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Youth Engagement Project

**A Research Report and Recommendations for OPHA to Support Public Health
Staff to Enhance Protective Factors, Increase Resiliency and Reduce Illicit Drug Use
with Students in Grades 6-8 in Ontario.**

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1.0 EXECUTIVE SUMMARY

The mission of the Ontario Public Health Association is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public and community health throughout Ontario. To that end it supports local public health departments in responding to the Ontario Public Health Standards developed by the Ministry of Health and Long Term Care (Ontario Public Health Standards, 2008).

The Youth Engagement Project is expected to be one such support. Funded by Health Canada's Drug Strategy Community Initiatives Fund in 2009, the project will train and provide resources for public health professionals in six pilot projects occurring in public health units across the province. Formative, process and outcome evaluation activities will take place as part of an overall evaluation strategy developed with an external consultant. Expected outcomes include an enhancement of youth engagement and other protective factors associated with resiliency for youth ages 11-14. A long-term goal is the reduction in illicit drug use or other risk-taking behaviour.

It is expected that the pilot projects will form youth groups led by people in the community, (teacher, parent, youth worker, student or public health staff). Youth will problem-solve about ways to enhance their protective factor and solutions will be developed looking at opportunities within their community to support youth engagement in the school, in volunteerism or recreation. This process follows on the learnings of the Smoke-Free Ontario Strategy which many public health units engaged in recently.

This research report was commissioned to provide current and relevant research and literature on best and promising practices that could guide the project and the resources.

Over a period of three months and in collaboration with the planning team from OPHA and the partners, the author searched out relevant literature from peer-reviewed journals, and grey literature and was directed by key informants about literature and programs which fit the inclusion criteria. A synopsis of this literature and analysis and several recommendations for OPHA's pilot project were presented and this report developed. The results of this search were limited by time and budget which reduced access to all information that had been formally studied and published.

The literature review focused on four key areas – resiliency and protective factors, youth engagement, the settings approach for health promotion, and the prevention of illicit drug use plus the relevance of each of these with the target age group, with each other and with the inclusion criteria identified by the partners.

Findings

1. Youth in Ontario ages 11-14 are experiencing or at risk for experiencing negative health outcomes based on current stats and trends. This relates to alcohol and drug use, mental health issues, violence and risky sexual activity.

2. These risk are enhanced by social determinants over which this age group has little control.

3. Disengaging/feeling disengaged from schools and communities seems to increase the risk and this does seems to be something they have control over.

4. Comprehensive approaches focusing on resiliency and the promotion of protective factors are more likely to change behaviour than focusing on risk factors.

5. Research into youth engagement as a protective factor is currently demonstrating that it is key to enhancing resiliency and improving health outcomes.

6. There are numerous organizations doing this research including governments and universities. Guidelines/principles are available from these groups about the best ways to support youth engagement in schools and in communities.

7. Less common are on-the-ground programs that support resiliency according to these principles especially those that address illicit drug use

8. Most drug education programs are not effective in reducing drug use.

9. There is a need for more research into programs and policies in schools and communities that support resiliency, youth engagement and the reduction of risk-taking behaviours including alcohol and other drug use. Promising programs in schools and communities are included in the report

10. Youth must be included as key partners in any initiative or approach - not just as recipients of programs or as token spokespeople.

Evidence-based programming for this age group addressing the specific criteria for inclusion is limited. Some of the more promising programs are:
In schools
- Comprehensive Youth Pilot Project CYPP – Toronto Public Health
- School-aged Children and Youth (SACY) Alcohol and Other Drugs Prevention Initiative – Vancouver Coastal Health
- Gatehouse Project – Centre for Adolescent Health, Victoria, Australia
In communities
- Communities That Care – United States and Canada
- Tiny Giant/The Students' Commission – Canada
- YACshops – McCreary Centre Society, British Columbia

Conclusions and Recommendations
- Within the scope of this project, Public Health professionals in Ontario have the opportunity to reach "at-risk" youth (youth at-risk of disengaging from school or community) with youth engagement activities in either the school or the community through already identified and evaluated processes, programs, and /or strategies **and** to expand the research into reducing risk-taking behaviours.

- A key challenge is the time allotted to this project and school/community readiness is essential for success.

- The evaluation strategy and projected outcomes for success should reflect this challenge.

- PH professionals will need guidance and mentoring by OPHA to achieve the outcomes. The training day, Tool Kit, website and ongoing support are essential for success.

- PH professionals need to understand, accept and follow the principles of "authentic" youth engagement and follow the guidelines developed by OPHA for successful youth engagement programs.

2.0 INTRODUCTION

"The young do not know enough to be prudent, and therefore they attempt the impossible - and achieve it, generation after generation." Pearl S. Buck

Peter Slattery is an Australian therapist and educator who has worked with young people for many years regarding "questions of choice" as he puts it. He says, *"We really do live in interesting times. Sexuality is no longer automatically determined by one's sex; for many, marriage is now more a choice than an inevitability; many people regard drug use simply as a a choice; women of all ages no longer feel automatically obliged to stay home and raise children. The arrival of HIV and AIDS has added an ingredient of immense importance to sexual behaviour. Confusion is common, cynicism is widespread.*

Against this background, young people face an 'interesting' and sometimes disturbing array of questions about the sorts of lives they would like to lead. Do I want to take drugs? Do I really want to have sex with this person? Do I want to leave home? Why am I so angry? What's important to me? What do I want out of life? Why do I feel so awful?

There is nothing new about young people asking questions, facing decisions and dilemmas. What is new is the nature of the times in which we live" (Slattery, P, 2001)

While there are several factors over which adolescents have no control - their genetic make-up, their gender, where they live and most likely where they go to school - they do have control over several aspects of their life that can enhance the quality of that life. But the ability to take control over those aspects needs to be fostered and supported by the structures and systems that are inherent in their families, communities and schools. Their ability to take control is based within an ever-evolving set of circumstances and systems that have multiple challenges to that ability to take control. These we call risk factors and they co-occur in personal, familial social and economic realms of life

However, there are young people who seem to rise above adversity and live healthy active lives with reduced harms from the risk factors they face. These resilient individuals have spawned a movement to understand how and why this happens and how we can replicate these situations to enhance the lives of so many other children. Psychologists, educators, child development specialists, health professionals (both public health and medical/clinical providers) have researched a plethora of programs in supporting youth through adolescence.

Research into the concepts and processes underpinning resiliency is relatively recent. While knowledge of risk factors has been around for longer, the study of protective factors originated in the United States in the 1970's and 1980's after it was noted that research on risk factors for social issues like delinquency was limited in its ability to predict which individuals experiencing similar risk factors would experience problems. (Werner 1993). Often this early work focused on resiliency when it came to youth and drug use (Hawkins et al 1992). While there was some focus on community and school systems that could enhance protective factors, the emphasis for most interventions was on

a deficit model with educational rather than environmental strategies. (Zimmerman and Arunkumar, 1994)

In Canada, research and advocacy around youth resiliency began with groups like the Sparrow Lake Alliance in Ontario (Steinhauer, 1999) and the Alberta Alcohol and Drug Abuse Commission whose youth experiences surveys were instrumental in helping health promoters and educators address youth drug use and mental health issues within resiliency perspectives. (AADAC, 2003).

More recently, researchers have begun to focus on the social and economic risk and protective factors found in families, schools and communities as just as and perhaps even more important in supporting behaviour change, particularly with young people. This report has reviewed literature associated with school and community protective factors as it will support public health professionals to develop interventions with youth to enhance protective factors within these systems.

However it is important to note the impact of familial protective factors in developing resiliency particularly with this target age group which has been noted in previous research conducted by the author (Sanagan and Miller, 2004). Although these interventions will not be addressed with this particular project, public health professionals are encouraged to investigate the viability of adapting or including family support programs (e.g. CAMH, Strengthening Families, 2009) as adjuncts to their school and community initiatives when they are looking at comprehensive strategies for this age group.

A review of the literature examining resiliency and how to support youth in making positive health choices is both stimulating and frustrating. There is strong evidence about the role that youth engagement/youth development plays in resiliency and in getting to these positive outcomes (CEYE, 2003). There is also good evidence about programming and policies that could support this engagement and these outcomes (WHO, 2008). Finally there is literature to recommend principles to guide families, schools and communities to support youth engagement in making healthier choices.

What is lacking is evidence that programs that have been initiated to date have actually helped youth change their behaviour in the long term. Often programs have focused on changes to an individual's knowledge and attitudes, and behaviour is not addressed because the research is not longitudinal. Or the program or policy looks at behaviour change in the individual without looking at the social structures or systemic features which may have impacted the individual positively or negatively..

What is also lacking is a range of on-the-ground programs that have followed the evidence we do have and have incorporated youth engagement to support resiliency around illicit drug use within school or communities.

Also, with regards specifically to the current OPHA project, this report is meant to guide OPHA in support of public health professionals to develop pilot projects in their

communities. However the programs or policies that have been shown to be effective in schools or communities may not be doable in the time given to this project or within the capacity of individual public health professionals.

Given those caveats, however, the author will provide information about programs that seem to be effective, and will develop a list a guidelines that will help public health professionals with their pilot initiatives. The report will focus on what researchers are saying about adolescent health outcomes and youth engagement. The author will review evidence for the impact of risk and protective factors in several domains, and give examples where programs and policies have been able to support behaviour change particularly with young people ages 11-14, and particularly in schools involved with a healthy school framework or in a community setting.

The behaviours addressed will be those associated with lifestyle choices specifically for illicit drug use and other risk-taking behaviour like violence. The author will present examples of programs and policies which demonstrate positive youth health outcomes when it comes to these behaviours as well as general physical and mental health.

The findings in this report should guide the Ontario Public Health Association in developing resources for public health professionals in Ontario to support youth engagement activities in schools and communities for more positive health outcomes when it comes to "questions of choice".

3.0 RATIONALE AND DEFINITIONS

"Engagement and participation are important for "social development, health, and well-being" because restricted participation results in deprivation of human capabilities. Clearly, the rationale for student participation and engagement extends well beyond good educational practice and into social policy, social development, health, and well-being". (World Health Organization)

3.1 Role of The Ontario Public Health Association

As paraphrased from their website, the Ontario Public Health Association (OPHA) is in the business of supporting the advancement of the public's health by influencing government and other decision-making bodies about best practices with regard to health promotion. Collaborating in this work are public health units in Ontario plus a range of other partners whose presence on the various working groups and projects contribute to the level of expertise that is expected in such an association.

With a series of projects that address topic issues from nutrition to alcohol, OPHA sees itself as a catalyst for change and educates, provides resources to and challenges the field to develop comprehensive strategies to enhance health.

When the Drug Strategy Community Initiatives Fund (DSCIF) became available, OPHA saw an opportunity to support its mandate as well as issues important to the field, plus enhance the body of knowledge about what seems to work in supporting youth and positive health outcomes.

One of the collaborative projects that OPHA supports is the Ontario Healthy Schools Coalition (OHSC) whose mandate is to support and expand the healthy schools movement according to the following definition: "A 'healthy school' promotes the physical, mental, social and spiritual health of the whole school community and constantly strengthens its capacity as a healthy setting for living, learning and working."(OHSC 2009). Framing the DSCIF project within a "healthy schools framework" as one potential opportunity for public health professionals, encourages the uptake of the OHSC's resources and enhances the environment for on-going "healthy schools" work.

The public health field in Ontario has recently received updated Public Health Standards from the Ministry of Health and Long Term Care (Ontario Public Health Standards, 2008). These Standards state minimum criteria for effective practice in public health in collaboration with community partners.

One standard identifies the need to address injury prevention and substance misuse and charges health units to:
1. "work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the

creation or enhancement of safe and supportive environments that address(es) alcohol and other substances (as well as others)

2. use a comprehensive health promotion approach to increase the capacity of priority populations (children and youth) to prevent injury and substance misuse by:

a. Collaborating with and engaging community partners;

b. Mobilizing and promoting access to community resources;

c. Providing skill-building opportunities; and

d. Sharing best practices and evidence for the prevention of injury and substance misuse."

OPHA's "Youth Engagement" project provides new opportunities to support public health professionals in meeting their mandates with regard to substance misuse.

Finally, the emerging evidence about the impact of emphasizing positive youth development rather than youth maladjustment is very strong but still needs refinement. There remains a gap in the research about the connections and processes that occur when protective factors support resiliency. Hopefully the outcomes of this project will increase the knowledge base about these links. The project will definitely support OPHA's mandate to provide "(leadership in) the development of expertise in public and community health through collaboration, consultation and partnerships."

3.2 - Description of project

According to the DSCIF proposal from OPHA, the following key points about the project are outlined.

Project goal:

The goal of this project is to increase the application of knowledge and skills among public health professionals working with grades 6, 7 and 8 students to increase youth engagement in activities that enhance protective factors and foster resilience among this age group.

Objectives:

1. To assess the needs of public health staff working on school health teams within 36 health units (approximately 180 staff in total) throughout the province by one-on-one consultation and an internet based survey and needs assessment. We will promote resources and offer training to staff to engage youth and support the development of protective factors against illicit drug use and to foster resilience within the school community. Evaluation methodology and implementation of this objective will be developed and conducted by an independent evaluator(s) and project staff.

2. To increase the factors that foster resilience and enhance protective factors against illicit drug use within 6 pilot test middle schools or elementary schools that include approximately 500 students Grade 6, 7 & 8 students. Attempts will be made to enlist one Francophone school. Evaluation methodology and implementation steps will be developed and conducted by an independent evaluator(s) and project staff.

3. To increase youth engagement and increase protective factors to reduce student drug use among approximately 500 students Grade 6, 7 & 8 students in the 6 test sites using the health promoting schools framework which involves the assessment of student needs. Implementation of this step will be conducted by project staff and evaluated through a newly developed template by an independent evaluator.

Project Outputs
1. Needs assessment of public health staff working with schools
2. Training module for public health staff based upon needs assessment / research
3. Package of existing evidence based resources on a project website
4. Workshops for 6 pilot sites
5. Work plans from 6 pilot sites based upon student engagement needs
6. Log of coaching sessions provided to public health staff in schools
7. Reports of activities of 6 pilot schools reported to OPHA
8. Interim and Final Evaluation reports including qualitative and quantitative results
9. Revised Training materials for dissemination
10. Workshop to school health staff for all public health departments

Project Outcomes
• Public health staff on school health teams in 6 health units will have higher knowledge and skill in youth engagement as a protective factor for illicit drug use and other risk behaviours.
• Public health staff on school health teams in 36 health units will have increased knowledge and skill in youth engagement as a protective factor for illicit drug use as well as other risk behaviours.
• Schools and school communities participating in the 6 pilot sites will have increased opportunities for student engagement.
• School staff and community members will have increased knowledge of ways to increase youth engagement.
• Grade 6, 7 students will have increased participation in youth engagement activities as they progress through Grade 7, 8.

There are two target groups for this project – public health professionals being the primary target group and youth ages 11-14 being a secondary group.

3.3 Public Health Professionals

This project will support public health nurses and health promoters who are working with youth ages 11-14 in schools and communities. It is understood that health units do their work very differently when it comes to addressing the Public Health Standards. Some work very closely with school or community youth groups while others have an arms-length responsibility. It is also recognized that school boards, individual schools within boards and communities work on youth health issues very differently with regard to priorities, structures, processes and expected outcomes.

In a recent Capacity Review Report developed by the Ministry of Health and Long Term Care, challenges were identified in the ability of the Public Health sector to fulfill its mandate because of a lack of training and support for professional development as well as high staff turnover and challenges implementing evidence-based public health practices. (DSCIF - OPHA Project Description obtained from OPHA).

This need was echoed in the an interim report from Toronto Public Health on "The Comprehensive Youth Pilot Project: Applying Best Practice Principles, Focusing on Changing School Resiliency and Using the Comprehensive School Health Model as a Framework for Delivery". Findings from a focus group with public health nurse engaged in implementing the project stated:

- Most of the PHNs felt they do not have the skills to support this project. Therefore, PHN training is required in the strength-based approach, advanced facilitation, working with at-risk youth, youth engagement and partnership development.

- PHNs reported that they couldn't connect to the community.
  Questions such as, "Who is out there?", What partnerships exist between TPH and external agencies?", "Who do we go to in order to obtain resources?" The PHNs need more knowledge of available resources and how to use them.

