard' critical appraisal tool for qualitative study designs, nor is there any widely accepted generic tool that can be applied equally well across study types[90], the CASP tool was chosen to assess the internal validity, the results and the relevance of the study within the subject that is being studied[90]. The tool was pilot tested in workshops, and was updated using feedback and reviews of the material provided at the workshops[90].

The reporting standards guidelines used for this review are those described by O'Brien (2014)[91]. O'Brien and colleagues states that: "Optimal reporting would enable editors, reviewers, other researchers, and practitioners to critically appraise qualitative studies and apply and synthesize the results"[91]. Although this may not lead to an

increase in methodological rigor, it does increase transparency of methods and results, which can also help the field progress[91]. They devised the guidelines by performing a systematic review and validating their results by experts in the field[91].

For the mixed methods studies, it was done using the Mixed Method Appraisal Tool (MMAT). This tool was created to assess mixed, qualitative and quantitative studies(4). As there is no consensus on how to assess mixed methods studies[93], a pilot project was devised to assess the validity of the MMAT[94]. Pace et al (2014)[95] concluded that, due to the MMAT's unique nature, the reliability of this tool is promising. The 2011 version of this tool, used for this review, is the product of the tool used in the pilot project in combination with feedback from testing workshops and the O'Cathian framework[96] to assess the quality of mixed methods studies[92]. The limit of this tool is that it only assesses the quality of the study and not it's reporting format. At this time, no reporting format tool has been validated, as mixed methods studies can be of different natures (a variety of quantitative studies, a variety of qualitative studies and the combination of said studies)[92]. This tool as been found to be adapted by NICE as their checklist for mixed methods[100].

For the quantitative study found, it was done using the EPHPP tool[97]. This tool was chosen due to its ability to assess any study within the health sector[97] and to provide high quality systematic reviews appraisals[98]. The overall methodological ratings are: strong, moderate or weak.

It was developed at McMaster University, Faculty of Health Sciences, School of Nursing. The original authors are B.H. Thomas, Associate Professor, McMaster University School of Nursing, D. Ciliska, Professor, McMaster University School of Nursing, M. Dobbins, Associate Professor, McMaster University School of Nursing, and S. Micucci, Project Coordinator[97].

This tool has been evaluated for content and initial construct validity and inter-rater reliability by Thomas, Ciliska, Dobbins & Micucci (2004)[98]. Also, the consistency of coding, interpretation, and examination of evidence tables and/or recommendations was assessed by comparing clarity, completeness and relevance, and an overall formatting with similar types of tools[98].

In the review protocol a priori written, it was stated that the Newcastle-Ottawa scale was to be used to assess the risk of bias of the studies found. However, this was not performed, as the studies found were not of study designs that could be assessed using the Newcastle-Ottawa scales.

As for the grey literature, NICE states that: "The Fourth International Conference on Grey Literature held in Washington, DC, in October 1999 defined grey literature as: 'that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers.'[sic]. Grey literature includes theses or dissertations (reviewed by examiners who are subject specialists); conference papers (often peer-reviewed or presented by those with specialist knowledge) and various types of reports from those working in the field. All of these fall into the 'expert opinion'."[100]

The quality assessment of this type of data found was done using the AACODS. This tool was developed by Jess Tyndall, Medical Librarian at Flinder's University as a way to systematically appraise Grey Literature[99]. We found that NICE recommends assessing grey literature should it be included in a review. Their checklist is based on the AACODS tool[100]. Also, Public Health Ontario recommends using the AACODS checklist for assessing grey literature[101].

This tool looks at 6 components:

- 'Authority': who is responsible for the intellectual content.
- 'Accuracy': the goal, the methodology, the value, the source
- 'Coverage': the report's limitations
- 'Objectivity': the author's position, presence of bias
- 'Date': the date of the report, of the content, of the references.
- 'Significance': a value judgment of the item, in the context of the relevant research area

For links and references to complete assessment tools, see Annexe 6.

7. Data extraction process

The process was done by one researcher. The data on the characteristics were extracted following the extraction tables designed for this purpose (see Annexe 9 and Annexe 10).

8. Analysis methods

We used thematic analysis. It can be data-driven or theory-driven[30]. It is a flexible method [19] that is commonly used in qualitative analysis when describing phenomenon[20]. It is useful when the researcher wants to analyse intricate meaning found in the data[19]. It can reflect the themes that have the highest frequency in the studies reviewed or it can reflect the themes that have a high level of explanatory value[31]. In this review, we will look at the descriptive themes that have high frequencies. The themes are a reflection of patterns found in the studies chosen for analysis[23] and thus become the categories of the analysis[24]. They will also be the bases for our final observations in the report. Thematic analysis is associated with grounded theory assertions and phenomenology concepts (perceptions, feelings and experiences[32]). The steps are[33]: searching for the studies, quality assessment of the studies, extracting data from studies, coding and developing descriptive themes, generating analytical themes, discussion. Grounded theory can be described as a way to construct theories from the data themselves[21, 22]. It is the systematic generation of theory from systematic research[34]. Data is looked at to see how they relate to each other and as such would explain an action or a phenomenon. The steps are: preparation, data collection, analysis (usually the Constant Comparative Analysis method), memoing (**"**Memoing is the act of recording reflective notes about what the researcher (fieldworker, data coder and/or analyst) is learning from the data: memos accumulate as written ideas or records about concepts and their relationships" [81]) sorting and theoretical outline creation. Data is coded, made into concepts, which in turn become categories or themes and from there theories can be created. Due to the limits of this review, theories won't be created. This part of the

process will be stopped once themes are found. However, using the themes and the data found in this review, we created a theoretical framework that reflects the key elements of this review (see Annexe 8).

9. Synthesis method

The narrative review method will be used to synthesise the data found, as per CADTH guidelines for a Summary with critical appraisal[25]. This method is used when the aim of the review is the description of the research outcomes or variables[26] or to describe and discuss certain themes or topics found in literature. It is one of the usual methods when the research is qualitative and the research question is not very specific[26]. This method is known to be flexible in its structure and to increase the transparency of the synthesis process[35]. This interpretive approach allows for the author to 'make sense' of the data found and to construct the themes or ideas as the narrative progresses[36]. It is used to facilitate the synthesis of evidence relevant to a wide range of questions including but not restricted to effectiveness. This is why this method is appropriate when studying complex knowledge, studying the source of a phenomenon or even decision-making processes[36]. It is described as a method that allows authors to deepen the analysis when looking at feelings/values or group/organisational dynamics[36].

10. Knowledge transfer strategies

This has been done in 3 parts. First, the results were presented to the internal orientation committee to discuss the findings and plan next steps in terms of their applicability to the context. Second, the executive summary was presented to the decision-maker/requestor to discuss results. Finally, an article for publication will be written and will be sent for publication. The journal will be selected because of its' pertinence to the subject of this report and approved by the internal orientation committee.

RESULTS

1. Synthesis of results of literature review

The literature review produced a total of 1252 articles. After looking through titles and abstracts, when available, 242 articles were kept to read completely. After reading the complete articles, 11 were kept for analysis and synthesis (see Annexe 4).

Of these 11 articles, was found:

- 1 PhD Thesis
    - Cyr, A.E. (2012). Music in urban youth development programs: developing resiliency and improving health and wellness. *Dissertation Abstracts International Section A: humanities and Social Sciences, 72(12-A),* pp4356
- 3 government reports
    - New Zealand Ministry of Health. (2009). *Evaluation of Youth One Stop Shops.*
    - Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés in Ireland, a best practice guide.*
    - Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés toolkit: how to set up and run a youth café in Ireland.*
- 1 qualitative study
    - Kang, M. et al (2006). Primary health care for young people. Are there models of service delivery that improve access and quality? *Youth studies Australia, 25(2),* pp49-59
- 2 mixed methods study
    - Rickwood, D., Van Dyke, N., and Telford, N. (2015) Innovation in youth mental health services in Australia: common characteristics across in the first headspace centers, *Early Intervention In Psychiatry, 9(1),* pp9-37
    - Patulny, R., Muir, K., Flaxman, S., and Oprea, I. (2013). Are we reaching them yet? Service access patterns among attendees at the *headspace* youth mental health initiative. *Child and Adolescent Mental Health, 18(2),* pp95-102
- 1 descriptive quantitative study
    - Illback, R.J. and Bates, T. (2011). Transforming youth mental health services and supports in Ireland, *Early Intervention in Psychiatry, 5(suppl 1),* pp22-27
- 3 demonstrative articles
    - McGorry, P., Bates, T., and Birchwood, M., (2013). Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. *The British journal of Psychiatry, 202*, pp s30-s35

- McGorry, P., et al (2007). Headspace: Australia's National Youth Mental Health Foundation – where young's minds come first. *Medical Journal of Australia, 187(7),* pp s68-s70
- Practice Notes: Strategies in Health Education. Program: Youth opportunity centers health suites. (2004). *Health Education and Behaviour, 31(3),* pp301-302

Following the article selection process and assessment for quality, youth centers websites were searched for added information (see Annexe 5).

Annexe 9 describes article characteristics: country, year, study design, target population, primary and/or secondary outcome measured and name of youth service model described in the article.

From these 11 articles, we note 7 models of youth services/centers.

- In her dissertation, Cyr discusses 'Youth UpRising', 'Ryse Center' and 'Youth Movement Record'. Her dissertation mostly discusses 'Youth Movement Record' but this youth center does not fit our research criteria. She states that due to time and resource limitations, she was unable to analyse 'Youth Uprising' and 'Ryse center' with the same depth but that this may be a future endeavour.
- Illback and Bates discuss 'Jigsaw'. They describe the beginnings of the first 5 centers and the needs assessment and organisational philosophy used as basis for the implementation of these centers.
- Kang et. al. compare 6 models of health care services for young people: 'youth health services', 'area youth health coordinator', 'GPs in schools', 'co-located GP-run clinic', 'school-based based' and 'innovative access points'. With our review criteria, only the 'youth health services' qualifies for our analysis. Due to time limitations and lack of access to certain journals, information on the specific centers that were used in this article was not found.
- The Office of Minister for Children and Youth Affairs of Ireland commissioned reports on 'Youth Cafés'; a 'Best practice guide' and a toolkit on 'How to set up and run a youth café' in Ireland. They also offer lists of other resource to facilitate implementing 'Youth Cafés' in Ireland. These documents are based on active youth centers such as 'The Gaf', 'The Attic', 'The Albury City Retro Youth Café', and 'The Squashy Couch' amongst other.
- The 'Yo!' centers are described in an un-authored practice note of a health journal. This note was published in the journal 'Health Education and Behaviour'. The publishers of this journal describe a practice note as being "an attempt to spread the word about exemplary strategies, initiative, and programs and share successes in overcoming obstacles or challenges". The 5 'Yo!' centers in Baltimore are described as a strategy to facilitate access to health care for young people.
- The Office of the New Zealand Ministry of Health commissioned an evaluation of 'youth one-stop shops'. This report consists of a literature review, surveys, document reviews, face-to-face meetings and focus groups. The youth centers used as basis for the evaluations are: 198 Youth Health (now referred to as '298

Youth Health'), 'Café for Youth Health', 'Directions Youth Health Center', 'Evolve Youth Service', 'Number 10 Youth Health Center', 'Kapiti Youth Support', 'YOSS', 'Rotovegas Youth Health', 'Vibe', 'Waves', 'Whai Marama Youth Connex' and 'Youth Services Trust'.

- '*headspace'* is described in 4 articles found:
    - Rickwood, Van Dyke and Telford look at common characteristics of the first 30 *headspace* centers in Australia and found 10 categories of commonalities.
    - Patulny, Muir, Powell, Flaxman and Oprea look at the characteristics of the young people attending *headspace* centers.
    - McGorry et al. describe how *headspace* is part of the health service continuum of care and what kind of services it will provide the young people attending the center.
    - McGorry, Bates and Birchwood describe 3 innovative health care practices designed to help young people to have access to health care: '*headspace*', 'Jigsaw' and 'Youthspace'. As 'Youthspace' is a strictly on-line platform, it will not be part of this review.

2. Critical Appraisal of Individual Studies

The articles found were assessed for quality, see Annexe 6 for detailed assessments.

As previously described, the ACCODS tool was used to assess the grey literature.

- First, we looked at Cyr, A.E. (2012)
    - In terms of 'Authority', 'Coverage', 'Objectivity', and 'Date', the article scores perfectly.
    - However, in terms of 'Accuracy', it only scored 6.5/9. The data collection strategy was not as explicit as it could be: the interview questions were not provided. As the article is a thesis, it was not peer-reviewed, and no official editor was mentioned.
    - The 'Significance' aspect scored 5/6, due to the fact that it is unclear if it adds significant advancements in the field.
    - Overall Rating: 18.5/22 (84%)
- Next, we assessed New Zealand Ministry of Health. (2009). *Evaluation of Youth One Stop Shops.*
    - The aspects of 'Authority' and 'Date' had a perfect score.
    - The 'Accuracy' aspect lacks in methodology. The authors mention having a detailed methodology but did not include it in the final and published report. It did not mention an official editor, nor if it was peer-reviewed.
    - The 'Coverage' aspect scored 0 as the authors do not mention any limits of their research questions, the methodology or the results.
    - The 'Objectivity' aspect scored 0.5/1 as the report mostly presents the expert/users consultations and the final results, but none the details of the literature review/results.
    - The 'Significance' aspect scores low as this report only focuses on the New Zealand context, without discussing transferability and generalizability. Also, as the methodology is not present, it is unclear if

this research area would advance or not should the methodology be accessible.
    - Overall Rating: 15/23 (65%)
- Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés in Ireland, a best practice guide.*
    - The 'Authority', the 'Coverage, the 'Objectivity' and the 'Date' aspects received a perfect score.
    - The 'Accuracy' aspect has a score of 6.5/9 due to the lack of details provided about the semi-structured interview during the data collection step. The article also is not peer-reviewed and does not have an official editor.
    - The 'Significance' aspect is not perfect due to lack of information provided by the authors on how the research area would not be as advance without the article.
    - Overall Rating: 17.5/22 (79.5%)
- Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés toolkit: how to set up and run a youth café in Ireland.*
    - The 'Authority', the 'Objectivity' and the 'Date' aspects received a perfect score.
    - The 'Accuracy' aspect received a low score due to the lack of methodology (including the data collection process), of a peer-review process and of an editor. Also, it is not representative of other articles found when looking at a research in this field.
    - The 'Coverage' aspect received a 0 as the authors do no provide any limitations of the report.
    - The 'Significance' aspect scored 3/6 as this report does not support an opinion or position, it does not add context to the research field nor does it specify how the field would change should this report had not been made.
    - Overall Rating: 11/21 (53%)

Overall, for the grey literature found, the main source of depreciation for the articles are the aspects of 'Accuracy' and of 'Significance', lacking in the 4 articles found; and the aspect of 'Coverage', lacking in 2 of the articles found. Therefore, we can question the validity of the reports and the generalizability of the results.

For the qualitative study, the CASP checklist was used, followed by the Standards of Reporting Guidelines.

- Kang, M. et al (2006)
    - The CASP results show us that this study is of mediocre quality. Although the study design and methodology seem appropriate for the research question, the lack of details provided in view of the data collection and analysis decreases the value of this report. Also, the lack of information in

relation to ethical issues that could have been addressed or that would be of consequences to this research contributes to the mediocre score.
    - The percentage of guidelines being respected by the authors is 72%. Although these aspects were present, the authors lack to provide enough details or lacked in conformity for the following aspects: the title and abstract, the research paradigm and the data collection methodology. However, they did not provide any information on Researcher characteristics, limitations, conflicts of interest and techniques to enhance trustworthiness. These missing elements carry some importance and the authors should have provided this information.

For the mixed methods study, the MMAT was used.

- Rickwood, D., Van Dyke, N., and Telford, N. (2015)
    - Results of the 'Screening question' section
        - Mediocre: the authors do not present the study design as a mixed method design, but pose a research question that can be addressed using said design.
    - Results of the 'Qualitative methodology' section
        - Good: The authors use adequate sources, an appropriate analysis strategy and relate the results to the context.
    - Results of the 'Quantitative methodology' section
        - Good: the sampling strategy, type and number of participants are appropriate. However, it is unclear what the results of the measurements used by the authors are, as they only provide the results as means.
    - Results of the 'Mixed methodology' section
        - Good: this methodology is appropriate to answer the research question and the integration of quantitative and qualitative methods are relevant for this question, but the authors do not provide information on how this study design can limit the review or the results
    - Final results: Good, despite the absence of the presentation of this study as a mixed-method study.

- Patulny, R., Muir, K., Flaxman, S., and Oprea, I. (2013).
    - Results of the 'Screening question' section
        - Mediocre: the authors do not present the study design as a mixed method design, but pose a research question that can be addressed using said design.
    - Results of the 'Qualitative methodology' section
        - Mediocre: The authors use adequate sources and relate the results to the context. However, the analysis strategy and author's influence on participants is unclear.
    - Results of the 'Quantitative methodology' section

        - Mediocre: the sampling strategy and the participation rate are not provided. The authors do provide information on the type of participants that are in the study and which measurements they used.
    - Results of the 'Mixed methodology' section
        - Good: this methodology is appropriate to answer the research question, the integration of quantitative and qualitative methods are relevant for this question, and the authors provide information on how this study design can limit the review or the results
    - Final results: Mediocre. The authors not only did not present this study as a mixed-method study, but also lacked to provide enough methodological details in their report.

For the quantitative study, the EPHPP tool was used.

- Illback, R.J. and Bates, T. (2011). In this article, the authors do not present the study as a descriptive quantitative study. The article is mostly a demonstrative article. However, as a part of the article falls into the category of a 'descriptive quantitative study', that part has been assessed using the EPHPP tool.
    - Selection bias: moderate
    - Study design: Weak
    - Confounders: Weak
    - Blinding: Weak
    - Data collection methods: Weak
    - Withdrawals and drop-outs: Weak
    - Intervention integrity: NA
    - Analysis
        - Indicate the unit of allocation: NA
        - Indicate the unit of analysis: the individual
        - Are the statistical methods appropriate for the study design: yes
        - Is the analysis performed by intervention allocation status rather than the actual intervention received: NA

Overall rating: Weak.

As this article consists of 2 study designs, it cannot be discarded based solely one 1 part of the study being of weaker value. However, as the 'quantitative descriptions study' assessment is very weak, this part of the article will not be considered in the analysis of this review.

