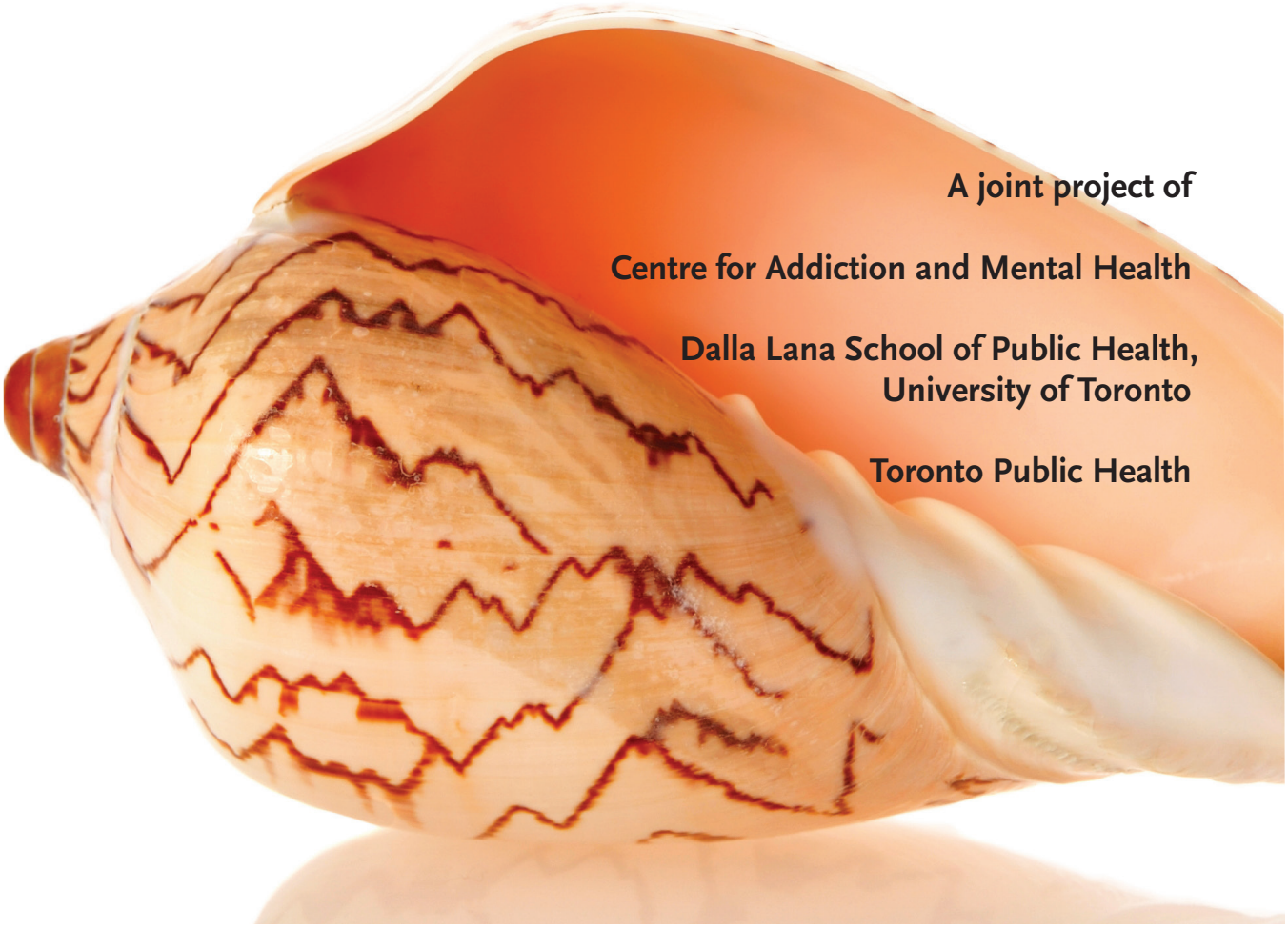
camh
Centre for Addiction and Mental Health

Best practice guidelines for mental health promotion programs: Children (7–12) & youth (13–19)



A joint project of

Centre for Addiction and Mental Health

Dalla Lana School of Public Health, University of Toronto

Toronto Public Health

camh
Centre for Addiction and Mental Health

Best practice guidelines for mental health promotion programs: Children (7–12) & youth (13–19)

A joint project of

Centre for Addiction and Mental Health

Dalla Lana School of Public Health, University of Toronto

Toronto Public Health

This publication may be available in other formats. For information about alternative formats or other CAMH publications, or to place an order, please contact Sales and Distribution:

Toll-free: 1 800 661-1111

Toronto: 416 595-6059

E-mail: publications@camh.ca

Online store: http://store.camh

5018 / 07-2014

Best practice guidelines for mental health promotion programs: Children (7–12) & youth (13–19)
ISBN: 978-1-77114-180-2 (PRINT)
ISBN: 978-1-77114-181-9 (PDF)
ISBN: 978-1-77114-182-6 (HTML)
ISBN: 978-1-77114-183-3 (ePUB)
Printed in Canada

Website: www.camh.ca

This resource was produced by CAMH Publications.

5018 / 07-2014

Contents

Acknowledgments

This resource is a joint project of the Centre for Addiction and Mental Health; the Dalla Lana School of Public Heath, University of Toronto; and Toronto Public Health.

Authors

Centre for Addiction and Mental Health
Marianne Kobus-Matthews, Senior Health Promotion Consultant

Dalla Lana School of Public Health, University of Toronto
Suzanne F. Jackson, Ph.D., Associate Professor, Social and Behavioural Sciences Division
Holly Easlick, Master of Psychosocial Studies student, University of Brighton, U.K.

Toronto Public Health
Angela Loconte, Consultant, Health Promotion

Development of the resource

This resource was revised from a previous version released in 2007. Holly Easlick (Master of Psychosocial Studies student, University of Brighton, U.K.) helped to refine the guide's content and design and Stephanie Hemmerick, MPH, BHSc, provided additional sections based on current research. Other contributors include Loukia Ioannou (practicum student, University of Brighton, U.K.), Neha Khorana (Adler School of Professional Psychology) and Melanie Glaschker (practicum student, University of Magdeburg, Germany).

Claudette Holloway and Patricia Stevens (Toronto Public Health) provided the guide's sample worksheet that describes Investing in Families (IIF), a city-wide project made available to vulnerable families in partnership with Toronto Employment and Social Services and Toronto Parks, Forestry and Recreation. This exemplary mental health promotion initiative demonstrates the worksheet's utility.

Both resources—the original (2007) and this revised version—were developed under the direction of a working group from Toronto Public Health (TPH), the Centre for Addiction and Mental Health (CAMH) and the Dalla Lana School of Public Health (DLSPH), University of Toronto. The group worked from an earlier draft document entitled *A Checklist: Guiding Principles of Best Practices in Mental Health Promotion across the Lifespan*, which was developed by Maria Au-Yee Choi (MHSc candidate, University of Toronto). This earlier document was based on the findings of the research report *Analysis of Best Practices in Mental Health Promotion across the Lifespan*, authored by Catherine Willinsky and Anne Anderson for CAMH and TPH in 2003.

We gratefully acknowledge the contributions of Lori Hale, Jennifer Boyko and Andrea Stevens Lavigne, formerly of CAMH; and Paola Ardiles and Gracie Lee, formerly of DLSPH, in creating the 2007 version.

Introduction

Originally released in 2007, *Best Practice Guidelines for Mental Health Promotion Programs for Children and Youth* is the first in a series of online guides for promoting positive mental health across the life span. Updated in 2014, this resource provides health and social service providers ("practitioners") with current evidence-based approaches in the application of **mental health promotion** concepts and principles for children and youth. It is intended to support practitioners, caregivers and others in incorporating **best practice** approaches into mental health promotion **initiatives** and **programs**[1] directed toward children (aged 7–12 years) and youth (aged 13–19 years).

This resource includes:

- background on how children and youth are defined in this document
- theoretical context for mental health promotion, including definitions and underlying concepts, with a focus on promoting resilience
- 10 best practice guidelines for mental health promotion interventions with children and youth, and examples of mental health programs that illustrate the guidelines and therefore incorporate good practice
- examples of outcome and process indicators for measuring program success
- worksheet for practitioners to plan and implement mental health promotion initiatives, and a sample worksheet showing how it has been used in a mental health promotion initiative
- glossary of terms commonly used in mental health promotion, references cited in this document and a bibliography of other works consulted in developing this material.

1 The terms *initiatives* and *programs* are used interchangeably in this resource. Definitions can be found in the glossary.

1. Background: Children and youth

In Canada, children and youth have been highlighted as a priority in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012), which addresses mental health across the lifespan. In Ontario, children and youth have been similarly prioritized, as described in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (Government of Ontario, 2011). Clearly, the mental health and well-being of children and youth are being recognized as important.

Although these guidelines focus on children aged 7 to 12 years and youth aged 13 to 19 years, the age range representing children and youth differs by country and organization because the concept holds cultural, political and economic significance. This age range was originally identified to include both children and youth, and to address mental health promotion research and programming relevant to young people aged 7 to 19. However, this resource does not include the vitally important transition years into early adulthood because mental health promotion programming and focus for this older age group are different.

Children and youth are not considered homogenous groups; rather, they are as diverse as society at large. Although two young people may be the same age, different factors will shape each person's identity, health and mental health. This diversity is reflected in how each person differs in terms of social determinants such as gender, ethnicity, language, sexual orientation, mental health status, socio-economic status, ability, religious views and geographical locations (i.e., rural or urban), as well as world views, social groups, lifestyles and responsibilities (Centre for Addiction and Mental Health [CAMH], 2012).

Seventy per cent of mental health problems have their onset in childhood and adolescence (Government of Canada, 2006). Therefore, it is not surprising that

Ontario has highlighted mental health for children and youth as a key priority in *Open Minds, Healthy Minds* (Government of Ontario, 2011). Fifteen to 21 per cent of children and youth report experiencing at least one mental health challenge. Anxiety disorder, attention-deficit/hyperactivity disorder, depression and substance use problems are the most common mental illnesses among children and youth aged 15 to 17 years (Government of Ontario, 2009).

Demographic profile

According to the 2011 census (Statistics Canada, 2012), Canada's population continues to grow due to small increases in fertility, a modest increase in the number of non-permanent residents and a slight increase in the number of immigrants. This growth represents an increase of almost six per cent from the period 2001–2006.

Although the number of children aged 14 years and under increased by 0.5 per cent, the proportion of children has decreased relative to the rest of the population. Nonetheless, Canada remains one of the youngest G8 countries, with only the United States and Russia having a lower proportion of older adults (Statistics Canada, 2012).

The Aboriginal population (i.e., First Nations, Métis and Inuit) in Canada is growing much more quickly than the rest of the population, at a rate of 20 per cent compared to five per cent for the rest of Canada between 2001 and 2006 (Statistics Canada, 2013a). The Aboriginal population has a median age of 27 years, which is far lower than the median age of 40 for the non-Aboriginal population (Statistics Canada, 2013a). Aboriginal people represent more than three per cent of the Canadian population and more than five per cent of all Canadian children (Canadian Council on Social Development, 2006).

The Canadian population is very ethnically diverse. In 2006, more than 200 different ethnic origins were reported for Canadian children. An estimated 20 per cent of children and youth were either foreign-born or had parents who were born outside Canada (Statistics Canada, 2013b).

Given the diversity that exists among children and youth, it is crucial to consider all of these factors when investigating ways to improve their health and well-being, and the benefits of implementing initiatives that promote positive mental health.

2. Theory, definitions and context for mental health promotion

This section provides the theoretical context for mental health promotion through definitions and underlying concepts, with a focus on promoting resilience.

How are mental health and mental illness related?

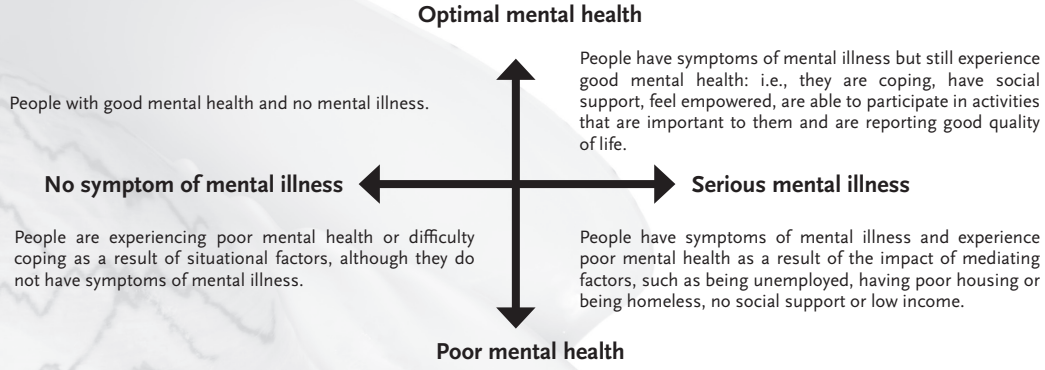
Mental health and mental illness are growing concerns worldwide, yet remain poorly understood concepts. Mental health and mental illness are two distinct dimensions that are seen as related and being part of a continuum across the lifespan (Westerhof & Keyes, 2009).

The World Health Organization ([WHO], 2014) has defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her **community**" (p. 1).

Mental illness refers to diagnosable mental health disorders and is defined as "a biological condition of the brain that causes alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning" (Public Health Agency of Canada [PHAC], 2006).

When mental health and mental illness are viewed as existing along intersecting continua, one continuum spans from poor mental health to optimal mental health, and the intersecting continuum ranges from no symptoms to serious mental illness (CAMH, 2012). This means that a person can have a mental illness but still flourish despite certain challenges or symptoms. It also means that the absence of mental illness does not necessarily indicate positive mental health because the person may still be experiencing challenges and having difficulty coping.

FIGURE 1: An intersecting continua approach to mental health



Adapted from Canadian Institute for Health Information, 2009; Canadian Mental Health Association, 2009.

How is mental health promotion related to health promotion?

Health promotion

Health promotion is defined by WHO (2009) as a "process of enabling people to increase control over, and improve their own health" (p. 1).

