Youth Engagement Project

Needs Assessment Report

Contact:
Ben Rempel, Manager
P: 416-367-3313 ext. 233
E: brempel@opha.on.ca

Production of this Needs Assessment has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Table of Contents

List of Appendices

Introduction

The Ontario Public Health Association (OPHA) recently received funding from Health Canada's Drug Strategy Community Initiatives Fund to undertake a project to enhance youth engagement with youth ages 11-14. Youth engagement has been found to be a key protective factor, particularly with this age group when it comes to resiliency around risk-taking behaviour.

As part of this project, a needs assessment of public health professionals working with schools was conducted to determine their resource and training needs around youth engagement and illicit drug use or other risk-taking behaviours. The needs assessment also asked about public health team's interest in and readiness for participating in the OPHA project as one of six pilot sites in Ontario.

This report presents the findings of the needs assessment of public health professionals. Overall findings are provided in Section I for the 33 health units who responded to the needs assessment survey. Section II describes the process for pilot site selection. Section III offers suggestions for training and resource design based on the needs assessment findings, and Section IV discusses next steps for the project.

Please note: This report has been stripped of identifying information for anonymity.

Section I: Overall Findings

A total of 28 out of 36 health units completed the needs assessment survey (response rate 78%). Responses can be grouped into 6 categories: Experience with youth engagement; Community characteristics; Community need; Readiness for pilot site participation; Interest in youth engagement and in pilot site participation; and, Training and resource design.

a. **Experience with youth engagement**

Four questions were asked about the health unit/team's prior experience with youth engagement. Sixteen (57%) health units reported that they were already involved in several youth engagement initiatives, the others reporting that they were beginning to learn, think about and implement some initiatives – 18 said that they had already been involved in youth engagement projects with the priority population (i.e. youth 11-14 yrs). Most of the 28 respondents felt that they would benefit from training on youth engagement either because it was a new area (29%); they thought training would be useful (64%), or they were looking for refresher (7%). Findings were similar when asked about training needs around drug use prevention; although 3 health units did say that they did not require any training at this time.

b**. Community characteristics**

Concerning the geographic make-up of the 28 responding health units, 50% described themselves as largely rural, 21% as largely urban, and 29% an equal mix. Health units were asked about the "type" of population they specifically work with, and about the geographic make-up of their region. Of the 23 health units who answered the question, the majority (74%; n=17) worked with vulnerable youth, although 13 said they work with LGBT2S youth, 8 said they work with Aboriginal youth or youth in care, and 10 reported working with Francophone youth. Other groups each reported by one health unit included: Mennonite youth; youth in shelters and prisons; rural youth; youth in military; youth with co factored challenges (ADHD, Aspergers); and, ethno-cultural youth.

c. **Community need**

Community need for youth engagement initiatives was determined by asking two questions. First, health units were asked how much illicit drug use or other risk-taking behaviours is a problem in their schools/community, to which 50% answered, it is somewhat a problem, and the other 50% said it is very much a problem.

Second, health units were asked to rate the degree to which risk factors and protective factors were present in each of five major life domains. For risk factors, almost all respondents rated risk factors to be moderate to high in each of the five life domains, with individual, family, and peer domains rating appearing to have a somewhat higher degree of risk factors. Protective factors were rated low to moderate by almost all respondents in each of four life domains with the school being the only domain which was reported to have a somewhat higher degree of protective factors.

d. **Readiness for pilot site participation**

A series of questions were asked to determine health unit's readiness for pilot site

participation. Indicators of readiness included: the priority given to youth engagement, access to at-risk, francophone, and school populations, involvement of parents in schools/community, and experience working with at-risk youth.

Only one health unit said that youth engagement was their primary focus, the rest saying it was a high priority (43%; n=12), just a priority (39%; =11), or somewhat of a priority (14%; n=4). Though not a necessity for pilot site participation, health units were deemed more ready if they had prior experience working with at-risk youth, to which 71% (n=20) said they have some experience and 11% (n=3) said they have a lot of experience; 18% (n=5) said they have very little experience.