- PHNs also reported that each school board had different ways to make decisions, and to deliver their curriculum and other programs. Given this, they reported that it was difficult to deliver the project in a consistent and uniform fashion across both boards.
  (Coughlin and Juby, 2008)

One of the deliverables for the OPHA project was a needs assessment of public health units across the province with regard to youth engagement and illicit drug use. An online survey was sent to each of the health units in May, 2009.

The complete assessment report is available from OPHA on request. The report indicated that while most health units are interested in supporting youth engagement, the ability to do so is limited in many cases because of a lack of knowledge about better practices as well as resources.

Having public health as the primary target group is key for its success since research is identifying that when it comes to youth and risk behaviors (particularly drug use) "multiple risk factors across multiple domains (for example individual, family, school and community) all need to be addressed. Risk factors and negative outcomes perpetuate one another such that addressing single risk factors will have little impact when other risk factors continue to be influential. In addition many of the risk and protective factors for drug abuse also affect other psychosocial problems like mental health problems, delinquency and school failure." (Spooner and Hetherington, 2004). Therefore public

health professionals with their health promotion mandate and skills in supporting comprehensive approaches are needed for such a project.

Also public health focuses for the most part on population health and it appears from the research that when one is looking at the target age group 11-14, a population approach is more effective than a targeted approach for youth who may be considered at higher risk because of life circumstances, illness or specific needs. Within a school, "it is theorized that whole school or universal approaches will lead to greater reductions in drug use both because they influence the larger number of young people at low or medium risk and because they can hope to have more impact on overall peer norms. (Bonell and Fletcher, 2007)

3.4 Youth ages 11-4 in Ontario - "Tweens"

"Tween" is a marketing term which defines the age group between 9 and 14. While its significance as a marketing term is not particularly useful for this project, the fact that the term has been coined at all says there is a common data set that could be helpful for research and programming.

The Health Behaviours in School-aged Children is an ongoing multi-country review of health behaviours, trends and patterns in youth health. It has been conducted since 1994 in collaboration with the World Health Organization. It was instituted in 1982 and Canada began to participate in 1989. The principal investigator in Canada is Dr. William Boyce in the Social Program Evaluation Group at Queen's University. The most recent survey, the seventh in the series, was conducted in 2005/06, but the most recent report available from the Public Health Agency in Canada is from the 2000-2001 series. (Boyce, 2004)

The survey polled 7000 Canadian students in three age groups 11, 13 and 15 and so the data is particularly useful for this project. The youth were asked questions on everything from their living and community determinants of health to their health behaviours and what influences them to make changes.

Some key points
- Clarified in this report are the links between the social and economic determinants of health, lifestyle choices and health outcomes particularly for this age group. While over 50 % of youth identified that they were well-off economically, healthy and quite satisfied with their life, 13% reported they went to bed hungry at least sometimes because of a lack of food at home. Poverty in Ontario is an issue and according to "Campaign 2000", Ontario remains the "child poverty capital," with 345,000 children living in impoverished conditions (Campion-Smith 2007).
- Having a good relationship with parents was related to higher life satisfaction and served as a protective factor against involvement in risk taking behaviours, such as smoking, getting drunk, and using marijuana. In addition, students with middle or high family affluence not only felt that their parents

provided them with the support they needed at school but they also reported being highly satisfied with their home life.

- Gender is a strong determinant of many aspects of adolescent life including physical and emotional health, satisfaction with school and home, healthy living patterns, and bullying and injuries.
- Most students liked school but this number has been decreasing steadily since 1994.

With regard to determinants of health, adolescents have little if any power or even choice over their family incomes, their gender and their school. And for the purposes of this project, public health professionals will not be able to have an impact on these factors.

However, the report also goes on to point out behaviours which programming and policies could actually impact

- Students who were well integrated socially and had positive peer influence reported higher life satisfaction and fewer risk-taking behaviours than did students who had poor social integration and negative peer influence.
- Being happy at school was related to the perception of having good and fair teachers, supportive relationships with teachers, and an increased sense of autonomy in the classroom. A major finding was that students who had positive experiences at school were less likely to be involved in health risk behaviours such as smoking, drinking, and using marijuana. This finding is replicated in other studies.(Boyce 2004, Miller 2008)
- The report focused on six aspects of the school experience: academic achievement, school satisfaction, school climate, teacher support, relationships with other students, parent support and the pressure to achieve at school many of which can be addressed within a healthy school framework.(Klinger, 2004)
- The feeling of belonging in school deteriorates between Grades 6 and 8 along with other protective factors (Boyce 2004, Search Institute, 2007)

The Health Communication Unit (THCU) is a resource for public health and health promotion in the province of Ontario and beyond. Their mandate is to provide resources and training in effective health communications as part of an overall health promotion approach.

In 2004, THCU completed a review and audience profile of "tweens". It is helpful for a project like this to see a picture of what this group seems to like, dislike, as well as their aspirations and values. The review noted that youth ages 11-14 are influenced mainly by their parents, their friends, the media and what is going on around them in their community. They care about "fun, friends and brand fulfillment". They are experimenters and are happy to try new things and adopt new behaviours, fads and trends. They look up to and identify with older teens. They get most of their health information from the media plus "mothers, teachers and schools" and 38% say their peers "find out 'a lot' about

issues like drugs, sex, and violence from TV, movies and other entertainment media. (THCU 2004)

Rural youth make up over 50% of Canadian youth according to the Town Youth Participation Strategy (TYPS) a national strategy which supports youth in the rural sector through involvement in youth centers. Rural youth may have additional specific risk and protective factors not always identified in programs and policies (TYPS 2006)

At a conference for rural youth leaders in the 4-H movement in Ontario, youth were asked to reflect on what were their most important assets and challenges to the quality of life in rural Ontario.

Assets included:

- sociability (ability to be a social part of the community)
- being and having access to community role models
- having a willingness to learn and work hard
- able to gain and maintaining respect among peers, elders and communities
- being open-minded
- having energy and enthusiasm for the community
- having knowledge of new and emerging technology

But barriers for communities wishing to use these assets included:

- transportation
- current responsibilities
- access to resources
- lack of opportunities "There just aren't opportunities to get involved in my community"
- stereotyping

Given the number of rural youth who may be accessed for the OPHA project, it behooves public health professionals to acknowledge and work around these challenges as much as possible.

It is hoped that this project will reach those young people who may be experiencing disengagement from school or community, or low commitment to academics or school activities or who may be "at-risk" for this to occur in the near future. Disengagement has been described as a process, not one event. It is influenced by interactions between the young person, his or her family, teachers and the school or community context. Disengagement is therefore most likely to be addressed with multiple interventions which are integrated. (Butler, 2005) While this project may not have the scope to address this completely, the pilot projects have the ability to help schools and communities put the spotlight on these youth and offer them options for engagement which extend beyond traditional school or sports activities.

Description of concerns

Health professionals have been concerned about adolescents and their risk-taking behaviour since the term "adolescence" was coined in 1904 (Hall, G 1904). While this is

certainly because patterns learned in adolescence may determine future health decisions, it also appears to be because of an over-arching negative focus on adolescence. Research has overwhelmingly addressed what can go wrong in adolescence when it comes to health. Concerns that unhealthy decisions could lead to multiple harms has fueled the research addressing adolescence risk-taking behaviour, particularly when it comes to drug use. In fact, it has been research into this specific risk-taking behaviour which seems to has taken precedence over other risks particularly in school-based prevention studies. However, currently one is more likely to see research into clusters of risk-taking behaviours that co-occur in adolescence (the process not necessarily the individual)(Paglia-Boak and Adlaf 2007, Center for Mental Health in Schools at UCLA, 2007). Even assessment tools for young people are addressing health issues broadly rather than risk specific. (McCreary 2009, Adlaf et al 2007, YLC-CURA, 2003)

Later in the report the author will address some of the current research which is focusing on protective factors and a positive focus on adolescence, but at this point it is helpful to see what researchers are saying about risk-taking behaviour.

According to several Ontario and Canadian-based research studies, many young people in the age group 11-14 are engaging in behaviours which could cause them problems or harms immediately and in the long-term.(Boyce, 2004, Adlaf et al 2007, McCreary 2009, Paglia-Boak and Adlaf, 2007)

These behaviours include alcohol and drug use, bullying and other aggressive acts and risky sexual activity. It is clear from the literature that greater engagement in risk-taking behaviours leads to more health issues from acute harms like injuries to chronic health problems like dependency or disease.(Paglia-Boak and Adlaf 2007, Boyce 2004)

It is also clear particularly when it comes to alcohol and other drug use that even if the individual does not suffer harms, use from a population perspective leads to an accumulation of harms and costs.(Gnam et al, 2006, Rhem et al, 2006)

Information on risk-taking behaviour, and young people's attitudes on health and well-being can be found in a several national and province-wide studies that are ongoing including the Health Behaviours in School-aged Children mentioned above, the McCreary Adolescent Health Survey from the McCreary Centre Society in British Columbia and of course Ontario's own Ontario Students Drug Use and Health Survey from the Centre for Addiction and Mental Health and the Adolescent Healthy Lifestyles Survey with Niagara secondary school students through Brock University (YCL-CURA).

Drug use rates

With regard to drug use, these studies present a picture of target age youth as mostly experimenting with substances although there are reports of more regular use. Alcohol, marijuana and opioid pain relievers are the top three substances of choice with the latter outranking tobacco for the first time in the latest OSDUHS survey from 2007. The following information on drug use rates comes from this survey.

Rates for all these substances have decreased in recent years except opioid pain relievers which has significantly increased. An interesting side note is that the use of glue as a psychoactive substance is mostly restricted to this age group with 3.1% of Grade 7 students and 5.2% of Grade 8 students reporting use at which point use decreases dramatically to 2.3% in Grade 9.

The use of alcohol and marijuana increases dramatically between Grades 7 and 9. Gender does not seem to affect these statistics. For the purposes of this project, the only illicit drug that the target age is using fairly regularly is cannabis with nearly 4% of youth in Grades 7, and 6.6% of Grade 8 students using cannabis at least once in the past year with a significant increase to 21% in Grade 9.

Other drug use statistics of significance for this age group include:
- opioid pain relievers – 12.5 % of Grade 7 students and 22.5 % of Grade 8 students report use in the past year
- binge-drinking is reported by 4% of grade 7 students and and 6.5% of Grade 8 students. This increases dramatically with nearly 19% of Grade 9 students reporting this
- cigarettes – 2.5% of Grade 7 students and 3.8 % of Grade 8 students with a significant increase in Grade 9 to10.2%

Violence and aggression

With regard to other risk-taking behaviours, a Canada-wide survey exploring the links between mental health, delinquency and criminal activity shows that in 2005/2005, just over 44% of youth ages 11-14 reported sometimes or often engaging in aggressive behaviour and more than one-half of this group reported engaging in "property delinquency" (destruction of their own or other's possessions etc.).(CIHI 2008) Males are more likely to engage in aggressive behaviour. (Adlaf et al 2007)

CAMH's Mental Health and Well-being Report states that among all students in grades 9 to 12, 30.9% report being bullied at school in the year of the study. This represents about 311,000 students in Ontario.(Adlaf et al 2007)

Mental health concerns

Child and youth mental health is a growing concern in Canada. A national report by the advisor to the federal Minster of Health on healthy children and youth highlights mental health as one of three national health priorities in this population (Leitch, 2007) However identifying the current burden of mental health difficulties among Ontario children is challenging because there is no coordinated approach to actually measure concerns in young people. What is commonly noted is that one in five suffer from a mental health disorder but this number may be higher or lower. (Schacter, 2009)

The Ontario Students Drug Use and Health Survey from 2007 gives us the following information

- younger students (about 13.5% of students in grades 7 & 8)are worried about their safety in their school – more so than their older peers
- very few students in our target group (1.5%) report being on medications for psychological distress, but about 2.4% have used a crisis line , 6% report "poor mental health" and about 5% identify symptoms that could put them at risk for a diagnosis for depression (frequency of crying, feeling lonely in past 5-7 days)
- 19% of students in Grade 7 report feeling psychological distress which includes items like feeling constantly stressed and losing sleep over worries. This increases to nearly 24% in Grade 8 and then significantly increases to 33% in Grade 9. This item continues to increase through secondary school.
- 10 % of all students reported suicide ideation in the past year and this number did not vary for grade

Risks with sexual activity

The literature on sexual activity and potentially risky behaviour reports on prevalence rates as well as potential harms associated with sexual activity. Information on this target age group is mostly retrospective

- 3% of males and females report they had intercourse for the first time in Grade 7. This doubles in Grade 8.
- 19% of males and 17% of females reported they were sexually active in grade 9. This increased to 27% and 25% respectively in Grade 10
- for this age group sexually transmitted infections like chlamydia are increasing
- withdrawal continues to be a fairly popular method of contraception with about 14% of both males and females in grade 9 and about 29% in Grade 10 reporting withdrawal as their contraceptive method.
- a significant portion of youth in both grades (18% of males, 7% of females) report using no form of protection/contraception the last time they had sex (Boyce 2004)
- sexual harassment is the most common form of sexual abuse experienced mostly by female and gay adolescents of varying ages (Safe Schools Action Team, 2008)
- "The burden of poor sexual health is unevenly distributed across the adolescent population with Canadian teens who experience the poorest sexual health living in families and communities where geographical, social and economic factors interact to create environments that increase the likelihood that youth will become sexually active early in their teens, will experience early pregnancies, will be victims of sexual abuse and will be more susceptible to sexually transmitted infections.(Maticka-Tyndale, 2008)

Emerging trends with regards to risk-taking behaviour

- **Adolescence, genetics and brain development**
  According to researchers studying brain function, adolescence is a time when the brain is continuing to grow into its adult form and complete its complex inter-connections with different brain regions. This maturing brain is also more responsive to some drug effects and less responsive to others at the same time that risk-taking as part of developmental tasks is seen as appropriate and necessary. The perception of risk and patterns of decision-making are impacted by brain functioning (Vaccarino 2007, Kutcher 2009) The National Research Council in the United States recently reported on the links between genetics and brain function and the economic and social environment when it comes to mental health and substance abuse issues and identified key programs and policies which could support a comprehensive approach based on these links.(National Research Council 2007)

- **Social determinants of health**
  As noted with sexual health risks, risks associated with the target age are exacerbated by social and economic determinants of health. All chronic disease including substance abuse, heart disease, depression and anxiety are more challenging in conditions of high employment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyles and human right violations. (WHO 2005, Theall K et al 2009, National Research Council, 2007), In Canada, this is borne out by figures that show girls and boys in Canada's northern regions report lower self-rated health and lower functional health, and small town rural and northern youth have a significantly higher rate of suicide that in youth in major urban centers (TYPS 2002

- **Risks with mental health issues and cannabis**

  While cannabis is often seen as a benign substance by young people and even many adults, emerging evidence is indicating strong correlations between use and mental health issues including psychoses. What is not clear is whether these conditions were underlying and became more florid with cannabis use or whether cannabis actually causes psychoses in some individuals. (Zammit et al, 2007)

- **Fire setting among children and youth**
  Fire-setting is a behaviour that carries significant health, social, and economic costs. It is also a symptom of current and future conduct and emotional problems. In Ontario 16% of students reported setting something on fire at least once during the 12 months before the survey. There is significant grade variation, showing that fire setting behaviour jumps between grades 7 and 8 (from 6% to 15%) and again in grade 9 where it peaks at 24%. (Adlaf et al, 2007)

Having described the project, the target groups and the concerns, the next section will address the four key concepts which will be addressed by the pilot projects in the six communities.

4.0 A CRITICAL REVIEW OF THE LITERATURE

Research into what helps to get and keep youth healthy has been in place for decades but in the past 20 years, the focus has moved beyond looking at ways to prevent unhealthy behaviour to focus on what can be done by the individual, the family, the school and the community to increase the odds towards healthy outcomes.

The next section of this report looks at the four concepts or topics which this project hopes to address within its pilot projects. The language describing these often overlaps and the research about them is intertwined. The author will lay out the ideas as if they were mutually exclusive, but it is understood that the concepts of resiliency and protective factors, youth engagement and a settings approach to health promotion reinforce each other and all these have an impact on illicit drug use by young people, unlike traditional approaches to reduce this behaviour.

This project's long term goal is to reduce demand for illicit drug use among youth. Short-term goals are to increase engagement of youth in school and community activities, plus increase the factors that foster resilience and enhance protective factors among youth. The project also hopes to see improvements to public health practice with respect to youth engagement. A critical review of the literature will support both the project's implementation and evaluation.