The *Ottawa Charter for Health Promotion* (WHO, 1986) defines five key health promotion strategies:

- building **healthy public policy**
- creating supportive environments
- strengthening **community action**
- developing personal skills
- reorienting services toward promotion, prevention and early intervention.

Population health is an approach often used in health promotion and is based on interventions that target the entire population rather than smaller, select target groups. Population health in a Canadian context builds on public health, community health and health promotion traditions for which Canada has been recognized internationally since the ground-breaking work of the *Ottawa Charter*. Other key documents that have shaped the population health framework include the Lalonde report, *A New Perspective on the Health of Canadians* (Lalonde, 1974), and *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986).

Population health aims to address the health needs of a whole population. It is based on the tenet that health and illness are the result of a complex interplay between biological, psychological, social, environmental, economic and political factors. The goal of population health is to achieve the best possible health status for the entire population by fostering conditions that enable and support people in making healthy choices and by providing the needed services that promote and maintain optimum health.

Social Determinants of Health: Canadian Perspectives (Raphael, 2004) identified a range of factors that influence health (the **determinants of health**). These factors include:

- income and social status
- housing
- **social support networks** and social connectedness
- education
- employment and working conditions
- unemployment and employment security
- physical environments
- biology and genetics
- personal health practices and coping skills
- healthy child development
- health services.

Determinants of mental health

The social determinants of health have an impact on overall health. Research around determinants of mental health has identified the three most important determinants of mental health: social inclusion, freedom from discrimination and violence and **access** to economic resources (Keleher & Armstrong, 2005).

Social inclusion

"**Social inclusion** means feeling you belong, are valued and respected and able to take part in your community and benefit equally from what your community has to offer" (CMHA Ontario et al., 2012). Communities are defined not only by place but also by identity, culture, ethnicity and faith (Keleher & Armstrong, as cited in CMHA Ontario et al., 2012).

There are three elements to social inclusion, as defined by YouThrive, a resource developed for school and community leaders in Ontario working with youth aged 12 to 19 years (CMHA Ontario et al., 2012). **Social connectedness** refers to connections to family, school and different types of community group, club and organizations and having informal relationships with people—family, friends, teachers, and youth workers. These social ties help people feel a sense of belonging and an enhanced sense of purpose. When these ties are not present, social isolation can ensue. The second element, **social capital**, emphasizes the value of social networks. Social capital refers to:

> the resources available to people and to society that are provided through social relationships and networks. This fosters a sense of neighbourliness, mutual trust, shared values and cooperation amongst network members. These resources can be cultural in nature such as libraries, schools and community centres as well as resources that provide support such as after-school programs, youth centres and youth-friendly health centres.

(CMHA Ontario et al., 2012).

The third element of social inclusion is civic engagement, which means getting involved, trying to address issues the community faces, or advocating for change. Participation means taking part in social and recreation opportunities, such as sports teams, cultural programs, faith-based groups, and youth groups.

Freedom from discrimination and violence

Positive mental health and well-being can be achieved when people live in communities that value diversity—communities where they feel physically safe and have access to the determinants that support good mental health and well-being. Across Canada, there are individuals and entire groups that are not accepted, valued, respected or treated fairly. They may experience violence, such as bullying, child abuse and neglect, and intimate partner violence. These experiences can be a factor in poor mental health (Keleher & Armstrong, as cited in CMHA Ontario et al., 2012).

Many people face discrimination and violence because of **stigma**. Stigma refers to negative attitudes and stereotypes held against a group of people, often because of their gender, sexual identity, ethnic or racial background, ability or mental health status.

Access to economic resources

Access to economic resources such as housing, education, employment and income protects and promotes the mental health and well-being of families (including youth and children). This access enables people to connect with others, and feel competent and in control, while also giving them an opportunity to improve their socio-economic status. Not having access to economic resources can result in poverty and hardship, making it difficult to afford quality housing, good food, clothing, transportation and many other things needed to be healthy (Keleher & Armstrong, as cited in CMHA Ontario et al., 2012).

When people cannot meet their own basic needs or those of their family due to income inequalities they can suffer negative stress, which can then affect their mental health.

Mental health promotion

The discussion paper *Mental Health for Canadians: Striking a Balance* (Health and Welfare Canada, 1988) provided the driving force for placing mental health within a health promotion framework and viewing mental health on a continuum, ranging from optimal to minimal. The document also provided a forum to define optimal mental health for the whole population, including people with a diagnosable mental health disorder. Furthermore, *Striking a Balance* supported the notion that promoting mental health is consistent with the health promotion process of "enabling people to increase control over, and improve their health" (WHO, 1986, p. 1).

The field of mental health promotion is continuing to evolve, as is the definition of the term. A 1996 international workshop hosted by the University of Toronto's Centre for Health Promotion and the Mental Health Promotion Unit of Health Canada defined mental health promotion as:

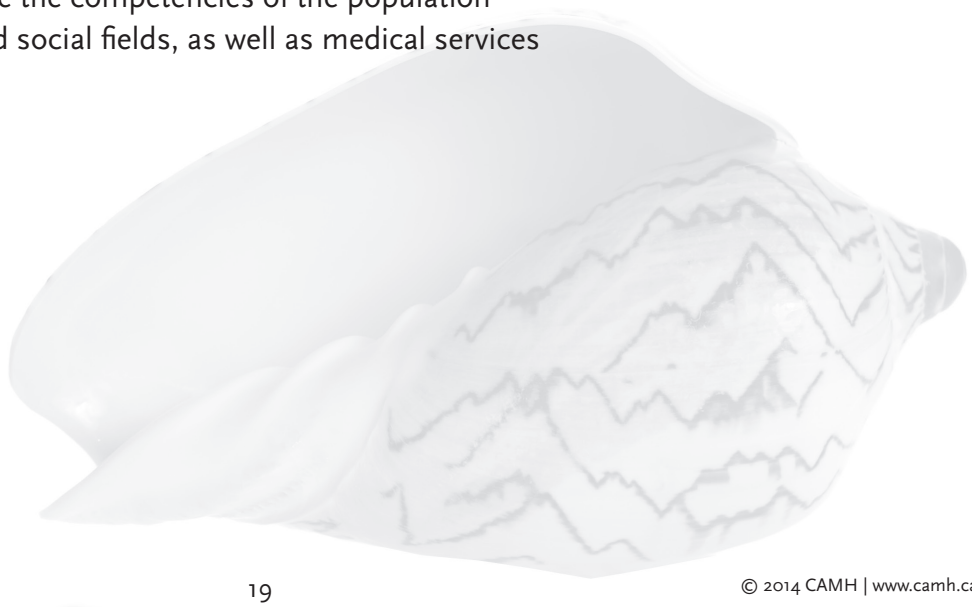
> The process of enhancing the **capacity** of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive

> environments and individual resilience, while showing respect for culture, **equity**, social justice, interconnections, and personal dignity.
>
> (Joubert et al., 1996)

This definition is very similar to the general concept of health promotion defined by the Ottawa Charter (WHO, 1986). Similarly, strategies used in mental health promotion—many of which are also used in the substance use field—also parallel health promotion strategies. Various interconnecting factors affect mental health, as they do substance use and general health. Mental health status is determined by a complex interplay of individual characteristics, along with cultural, social, economic and family circumstances at both the macro level (society) and the micro level (community and family) (Commonwealth Department of Health and Aged Care [CDHAC], 2000).

In summary, both health promotion and mental health promotion:

- focus on the enhancement of well-being rather than on illness
- address the population as a whole, including people experiencing risk conditions, in the context of everyday life
- are oriented toward taking action on the **determinants of health**, such as income and housing
- broaden the focus to include protective factors, rather than simply focusing on **risk factors** and conditions
- include a wide range of strategies such as communication, education, policy development, organizational change, **community development** and local activities
- acknowledge and reinforce the competencies of the population
- encompass the **health** and social fields, as well as medical services (Joubert et al., 1996).



How does mental health promotion differ from health promotion?

Mental health promotion emphasizes two key concepts: power and resilience. Power is defined as a person's, group's or community's sense of control over their life and the ability to be resilient (Joubert & Raeburn, 1998). Building on one's existing capabilities can increase power and control.

Resilience has been defined as "the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity" (Health Canada, 2000, p. 8).

Resilience is influenced by risk factors and protective factors:

Risk factors are variables or characteristics associated with an individual that make it more likely that the person will develop a problem (Mrazek & Haggerty, as cited in CDHAC, 2000). They "are vulnerability factors that increase the likelihood and burden of a disorder" (CDHAC, 2000, p. 14). Risk factors can be biological or psychosocial and may reside within a person, his or her family or social network, or the community or institutions that surround the person. They occur in innumerable contexts, including perinatal influences (e.g., the mother's health, diet and substance use while pregnant), family relationships, schools and workplaces, interpersonal relationships, media influences, social and cultural activities, the physical health of the individual, and the physical, social and economic "health" of the community.

Protective factors buffer a person "in the face of adversity and moderate the impact of stress on social and emotional well-being, thereby reducing the likelihood that disorders will develop" (CDHAC, 2000, p. 13). Protective factors may be internal (e.g., temperament, cognitive abilities) or external (e.g., social, economic or environmental supports). They enable a person to protect his or her emotional and social well-being and cope with everyday life events (whether positive or negative). Protective factors act as a buffer against stress and may be drawn upon in dealing with stressful situations.

Potential risk and protective factors are described on pages 33–36.

Some research has suggested that a person's resilience can be enhanced by strengthening coping skills, reducing risks and improving protective factors. However, others suggest that resilience involves more than simply improving these factors. Resilience is reflected in the ability to respond over time to change in one's life. Resilience is dynamic, not static, and directly affects the person's coping ability.

People who have high resilience (i.e., the capacity to "bounce back" after adversity) are still vulnerable to adverse events and circumstances (CDHAC, 2000). However, a person's level of protective factors—regardless of the number of risk factors—has been shown to lower the level of risk (Resnick et al., as cited in CDHAC, 2000). Protective factors also reduce the likelihood that the person will develop a mental health disorder by reducing exposure to risk, reducing the effect of risk factors or both.

Resilience involves a balance between stress and adversity on one hand and the ability to cope and availability of support on the other. When stresses exceed a person's protective factors, even someone who has previously been resilient may become overwhelmed.

The relationship between risk and protective factors is complex: "It is not simply the presence of risk or protective factors, but their interaction and the accumulation of factors over time that affects the development of mental health problems and mental disorders" (CDHAC, 2000, p. 53).

Mental health promotion efforts should start by:

- respecting people as they are at any given stage in their lives
- recognizing that people have the capacity to cope with life (regardless of whether they are currently coping well or not)
- acknowledging that people themselves know best how to access their own intrinsic capabilities.

This increased sense of power and resilience is important not only as an outcome, but also as an integral part of the mental health promotion process—where the person truly feels that he or she is part of the process.

What are the goals of mental health promotion?

This section is adapted from: Canadian Public Health Association. (1998). *Documenting Projects, Activities and Policies in the Field of Mental Health Promotion in Association with CMHA*. Ottawa: Author.

The goals of mental health promotion are to:

- increase resilience and protective factors
- decrease risk factors
- reduce inequities.

Increasing resilience and protective factors

Mental health promotion aims to strengthen the ability of individuals, families and communities to cope with stressful events that happen in their everyday lives by:

- increasing individual or community resilience
- increasing coping skills
- improving quality of life and feelings of satisfaction
- enhancing self-esteem
- enhancing a sense of well-being and belonging
- strengthening social supports
- strengthening the balance of physical, social, emotional, spiritual and psychological health.

Decreasing risk factors

Mental health promotion aims to reduce the factors that place individuals, families and communities at risk of diminishing mental health by reducing or eliminating:

- anxiety
- depression
- stress and distress

- sense of helplessness
- abuse and violence
- social exclusion
- problematic substance use
- suicidal ideation or history of suicide attempts.

Reducing inequities

Mental health promotion aims to reduce inequities and their consequent effects on mental health. Inequities are often based on:

- gender
- age
- poverty
- physical or mental disability
- employment status
- race
- ethnic and/or cultural background
- sexual orientation
- geographic location.

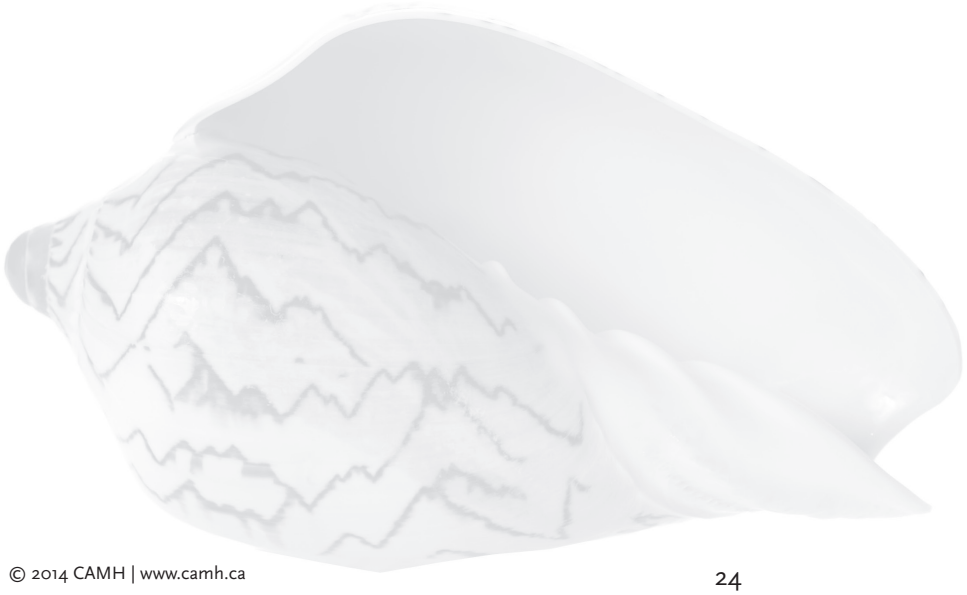
Mental health promotion attempts to reduce inequities by:

- implementing diversity and equity policies
- providing regular diversity and equity training and evaluating the results
- creating transitional programs for identified groups (i.e., tailoring programs to make them more inclusive of or responsive to marginalized populations)
- promoting anti-stigma initiatives or campaigns.