Most health units said they have access to at-risk school populations (82%, n=23), and to at-risk youth in community centres (71%, n=20); less access was reported to at-risk youth in after-school programs (61%, n=17) or to Francophone youth, although 48% (n=13) said they could access Francophone youth in schools. Over half (57%) said they could access 80 youth to participate in a pilot project 'with some effort'. Another 32% (n=9), felt this would be very difficult to do, and 11% (n=3) said it would be no problem. The majority (89%, n=25) said that parents were active in the schools/community but only moderately.

Prior ethical approval from schools or policies for working with youth in schools was considered an indicator of readiness, though not a requirement for pilot site participation. Approximately half of the health units (52%, n=14) said they have had prior ethical approval for a research project in a school and 30% were unsure. Similarly, 68% said they have policies for working with youth in schools while 11% were unsure.

e. **Interest in youth engagement and in pilot site participation**

Interest in youth engagement and in the project was assessed through a series of questions which asked about the degree to which health units were interested in training on youth engagement, on drug prevention/illicit drug use, and whether or not they would be interested in becoming a pilot site.

All but one health unit said they were interested in training on youth engagement. Twenty-four of the 28 health units said they would be interested in training on drug prevention/illicit drug use; 2 said they were not interested and 1 was unsure. Nineteen health units reported being interested in participating as a pilot site; 4 were not interested, and 5 were unsure.

f. **Training and resource design**

Six questions were asked to gather information about the areas of training required by health units and the format of the training that was most desirable. Responses are provided in Section III of this report.

Section II: Methodology for Pilot Site Selection

A screening process was used to select pilot sites for the youth engagement project. The screening process is described below.

First, because the outcomes of interest for the youth engagement project are to improve the capacity of public health professionals to undertake youth engagement, health units who were already "already involved in several youth engagement initiatives", or for whom youth engagement was "a primary focus", and thus who already exhibited a capacity for youth engagement, were disqualified as potential pilot sites. However, those who reported already being involved in youth engagement but not with the population of interest for this project (i.e. 11-14 year olds) were still considered as potential sites.

Second, it is of course important that pilot sites have an interest in participating in youth engagement initiatives. Therefore, those respondents who said that they were "not thinking about youth engagement at all", those for whom youth engagement was "not a priority at all", or those who reported not being interested in training or in becoming a pilot site, were disqualified as potential pilot sites.

Third, health units who reported that illicit drug use or other risk-taking behaviours were not a problem in their schools/community were disqualified as potential pilot sites. Similarly, those who reported a high degree of protective factors and a low degree of risk factors were also disqualified.

Finally, readiness to undertake youth engagement and to work with youth in schools is an important consideration for pilot site selection. Only those health units who reported having access to at-risk school populations were included as potential sites. Those who reported gaining ethical approval from school boards for previous work, or who had policies in place for working with schools were considered to be more ideal sites.

The screening process resulted in 5 sites who were considered to be ideal candidates for pilot site selection. One of these sites was eliminated because they were already involved in a DSCIF project on youth engagement, leaving four sites. The additional two suggested sites met all but the requirement of experience with at-risk youth and/or sited difficulty accessing 80 youth to participate in a pilot project.

Section III: Findings for Training and Resource Design

It was clear from the responses that health units were interested in training on youth engagement. When asked to what extent the health unit team would benefit from training on youth engagement, 29 % (n=8) reported that youth engagement "is a new area for us so we would benefit a lot from some training", and 64% (n=18) reported that "the team has worked in this area but some training would be useful". Seven percent (n=2) said that "the team is very knowledgeable but that there is always some room for improvement or refresher". Respondents seemed less enthusiastic about training on drug use prevention/illicit drug use or other risk-taking behaviours, but still reported some interest: 11% (n=3) reported they did not require training, or that they were already knowledgeable (7%, n=2); 14 (n=4) said that the area was new so they would benefit a lot from training; and, the majority, (68%, n=19) said they had worked in the area but some training would still be useful.

The top 3 areas of training in youth engagement reportedly needed were: outreach and recruitment; informal vs. formal youth engagement; and, incentives and enabling participation. Additional areas of need are shown in table 1 below.