4.1 - Youth, resiliency, protective factors and health outcomes

According to Health Canada' s definition of resiliency for this project, resiliency "can be understood as the behaviours that young people exhibit in making their decisions not to use drugs and putting this in practice, despite having been exposed to drugs and other risk factors." (Guide for Project Evaluation, 2009).

As stated earlier, resiliency is a relative newcomer to the child development field. It has indeed been used to look at the prevention of drug taking behaviour as well as numerous other risk-taking situations but resiliency is a much more complex concept that can impact healthy youth development in many spheres..

According to Resiliency Canada, resiliency is "the capability of individuals and systems to cope with significant adversity or stress in ways that are not only effective but tend to result in an increased ability to constructively respond to future adversity." (Resiliency Canada website www.resiliencycanada.ca). Further, "resiliency is the human capacity for all individuals to transform and change, no matter what their risks; it is an innate "self-righting mechanism" (Lifton 1994)

Resiliency changes over time, is developmental, and is impacted by changes to the person's family, community and personal environments. Models for resiliency have been identified in the research including the compensatory model, challenge model and the

protective factor model. It is the latter model that is addressed in this project. (Zimmerman and Arunkumar 1994)

While risk factors which impact on a person's health have been identified for a long time, the concept of resiliency and the ability to withstand or even thrive given these risk factors is more recent including the theory that resiliency determines the individual's ability to withstand and even succeed in harmful environmental pressures determined by the person's economic and social status (Resnick, 2000).

The factors that support the individual through the tough times are protective in nature, factors in at least four domains that have been identified through numerous research studies with surprising consistency. (Schonert-Reichl, 2008). These are particularly noteworthy for the purposes of this project as it is important to note the range of protective factors which can be enhanced within the scope of the project.

The language of protective factors does change within the literature. For the purposes of this report, the author will use protective factors, developmental strengths and assets to mean the same thing. The actual numbers of protective factors may differ and there are tools to assess protective factors that identify 40 "developmental assets" from the Search Institute; 31 "developmental strengths" from Resiliency Canada; 28 "items" in the Child and Youth Resilience Project at Dalhousie University. These latter items are nameless at this point because the tool is being validated by youth themselves – a growing trend in the protective factor/ developmental strength literature to ensure the tools are valid across cultures and with different genders.(Search Institute, 2009, Hammond, 2008, Ungar et al, in press).

Protective factors for youth usually fall into four or five categories – personal (individual), within peer groups, within the family, within schools and within communities. The framework of risk and protective factors identified by the Drug Strategy Communities Initiatives Fund for this project comes from the former Alberta Alcohol and Drug Abuse Commission (AADAC, 2003). (AADAC is now a part of Alberta Health Services).

In this framework, the risk factors appear to overwhelm the number of protective factors, and in more recent frameworks, more protective factors have been identified. This is helpful for the project's outcomes as it hoped that the school and community projects will enhance protective factors above and beyond youth engagement.

It appears that risk factors cluster in many individuals and it is this clustering that actually tends the individual towards distress or ill health (Crooks, 2006) It is the same with protective factors. When interventions can be focused on multiple protective factors rather than on one or another risk factor, schools and communities can change their environments to support youth. Across an array of adverse outcomes, researchers have identified recurring cross-cutting protective factors that show promise for application across varied populations of adolescents and towards reductions in many health-jeopardizing behaviours. (Resnick, 2000) Also, by virtue of the enhancement of protective factors, the individual will face fewer risk factors since the factors are often inter-related.(Search Institute, 2009)

The added bonus is that changing the environment to support youth protective factors in order to reduce or delay one area of risk-taking behaviour (drug-taking for example) leads to the enhancement of youth health outcomes occurs across a number of risk-taking behaviours including mental health issues, bullying and risky sexual behaviour.(Kelleher et al 2005, Chan et al, 2004, Hahn et al, 2007.)

Unfortunately, at the implementation level at the individual school, there still remains a preference for interventions that address individual risk factors and how to increase "refusal skills" and "coping mechanisms" within general populations. Yet, resiliency investigators have clearly demonstrated that it is the protective factors in resilient children that buffer risk factors, decrease the likelihood of engaging in problem behaviours and often promote successful transition through the developmental milestones towards adult hood" (Hammond, 2008)

So what are the protective factors that research has identified within schools and communities from the AADAC Tool?
Schools:
- Caring and supportive environment
- High expectations
- Clear standards and rules for appropriate behaviour
- Youth participation involvement and responsibility in school talks and decisions
Communities:
- Caring and supportive environment
- High expectations of youth
- Being media literate
- Counter-advertising messages (youth educated about advertising)
- Religious-based activities and community-sponsored activities

These are expanded in the other two most common frameworks - Resiliency Canada's Developmental Strengths Frameworks (Hammond, 2008) and the Search Institute's 40 Developmental Assets (Search Institute, 2009):
Schools:
- Bonding to school – a feeling of belonging
- School boundaries – school provides clear rules and consequences
- School work – is valued
- School engagement - young person is actively engaged in learning
- Achievement – young person is motivated to do well
- Parental involvement in school
Communities
- Neighbourhood boundaries - Neighbors take responsibility for monitoring young people's behavior
- Adult relationships. – young person has at least three relationships with caring adults other than parents

- Community values youth – young person perceives that the community values its youth

The Search Institute identifies a few more factors that the others do not address:
Schools and communities

- Adult role models – both parents and other adults in the community model positive responsible behaviour.
- Youth as resources—Young people are given useful roles in the community.
- Service to others—Young person serves in the community one hour or more per week.
- Safety—Young person feels safe at home, school, and in the neighborhood.
- Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
- Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
- Time at home—Young person is out with friends "with nothing special to do" two or <u>fewer</u> nights per week.

Lerner has reported on the "5C's" as specific to youth in communities and while the target group for his research was students in Grade 5, Brock University has taken his research and adapted it for older youth with similar results. Protective factors identified by this research are:

- competence
- confidence
- character
- connection
- caring

Lerner states that if all the other "Cs" are present, a new 'C' will arise and that is contribution. (Lerner, 2005)

The evaluation component for this project needs to ensure that the enhancement of protective factors can be accomplished in the project timelines. Therefore choosing realistic indicators for outcomes is important for project success.

Emerging trends in resiliency and risk and protective factor research:

Dr. Michael Ungar at Dalhousie University and Dr. Wayne Hammond of Resiliency Canada are two of Canada's leading researchers in the field of resiliency. They are exploring several new ideas about risk and protective factors including:

- **All risk is not bad** The "challenge" model of resiliency described by Zimmerman and Arunkamar is getting more attention recently. This is a new paradigm that looks more closely at the interplay between risk and protective factors and is supported by other researchers. They believe there is a "right " amount of risk and responsibility that every youth needs to find – too little risk and responsibility can be as dangerous as too much. As Dr. Hammond says, "We need to discern between dangerous risk that will overwhelm, and

contructive risk that leads to mastering the art of navigating challenges with a sense of purpose and responsibility. Avoiding risk altogether robs a person of the opportunity for growth and positive psycho-social development (Ungar, 2002 & 2009, Hammond, 2008, Center for Mental Health in Schools In UCLA, 2007)

- **Resiliency can be modified by gender and culture.** The purpose of the International Resiliency Project (IRP) is to develop a better, more culturally sensitive understanding of how youth around the world effectively cope with the adversities they face. This project and its associated "Negotiating Resilience" projects aims to:
    a. document a plurality of protective processes in the lives of youth exposed to significant amounts of risk as defined by different communities, from the perspectives of youth themselves
    b. further the understanding of children as social actors, interacting with their environments in ways that shape, and are shaped by, their social ecologies and
    c. explore gender-based differences in youths' interactions with their social ecologies and the protective processes they engage in (Ungar 2009)

- **There are differences in risk and protective factors for those youth not in schools, who are street-involved or using multiple services** The "Pathways to Resilience" Project will identify pathways most predictive of healthy outcomes for youth who use multiple services. The website is http://www.resilienceproject.org/index.cfm?fuseaction=text.&str_cmpID=103

Dr. Kimberly Schonert Reichl and Dr. David Wolfe are both investigating the impact of relationships in the midst of other risk and protective factors and the ways in which youth connectedness or engagement in the family, at school and in communities is very important for resiliency especially involvement with one or more caring adults. (Schonert-Reichl, 2008, Wolfe 2008)

4.2 - Youth engagement and health outcomes

Research has identified the impact of youth engagement as a protective factor in several aspects of youth health outcomes. For health promoters, the activity of participation in decision-making about one's own health is a keystone of the Ottawa Charter. Health inequities are often enhanced because of the lack of choice in what happens to secure health.

Youth become disengaged usually around Grade 5 or 6 as schools and communities begin to focus on them more negatively and heap expectations for academic and social successwhich are more likely adult-centred than child-centred.

Disengagement at schools may be fostered by personal factors like:
- falling behind in work

- having limited access to help
- difficulties with numeracy and literacy
- perception of curriculum as boring or irrelevant
- limited opportunities to experience success
- being teased or bullied
- feeling negatively judged by teachers/peers
- having no adults who know you well
- going unnoticed
- having difficulty getting to school
- episode of suspension or exclusion
- being humiliated in front of others
- institutional factors like school size

(Butler 2005, Clea 2002)

Youth themselves tell us that they want to be heard and want to take part in the decisions which impact them. Dr. Michael Ungar of Dalhousie University says, "The teenagers I work with tell me that gaining control over how they are seen by others is the most important part of feeling good about themselves. When positive labels are scarce, however, being crazy or delinquent can make as much sense as excelling at school. Maybe if we understood better how kids grow up feeling good about themselves we'd be more ready to put our social and economic capital where it can really help kids: back into their communities, opening up opportunities for youth to feel like they belong there as contributing members". (Ungar, 2007)

Dr. Kimberly Schonert- Reichl identifies a variety of evidence that emphasizes the importance of *belonging* as a critical component of doing well in life, a feeling that one is valued and a part of something beyond one's self. These studies have consistently indicated that young people in schools and/or communities where they feel accepted, competent and valued are much less likely to become involved in problem behaviours. (Schonert-Reichl, K (2008),)

Yet the HSBC Study indicates that a "liking of school " declines between Grades 6 and Grade 10. The "liking" notion appears to be tied up with feelings that schools are teacher-centred and that youth involvement or engagement is token at best.

For young people this sense of being a part of the decisions that will affect their activities and their health is very important. Supporting this activity has been recognized in the literature and by the Canadian government which has developed the Canadian Centres for Excellence in Youth Engagement (CEYE, 2009). A model of what is called "authentic" youth engagement is the framework for the Centres. It refers to a philosophical approach to youth engagement where youth are front and center.

As early as 1969, Roger Hart defined what meaningful youth participation needed to include and it later came to be described as "Hart's Ladder" (McCreary Center Society, 2009). This has been upgraded (and turned on its side actually) by CEYE and given the title; "The Level of Youth Engagement" and is an important tool in helping professionals

understand what is meant "authentic" youth engagement, "the meaningful and sustained involvement of a young person in an activity focusing outside the self. Full engagement consists of a cognitive component, an affective component, and a behavioral component - Head, Heart, Feet." (CEYE, 2009).

Engagement activities range from the manipulative, where young people are manipulated or coerced into giving input to shared decision-making where the young person is authentically engaged.

Resnick identified youth engagement for professionals as "a philosophical commitment that young people are resources to be developed not problems to be solved". He defines youth engagement as experiences or circumstances that permit the achievement of developmental tasks. Critical to these efforts is the ongoing involvement of caring adults. (Resnick, 2000)

With regard to the reduction of alcohol and drug use, youth engagement in prevention activities or in health promotion activities is seen as extremely important. In prevention programs young people are usually the captive audience for the information and the skills that are identified by adults as necessary for prevention, however research shows that when that young people have a greater sense of control, meaning and connectedness about the decisions affecting them in daily life, this carries over into healthier decision-making about risk-taking behaviours (CEYE, 2003, Oliver et al, 2006, Clea, 2002)

Emerging trends in research into youth engagement:

- **Why do youth choose to engage in certain activities?** While youth engagement has been shown to be linked with positive health outcomes, the rationale about this process is somewhat lacking. Researchers associated with the Centers for Youth Engagement are investigating this process with youth telling their own stories (Loiselle, 2003) Studies in ways to foster youth engagement and school connectedness will be helpful in filling in the gaps (CDC, 2009).

- **Youth engagement, decision-making about drugs and the abstinence mandate**. Considering the concepts inherent in resilience, concern is being generated about the effectiveness of a no-use drug education mandate. If "no-use" is enshrined in the education and policy of the school or community, where is the learning for youth to make their own decisions? What is indicating more effectiveness is when youth are valued no matter what choices they have made and have the opportunity to discuss situations and share credible information (Brown, J, 2001, Tupper, K, 2008, Moffatt 2007)

- **How to "do" youth engagement** - Models for "meaningful" participation are being researched both at the CEYE and in other countries. "Reachout" from Australia is an online service by young people for young people. They asked

youth what could be done to encourage youth involvement in existing health services and they answered:

- o Being accessible
- o Making one feel comfortable
- o Flexible and unique approaches
- o Being non-judgmental
- o Knowing what to expect
- o Confidentiality
- o Openly communicating – engage and listen!
- o Making one feel connected and valued
- o Using technology

Youth then expounded on each of these processes and values, helping professionals to operationalize youth engagement and to ensure these values guided program goals, program atmosphere and program activities (Reachout - http://au.reachout.com/)

4.3 – Settings, youth engagement and resiliency

Settings that can support health have been defined by the World Health Organization as "places or social contexts in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being". As described at the recent Canadian Council for Learning conference in Gatineau in May, 2009, they are also geographical social or economic contexts such as neighbourhoods, communities or regions within communities, formal like schools or informal like churches or drop-in centers. Settings can even be virtual as the internet becomes firmly fixed in our environment as a knowledge exchange tool and a provider of social networking. A settings approach is more than just simply delivering interventions to a population or "captive audience" and it is not a single intervention or program. A settings approach seeks to influence health by influencing the conditions, policies and practices inherent in that setting through multiple interventions (Canadian Council on Learning, May, 2009).

Settings for the OPHA project have been defined as school or communities as it is here that public health professionals will likely engage youth in activities to support their own health.

Healthy Schools

Schools as settings for health promotion have evolved over the past 50 or so years. The language used differs (comprehensive school health, health-promoting schools, healthy active schools) but the values and vision are the similar and are based in health promotion theory.

The most common health promotion practices supported in schools are increasing awareness of health issues and development of skills to resist unhealthy lifestyles. (Stewart-Brown, 2006). A wealth of research more recently has recognized the value of addressing physical and social environments, policy initiatives and school health services as parts of a comprehensive approaches that can actually help to change behaviour. (Ottawa Charter)

The value of using these approaches are recognized not only by health promoters and researchers but also educators and policy developers. Today numerous national groups (Canadian Council on Learning, Canadian Education Association, Canadian Partnership for Learning, Joint Partnership on Comprehensive Schools Health, Canadian Association for School Health and many university departments) as well as local organizations (Ontario Healthy Schools Coalition, Safe Schools, Ontario Physical and Health Education Association) have taken on the research or enhanced it and have attempted to apply it to local initiatives.

The Canadian Consensus Statement on Comprehensive Schools Health has been endorsed by many of the groups named above as well as what might be considerd non-traditional partners in health-promoting schools such as medical groups like the Society of Obstetricians and Gynecologists and cultural groups like the Metis National Council. It is a statement that identifies the issues and the goals of a comprehensive school health approach and the benefits that can accrue from such an approach. (Canadian Consensus Statement, 2007).

Within Ontario, the Ministry of Education has developed a supportive framework for healthy schools (Foundations for a Healthy School) and all school are encouraged to follow the framework which has as its four main components:

- high quality instruction and programs,

- a healthy physical environment,

- a supportive social environment

- community partnership.