What are the characteristics of successful mental health promotion interventions?

Willinsky and Anderson (2003) found that successful mental health promotion initiatives include the following characteristics:

- clearly stated outcome targets
- comprehensive support systems with multiple approaches, including emotional, physical and social support, together with tangible assistance
- interventions in multiple settings (e.g., home, school, community)
- screening and early interventions for mental health problems throughout the lifespan
- involvement of relevant parts of the social network of the specified population
- intervention over an extended period
- long-term investment in program planning, development and evaluation.



What factors influence the mental health and social well-being of children and youth?

From a population health perspective, the health status of individuals, population subgroups and the population as a whole results from a complex interplay among various factors. These factors include individual characteristics, the physical environment and social and economic factors (i.e., the determinants of health). There is no single cause of any mental health problem or illness, and no one is immune, no matter where they live, how old or young they are or what their social standing is (Mental Health Commission of Canada, 2012).

Strengthening the determinants of positive mental health increases a child's performance in school, with peers, in later intimate relations and with broader connections within society, contributing to improved health and well-being across the lifespan (Jané-Llopis & Barry, 2005).

The Health of Canada's Young People: A Mental Health Focus (Freeman et al., 2011) identified behavioural factors (i.e., substance use, bullying, gambling, body image) and contextual factors (i.e., peer relationships, family relationships, school setting) that affect youth mental health. Mental illness and psychological distress as well as experiences of violence can also negatively affect mental health. These factors and their relationship to mental health are explained below.

Behavioural factors

Although there are established relationships between behavioural factors and mental health outcomes, the causal relationship is not clear—whether the health behaviour leads to the mental health outcome or whether the mental health outcome leads to the health behaviour. It is most likely that reciprocal causation is involved—a complex interplay of factors affects mental health—rather than a straightforward cause-and-effect relationship (Freeman et al., 2011).

Substance use

Some youth use substances to cope with stressors, such as conflicts with family, poor school performance or difficult feelings. Substance use is linked to mental health. It can contribute to major depression and other mental health problems in youth. Substance use can also exacerbate the symptoms of mental health problems. Some substances can cause feelings and behaviour that look like the symptoms of a psychiatric disorder, such as paranoid delusions, whereas others can mask symptoms (CMHA Ontario et al., 2012).

According to the 2013 Ontario Student Drug Use and Health Survey (OSDUHS) (Boak et al., 2013), the drug most commonly used by Ontario students is alcohol: almost half of the students in grades 7 to 12 (49 per cent) reported drinking alcohol in the 12 months before the survey, and 23 per cent reported using cannabis in the past year. Moreover, 12 per cent reported using prescription opioid pain relievers for non-medical purposes in the last year. Not surprisingly, the OSDUHS (Boak et al., 2013) found that alcohol and other substance use was more likely as grade level increased, with the exception of inhalants, which significantly decreased with grade level.

Tobacco also contributes to poor mental health and is often used as a way to cope with stress. Although youth smoking has decreased over the decades, the OSDUHS (Boak et al., 2013) found that one in every 11 Ontario students (8.5 per cent) reported smoking in the past year, and one in every 20 students (5.7 per cent) reported having used smokeless tobacco. Young people with many stressors in their lives are more likely to become regular tobacco users later in life.

Bullying

Bullying is a huge public health concern with serious consequences for children and youth. The harmful effects of bullying can so affect the mental health and well-being of children and youth that, in extreme cases, it can lead to suicide.

According to Craig and McCuaig Edge (2008), "Bullying is a relationship problem. It is a form of repeated aggression where there is an imbalance of power between the young person who is bullying and the young person who is victimized" (p. 167).

Many children and youth report being bullied, and many report bullying others. Thirty-three per cent of students between grades 6 and 10 reported bullying others and similar proportions were victims of bullying (Craig & McCuaig Edge, 2011). Paglia-Boak et al. (2011) found that females are more likely to report being bullied than males, although males report higher rates of being bullied physically than females. Bullying and victimization can have negative mental health

consequences for everyone involved, both for those who are victimized and for those who bully: physical, social and emotional injuries may lead to poorer mental health across the lifespan (Craig & McCuaig Edge, 2011).

Gambling

In Canada and the United States, rates of gambling are higher among youth than adults (Shaffer et al., 1999). In the 2011 OSDUHS (Paglia-Boak et al., 2011), 38 per cent of students in grades 7 to 12 reported gambling in the year before the survey, with males (47 per cent) being more likely than females (30 per cent) to report gambling. Only a small number of students (two per cent) reported a gambling problem (Paglia-Boak et al., 2011).

People who develop gambling problems usually started gambling as youth (Derevensky & Gupta, 1999). Gambling problems can affect people's social, academic and professional life, their mood, personality, physical and mental health, and personal relationships. The level of impact and severity of symptoms will vary for each person (International Centre for Youth Gambling Problems and High-Risk Behaviors, 2013).

Although gambling does remain problematic, it has declined over the past few years. Over the last decade, the proportion of students identifying difficulties due to their gambling has decreased (Paglia-Boak et al., 2011).

Body image

Craig and McCuaig Edge (2008) reported that about half of Grade 10 students think that their body weight is normal. About a quarter of the male youth believed they were too fat, and 22 per cent thought they were too thin. Girls were more likely to think they were fat (40 per cent) and less likely (10 per cent) to think they were too thin. Negative body image is linked to low self-esteem and can lead to eating disorders such as bulimia and anorexia. Even though appropriate help is available to children and youth who are obese in terms of monitoring and regulating their weight, sometimes focusing too much on weight can negatively affect psychological well-being. In more extreme situations, dieting can result in nutritional deficiencies that postpone or harm physical development (Craig & McCuaig Edge, 2008).

Contextual factors

The latest research in Canada indicates that interpersonal relationships affect well-being (Freeman et al., 2011). Youth with positive interpersonal relationships tend to enjoy better mental health.

Family relationships

Families come in all shapes and sizes and can include anyone children or youth see as important because of a strong, enduring connection, whether related by blood or not (Barankin & Khanlou, 2007).

Families that are resilient and function well give children and youth a positive identity, a sense of connectedness and an environment in which they can flourish. Families differ in the challenges they face, the social and financial resources they can access and how well they respond to life's challenges. Some families may be very taxed and have insufficient resources to be able to fully focus on nurturing their children (Barankin & Khanlou, 2007).

Research into family influences on young people shows that having parents who set firm limits and are empathetic and nurturing contributes to self-esteem, social development and good health. Stability in the home and the emotional availability of parents is especially important in protecting children and youth from getting involved early with alcohol and other drug use, risk-taking behaviour, bullying and the peer groups associated with these activities (Craig & McCuaig Edge, 2008).

Peer relationships

For children and youth, peer relationships are significant sources of support, companionship, information and advice. Peer relationships also help them adjust socially, cognitively and academically, both in the short and long term (Scholte & Van Aken, as cited in Craig & McCuaig, 2008).

Having friends as well as supportive friendships is associated with positive outcomes such as feeling good about oneself, feeling connected with others, having a positive outlook, and succeeding in future romantic relationships (Hartup, as cited in Craig & McCuaig, 2008).

Just as peers can have a positive impact on children and youth mental health, they can also have a negative impact if friendships are based on shared interests such as drug use, weapon carrying or delinquency (Craig & McCuaig, 2008).

School setting

Children and youth spend a lot of time at school, so it is not surprising that school-related experiences can have a significant influence on their mental health. Schools provide a "critical context for shaping children's self-esteem, **self-efficacy** and sense of control over their lives" (Stewart et al., as cited in Klinger et al., 2011, p. 47).

Positive school environments and higher levels of teacher support are associated with more positive levels of mental health and lower levels of behavioural problems. Most young people feel supported by their schools and have a sense of belonging (Klinger et al., 2011).

Yet school is not a positive place for some Canadian youth, who increasingly report lower levels of achievement and satisfaction. As children and youth progress through school, they are less connected to school at a time when their emotional well-being is most vulnerable (Klinger et al., 2011).

Psychological distress and mental illness

Although psychological distress and mental illness are often thought to only affect adults, 70 per cent of adults with mental health problems developed symptoms in childhood and adolescence (Government of Canada, 2006).

At any given time in Canada, an estimated 14 per cent of children aged 4 to 17 years will experience mental disorders (Waddell et al., 2007). According to the 2011 OSDUHS (Paglia-Boak et al., 2011), the three most commonly reported distress symptoms experienced by Ontario students were constantly being under stress (41 per cent), losing sleep because of worrying (30 per cent) and feeling unhappy and depressed (27 per cent). Moreover, 34 per cent of students reported experiencing elevated psychological distress, defined as having at least three of the 12 symptoms related to depressed mood, anxiety and social functioning. The rate was higher for females than males (43 per cent vs. 24 per cent) (Paglia-Boak et al., 2011). This psychological distress can negatively affect their everyday life at home, school and in the community.

Experiences of violence

This section is adapted from Ogrodnik, L. (2010). *Child and Youth Victims of Police-Reported Violent Crime, 2008.* (Statistics Canada catalogue no. 85F033M). Retrieved from www.statcan.gc.ca/pub/85f0033m/85f0033m2010023-eng.pdf

Children and youth can face the same types of violence as adults, such as physical and sexual assault, robbery, criminal harassment and homicide. Violence toward them can occur in their home, neighbourhoods or at school and be perpetrated by a relative, friend, acquaintance or stranger. Data on the type and the degree of violence are obtained from police reports; however, some of the

harmful behaviours are hard to measure. And because of limited data available for people under age 15, little is know about children and youth who are victims of violence.

In 2008, Statistics Canada revealed that more than 75,000 children and youth were victims of police-reported violent crime: this meant that 1,111 per 100,000 children and youth in Canada were victims of a violent offence (Ogrodnik, 2010). The rate of reported violence among children and youth appears to increase as children get older. Boys were more likely to be victims of reported physical assault than girls. Child and youth victims of violence may experience immediate physical and emotional effects as well as long-term consequences, which can include an increased risk for behavioural, developmental and emotional disorders such as depression, fear or anxiety (Hotton as cited by Ogrodnik, 2010).

Special groups

Youth who belong to groups that face social and economic exclusion tend to experience greater health and mental health difficulties than their counterparts.

Below are a few examples of groups of young people who face greater health inequities.

Aboriginal youth

Aboriginal youth from First Nations, Métis and Inuit backgrounds differ in culture, history, language and beliefs. Aboriginal youth living in Canada are not only more likely to use alcohol, tobacco and other drugs than non-Aboriginal youth; they are at greater risk for more health problems (Elton-Marshall et al., 2011).

Challenges for Aboriginal people include the consequences of intergenerational transmission of poverty and the geographical barriers to attend post-secondary institutions. Factors such as racism, marginalization, and the loss of land and traditional culture are examples of other challenges that can be linked to psychosocial problems among Aboriginal youth (Totten, 2009).

Lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex and queer youth

Although the research on lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex and queer (LGBTTTIQ) youth has only recently emerged, a Canadian study in 2011 indicated that LGBTQ students and students with LGBTQ parents experience much higher levels of verbal, physical, sexual and other forms

of discrimination, harassment and abuse than other students. Most LGBTQ students and students with LGBTQ parents also report not feeling safe at school (Taylor et al., 2011).

The B.C. Adolescent Health Survey (McCreary Centre Society, 2007) highlighted many health inequities that lesbian, gay and bisexual (LGB) youth face compared with their heterosexual peers and indicates that LGBTQ youth are more likely than non-LGBTQ youth, to for example, have used alcohol or other substances.

Newcomer youth

For youth, immigration is associated with many challenges, such as the need to adjust to a new place, meet new people and make new friends. At the same time, youth who have immigrated may also feel loss or abandonment of familiar environments and old friends. Behaviours and customs that may have been commonplace in the child's country of origin, such as wearing religious dress in public spaces, may hinder a sense of belonging when practised in their new country, which can have an impact on their mental health and well-being (Caxaj & Berman, 2010).

Youth who have recently immigrated to Canada experience higher psychological distress than their peers. They report struggling with racism and discrimination, isolation, new customs and processes, and family stress from income insecurity (Shayka et al., 2010).

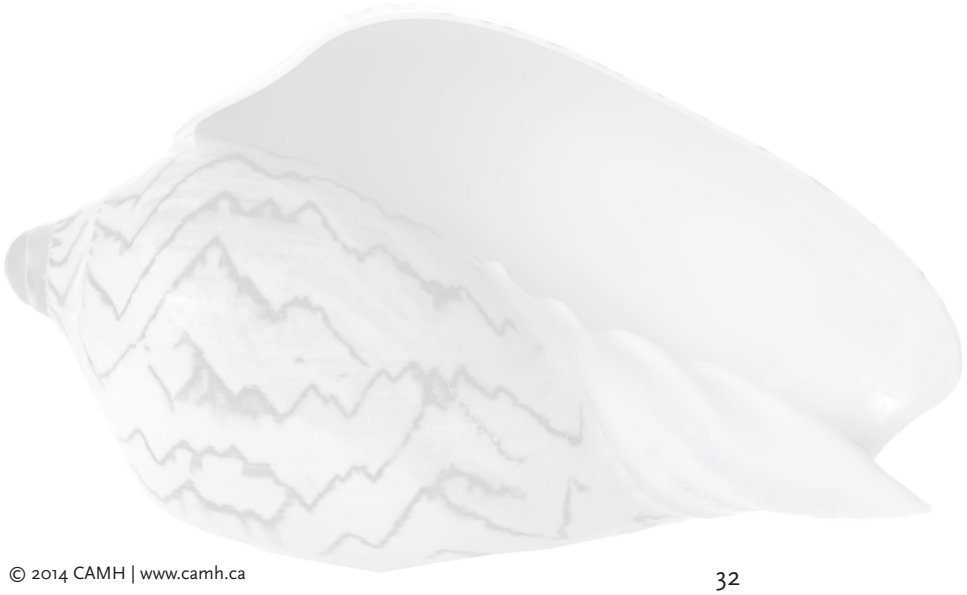
Street-involved youth

Street-involved youth often lack access to the resources they require to meet their basic needs, such as adequate shelter, clothing, nutrition and personal safety.