The 3 final articles found McGorry, P., Bates, T., and Birchwood, M., (2013), McGorry, P., et al (2007), and Practice Notes: Strategies in Health Education. Program: Youth opportunity centers health suites. (2004) will not be assessed.
These articles are neither quantitative or qualitative studies, as there are not based on any empirical data, nor do they answer any research question.
Although they seem to be 'expert opinion', they also do not fall into the category of 'grey literature' as they are published in journals[100]. As such, the term 'demonstrative article' is being used to describe them based on the definition of 'demonstrative studies': a study

that "looks at an information resource, exploring such issues as the resource's value to a certain professional group or its impact of the processes and outcome of healthcare, research and education"[102].
As previously stated, Illback, R.J. and Bates, T. (2011) consists of 2 parts, the first being a quantitative study and the second being a demonstrative article. Therefore, we consider the later as having some value despite the former having a 'weak' assessment score.

If we look at the all the needed criteria for the different studies found, we find that 2 are of good quality: Cyr (2012) and Rickwood, D., Van Dyke, N., and Telford, N. (2015) and the rest are of mediocre quality due to a lack of methodological clarity. As such, the validity, generalizability and transferability of results based on this data alone cannot be established with certainty.

3. Unfruitful concepts

After synthesising the results, we note certain elements missing from our search results.
In our PICO, we specified the following elements: youth of 14-25 years of age, immigrant, urban, organizational practices, clinical practices, the center in itself, the efficiency of the center, and the efficiency of the center in view of facilitating access to health care.
Our search results do not cover all sub-concepts. In fact, some sub-concepts are not present at all, as we had noted after performing a preliminary search.

The sub-concept of 'immigrant', which encompasses all notions of immigration, culture and multiculturalism, does not come through in the results. Only one document[41] specifies data on the New Zealand aboriginal population but as a sub-section of their report, not within their global analysis of the One-Stop shops of New Zealand as a whole.

The sub-concept of urban, which means to highlight the possible nuances between urban vs. rural setting, was not well represented. In most documents[41, 44, 51, 56, 59, 67, 68], the authors describe where the center is located and what strategies they used to facilitate its access. However, no data was found on how the location of the center has an impact on the organizational practices, the clinical practices, the efficiency of the center, or the efficiency of the center in view of facilitating access to health care.

Finally, the sub-concept of efficiency of the center in view of facilitating access to health care was not as explicitly described as we hoped it would have been. In some articles[41], the preoccupation of facilitating access to health care or even specifically mental health care was mentioned. In fact, some articles describe the center having this preoccupation as one of the reasons of the center creation[44, 59, 67, 68]. However, of these, none describe on which data they based the choice of strategy to address this need; which decreases the validity of their choice. Furthermore, most do not provide quantitative data to show the efficiency of their strategy[7, 41, 44, 51, 67, 68], which decreases the credibility of their choice.

4. Synthesised concepts

In view of the previous section, the thematic analysis is based on the following concepts: youth of 14-25 years of age, organizational practices, clinical practices, the center in itself and efficiency of the center.
Therefore, the themes emerging from the analysis will look at what are the clinical and organisational practices and characteristics of an efficient youth center for 14-25 years old.

5. Descriptive themes

The clinical descriptive themes found are: staffing/clinical titles, staffing characteristics/training/evaluation, activities offered (clinical and non-clinical) and clinical values of noted importance to some centers.

- Staffing consists of administrative and clinical staff. These positions are a reflection of the activities given on site but also a reflection on the needs of the population. Some articles describe each position in depth[37, 38], while others only give the titles of their present staff [39, 40] . We can see that there are always multidisciplinary teams at all centers[37, 39, 41, 42, 43, 44, 45], and a variety of sizes for the administration staff, from having only a receptionist[37] to enough support staff to need a project manager[42]. Some centers have volunteers (adults and youths[42]) and some emphasise the value/need of having peer support workers who can have simple support mandates[46] to being therapeutic group animators[41, 42, 44, 45, 47].
- Staffing characteristics/trainings are also important. Most staff, clinical and administration, is described as 'youth-friendly', respectful, passionate[48]. Some websites go into details about who their staff are to increase ease of contact with the young people should they want to come to their center[49]. Some youths described staff personalities and characteristics as being of critical importance[38, 41, 44]. If a youth does not feel comfortable from the first meeting, chances of him/her coming back are extremely low[47]. Staff trainings include initial training (md, nurse, psychologist, etc.) but also continuing education. This is primordial for keeping up with what is going on with this target population. Knowledge about how this population evolves is key to keeping them interested in coming back to youth centers[41, 44]. Society's values, stress factors, technology and even diagnosis and treatment options evolve over time[50] and staff needs to be up-to-date with these aspects to ensure that best quality care is offered.
- Activities can be divided into clinical and non-clinical.
    - Clinical activities, from a larger perspective are very homogenous: MD clinic, STI/sexual health clinic, health education workshops, individual and group support. However, each center has its own specificities, which

are reflections of its population's needs. Some have access to alternative medicines (massage therapy, acupuncture, chiropractic therapy[51]), some have creative therapies treatment options (art, drama, music, sports[42]) while some have more services dedicated to the LGBTIQ population[42]. Some centers also have a variety of different mental health services: social work[37, 38, 39, 41, 47], case manager[37, 42, 46], life coaches[43, 46], mentorships[41, 43, 46], support and therapy groups[37, 39, 41, 42, 43, 51], and FEPP screening clinics[42].

- Non-clinical activities are a reflection of the population's needs as well but also the location of the center and partnerships with other community resources. Some centers have access to gym equipment[39], soccer/baseball fields[51], some have access to recording/music studios or instruments[42, 43, 51, 52], which allows youths to have access to these activities for free or small cost[51]. Some have very established tutoring programs[39, 41, 42, 46, 53] and work apprenticeships[41, 42, 46, 54] either as partners with the community or as independent enterprises[42, 47, 55]. There are also those that have kitchen facilities, which allows either for staff to prepare food on site for youths, or encourage health cooking within a health workshop where youths can learn how to cook and have a healthy eating model[39, 44, 51]. Some have partnerships with libraries[37], increasing access to books and other resources.

- The list of activities is not exhaustive as youth centers have developed their clinical practice to continuously evolve and ensure quality activities. For most centers being studied, this task is part of the youth committee's mandate[37, 39]. This committee has different name: Youth Council[38, 56], Youth Advisory Panel[37], etc. But its role is to guide and ensure that the center is up-to-date in terms of youths' needs and remains pertinent within its purpose[47]. Some youth committee have very vague and wide mandates [41, 44, 47, 52] while some have more targeted roles[42], but this is a crucial part of an efficient youth center programming.
- Five clinical values have been qualified as essential when producing quality care: Compassion, Respect, Commitment to Integrity and Ethical Practice, Commitment to Excellence and Justice in Health[57]. These can be found in most of the studied centers descriptions[38, 41, 48, 56, 58, 59]. We also find empowerment[48, 60], inclusivity[48] and accountability[40]. Put together, these values, disseminated by the staff through activities offered ensure the highest level of respect of the attendees' needs.

The organisational descriptive themes are: opening hours/schedule, building design, location, youth participation, partnerships, research, marketing and outreach strategies and approaches/practices

- Opening hours are key when wanting to attract youths. Most centers offer a mixed schedule[37, 39, 41, 42]: most days have usual business hours (8h-16h or 9h-17h) and some days have extended hours, open up to 21h. Only 1 center of the review had opening hours on a Saturday, which was only for 1st meeting appointments already scheduled. Most centers that have these extended hours are opened 1 or 2 evenings per week, and it is for scheduled individual or group meetings. Drop-in times are mostly during the day and after school hours (until 17h) and not necessarily on all days[42]. Some centers have specific time/day slots allotted to drop-in times, these being well indicated on their websites[37]. On most websites, one can see when the schedule clinic hours are and when the support/therapy groups are (dates and times)[37, 42].
- The building design is an interesting factor as it has an impact on potential activities. Some centers are newly built, with certain activities in mind[46, 65]; some are older buildings transformed and adapted for its new purpose[42]. Others are in rented locations[42] making adaptation to future needs challenging. However, as sustainability is an important key to an efficient health service[38, 41, 44, 60], building design decisions may supersede proven or optimal clinical activity needs.
- Another factor is location of youth center. The same rationalisations can be made for the location as for the design, and all agree that physical accessibility to the building is primordial[38, 39, 41, 47, 48, 65]. Either by being central, close to public transport or having a shuttle service[37, 41, 42, 47], the center needs to ensure accessibility for its attendees. We also note that some centers are independent buildings [46], while some rent space within a bigger building for financial or capacity reasons [82]. In some of those instances, other resources are housed in the same building, increasing the accessibility of said resources[42].
- Youth participation can take up many forms. One form previously mentioned is the youth committee, which can have a mandate as clinical support to decision-makers. But, from an organisational point-of-view, it is necessary to see youth participation as part of the organisational structure, to see the youth committee as having a deciding voice/vote[38, 44, 47, 48, 56, 58], not just as a support/advisory committee. Youths can have clinical roles (peer-to-peer socialisation[41, 42, 46, 48], service design, organising events[41, 42, 44, 51]), but also organisational roles as committee members, building marketing design strategies, being center representative, etc. [41, 42, 46]. As the roles of youths within the center evolves, some centers have started training programs [46] where youths can be financially compensated for their time worked at/for the center[52], some have also started to define youth participation roles more specifically as some mandates need levels of maturity or implication time only suited for a certain group of youths[42].
- Partnerships with other community resources and other sectors are crucial. As each community is composed of different resources, specific partnerships are not to be

determined in this review, but some sectors of resources can be targeted: education/labor[38, 41, 43, 46, 47, 48, 52, 56], health[38, 43, 44, 46, 47, 48, 52], justice[41, 43, 46, 47, 52]. Each youth center has added value when links with the surrounding schools and health clinics work together to help their population[38, 41, 60]. Also, working with youth protection agencies and local police can prevent some youths from going into an unsafe or even criminal life trajectory[62].

- "Research": evaluation, surveys, focus groups, feedback, outcomes, indicators, and outputs. These concepts are part of ensuring quality care, efficiency and sustainability[38, 41, 47, 52, 60, 63]. "Research" can be as simple as a satisfaction survey[52, 64] or as elaborate as an evaluation framework strategy[38, 41, 44]. In any form, it is seen as a sign of respect given to these youths[56] and as an attempt to understand their needs[56]. As previously mentioned, continuous education for staff is key, and research and/or evaluation are some of the strategies that can be put into place for all staff members to ensure that youths' needs are being met and that decision-makers and budget allotment reflects the reality of these youth's needs[41].
- As technologies emerge, one must use creativity and innovations for marketing and outreach strategies. In fact, not having a website or a Facebook page can be seen as a deterrent[65]. Phone numbers are being specifically identified as either for calling or for texting, and some centers even specify a numbers of hours within which a text, email or Facebook message will be answered[37]. But, besides social media, most centers also promote their space at local schools and other community resources by either putting up flyers[37, 38, 40, 44, 47, 48] or by asking to have an allotted time spot within school hours to promote the center and some of the activities being offered[37, 38, 42, 44, 48]. Some try to attend events with big media coverage, making sure the center's logo is visible; some center representative are invited on local radio or TV-spots to promote the center[42, 44, 47].
- Organisational approaches or practices are a part of the building blocks for any enterprise. From this review, we found some targeted administrative aspects that decision-makers need to look at when implementing a center. These aspects do not make an entire category or fit into a previously described one, but are discussed in some fashion in most of the articles found.

a. Up to what level of care do we provide for our patients/clients[63, 66]? Some patients may need different intensity of care at the same time or may have too many needs to be seen strictly at a youth center. How this is addressed, and possibly coordinated, needs to be looked at. Some centers have taken time to create decisional flow charts[60, 63] to help orient the youth to the appropriate service and have devised a "service coordination" service or case management service to ensure that youths do not "fall between the cracks" of the health system[60].
b. Does the center need to have an initial screening of new patients/clients[38, 41, 44] and is this done with an intake worker or a regular staff? Can this be done on-line or only

with a face-to-face contact? As first contact is an important retention factor, this question needs to be carefully discussed by decision-makers and youths to ensure that the strategy used will not deter youths from seeking help for the center.

c. Services should be seen as holistic[38, 43, 47, 48, 56, 60, 67, 68]. Although our health care system separates mental health services from physical health service[15], youths should have the benefit of being seen as a whole. The youth center should not only addressed mental health and physical health[38, 41, 46, 48, 56, 67, 68], but also provide support if another institution is needed to care for one of these aspects[38, 41, 44, 47, 48, 52, 56, 59, 60, 67, 68].

d. Staff characteristics, staff training and staff evaluations have already been mentioned, but we also found that some studies[26, 37, 52] emphasise staff supervision and/or peer support. Even though youth centers are not seen as a traditional clinic milieu, staff may need time to discuss certain cases, give feedback to each other, have time to brainstorm about innovative ideas they may want to implement and devise plans to implement them, discuss any other program planning decisions or communications between center staff and other departments/other partners' staff.

e. Internal policies may need to be developed[44, 46, 65]. Depending on the different activities being offered, some youth centers have needed to create certain internal policies: for kitchen-based activities, or around the use of the pool table, or basketball courts, etc. Some have also been more specific and develop code of behaviours, dress code, values statement and the consequences the youth will be looking at if the center's rules are broken or disrespected.

f. Lastly, putting in place a governance committee. Most studies found[38, 41, 44, 47, 48, 56] mention this type of committee as being a key to ensure the credibility, transparency, sustainability and standards of care for a youth center.

6. Analytical themes

From these descriptive themes, analytical themes emerged. These themes answer the questions of who operates the center, what it offers, its accessibility, and the organisational practices used as the framework for the centers.

a. Who works in the center

There are 2 categories of people who make these youth centers operational: adults and youths. In the adult category, there are clinical staff, administrators, internal and external partners, consultants, etc. And in the youth category, there are youth committee members, youth peer support workers, youth volunteers and youths who participate in any of the research or evaluation activities.

Between these 2 categories, there needs to be easy, open and flexible communication and respect for each other's opinions/expertise. Therefore, the people who make up these 2 categories need to have certain qualifications, academically and

personally. In some countries, academic qualifications are not youth-targeted or youth-specific[69], but having previous experience working with young people is necessary when working in a youth center[41, 44]. Staff does not necessarily have much on-site support[41, 70], so feeling comfortable in an autonomous and independent work setting is vital. Passionate and compassionate[41, 44, 47], open to creativity and innovations[44, 47], respectful of others[41, 44, 47] and supportive[44, 47] are some of the personal traits found in all staff. Some youths note that it was the receptionist's welcome that convinced them to give the center a try[37, 42]. As for the youths who participate to operate the center, as they do not need any academic qualifications, motivation, non-judgemental attitude, and commitment are some of the personal qualifications looked for when being part of the youth committee for some centers[44], but for most, just being a youth is enough to participate in center operations[44, 47].

In terms of who the clinical staff are, most centers have MDs (part-time or full-time[37, 42]), nursing staff, counsellors[37, 39, 41, 42, 43, 44], but the specific staffing needs are a reflection on youths' needs, budget allotments but also partnerships (see Annexe 10 for complete lists). Some centers have 'borrowed' staff[41, 42]: a person working at a different institution comes to the center for a workshop or a number of clinic hours to offer a specific service that cannot be housed in the center due to budget or other management reason.

b. What is being offered

The 'what' is viewed by some youths as being the second main ingredient for a functional youth center[44, 46]. Some centers have focused their time and resources on offering more mental health support, while others have tried to balance clinical and non-clinical activities to ensure that as many youths would attend the center, not only those who feel they could benefit from support/counselling[51]. The complete list of activities found at the centers being reviewed can be seen in Annexe 10, but certain key aspects can be found throughout the list: interest, need, feasibility, sustainability.

- Interest for activities needs to be demonstrated from the youths' perspective, but also from the staff's perspective. When staff members are not interested in proposed activities, most likely it will not be put into place[41]. Putting together workshops or groups, clinical or not, takes many hours of work[71]. Interest of the animators is key for the activity to be successful in terms of outcomes of interest and appreciation. Decision-makers should make note of their staff's interest and remain flexible in their programming. Youth's interest can be solicited via research activities and communicated with staff/decision-makers via written communications or staff meetings.
- Interest must not be confused with need. Need for certain activities may come from a concern (health or social) and involves outcomes that reflect change. An example would be to create sexual health workshops to address an increasing

number of teen pregnancies[72] or, allow for drop-in time with direct access to a counsellor/therapist to facilitate access to more intensive mental health services[38, 47, 60].

- Feasibility and sustainability are also 2 close concepts. Putting in place a needed and interesting activity is good, but sustaining it over time is better[41]. Having appropriate resources, through staff, budgets and partnerships to put in place an activity is the basis. Using research, we can provide data to show how these activities perform using outcome measures that are of importance to decision-makers, creating justification of sustainability of said activity.

c. Accessibility

Accessibility includes location and design but also activity schedules and social media access.

"Being central" and "having easy access through public transportation" are fairly common descriptors when discussing accessibility strategies. One study also mentioned that it was requested by the youth attending the center to not be so central that people would notice if a youth walked into the clinic and so, it was requested that the clinic be moved to a less obvious location[47]. Despite having an attractive and 'cool' logo and brand, need for confidentiality and fear of stigma were more important[47]. Some centers have even refrained themselves from putting a sign outside their building to ensure most confidentiality and respect of privacy for their attendees[46].

As our target population are youths, school and work schedules come into play when looking at scheduling decisions. Having most requested activities during school hours may not be strategic, but having drop-in hours during the day may allow for youths suffering from stress or mental health issues, not able to go to school to come to the center instead and work on their recovery.