This framework is supported within the Ministry of Health and Long Term Care "Standards" that were released in 2008

There is also support for public health professionals working on a comprehensive approach in schools through the Ontario Healthy Schools Coalition, a working group at the Ontario Public Health Association with members from health units, school boards, hospitals, mental health agencies, universities, health-related organizations, parents and students. There vision is that every child and young person in Ontario will be educated in a "healthy school" using the WHO definition for the most part to define the parameters.. The OHSC has numerous tools and guides and training opportunities to build capacity for the implementation of a healthy schools approach.(OHSC, 2009)

However, the uptake of the model and the framework in Ontario has been limited. A discussion paper on making "healthy schools " a reality in Ontario acknowledged this limited response and worked with stakeholders to identify "critical success factors" to make healthy schools a reality (OPHEA, OASPHE, OHSC, 2008). Some of these factors have begun to be realized with " a shared leadership" among Ministries. But it may be awhile till the passion trickles down to the Board level where strategic priorities and reduced budgets continue to be immense challenges for meeting educational objectives and preparing students for academic requirements.

Emerging trends in research into a healthy-schools approach that are relevant for this project include:

- **New Canadian standards for school-based substance abuse prevention state that education on drugs should be framed within a healthy schools approach.**
  The Canadian Centre on Substance Abuse has just released its report on how schools can strengthen their drug prevention efforts. It recommends as the first principle that drug education should be addressed within a comprehensive approach that is found in a healthy school concept. As it states in the report, "In a dynamic and vibrant health promoting school, participation, empowerment, equity and democratic processes are considered key values." See Section 5 Environmental Scan for more information.

- **Health and learning are linked**

  School boards and administrators are caught up in the core mission of schools, which includes the social and emotional well-being of children, but seems to be more focused on academic outputs. There is evidence now that a focus on the social and emotional well being may be actually linked to an enhanced academic response from students. (Dewitt D et al 2002, Willms J et al, 2009)

- **Schools can promote and enhance the mental health of their students**
  thereby reducing issues like violence, acting out and to some extent substance use and abuse. For example, a study of the impact of school "climate" on the well-being and mental health of children in the Czech Republic found that schools with a climate of confidence and respect among principals, staff, pupils and parents had the least number of negative characteristics, including general anxiety, school anxiety, emotional and psychosomatic balance, attitudes toward school, etc. (Stewart Brown, 2006, Birdthistle and Jones, 2003)

- **A healthy schools approach can lead to enhanced youth engagement**
  Participation and decision-making by all stakeholders in schools (administration, teachers, parents and students) is a core principle of the healthy schools approach. As noted in the previous section, when youth are engaged in deliberations about the their health outcomes, changes occur for the better. The Health Action Team – a core component of the Healthy Schools approach - is an example of how students can participate and have a voice in their health outcomes.(CDC 2009)

  What is challenging is that "authentic" youth participation as identified in the last section is not occurring. Often this philosophy is not taken on even by the educators and health professionals who work with Health Action Teams. As was noted in the Interim Evaluation of the Comprehensive Youth Pilot Project in Toronto Public Health, one of the biggest challenges were teachers who struggled with giving up power to students for fear of criticism of their work. As a result students on the committee felt their work was not important to the school (Coughlin and Juby 2008).

- **School policies and practices to reduce risk-taking behaviours may actually increase them.** Recent initiatives to keep schools safe have resulted in harsh and punitive schools policies that support zero tolerance and suspension for drug use or acting out. However research is indicating that this approach is not as effective as originally thought and instead of "shaping kids up", it is often contributing to "shipping kids out". Recommendations from researchers include reworking policies and practices that overemphasize social control and punitive responses to acting out behaviour. (Skiba et al, 2006, Center for Mental Health in Schools at UCLA, 2007, Evans-Whipp et al, 2004)

Healthy communities

The Ontario Healthy Communities Coalition (OHCC) is funded by the Ministry of Health Promotion in Ontario to support the values and objectives of the healthy communities and healthy cities movement begun in the 1980's.

According to the OHCC website, recognizing that "everything is connected to everything" and "the whole is more than the sum of its parts" arecore values behind the movement. Healthy community initiatives are multi-sectoral collaborations which integrate social, economic and enviromental goals to benefit the whole community and strengthen community capacity to promote and sustain health. The OHCC promotes healthy community principles across all sectors, providing support, facilitation, resources and tools to communities that pursue local healthy communities goals.(OHCC website)

Youth intiatives at the community level often have a history of youth engagement and youth-centred principles because the young people involved are not a captive audience. Voluntarism is more likely. (4-H, Boys and Girls Clubs etc.)

In the late 1980's and early 1990's young people began to get involved in community intiatives around drug use. Often a mayor would institute a youth advisory or "Task Force" in municipalities to get input on what might work in engaging youth in the prevention of drug use. The results of these programs were often limited, perhaps because of the topic, or the process, but what was learned that there is added value in having young people engaged around health issues because that the engagement actually served to enhance protective factors for the youth so engaged.(Rose-Krasnor, 2002)

With regard to the "Youth Engagement" project, there may be many reasons, public health professionals choose to look at community-based intiatives that could enhance protective factors.

- They might not be involved specifically with one school that is interested or able to take on this project.
- They already have buy-in from a community that wants to address such a project.
- They are concerned that there is little for youth in the community after school.

- They are concerned that risk-taking behaviours occur more often after school than during school particularly for the target age group.
- There are existing community-based programs which appear to meet the criteria for this project.
- There is some research that states that community-based youth intiatives have greater impact than school-based intiatives depending on the behaviour being addressed. (Vanderwaal et al, 2005)
- There may be tie-ins for communities with additonal funding bodies addressing at-risk youth (The New Mentality) or provincial strategies like the after-school strategy which will form part of the new Breaking the Cycle of Poverty Strategy.(Ministry of Education and Ministry of Health promotion, 2009)

Community strategies that are supportive of authentic youth engagement are in larger centres like Calgary (http://www.calgary.ca/docgallery/bu/cns/cys_guide.pdf) and in smaller centres like Grey and Bruce counties in Ontario (http://www.targetyouth.ca). They may be supported on a large scale within municipalities or on a smaller scale through public health, community health centres or youth centres.

Emerging research on community-based youth engagement

- **There seems to be a relationship between community involvement and social responsibility.**

  A study completed by the University of Brock with youth who were already involved with community groups looked at what they thought about social responsibility, optimism, valuing of diversity, and belief that youth could influence the world around them. The findings supported that the more youth were involved, the more socially responsible they appeared to be. It was not clear what came first, the community involvement or the social responsibility and research is ongoing (Rose-Krasnor, 2002)

- **Community-based programs that address prevention of drug use are not effective.**

  A Cochrane Collaboration review of several studies of programs addressing education and skill-building around drug use and resistance skills showed there is a lack of evidence that non-school based interventions are effective in preventing or reducing drug use. These programs did not have a youth engagement or resiliency perspective but relied on the more traditional deficits-based focus with a didactic approach. **What does appear to work are** community programs which support a social development model and look at drug use within a range of risk factors and promote protective factors that will enhance positive health outcomes for drug use as well as several other risk factors. (Gates S, 2006, Catford 2001, Toumbourou, 2004, Weissberg 2003)

- **Community-based programs which support youth engagement enhance protective factors**.

    In recent studies of Boys and Girls Clubs and the 4-H program in the US, and Youth Centres in Canada, positive outcomes were associated with attendance and participation in the club activities including prosocial behaviour, increased liking for school and reduced risk-taking behaviour (Radhakrishna & Doamekpor,P 2009, TYPS, 2002, Arbreton et al 2007, Weissberg 2003)

4.4 - Prevention of illicit drug use and other risk-taking behaviours

Reduction of illicit drug use is the long-term outcome for the pilot projects as a result of the increase of youth engagement strategies within school and community settings. It is useful for the purposes of the project to review the topic in more detail both in the way it has been dealt with historically and what emerging research is saying.

Interestingly, a focus on the prevention of drug use has been at the core of many school and community-based prevention activities since pro-social education began in the late 1800s as part of the Temperance movement. (Tupper, 2007), For the most part, programs have been educational in nature with abstinence as the goal and scare tactics as the format. Public education programs like the "Just Say No" and "Your brain on drugs" campaigns supported this approach.

Unfortunately, the research seems to indicate that much of this education has failed. (Catford 2001, Reuter 2007, Toumbourou, 2007, Weissberg, 2003, Schwartz, 2007)

With regard to school-based education, there are reports indicating increases in knowledge although there is concern from researchers about that knowledge when there appears to be underlying ideological attitudes about the drugs being used. (Tupper, 2008) Skill-building programs have somewhat better outcomes but only if the interventions occur over time throughout the school life of the students (Faggiano et al, 2009, Botvin's Life Skills Program, Coggans, 2002).

The commonly-cited meta-analyses of Tobler and Cuipers report several principles for classroom-based drug education that seem to boost their effectiveness including using interactive activities within a social influences model and addressing teacher/peer training on drug issues. (Tobler, 2000, Cuipers, 2002, McGrath, 2006)

In the US, the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices reports on programs which may be useful for schools and communities which want to look at programs to address education and support for students. In Canada the Best Practice Portal through the Public Health Agency of Canada has a broader focus and identifies programs that address comprehensive approaches.

However, these are few in number and those that show signs of success (Project ALERT, Lifeskills Training, Positive Action) come with a price tag for replication. The Lifeskills Training Program costs approximately $6000 US for 20 trainees.

So despite a significant expenditure on drug prevention, and a history of prevention spanning a century, problematic drug use has increased and new drug-related problems have emerged. Old drugs like alcohol and cannabis continue to be used and new drugs like ecstasy come along and stay. In Ontario, most young people in secondary school use alcohol and cannabis to some extent even after several years of curriculum to address substance use and abuse and even though both are illegal for this population. The perception of risks for a substance like cannabis actually decreases as the student ages. (Adlaf et al, 2007)

Overall, researchers have identified that drug use (and perhaps more importantly drug abuse) needs to be addressed within a wider scope of the adolescent experience with influences to use coming from a variety of sources including family, peers, media and communities (Spooner and Heatherington, 2004, Crooks 2006) and decisions about that use being tied into genetics, brain function, along with social determinants of health (Kutcher, S, Spooner and Heatherington, 2004, Paglia-Boak 2007)

The Canadian Association for School Health recently developed a "Knowledge Summary" of what goes into effective school-based and school-linked prevention of substance use problems. Their "Best Advice" includes the following:

- develop a response based on a strong understanding of the nature and extent of the problem (local information on use and trends, primary prevention or harm reduction, address risk and protective factors)

- implement universal substance use education based on the social influences model with students in Grades 7&8, focus on student-to-student information and learning rather than didactic approaches, use interactive activities

- ensure targeted programming for higher-risk students including family approaches and early intervention and support activities

- strive for a comprehensive whole school approach that is developmental and is guided by a school policy that addresses students and teachers with education and intervention options. Acknowledge the impact of the social determinants of health as key risk factors

- give attention to the requirements of real-world implementation and infuse substance abuse prevention education within a health promotion framework and addresses the professional development needs of teachers and others

(Roberts et al 2008)

In a recent review of best and promising practices for youth in relation to alcohol and drug use prevention, the Vancouver School Board and the Vancouver Coastal Health Authority identified the need for a focus beyond school-related drug education programs "to embrace all policies and practices that protect and promote healthy development" thereby placing alcohol and drug use within the wider experience and including a focus on programming for parents, schools, communities and youth that enhanced protective factors and assets.(Ripley L, 2005) This has resulted in the development of the SACY program which will described in more depth later in the report.

Challenging approaches are being discussed in the literature. Harm reduction rather than abstinence is suggested for older youth since the use of substances is pervasive in society. Specific recommendations include regulatory, early intervention and harm reduction approaches. (Toumbourou et al, 2007).

However harm reduction is an even more challenging approach when looking at the target age youth for this project. What is more likely effective is realistic and accurate information about alcohol and other drug use within a comprehensive approach that enhances protective factors.

Emerging research about education and the prevention of illicit drug use

- **"We can't even talk about it"**

  Researchers in British Columbia have recently completed a participatory research project with youth in the target age range. While the sample is small, what the students have to say is revealing about education particularly around cannabis. "There was a pervasive message from many participants that there was a need for open discussion and dialogue about marijuana use. Most teens indicated they wanted a chance to discuss the effects of drugs and did not want to be shut down." (Moffat et al, 2007).

- **Drug information is not remembered**. Ontario students recall tobacco and alcohol information but not information about cannabis Although mandated since 1997, currently only about 1/3 of students in Grade 7 and 8 recall receiving at least one class on cannabis and this number has increased only slightly since 1999. (Centre for Addiction and Mental Health, January February, 2008)

- **Teachers are not being prepared to teach complex drug issues nor do they have the time to be the principal providers of that education**. In studies addressing teacher competence and ability to deliver drug information within a social influences model using the techniques identified as useful by Tobler and Cuipers, it is reported that teachers have limited ability. This may be related to time and resource constraints as well as teachers' own values, attitudes and behaviour and their level of knowledge about the substances. With regard to restrictions because of time and resources, teachers themselves report wanting a collaborative approach with partners in the community with expertise in specific information and approaches (Join Together 2007, Ennet 2003, Tupper 2007)

- **Changing school structures, processes and policies can reduce drug use.** In a report for the Australian Drug Foundation, Toumbourou and his colleagues examined research that evaluated school reform interventions for their ability to reduce drug use. Several programs were identified that looked more comprehensively at the reduction of drug use including the 'Health promoting school model" for both prevention and intervention activities all within school policy that sets norms and established guidelines for student behaviour. (Toumbourou 2004, Catford 2001, Weissberg 2003)

Summarizing the literature in this section, it seems clear that when it comes to drug use or abuse by young people there are numerous causes and influences. Preventing, or reducing this use means that all the numerous causes and influences must be addressed within a comprehensive framework. The framework can be followed in schools or communities but needs to address protective factors that support resiliency. The framework must include youth as partners in planning, developing activities and evaluating changes in knowledge, attitudes and behaviour. Health promotion is a natural framework for addressing the health issues and has been proven to be effective in reducing use and the harms associated with use.

Public health personnel are well placed to support a health promotion framework and comprehensive activities for this project because of their skill and expertise in health promotion and because of their mandate.

Currently in Ontario there are several other initiatives that may also help public health to deliver these projects within a health promotion framework. The next section identifies a brief environmental scan of these supports.

5.0 ENVIRONMENTAL SCAN

There is currently in Ontario an appetite to address the prevention of drug use and other risk-taking behaviours by youth within a comprehensive framework that promotes protective factors. This is supported and sponsored by several strategies and province-wide activities that may be useful for the public health professionals engaged with this project. All websites are included Appendix 4.

The Centre for Addiction and Mental Health is the premier health-promoting hospital addressing mental health and addictions in the country. As well as resources and training opportunities for public health and for students, CAMH has the provincial service division with community consultants as resources in several parts of the province. These consultants are usually very engaged with their communities and will have important local information about needs and services. Also of note, the Ontario Student Drug Use and Health Survey is being conducted this year and the results will be released in November 2009.

The Ministry of Education has a stated a vested interest in supporting "healthy schools". Its website offers resources and tools on ways to incorporate comprehensive activities. Also the Ministry has been promoting the "Student Success Initiatives" in which Boards of Education and in some cases Boards of Health are working together to help students in Grade 7 to 12 tailor their education to their individual strengths, goals and interests. An existing interest and involvement in the Student Success Initiatives may be a motivator for schools to get involved with this project.

The Ministry of Education also supports "Student Voice" – a project to help students speak up and take action. Two types of projects are currently being funded:
- Student-led teacher-facilitated projects
- Student council projects about transitions, diversity and inclusion.

See - http://www.edu.gov.on.ca/eng/students/speakup/projects.html

Finally, it may be helpful to know there is a Minister's Student Advisory Council with representatives from students across the province from both elementary and secondary school and the Ministry supports "school recognition awards" for healthy schools..

The Ministry of Health Promotion has recently announced the Healthy Community Strategy with funds available for community programs. The funding will be annual and applications can be accessed online at the MHP website.

As well, the Ministry of Health Promotion has been collaborating with the Ministry of Education to develop an "After-School Strategy" as part of the "Breaking the Cycle of Poverty" plan of the government. There may be opportunities for funding community and school-based programs within this strategy.

The Ontario Healthy Schools Coalition is a collaboration supported by OPHA. As stated earlier, it has numerous tools and resources for public health practitioners working on the project through a healthy schools framework.