As a result, street-involved youth have high rates of emotional distress and substance use. In a Toronto study (Barnaby et al., 2010) conducted by the Shout Clinic and Wellesley Institute, only 35 per cent of the youth rated their mental and emotional health as excellent or good. Many of the 100 youth also reported using drugs in the past six months: 71 had used crack, 51 had used methamphetamine, 53 had used opiates that were not medically prescribed, and 33 had used injection drugs. When asked why they use substances, these youth often gave reasons related to mental health—they used substances as a way to cope and escape, and many were dependent on them (Barnaby et al., 2010).

***

The many challenges children and youth face are worsened when the family is living in poverty or in unstable housing, which can also influence their ability to eat and sleep well and make and keep friends. In the next part of the guide, emphasis is put on the determinants of health, reducing the risk factors, and promoting the positive factors that foster optimal mental health in children, youth and their families.



What are potential protective factors against mental health problems?

According to Solin (2006), "protective factors maintain 'mental well-being,' whereas risk factors may weaken 'mental stability'" (p. 4). The following tables list protective factors and risk factors extrapolated from the best practice examples identified in this resource (see page 51) as well as factors identified by Willinsky & Anderson (2003). The categories are adapted from Australia's National Mental Health Strategy "Promotion, Prevention and Early Intervention for Mental Health, A Monograph, 2000," p. 15–16.

Type of protective factors	Specific protective factors
Individual factors	• adequate nutrition • attachment to family • above-average intelligence • school achievement • positive self-related cognitions • history of competence/success • easy temperament • optimism
Family factors	• supportive, caring parents • family harmony • small family size • more than two years of age between siblings • healthy family attachments
School context	• opportunities for some success and recognition of achievement • positive school climate • sense of belonging

Type of protective factors	Specific protective factors
Life events and situations	• healthy early life • healthy attachments with one or more adults • availability of opportunities at critical turning points or major life transitions • positive peer relations
Community and culture	• sense of connectedness • attachment to and networks within the community • community cultural norms against violence • participation in faith community • strong cultural identity and ethnic pride
Determinants of health	• healthy child development • access to services, such as health, education and recreation • social safety net • acceptable housing in a safe neighbourhood or community • adequate family income • food security • social inclusion • freedom from prejudice, discrimination and violence

Adapted from Commonwealth Department of Health and Aged Care. (2000). *Promotion, Prevention and Early Intervention for Mental Health: A Monograph.* p. 15

What are potential risk factors for mental health problems?

The following table lists risk factors for developing mental health problems.

Type of risk factors	Specific risk factors
Individual factors	• prenatal brain damage • premature birth • birth injury • low birth weight, birth complications • insecure attachment in infant or child • difficult temperament • poor health in infancy
Family factors	• having teenage mother or single parent • absence of father in childhood • large family size • antisocial role models (in childhood) • relationship discord in parents • poor supervision and monitoring • neglect in childhood • low parental involvement • long-term parental unemployment • criminality in parent • parental substance misuse • parental mental health problem • harsh or inconsistent discipline style • lack of warmth and affection
School context	• bullying • peer rejection • poor attachment to school • inadequate behaviour management • deviant peer group • school failure

Type of risk factors	Specific risk factors
Life events and situations	• school transitions • divorce and family break-up • frequent moves • physical illness or disability • death of family member
Community and culture	• deviant peer group • population density and poor housing conditions • poor quality neighbourhoods • social or cultural discrimination • socio-economic disadvantage • community violence • isolation • lack of support services
Determinants of health	• inadequate or insecure housing • unsafe neighbourhoods and communities • material deprivation • inability to participate in society • living with a low family income • food insecurity • social exclusion • inability to access services, such as health, education and recreation • exposure to prejudice, discrimination and violence

Adapted from Commonwealth Department of Health and Aged Care. (2000). *Promotion, Prevention and Early Intervention for Mental Health: A Monograph.* p. 15

The ultimate aim of mental health promotion is to help people focus on their strengths and potential in maintaining good mental health through increasing protective factors and reducing risk factors.

3. Guidelines for mental health promotion for children and youth

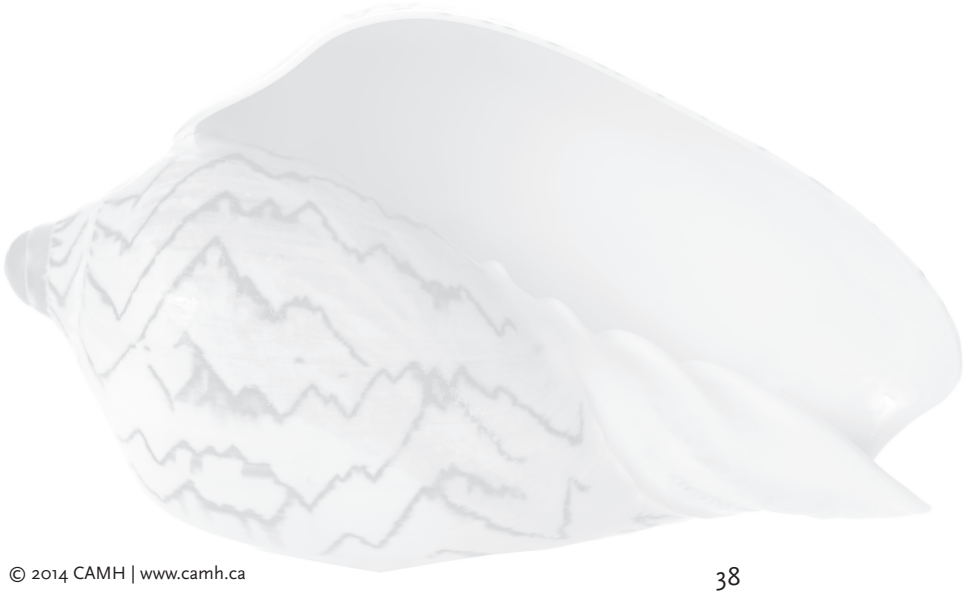
These guidelines define **best practices** for mental health promotion initiatives, which comprise a broad range of interventions, including services, information, programs, campaigns, strategies, research and evaluation. The guidelines are based on mental health promotion principles that have been identified through critical analysis of literature reviews. These guidelines are not intended to be used as an evaluation tool, but are designed to encourage health and social service practitioners and others who work with children, youth and families to include mental health promotion principles in existing services as well as to assist them in developing new initiatives. The guidelines may also help when advocating with and on behalf of children and youth.

Not all components will apply in all contexts, because the guidelines are based on ideal mental health promotion initiatives. Practitioners will have to take into consideration their available resources and possible restrictions, given the overall mandate of their organization, and should apply what is relevant for their programming needs.

For illustrations of the guidelines in practice, see Chapter 4: Examples of programs that incorporate good practice.

Summary of guidelines

1. Address and modify risk and protective factors, including determinants of health, that indicate possible mental health concerns.
2. Intervene in multiple settings.
3. Focus on skill building, empowerment, self-efficacy and resilience.
4. Train non-professionals to establish caring and trusting relationships with children and youth.
5. Involve multiple stakeholders.
6. Help develop comprehensive support systems.
7. Adopt multiple interventions.
8. Address opportunities for organizational change, policy development and advocacy.
9. Demonstrate a long-term commitment to program planning, development and evaluation.
10. Ensure that information and services provided are culturally appropriate, equitable and holistic.



Guideline 1

GUIDELINE

NOTES

Address and modify risk and protective factors, including determinants of health, that indicate possible mental health or substance use concerns and violence in children, youth and/or parents/caregivers by:

- identifying the population(s) of concern
- identifying relevant protective factors, risk factors and determinants of health
- assessing which factors and health determinants can be modified
- developing a plan to enhance protective factors, reduce risk factors and influence determinants of heath relevant to the population(s) of concern.

Protective factors include:

- social skills
- family harmony
- positive school climate
- positive life events in childhood
- attachment to and networks within the community.

Risk factors include:

- insecure attachment in infant or child
- family violence and disharmony
- poor attachment to school
- negative life events in childhood
- neighbourhood violence and crime.

Determinants of health include:

- housing
- employment and working conditions
- income and income distribution
- social supports
- freedom from discrimination and violence
- gender, age, ethnoracial or ethnocultural background
- physical environment.

GUIDELINE

NOTES

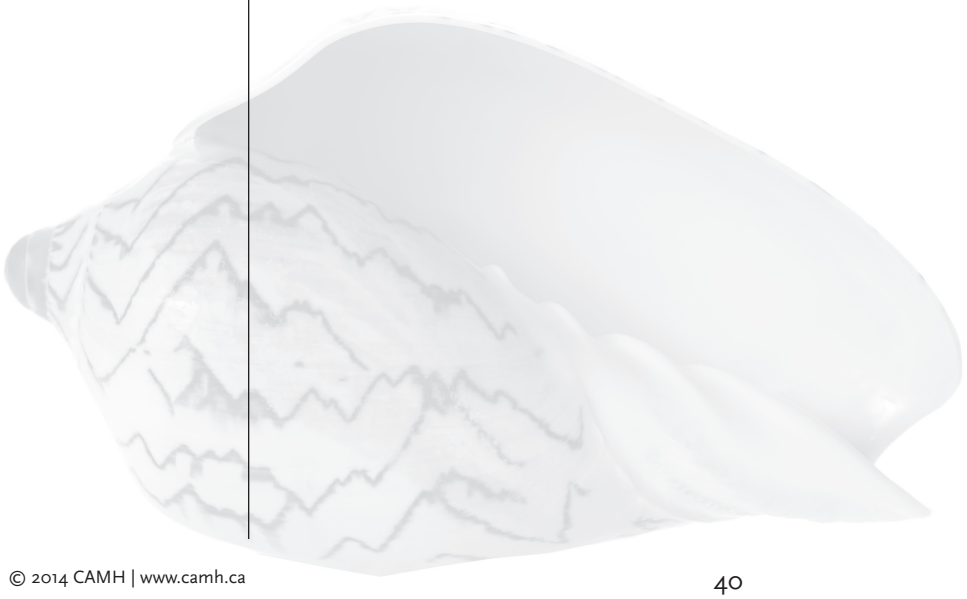
Guideline 2

Intervene in multiple settings, with a particular focus on schools as a key setting for intervention with children and youth by:

- developing strategies to intervene in all settings (e.g., school, daycare, home, community)
- looking at all aspects of the setting environment that affects children and youth (e.g., norms, policies, social environment, physical environment)
- looking at how children use space and interact with each other and how this affects their mental health
- aiming to improve the overall social environment of the setting
- providing early identification of behavioural problems and disorders and early intervention for children having difficulty adapting to the school environment and in relating to peers.

Examples of how to implement Guideline 2 include:

- school-wide social events
- links between the school and the community around youth-friendly issues
- parenting programs for pre-school children in libraries, community settings and schools.



Guideline 3

GUIDELINE

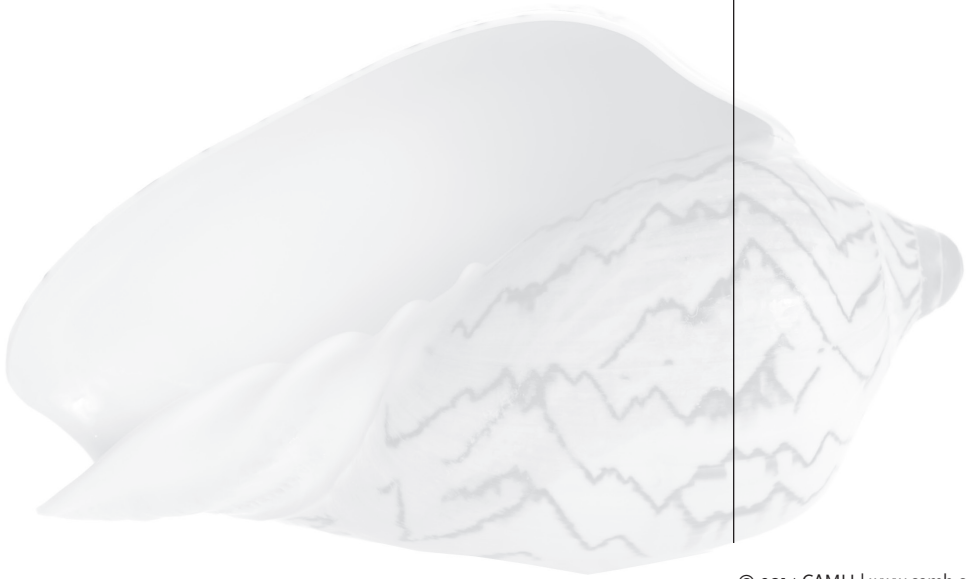
NOTES

Provide a focus on skill building, empowerment, self-efficacy and individual resilience, and ensure that children and youth are treated with respect, by:

- providing individual skills training
- providing parental skills training
- providing family communication skills training
- dealing with feelings of loss, conflict and anger
- dealing with clients' feelings in a respectful and dignified manner.

Examples of how to implement Guideline 3 include:

- building young people's:
  - social skills
  - self-control and emotional awareness
  - peer relations
  - problem-solving skills
  - cognitive and social development
  - self-esteem
  - academic skills
- building parents':
  - parenting skills
  - family management skills.