In today's world, youths are used to living a part of their lives in a virtual world[73]. Having access to youth centers services through their websites or social media platforms has become an increasing necessity[73]. From having a website where all activities information is posted, to putting up pictures on Facebook of a past event or using twitter to ask for feedback, social media can help to encourage youth participation and youth empowerment, building confidence and autonomy. It can also be used as a platform to share information about life stressors[37, 42] or illnesses[37, 42] and provide lists of other helpful local resources[37, 42]. Some centers are implementing technology in their intake process[37] and some are looking to implement on-line counselling services[42] for youths who cannot or prefer to interact through technologies.

d. Organisational framework

Organisational strategies can be simple or complex[38, 63], but should reflect the outcomes being assessed by the youth center. After analysing who should do what and

where, outcomes are the last piece of the implementation equation. Some centers have based their organisational framework on more medical/health outcomes[41]. They choose the Hardiker Framework[74] as a reflection of a populational approach, and as a guide to ensure that they would include as much of their target population as possible in their services. Some centers have chosen to start with needs assessment and built their centers using a more objectives-driven framework[65]. In any case, certain qualities are emphasised: ease of access, flexibility, respectfulness, confidentiality, and inclusiveness. From an organisational point-of-view, these values can be translated to concrete practices.

- Ease of access refers to minimising the number of steps, including paperwork, phone calls and face-to-face meetings, that youths need to go through before accessing the desired or required service.
- Flexibility refers to opening hours but also choice of activities or services, choice of counsellor, choice of frequency of service or level of participation.
- Respect refers to personal choice in values, religious and cultural choices, in school or employment situation, in sexual identity and orientation. Respect as an organisational practice implies that the center allows for these individual characteristics to not interfere in the youth's ability to participate or to have access to services.
- Confidentiality is part of any clinical setting but fear of stigma and of judgement by others is particularly present for youths[44, 60]. This needs to be considered when deciding on building design, which services will be offered and when. Having a waiting room for counselling services next to a room designed for social gatherings is not optimal for confidentiality.
- Inclusiveness and its promotion are important attraction strategies. Ensuring that no youth get turned away or are told the center is not a place for them opens the possibility for other youths to perceive the center as being unwelcoming, judging and that it doesn't understand youths' needs.

7. Valuable opportunities

This review looks at many qualitative outcomes. However, some studies mention qualitative factors that, although are consequences of the center's operations, are seen as opportunities.

- Understanding and acceptance of treatment: youths have been known to have difficulty understanding their life experiences, as much the positive as the negative aspects. Therefore, understanding what they are going through can be challenging[44, 60]. By attending non-clinical activities, youths have the opportunity to socialise with peers and adults and to begin to understand that they may not be alone in the distress and/or that it is not "ok" to feel such distress. Also, they have

an opportunity to understand what support actually is. For some communities, demystifying "services" can become an important service provided by the youth center.

- Mentorships: having access to appropriate role models can be, in itself, a very powerful therapeutic influence[38, 41, 44, 46], helping with self-esteem, self-respect, and self-accomplishment. For some communities, poverty and lack of education is very present. The staff at the youth center can be called upon as important role models, coaches, mentors and even advocates for the attendees.
- Fighting stigma: the more youths are understanding of mental health and mental ill health and how to help one-self, the more stigma will whither. The combination of peer-support and inclusiveness is, therefore, helping to decrease mental health stigma.
- Family involvement: by nature, youths are in a developmental stage when they want to increase their independence from their family. But knowing that families are welcomed to contact staff members and even participate in some activities themselves, it may help for family dynamic interventions and also may reassure families that the center is a trustworthy place.

8. Limitations

As this review is a RR, limitations due to time and resource allocation were a deciding factor when looking at the scope of this review. Therefore, we can speculate that more data could be found on this subject if time had allowed for a more thorough search and for broadening of the search terms, as the terms 'youth center' and 'first-line services' can reflect a wide array of definitions depending on which country and region being studied. Reference lists were not searched to verify if other pertinent articles could be found.

Also, due to the selection process, critical appraisal and extraction processes being done by one researcher, one can also say that methodological rigour may be questioned which can lead to questioning the credibility of the findings.

As our review consists more in looking at the centers/models' characteristics, other sources were found to complete the data extraction process (see Annexe 5). Consequently, this process may have been based more on the other sources than on the original article found. As such, the quality of the original articles ends up being less important than they could be in other reviews.

DISCUSSION

After synthesising the results found, we need to assess their applicability to different contexts. As such, the following sections describe some concepts that decision-makers should take in consideration when applying the results to their context.

1. Definition of efficiency and outcomes of interest

The outcomes used as search criteria were decided upon as a reflection of what defines, in the decision-makers point of view, an efficient youth center. First, the attendance rate, the appreciation and impact of the center on quality of life, these outcomes reflect the center's ability to attract and retain youth. This could be enough to define efficient, but in our review we also added the ability to link youths attending the center to appropriate health services, either on-site or as external partners. As such, the articles found were coherent with this definition. However, as some youth centers have different preoccupations, the outcome measures may differ. Some look at the attendance rates/appreciation only, or school re-integration[46], or youth crime rates[62] as main preoccupations of their youth population. In the selection process of our review, many articles were excluded due to different outcomes measured. This leads us to conclude that the data found and analysed are focused more on the outcomes we are looking at, which increases the credibility of this review.

2. Reach

As the youth center is not strictly a medical clinic, the clinical indication for attending the youth center is: to be any youth who wishes to participate in any activity offered.

As such, measuring the attendance rate and participation rate will allow us to see how many youths come to the center. However, in our introduction, we state that the youth center being implemented is an innovative way to facilitate access to health services. It remains unclear, and up to the decision-makers to ensure research activities to measure the actual number and the characteristics of youths who, without attending to youth center, would and would not have benefited from the usual pathways of care. Also, it would be interesting to measure who, despite going through the usual pathways of care, would be attending or recommended to participate in the center's activities.

3. Impact of the technology on health services

From the population perspective, the point of the center is to create a new entry point to services, to facilitate access to different services and to receive help to navigate through the health system, should it be necessary. We predict that the youth center would

be seen as a welcomed addition to the range of services already being offered. From the institution point of view, this creates a new level of care, which allows for the less severe cases, short-term cases, and promotion of health/prevention of illness to be dealt with in another setting. This allows for waitlist for specialised care or for GPs to decrease. This leads to appropriate prioritising of cases waiting to be seen by those services. The same can be said for the societal point-of-view with the plus that it would decrease cost for services for this population, once the initial costs to open the center were covered.

4. Implementation issues

Building design and location have previously mentioned as being important. But we also find that having access to proper equipment may come into play as retention and appreciation strategies. Examples of this could be: computer and internet access[39, 42, 44, 46, 65], video game consoles[39, 42, 44], furniture (chairs, sofas)[41, 42, 43, 44, 52], pool/Ping-Pong tables or access to sports equipment (basketball, soccer balls)[42, 44, 46, 65], kitchen[46], laundry[52], etc.

Another issue is staffing. As this center is going to be part of a service offer of a bigger institution, where staff is being hired from needs to be looked at: will positions be offered to already hired staff, will staff in place be expected to include time spent at the youth center, will new staff be hired? These questions can be asked for management staff as well: will this center be part of a bigger department; will it be managed separately from other services?

Lastly, as this center will be part of a publicly funded institution, all patients being offered services in this institution must have files kept where all services being provided are being tabulated. As such, decision-makers need to look at how files will be created and managed, what information needs to be kept and if all youths attending the center need to have a file. Also, for accountability purposes and statistical analysis, data from active files needs to be uploaded in an intervention database. As such, decision-makers need also to look at how and which data from which youth needs to be uploaded in the logistic system.

5. Procedural issues

As empowerment and leadership are encouraged, youth participation in decision processes is expected and desired. Youth participation, flexibility and respect are seen as key factors in an efficient youth center. But this shouldn't impede the right to privacy or confidentiality of the attendees. Also, this should be taken into consideration within the accepted and possible limitations of the center and its service offer, and be part of an active communication between youths and decision-makers.

Also, as our target population is 14-25 years old, any legal need for parental consent to services is circumvented. Even if parental involvement can be beneficial to youths[38], it is not mandatory.

6. Ethical issues

The right to quality medical care is a fundamental right[75]. Knowing that there are, for youth services, months on waitlists to have access to mental health services, including psychiatric assessments[75] is not acceptable.

The youth center envisioned by decision-makers address ethical values such as 'beneficence' but also 'non-maleficence' since going to the center will allow to have access or help to access service, and even only attending activities can benefit youths while fighting stigma, isolation and creating a positive place in the youths' life. It also allows for 'respect for autonomy' as the youths will not be forced to undertake a certain service pathway, but allowed flexibility and choice through youth empowerment.

It also addresses equity issues. The usual pathways to services are previously described as either: going through the ER, to the GP or finding a private service. All of these options need a certain amount of time or money. For families in our designated neighbourhood, time and money can be scarce[17], jobs are precarious and understanding the health system can be non-existing[76]. Consequently, waiting 12 hours at the ER, or months to see the GP when one is available to you, or spending 100$ per hour for private services are not feasible options. Going to the youth center can help to overcome these obstacles.

Other aspects not yet mentioned are the language and cultural issues. In the introduction, we mention that the designated neighbourhood is very multicultural and so many youths of this neighbourhood speak 2 or 3 languages[17]. Understanding the cultural background and speaking the youths' preferred language could facilitate therapeutic alliance[41, 44, 70]. Staffing and scheduling should be flexible enough to allow for these to be taken in consideration, should they need to be.

7. Generalizability of Findings

Due to search parameters, we can think of 3 different ways in which we question generalizability.

a. Age: can the results be applicable to other age groups? If we look at a younger population, due to developmental stages and levels of maturity, a younger age group may not have the capabilities as youths and as such may not appreciate the clinical and organisational structure. An older age group may benefit from these results but as 'adults' already have most of the health care structure and societal structure to their benefit, this would be a moot analysis. The 'older adult' age group is a new and

developing group[77] and as such they may have some interest in having older adult targeted services.

b. Culture: the centers studied are mostly western or developed countries with some aboriginal population within the country. One article (a review of many centers) does have details pertaining to its aboriginal population but not in view of our outcomes of interest.
c. Outcomes: as our review looked at centers that have components of clinical practice, educational support and leisure activities, we can say that these results can be used for centers that look at all or some of the same outcomes.

8. Transferability of findings

In this review, we have highlighted the need for youth participation and community partnerships. As such, the themes revealed by this review are transferable to other settings but an added step of applying the themes to the local level is needed. We would argue that to optimise youth satisfaction and retention to the local youth center, one should not expect to have a very detailed list of findings after such a review, as it would undermine the individuality of the local community. However, as all of the youth centers studied in this review have strong youth participation, we believe that the themes revealed remain pertinent for any youth population. Therefore we find that this review's findings are as transferable as one could find within the scope of this RR.

9. Impact of unfruitful concepts

As previously stated, the search for some concepts was unsuccessful. However, all stakeholders agreed upon their potential importance within this review and the context of the target population. As such, the lack of these concepts within our search results and the restraint amount of literature found leads us to believe that this type of research is at its beginning. Therefore, we can speculate that the unfruitful concepts should be looked at as primary research projects in view of further analysis to assess their potential impact.

The notion of culture, in this case, encompasses two meanings. The first meaning is the culture of the youth attending the drop-in center: how do the people of this culture view this type center? How do they view health care? The second meaning is linked to immigration status of the families: how do they feel about allowing their youth to go to a local drop-in center? How do they understand having access to free health care?

The notion of geographical location implies looking at the consequences of the location of the center in view of different outcomes. Examples of this can be: the difference in costs of accessibility strategies, of staff availability, of clinical practice of a rural vs. an urban center. It could also be: the difference in choice of strategy to facilitate

access to other health care services in relation to geographical setting, i.e. is being close to other services facilitating or hindering developing privileged access to other services?

The last unfruitful concept is the efficiency of the center in view of facilitating access to health care. The quantification of this idea would facilitate creating evidence that this type of center is worth its development and the costs to do so. But, as with the other concepts, one would want to have some notions about the associated considerations: are all facilitating strategies as efficient? Is efficiency defined similarly in all centers? Are the strategies based on youth preferences or administrative/management needs?

10. Knowledge Gaps

In addition to the unfruitful concepts previously described and in view of the research question, we note a few additional knowledge gaps, specifically in terms of the target population:

- The difference in genders. What is more targeted and appreciated by young men vs. young women? And is gender an important variable in activity program and for which outcomes of interest?
- This leads us to wonder about the LGBTIQ population. Some studied centers[41, 42] mention having support groups targeted to help this population, or other activities to help fight stigma around sexual identity and orientation. More studies would be needed to see how to better help this community within the youth population.
- Religious differences. Differences in cultural background and respect of cultural heritage have been mentioned, but how to ensure religious expression within a youth center would need further assessment.
- Double cultural identity. Some youths, born in Canada but with parents born in another country, can be considered to have 2 cultural identities. Managing that adaptation can be quite challenging for some youths. How this interacts with health issues would be interesting to look at within a youth center context.

11. Study limitations

As previously mentioned, the research protocol methodology itself had some limitations: the number of databases, the extent of the literature review and the number of researchers. But we also found other study limitations.

Due to the lack of experience of the librarian in searching for this type of qualitative data, keywords and MeSH terms used may not cover all pertinent terminology and as such may lead to miss articles.

Due to time limits, the data extraction process was not optimally completed, i.e. centers were not contacted directly to complete data on specific center traits.

FINAL OBSERVATIONS

As we have seen, the definition of an 'efficient youth center' is linked with definitions of cultural background, youths' needs and beliefs and managers' beliefs and restrictions about the role of the center, we found that the same variable can facilitate or hinder the implementation process. Therefore, we state these final observations as key points to take into consideration during the implementation process.

Clinical observations

a. Choosing the right staff, as previously described (personal and professional characteristics, past experience)

b. Allowing for "borrowed staff" (from internal or external partners) or for attendees to have privileged access to partner organisations

c. Optimising work conditions (continued education, appropriate ratio, and peer support/supervision)

d. Building clinical activity programming based on present needs of decision-makers and on youth health concerns

e. Building non-clinical activity programming to reflect youth's needs and desires to the extent that the building design and location can allow, and with the available local partnerships

Organisational observations

a. Putting in place a governance board

b. Putting in place a youth committee with decisional power and define its mandate, to be reviewed if necessary

c. Having clear a statement about youth participation options

d. Having clear a statement about type and level of health care being offered at the center

e. Establishing local partnerships with other health institutions, local school and school boards and with local police and/or youth protection agency.

f. Allowing for flexibility within clinical activities (frequency of visits, face-to-face and on-line interventions, text reminders)

g. Allowing for flexibility in programming of non-clinical activities (open groups, no minimum number of attendance to a group unless specified)

h. Allowing for creativity and spontaneity in programming to maximise motivation and interest of staff and youths

i. Having dedicated days/times for drop-in time, for clinical meetings and for group activities

j. Having at least 1 day open until evening hours

k. Minimising the number of steps and the time to access the needed to appropriate service

l. Developing the intake process in view of youths' and decision-makers' needs

m. Having appropriate on-site equipment for staff and for youths

n. Developing youth-friendly and optimally youth-based marketing strategies, including social media and on-line forums

o. Developing a social media presence using logo/brand

p. Having easy access to information about center's programming and other useful information such as staff descriptions or health information

q. Developing youth-friendly research activities

CONCLUSION

The design of the present health system, particularly youth services, is not optimal: long waitlists or wait times, short staffed, medical buildings.

Like most of the models studied in this review, the idea is to create a youth center that is designed with one of its purposes being to facilitate access care and health services. And so, considering the final observations made, one should be able to optimally design a youth center, a new pathway to care, specifically for its neighbourhood's youth population. As such, one could say that designing youth centers in this fashion would allow the decision-makers to reflect on what should be the new standard of care for this target population needing less or no specialised care.

It would be interesting, for future research to look at gender, sexual identity and cultural background differences and how these aspects could help better target service offer at youth centers. We also need to look at cost-efficiency strategies in view of the geographical location of the center, youths' preferences and youths' needs for other health care services.

As this new pathway does not come to replace the other pathways, further research should be done to assess the complimentary aspects of these pathways and how to ensure optimal communications between them. This could be seen as a crucial part of health care service planning as symptom progression for mental health pathologies, for this population, is not predictable nor does it understand the concept of waitlists.

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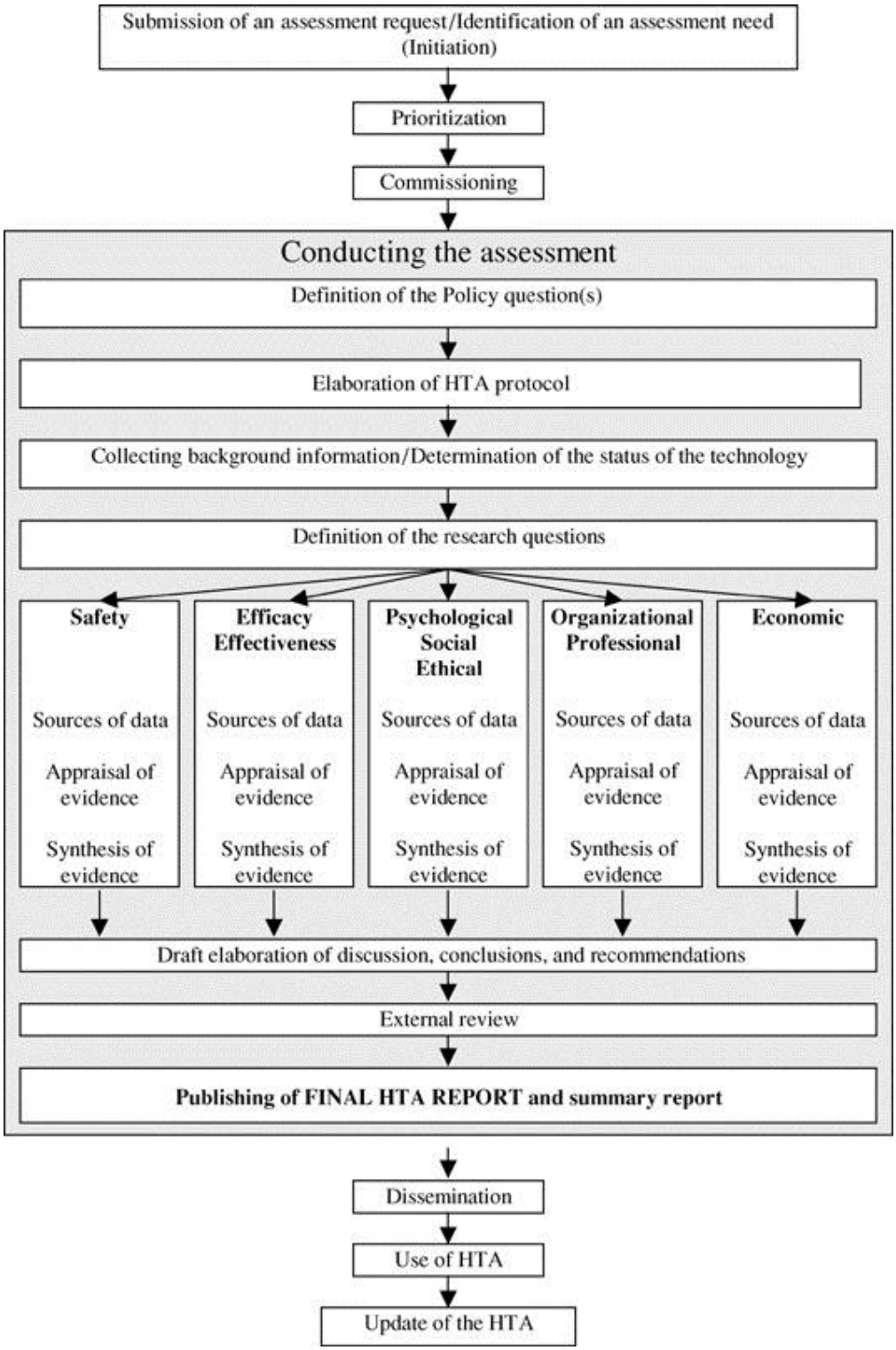
ANNEXE 1: Definitions

Activity[80]	A pursuit in which a person is active. This can be as an individual or as a group. It can be clinical, educational or for leisure (structured or unstructured).
First line services[78]	They are all services that address common health issues. They offered to a large number of people and are dispensed directly to community members. According to the World Health Organisation (WHO), these are primary care services at affordable cost, accessible to all and with full participation of the community. In our report, this also refers to 'community-based care'.
Youth[79]	It is best understood as a period of transition from the dependence of childhood to adulthood's independence and awareness of our interdependence as members of a community. 'Youth' is a more fluid category than a fixed age group. The United Nations, for statistical consistency across regions, defines 'youth', as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States.
Youth center[45]	It is a safe meeting place where young people can hang out with their friends, chat, drink coffee or soft drinks, watch TV or movies, or surf the Internet. Also, it can have a variety of recreational and educational activities, chosen by the young people themselves, plus information on State and local services of interest to young people. The activities or programmes in this kind of café are usually developmental and/or community-focused. It can as well include a range of specific services, directly designed for young people. These might include, for example, education and training, healthcare information (both physical and emotional) and direct targeted assistance.