Table 1 - Training Needs Concerning Youth Engagement

[1] Reporting that it would be very difficult to access 80 youth to participate in a pilot project did not disqualify health units as potential sites. The reason for this is that it is possible that the way the question was worded on the survey led health units to believe that they needed to access this large number of youth themselves directly. In reality, the sites are required to access a small group of youth to act as leaders in their community who will then engage approximately 80 youth in various activities.

[2] Out of a total of 29 respondents.

Area of Training	Percent reporting need	# of respondents reporting need
Outreach and recruitment	79	23
Informal vs. Formal youth engagement	79	23
Incentives and enabling participation	76	22
Engagement within an anti-oppression framework	72	21
Absenteeism and disinterest	66	19
Preparing an organization for youth engagement	62	18
Dominant personalities	48	14
Representation	48	14
Sustainability of youth engagement programs		2
Understanding youth development process		1

Generational differences and how to work between generations		1
Working with youth who "drop through the gaps"		1
How staff's communication influences youth		1
Communication with youth (new media – facebook, texting)		1

The top 3 resource centres or agencies teams reported to have utilized in order to obtain youth engagement resources were: OPHEA (85%, n=23); CAMH (82%, n=22) and, OHSC (74%, n=20). Additional resource centres and agencies accessed are shown in Appendix A.

The top 3 preferences for training activities/formats on youth engagement were: hearing directly from youth, schools, and other public health professionals (75%, n=21); interactive activities (71%, n=20); and, review of case-studies of what works (61%, n=17). These three types of activities/formats were also the most desired for training on illicit drug use or other risk-taking behaviours. For a complete list of responses see Appendix C.

The most desired formats for resources/supports on youth engagement included:

- Research on what works (96%, n=27)
- Ongoing consultation (64%, n=18)
- Package/tool kit that can be shared with school (57%, n=16)
- Websites (54%, n=15)
- Networking opportunities (50%, n=14)

Additional resources/supports on illicit drug use were mentioned by 10 respondents. These included: plain language resources, money/grants, county level usage data, access to local consultants/contacts, facts on drugs and their effects, evaluation methodologies and tools, dedicated professionals who are youth-focused.

For a complete list of responses see Appendix C.

Section IV: Next Steps

Each of the six pilot sites will be notified of their possibility of being included in the OPHA Youth Engagement project and the terms and conditions of participation outlined. Interest from the six pilot sites will be confirmed.

Telephone interviews with front-line staff from each of the six pilot sites should then be conducted. Interviews will explore the findings of the needs assessment survey in more depth and detail, specifically with respect to training and resource design, website content, youth engagement experience, and ethical issues and policies for gaining access to youth in schools.

Appendix A Resource centres or agencies that teams have utilized to obtain youth engagement resources.

Resource Centre/Agency	% reporting access	Number reporting access (out of 29)
OPHEA	85%	23
CAMH	82%	22
OHSC	74%	20
PAD	74%	20
CASH	52%	14
RNAO	41%	11
PRO	37%	10
Youth Advocacy Training Institute (YATI)	31%	9
United Way	26%	7

Appendix B Preferences for training activities/formats on youth engagement

Training activity/format	% respondents	N (out of 27)
Review of case studies of "what works"	82%	22
Hearing directly from youth, schools, other ph professionals	67%	18
Interactive activities	56%	15
Whole group presentation/lecture	33%	9
On-line modules	30%	8
Networking opportunities	15%	4
Small group discussions	11%	3

Appendix C Desired formats for resources/supports on youth engagement

Desired format for resources/supports on youth engagement	% respondents	N (out of 28)
Research on what works	96%	27
Ongoing consultation	64%	18
Package/tool kit that can be shared with school	57%	16
Websites	54%	15
Networking opportunities	50%	14
Coaching	46%	13
Listservs, blogs, social networking websites	39%	11
Articles in peer reviewed journals	21%	6
DVD	14%	4
Fact sheets	11%	3
books	4%	1
Virtual communities of practice	4%	1
How-to Kit for staff	4%	1
Mentoring opportunities for staff	4%	1
Dedicated professional	4%	1
Comprehensive reflective materials	4%	1
Participatory research	4%	1
newsletters	0%	0
pamphlets	0%	0