GUIDELINE

NOTES

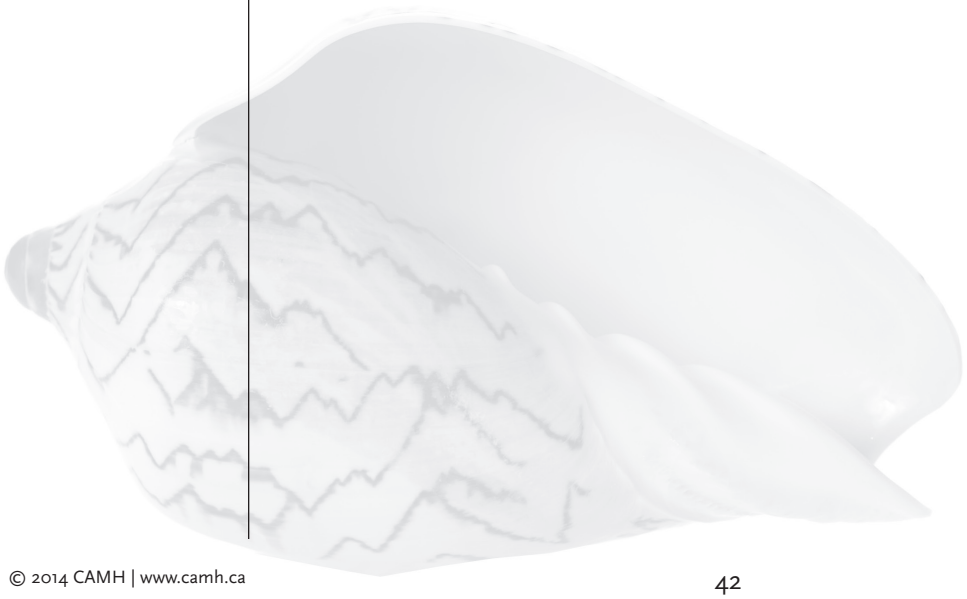
Guideline 4

Train non-professionals to establish caring and trusting relationships with children and youth by:

- providing training to supervised non-professionals on how to establish caring and trusting relationships with children and youth
- involving and training youth to be peer supports and educators where appropriate.

Examples of how to implement Guideline 4 include:

- mentorship programs within community setting (e.g., schools, Big Brothers, Big Sisters)
- youth clubs, recreational facilities, community groups
- peer relations, peer tutoring
- relationship building.



Guideline 5

GUIDELINE

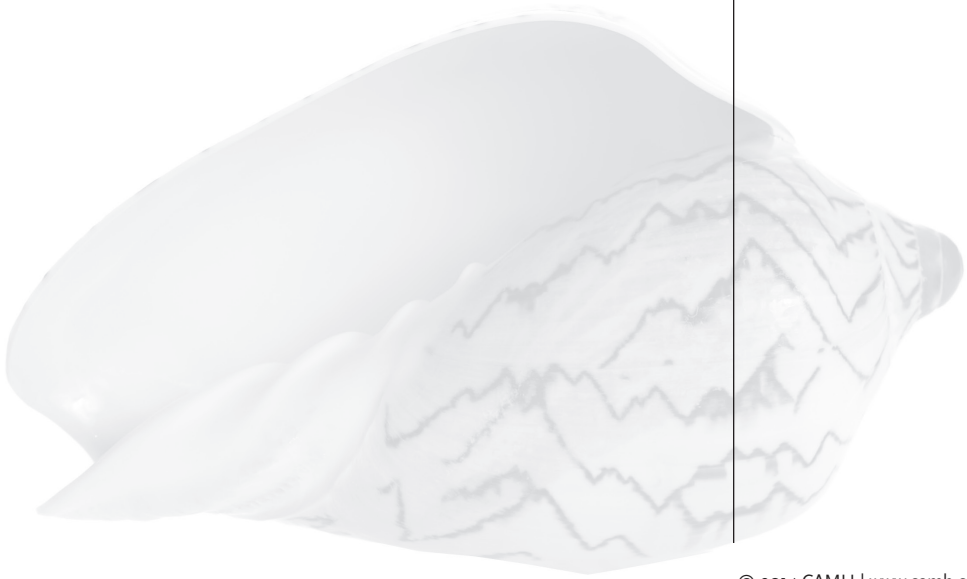
NOTES

Involve multiple stakeholders by:

- including students, school staff, parents, family members, community members and others in program planning, development and implementation
- enabling participants to be involved in the planning and decision-making process.

Examples of how to implement Guideline 5 include:

- establishing planning retreats and/or planning days with specific client group(s)
- establishing and maintaining ongoing partnerships with community members, coalitions and networks.
- including many stakeholders on program advisory committees and school councils
- establishing parent–student education sessions.



GUIDELINE

NOTES

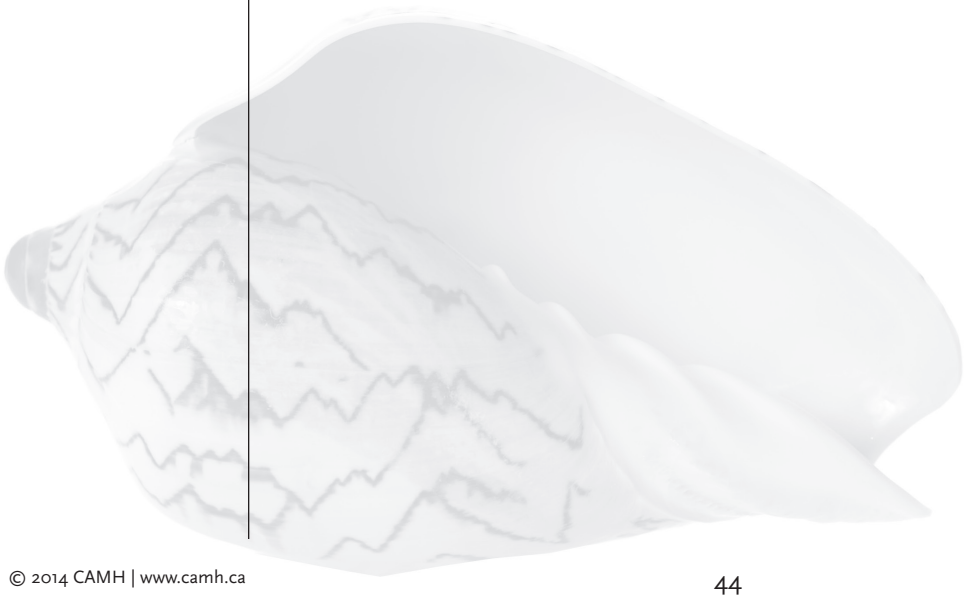
Guideline 6

Help develop comprehensive support systems that focus on peer and parent–child relations and academic performance by:

- identifying populations(s) of concern
- facilitating the development/improvement of a strong support system/network for the population(s) of concern, including emotional, social and physical support, tangible assistance, school, community and health services support.

Examples of how to implement Guideline 6 include:

- counselling, reassurance, sympathetic listening
- fostering caring and supportive relationships with family, friends and service providers
- providing tangible assistance such as transportation to group sessions, childcare and other services.



Guideline 7

GUIDELINE

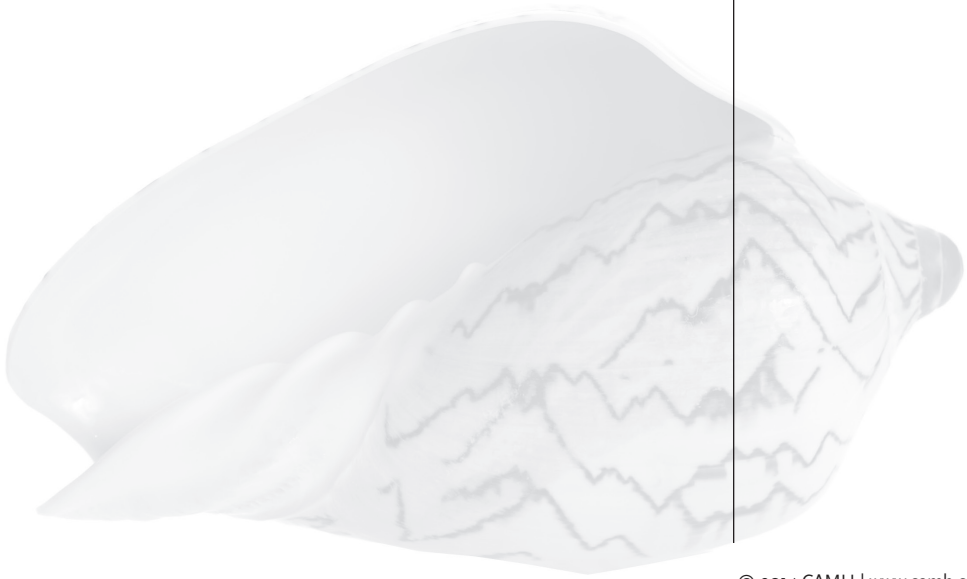
NOTES

Adopt multiple interventions by:

- identifying population(s) of concern
- planning a comprehensive approach using multiple strategies, which include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services
- using strategies to reach multiple audiences in formats appropriate to their needs and preferences
- using strategies that reinforce each other to reach a common goal.

Examples of how to implement Guideline 7 include:

- out-of-school-time programs
- parent support groups
- self-help groups
- skill-building workshops (e.g., behavioural management, anger management)
- school policies
- community engagement.



GUIDELINE

NOTES

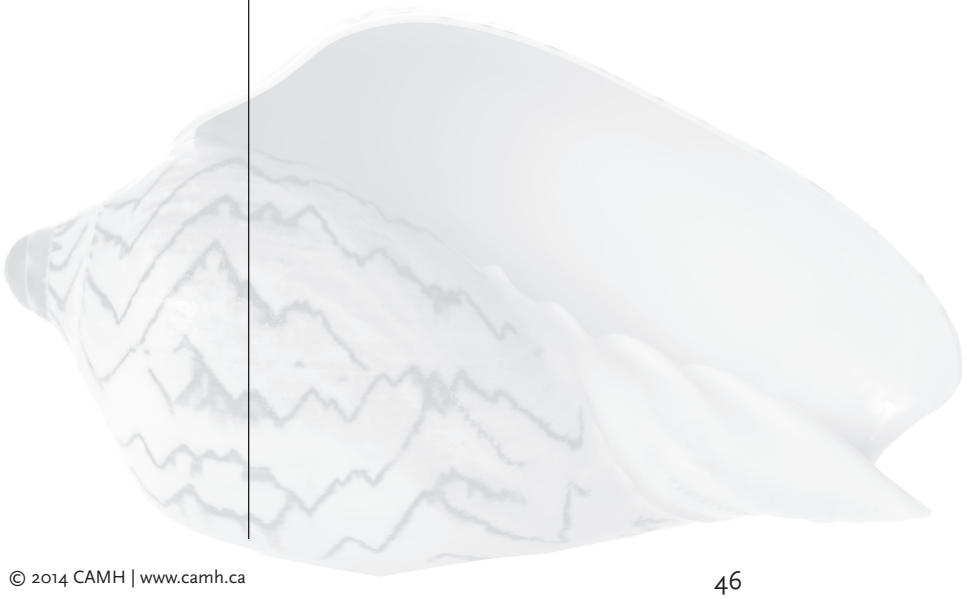
Guideline 8

Address opportunities for organizational change, policy development and advocacy by:

- mobilizing parents, teachers and youth
- being aware of and monitoring upcoming legislation and government initiatives in order to identify and influence change that incorporates a mental health promotion approach
- implementing client and/or staff surveys to assess organizational climate
- working with management, students and staff to create a health-promoting school and workplace
- identifying policy initiatives to influence school culture.

Examples of how to implement Guideline 8 include:

- safe schools policy
- health promoting schools—policies, education
- advocacy for physical activity in the school
- advocacy for healthy school cafeteria policies (e.g., policies regarding vending machines)
- advocacy for green space and gardens
- giving opportunities to community members, parents, teachers and youth to voice issues and engage in dialogue and problem solving
- lobbying for legislative change.



Guideline 9

GUIDELINE

NOTES

Demonstrate a long-term commitment to program planning, development and evaluation by:

- conducting a situational assessment to inform the design of an intervention, taking into consideration the diversity of the population(s), and their strengths and assets
- clearly defining for whom the mental health promotion programs, interventions and policies are intended
- involving members of the intended audience in program design and implementation
- ensuring the length and intensity of your intervention is appropriate for the population(s) of concern and will achieve intended outcomes
- continuously revising program objectives to ensure progress toward goals
- ensuring that data collection methods and mechanisms are in place
- outlining an evaluation process that states outcomes clearly, and considers outcome and process indicators
- drawing on a variety of disciplines (e.g., psychology, sociology, social work and statistics)
- reviewing and using successful research-based programs, interventions and policies
- exchanging knowledge with a deliberate commitment to sharing best and promising practices

Examples of how to implement Guideline 9 include:

- program logic models and evaluation plans
- community advisory committees engaged in program planning and evaluation
- monitoring systems to review information about mental health, including assets and strengths as well as problems for children and youth
- communicating intervention results through online "communities of interest" or knowledge exchange networks that support interactive sharing.

GUIDELINE

NOTES

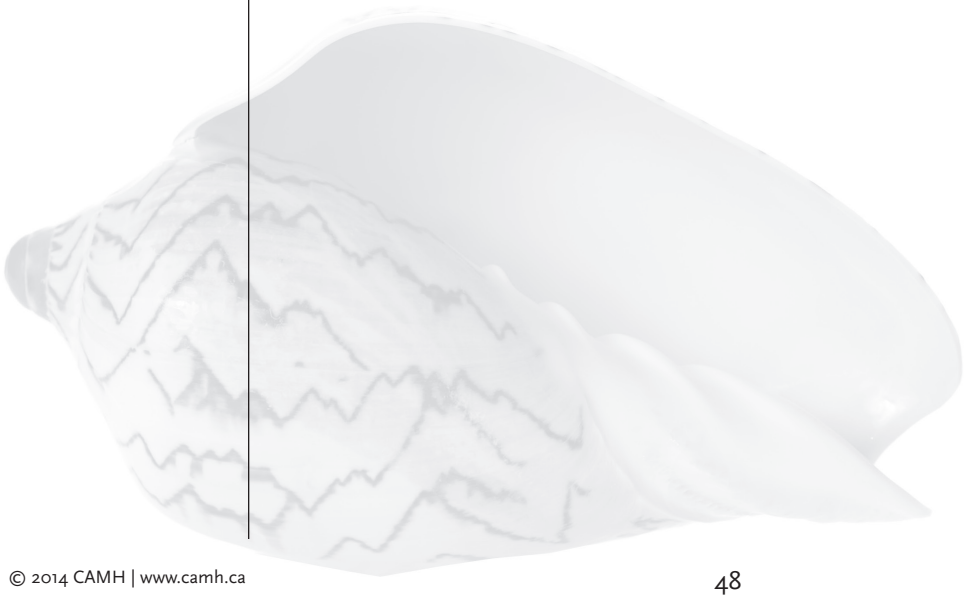
Guideline 10

Ensure that information and services provided are culturally appropriate, equitable and holistic by:

- facilitating access for parents and children to culturally relevant supportive social networks
- providing relevant information (e.g., about child and adolescent development and mental health) in an understandable and culturally appropriate manner
- facilitating participation from culturally and linguistically diverse groups
- considering the possible consequences to socially disadvantage families
- considering the person as a whole, taking into account the physical, emotional, spiritual, mental and social factors that affect their mental health
- providing a holistic and integrative approach to dealing with mental health issues.