ANNEXE 2: Schematic assessment process



ANNEXE 3: Literature Search Strategy

3.1 Medline

Database: Ovid MEDLINE(R) <1946 to July Week 3 2015>
Search Strategy:
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1 exp Community Health Nursing/ec, ma, mt, og, st, sn, sd, td, ut [Economics, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (7990)
2 Counseling.mp. or Counseling/ (71263)
3 exp Social Work/ec, ma, mt, og, st, sn, sd, td, ut [Economics, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (4607)
4 nursing.mp. or Nursing/ (456752)
5 intervention*.mp. (584431)
6 (clinical adj2 best adj2 practice*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (329)
7 health care.mp. (580013)
8 (health adj2 care adj2 service*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (11356)
9 psychoeducat*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (2587)
10 psychosoc*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (61959)
11 social service*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (7733)
12 "Delivery of Health Care"/ec, eh, ma, mt, og, st, sn, sd, td, ut [Economics, Ethnology, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (39038)
13 (adolescent adj2 friendl*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (88)
14 (youth adj2 friendl*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (158)
15 (teen* adj2 friendl*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (16)
16 exp Health Planning/ec, ma, mt, og, st, sn, sd, td, ut [Economics, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (95981)
17 exp Community-Institutional Relations/ec, mt, st, td [Economics, Methods, Standards, Trends] (756)

18 exp Public-Private Sector Partnerships/ec, og, st, sn, td, ut [Economics, Organization & Administration, Standards, Statistics & Numerical Data, Trends, Utilization] (471)
19 exp Social Participation/ (792)
20 exp Consumer Participation/ec, mt, og, px, st, sn, td, ut [Economics, Methods, Organization & Administration, Psychology, Standards, Statistics & Numerical Data, Trends, Utilization] (6835)
21 (adolescent* adj2 participat*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (1112)
22 (youth adj2 participat*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (450)
23 (teen* adj2 participat*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (90)
24 implement*.mp. (241935)
25 exp Health Plan Implementation/ec, mt, og, st, sn, td, ut [Economics, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Trends, Utilization] (1606)
26 exp Efficiency, Organizational/ec, st, sn, td [Economics, Standards, Statistics & Numerical Data, Trends] (2742)
27 effectiv*.mp. (1193488)
28 exp "Organization and Administration"/ec, mt, og, st, sn, td [Economics, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Trends] (293742)
29 exp Adolescent Health Services/ec, ma, og, st, sn, sd, td, ut [Economics, Manpower, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (2989)
30 exp Health Services/ec, ma, mt, st, sn, sd, td, ut [Economics, Manpower, Methods, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (488274)
31 exp Community Health Services/ec, ma, mt, og, st, sn, sd, td, ut [Economics, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (200180)
32 exp Health Services Accessibility/ec, og, st, sn, td, ut [Economics, Organization & Administration, Standards, Statistics & Numerical Data, Trends, Utilization] (29525)
33 access*.mp. (328075)
34 accessibility.mp. (78101)
35 exp "Referral and Consultation"/ec, ma, mt, og, st, sn, td, ut [Economics, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Trends, Utilization] (17086)
36 refer*.mp. (703563)
37 attend*.mp. (114530)
38 rural.mp. (113646)
39 exp Rural Population/ (42386)
40 exp Rural Health/ (21987)
41 homeless.m_titl. (3327)
42 exp Hospitals/ (215348)
43 exp Hospitals, Pediatric/ (9656)
44 medical clinic.mp. (1218)
45 (teen* adj3 center*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (79)

46 (adolescen* adj3 center*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (278)
47 (youth adj3 center*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (229)
48 (young adj1 adult* adj3 center*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (22)
49 (youth adj3 program*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (1201)
50 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 (1737226)
51 exp Human Activities/ec, ed, px, st, sn, td [Economics, Education, Psychology, Standards, Statistics & Numerical Data, Trends] (36888)
52 exp Leisure Activities/ec, px, td [Economics, Psychology, Trends] (10594)
53 1 or 2 or 3 or 4 or 5 or 6 or 8 or 9 or 10 or 11 or 31 or 51 or 52 (1295328)
54 exp Primary Health Care/ec, ed, ma, mt, og, st, sn, sd, td, ut [Economics, Education, Manpower, Methods, Organization & Administration, Standards, Statistics & Numerical Data, Supply & Distribution, Trends, Utilization] (42942)
55 32 or 33 or 34 or 35 or 36 or 37 (1117408)
56 (young adj1 adult* adj3 program*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (147)
57 (adolescent* adj3 program*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (2214)
58 (teen* adj3 program*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (484)
59 45 or 46 or 47 or 48 (597)
60 49 or 56 or 57 or 58 (3892)
61 one-stop shop*.mp. (325)
62 (youth* adj3 organization*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (158)
63 50 or 53 or 60 (2735709)
64 59 or 61 or 62 or 60 (4888)
65 "vaccin*".m_titl. (121180)
66 exp Occupational Health/ (26363)
67 emergency.mp. (200034)
68 "prison*".m_titl. (6380)
69 Reproductive Health/ or Pregnancy/ (725795)
70 transition.mp. (162734)
71 school-based health.mp. (631)
72 medical home.mp. (1595)
73 38 or 39 or 40 or 41 or 42 or 43 or 44 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 (1519855)
74 weight.m_titl. (72615)
75 obesity.m_titl. (50942)

76 asthma.m_titl. (64174)
77 injury.m_titl. (143312)
78 cancer.m_titl. (617954)
79 residential.m_titl. (5501)
80 ten-state.m_titl. (17)
81 screening.m_titl. (104954)
82 contraceptive.m_titl. (11734)
83 smoking.m_titl. (46075)
84 voucher.m_titl. (128)
85 harm.m_titl. (4763)
86 detention.m_titl. (659)
87 randomized.m_titl. (86395)
88 "vaccin*".m_titl. (121180)
89 immunization.m_titl. (22703)
90 occupational health.m_titl. (4871)
91 emergency.m_titl. (57789)
92 "health nurse*".m_titl. (3235)
93 30 or 53 or 54 (1551934)
94 (("14" or "15" or "16" or "17" or "18") adj1 years old).tw. (13716)
95 exp Adolescent/ (1689850)
96 94 or 95 (1692744)
97 (("19" or "20" or "21" or "22" or "23" or "24" or "25") adj1 years old).tw. (7938)
98 exp Young Adult/ (442839)
99 97 or 98 (448987)
100 96 or 99 (1895902)
101 93 and 100 (218986)
102 29 or 101 (219357)
103 50 or 60 (1739466)
104 100 and 103 (185161)
105 102 or 104 (346558)
106 55 and 64 and 105 (820)
107 limit 106 to (yr="2000 -Current" and (english or french)) (529)
108 107 not 73 (383)
109 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86 or 87 or 88 or 89 or 90 or 91 or 92 (1364222)
110 108 not 109 (284)

3.2 CINAHL

[(((("youth* program*" OR "young adult* program*" OR "adolescent* program*" OR "teen* program*" OR MH "Nurse-Managed Centers/AM/EC/EV/MA/MT/OG/PF/ST/SN/TD/UT OR MH "Health Care Delivery+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR MH "Health Care Delivery, Integrated/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR "adolescen* N2 friendl*" OR "youth friendl*" OR "teen* friendl*" OR """health planning""" OR MH "Health and Welfare Planning+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR MH "Community-Institutional Relations/AM/EC/EV/EH/MA/MT/ST/SN/TD/UT OR """public private partnership*""" OR MH "Social Participation/EC/EH/EV/PF/ST/SN/TD/UT" OR MH "Consumer Participation/AM/EC/EV/MA/MT/PF/ST/SN/TD/UT" OR ""teen* participat*" OR ""adolescent* participat*" OR implement*; MH "Program Implementation/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR ""health plan implementation"" OR MH "Organizational Efficiency+/AM/EV/EC/MA/MT/ST/SN/TD/UT" OR MH "Clinical Effectiveness/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR MH"Management +/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR effectiv* OR MH "Community Health Nursing+/AM/EC/EV/MA/MT/ST/SN/TD/UT OR MH "Counseling+/AM/EC/EV/MA/MT/PF/ST/SN" OR "counseling" OR MH "Social work+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR MH "Nursing process+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR "intervention*" OR ""clinical best practice"" OR ""health care"" OR ""health care service*" OR "Psychoeducation/AM/EC/EV/MA/ST/SN/TD/UT" OR psychosoc* OR ""social service*" OR MH "Community Health Services+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR MH "Human Activities/EC/ED/PF/ST/SN/TD/UT" OR MH "Leisure Activities+/EC/PF/ST/SN/TD/UT/EV" OR MH "Social Work Practice/AM/EC/EV/MA/MT/ST/TD/UT" OR MH "Health Services+/AM/EC/MA/EV/MT/PF/ST/SN/TD/UT" OR MH "Primary Health Care/AM/EC/EV/MA/MT/ST/SN/TD/UT") ET (MM "Young Adult" OR MH "Adolescence")) OR MH "Adolescent Health Services/AM/EC/MA/MT/PF/ST/SN/TD/UT"))) **ET** (""one-stop shop*" OR ""youth* organization*" OR ""teen* center*" OR ""adolescen* center*" OR ""youth* center*" OR ""young adult* center*" OR ""youth* program*" OR ""young adult* program*" OR ""adolescent* program*" OR ""teen* program*" OR MH "Nurse-Managed Centers/AM/EC/EV/MA/MT/OG/PF/ST/SN/TD/UT) **ET** (MH "Health Services Accessibility+/AM/EC/EV/MA/MT/ST/SN/TD/UT" OR access* OR accessibility OR MH "Referral and Consultation+/AM/EC/EV/MA/MT/ST/SN/TD" OR refer* OR attend*)) **SAUF** (rural OR MH "Rural Population" OR MH "Rural Health" OR TI homeless OR MH "Hospitals+" OR MH "Hospitals, Pediatric" OR ""medical W1 clinic"" OR TI vaccin* OR MH "Occupational Health+" OR emergency OR prison MH "Reproductive Health" OR MH "Pregnancy+" OR transition OR school-based health OR ""medical W1 home"" OR MH "Reproductive Health" OR MH "Pregnancy+")) **SAUF (**TI weight OR TI obesity OR TI asthma OR TI injury OR TI cancer OR TI residential OR TI ten-state OR TI screening OR TI contraceptive OR TI smoking OR TI voucher OR TI harm OR TI detention OR TI randomized OR TI vaccine OR TI immunization OR TI occupational health OR TI emergency OR TI health nurse)] *Limites* (placées avant le premier SAUF : 2000-01-01/2015-07-31; anglais, français)

3.3 PsychInfo

1. Adolescent development/
2. Adolescent attitudes/
3. Adolescent psychology/
4. Adolescent psychotherapy/
5. At-risk population/
6. College student/
7. High school students/
8. Predelinquent youths/
9. youth.mp
10. Cultural sensitivity/
11. immigrant.mp
12. Minority groups/
13. Immigration/
14. Multiculturalism/
15. Racial and ethnic differences/
16. Racial and ethnic groups/
17. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16
18. urban.mp
19. Urban environments/
20. 18 OR 19
21. Clubs (social organisation)/
22. Community mental health services/
23. Community Services/
24. Crisis intervention/
25. Crisis intervention services/
26. Day care centers/
27. Community Facilities/
28. Health care services/
29. Intervention/
30. Mental Health Programs/
31. Mental Health Services/
32. Outreach Programs/
33. Peer Counselling/
34. Self Help Techniques/
35. Social Support/
36. Support Groups/
37. Walk-in Clinics/
38. youth center.mp
39. Community mental health centers/
40. Community mental health/
41. Community involvement/
42. Community development/
43. Health promotion/
44. Health care seeking behaviour/
45. 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44
46. Best practices/
47. Client Education/
48. Clinical Models/
49. clinical best practices.mp
50. Clinical practice/
51. Community counselling/

52. Counselling/
53. Counsellors/
54. Crisis Intervention/
55. Crisis intervention services/
56. Cross-Cultural Counselling/
57. Early Intervention/
58. Educational Therapy/
59. Evidence Based Practice/
60. Extracurricular Activities/
61. Government Programs/
62. activies.mp
63. counselling.mp
64. Education/
65. health care services.mp
66. Health care services/
67. intervention.mp
68. Intervention/
69. Models/
70. good practices.mp
71. Group Counselling/
72. Group Intervention/
73. Health Care Delivery/
74. Health Care policy/
75. Integrated services/
76. Interdisciplinary Treatment Approach/
77. Mental Health Programs/
78. Mental Health Services/
79. Multicultural Counselling/
80. Multimodal Treatment Approach/
81. Outreach Programs/
82. Peer Counselling/
83. Psychoeducation/
84. psychoeducation.mp
85. Quality of Services/
86. Self Help Techniques/
87. Self-Referral/
88. Sex Education/
89. Social Casework/
90. Social Group work/
91. social services.mp
92. Social services/
93. Support Groups/
94. Therapeutic Processes/
95. Treatment Guidelines/
96. Professional Standards/
97. psycho*.mp
98. services.mp
99. Treatment/
100. Health service needs/
101. Social Program/
102. youth services.mp
103. best practices.mp
104. 46 OR 47 OR 48 OR 49 OR 50 OR 51 OR 52 OR 53 OR 54 OR 55 OR 56 OR 57 OR 58 OR 59 OR 60 OR 61 OR 62 OR 63 OR 64 OR 65 OR 66 OR 67 OR 68 OR 69 OR 70 OR 71 OR 72 OR 72 OR 73 OR 74 OR 75 OR 76 OR 77 OR 78 OR 79 OR 80 OR 81 OR 82 OR 83 OR 84 OR 85 OR 86 OR 87 OR 88 OR 89 OR 90 OR 91 OR 92 OR 93 OR 94 OR 95 OR 96 OR 97 OR 98 OR

99 OR 100 OR 101 OR 102 OR 103
105. Best practices/
106. Business Management/
107. Clinical Models/
108. Clinical Practice/
109. Collaboration/
110. Community mental health services/
111. Government Policy Making/
112. active participation.mp
113. active participation in center-programming decisions.mp
114. administration.mp
115. Business Organisations/
116. Community Facilities/
117. Decision Making/
118. Health care services/
119. Innovation/
120. management.mp
121. Models/
122. Organisations/
123. Health Care Administration/
124. Health Care delivery/
125. Health care policy/
126. Implementation.mp
127. Management/
128. Management decision-making/
129. Management Methods/
130. Marketing/
131. Mental Health Program Evaluation/
132. Mental Health services/
133. Outreach Programs/
134. Participation/
135. partnership.mp
136. Program development/
137. Self-Managing Work Teams/
138. Strategies/
139. Transportation/
140. Program Evaluation/
141. Treatment Barriers/
142. best practices.mp
143. 105 OR 106 OR 107 OR 108 OR 109 OR 110 OR 111 OR 112 OR 113 OR 114 OR 115 OR 116 OR 117 OR 118 OR 119 OR 120 OR 121 OR 122 OR 123 OR 124 OR 125 OR 126 OR 127 OR 128 OR 129 OR 130 OR 131 OR 132 OR 133 OR 134 OR 135 OR 136 OR 137 OR 138 OR 139 OR 140 OR 141 OR 142
144. efficiency.mp
145. referral rates.mp
146. Professional referral/
147. Participation/
148. Integrated Services/
149. Health Care utilisation/
150. Health Care services/
151. Group participation/
152. effectiveness.mp
153. Client satisfaction/
154. Client participation/
155. attendance to the center.mp
156. attendance at the center.mp

157.Advocacy/
158.Access.mp
159. 144 OR 145 OR 146 OR 147 OR 148 OR 149 OR 150 OR 151 OR 152 OR 153 OR 154 OR 155 OR 156 OR 157 OR 158
160. 17 AND 20 AND 45 AND 104 AND 143 AND 159

3.4 Google Scholar

The following questions or word combinations were used to search in Google Scholar. For each search results, the first 50 results were looked at only.