Youth Action Alliances (YAA) – Smoke-free Ontario's key component for youth prevention programming was recently de-funded by the government leaving many health units scrambling to continue to support the work of peer leaders. The initiative was beginning to show signs of success when the cuts occurred and communities are struggling with the government's decision. In Grey and Bruce counties for instance the YAAs were instrumental in supporting the development of other Youth Health Coalitions across the region with youth identifying local health needs and furthering a vision of youth-friendly communities.

The formative results from the program indicate that the model of youth engagement and leadership is effective in raising awareness of the issues and supporting healthier environments. (Fiissel et al, 2008).

Having had this program in one's community may support the OPHA project or it may challenge its implementation, as communities may be discouraged about this loss of program just when it appeared that it was showing positive results.

One of the underpinnings of this project is to learn from the YAA program regarding better practices in the process of engaging youth; therefore the report itself is a useful adjunct to project planning.

The New Mentality – This program is a collaboration of Children's Mental Health Ontario and the Provincial Centre for Excellence for Child and Youth Mental Health at CHEO to engage youth ages 13-25 as partners in addressing and ending stigma about mental health problems and in enhancing mental health services. The idea for this initiative originated from youth members of the Centre's Consumer and Advocate's Network.
New Mentality groups have been established across eight regions, in Toronto, Hamilton, Burlington, Kingston, Ottawa, Sault Ste. Marie, Thunder Bay and London.

This network is based on a youth/adult partnership model – where youth act as leaders of their own initiatives, supported and mentored by adult allies from child and youth mental health organizations and other youth serving agencies. The New Mentality's goal is to foster meaningful engagement opportunities for the young people who are involved and to serve as a model for Ontario mental health organizations. See more at http://www.thenewmentality.ca/

Canadian Center on Substance Abuse (CCSA) – The release of standards to support school-based drug education has been anticipated in the field across Canada. Part of CCSA's Youth Strategy, **The Canadian School-based Standards for Youth Substance Abuse Prevention** were developed as a resource for school or board staff and other public health or addictions prevention professionals. Their aim is to further strengthen the effectiveness of school centred youth substance abuse prevention and health promotion efforts by providing both a performance benchmark and a supportive guide to reference when pursuing improvements to prevention activities.

Two databases have been created to encourage the sharing of programs. The publication is meant to be a "living" document and able to evolve and change as new information becomes available.

Other organizations with a provincial or national focus that may be able to support the project are included in Appendix 4.

6.0 RESEARCH QUESTIONS

Given the project description, target groups, objectives and expected outcomes, the author developed three research questions to guide the search process. These were confirmed and modified with the partners of the project.

- What research literature and programs are available that prove the effectiveness of enhancing protective factors (and thereby resiliency) in youth ages 11-14 in schools or after school recreation settings (e.g. feeling safe in school and community) in order **to prevent, delay or reduce illicit drug use or other risk-taking behaviour?**

- What research literature and programs are available that prove the effectiveness of youth engagement of youth ages 11-14 in school settings or after school recreation settings as a protective factor **in preventing, delaying or reducing illicit drug use or other risk-taking behaviour**?

- What organizations and programs are available that answer the above questions and if possible (inclusion criteria)
    o meet the requirements for a "Health Promoting School" model or
    o have potential for adaptation by a school with public health staff support
    o recognize the importance of determinants of health in addressing behaviour change
    o are web-based or could be accessed using the web
    o are bilingual for French and English.
    o have been delivered in schools or community centres in vulnerable neighbourhoods.
    o have been delivered in Ontario schools if possible
    o are from Canadian sources if possible

7.0 RESEARCH METHODOLOGY

Research Methodology/Process

As well, the Partners agreed that the author should include programs:
1. that had been evaluated in some way to show an increase in awareness, a change in attitudes or a change in behaviour or intention to change behaviour with regard to illicit drug use or other risk-taking behaviour.

2. that show an increase in protective factors specifically an increase in youth engagement.

3. that have been defined as best or better practices.

4. that have been published in peer reviewed journals.

5. that were listed on government websites, organizational websites – so-called "grey literature"

Process of review:
1. In collaboration with the OPHA Planning team and the Partners, the author developed the research questions, key criteria and priorities for the review (e.g. target age 11-14, drug education)

2. The author identified and searched broad areas of interest, then narrowed down the search to studies/programs that fit the criteria and priorities.

3. The author reviewed published literature and grey literature that were part of this narrower focus.

4. In collaboration with the Planning Team and Partners, key informants were identified and interviewed including researchers and practitioners of youth engagement, comprehensive school health, resiliency and illicit drug use

5. The author analysed the literature and interview results given the research questions. Common principles of youth engagement that were effective in reducing risk-taking behaviour and enhancing positive health outcomes were identified. Several recommendations for both OPHA and public health staff in schools and community settings were developed. These principles and recommendations are meant to support OPHA in developing resources and training activities for public health for this project.

6. A final report was presented which included the review process, analysis, principles and recommendations for the OPHA pilot project along with a list of organizations and agencies currently engaged in similar work and recommendations for resources and activities that are congruent with the principles.

Limitations

While the most desired outcome for this review was research from reliable sources which was peer reviewed, with strong behaviour outcomes, this was limited in several ways:
- Peer-reviewed studies that fit all criteria were not found in the time allotted. Most peer-reviewed studies/ programs concentrated on three or four designated criteria at the most.

- Most evaluation of programming that did relate to more criteria was not in-depth or was process rather than behaviour related.
- The timeframe for the search itself was limited. Therefore within the time allotted, it is likely that all significant studies were not reviewed.
- Often literature addressing "youth engagement" does not specific the age group and may reflect an older age group than 11-14. Every attempt was made to include programs and reviews that addressed this age group specifically.

Search Strategies
The following were considered as influences in this review:
- the aims of the research
- matching inclusion criteria
- the appropriateness and rigour of the method
- the setting in which data was collected
- any bias of sponsorship
- outcomes related to aims

These strategies were then followed:
- Identify broad selection of electronic based databases relevant to the criteria. These represented evidence-based, peer reviewed articles/studies, abstracts of articles, individual group programs (national or local), school and community interventions, qualitative and quantitative studies
- Narrow to priority databases, or databases that had offered up studies of interest through the initial search.
- Search databases using individual and variations of these key words/phrases that reflected the terms identified in the criteria.
- Identify reports that described, evaluated or discussed an intervention that included youth engagement or other protective factors in school or community settings with the objective of preventing, delaying or reducing illicit drug use or increasing positive health outcomes youth aged 11 to 14.

Sources searched:
Sources searched were known, recommended or had a strong possibility for matching the criteria. Because so many programs or studies were not supported by strong evaluation, the author included for review interventions with quasi-experimental results, pre/post tests, or other less rigorous processes.

Online libraries included Cochrane Group for Systematic Reviews , Medline, pubmed ERIC, SAMHSA's National Registry of Evidenced-based Programs and Practice, EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) APA, PsycNET, Best Practice PHAC's Portal for Health Promotion and Chronic Disease Prevention.

Key words included;
Middle school students, youth, young people, drug education, substance abuse prevention, illicit drug use prevention, Canadian, risk factors, protective factors, youth

ages 11-14, resiliency, youth engagement, youth connections, school connectedness, mental health promotion, violence prevention, risky sexual activity, healthy relationships, after-school programs, after-school strategies, youth strategies

Some websites offered a review of several studies (Cochrane Collaboration, the World Health Organization (WHO), Health Canada, the Canadian Centre on Substance Abuse (CCSA), the Centre for Addiction and Mental Health (CAMH), Centres for Excellence in Youth Engagement, the Alberta Alcohol and Drug Abuse Commission (AADAC), the McCreary Centre Society (in B.C.), the FOCUS Resource Centre, the Alcohol Policy Network (APOLNET), the Centre for Health Promotion at the University of Toronto, the Canadian Association for Health Physical Education, Recreation and Dance (CAPHERD), TYPS (Town Youth Participation Strategy), SAMHSA (Substance Abuse and Mental Health Services Administration), National Clearinghouse for Alcohol and Drug Information (U.S.), the Australian Drug Foundation (ADF), as well as many others

In these cases, the author looked for model and promising programs that fit the criteria, as they were most likely to provide effective programming for OPHA.

As well, several university programs and departments are addressing the criteria including the target age, risk and protective factors, youth engagement, comprehensive school health and resiliency. These sites offered the current state of research in these criteria and included:

In Ontario:
Canadian Adolescent At-Risk Research Network (Queen's University)
Centres for Excellence in Youth Engagement (Brock University, Students' Commission/Tiny Giant, Queen's University)
Children's Mental Health Ontario
Centre for Excellence In Child and Mental Health
Children's Hospital of Eastern Ontario
Ministry of Children and Youth
Ministry of Education
Ministry of Health and Long Term Care
Ministry of Health Promotion
Ontario Healthy Communities Coalition
Ontario Healthy Schools Coalition
Ontario Physical and Health Education Association
Ontario Public Health Association
Registered Nurses Association of Ontario
The Health Communication Unit
University of Waterloo
University of Western Ontario

Other Canadian sources:
Agriculture and Agri-foods Canada
British Columbia Ministry for Children and Families

British Columbia Ministry of Health Planning
Boys and Girls Clubs of Canada
Canadian Council on Learning
Canadian Institute for Health Information
Canadian Education Association
Canadian Journal for Public Health
Centre for Youth and Society (University of Victoria, BC)
Cente for Addictions in British Columbia CAR-BC
Dalhousie University
Public Health Agency of Canada - Best Practice Portal
McCreary Centre Society
Simon Fraser University
The Learning Partnership
Resiliency Canada
University of Calgary
University of British Columbia
University of New Brunswick
University of Prince Edward Island
University of Victoria
Vancouver Coastal Health
Vancouver School Board

International sources (including peer-reviewed journals):
Centers for Disease Control and Prevention, US
Rand Corporation of Santa Monica, California, Rand Corporations Promising Practices
Network
Australian Drug Foundation
International Journal of Drug Policy
Health Promotion International
Journal of Drug Education
Journal of School Health
British Journal of Psychiatry
Prevention Science
American Journal of Preventive Medicine
Join Together Online
Victoria Government, Australia
National Institute for Health and Clinical Excellence (NICE), UK
UK Drug Policy Commission
National Drug and Alcohol Research Centre (NDARC) Australia
The Lancet

8.0 FINDINGS FROM THE LITERATURE REVIEW/RESEARCH

There has been no lack of research into what helps young people thrive, function well, avoid health problems and become healthy adults.

What is unclear is "how" these programs work and the processes that are in place that can be replicated to advance the science through to the school and the community.

Previous thinking – that one "silver bullet", perfectly delivered, would fix the situations of countless youth has been discarded. Comprehensive strategies are seen as most effective.

And yet, theory and practice remain separated. Schools and communities continue to support one-off activities, particularly when it comes to drug education or drug prevention. This is probably because drug use prevention is a field that stirs controversy and challenges health promoters and educators to help youth "do the right thing", particularly when youth are in the early stages of experimentation or before they have tried any psychoactive substance. The silver bullet theory thrives in schools and communities where it is hoped that resources such as frighteningly graphic posters will help youth refuse drugs; that four-colour brochures will help parents talk so youth will listen and that passionate motivational speakers will ensure youth stay in school.

The silver bullet theory does not work and we now have the theory and the research to explain why and what works much better.

It appears that the most effective programming to reduce drug use, doesn't even focus on that use. According to the literature reviewed for this report what is most effective in school and community programming is an emphasis on mental health promotion. "There is general consensus in the research that drug education should focus on a life and social skills approach, linking that with overall child/youth development and mental health promotion."(Reist, 2008)

A focus on mental health promotion in schools or at the community level will not just improve mental health outcomes, but will also improve risk-taking behaviours like drug use, violence and risky sexual activity. A focus on mental health promotion enhances protective factors in the individual, family school and community. A focus on mental health promotion will ensure that the voice of the student is heard and that social determinants are taken into account.

"Reviews of programmes that promoted mental health in schools (including violence and aggression) showed these programmes to be among the most effective ones in promoting health. Of these, the ones that were most effective were of long duration and high intensity and involved the whole school. Programmes on preventing substance abuse have not been shown to be effective and may be better addressed in a more holistic programme that addresses mental health" (Stewart-Brown 2006)

Internationally, the World Health Organization states there is no health without mental health, and it has published a monograph on mental health policy and service guidelines. (Funk, 2005).

Schools are particularly well placed to integrate the essential protective factors shown to contribute to mental health development and maintenance. (Trussell, 2008).

Health promotion as a set of strategies acknowledges the complexity of health and illness and addresses a comprehensive approach, understanding the impact of social determinants of health and identifying the factors that support resiliency. While mental health promotion may be a new concept for public health practitioners, it may actually be more acceptable concept to schools and communities since even by its name, it avoids the negative stereotyping that often accompanies "anti-drug" or "anti-violence" programs.

It also lends itself to an overall framework that health – promoting schools and healthy communities can embrace with its positive emphasis.

With this in mind, the author offers 10 other key findings to guide the development of the pilot projects.

1. Youth in Ontario ages 11-14 are experiencing or at risk for experiencing negative health outcomes based on current stats and trends. This relates to alcohol and drug use, mental health issues and risky sexual activity.

2. These risk are enhanced by social determinants most of which they have little control over including geography (urban versus rural communities).

3. Disengaging/feeling disengaged from schools and communities seems to increase the risk and seems to be something these youth have more control over.

4. Resiliency and the promotion of protective factors are more likely to enhance behaviour change rather than focusing on risk factors.

5. Research into youth engagement as a protective factor is currently demonstrating this is key to enhancing resiliency and improved health outcomes.

6. There are many groups doing this research including governments and universities. Guidelines are available from these groups on ways to support youth engagement in schools and in communities

7. Found less commonly are on the ground programs that support resiliency according to these principles and those that address illicit drug use using these principles that could be used as a model for public health and which have been evaluated to support these links

8. Most drug education programs are not effective in reducing drug use.

9. There is a need for more research into programs and policies in schools and communities that support youth engagement and reduce risk-taking behaviour.

10. Youth must be included as key partners in any initiative or approach - not just as recipients of programs or as token spokespeople.

Evidence-based programming for this age group addressing the specific criteria for inclusion is limited. The author has listed the most promising programs below.

Most promising programs to support public health in developing pilot projects in youth engagement

According to Lerner, "positive youth development" programs have three core elements - program goals; program atmosphere; and program activities. Program goals include the promotion or enhancement of strengths and competencies; program atmosphere refers to

an environment that encourages the development of supportive relationships with others and supports opportunities for recognition and program activities include opportunities for engaging in real and challenging activities, broadening horizons, and increasing available supports. (Lerner, 2002)

The programs described below meet these criteria as well as having shown some degree of success in meeting expected outcomes.

School-based

- **Comprehensive Youth Pilot Project (CYPP) - Canadian, Ontario, Toronto**

    The Comprehensive Youth Pilot Project (CYPP) has been developed by Toronto Public Health to engage and mobilize Grade 6- Grade 8 youth on their own health issues using a comprehensive school health model. Goals included enhancing the resiliency of the youth and of the school.

    Working aver four years with four schools and two school boards in priority neighbourhoods, public health nurses developed "School Health Committees" with teachers and students. The evaluation strategy was developed with Resiliency Canada.

    The interim evaluation of CYPP has demonstrated the value of School Health Committees to engage youth and increase protective factors through the implementation of numerous projects carried out in the short-term – a model which is useful for the expected outcomes of the OPHA project.

    Developmental strengths which according to the literature tend to decrease between Grades 6-8 were stabilized in this program. The interim report identified many important learnings that have been included in this review. As well Toronto Public Health has developed several tools which will help public health professionals when the project continues in the 2009/2010 school year and could be useful for public health practitioners for this project. These are included in Appendix 3. The final report on the first round of schools can be accessed by calling Robert Coughlin or Brendy Juby at (416) 368-7057 or 0910 (Juby and Coughlin, 2008)

- **School-aged Children and Youth (SACY) Alcohol and Other Drugs Prevention Intiative. Canadian, BC, Vancouver**

    SACY is a school-based comprehensive health promotion program that engages students, teachers, parents and the wider community in a process to improve protective factors and reduce risk factors. The program is a collaboration between the Vancouver School Board and the Vancouver Coastal Authority and has been delivered in several schools since its inception in 2006 and the num ber of schools continues to increase.