Examples of how to implement Guideline 10 include:

- Centre for Addiction and Mental Health (CAMH) Diversity Policy and Framework: www.camh.ca/en/hospital/about_camh/health_equity/policy_framework/Pages/policy_framework.aspx
- City of Toronto Equity, Diversity and Human Rights division, which ensures that services, programs and policies are responsive to the needs of diverse communities. For more information, visit www1.toronto.ca/wps/portal/contentonly?vgnextoid=d84ae03bb8d1e310VgnVCM10000071d60f89RCRD



Outcome and process indicators

Outcome and process indicators are tools organizations can use to gauge the success of their work.

Outcome indicators

Outcome indicators measure how well your initiatives are accomplishing their intended results. They compare the results of an initiative to the situation beforehand.

The examples in the table below show how a well-chosen outcome indicator can measure an initiative's success:

Intervention type	Possible outcome indicator
Changing a risk factor	• percentage of children and youth reporting experiences of bullying • percentage of children and youth reporting experiences of depression or other mental health concerns
Changing a determinant of health	• percentage of families living above the poverty line • percentage of children and youth who live in safe housing
Intervening in multiple settings	• percentage of programs for children and youth that link schools, families and communities • percentage of schools that are recognized as part of the "Healthy Schools" movement

Intervention type	Possible outcome indicator
Building relationships	• percentage of children and youth who report that they are satisfied with the relationships they have with family and friends
Building skills	• percentage of youth who graduate from high school • percentage of parenting training programs
Policy change	• list of policies that exist at the local level that reduce unemployment for the parents of children and youth
Overall change in mental health	• scores on self-perceived health and happiness measures • percentage of children and youth reporting good to excellent self-esteem or well-being

Process indicators

Process indicators measure how well you are running your activities. They track how much you are doing and how well people like the activity. Examples include:

- number of people who attended your parent training sessions
- number of times your organization offered skills training to youth
- number and type of community organizations that have collaborated with your organization to improve the mental health of children and youth
- number of meetings held to undertake a strengths-based needs assessment of the community and who attended
- participants' satisfaction rating of your training session(s).

4. Examples of mental health programs that incorporate good practice

Based on best practice guidelines, the following examples were found to follow some of the guidelines and have been deemed good practice. A brief description of the projects is provided, along with a reference or web link for further information about the initiative.

The Canadian Best Practices Portal (http://cbpp-pcpe.phac-aspc.gc.ca) also offers examples of trusted and credible information, making it a one-stop shop for busy health professionals and decision-makers. This enhanced portal provides resources and solutions to help you plan programs for promoting health and preventing diseases in your community.

Youth Net

Goals and objectives

- The objective of Youth Net / Réseau Ado is to reach out and help youth develop and maintain good mental health and healthy coping strategies for dealing with stress, while decreasing stigma around mental illness and its treatment. We do this through education and intervention.
- We educate service providers, families, the community, policy makers and youth on youth mental health issues.
- We have tools to help identify youth in need of an intervention, preferably early, but also those already in crisis.
- We promote mental health to decrease the stigma associated with mental illness in the public, and particularly with youth.

Description

Youth Net / Réseau Ado is a regional mental health promotion and intervention program run by youth, for youth, in various Ontario locations.

By 2004, more than 12,000 had participated in Youth Net, with programming offered in Ottawa, Halton, Peel, Grey Bruce and Hamilton in Ontario; Delta, B.C.; Montreal, Montérégie and Montmagny in Quebec; and Newcastle, England.

Start date
1994

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resiliency

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

Although programming can differ by site, an example of the programming includes discussion groups, which provide a one-time discussion as a group where youth have an opportunity to express, explore and discuss their concerns about mental health.

Discussion-generating topics for youth include thoughts on mental health and mental illness, what is stressful in their lives, healthy and unhealthy coping strategies, and the importance of developing peer connections.

Discussion groups last 70 to 90 minutes, and are offered at high schools and other community settings where youth gather. Youth Net Facilitators are trained to assess and identify youth at risk of suicide ideation or behaviour and link these youth with supports in the school and/or community.

A network of trained mental health professionals support Youth Net discussion groups and are able to assess, refer and counsel youth on a short-term basis.

Learn more

Youth Net: www.youthnet.on.ca

Youth Net Halton: www.halton.ca/cms/one.aspx?objectId=11463

Youth Net Hamilton: www.youthnethamilton.ca

List of Canadian Youth Net sites: www.youthnethamilton.ca/about.php?contentid=69

Fourth R: Aboriginal Perspective Program

Goals and objectives

- Fourth R initiatives use best practice approaches to target multiple forms of violence, including bullying, dating violence, peer violence, and group violence. By building healthy school environments we provide opportunities to engage students in developing healthy relationships and decision making to provide a solid foundation for their learning experience. Increasing youth relationship skills and targeting risk behaviour with a harm reduction approach empowers adolescents to make healthier decisions about relationships, substance use and sexual behaviour.

Description

The Fourth R operates in various locations across North America and Europe. This comprehensive school-based program involves students, teachers, parents and the community in reducing violence and risk behaviours. It is important that young people receive information that will help them make good decisions and experience positive relationship models that will demonstrate alternatives to the negative examples they frequently see in the world around them.

Start date
Developed in 2001. Updated and evaluated in 2004–2006, 2007

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

This evaluated program has been developed for the general population and adapted for Aboriginal youth. The Aboriginal Perspectives version of the Fourth R program was developed with Aboriginal educators, students, counsellors and community partners. The Aboriginal Perspectives curriculum adds a cultural identity framework for youth and situates some of the issues facing Aboriginal youth in a historical context. Notably, the curriculum draws links between residential schools and the widespread effects of trauma in communities. Youth have opportunities to identify individual and community strengths that will support them in making healthy choices. Teaching strategies have been adapted to include sharing circles and bringing community members into the classroom. Additional educational materials and role-play examples support the program by demonstrating healthy relationship skills in situations relevant to Aboriginal youth (e.g., racism at school).

Learn more

The Fourth R Aboriginal Perspectives Program:
https://youthrelationships.org/aboriginal-perspectives

Tel.: 519 858-5144

E-mail: thefourthr@uwo.ca

Support and Intervention to Promote Health and Coping among Homeless Youth, Edmonton, Alberta

Goals and objectives

- To facilitate the development of positive interactions and to help compensate for the limited social networks for youth who are homeless, a network of peers and professionals was formed to provide emotional, informational and other forms of support.

Description

Support and Intervention to Promote Health and Coping among Homeless Youth was a pilot project consisting of four support groups that met once a week for three to four hours over five months in Edmonton, Alberta. It involved both group and one-on-one support. This mode was selected because youth preferred face-to-face support. Space for the program was provided by two partner agencies serving homeless and at-risk youth, as well as one community centre. The groups were facilitated by professional mentors and included opportunities for one-on-one support delivered by both peer and professional mentors.

This pilot intervention study was guided by seven research questions:

Start date

2007

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

What are the effects of the pilot support intervention on homeless youths with respect to:

1. quality, composition and size of social network
2. satisfaction with support received
3. loneliness and isolation
4. support-seeking coping
5. self-efficacy
6. mental health
7. health-related behaviours?

The study found that the youth not only built new ties and expanded their social networks but also strengthened their social skills through their interactions with other youth who are homeless, and with peer mentors and professionals. Participants reported being more social, engaged and positive in their relationships, and more frequently seeking support from people outside the intervention.

Learn more

The Homeless Hub: www.homelesshub.ca/resource/support-intervention-homeless-youths

Alberta Homelessness Research Consortium: www.homelesshub.net/research/AHRC

School Mental Health Program, Maryland, United States

Goals and objectives

- The primary goal of school mental health programs is to facilitate school success by removing or reducing conditions of stress and emotional or behavioural problems that are barriers to learning.

Description

The School Mental Health Program was established in 1989 by the University of Maryland Medical Center to provide services to elementary, middle and high-school students. Staff provide comprehensive, developmentally and culturally sensitive mental health services in a natural school setting. This evidence-based intervention aims to improve the school environment and promote mental health for all students.

Start date
1989

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

Information source

Weist, M., Goldstein, A., Morris, L. & Bryant, T. (2003). Integrating expanded school mental health programs and school-based health centers. *Psychology in the Schools*, *40*, 297–308.

Learn more

University of Maryland Medical Center School Mental Health Program: www.homelesshub.ca/resource/support-intervention-homeless-youths

Substance Abuse Program for African Canadian and Caribbean Youth, Toronto, Ontario

Goals and objectives

- The Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) offers counselling and support services to Black youth, aged 13 to 24 years, and their families to improve their spiritual, emotional, mental and physical well-being.

Description

SAPACCY is a an empowering and capacity-building program that provides services to a diverse clientele of black youth, aged 13 to 24 years, in Toronto. The program uses a strength-based approach that enables young people to discover their talents and successfully transition from drug-related behaviours to pursuing education or attending work-training programs. The program has collaborated with many community agencies and also engages in youth advocacy by raising awareness about violence and substance use. Examples include work with Toronto Police Services (Empowering Student Partnership Program) and the City of Toronto Working Group on Youth Gangs.

Start date
2006

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

Learn more

SAPACCY, Child, Youth and Family Program, Centre for Addiction and Mental Health (CAMH): www.camh.ca/en/hospital/care_program_and_services/child_youth_and_family_program/Pages/guide_sapaccy.aspx

Contact information:
Lew Golding: 416 535-8501 ext. 36767

Gatehouse Project, Australia

Goals and objectives

- Using a "whole school approach," The Gatehouse Project promotes student engagement in schools to improve emotional well-being and learning outcomes. The project provides schools with strategies to:
  - increase students' connectedness to school
  - increase students' skills and knowledge for dealing with everyday life challenges

Description

The Gatehouse Project was an Australian secondary school initiative developed in 1996 to promote student engagement and school connectedness as a way to improve emotional well-being and learning outcomes. The project established a school-based adolescent health team and identified protective and risk factors in each school. The three priority action areas were:

1. building a sense of security and trust
2. enhancing skills and opportunities for good communication
3. building a sense of positive regard through valued participation in aspects of school life.

Start date
1996

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 8: Address organizational change, policy development and advocacy

Guideline 9: Commit to program planning, development and evaluation

The Gatehouse Project team developed, implemented and evaluated a practical and flexible whole school strategy that can be adapted for individual schools and systems. Online teaching resources were developed based on the evidence-based project design and intervention strategies:

1. Promoting Emotional Well-Being: Team Guidelines for Whole School Change: www.mentalhealthpromotion.net/resources/gatehouse-project.pdf
2. Teaching Resources for Emotional Well-Being: www.wellbeingaustralia.com.au/Gatehouse%20project%20resources.pdf

Information source

Bond, L. Glover, S., Godfrey, C., Butler, H. & Patton, G. (2001). Building capacity for system-level changes in schools: Lessons from the Gatehouse Project. *Health Education & Behavior*, *28*, 368–383.

Contact information:
Gatehouse Project, Austrian Clearinghouse for Youth Studies: www.acys.info/sector_resources/programs/q-t/the_gatehouse_project

Miyupmaatisiiuwin Wellness Curriculum, Canada

Goals and objectives

- The Miyupmaatisiiuwin Wellness Curriculum focuses on suicide, substance use problems and violence.

Description

The Miyupmaatisiiuwin Wellness Curriculum is a Canadian school-based suicide prevention program developed in 2000 to promote a wide range of healthy lifestyle choices to counteract the long-term incidence of suicide, as well as substance use problems and violence in First Nations and Inuit communities. It focuses on wellness and targets children from kindergarten to Grade 8. This holistic program emphasizes Aboriginal culture and was developed with the Cree community to encourage family and community participation.

Start date
2000

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 6: Provide comprehensive support systems

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

Learn more

Kirmayer, L., Boothroyd, L., Laliberte, A. & Simpson, B.L. (1999). *Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities.* Montreal: Institute of Community & Family Psychiatry, Jewish General Hospital. www.mcgill.ca/files/tcpsych/Report9_Eng.pdf

Investing in Families, Toronto, Ontario

Goals and objectives

The goals of the Investing in Families Project are to:

- promote healthy lifestyles
- increase personal and family resilience
- improve physical and mental health
- enhance social and community supports
- improve family's circumstances through greater access to employment training and supports.

Description

Expanded from a pilot project to a Toronto city-wide initiative in 2010, Investing in Families (IIF) seeks to reduce health inequalities and improve the health and social status of families that are vulnerable in an ethnoculturally and linguistically diverse urban setting. Pivotal to the success of the project is a collaborative, intersectoral partnership. Toronto Public Health focuses on promoting health. Toronto Employment and Social Services provides funding for the project and financial support for IIF participants to engage in various activities leading to job readiness. Toronto Parks,

Start date
2006

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 2: Intervene in multiple settings

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

Forestry and Recreation helps families to access recreational opportunities. Another partner is the Toronto Public Library. The IIF project is an example of an innovative, wraparound approach to delivering services to families that are vulnerable, based on research conducted in 2001 by Gina Browne and colleagues.

Integral to IIF is "Let's Talk," a neighbourhood-based group approach that addresses child and family health outcomes related to social isolation, anxiety, depression and lack of social supports. With experienced facilitators and guest speakers, Let's Talk groups aim to improve the physical and emotional well-being of families by building social networks, providing health teaching and employment readiness training and promoting engagement with community resources.

Let's Talk engages families that are socially and economically disadvantaged. A 2012 evaluation found that the program has contributed to "the practical knowledge of how to provide meaningful support to vulnerable clients while improving their overall health and well-being in a group setting" (Toronto Public Health, 2012).