What are optimal management strategies at a youth center to increase referral rates to health services?

What are optimal administrative strategies at a youth center to increase referral rates to health services?

What are optimal organizational strategies at a youth center to increase referral rates to health services?

What are the optimal implementation strategies, when starting up a youth center, to increase referral rates to health services?

What partnerships should a youth center develop to increase referral rates to health services?

What health care services should be offered in a youth center to increase referral rates to health services?

What psychosocial services should be offered at a youth center to increase referral rates to health services?

What are optimal management strategies at a youth center to increase attendance?

What are optimal administration strategies at a youth center to increase attendance?

What are optimal organizational strategies at a youth center to increase attendance?

What are services should be offered at a youth center to increase attendance?

What are optimal implementation strategies when starting up youth center to increase attendance?

Does "active participation of youths" at youth center increase attendance/participation?

What activities should be offered at a youth center to increase attendance?

What health care services should be offered at a youth center to increase attendance?

What are optimal administration strategies in a youth center to access health services?

What are optimal organizational strategies in a youth center to access health services?

What services should be offered at a youth center to increase access to health services?

What activities should be offered at a youth center to increase access to health services?

What are good practices for a youth center to increase access to health services?

What psycho-educational services should be offered at a youth center to increase access to health services?

What are optimal management strategies in a youth center to increase its efficiency?

What partnerships are needed in a youth center to increase its efficiency?

Does "active participation of youths" at youth center increase its efficiency?

'activities' + "youth center"

'attendance' + "youth center"

"management strategies" AND "drop-in center"

"organisation strategies" AND "drop-in center"

'services' AND "drop-in center"

"best practices" AND "drop-in center"

"social services" AND "drop-in center"

"youth-friendly services"

"youth support center"

"youth organizations"

"youth outreach center"

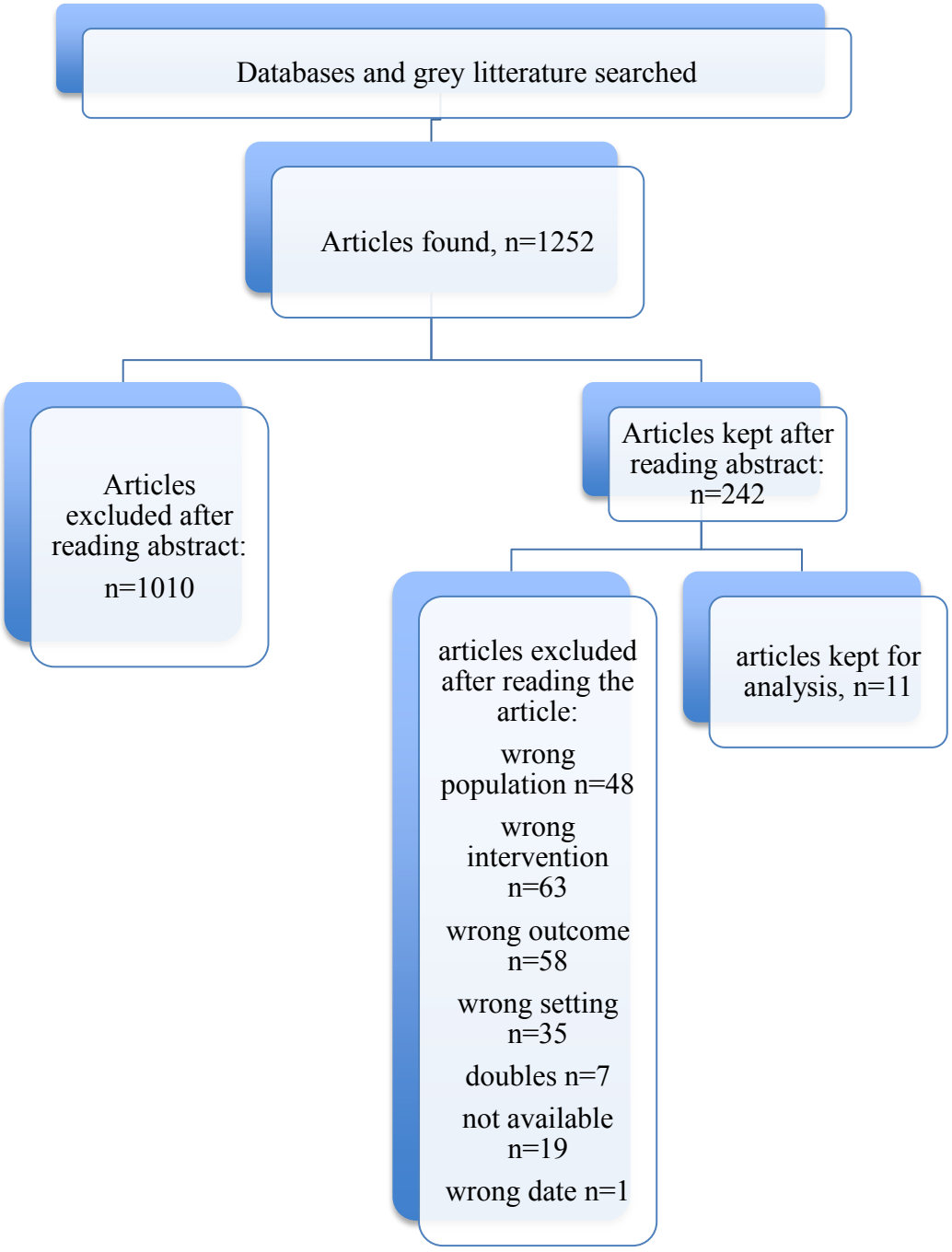
"youth one-stop shop"

3.5 Grey literature search

Grey literature was searched as per the recommended CADTH list.
The following resources were searched:

-Alberta College of Family Physicians
-Alberta Health and Wellness
-Canadian Agency for Drugs and Technologies in Health
-Health Quality Council of Alberta
-Health Quality Ontario
-Institut national d'excellence en santé et en services sociaux
-Manitoba Center for Health Policy
-McGill University Health Center
-Newfoundland and Labrador Center for Applied Health Research
-Ottawa Hospital Research Institute
-Program for Assessment of Technology in Health
-Saskatchewan Health Quality Council
-Therapeutics Initiative
-University of British Colombia
-EuroScan Secretariat
-INAHTA Secretariat
-World Health Organisation
-Joanna Briggs Institute
-Monash Health Center for Clinical Effectiveness
-National Prescribing Service
-Queensland Government
-Royal Australian College of Surgeons
-Institute of Technology Assessment
-Ludwig Boltzmann Institut für Health Technology Assessment
-Belgian Health Care Knowledge Center
-Danish Health and Medicines Authority
-Comité d'évaluation de diffusion des innovations technologiques
-French National Authority for Health
-German Institute of Medical Documentation and Information
-Health Information and Quality Authority, Ireland
-Health Services Executive, Ireland
-Health Council of the Netherlands
-Norwegian Knowledge Center for the Health Services
-Catalan Agency for Health Technology Assessment
-Swedish Council of Technology Assessment in Health Care
-Swiss Federal Office of Public Health
-Health Care Improvement Scotland
-National Health Service for Wales
-National Institute for Health and Clinical Excellence
-NHS Purchasing and Supply Agency
-NIHR Evaluation, Trials and Studies Coordinating Center.
-Agency for Healthcare Research and Quality Blue Cross and Blue Shield Association
-California Technology Assessment Forum
-Centers for Medicare & Medicaid Services
-Institute for Clinical and Economic Review
-Washington State Health Care Authority
-National Guideline Clearinghouse
-Canadian Medical Association
-Health Canada
-Bandolier
-National Center for Biotechnology Information
-Latin-American and Caribbean Center on Health Sciences Information
-TRIP Database
-BMJ Publishing Group
-Wiley InterScience
-ECRI Institute
-Canadian Institute for Health Information
-IMS/Brogan
-Institute for Clinical Evaluative Sciences
-New Brunswick Ministry of Health Epidemiological Service
-Google
-Lund University Libraries
-Substance Abuse & Mental Health Services Administration
-National Rehabilitation Information Center
-University of Ottawa
-University of Queensland

ANNEXE 4: Selection of Included Studies



ANNEXE 5: Included Studies For Clinical Evidence

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Illback, R.J. and Bates, T. (2011). Transforming youth mental health services and supports in Ireland, *Early Intervention in Psychiatry, 5(suppl 1),* pp22-27

Kang, M. et al (2006). Primary health care for young people. Are there models of service delivery that improve access and quality? *Youth studies Australia*, *25(2),* pp49-59

McGorry, P., Bates, T., and Birchwood, M., (2013). Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. *The British journal of Psychiatry, 202,* pp s30-s35

McGorry, P., et al (2007). Headspace: Australia's National Youth Mental Health Foundation – where young's minds come first. *Medical Journal of Australia*, *187(7),* pp s68-s70

New Zealand Ministry of Health. (2009). *Evaluation of Youth One Stop Shops.*

Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés in Ireland, a best practice guide.*

Office of the Minister for Children and Youth Affairs on behalf of the National Children's advisory council, Ireland. (2010). *Youth cafés toolkit: how to set up and run a youth café in Ireland.*

Patulny, R., Muir, K., Flaxman, S., and Oprea, I. (2013). Are we reaching them yet? Service access patterns among attendees at the *headspace* youth mental health initiative. *Child and Adolescent Mental Health, 18(2),* pp95-102

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54. Yo! Baltimore, U.S.A. (n.d.) **Internship program evaluation.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_internship_eval.pdf [Accessed on November 15th, 2015]

55. Yo! Baltimore, U.S.A. (n.d.) **Report on participants' employment and earnings.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_employment_earnings.pdf [Accessed on November 15th, 2015]

61. Yo!, Baltimore, U.S.A. (n.d.) Retrieved from: http://www.yobaltimore.org [Accessed on October 11th, 2015]

62. Yo! Baltimore, U.S.A. (n.d.) **Report on arrests and convictions.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_arrests_convictions.pdf [Accessed on October 11th, 2015]

64. Yo! Baltimore, U.S.A. (n.d.) **Community impact survey.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_survey_summary.pdf [Accessed on October 11th, 2015]

72. Yo! Baltimore, U.S.A. (n.d.) **Report on youth birth rates.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_birth_rates.pdf [Accessed on October 15th, 2015]

-Yo! Baltimore, U.S.A. (n.d.). **Report on comparison of urban youth opportunity grants performance.** Retrieved from: www.yobaltimore.org/documents/Impact/impact_comparison_yo_grants.pdf [Accessed on November 15th, 2015]

ANNEXE 6: Critical Appraisal Assessments

- **Mixed Methods Appraisal**

For complete tool, please see:
Pluye, P., et al., (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.* Retrieved on 2015-11-01 from http://mixedmethodsappraisaltoolpublic.pbworks.com . Archived by WebCite[R], at http://webcitation.org/5tTRTc9yJ

		Rickwood, van dyke and telford	Patulny
Screening questions	Are there clear qualitative and quantitative research questions or a clear mixed-methods question?	No, the author state using qualitative thematic analysis, but also provide descriptive quantitative results (p.35)	No, the author state comparing data sets quantitatively, but also provide qualitative results (p.97)
	Do the collected data allow address the research question?	Yes	Yes
Qualitative	1. Are the sources of qualitative data relevant to address the research question?	Yes, p.31	Yes, p97
	2. Is the process for analyzing qualitative data relevant to address the research question	Yes, p.31	Can't tell
	3. Is appropriate consideration given to how findings relate to the context?	Yes, p.35	Yes, p.97
	4. Is appropriate consideration given to how the findings relate to researcher's influence through their interactions with participants?	NA: researchers did not have interactions with 'participants'	Can't tell
Quantitative randomized controlled	NA		NA

Quantitative non-randomized	NA		NA
Quantitative descriptive	Is the sampling strategy relevant to address the quantitative research question?	Yes	No sampling strategy, the choice of data sets is not justified
	Is the sample representative of the population understudy?	Yes, it is 'all' the population that could be studied	Yes, p.97
	Are the measurements appropriate?	Can't tell, the authors use the data collected to provide means but do not provide data that means derive from (no tables showing levels of activity per center)	Yes, the measurements are: utilization rates and demographics.
	Is there an acceptable response rate?	Yes, all center provided reports	Can't tell as the creation of the data sets used in this study is explained in another study. (p97)
Mixed methods	Is the mixed-methods research design relevant to address the qualitative and quantitative research questions or aspects of the questions?	Yes, but the authors did not present this study as a mixed-method design.	Yes
	Is the integration of qualitative and quantitative data relevant to address the research question?	Yes	Yes
	Is appropriate consideration given to the limitations associated with this integration?	No	Yes, p.100
Final Rating		Yes: 8 No: 2 Can't tell: 1 NA: 1	Yes: 8 No: 2 Can't tell: 3 NA: 0

- **Critical Appraisal Skill Program**

For complete tool, please go to CASP website, http://www.casp-uk.net/
The CASP-Qualitative Checklist, was retrieved on 2014-10-01 from
http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf

CASP qualitative	Kang et al
1. Was there a clear statement of the aims of the research?	Yes, p.49
2. Is a qualitative methodology appropriate?	Yes, p.50-51
3. Was the research design appropriate to address the aims of the research?	Yes, p.51
4. Was the recruitment strategy appropriate for the aims of the research?	Yes, p.51
5. Was the data collected in a way that addressed the research issue?	Can't tell
6. Has the relationship between researcher and participants been adequately considered?	Can't tell
7. Have ethical issues been take into consideration?	No
8. Was the data analysis sufficiently rigorous?	Can't tell
9. Is there a clear statement of findings?	Yes, p54-55
10. How valuable is the research?	Confirms that these models are used frequently, that they lack in evaluation processes (in terms of sustainability particularly). The authors noted further research needs consequent to their conclusions.
OVERALL RATING	Yes: 5 No: 1 Can't tell: 3

- **Standards of reporting qualitative research**

For complete tool, please see:
O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, 89(9), pp1245-1251

	Kang et al	Rating
Title	Yes, p.49. However, as title not clear in terms of nature of study or approach = poor	0.5
Abstract	Yes, p.49 but methodology/structure is poor	0.5
Problem formulation	Yes, p.49-50	1
Purpose or research question	Yes, p.50	1
Qualitative approach and research paradigm	The authors state that they used qualitative methods, but do not state which ones	0.5
Researcher characteristics, reflexivity	Not found	0
Context	Yes, p.50	1
Sampling strategy	p.51, and table 1	1
Ethical issues pertaining to human subjects	Not required to pass in front of ethics board, p.52	1
Data collection method	p. 52 Type of data not specified, topics specified, rationale (based on previous study findings), detailed procedure of collection method not found	0.5
Data collection instruments / technologies	p.52: tape-recorded, hand written notes	1
Units of study	p.52, Managers and/or senior staff	1
Data processing	p.52, formatted for entry in computer program	1
Data analysis	p.52, use of the program NUD*IST 4 and also 1 manually processed by project manager.	1
Techniques to enhance trustworthiness	None found	0
Synthesis and interpretation	6 Models, and detailed info on 7 principles applied to each model	1

Links to empirical data	A few references of empirical data, see bibliography	1
Integration with prior work, implications, transferability and contributions	Application of the 7 principles/indicators to 6 service delivery models. These principals are results of previous research in this field. This study uses these 7 principles as a first/standardised way of evaluating these service delivery models, demonstrating their strengths and weaknesses and the need for further evaluations.	1
Limitations	No limitations noted by the author. This study only interviews staff of clinics. As one of the aims of this study was to evaluate service delivery models in view of decreasing barrier to access to care, patient participation is lacking. This study takes places in the New South Wales region of Australia only.	0
Conflicts of interest	Not declared	0
Funding	P.58, funded by NSW Health	1
% Of recommended standards present		**15/21**

- **Quantitative study Appraisal**

Please see Effective Public Health Practice Project website http://www.ephpp.ca/
Accessed on 2015-12-05, retrieved from http://www.ephpp.ca/PDF/Quality%20Assessment%20Tool_2010_2.pdf

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES (EPHPP)	Illback and bates
Selection bias 1. Are the individuals selected to participate in the study likely to be representative of the target population? 2. What percentage of selected individuals agreed to participate?	 Yes Can't tell
RATE THIS SECTION: Moderate	
Study design • Indicate the study design • Was the study design described as randomized?	 Descriptive No

• If yes, was the method of randomization described? • If yes, was the method appropriate?	
RATE THIS SECTION: Weak	
Confounders • Were there important differences between groups prior to the intervention? • If confounders present, indicate the percentage of relevant confounders that were controlled.	 Can't tell Can't tell
RATE THIS SECTION: Weak	
Blinding • Was the outcome assessor aware of the intervention or exposure status of participants? • Were the study participants aware of the research question?	 NA Can't tell
RATE THIS SECTION: Weak	
Data collection methods • Were data collections tools shown to be valid? • Were data collection tools shown to be reliable?	 NA: database being completed by staff Can't tell
RATE THIS SECTION: Weak	
Withdrawals and drop-outs • Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group? • Indicate the percentage of participants completing the study	 Can't tell Can't tell
RATE THIS SECTION: Weak	
Intervention integrity • What percentage of participants received the allocated intervention or exposure of interest? • Was the consistency of the intervention measured? • Is it likely that the subjects received an unintended intervention that may influence the results?	 NA NA NA
Analysis • Indicate the unit of allocation • Indicate the unit of analysis • Are the statistical methods appropriate for the study design?	 NA Individual Yes

• Is the analysis performed by intervention allocation status rather than the actual intervention received?	NA
GLOBAL RATING: Weak	

- **Grey Literature Assessment**

Please see Flinders University website, www.**flinders**.edu.au/
Accessed on 2016-06-01, retrieved from https://dspace.flinders.edu.au/jspui/bitstream/2328/3326/4/AACODS_Checklist.pdf

	Thesis Cyr	Ireland report	Ireland report	Communio, New Zealand
Authority				
Individual or organisation	Individual author: Amy Cyr, PhD candidate at University of California, Santa Barbara; under supervision of 3 professors. Received multiple honours and grants and has previous publications (p.viii)	Organisational author: The Child and Family Research Center, commissioned by the Office of the Minister for Children and Youth Affairs, on the behalf of the National Children's Advisory Council.	Organisational author: The Child and Family Research Center, commissioned by the Office of the Minister for Children and Youth Affairs, on the behalf of the National Children's Advisory Council.	Organisational author: Communio (see website), seems to be an authority in the field: "professional health services management and consulting company that focuses on improving the delivery of services in New Zealand" http://www.communio.co.nz/
In all cases: bibliography	Yes	Yes	Yes	Yes
	Rating: 2/2	**Rating: 2/2**	**Rating: 2/2**	**Rating: 2/2**
Accuracy				