    The program has four components –

o   student engagement through two programs - a support and education program for youth-at-risk of suspension (STEP)
o   a universal drug education for Grade 7&8 students using the "Iminds" curriculum developed by the Centre for Addiction Research in BC
o   parent engagement
o   curriculum and teacher training

To date the program has seen increases in protective factors (having at least one adult that the student can talk to); a reduction in risk factors (a reduction in drug use at school) and an increase in resliency factors for those youth who are involved with drug use and who are at risk for suspension. One of the guiding philosophies of the program is that the schools are approached to augment what they are already doing. An environmental scan ahead of programming is conducted to see how the program can be addressed within the schools' existing structures and processes.

For more information about the SACY program , see the online broochure with contact numbers: http://www.vsb.bc.ca/NR/rdonlyres/16820617-660C-49C9-8D31-39B3D60D5B98/0/SACY_Brochure_Sept302008.pdf

- **The Gatehouse Project - Australia**

  This project was developed in 1996 to promote student engagement and school connectedness as the way to improve emotional well being and learning outcomes. Using a youth health team, risk and protective factors are identified in each school and actions are planned that will build a sense of security, enhance skills and opportunities for communication and increase participation in school life. While the project's original aim was to promote mental and emotional health, outcomes have shown reduced use of alcohol and other drug use including cannabis. Like "Communities That Care' described below, the Gatehouse Project has taken on a life of its own and the website (http://www.rch.org.au/gatehouseproject/) has resources that can help schools replicate the model.

  Evaluation looked at two measurements – whether or not the students' changed and whether or not the school changed. An Adolescent Health Questionnaire was used to understand students' perceptions of school life, and identify relevant risk and protective factors in each school's social and learning environments. Priorities for action were then identified, multi-level strategies were then chosen and theses strategies were supported from an external facilitator.

  Health promotion practitioners were involved as facilitators and their observations are found in an article by Sara Glover and Helen Butler. Challenges that arose (e.g. engaging adult members of the school community) and accompanying strategies will be helpful for Ontario public health professionals (Glover and Butler 2004)

Because each school project was different based on its own perceived risk and protective factors, evaluation was challenging in schools. However, there was an overall reduction of risk-taking behaviours of 3-5% between the implementation and control schools. This difference arose from lower rates of substance use, antisocial behaviour, and early initiation of sexual intercourse by students in the intervention schools.

This program is listed in Public Health Agency of Canada's 's Best Practice Portal for Health Promotion and Chronic Disease Prevention as well as CAMH's Best Practice Guidelines for Mental Health Promotion.

Two other school-based programs which merit attention occurred in Lambton County Health Unit in Ontario . **"Healthy Happenings"**, while not a program to address drug or mental health issues, followed the school health model and had an evaluation component to assess process, outcomes and impact. Starting in seven schools, the program is now in eleven schools and an after-school component has been added. The program scored highly in increasing student leadership and in enhancing teacher and school capacity. It is now one of the programs recommended by the Public Health Agency of Canada's Best Practice Portal.

 "Taking Steps" was more closely aligned with the objectives of this project with activities to change the school culture and create a safe school environment. Only one school was involved but it was a school where 90% of students were identified as having learning disabilities or other learning challenges. Activities were based around enhancement of the four components of the healthy school framework. Evaluation was qualitative and quantitative. The project showed changes in knowledge and attitudes but few changes to behaviour although student leadership increased.

Both of these programs have aspects which can be useful for the public health professionals involved in the OPHA pilots, particularly about setting outcomes within time and resources. (Lambton County Community Health Services, 2008, Preece,C, 2008)

Community-based

- **"Communities That Care** (CTC)"** is probably the gold standard community-based strategy that addresses the risk factors common to this project. Begun in 1992 , it was developed originally to address substance abuse in communities but has since broadened to address numerous health behaviours and is actually more of model of a comprehensive approach that communities can take to support their youth. It is based on a "social development model" which promotes "the constructive involvements by young people within the community (bonding), encourages them to develop the competencies needed to deal successfully with situations that put them at risk of developing

problem behaviours (skills-enhancement), and provides positive reinforcement for adherence to desirable community standards and norms."(Flynn, R, 2008)

Surveys for community needs assessments identify 23 risk and 10 protective factors that could be addressed over time. They include many of the protective factors identified earlier in this report from the Search Institute and Resiliency Canada but add a few more

o Community opportunity for prosocial involvement
o Community rewards for prosocial involvement

And for risk factors

o Transitions and mobility
o Laws and norms favourable to drug use
o Perceived availability of drugs
o Perceived availability of handguns

Tools are available to assess the readiness of the community to engage and to mobilize around youth and evaluations have been positive with regard to the reduction of some risk-taking behaviours and enhancement of protective factors. There have been communities in Ontario which have taken on the model including Hawkesbury, Sudbury, and Ottawa. Hawkesbury focused on increasing out-of school activities for youth; Sudbury looked at needs and service gaps for urban aboriginal youth and Ottawa focused on immigrant youth and risk and protective data. (Flynn, 2008). Squamish BC one of the first Canadian communities has managed to sustain their projects with the addition of funding from numerous partners. Their website identifies the comprehensive nature of community activities including pre-school programs, two strengthening families programs – for both younger and older children and youth, community trials to reduce high-risk drinking plus the development of a municipal alcohol policy.

More information on CTC programs in Canada can be found on the PHAC Best Practice Portal at http://cbpp-pcpe.phac-aspc.gc.ca/intervention/25/view-eng.html

- **Tiny Giant/The Students Commission Canada based in Toronto** (one of the Centres for Excellence in Youth Engagement)

Tiny Giant/The Students Commission is a charitable organization of youth for youth dedicated to creating and promoting opportunities for young people to learn and grow in a positive and safe environment. It is their belief that engaging young people in an effective and meaningful way creates resiliency, in turn building community and citizenship. The Commission works from an evidence-based format within a philosophy that mandates the voice of youth in any activity or program that is developed for them. Tools available on their website include ways to "do" participatory action research with youth.

Through workshops conferences and training, the Commission's facilitators work with youth and adults to foster youth engagement. This project could be

very useful for public health practitioners interested in developing capacity with adults in the community or school around youth engagement.

The Commission has several projects including YDM – Young Decision-Makers where young people ages 13-24 are invited to be a part of national and global change. Two members of YDM sit on the CCSA's National Advisory for Youth Substance Abuse Prevention. This project takes youth engagement to the next level with attention to matters of national and global importance. As the website notes, "In the summer of 2006 the Students Commission and the Centre of Excellence for Youth Engagement Centre were able to hire 18 youth summer staff to collect data from youth about the concept of a national youth body and to answer the question, "Is this something youth think is important and something that they want?" Since then, something more meaningful has occurred: young people have identified a desire to take a much more active role, promoting the concept to their friends, classmates, teachers and other youth, engaging more and more people in the discussion about the development of not just a structure or a body – but to explore a process that can exist to ensure youth voice is heard in Canada". (See Appendix 1 – YDM)

- **YACshops – Canada, BC**

  The McCreary Foundation is another Centre for Excellence in Youth Engagement. One of their key activities is providing YACshops across the province where youth have the opportunity to identify risk and protective factors that have been reported in the Adolescent Health Survey and then implement activities to meet their needs. The target age is middle and secondary school youth. In 2005, 13 communities were involved in this project and a summary report "From the Inside Out" reported on the process with three of them, (two First Nations communities in northern BC and one urban rural mixed community in the south) and the impact (Murphy A, 2005).

  Framing the workshops around Lerner's 5 Cs (Lerner 2005), the Project staff worked with local youth to plan and implement activities including community-mapping, and developing positive public relations campaigns to enhance the reputation of youth in the community.

  The most recent Adolescent Health Survey was completed in 2008 but no report has yet been released. Information about the report can be accessed on the McCreary Foundation website at http://www.mcs.bc.ca/files/AHS_4_info_booklet_web.pdf

  Public health practitioners in the OPHA project can learn from the experience of McCreary's community development team around youth engagement and health issues, including a number of activities, found on the website, that have been tested with the target group and found useful.

9.0 CONCLUSIONS AND RECOMMENDATIONS

Within the target age group for these pilot projects, Ontario youth ages 11-14, there is the potential for risk-taking behaviours. Public health professionals in Ontario have the ability to reach these youth through youth engagement activities in both the school and the community using already verified processes (healthy schools framework, healthy communities strategy).

There are well-validated programs which can be used as models for each of the settings. Getting youth engaged and feeling part of the decision-making into their own health outcomes should help to change less healthy behaviours. However the outcomes of this project must be restricted to what can be accomplished given timeline and resources. An enhancement of youth engagement plus reports from the youth about how project activities helped youth feel more connected to schools, to communities to teachers and to role models is very realistic.

This is an opportunity for Ontario's public health professionals to demonstrate the power of youth engagement in helping youth feel connected to their schools or communities. The results of a multi-site evaluation into the enhancement of protective factors will support further uptake of youth engagement strategies at the local level as well as support health departments in their implementation role associated with the Standards.

1. With regard to the project outcomes, the author recommends that the evaluation component for the pilot project focus on indicators and outcomes that can be accomplished realistically within the time limits and processes of the projects. This could be (language is the author's own based on this review):

- Increased engagement of youth in school or community activities (more youth involved)

- Increased "meaningful" participation of youth in school or community activities (more youth feeling like they belong and have a part to play in the activities)

- Enhancement of a sense of connectedness to school or community (more youth identify that they feel more connected to the school/community

- Enhancement of feeling valued in school or community (more youth identify a sense that the school/community values their input)

- Enhancement of school or community bonding (more youth report that they like their school/community)

- Enhancement of ability to be part of decision-making for the school or the community (more youth identify that they have a say in what happened in their schools)

- Increase in positive adult role models (more youth identify positive role models or teachers/community members they feel comfortable/safe with)

- Increase in "liking "school/community/teachers etc.

2. With regard to the target age youth, the author recommends that public health professionals understand and accept the concept of "authentic" youth engagement as described in this review and that they have tools to be able to support this within the settings they choose for their projects. This should be supported in both the training day, the tool kit for professionals and the website.

3. With regard to settings, the author recommends that public health professionals choose settings for these pilot projects that already have a readiness to support youth engagement activities either because of policies or previous commitment.

4. With regard to OPHA's role in the project, the author recommends that OPHA encourages public health professionals to follow the guidelines and processes identified as a result of this research review and offers training and ongoing support throughout the span of the project via the following tools:

- **Training Day**
- **Tool Kit with at least the following items**
  - Guidelines (hard copy and on website)
  - Process
  - Expectations
  - Evaluation plan
  - Tools and Resources (e.g. readiness survey)
- **On-going mentoring**

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11.0 APPENDICES
1. List of online tools to support public health initiatives in schools and communities (English and French)
2. Guidelines/Principles for Delivery of Pilot Programs
3. "Assessment of readiness" tools from Toronto Public Health
4. Key Organizations and Agencies Currently Involved in Supporting Youth Engagement with the Target Age
5. Training Day Recommendations

Appendix 1. List of online tools to support public health initiatives in schools and communities (English and French)

1. Sites Supporting Youth Activism.
   - YDM – Young Decision Maker – Part of the Tiny Giant/Students Commission Centre for Excellence for Youth Engagement (English and French)
   - YAC – Youth Action for Change, Australia – (English) http://www.youthactionforchange.org/
   - The Innovation Centre for Community and Youth Development - US (English)
   - http://www.theinnovationcenter.org/activities-toolkits-and-reports
   - Volunteer Connections: New Strategies for Involving Youth - (English an French)
   - http://volunteer.ca/volunteer/pdf/NewstratEng.pdf
   - ACT for Youth - US (English) http://www.actforyouth.net/?ydManual
   - A Strong Start: Good Practices in Using a Local Situation Assessment to begin a Youth Substance Abuse Prevention Project (English) http://www.unodc.org/pdf/globalinitiative/initiative_goodpractice_assessing_strong_start.pdf
   - Youth centers in Ontario (English and French Youth Centres identified) http://www.typs.com/youthcentres/main.php?action=listcentres&order=region
   - Youth and health – be you be healthy (English and French and many other languages) http://ec.europa.eu/health-eu/youth/index_en.htm

2. Sites Supporting Planning
   - Ontario Healthy Schools Coalition – resources to support healthy schools (English)http://www.opha.on.ca/resources/topics/h.shtml#schools
   - Canada's Best Practice Portal for Health Promotion and Chronic Disease Prevention (English and French). Retrieved June 2009 from: http://cbpp-pcpe.phac-aspc.gc.ca/intervention/find
   - Making Health Happen – Tool Kit for School Councils Retrieved June 2009 from: http://www.opha.on.ca/resources/docs/SchoolCouncilKit.pdf
   - Planning process checklist for Comprehensive School Health – Canadian Association for School Health. (English) http://www.safehealthyschools.org/CSH%20Planning%20Process.pdf
   - CTC website on SAMHSA http://ncadi.samhsa.gov/features/ctc/resources.aspx
   - Tools for Knowledge Exchange Checklist, Children's Hospital of Eastern Ontario (English and French)
   - http://www.onthepoint.ca/kec/documents/Kechecklist.pdf
   - WHO Psycho-social profile assessment tool for schools (WHO site is in English and French but unclear whether or not this resources is in both languages).http://www.who.int/school_youth_health/media/en/sch_childfriendly_03_v2.pdf
   - Exploring engagement (English)- http://www.engagementcentre.ca/files/discYE_e.pdf
   - Reach Out 'pro' (English) - http://www.reachoutpro.com.au/working-with-young-people/top-ten-tips-from-young-people.aspx

3. Sites specific to mental health promotion
- CAMH Mental Health Promotion (English and French)
  http://www.camh.net/About_CAMH/Health_Promotion/Community_Health_Promotion/Best_Practice_MHYouth/index.html
- Worksheets for above
  http://www.camh.net/About_CAMH/Health_Promotion/Community_Health_Promotion/Best_Practice_MHYouth/index.html
- ruMad? Youth website from Australia examples of youth engagement in school and community-based projects on mental health promotion
  http://www.rumad.org.au/

Additional French links

- The Ministry of Education Foundations for a Healthy School
  http://www.edu.gov.on.ca/fre/healthyschools/foundations.html
  http://www.edu.gov.on.ca/fre/healthyschools/foundations.pdf

- The Porcupine Health Unit
  http://www.porcupinehu.on.ca/Schools/documents/HN-Sep-FR.pdf

- OSNPPH: http://www.osnpph.on.ca/pdfs/action_nutrition_ecole.pdf
- Dairy Farmers: http://www.plaisirslaitiers.ca/fr/teachers/nutrition-education/province-ontario/elementary-school-milk-programs/esmp.htm
- Eat Right Ontario:
  http://www.eatrightontario.ca/fr/ViewDocument.aspx?id=59
  http://www.eatrightontario.ca/fr/ViewDocument.aspx?id=41

- Dare to dream –"Programme Oser Rever"
  http://www.daretodreamprogram.ca/index_f.htm

- Prevention of drug use and abuse by young people ages 11-14 needs a complex, comprehensive approach and education or skill-building alone won't work.

- Many risk-taking behaviours (like drug use or mental health issues) cluster in this age group.

- Focusing on protective rather than risk factors is more effective for behaviour change and this enhances resiliency as well so that if a young person is involved in any higher-risk activity, they will be able "bounce back".

- In schools and communities, protective factors are enhanced by youth engagement and authentic youth engagement means sharing power and decision-making with youth.

- There are criteria for successful youth engagement programs and these include:
  - having a balance between structure and flexibility
  - offering a range of ways for youth to be involved that vary in commitment
  - tailoring the engagement strategies to the needs of the group
  - offering youth opportunities to act as leaders as well as participants
  - offering a range of programming including mentoring, skill-based activities and leadership
  - including youth in planning and evaluation – let them give their ideas and then tell the story afterwards – what changed for them.