Learn more

Toronto Public Health. (2012). *Let's Talk: Strengths, Client Benefits and Challenges: Perspectives of Staff and Managers*. A Toronto Public Health project provided in partnership with Toronto Employment and Social Services, and Parks, Forestry and Recreation through the Investing in Families Initiative of the City of Toronto.

Browne, G., Byrne, C., Roberts, J., Gafni, A. & Whittaker, S. (2001). When the bough breaks: Provider-initiated comprehensive care is more effective and less expensive for sole-support parents on social assistance. *Social Science & Medicine*, *53*, 1697–1710.

Contact information:
Claudette Holloway, Healthy Families manager, Toronto Public Health.
E-mail: chollowa@toronto.ca

www1.toronto.ca/wps/portal/contentonly?vgnextoid= eaa9707b1a280410VgnVCM10000071d60f89RCRD

Strengthening Families for the Future, Ontario, Canada

Goals and objectives

The goals of Strengthening Families for the Future are to:

- reduce children's or adolescents' intention to use alcohol and/or other drugs, and reduce other behavioural problems
- increase children's resilience and life skills
- increase positive and effective parenting
- increase family communication.

Description

Strengthening Families for the Future (SFF) is modelled on a program developed in the late 1980s by Karol Kumpfer of the University of Utah. It is a 14-week prevention program for families with children aged 7 to 11 years at risk for substance use problems, depression, violence, delinquency and school failure. SFF is unique because it was designed specifically to reduce risk factors, build individual resilience and enhance family protective factors. Program resources involve four components: a section on getting started, as well as parent, child and family manuals. Each manual includes reproducible handouts in English and French.

SFF has been shown to address substance use problems by reducing risk factors and enhancing protective factors within the family. Foxcroft and colleauges (2003) found that SFF was the only one of 56 programs reviewed that showed promise as a prevention intervention.

Start date
2006

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resiliency

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

An evaluation (De Wit et al., 2007) found that the SFF is "a promising intervention for fostering significant improvements in several areas of family functioning, parenting and chlldren's psychosocial functioning (for families struggling with alcohol problems)." Some outcomes, such as family functioning, task accomplishment, role performance, affective expression and children's social skills in co-operating were maintained six months after the last program session.

Learn more

Foxcroft, D.R., Ireland, D., Lister-Sharp, D.J., Lowe, G. & Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: A systematic review. *Addiction*, *98*, 397–411.

De Wit, D.J., Maguin, G., Nochajski, T., Safyer, A., Macdonald, S. & Kumpfer, K. (2006). *An Outcome Evaluation of the Strengthening Families Program in Ontario, Canada.* Paper presented at the 14th Annual Meeting of the Society for Prevention Research, San Antonio, TX.

Contact information:
Barbara Steep, Project Consultant, CAMH
Tel.: 416 535-8501 ext. 4553

E-mail: barbara.steep@camh.ca

www.camh.ca

To purchase the manuals, visit
http://store.camh.ca

Strengthening Families for Parents and Youth 12–16 Ontario, Canada

Goals and objectives

The goals of the program are to:

- increase youth resilience, mental health and social skills
- reduce adolescents' use of alcohol and/or other drugs
- increase consistent, positive parenting
- increase parent-teen communication and empathy
- increase positive family functioning and reduce family conflict.

Description

Strengthening Families for Parents and Youth (SFPY) is a nine-week skill-building family change program for families with youth, aged 12–16 years. It is a shortened, adapted version of the successful 14-week Strengthening Families program developed by Dr. Karol Kumpfer of the University of Utah. SFPY is a prevention program for parents and youth who may be at risk due to mental health and substance use concerns, high levels of family conflict and other environmental risk factors, such as family isolation and economic stress. The adapted nine-week SFPY curriculum underwent a rigorous evaluation and showed positive increases in youth, parent and family functioning in line with the evidence established for the original 14-week curriculum.

Start date
2009

The guidelines that apply to this program are:

Guideline 1: Enhance protective factors, reduce risk factors, and impact determinants of health

Guideline 3: Focus on skill-building, empowerment, self-efficacy and resilience

Guideline 5: Involve multiple stakeholders

Guideline 6: Provide comprehensive support systems

Guideline 7: Adopt multiple interventions

Guideline 9: Commit to program planning, development and evaluation

Guideline 10: Provide culturally appropriate, equitable and holistic services

This research-based program takes a "whole family" approach to help parents and teens develop trust and mutual respect. In the first hour, participants enjoy a healthy family meal together. In the second hour, parents and youth participate in separate sessions where they discuss a range of topics. In the last hour, participants come together again for a session where they build on the topics and skills they've explored separately. Four facilitators deliver the program (two co-group leaders for the youth sessions and two for the parent sessions).

SFPY has been implemented by agencies serving diverse communities, including First Nations, African-Caribbean-Canadian and Asian groups and newcomer populations. A French language rendition is currently underway with Francophone communities.

Information source

Organizations wishing to implement SFPY have access to program downloads via the Parent Action on Drugs website (www.pad-sfpy.org), including an overview of SFPY, implementation guidelines and evaluation reports. To order curriculum manuals or schedule facilitator training, contact pad@parentactionondrugs.org.

Contact information:
Andrea Zeelie-Varga
Parent Action on Drugs (PAD)
Tel.: 416 395-4970, toll-free: 1 877 265-9279

E-mail: pad@parentactionondrugs.org

Appendix 1

Worksheet

Practitioners can use this worksheet to plan and implement mental health program initiatives. This section also includes a sample worksheet that shows how it has been used in a mental health promotion initiative.

Worksheet information

Purpose of the worksheet

This worksheet is an important part of *Best Practice Guidelines for Mental Health Promotion Programs for Children and Youth*. It is a tool to help service providers identify which guidelines could be implemented within new or existing mental health promotion initiatives for children and youth. Some guidelines may prove a higher priority or, conversely, may not be relevant to your specific initiative, so we recommend that you focus on the guidelines that relate best to your initiative when you are completing the worksheet. This worksheet is not meant as an evaluation tool, but as a resource of referral for planning, implementing and promoting best mental health practices within your initiative.

Why should you use this worksheet?

1. Using the worksheet to follow the best practice guidelines will contribute to an evidence base that will help advance mental health promotion for children and youth.

2. Using the worksheet along with the guidelines will contribute to better understanding of issues faced by children and youth and what your initiative can do to further help them.

3. Using information provided in this worksheet could help other organizations and service providers apply these practices aimed at helping children and youth.

4. By documenting your efforts on the worksheet, you can recognize the full potential of your initiative to empower children, youth and their families and engage them in learning new skills.

5. Using the guide and completing the worksheet will help you to carefully analyze your efforts, better understand your strengths and pinpoint areas to improve, thus making your work more effective.

6. Documenting your efforts will make it possible to communicate what you have accomplished to others.

7. Describing your accomplishments can raise your organization's profile, which in turn could increase your possibilities for funding and other support.

How to use the worksheet

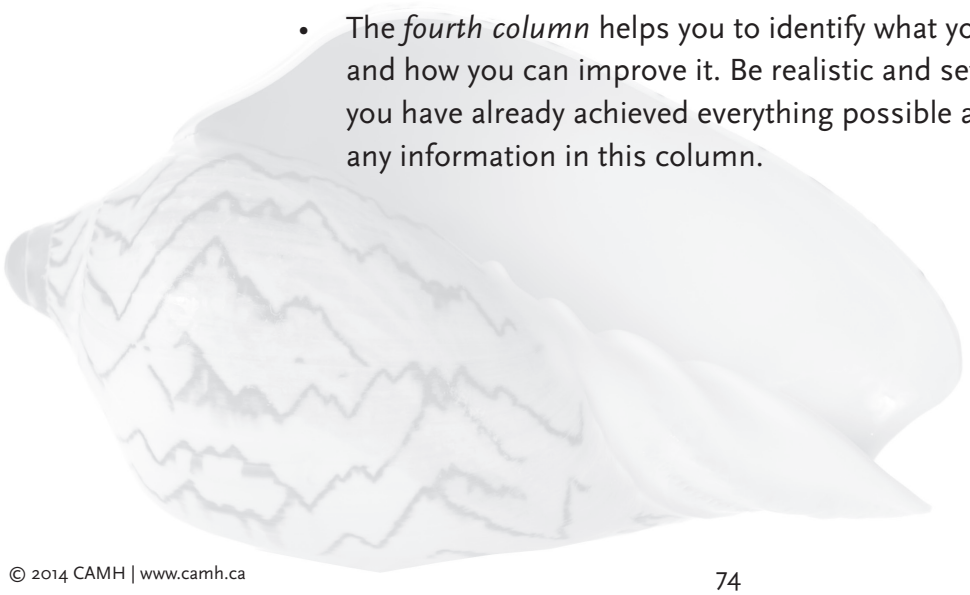
The worksheet has a user-friendly format to help you identify where your initiative stands in relation to the guidelines and what more you intend to achieve.

- The *first column* of the table includes the 10 guidelines relevant to promoting the mental health of children and youth. The guidelines are posed as questions to encourage you to think about how your intervention relates or does not relate to each guideline.

- The *second column* provides more detailed components of each guideline question and offers suggestions for how you can implement such practices within your initiative. The column can also be used as a preliminary checklist for actions you already carry out. Please refer back to the original set of guidelines for more information and examples of each action.

- The *third column* allows you to identify what your initiative has achieved in relation to the guidelines so far and how you have achieved this. Referring to your initiative's aims and objectives will be useful here. However, do not feel you have to fill in every row: only complete areas relevant to your initiative. Adding general notes here may also be useful for future reference as you continue to develop your initiative.

- The *fourth column* helps you to identify what your initiative may be missing and how you can improve it. Be realistic and set goals for the next year, unless you have already achieved everything possible and may not need to provide any information in this column.



- The *fifth column* allows you to document specific actions you plan to take to achieve the goals over the next year. This could also be an opportunity to collaborate with people who use your services to receive their input about how you can improve your initiative and services for children and youth. Again, you may not need to complete this column if your initiative has already achieved its goals.

- The *sixth column* helps you to set a date for achieving these goals and to later identify what your initiative has achieved over a given period. The worksheet is a long-term tool that you can duplicate for the future development of your initiative aimed at promoting the mental health of children and youth.

Worksheet for mental health promotion initiatives for children and youth

Date: _____

Name of intervention: _____

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
1. Does your initiative address and modify risk and protective factors (including determinants of health) that indicate possible mental health concerns, substance use or violence in children, youth and/or parents or caregivers by...	...identifying the population(s) of concern?				
	...identifying relevant protective factors, risk factors and determinants of health?				
	...assessing which factors and health determinants can be modified and how?				
	...developing a plan to enhance the protective factors, reduce the risk factors and influence the determinants of heath relevant to the population(s) of concern?				
	...other means?				
2. Does your initiative intervene in multiple settings, with a particular focus on schools as a key setting for intervention with children and youth, by...	...developing strategies to intervene in all settings?				
	...looking at all aspects of the setting that affect children and youth?				
	...looking at how children use space and interact with each other and how this affects their mental health?				
	...aiming to improve the overall social environment of the setting, providing early identification of behavioural problems and disorders, and early intervention for poor adaptation to peers and the school environment?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
3. Does your initiative provide a focus on skill building, empowerment, self-efficacy and individual resilience, and ensure that children and youth are treated with respect, by...	...providing individual skills training?				
	...providing parental skills training?				
	...providing family communication skills training?				
	...dealing with feelings of loss, conflict and anger?				
	...dealing with clients' feelings in a respectful and dignified manner?				
	...other means?				
4. Does your initiative train non-professionals to establish caring and trusting relationships with children and youth by...	...training supervised non-professionals to establish caring and trusting relationships with children and youth?				
	...involving and training youth to be peer supports and educators where appropriate?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
5. Does your initiative involve multiple stakeholders by...	...including students, school staff, parents, family and community members, and others in program planning, development and implementation?				
	...ensuring the intended audience is directly involved in planning and decision-making?				
	...other means?				
6. Does your initiative help develop comprehensive support systems that focus on peer and parent-child relations, and academic performance, by...	...identifying population(s) of concern?				
	...facilitating the development or improvement of a strong support network for the population(s) of concern (including emotional, social and physical support, through school, community and health services)?				
	...providing tangible assistance, such as financial support and transportation?				
	...other means?				
7. Does your initiative adopt multiple interventions by...	...planning a comprehensive approach using multiple strategies (i.e., building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health services)?				
	...using strategies to reach multiple audiences in formats appropriate to their needs and preferences?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
8. Does your initiative address opportunities for organizational change, policy development and advocacy by...	...mobilizing parents, teachers and youth?				
	...being aware of and monitoring upcoming legislation and government initiatives to identify and influence change that incorporates a mental health promotion approach?				
	...implementing client or staff surveys to assess organizational climate?				
	...working with management, students and staff to create a health promoting school and workplace?				
	...identifying policy initiatives to influence school culture?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
9. Does your initiative demonstrate a long-term commitment to program planning, development and evaluation by...	...conducting a situational assessment to inform design of an intervention (considering diversity of the population, its strengths and assets)?				
	...clearly defining for whom the programs, interventions and policies are intended?				
	...involving members of the intended audience in program design and implementation?				
	...ensuring length and intensity of the program is appropriate for the population and achieves intended outcomes?				
	...continuously revising objectives to ensure progress toward goals?				
	...ensuring data collection methods and mechanisms are in place?				
	...outlining an evaluation process that states outcomes clearly, and considers outcome and process indicators?				
	...drawing on a variety of disciplines?				
	...reviewing and using successful research-based programs, interventions and policies?				
	...exchanging knowledge with a deliberate commitment to sharing best and promising practices?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
10. Does your initiative ensure that information and services provided are culturally appropriate, equitable and holistic by...	...facilitating access for parents and children to culturally relevant, supportive social networks?				
	...providing relevant information in an understandable and culturally appropriate manner?				
	...facilitating participation from minority groups?				
	...considering the possible consequences for families who are socially disadvantaged?				
	...considering the person as a whole (i.e., the physical, emotional, spiritual, mental and social factors that affect their mental health)?				
	...providing a holistic and integrative approach to dealing with mental health issues?				
	...other means?				