Does the item have a clearly sates aim or brief? If so, is this met?	Yes, p2 Yes	Yes, p.13 Yes	Yes, p. vii	Yes, to provide to the Ministry of Health a final report on the evaluation of 12 One Stop Shops in New Zealand (p.3) Yes
Does it have a stated methodology?	Yes, p7-14	Yes, p.14	No	Yes, but incomplete, see Appendix 3, p114
If so, is it adhered it?	Yes	Yes	NA	Yes
Has it been peer-reviewed?	No	No	No	No, only by the director of the company, p.3
Has it been edited by a reputable authority?	Not mentioned	Not mentioned	Not mentioned	None mentioned
Supported by authoritative, documented references or credible sources?	Yes, see bibliography p.399	Yes, see bibliography p.83	Yes, see bibliography p.58	The footnotes seem to be from reputable sources
Is it representative of work in the field?	Yes, discusses many theories/authors within the realm of music-therapy and musicology	Yes, it is a literature review with validation for clients/managers/stakeholders	No, it is a 'how-to' guide with no specific methodology as to how it was created.	Yes, it is validated by clients/managers/stakeholders, p.114
If NO, is it a valid counterbalance?	NA	NA	Yes, it is a concrete tool developed with the support of staff/clients of 4 youth cafés, devised	NA

			as a validated support when developing a youth café	
Is any data collection explicit and appropriate for the research?	Data was collected through interviews, transcripts are available but not any template/drafts of semi-structured interview questions author may have used (p.10, 12)	Data was collected through interviews, no template/drafts of semi-structured interview questions author may have used is provided	They precise that staff/client participated in the creation of tool-kit, but no data collection methods was not specified	Yes, from the studies found: unknown; from the surveys: see Appendix 7, p163; from interviews (workshop) see Appendix 8, p195
If item is secondary material refer to the original: is it an accurate, unbiased interpretation or analysis?	NA	NA	NA	NA
	Rating: 6.5/9	**Rating: 6.5/9**	**Rating: 3/8**	**Rating: 8/11**
Coverage Are any limits clearly stated?	P3: scope of the review specified p.8: authors chooses to focus on one youth center, narrowing the scope of her research	P.10, the authors list the names of the youth cafés participating in the survey	No	No
	Rating: 1/1	**Rating: 1/1**	**Rating: 0/1**	**Rating: 0/1**
Objectivity				
Opinion, expert or	P15-19: section called	The Child and Family Research	The Child and	Communio does not have a stated

otherwise, is still opinion: is the author's standpoint clear?	'Reflexivity' is which the author discusses her own opinion on who she is and how this may impact the research findings	Center does not have a stated opinion, they were commissioned to perform this review by the Office of the Minister for Children and Youth Affairs. NA	Family Research Center does not have a stated opinion, they were commissioned to perform this review by the Office of the Minister for Children and Youth Affairs. NA	opinion; they were commissioned to perform this review by the Ministry of Health. NA
Does the work seem to be balanced in presentation?	Yes	Yes	Yes	More or less: much information on the surveys, the workshops, the results and the recommendations, but none on the literature review results
	Rating: 2/2	**Rating: 1/2**	**Rating: 1/2**	**Rating: 0.5/2**
Date				
Does the item have a clearly states date related to content (no easily discernable date is a strong concern?	Yes, on the cover page	Yes, on the cover page	Yes, on the cover page	Yes, on the cover page
If no date is given, but can be closely ascertained, is there a valid reason for its absence?	NA	NA	NA	NA
Check the bibliography: have	Yes, articles published between	Yes, articles published between 1990 and 2009 were cited.	Yes, articles published between	Yes, articles published between 2001 and 2009 are cited.

any key contemporary material been included?	1904 and 2011 were cited; most articles are from 1990-2009.		1989 and 2009 were cited.	
	Rating: 2/2	**Rating: 2/2**	**Rating: 2/2**	**Rating: 2/2**
Significance				
Is the item meaningful (this incorporates feasibility, utility and relevance)?	Yes	Yes	Yes	Yes
Does it add context?	It explores the concept of music-therapy and youth centers	It explores the subject within a specific context	No	It doesn't add context, it explores the subject within a specific context
Does it enrich or add something unique to the research?	Yes, it adds value to arguments for accessibility to music-therapy for youths	Yes, the point of view of client/managers/stakeholders of Youth Cafés in Ireland on a variety of subjects within the subject of youth centers	Yes, it gives concrete tips and tools to set up a youth café	Yes, the point of view of client/managers/stakeholders of One Stop Shops of New Zealand on a variety of subjects within the subject of youth centers
Does it strength or refute a current position?	Yes, it strengthens the arguments that youth centers can provide holistic care and facilitate access to more specialised services.	Yes, it strengthens the arguments that youth centers can provide holistic care and facilitate access to more specialised services.	No	No
Would the research area be lesser without it?	Unsure	Unsure	Unsure	Perhaps within the context of New Zealand. As the methodology of the literature review is not present, we cannot

				ascertain the validity of the review as more then that of a synthesis of surveys from particular groups.
Does it have an impact (in the sense of influencing the work or behaviour of others)?	Yes	Yes	Yes	Same answer.
	Rating: 5/6	**Rating: 5/6**	**Rating: 3/6**	**Rating: 2.5/6**
OVERALL RATING	**Rating: 18.5/22**	**Rating: 17.5/22**	**Rating: 11/21**	**Rating: 15/24**

ANNEXE 7: Excluded Studies For Clinical Evidence (And Reasons)

7.1 Population

Anderson, S. A., Sabatelli, R. M., & Kosutic, I. (2007). Families, urban neighbourhood youth centers, and peers as contexts for development. *Family Relations, 56(4)*, pp.346-357

Annesi, J. J. and Vaughn, L. L. (2011). Effects of extension of the Youth Fit For Life intervention program by video vs. instructor supervision. *Archives of Exercise in Health and Disease, 2(2),* pp.102-107

Apsler, R. (2009). After-school programs for adolescents: a review of evaluation research. *Adolescence, 44(173),* pp.1-19

Arbesman, M., Bazyk, S., & Nochajski, S. M. (2013). Systematic review of occupational therapy and mental health promotion, prevention, and intervention for children and youth. *American Journal of Occupational Therapy, 67,* pp.e120–e130

Black, D.S., Milam, J. and Sussman, S. (2009). Sitting-Meditation Interventions Among Youth: A Review of Treatment Efficacy. *Pediatrics, 124,* pp.e532–e541

Borden, L. M., Perkins, D. F., Villarruel, F. A., & Stone, M. R. (2005). To participate or not to participate: That is the question. *New Directions for Youth Development, 105*, pp.33-49

Corcoran, J., Dattalo, P., Crowley, M., Brown, E. and Grindle, L. (2011). A systematic review of psychosocial interventions for suicidal adolescents. *Children and Youth Services Review, 33,* pp.2112–2118

Crawley, S.A., et al. (2014). Somatic Complaints in Anxious Youth. *Child Psychiatry and Human Development, 45*, pp.398–407

Decat P., et al. (2013). Community embedded reproductive health interventions for adolescents in Latin America: development and evaluation of a complex multi-centre intervention. *BMC Public Health, 13(31)*

Drolet, M. and Arcand, I. (2013). Positive Development, sense of belonging, and support of peers among early adolescents: perspectives of different actors. *International Education Studies, 6(4),* pp.29-38

Earls, F. and Carlson, M. (2002). Chapter: Adolescents as collaborators: In search of wellbeing. In Tienda, M. and Wilson, W.J. (2002). **Youth in cities: a cross-national perspective. (pp.58-83).** New York, NY, US: Cambridge University Press; US

Erford, B.T., Paul, L.E., Oncken C., Kress, V.E. and Erford, M.R. (2014). Counselling Outcomes for Youth With Oppositional Behaviour: A Meta-Analysis. *Journal of Counselling & Development, 92,* pp.13-24

Fagan, A.A. and Catalano, R.F. (2012). What Works in Youth Violence Prevention: A Review of the Literature. *Research on Social Work Practice, 23(2),* pp.141-156

Farahmand, F.K., et al. (2011). School-based mental health and behavioural programs for low -income, urban youth: A systematic and meta-analytic review. *Clinical Psychology: Science and Practice, 18(4),* pp372-390

Farahmand, F.K. et al. (2012). Community-based mental health and behavioural programs for low-income urban youth: A meta-analytical review. *Clinical Psychology: Science and Practice, 19(2),* pp.195-215

Fiester, L. M., Simpkins, S. D., & Bouffard, S. M. (2005). Measuring attendance in out-of-school time programs. *New Directions for Youth Development, 105,* pp.91-107.

Galaskiewicz, J., Mayorova, O.V. and Duckles, B.M. (2013). Studying the roles of non-profits, government, and business in providing activities and services to youth in the Phoenix metropolitan area. *Annals of the American Academy of Political and Social Science, 647(1),* pp.50-82

Gonzalez, M.J. (2005). Access to mental health services: the struggle of poverty affected urban children of color. *Child & Adolescent Social work journal, 22(3-4),* pp.245-256

Green, B. L., Everhart, M. C., Gettman, M. G., Gordon, L., and Friesen, B. (2003). Mental health consultation in Head Start: Selected national findings. *Mental Health Services Survey report*. Guidance for early childhood program design research & training center on family support & children's mental health, regional research institute, Portland State University

Greene K.M., Lee B., Constance N. and Hynes K. (2013). Examining youth and program predictors of engagement in out-of-school time programs. *Journal of Youth & Adolescence, 42(10),* pp.1557-1572

Grossman, J.B. and Rhodes, J.E. (2002). The test of time: predictors and effects of duration in youth mentoring relationships. *American Journal of Community Psychology, 30(2),* pp.199-219

Guzder, J., Paisley, V., Robertson-Hickling, H and Hickling, F.W. (2013). Promoting resilience in high-risk children in Jamaica: A pilot study of multimodal intervention. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 22(2),* pp.125-130

Haney, S.E. (2014). Program evaluation of the girls' action team. *Dissertation Abstracts International: Section B: The Sciences and Engineering. 75(2-B (E))*

Holleman, M. A., Sundius, M. J., & Bruns, E. J. (2010). Building opportunity: Developing city systems to expand and improve after school programs. *American journal of community psychology, 45(3-4),* pp.405-416

Kalish R.E., Voigt B., Rahimian A., Dicara J. and Sheehan K. (2010). Listening to youth: reflections on the effect of a youth development program. *Health Promotion Practice, 11(3),* pp.387-393

Lewis, K.M. (2013). Evaluation of a social-emotional and character development program: Methods and outcomes. *Dissertation Abstracts International: Section B: The Sciences and Engineering. 74(3-B (E))*

Lewis, K.M. et al. (2013). Problem behaviour and urban, low-income youth: A randomized controlled trial of Positive Action in Chicago. *American Journal of Preventive Medicine, 44(6),* pp.622-630

Little, P., Wimer, C., & Weiss, H. B. (2008). After school programs in the 21st century: Their potential and what it takes to achieve it. *Issues and opportunities in out-of-school time evaluation, 10(1-12)*

Macias, C., Propst, R., Rodican, C., and Boyd, J. (2001). Strategic planning for ICCD Clubhouse implementation: Development of the Clubhouse Research and Evaluation Screening Survey (CRESS). *Mental Health Services Research, 3(3),* pp.155-167

Marshall, M., et al. (2001). Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) Acute day hospital versus admission; (2) Vocational rehabilitation; (3) Day hospital versus outpatient care. *Health Technology Assessment, 5(21)*

Mmari, K., et al (2014). Adolescent perceptions of health from disadvantaged urban communities: Finding from the WAVE study. *Social Science and Medicine, 104*, pp.124-132

Nair M.K., et al. (2012). A panchayat level primary-care approach for adolescent services *Indian Journal of Pediatrics, 79(Suppl 1),* pp.S6-10

Pedersen, S. (2005). Urban adolescents' out-of-school activity profiles: associations with youth, family, and school transition characteristics. *Applied Development Science, 9(2),* pp.107-124

Perkins, D. F., Borden, L. M., Villarruel, F. A., Carlton-Hug, A., Stone, M. R., & Keith, J. G. (2007). Participation in Structured Youth Programs Why Ethnic Minority Urban Youth Choose to Participate—or Not to Participate. *Youth & Society, 38(4),* pp.420-442

Pinter-Grigoras, A.M. (2012). Effectiveness of after-school interventions on positive youth development in culturally diverse urban communities. *Dissertation Abstracts International: Section B: The Sciences and Engineering. 72(10-B),* pp.6423

Richardson, L., McCauley, E., and Katon, W. (2009). Collaborative care for adolescent depression: A pilot study. *General Hospital Psychiatry, 31(1),* pp.36-45

Rhodes, C., Mihyar, H.A. and El-Rous, G.A. (2002). Chapter: Social learning and community participation with children at risk in two marginalised urban neighbourhoods in Amman, Jordan. In Tienda, M. and Wilson, W.J. (2002). **Youth in cities: a cross-national perspective. (pp.191-214).** New York, NY, US: Cambridge University Press; US

Roffman, J.G., Pagano, M.E. and Hirsch, B.J. (2001). Youth functioning and the experiences of inner-city after-school programs among age, gender, and race groups. *Journal of child and family studies, 10(1),* pp.85-100

Salzer, M. S. (2002). Consumer-Delivered Services as a Best Practice in Mental Health Care Delivery and The Development of Practice Guidelines: Mental Health Association of Southeastern Pennsylvania Best Practices Team Philadelphia. *Psychiatric Rehabilitation Skills, 6(3),* pp.355-382

Sanderson, R.C. and Richards, M.H. (2010). The after-school needs and resources of a low -income urban community: Surveying youth and parents for community change. *American Journal of Community Psychology, 45(3-4),* pp.430-440

Shek D.T., Ma H.K. and Sun R.C. (2011). Development of a new curriculum in a positive youth development program: the project P.A.T.H.S. in Hong Kong. **Thescientificworldjournal.** 11:2207-18

Souza, R., Porten, K., Nicholas, S. and Grais, R. (2011). Outcomes for street children and youth under multidisciplinary care in a drop-in center in Tegucigalpa, Honduras. *International Journal of Social Psychiatry, 57(6),* pp.619-626

Stock, C. and Ellaway, A. (2013). **Neighbourhood structure and health promotion (viii, 367pp)**. New York, NY, US: Springer Science + Business Media; US.

Weitzman, B.C., Mijanovitch, T., Silver, D and Brazill, C. (2008). If you build it, will they come? Estimating unmet demand for after-school programs in American's distressed cities. *Youth and Society, 40(1),* pp.3-34

Wilson, D.M., Chamberland, C. and Hewitt, J.A. (2012). Educations youths to make safer choices: results of a program evaluation study. *Global journal of health science, 4(2),* pp.77-86

Young-Griffin, J.L. (2013). The effectiveness of music mentoring at the true music workshop, incorporated in an Eastern city. *Dissertation Abstracts International Section A: Humanities and Social Sciences. 74(5-A (E))*

Zagar, R.J., Busch, K.G. and Hughes, J.R. (2009). Empirical risk factors for delinquency and best treatments: Where do we go from here? *Psychological Reports, 104(1),* pp.279-308

Zuurmond M.A., Geary R.S. and Ross D.A. (2012). The effectiveness of youth centers in increasing use of sexual and reproductive health services: a systematic review. *Studies in Family Planning, 43(4),* pp.239-254

7.2 Intervention

Alloway-Higgins, A. (2012). Understanding the ways that program mentoring influences the decision of urban, at-risk, high school students to apply for college. *Dissertation Abstracts International Section A: Humanities and Social Sciences. 73(2-A))*, pp.798

Anderson-Butcher, D., Stetler, E. G., & Midle, T. (2006). A case for expanded school-community partnerships in support of positive youth development. *Children & Schools, 28(3),* pp.155-163

Aratani, Y., Schwarz, S.W. and Skinner, C. (2011). The economic impact of adolescent health promotion policies and programs. *Adolescent Medicine, 22(3),* pp.367-386

Baier, V., Favrod, J., Ferrari, P., Koch, N., and Holzer, L. (2013). Early tailored assertive community case management for hard-to-engage adolescents suffering from psychiatric disorders: an exploratory pilot study. *Early intervention in psychiatry, 7(1),* pp.94-99

Bandurraga, A., Gowen, L. K., and The Finding Our Way Team. (2013). **"I Bloomed Here": A Guide for Conducting Photovoice with Youth Receiving Culturally- and Community-based Services.** Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University

Berry, V., Little, M., Axford, N. and Cusick, G.R. (2009). An Evaluation of Youth at Risk's Coaching for Communities Programme. *The Howard Journal, 48(1),* pp. 60–75

Branson C.E., Barbuti A.M., Clemmey P., Herman L. and Bhutia P. (2012) A pilot study of low -cost contingency management to increase attendance in an adolescent substance abuse program. *American Journal on Addictions, 21(2),* pp.126-129

Bowers, S. and McKee, T. (2003). The jump start initiative. *Recovery & Rehabilitation, 2(4)*

Carswell, S.B., Hanlon, T.E., Watts, A.M. and O'Grady, K.E. (2014). Prevention-related research targeting African American alternative education program students. *Education and Urban Society, 46(4),* pp.434-449

Christensen, H., Pallister, E., Smale, S., Hickie, I.B. and Calear, A.L. (2010). Community-Based Prevention Programs for Anxiety and Depression in Youth: A Systematic Review. *Journal of Primary Prevention, 31,* pp.139–170

Diamond, S. et al. (2009). Building Xperience: A multilevel alcohol and drug prevention intervention. *American Journal of Community Psychology, 43(3-4),* pp.292-312

DiFranza, J.R. (2002). Is it time to abandon youth access programmes? *Tobacco Control, 11(3),* pp.282