Process for Public Health Professionals in Developing Pilot Project

1. Understand and accept the definition of "youth engagement" according to the training day and the guidelines.

2. Reflect on what expectation you have for such a project.

3. Determine the amount of time you can give to this project.

4. Use readiness tools for assessment of the school or community settings

5. Market the pilot and the idea of a Health Action Team (HAT) to key stakeholders (Head teacher, Principal, head of the parent council, other ph staff in the school, community center administration, youth/student council)

6. Involve youth from the beginning

7. Identify other important members for the HAT (teachers, parents, community members)

8. Bring in additional community support people who are involved in youth engagement – secondary school, Community Health Centres, Youth Centres, 4-H, Boys and Girls Clubs, Girl Guides, Scouts

9. Ensure a place for HAT in the school/community (space, time, resources)

10. Use tool for assess school needs

11. Identify top three prioritize – discuss, choose priorities

12. Facilitate an assessment of the potential partners that will support these priorities

13. Facilitate the choice of one that can be realistically addressed in the time you have (February – June, 2010 - September – December, 2010)

14. Get going!

Appendix 3 – Additional readiness tools from Toronto Public Health

Healthy Communities
School Consultation and Engagement Guide

Purpose of School Consultation and Engagement Process:

1) To assess school readiness to work towards implementing the Ontario Ministry of Education's Foundations for a Healthy School, Ideas and Shared Practices (FHS)
2) To establish a Healthy Schools Committee (HSC) in schools which have been determined to be ready to begin this process
3) To enhance the collaborative relationship between the Liaison Public Health Nurse (LPHN) and school administration (whether or not the school is ready to form a Healthy School Committee (HSC)
4) To reinforce strength based approaches to Toronto Public Health (TPH) practice in schools.

Objectives:

1) To assess the strengths and needs of the school from the perspective of school administration, ii) identify key stakeholders and decision makers and iii) share information about the school and the school community (note: this information is useful to the LPHN whether a Healthy School Committee (HSC) is formed or not – will inform the LPHN's school plan).
2) To inform school administration of the Foundations for a Healthy School (FHS) framework and to explore their readiness to work towards implementing this Ministry of Education endorsed framework.
3) To capture LPHN's impressions of school administration's readiness and commitment to the formation of a HSC.
4) To confirm school administration's commitment to form a HSC through the identification of or voluntary participation and approval of lead staff (LS).
5) To clarify tasks, roles and responsibilities of LPHN and LS in the formation, development and sustainability of a HSC.
6) To develop an alternative plan with schools which are not ready to form a HSC.

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Healthy Communities
School Consultation and Engagement Guide

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BACKGROUND PREPARATION FOR LPHN INTERVIEW WITH PRINCIPAL/VP

The following are some steps the LPHN can take to prepare for their interview with the Principal/VP:

☐ Schedule an appointment to meet with the Principal /VP (approximately 30 minutes)

☐ Gather demographic data of the community (ward profiles website: http://app.toronto.ca/wards/jsp/wards.jsp

☐ Connect with former LPHN (if any) and/or program staff involved with school

☐ Review previous year(s) school documentation

☐ Develop example of a Healthy School project that utilises Foundations for a Healthy School [CSH] framework and is relevant to some of the issues facing the school community the LPHN is trying to engage (based on the demographic data above)

☐ Review healthy schools and link between health and learning (**see appendix A**)

☐ Review Ministry of Education's Foundations for a Healthy School document http://www.edu.gov.on.ca/eng/healthyschools/foundations.pdf

☐ Review role of members of HSC (**see appendix B**)

☐ Review dimensions of health (see **appendix C**)

☐ Gather other relevant school data (e.g. LOI, LOG, EQAO, existing committees, Quest for Excellence, etc.)

Information for meeting with administration
Purpose:

1) To: i) Assess the strengths and needs of the school from the perspective of school administration, ii) identify key stakeholders and decision-makers and iii) mutual sharing of information about the school and the school community.

2)   To inform the Principal/VP of the supportive role(s) TPH can play to help achieve a healthier school.

3)   To capture LPHN's impressions of school administration's readiness and commitment to the formation of a HSC

Introduction to meeting with Administration

- Explain purpose of meeting
- Share your perspectives of the school community (key features and strengths of the school community)
- Briefly discuss benefits of a healthy school and the links between health and learning
- Refer to the Ministry of education and Ministry of Health Promotion Healthy School Recognition Program
- Discuss the Foundations for a Healthy School and the establishment of a Healthy School Committee to address health needs
- Give an example of each component using a success story and based on an issue(s) relevant to the particular school community
- Describe LPHN role
- Discuss the role of the HSC and its members **(Appendix B)**
- Emphasize the importance of engaging students

Information for LPHN interview with Lead Staff
Purpose:
        To assess readiness and commitment of lead staff to the HSC

Two possible scenarios:

1. Staff assigned as lead in formation of HSC by admin. (VP or principal)
2. Staff volunteer to be lead in the HSC

Introduction to meeting with Lead Staff
- Provide overview of school consultation and engagement thus far:
  →Meeting with administration to assess school readiness to implement Foundations for a Healthy School and the establishment of HSC, strengths and needs of the schools (from admin. perspective), identifying key stakeholders and describing school community
- Provide introduction to or review with staff re: FHS approach, links between health and learning, importance of HSC in addressing health issues and provide real-life examples of success stories as it relates to the above
- Outline role of lead staff in HSC – **See Appendix B**

Information for LPHN interview with students
Purpose:
>To assess readiness and commitment of students to the Healthy School Committee.

Two possible scenarios:

>1. Students assigned by administration as members of Healthy School Committee
>2. Students volunteer through presentation to student group

Introduction to meeting with Students
- Provide overview of school consultation and engagement thus far:
  →Meeting with administration to assess school readiness to implement FHS and the establishment of HSC, strengths and needs of the schools (from admin. perspective), identifying key stakeholders and describing school community
  →Explore students' perspective on health issues
- Provide introduction to FHS, links between health and learning, importance of HSC in addressing health issues and provide real-life examples of success stories as it relates to the above
- Outline role of students in HSC – **See Appendix B**

Information for LPHN interview with parents (In schools where there are active parent groups such as parent council, parent volunteers etc).

Purpose:
>To encourage parent interest and participation in working on a Healthy School Committee.
>To recruit volunteers for the Healthy School Committee

Introduction to meeting with parents
- Provide overview of school consultation and engagement thus far:
  →Meeting with administration to assess school readiness to implement FHS and the establishment of HSC, strengths and needs of the schools (from admin. perspective), identifying key stakeholders and describing school community
  →Explore parents' perspective on health issues
- Provide introduction to FHS, links between health and learning, importance of HSC in addressing health issues and provide real-life examples of success stories as it relates to the above
- Outline role of parents in HSC – **See Appendix B**

LPHN Assessment of HSC Formation
Purpose:
>   To assist the LPHN in determining the school's readiness to work with the LPHN
>   on school health issues identified and addressed through a HSC

Procedure:
- The Liaison Public Health Nurse completes the *LPHN Assessment of HSC Formation* form after meeting with the school Administration (Principal/VP) and Lead Staff and students.
- Make a decision about school readiness to form a HSC using the Decision Criteria
- If the school is not ready, the LPHN must complete a plan for working with the school for the school year.

Appendix A
Health Promoting Schools

The goals for a health promoting school are:

- Foster health and learning with all the measures at its disposal
- Engage health and education officials, teachers, teacher's unions, students, parents, health providers and community leaders in efforts to make school a healthy place for all
- Strive to provide a healthy environment, school health education and school health services, health promotion programs for staff, healthy food choices, daily physical activity/education, and programs for counselling, psychological intervention, social support and mental health promotion
- Implement policies and practices that respect an individual's well-being and dignity, provide multiple opportunities for success and acknowledge good efforts and intentions as well as personal achievements (Canadian Consensus statement on Comprehensive School Health May 31, 2006 and adapted from those prepared by the WHO)

Link between Health and Learning

- Maximizes student achievement and staff performance
- Schools lay the foundations for future health behaviours
- Healthy children (in all dimensions of health) learn better – better health enhances capacity to learn. Students who view themselves as healthy are more likely to have a positive attitude toward school, good relationships at home and with peers, self confidence, healthy eating patterns and greater acceptance of their body image.
- Studies have shown that a higher standard of school health leads to less absenteeism and lateness, higher test scores, and less disciplinary action required within the school. Students who do poorly at school are at increased risk for dropping out, being unemployed and engaging in a wide range of unhealthy behaviours. Students who have positive experiences at school are less likely to be involved in smoking, drinking and drug use.
- Healthy schools enable students to make positive life choices that last a life time.
- Healthy schools enable students to be more involved in decision making, leadership opportunities, and problem solving in their communities
- Students are generally better connected to their communities
- Healthy schools foster the total development of students (mental, physical, emotional, spiritual)
- Healthy schools enable students to enhance their own personal health and enable them to become change agents in their schools
- Healthy schools become more positive places to learn.
- "You can't educate a child who isn't healthy, and you can't keep a child healthy who isn't educated" (as quoted by Former U.S. Surgeon General Joycelyn Elders)

HSC Members
- The role of each Healthy School Committee (HSC) member is to champion health in the school community, and to recruit school community members to participate in HSC initiatives. The HSC is responsible for i) developing Terms of Reference for the committee, ii) identifying health issues/needs, iii) assessing and building on strengths to improve school health, iv) prioritizing issues, v) developing, implementing and evaluating action plans, vi) informing the school community about plans and activities, and vii) celebrating HSC achievements. **The school maintains ownership of the HSC and its work.**

Students:
- Commit to working on the HSC
- Ideally students on the HSC reflect a mix of ages/grades/gender/skills, and reflect the ethno-racial composition of the student body
- Take lead role in recruiting peers as HSC members and to participate in HSC initiatives
- Bring forward health issues identified by peers to the HSC

Parents:
- Participate as members of the HSC, or provide input through other means (e.g. issues channelled through Parent Council, responding to surveys, etc.)
- Take lead role in recruiting parent participants

School Lead Staff (LS):
- Commits time dedicated for the work of the HSC with approval from administration
- Coordinates the mobilization of the HSC, with assistance from the Liaison Public Health Nurse (LPHN)
- Coordinates time, location and frequency for HSC meetings
- Supports the HSC as it moves through the process

Principal
- Supports the efforts of the HSC (e.g. ideally allows dedicated time of the LS person(s) to the HSC, encourages support by other staff for the HSC and the lead staff person(s), supports recruitment of appropriate HSC members, and ideally incorporates time for HSC initiatives into the academic timetable for both teachers and students).

Liaison Public Health Nurse (LPHN)
- Works with the LS to establish and maintain the HSC (i.e. recruiting members, completing the Priority Identification tool, developing, implementing and evaluating the action plan)
- Refers to Toronto Public Health (TPH) program staff for expertise and resources

- Links with community partners for additional expertise, programs and services
- Coordinates and/or delivers programs for teachers or students e.g. Train-the-trainer programs
- Collaborates with LS to develop support from the broader school staff

Appendix C
Dimensions of Health

PHYSICAL

(e.g. - **Physical Activity, Nutrition**
- **Prevention of Injury, Sun Exposure, and Alcohol, Drug, and Tobacco Use**
- **Comfort with Body Changes)**

MENTAL/EMOTIONAL

HEALTH

- enables you to do what you want to do

- assists you to cope if

SPIRITUAL

SOCIAL
(Social Support, Caring, Connectedness)

Community's Strengths and Needs - St...
ct School Board, Toronto District School B...

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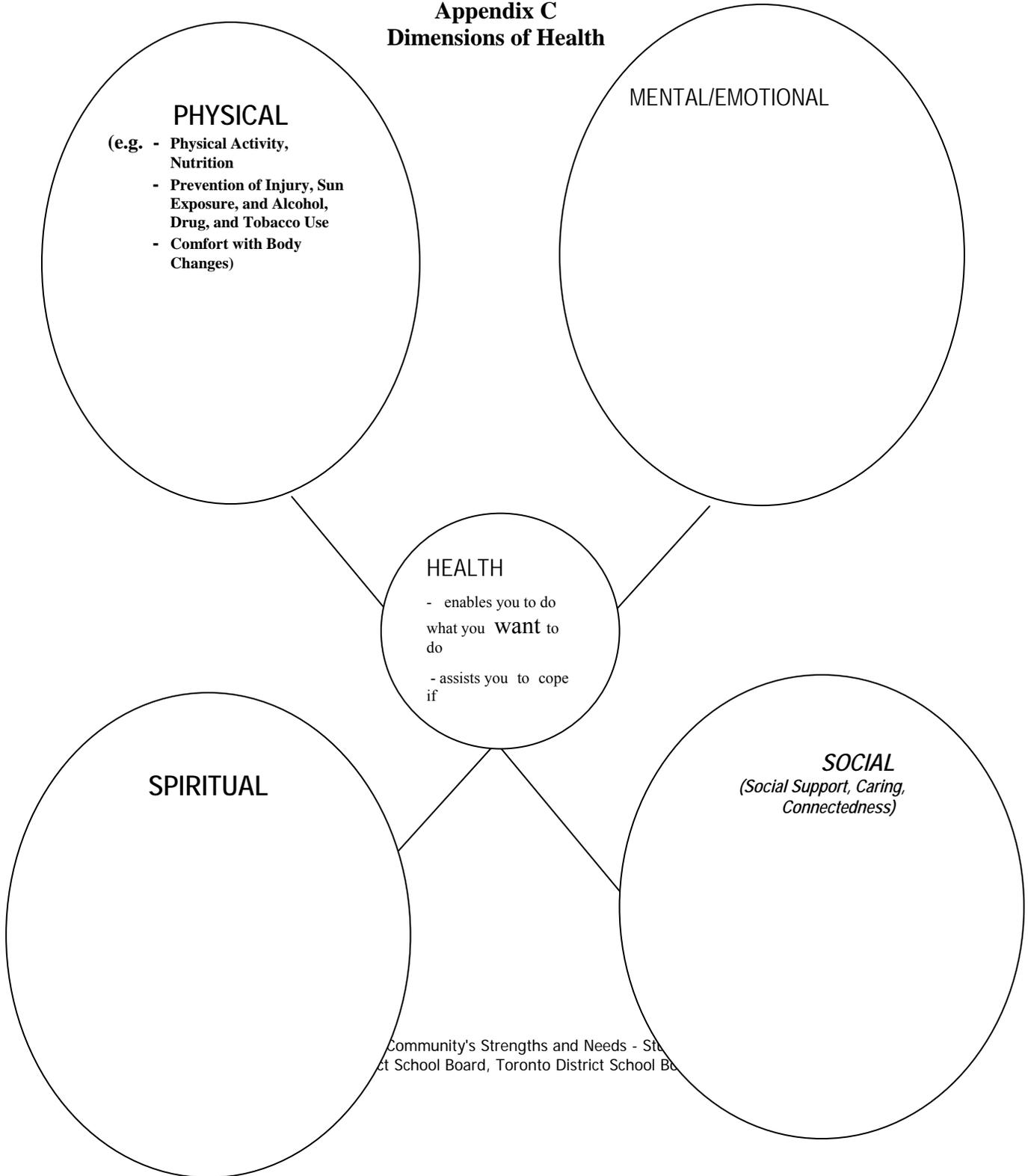
Appendix D
Priority Setting Through a "Dotocracy" Method

What is it?

Dotocracy is a prioritization tool that allows groups to quickly see which proposals or ideas are the most popular by allowing participants to vote with "dot" stickers.

Why use it?

This tool is useful because it does not require significant time. It allows quiet participants to contribute to decision-making, avoids loud debate, and can be conducted with many people. In addition, Dotocracy produces a fully documented record of what participants think is most important.

Importance of Issue (Red Dots)	Resources/Opportunities – How Doable Is it? (Green Dots)	Final Rating Based on Consensus
1. Low self-esteem, lack of student leadership skills	1. Unhealthy lunches	1. Low self-esteem, lack of student leadership skills
2. Unhealthy lunches	2. DPA requirement	2. DPA requirement
3. Need help meeting DPA requirement	3. Low self-esteem, lack of student leadership skills	3. Unhealthy lunches

Using the "Dotocracy" Method:
- Write all of the issues identified through the brainstorming session on flip chart paper posted around the room
- Have a brief discussion of each item before voting begins to ensure the group has a common understanding of each specific issue
- Provide 10 red coloured stick-on dots to each Healthy School Committee member
- Have the members place the stickers next to those issues they think important. If someone feels strongly about an item, they can put up to 3 dots beside it
- The item receiving the most stickers is considered to be the most important
- Record the top 3 priority issues
- Now, discuss the resources, opportunities and level of commitment available to address each of the 3 priority issues that have been identified
- Provide 6 green stick-on-dots to each member, which they place beside the issues they think are most doable
- Discuss the importance and "doability" of each issue, and have the group decide the final rating of the priorities for action over the coming school year

Canadian Rural Partnership – *Community Decision-Making Toolkit*, Government of Canada
For additional Priority Setting tools, refer to *Facilitating with Ease!* by Ingrid Bens..