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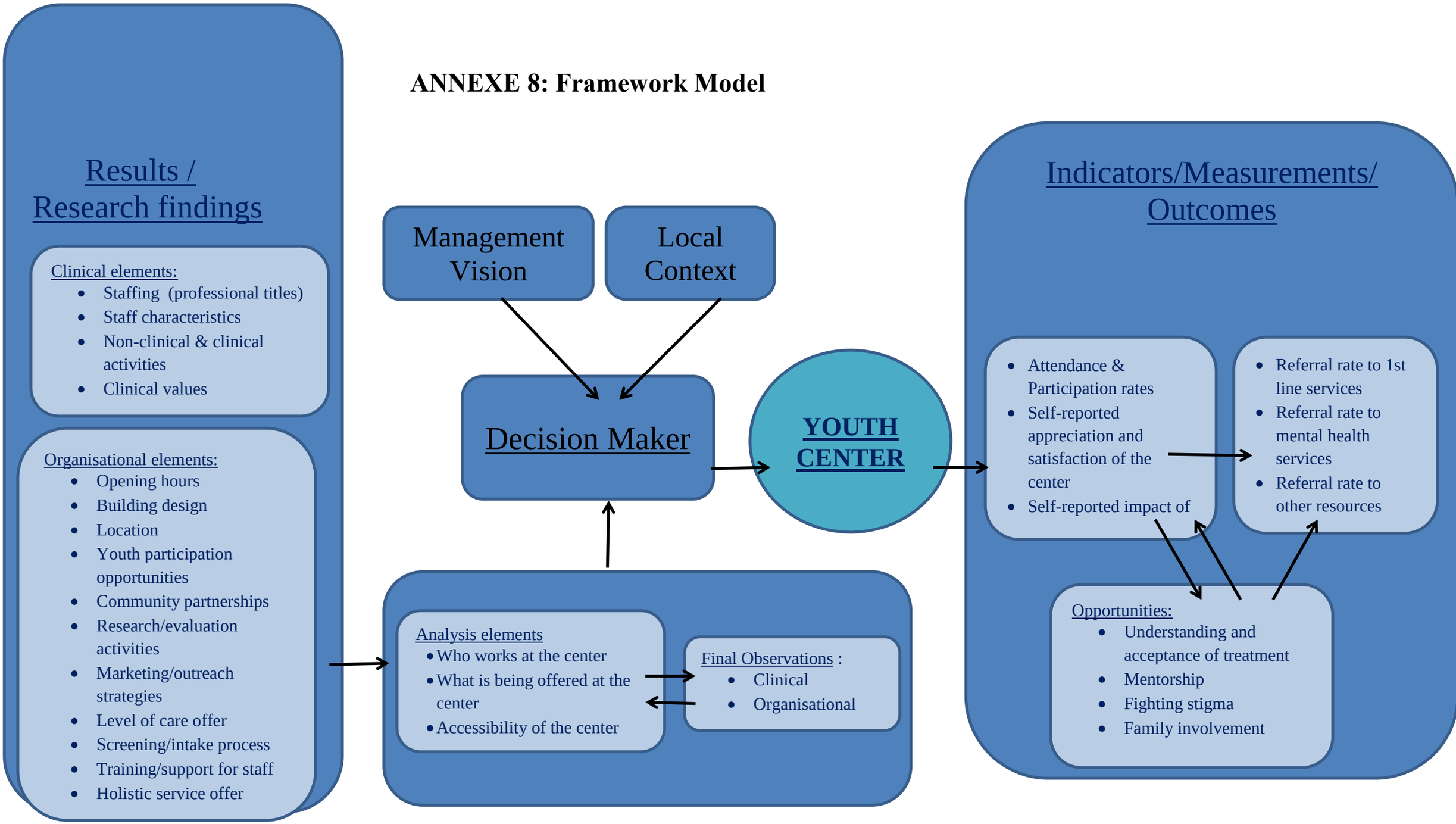
ANNEXE 8: Framework Model



ANNEXE 9: Clinical Evidence — Study Characteristics

Authors	**Cyr**	**Illback, Bates**	**Kang et al.**
Publication year	2012	2011	2006
Country	USA	Ireland	Australia
Study design	Grey matter: Thesis	Descriptive quantitative study	Qualitative study
Population	13-24 years old	12-25 years old	"adolescents"
Primary and/or secondary outcome measured	*2010-11: 5060 mental health and health clinic visits * More than 3000 visits each year; 1500 hours for 152 youths for counselling and support in 2011 * In 2011, YU provided services for 1900 unduplicated youths *73% received needed guidance, 74% emotional support, 71%practical support *77% reported they have long-term plans related to career; each year 200 youths have job placements	* In 2011, Jigsaw Galway referred 12 patients *12518 youths have been seen between 01-2008 and 10-2015 3256 visits in 2014: 14% brief contact, 52% brief interventions, 34% individual case consultations * Many testimonials can be found on Facebook/ website * Qualitative data based on satisfaction survey results: levels of psychological distress pre- and post, changes in psychological distress	*Not measured but used as justification for designing the center
Comments	"Youth UpRising"	"Jigsaw"	Youth Health Service model

Authors	**McGorry, Bates, Birchwood**	**McGorry, Tanti, Stokes, Hickie, Carnell, Littlefield, Moran**	**Minister for Children and Youth Affairs**	**Minister for Children and Youth Affairs**
Publication year	2013	2007	2010	2010
Country	Australia	Australia	Ireland	Ireland
Study design	Demonstrative article	Demonstrative article	Grey Matter: government reports	Grey Matter: government reports
Population	12-25 years old	12-25 years old	"Young people"	"Young people"
Primary and/or secondary outcome measured	*Not measured but used as justification for designing the center	*Not measured but used as justification for designing the center	*Outcome measured = health-promoting service: indicator = health workshop and learning: 10 visits per year to health professional *Outcome measured = engagement: indicator = attendance: 30 each week, 20 regularly, 30 irregularly, 30 once off *Outcome = personal development: indicator = leadership and assertiveness, listening and communication skills	*Same as previous article
Comments	"youthspace": on-line space for youths and partners to find information on variety of pertinent topics. However, there is a 'Youth Board' of Youth Space, but no drop-in or youth center associated...	"headspace"	"Youth Cafés"	"Youth Cafés"

Authors	**Patulny, Muir, Powell, Flaxman, Oprea**	**Unknown**	**Rickwood, Van Dyke, Telford**	**New Zealand Ministry of Health**
Publication year	2013	2004	2015	2009
Country	Australia	USA	Australia	New Zealand
Study design	Mixed methods study	Demonstrative article	Mixed methods study	Grey Matter: government report
Population	12-25 years old	16-21 years old	12-25 years old	10-25 years old
Primary and/or secondary outcome measured	* Qualitative: successful at increasing access * By June 2009, 14000 youths have attended headspace, On average 6.8 times per year * Qualitative description: Attractive features: environment, staff, encouragement of youth participation *Improvement of mental health, physical health, sexual/reproductive health, drug and alcohol use, feelings about bodily appearance, involvement in social/community activities, being able to go to school, getting on with family, getting on with friends, sleep issues, self-care and functionality, emotions/anger managements, home	*Not measured but discussed as an outcome when designing the center *4300 youths over 5 years * Websites has many testimonials *Educational impact: better attendance, less drop-out, higher overall grade average *Impact on Youth pregnancy: decrease in number of pregnancies for those attending the center *Impact on crime: decrease in arrests and conviction, and in recidivism *Impact on work readiness, and internship program: increase in successful preparation	*Services on-site	*Qualitative description of improving-access strategies used, of reduction inequalities re: service access *Impression of helping improvement of health and wellbeing: manager 100%, client 94%, stakeholder 89% *Top reasons for using services: confidentiality, service flexibility, feeling at ease with staff, aversion to feeling 'judged' in waiting rooms *Referrals: Not measured but used as justification for designing the center *Attendance: 20% 1-2 uses; 33% 3-5 uses, 46% 6 + uses *Impression of Effectiveness to access other services: manager

	environment, accessing health workers or doctors when you want, general happiness, being able to care for others, help to developed strategies to manage their own mental health as well as greater insight into their own behaviour *93,2% YP said their MH improved since attending, decrease in symptoms, increase in confidence change emotions and behaviours; substance use decreased			91%, client 95%, stakeholder 90%
Comments	“headspace”	“Yo! Centers” in Baltimore	“headspace”	“Youth One Stop Shop”

ANNEXE 10: Clinical Evidence — Study Results

10.1 Patient data

Author	**Cyr**	**Illback and Bates**	**Kang et al.**	**McGorry, Bates and Birchwood**	**McGorry, et al**	**Ministry of Health, New Zealand**
Age	14-20 years old	12-25 years old	12-17 years old	As per 'headspace' data	As per 'headspace' data	10-25 years old
Sex	Any	Male and female	Male and female			Male and female
Education level	Not specified	Not specified	High school and out-of-school			School, educational facility or employed
Culture	Not specified	Not specified	Australian			New Zealand European, Maori, Samoan, other
Migration status	Not specified	Not specified	Unknown			Unspecified
Language	English by default	English by default	English assumed			Unspecified
Reasons to come to the center / expectations of the center	To hang out, for personal reasons, for the programs	Problems with relationships, with school with family, with alcohol or drugs, with work, every other area of life, low mood, easily angry, feeling like things are getting on top of you; help with feeling low, depressed, anxious, distressed; anxiety, low	Characteristics of 'ideal' center: casual, friendly-setting with pool, TV, Ping-Pong, music; flexible service hours, able to use pseudonym, having a choice of provider gender, possibility of peer-			To address: poverty, family violence, mental health, alcohol and drug-related issues; no/low costs, confidentiality, service flexibility, drop-in, location, feeling at ease, judgement-free; service 'grazing' or 'snacking'; GP, sexual and reproductive health, counselling

		mood, family problems, anger, stress, isolation/withdrawal, sleep changes/issues, parent/youth conflict, thoughts of hurting self, low self-esteem	group discussions, well publicised, alternative means of accessing (phone, websites, videos….)			

Author	**Patulny, Muir, Powell, Flaxman, Oprea**	**Practice notes: Unknown**	**Rickwood, Van Dyke and Telford**	**Ministry of Children and Youth Affairs, youth cafés**	**Ministry of Children and Youth Affairs, tool kit**
Age	10-25 years old	14-21 years old	As per 'headspace' data	14-18 (11-25) years old	As per 'youth cafés' data
Sex	Male and female	Male and female		Male and female	
Education level	Varied	Varied		Unspecified, varied	
Culture	6% aboriginal	Unspecified		Unspecified	
Migration status	Indigenous and non-indigenous	Unspecified		Unspecified	
Language	Country of birth	Unspecified		Unspecified	
Family MD follow-up	Main language	English by default		Unspecified	
Presence at the center	Not specified	Unspecified		Number varies	
Reasons to come to the center / expectations of the center	Anxiety and depressive disorders, co-morbidity; most attending have no, low or medium levels of psychological distress	Unspecified		Unspecified	

10.2 Center data: Organisational Strategies Data

Author	**Cyr**
Opening hours	
Building design	*Living room space *Multiple sitting areas with couches *A computer lab *A restaurant with seating and 3 internet/computers *Atmosphere not like a medical clinic *Career & Education Center *Youth leadership and community building *Medical clinic with lab but NO signage *Pharmacy *Counselling space *Media and computer labs *Basketball, baseball and soccer fields *Skate Park *Dance studio
Location	
Youth participation	*Peer-to-peer socialisation
Approach/ Practices	*Integrative program model *Framework for establishing adult-youth mentorship relationship *Mentorship *Cultural competence *Provide structure and consistency *Intervention for at least 9 months or longer *Shape message about clear standards for youth behaviour *Empowerment *Adapted and variety of programming *Policies (House rules, peacekeeping agreement)
Partnerships	*Institutional funders *Employment Partners *Strategic Partners
Research	
Marketing and Outreach strategies	

Author	**Illback and Bates**	
Opening hours	*Differs from center to center *Examples: 9h30-16h30 or 9h30-17h30 or 9h-19h30 or 9h-16h45 or 11h-18h or 12h-18h or 16h-18h or 16h-20h or 10h30-15h *Drop-in at specific times/days *phone message checked on Monday, Wednesday, Friday only, response within 3 working days	
Building design	*Store-front	
Location	*In the city center	
Youth participation	*Youth advisory panel *Youth participation mechanisms *Mechanisms to ensure their voice is heard, respected and acted upon *Sitting in on interviews, design and location of building, creating promotion materiel *Input on attract ability of center *Keep jigsaw focused *Challenge stigma *Breathe life into jigsaw project	*Engage young people *Youth Partners for the project *Input into all areas of Jigsaw *Public speaking *Promoting youth mental health *Developing specific plans for services *Consulting with relevant groups on request *Working to developing services and contributing to the overall development of the project
Approach/ Practices	*Promotion and prevention as per 4 tier strategic framework *Focusing on systems change through re-engineering of resources *Involving key statutory agencies/services *Building integrated support networks through training *For front-line providers, promoting resilience through prevention, coordinating community-wide awareness, committing to rigorous planning and evaluation processes *Gives access to center for those who live, work or go to school in sector *Clinical governance committee *Guiding principles to ensure highest professional standard *Aspirations/structure: universal service, person centeredness, holistic, accessibility, non-judgemental *Components framework: needs-intervention-goals-activities/actions *Initial screening for what level of support is required *Case handling and decision-making procedure *Flow chart	
Partnerships	*Read your mind project (libraries)	

	*Partnerships: mental health services, health services, other community services, social services, educational services, juvenile justice services, youth programmes, substance abuse services *Joined up integration with other services and supports
Research	*Rigorous and evaluation processes *Clinical Governance group *Quick initial assessment *Framework for evaluating complex community initiatives (context, progress, effects) *Interventional outcomes for YP *Logic model of evaluation
Marketing and Outreach strategies	*Websites within the Headstrong website *Facebook *Promotion of community-wide awareness *Phone, Email, Facebook, Fax, Text *Outreach in community and schools (in other centers appointments only) *Meath schools and centers project *Community engagement

Author	**Kang et al.**
Opening hours	*Examples: Monday-Friday: 9h-16h30h (drop-in 13h-15h) * Monday-Thursday: 9h-14h

	* Monday-Thursday: 14h-21h, Friday:14h-18h
Building design	*Informal spaces *Appropriate décor *Reading materials
Location	*Close to public transport
Youth participation	*Committees *Consultations *Training and paid for participation *Collaboration *ID of appropriate partners *Documentation of roles and responsibilities *Interagency reps *Formal service agreements *Interdisciplinary clinical work
Approach/ Practices	*Access facilitation *Confidentiality policies *No cost
Partnerships	*Informal linkage between YHS and others services (education, Centrelink, accommodation agencies, juvenile justice, legal and others)
Research	*Client satisfaction process evaluation *Process evaluations re: satisfaction, service quality processes *Project evaluations linked with aims/objectives *Impact evaluation by target groups *Sustainability (funding, evaluations) *Procedures relevant to better practice and good process evaluations.
Marketing and Outreach strategies	*Multiple access points *Local needs assessment *Access facilitation (outreach and networking)

Author	**Minister for Children and Youth Affairs**
Opening hours	*Extended hours (17h30-21h)

Building design	*Homely and welcoming atmosphere *Seen by YP as 'cool' *No stigma or label *Comfortable *Homely *Cosy area *Colourful *Friendly surrounding and relaxed atmosphere to chill out *Interconnected rooms *Jukebox *Bookshelf *Seating area *Tables in eating area	*Pool *Table tennis *Hockey tables *PlayStation *Bean bags *Youth info display board *Recreational area seating *Coffee dock *Internet access point *Sound-proof music room state-of-the-art music recording and mixing facilities *Kitchen area *Arts-and crafts area *Soccer and basketball areas
Location	*Accessible *Convenient *Close to transportation *Place where its viewed as positive addition *Relax *Safe	*Social/emotional accessibility *Could act as a point of congregation for youth *Neutral *Should fit in the community *Not unduly change the landscape *Central
Youth participation	*Partnerships throughout conceptual to daily running of the center *Precise model is something YP decide themselves *Gives them a greater sense of civic responsibility	*Youth-led approach *Basic & core principle *Planning, setting up, running of the center
Approach/ practices	*Initial assessment of patients/ participants needs *Outcomes-focus framework *Policies: re: code of behaviour for staff/volunteers, re: parental involvement and confidentiality, re: staff and volunteers, re: complaints, re: accidents, child protection issues and health and safety and insurance, alcohol, drugs and smoking, drop-in center during school hours, protocol for the use of pool table *Reporting procedures to HSE and other partners, parental involvement and sharing of info, confidentiality statement, state recruitment and selection procedures, safe management of staff and volunteers, allegations against staff and complaints procedure, accidents procedure, managing a drug-related incident, use of toilets, policy for outside groups using the center *Guidelines/principles: youth participation, safe and quality space, clear purpose, inclusive, accessible, flexibility re: culture, support by	

	volunteerism, respectful of individuality, sustainable, strengths-based approach, committed and passionate staff, well-resourced into the future, location and internal environment, drug and alcohol-free, opening hours meet YP requirements, place to develop good quality relationships between YP, peers and adults, variety of activities and opportunities/workshops, programmes and events, raising awareness and giving info on resources and supports *Sustainable (ownership by young people, acceptance by the community)
Partnerships	*Service corridors *Privileged access
Research	*Monitoring and evaluation is paramount importance *Qualitative and quantitative measurements *Examples of research outcomes, indicators and targets *Research based on AFQuATS
Marketing and Outreach strategies	*Local/social media *Promotion strategy *Website *Free internet *Free mobile charger *Having a good message / mission / why you're setting up the center *'an Opening Day' *Young people need to be proactive in encouraging others to come *Websites *Promotion in schools *Produced a DVD for school/youth groups/community services

Author	**Patulny, Muir, Powell, Flaxman, Oprea**
Opening	*Regular hours (starts between 8h-9h and closes between 16h-17h30) *Flexible hours: 1-2 evenings a week after 17h or 1 evening closes at 18h or later or more than 1 evening closes at 18h or later and/or is opened on

hours	Saturday	
Building design	*Colourful walls *Colourful waiting area *Comfortable lounges *Converted houses *Custom built *Sound proof *Example of barriers: intercom system	*Relaxed *Safe environment *Open waiting area *High ceilings *Not too clinically 'white' or like a medical clinic *Non-clinical
Location	*Near public transport *Close to other services *Frequented by YP *Not obvious	
Youth participation	*Organising social events *Participation policies *Contribution to look and feel of environments and advice materials *Participate in staff recruitment *Help to address gaps in service provision	*Promotion/marketing and local campaigns *Needs to be directly or indirectly affected by mental health *Passionate of mental health and/or their work *Over age of 15 (due to complexities of duties)
Approach/ Practices	*Holistic services *Regular clinical meeting and case review meetings *Cross-disciplinary training *External providers in case review meetings *Should have staff supervision structures *Strategic goals: awareness, access, integration, sustainability, effectiveness *Clinical governance guidelines *Clinical quality and risk management group *Factors contributing to sustainability include: effective clinical governance, appropriate policies and procedures, divers funding, a full complement of staff, framework for good practice episode of care *CYS model diagram *Best-practice frameworks: accessible, acceptable, appropriate, sustainable *Communication strategy (Phone/Fax, Email, Facebook) *Initial assessment within 1 week to determine most appropriate individual needs and type of service/support	
Partnerships	*Partnerships with headspace national office *Research and dissemination component *Service provider education and training program *Community awareness program *Youth national reference group *Service coordination activities: joint planning, referrals to other agencies, joint service delivery, case management, exchanging info, joint staff training,	

	multi-disciplinary meetings *Factors that promote coordination: respect for and understanding of needs, willingness among stakeholders to work together, common working culture *Culture that includes: the goal of cooperation, leadership among agencies administrator, providing a forum to work together, leadership for the local site, government mandates for more efficient and effective service provision *Developing seamless referral pathways	
Research	*Feedback form *Research and evaluation strategy *Evaluation framework *Collaborative research *Provide data that captures all the work that centers undertake, while clients progress, within the service, when clients exit the service longer-term data for longer-term outcomes	
Marketing and Outreach strategies	*Participation in national and local events *Advertising campaign *Website *Twitter/Facebook *Other social media *Media *Marketing: TV, print and electronic media *Evidence maps *Evidence summary *'mythbuster' factsheets *Training modules *Newsletter *Radio *Links with sporting events *Presence at music and festivals *Regular reviews of appropriateness and effectiveness of its marketing and activities with particular focus groups *Advocacy *Informing stakeholders *Participation in communications campaigns and development	*Liaising with local youth groups *Producing communication bulletins for the website *Participation in media activities *Providing advice to other organisations *Promoting the importance of providing mental health materials in schools *Different access points: center, clinic e-mental health *School initiative to support high-schools *Strategies to promote engagement *Phone call reminder the night before *Phone call the day of *Txt message the night before *Txt message the day of *Pick up the YP *Charge the YP for unattended appointment *Charge the service provider for the unattended appointment *Schedule appointment at appropriate times for the YP *Eheadspace to compensate for regular opening hours *Appointment reminders

Author	**Practice Notes**
Opening hours	
Building design	
Location	*In the city

Youth participation	
Approach/ Practices	*Holistic service approach *Effective case management *Partnerships *Continued staff development **Expectations for participants:* no loitering/littering; no selling anything during school hours; to follow proper late arrival and early dismissal procedures; follow dress code; not use cell phones I-pods/or other electronic device during classroom hours; respect yourself; appropriate language; to take care of school property and materials; to arrive on time everyday
Partnerships	*Baltimore city educational system partners *B.C. department of social services *B.C. health departments *B.C. Police Department *B.C. Recreation Department *Center for Law and Public Policy *Chesapeake Center *Civic Works *Community Programs *Governor's office on Crime Control and Prevention *John Hopkins Hospital *Mayor's Office of Employment Development *National Urban Technology *Safe and Sound Campaign *Sinai Hospital
Research	*Performance benchmarks: program participation, program completion, service goal, long-term placements, retention, employment activities *Community impact survey
Marketing and Outreach strategies	

Author	**YOSS**
Opening hours	*Youth-friendly opening hours *Average 39-44 hours *Late/after 17h hours

	*Varies day-to-day, dep. on the clinics/activities being offered	
Building design	*Youth-friendly settings *Canvas for youth-art *Art *Pet fish	*Safe and relax atmosphere *Review of centers, some of them have been opened for over 10 years
Location	*Good location/privacy *Free parking	*Located centrally *Close to public transport
Youth participation	*Youth involvement/participation structure *Youth peer support worker	*Youth focus groups/perspective to help with service planning and review *Youth advisory group
Approach/ Practices	*Service integration and coordination *Culturally respectful *'Wrap-around packages' *Encouragement of self-care *Initial needs assessment and integration *No cost *Culturally appropriate services	*Combination of walk-in and appointment based *Youth peer workers *Governance board *Quality standards and improvement activities *Youth development framework: Youth Development Strategy *Initial assessment of patients/participants needs
Partnerships	*Good communication links which maintain funding, accountability and referral networks *Sharing accommodations/ co-location *Collaboration on projects/events *Providing or receiving training *Collaboration in development of resources *Advice seeking from experts	*Acting as community advocates *Collaborating and working with services for youth offenders *Informal and informal links *Ongoing contact and liaison through youth workers *Funding and sustainability strategies
Research	*Evaluation framework re: government expectation/plan *Reports on outputs *HEADSS	
Marketing and Outreach strategies	*Free soup *Phone *Texting *Facebook page	*Outreach or mobile services *School-service delivery within alternative education sites *Text reminders

Author	**Rickwood, Van Dyke, Telford**
Opening hours	(see Patulny, Muir, Powell, Flaxman, Oprea data)
Building design	Idem

Location	Idem
Youth participation	Idem
Approach/ Practices	*Establishment and support of a Youth Reference Group to guide center development and implementation *Governance arrangements: overseen by a consortium of relevant local services, composition varies according to local capacity, but is expected to comprise, at minimum, representatives from the 4 core streams of mental health, alcohol and other drugs, physical health and vocational assistance *Significant local differences in population need, geographic location, workforce availability consortium and lead agency capacity and focus, community support and a variety of factors led to differences in focus and priorities *Common characteristics: local partnerships, community engagement activities, clinical governance structures, youth-friendly environment, coordinated and integrated services, care coordination mechanisms, comprehensive assessment, involvement of young people and families, workforce development strategy, social recovery
Partnerships	(see Patulny, Muir, Powell, Flaxman, Oprea data)
Research	Idem
Marketing and Outreach strategies	Idem

**For the articles by McGorry, Bates and Birchwood and by McGorry, Tanti, Stokes, Hickie, Carnell and Littlefield and Moran, see data from the Patulny, Muir, Powell, Flaxman and Oprea article

Center data: Clinical Strategies Data

Author	**Cyr**

Staffing	*Can be deduced re: activities
Staff training, and Evaluation	
Non-clinical activities	*Non-clinical case management *A restaurant and catering center offering training in culinary arts and business *Basketball court, baseball field, soccer field, skate park, hip hop dance classes *GED prep courses, school re-enrolment assistance, individual academic planning, study habits clinics, computer literacy, basic skills remediation, service learning, prep for ACT/SAT, assistance identifying financial aid and scholarship opportunities, completing college applications, developing personal statements, college tours, job readiness and placement, YU EXCEL, YU Eat, YU Count, YU Create, YU Work, employment services and support, tutoring, vocational education *Studio recording/engineering sessions, radio and club dj-ing workshop, music and lyrical composition class, beginning and advanced piano class, performing arts class, video/film production workshop, (camera, lightning sound, video editing, writing, directing, producing, editing and distributing), visual arts workshop (beginning and advanced studio art; digital photography; graphic design; web design), music and video production, ceramic class, art class, dance battles, modeling/fashion *Youth leadership development program, youth advisory board, developing direct actions and responses to current events in our community *Organising events to raise awareness about issues affecting our community, hosting monthly house meeting with members, YU Lead program
Clinical activities	*Health and wellness clinic: massage therapy, acupuncture, chiropractic, wellness workshops, medication referrals, herbal and homeopathic remedies, acupressure, nutrition advice, physicals, immunisations, treatment for acute and chronic illness, testing for STIs and pregnancy, counselling to support youth struggling with sex- and sexuality-related issues sexuality-related issues, preventive screening for asthma, diabetes and hypertension *Mental health care: individual and group music therapy, counselling, crisis intervention/management, individual/group/family therapy, psycho-education, mentors, life coaches, case management, advocates
Values	*Empowerment *Paradigm based on the development of: social, emotional, cognitive, behavioural and moral competences *Self-efficacy *Holistic approach *Peer worker approach

Author	**Illback, Bates**	
Staffing	*Clinical coordinator	*Clinical support worker

	*Community outreach worker *Counsellor *Psychotherapist *Youth and community engagement worker *Fundraising events intern *Administrator officer *Receptionist *Project assistant	*Project manager *Social worker *Mental health nurse *Psychiatric nurse *Counselling psychologist *Clinical psychologist *Occupational therapist
Staff training, and Evaluation	*Recovery oriented *Multi-disciplinary focus	
Non-clinical activities	*Youth advisory panel *Significant Adults Advisory Forum	
Clinical activities	*CBT informed support *Stress and anxiety reduction *Psycho-education *Problem solving *Case management / service coordination *Mindfulness *Anger management *Support and information for youth's parent *Social skills support *Conflict management *Interventions/other *Family work *Suicide presentation strategies *Bereavement support *Alcohol/substance misuse support *Mental health assessment *Goal-setting & support	*Orientation to appropriate services *Parental support *Professional support *Book Project: read your mind (catalogue of books on mental health topics) *Brief intervention model *Goal-focused problem solving and support *Screening for risk *Prevention of self-harm *One on one support *Support for the young person or a friend/young person in their life and parents *Self-advocacy *Workshops for young people or those who work with young people *Peer interventions
Values		

Author	**Kang**	
Staffing	*Multidisciplinary *Specialised teams	*Nurse practitioner *Outreach worker

	*Manager *Youth worker *Nurse	*Intake worker *Counsellor *Pediatrician
Staff training and evaluation	*Bilingual *Cultural rep *Professional development: orientation procedures, budget allocation, annual appraisal, equitable access	
Non-clinical activities	*Art *Music *Drop-in times and space *Shower and laundry *Computer/internet access *Information/education groups *Gym *Kitchen/cooking area/times	
Clinical activities	*Contraception info *Counselling *General health check-ups *Peer support/support groups *Individual/group therapy *Referral and support access to mainstream health services *Advocacy	
Values	*Evidence-based practice *Flexible service provision	

Author	**Minister for Children and Youth Affairs**
Staffing	*Presence of resource/liaison/non-administrative coordinator
Staff training and	*Specific staff training and selection (support, education, management, mediation)

evaluation	*Committed staff
Non-clinical activities	*Hang out space with drop-in and activity times, including music and dancing *Workshop and programs, afterschool development programmes, opportunities to be challenged and learn new skills ex: leadership skills *Both entertaining and educational *Food, food menu *Dance *Cyber-bullying info *Big range and content of activities *Relaxation *Recreation *Entertainment
Clinical activities	*Health specific info *Initial assessment of patients / participants needs *Advice or even direct care / service provision *Confidential advice and help from counsellor, teenage pregnancy, alcohol and drugs and sexual mental and general health issues
Values	

Author	**Patulny, Muir, Powell, Flaxman, Oprea**	
Staffing	*Aboriginal youth engagement officer *Aboriginal Medical Service *Aboriginal Mentor	*Midwife *Nurse *Nurse intake

	*Aboriginal Health Worker	*Nutritionist
	*Access Worker	*Occupational Therapist
	*AOD counsellor	*Practice Nurse
	*Anger Management worker	*Practice Support Officers
	*Art Therapist	*Program support worker
	*ATAPS Counsellor	*Psychologists
	*Baby Health Clinic Nurse	*Psychologist intern
	*CAMH Workers from Mental Health ACT	*Psychotherapist
	*Case Managers	*Psychiatrist Registrar
	*Clinical Support Officer	*Psychiatrist
	*Clinical Nurse Specialist AOD	*Registered Psychologist
	*Clinical Psychologists	*School Support Clinician
	*Clinician (Youth Early Psychosis Program)	*Sexual Assault Counselling Service
	*Community Engagement Workers	*Sexual Health worker
	*Community development and engagement officer	*Sexual Health Nurse
	*Counsellor	*Social Worker
	*Counselling psychologist	*Student Program Assistant
	*Community awareness/youth participation worker	*Suicide Prevention Psychologist
	*Community Awareness and business engagement officer	*Researchers
	*Community Support	*Tenancy Support
	*Dietician	*Trainer
	*Dietetics Students	*Visiting/Tele Psychiatrists
	*Doctor	*Vocational Support
	*Early Intervention Mental Health Clinician	*Volunteers
	*Educational Support	*Women's health nurse
	*Education & Health Promotion Officer	*Youth Access & Awareness Workers
	*Engagement Officer	*Youth Access Clinicians
	*Employment worker	*Youth Access Clinician (Community)
	*Financial advice worker	*Youth And Family Access worker
	*Family relationship worker	*Youth CNC (Clinical Nurse Consultant)
	*Family & Carer Support	*Youth counsellor
	*Family Counsellors	*Youth Development worker
	*Family Therapist	*Youth Engagement Worker
	*Forensic Psychologist	*Youth Health Worker
	*Gambling Counsellor	*Youth Mental Health Workers
	*General Practitioners	*Youth Intake Worker
	*Intake Case Coordinator	*Youth Project Officer

	*Mental Health Advocate *Mental Health Clinicians *Mental Health Nurses *Mental Health Social Workers *Mental Health Occupational therapist	*Youth Social & Emotional Wellbeing Worker *Youth Outreach Workers *Youth Worker *Zoo-therapy (dog)
Staff training and evaluation	*Annual training calendar (clinicians and managers) *Webinars *On-line resource library *Training areas were: psychosocial development of young people and the purpose of aggression, how to identify YP at risk of suicide and deliberate self-harm, the role of policies and procedures in managing challenging behaviours and preventing staff burnout *The Comprehensive Assessment of At Risk Mental State Tool and its application *Motivational Interviewing principles to prepare YP for CBT interventions *When to apply Problem Solving Skills Training *Staff supervision: one-on-one and group *Training modules: screening-engaging-early, early identification of psychosis, managing challenging behaviours, MI and behaviour change techniques, problem-solving skills training *Working with families and significant others *Promoting access and support seeking in YP *Friendly and welcoming staff *Flexible *Respectful *Responsive	
Non-clinical activities	*School assistance *School and services *School support *Recreational activities (important early-identification strategy to engage young people) *Music *Games *Computers and internet access *Work and Study Services *Youth Reference Group *Youth Programs * ‘ARAFMI’ * ‘Cyber Cats’ *Distance education *Free yoga classes	* ‘Play pop up shop’ * ‘Q Youth’ * ‘Raise your card – film project’ * ‘Read the play’ * ‘SAFEMinds’ *Skillhire resume rescue workshop * ‘Talking about Your headspace’ Youth Ambassadors * ‘YOUTH FOCUS’ *Aboriginal services *Advisory committee *Sports club support *Student assignments *Youth participation and volunteering *Youth advisory/reference group/program *Quality and innovation (support and enhances services, continue

	* 'Headspace PASS' * 'Move aHead' * 'Open access' * 'Pineapple Jam' *Players Drama group	to build services) *Workforce (build workforce) *Advocacy and engagement (continue awareness and community engagement, advocacy) *Information management and infrastructure *Business capacity (enhance internal procedure and processes)
Clinical activities	*Mental Health Services *Doctor (GP) *Sexual health Services *Alcohol & Drug Services *Youth Early Psychosis Program *Docs and teen *Zoo-therapy walks *Family counselling services *Community participation *Education sessions *Family support *Family inclusive program *Information session and events *Mental health workshops *Personal/individual support *Phone support *School presentation *Young parenting program *Young parents support group *Youth mental health first aid training *Clinical programs (early intervention services, e-headspace, school support)	
Values	*Values: compassion, inclusivity, responsiveness, passion, leadership	

Author	**Practice Notes**
Staffing	*Highly skilled and professional staff members *Trained for the employment

Staff training and evaluation	*Development of well-planned and challenging "youth worker" training *Youth Practitioners curriculum specifically for YO! Baltimore *Caring adults *Coaches *Mentors *Mobile health team =medical assistant and 2 health educators *Committed role models *Qualified, supportive, and nurturing staff *Experienced and trained in: case management, youth development, resource coordination for youth at-risk/ sexual minority/ juvenile offenders	
Non-clinical activities	*Basic literacy, pre-GED and GED classes *On-line tutorials and courses to help *Youth earn a diploma *Life skills, clubs and fun social events *Job readiness classes and job placement services *Career training in high growth industries *Community service projects and civic engagement *Recording studio (YO! Westside only) *Fitness center (YO! Westside only) *Comprehensive education *Employment preparation	*Support services (recreation and cultural enrichment, transportation) *Leadership development *Creative programming *Individualised schedules *Experiential service-learning opportunities *Field trips *Creative after-school programming *Career-related education *Non-paid and paid work experience *Performance incentives
Clinical activities	*Health education *Substance abuse and m. h. counselling on site *Physical and mental health *Group counselling *Mentoring	
Values	*Easy assessments to identify *Development benchmarks and the level of required services	

Author	**YOSS**	
Staffing	*Youth worker *Youth counsellor *Nurses	*Social worker *Youth worker interns *Counsellor

	*MDs *Office admins	*Midwife *Psychologist
Staff training, Staff evaluation	*Specialised staff re: expertise with youth, about youth *Passionate and committed *Mentoring program *Youth friendly staff *Multi-disciplinary *Professional development and training *On going, on-site supervision	
Non-clinical activities	*Advocacy *Coaching *Youth transition support *Youth development support *Mentoring *Training and education *Service integration and coordination *Information *Support	*Preparatory or life skills programs *Holiday programs *Recreational services (pool/table tennis…) *Interpreter services *Education & employment support *Transitioning services/support *Help with driver's license *Inter-generational urban community garden
Clinical activities	*GP & walk-in health clinic *Sexual and reproductive health *Vaccinations *Health promotion and education *Alcohol and other drug services *Counselling	*Social services *Wellbeing group *Antennal group *Parents' group *School Clinics *After school groups
Values	*Responsible/accountable to each other *Hold fast to beliefs/confidence that what we are doing is right *Moral and ethical *Maintain unity	

**For the articles by McGorry, Bates and Birchwood, by McGorry, Tanti, Stokes, Hickie, Carnell and Littlefield and Moran, and by Rickwood, Van Dyke and Telford, see data from the Patulny, Muir, Powell, Flaxman and Oprea article