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Appendix E

EXAMPLE
General Template
Healthy School Committee

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Terms of Reference

Purpose:

[For Example: To maximize the physical, social, emotional and spiritual health of the school community through the work of a Healthy School Committee comprised of student, staff, parent and community representatives, and which is supported by school Administration and staff].

Accountability:

[For Example: To school Administration, or to the Parent Council, or to the Student Council]

Membership:

[For Example: Student Rep(s), School Staff Rep(s), Parent Rep(s), Community Agency Rep(s)]

Meetings:

[For Example: Monthly meetings or meetings as considered necessary by HSC members]

Decision Making:

[For Example: one person one vote or students have two votes, consensus decision-making, etc.]

Roles and Responsibilities of HSC Members:

[For Example:
- Support and promote health in the school
- Attend and participate in HSC meetings
- Discuss meeting management (i.e. chair, minute taking etc)
- Identify and prioritize school health issues to be addressed, e.g. brainstorming session amongst HSC members; conduct a school survey, etc.
- Develop, implement and evaluate the plan for addressing the issue(s)
- Recruit appropriate HSC participants for effective implementation of the plan
- Develop and implement plans to maximize student involvement in the HSC
- Keep the school informed of HSC activities, plans and outcomes e.g. newsletter

- Respond to urgent emerging issues affecting the health and well being of the school community
- Celebrate successes

Appendix F
Youth Engagement

Youth Engagement can be defined as "meaningful participation and sustained involvement of a young person in an activity with a focus outside of him or herself (Centre of Excellence for Youth Engagement, 2004), instilling a sense of active citizenship and social responsibility. (Sten 2006)

Some essential characteristics of youth engagement

- It is very important to decide at the beginning, what level of power one is willing to give the youth. Let them know how much power or influence they will have and then stick to it.

- Provide opportunities for skill development and capacity building. (Success requires ongoing support and training)

- Provide opportunities for leadership development. (A genuine transfer of decision-making power from adults to youth. E.g. Youth could be equal partners on committees or some organizations have youth advisory councils or boards)

- Encourage reflection on identity. (Familiarity with identity issues helps youth make the links between factors that affect their lives to those that affect their community)

- Develop social awareness. (Help guide youth from self-awareness to social-awareness and provide opportunities to reflect on responsibility of citizenship)

- Effective youth engagement requires a commitment to youth by the whole organization
  (Organizations need to be respectful and a hospitable environment for youth is required for transfer of power from adult to youth)

- Organizations should ensure that staff are well trained and supported to meet the complex needs of diverse youth

- No one person speaks for a whole community. (If youth are representatives of larger communities, ensure mechanisms are in place to support that young person's role and engage the community in ongoing dialogue.

- Build supports from parents and other caring adults/mentors

Youth Engagement Continuum

Intervention - *Youth services approach*

- Defines young people as clients
- Provides services to address individual problems and pathologies of young people
- Programming defined around treatment and prevention

Development – *Youth Development*

- Provides services and support, access to caring adults and safe spaces
- Provides opportunities for the growth and development of young people
- Meets young people where they are
- Builds young people's individual competencies
- Provides age appropriate support
- Emphasizes positive self identity
- Supports youth/adult partnerships

Youth Leadership - *Includes components of youth development plus:*

- Builds in authentic youth leadership opportunities within programming and organization
- Helps young people deepen historical and cultural understanding of their experiences and community issues
- Builds skills and capacities of young people to be decision makers and problem solvers
- Youth participate in community projects

Community Empowerment or Civic Engagement
Includes components of youth development and youth leadership plus:

- Engages young people in political education and awareness
- Builds skills and capacity for power analysis and action around issues young people identify
- Begins to help young people build collective identity of young people as social change agents
- Engages young people in advocacy and negotiation

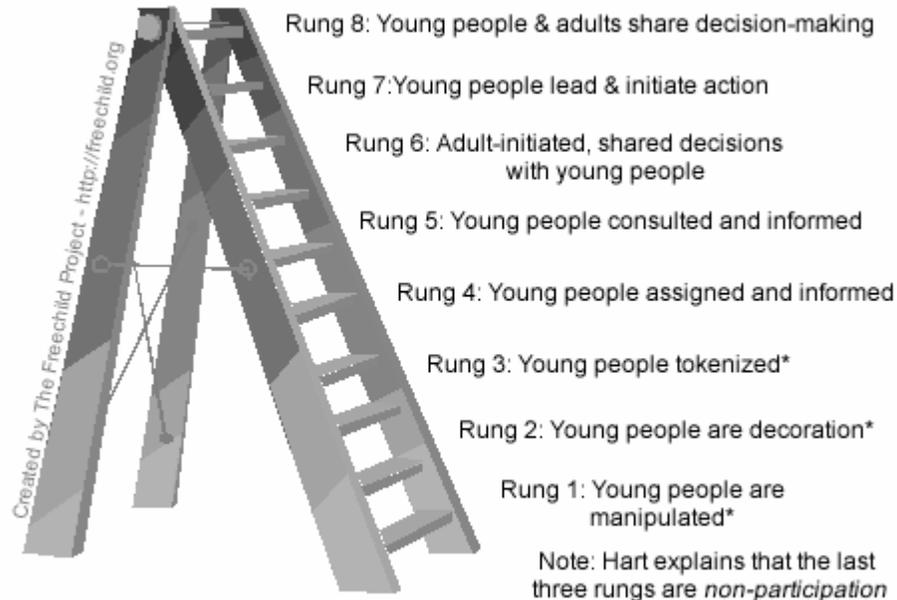**Systemic Youth Organizing**
 Includes components of youth development, youth leadership and civic engagement plus:

- Builds a membership base
- Involves youth as part of core staff and governing body
- Engages in direct action and mobilizing

- ˳ Engages in alliances and coalitions

Roger Hart's Ladder of Young People's Participation

Rung 8: Young people & adults share decision-making

Rung 7: Young people lead & initiate action

Rung 6: Adult-initiated, shared decisions with young people

Rung 5: Young people consulted and informed

Rung 4: Young people assigned and informed

Rung 3: Young people tokenized*

Rung 2: Young people are decoration*

Rung 1: Young people are manipulated*

Note: Hart explains that the last three rungs are *non-participation*

Created by The Freechild Project - http://freechild.org

Adapted from Hart, R. (1992). *Children's Participation from Tokenism to Citizenship.* Florence: UNICEF Innocenti Research Centre.

Working Effectively with Youth:

Adults who want to work with young people need to respect them as individuals who can make contributions to the well being of the community. While it is important to recognize the differences between adolescents and adults, it is equally important to recognize the similarities. The first task that collaboration needs to undertake when involving youth is to spend some time listening. Ask them about their concerns, what they like to do, their suggestions for addressing identified needs and what kinds of support from adults would be helpful.

Ten Tips for Working with Youth:

1. Share the responsibility of leadership. Provide guidance, but avoid total control.
2. Listen carefully to youth and try to understand their perspective.
3. Provide meaningful roles and assignments for youth.
4. Share all work activities, even tedious ones.
5. Treat young people as equals and develop a partnership relationship.
6. Keep youth informed about activities, even when problems occur.
7. Be energetic and excited about activities. Have a positive, open attitude.
8. Make activities fun and challenging.
9. Be clear about the levels of authority for youth and back their decisions when they fall within the agreed upon guidelines.
10. Serve as role models for the youths, and be fair and consistent in your actions.

Healthy Communities
School Consultation and Engagement Guide
LPHN Assessment of HSC Formation

Date and Time:_____
—

Name of school:_____
—

Name of school Administrator:_____

Name of Lead Staff:_____

1)   **To what extent do you think the Administration will commit to forming the HSC? (Please check one)**

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

2)   **To what extent do you think the Lead Staff will commit to the HSC? (Please check one)**

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	

Non-supporting factors:	
Additional comments:	

3)   **To what extent do you think the Administration will support the Lead Staff on the HSC? (Please check one)**

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

4)   **To what extent do you think other teachers/staff will be supportive of the HSC and its initiatives? (Please check one)**

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

5)   **To what extent do you think parents will become involved in the HSC? (Please check one)**

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

6) **To what extent do you think the students would be interested in joining the HSC?**
(Please check one)

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

7) **Overall, to what extent do you think this school is ready to form a HSC?**
(Please check one)

☐ Not at all **(1 Point)**
☐ Not Very Likely **(2 Points)**
☐ Maybe/Maybe Not **(3 Points)**
☐ Somewhat Likely **(4 Points)**
☐ Definitely **(5 Points)**

Supporting factors:	
Non-supporting factors:	
Additional comments:	

8) Overall, what strengths did you identify that would assist in the formation and success of a Healthy School Committee?

**9) Overall, what challenges did you identify that would hinder the formation and success of
a Healthy School Committee?**

Decision Criteria

Please write the numbers you circled for questions 1- 6 in the table below and add them up.

	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Total
Score							

The school should have a score of 20 or more to indicate readiness to address issues and form a HSC.

Detailed Rationale

Responses to questions **1-4 and 6 should score 4 or higher** to indicate readiness. Response to question **5** may score at any level. (The literature indicates that obtaining parent participation is the most difficult to achieve. Therefore, a score of 1 does not necessarily mean that the school is not committed to the HSC. Part of the work of the HSC will be to develop strategies to recruit parents and/or involve parents in the work of the committee).

10) Is the school ready to work with the LPHN in addressing health issues via formation of a healthy school committee? (Please check one)

☐ **Yes**   ☐ **No**

If No, please describe the plan for the school:

2. School Consultation and Engagement Guide

Liaison Public Health Nurse (LPHN) Interview with Lead Staff

Date and Time:_____

**Name of
School:**_____

**Name & Designation of Lead
Staff:**_____
                                       Name   **Designation**

1. What is your vision of a healthy school?

2. What would you like to see achieved through a Healthy School Committee?

3. What would be some of the highlights of forming a Healthy School Committee?

3. What do you see as the challenges in forming and maintaining the HSC?

4. Will students and/or parents agree it is important to address health issues?

5. Let's talk about ways to involve students that are representative of the student body.

- Are there barriers to parental involvement (e.g. language, culture, work schedules etc.) Comments?

6. What are your thoughts about the role and responsibilities outlined for us (Lead Staff and Liaison   Public Health Nurse) on the HSC?

7. What is your sense of the time commitment required from both the Lead Staff and LPHN to organize   and develop a HSC? Comments?

Mutually agreed time commitment: _____

7. Let's talk about support for you and the HSC from school Administration and staff.

What level of support could you anticipate from school administration and colleagues? (e.g. dedicated

Staff time for the HSC, picking up of workload, promotion and participation in HS initiatives)

Can we set a time within the next week or so to plan how we'll work together to organize the HSC?

3. School Consultation and Engagement Guide

LPHN Interview with Administration

Date and Time:_____

Name of
school:_____

Name and Designation of school administrator:

_____

                                               Name

    Designation

1. Can you share your perspectives on the community? (**Information pertaining to the general community):**

2. What are some structures/initiatives that are already in place that contribute to a healthy school?

3. Given the work that has already been done, do you think there any student health needs/issues in your school community that still need to be addressed? (Circle)

     Yes   **No**

If The Answer is Yes:
3(a).   Can we discuss what they might be?

     Yes   **No**

Comments:

4. Do you think your staff would identify any additional or different issues?

Yes   No   Not Sure

If the answer is No, go to question 5.

If the answer is Yes:

4(a). Can we discuss what your staff would identify as health issues?
Yes   No

Comments:

5. Do you think your students would identify health needs or issues that are different from those we've discussed so far? (Circle)

Yes   No   Not Sure

If the answer is No, go to question 6.

If the answer is Yes:

5(a). Can we discuss what your students see as health issues?

Yes   No

Comments:

6. Have parents indicated concern or taken any action regarding any health issues we have discussed?

Yes   No

Comments:

7. Has your school partnered with service organizations or community groups (e.g., public health, parks & recreation, the police, Toronto Parent Network, Neighbourhood Action Team, etc.)?

Yes   No

If the answer is No, go to question 8.

If the answer is Yes:

7(a).   Who have you partnered with and what initiatives have you done together?

8.   Are there other policies, programs and/or special initiatives that your school has undertaken to address any of the issues you have identified?

Yes   No

If the answer is No, go to question 9.

If the answer is Yes:

8(a).   Can we talk about this in more detail?
Yes   No

Comments:

9.   Are there specific processes in place to identify and respond to student health issues/needs? (e.g., are there assigned staff, individual parent council rep., designated group such as TSM, HAT, Athletic dept group, safety committee, staff, parents, community partners etc.)?

Yes   No

If the answer is No, go to question 10.

If the answer is Yes:

Can we talk about this in more detail?

Comments:

10. You have identified the following health issues at your school (R**eview health issues with administration**). Would you like TPH to support you in addressing these issues?

Yes   No

If the answer is Yes:
10(a) The best way to do this is by having a dedicated group of people working together to address issues such as in a healthy school committee. Members should include students, parents, and staff. Would you like to consider setting up a Healthy School Committee**?**

Yes   No

OR

10(b) Would you like to set up a HSC that builds on an existing committee?

Yes   No

If the principal/VP state that they **are interested:**

10(c) Can the LPHN attend a staff meeting to ask for **volunteer(s)** to work on the committee, to raise awareness about the committee and to engage staff in the process?

Yes   No

Comments:

10(d) Do you have any suggestions regarding recruitment of students for the HSC?

   Yes   No

Suggestions:

10(e) Can the LPHN attend a Student Council meeting, or any other appropriate student groups to discuss the idea of a HSC?

   Yes   No

10(f) Do you have any suggestions regarding recruitment of parents for the HSC?

   Yes   No

Suggestions:

10(g) Can the LPHN attend a Parent Council meeting or any other appropriate parents group to discuss the idea of a HSC?

   Yes   No

If the answer is No to the formation of a Healthy School Committee

11. Can we explore other ways in which TPH can support the school in addressing health issues?

Comments:

Appendix 4 – Organizations and Agencies Currently Involved in Supporting Youth Engagement with the Target Age

1. Center for Addiction and Mental Health (CAMH) – English and French http://www.camh.net

2. Canadian Association for School Health (CASH) - English with some French resources http://www.safehealthyschools.org/

3. Centres for Excellence in Youth Engagement – (CEYE) - English and French http://www.phac-aspc.gc.ca/dca-dea/allchildren_touslesenfants/centres_you-eng.php

4. Curriculum & School-based Health Resource Centre (CSBHRC) –English and French http://www.ophea.net/curriculumresourcecentre.cfm

5. Canadian Centre on Substance Use – English and French - http://www.ccsa.ca/Pages/Splash.htm

6. The Health Communication Unit (THCU) – http://www.thcu.ca - English with some French resources

7. Parent Action on Drugs – English with some French resources http://www.parentactionondrugs.org

8. Ontario Healthy Communities Coalition - English and French – http://www.healthycommunities.on.ca

9. Ontario Physical and Health Education Association – English with some French Resources - http://www.ophea.net/

10. Ontario Healthy Schools Coalition – English - http://www.opha.on.ca/our_voice/collaborations/ohsc.shtml/

11. Ontario Public Health Association – English with some French resources - http://www.opha.on.ca/index.shtml

12. Ministry of Education – English and French - http://www.edu.gov.on.ca/eng/

13. McCreary Centre Society – English - http://www.mcs.bc.ca/

14. Provincial Centre for Excellence in Child and Youth Mental Health at CHEO – English and French http://www.onthepoint.ca/index_e.htm

15. Tiny Giant /The Students Commission - English and French - http://www.tgmag.ca/index_e.htm

16. Boys and Girls Club – English and French - http://www.bgccan.com/index.asp

17. 4-H Canada - English and French - http://www.4-h-canada.ca/

18. Girl Guides Canada – English and French - http://www.girlguides.ca/

19. Scouts Canada _ English and French - http://www.scouts.ca/dnn/

Appendix 5 - Training Day Recommendations

- Set realistic objectives based on what OPHA hopes will happen and what PHNs have asked for.

- Describe the project generally and use local stats to show the need.

- Use interactive activities (e.g. 4 corners) – not just small groups with discussion and debriefing.

- Deliver the activities in a "train-the trainer" model so professionals know what to do with youth.

- Use media – video, music, to get and keep attention.(http://www.youtube.com/watch?v=iC8V8S_Rehk)

- Training day is the beginning – Include opportunities for planning next steps today.