Sample worksheet demonstrating mental health promotion initiatives established by Investing in Families

Investing in Families (IIF) is a Toronto city-wide project that seeks to reduce health inequalities and improve the health and social status of families who are vulnerable. As the lead agency, Toronto Employment and Social Services (TESS) co-ordinates the project and provides financial support for IIF participants to engage in a variety of activities leading to job readiness. As a project partner, Toronto Public Health (TPH) focuses on promoting health, while Toronto Parks, Forestry and Recreation (TPFR) assists families to access recreational opportunities. The Toronto Public Library (TPL) is a third collaborative partner that provides space for various IIF activities. Together, the IIF project is an example of an innovative, wraparound approach to service delivery for vulnerable families based on research by Gina Browne in 2001.

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
1. Does your initiative address and modify risk and protective factors (including determinants of health) that indicate possible mental health concerns, substance use or violence in children, youth and/or parents or caregivers by...	...identifying the population(s) of concern?	The Investing in Families (IIF) project in Toronto provides comprehensive services to socially and economically disadvantaged families who are receiving social assistance and are parent and are parenting children from birth to age 17 years in ethnoculturally and linguistically diverse urban settings.	Advance focus on youth mental health by increasing practitioner skills and knowledge of related issues.	Plan at least four professional development events (e.g., relevant internal or external guest speakers).	Dec. 2015
	...identifying relevant protective factors, risk factors and determinants of health?	Several risk factors are being addressed through the combined interventions of the three partners. Risk factors being addressed include: • poverty • lack of employment • chronic untreated medical conditions • anxiety and depression • social isolation. Protective factors being addressed include: • healthy lifestyles • personal and family resiliency • physical and mental health • parenting capacity • healthy family relationships • social and community supports • family's circumstances through greater access to employment training and supports.	Continue to address and modify risk and protective factors based on client need.	Focus primarily on addressing the mental health challenges facing youth in the IIF project.	Dec. 2015

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	...assessing which factors and health determinants can be modified and how?	IIF is a city-wide project operating in 15 Toronto Employment and Social Services (TESS) offices. Clients are selected by Social Services based on postal code. Clients receiving services are parenting at least one child in the identified age range (from birth to age 17 years). Clients are invited to attend information sessions to determine whether the project is right for them.	Continue interventions from all three partners to modify risk factors and assist IIF families to identify goals that address their needs.	Continue home visiting, telephone support and group interventions. Generate referrals to appropriate resources in the community.	Dec. 2016
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
2. Does your initiative intervene in multiple settings, with a particular focus on schools as a key setting for intervention with children and youth, by...	...developing strategies to intervene in all settings?	IIF takes a holistic approach with strategies that intervene at the individual, family and community levels. At the **individual level**, TPH takes the lead for health promotion and for providing health- related information, TESS takes the lead in providing employment-related skill building and PFR takes the lead in linking families to recreation. All project partners collaborate to link and refer families to community resources (e.g., to modified food handler groups, and other community resources). Funding for mental health counselling is available through TESS. At the **family level**, public health nurses provide information on health promotion (e.g., parenting and other topics as necessary). TESS supports families to achieve employment and education goals. At the **community level,** public health nurses link and refer families to resources. With funding from TESS, public health nurses assist families to participate in recreational activities and obtain related equipment and supplies.	Continue to work with project partners.	Continue to provide support in the schools; for example, by public health nurses assisting families as needed to develop skills to communicate with school personnel, attending school meetings with families and acting as advocates for them on health-related issues, including parenting.	2016

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	...looking at all aspects of the setting environment that affect children and youth?	Using multiple strategies, the project intervenes in specific environments that affect children and youth including the school and family. In the school, public health nurses assist families as needed to develop skills to communicate with school personnel. Public health nurses also attend school meetings with families and act as advocates for them in on health related issues including parenting. Public health nurses provide home visits, telephone interventions and group-based support to IIF families.	Increase the number of home visits and face-to-face contacts so more people are served.	Participate with project partners to provide information sessions for potential IIF families selected by TESS to increase potential participants' knowledge and comfort with the services provided by pubic health nurses.	2014
	...looking at how children use space and interact with each other and how this affects their mental health?				
	...aiming to improve the overall social environment of the setting, providing early identification of behavioural problems and disorders, and early intervention for poor adaptation to peers and the school environment?	The "Let's Talk" group intervention provides health information on parenting, physical activity, dealing with stress and other issues that affect the social environment of the family. Project funding is available for interventions such as counselling and learning assessments for school-aged children and youth.	Provide comprehensive services (from all partners) to ensure that children and youth at risk continue to access early intervention services.	Facilitate a co-ordinated approach to service provision among all partners; for example, through service co-ordination meetings using a client-centred approach with services offered based on the complexity of the family situation and the number of service providers involved.	2015

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	...other means?	We offer modified food handler groups, which combine a safe food handling certificate course with our health promotion "Let's Talk" group intervention offered by TPH.	Build on our Modified Food Handler training for youth.	Offer three to four youth groups, including a Modified Food Handler group for participants aged 15 to 17 years that might then lead to summer employment opportunities.	Dec. 2014
3. Does your initiative provide a focus on skill building, empowerment, self-efficacy and individual resilience, and ensure that children and youth are treated with respect, by...	...providing individual skills training?	TESS offers Life Skills courses that facilitated by their workers.	Facilitate at least 21 "Let's Talk" groups in 2014.	Target outreach and collaboration with partnering organizations.	Dec. 2014
	...providing parental skills training?	"Let's Talk" group sessions take a client-centred approach. Topics include parenting, physical activity, dealing with stress, sexual health, healthy eating, safety and information on community resources.	Facilitate a client-centred approach to enhancing parenting skills that recognize the unique needs of our clients.	Link IIF families to TPH parenting programs (e.g., Incredible Years).	2015
	...providing family communication skills training?	"Let's Talk" group sessions provide opportunities to practice positive family communication between parents, children and youth.	Provide opportunities in the group for clients to practise communication skills.	Provide comprehensive interventions in a group setting to strengthen client's ability to communicate effectively.	2015

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	...dealing with feelings of loss, conflict and anger?	Project partners have provided one-to-one visits in homes or community spaces.	Increase the number of home visits and face-to-face contacts so more people are served more effectively.	Participate in information sessions with our project partners to increase clients' knowledge and comfort with the services of public health nurses among potential participants of the project.	2014
	...dealing with clients' feelings in a respectful and dignified manner?	We provide a client-centred approach to "Let's Talk" group interventions by, for example, making interventions accessible and equitable for all clients, using interpreters as needed, and offering one-to-one visits, phone support and referral to appropriate resources.	Maintain respect and dignity for IIF families.	Provide staff awareness and training (e.g., cognitive behavioural training, a narrative solution-focused approach, motivational interviewing. Develop a means for clients to consent to share their stories with decision-makers as a way to recruit more families and fundraise.	2016
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
4. Does your initiative train non-professionals to establish caring and trusting relationships with children and youth by...	...training supervised non-professionals to establish caring and trusting relationships with children and youth?				
	...involving and training youth to be peer supports and educators where appropriate?				
	...other means?				
5. Does your initiative involve multiple stakeholders by...	...including students, school staff, parents, family and community members, and others in program planning, development and implementation?	The IIF partnership includes Toronto Public Health (TPH), Toronto Employment and Social Services (TESS), Toronto Parks, Forestry and Recreation (PFR) and the Toronto Public Library (TPL). Financial support is provided by TESS. Nursing services are provided by TPH. Recreation support is provided by TPFR. Additional community support is provided by the TPL. The project has provided opportunities for undergraduate and graduate university students on placement.	Continue to refine partner roles in delivering the "Let's Talk" groups (e.g., in recruitment, facilitation). Have partners continue to collaborate to offer comprehensive services city-wide.	Develop strategies to engage clients to accept the comprehensive services the project offers.	Dec. 2014

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	.....ensuring the intended audience is directly involved in planning and decision-making?	We take a client-centred approach. Clients are encouraged to identify priority concerns and to set goals for addressing them. We have conducted qualitative research on the "Let's Talk" parenting groups. We have also done client surveys to assess the overall project.	Incorporate any appropriate suggestions from clients.	Review and evaluate client feedback and obtain client stories to incorporate in reports.	2015
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
6. Does your initiative help develop comprehensive support systems that focus on peer and parent-child relations, and academic performance, by...	...identifying population(s) of concern?	We provide comprehensive services to socially and economically disadvantaged families parenting children from birth to age 17 years in ethnoculturally and linguistically diverse urban settings.	Increase parent attendance at "Let's Talk" groups and offer "Let's Talk" groups for youth (up to aged 17 years).	Develop social marketing strategies (e.g., postcards for public health nursing services and the "Let's Talk" group).	2014
	...facilitating the development or improvement of a strong support network for the population(s) of concern (including emotional, social and physical support, through school, community and health services)?	The "Let's Talk" group interventions include parenting and health information, household budgeting, physical activity, stress management and linking to community services. Guest speakers provide diverse topics and include dietitians, legal services as well as youth employment services. Peers in the "Let's Talk" group may be sources of social support.	Increase participant attendance at "Let's Talk" groups.	Collaborate with project partners to advertise "Let's Talk" groups to IIF clients. Create a "Let's Talk" postcard for project partners to provide to IIF families to help promote the group intervention option.	Sept. 2014
	...providing tangible assistance, such as financial support and transportation?	TESS covers the cost of transportation to and from the group intervention. The "Let's Talk" group also offers supports such as nutritious food and child minding.	Advocate for TESS to provide funds to support relevant client interventions (e.g., counselling and assessments).	Ensure project partners work collaboratively to advocate for continued funding.	Ongoing
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
7. Does your initiative adopt multiple interventions by...	...planning a comprehensive approach using multiple strategies (i.e., building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health services)?	We offer telephone support, home visits, community visits and group interventions. The intersectoral approach of the overall project builds healthy public policy to reorient social and health services through: • improved service delivery to vulnerable families using an innovative approach • enhanced service co-ordination for families • more efficient services using a holistic approach.	Strengthen collaboration between project partners and other city divisions involved in the IIF project.	Maintain communication between project partners. Explore new "Let's Talk" group intervention possibilities (e.g., engage youth in nutrition modules using tablets).	Dec. 2015
	...using strategies to reach multiple audiences in formats appropriate to their needs and preferences?	Seven variations of the "Let's Talk" group have been created for health teaching to accommodate diverse client needs and interests.	Increase the number of "Let's Talk" modified food handlers for Youth groups and "Let's Talk" language-specific groups.	Focus outreach to specific clients in the IIF project	Dec. 2014
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
8. Does your initiative address opportunities for organizational change, policy development and advocacy by...	...mobilizing parents, teachers and youth?	We assist parents to increase their self-esteem and their knowledge of health and other relevant resources for home and school.	Obtain permission for clients to share their stories (e.g., speak to other IIF participants, City staff and other professional groups).	Explore having clients sign consent forms to participate.	Jan. 2015
	...being aware of and monitoring upcoming legislation and government initiatives to identify and influence change that incorporates a mental health promotion approach?	TPH's IIF Public Health Nurses team identified youth mental health as a learning need.	Increase staff understanding of youth mental health and related issues.	Offer professional development opportunities.	2014
	...implementing client or staff surveys to assess organizational climate?	We conducted two-part qualitative research on "Let's Talk" groups. We first assessed project partners' communications. We then held client perceptions focus groups. The partner data was then analyzed: results showed the importance of communication among partners.	Analyze the client data and data from the project partners in the months ahead to inform project improvements.	Have the "Let's Talk" and Project Partner Workgroup (LTPPW) review this data.	Dec. 2014
	...working with management, students and staff to create a health promoting school and workplace?	Healthy Communities, another directorate in TPH, works with schools and workplaces more directly than the IIF project.			
	...identifying policy initiatives to influence school culture?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
9. Does your initiative demonstrate a long-term commitment to program planning, development and evaluation by...	...conducting a situational assessment to inform design of an intervention (considering diversity of the population, its strengths and assets)?	Situational assessments have been conducted by all partners.	Continue to promote a standardized approach for project operations.	Organize meetings to compare practices and examine statistics.	Ongoing
	...clearly defining for whom the programs, interventions and policies are intended?	See above.			
	...involving members of the intended audience in program design and implementation?	Client feedback from home visits and groups is obtained using the Results Based Accountability (RBA) Framework principles tool. Questions in the tool ask: • How much did we do? • How well did we do it? • How hard did we try? • What change did we produce?	Conduct additional evaluations that support this project.	Look at data gathered from clients to inform future research directions.	Ongoing
	...ensuring length and intensity of the program is appropriate for the population and achieves intended outcomes?	The length of the project is determined by TESS as funder. The intensity of TPH nursing interventions is assessed by the nurses involved in the project.	Advocate for the project to continue with funding in place to continue beyond the current funding cycle and confirm staffing allocations from partnering organizations.	Continue to evaluate RBA practices, collect and analyze data on the project's impact on clients (from TESS and clients) and advocate for appropriate staffing to maintain the multiple components of the project.	Ongoing, data analysis by end of 2014

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	...continuously revising objectives to ensure progress toward goals?	We have work groups that inform planning. They include: • a city-wide program planning committee • IIF project partners and Let's Talk work group • ad hoc work groups (e.g., Modified Food Handlers Steering Work Group under the auspices of the Healthy Environments Directorate and Peer Nutrition Program).	Continue to develop project-specific guidelines. Be inclusive of all project partners.	Continue with current work groups.	Ongoing
	...ensuring data collection methods and mechanisms are in place?	Using RBA, we request feedback from home visits and "Let's Talk" group participants.	Collaborate internally with Performance and Standards Directorate to collate feedback from clients. Increase feedback from clients who received home visit services.	Review potential alternative strategies to obtain feedback from people who have received home visits.	Ongoing
	...outlining an evaluation process that states outcomes clearly, and considers outcome and process indicators?	See above.			
	...drawing on various disciplines?	According to Gina Browne's research, the project draws on health promotion, employment retraining and recreation activities for children.	Continue to collaborate with our project partners to meet project goals.	Run two to three multidisciplinary professional development days.	Dec. 2014
	...reviewing and using successful research-based programs, interventions and policies?	The IIF project is based on the research conducted by Dr. Gina Browne and colleagues.	Receive an update from the primary researcher Dr. Gina Browne.	Organize a professional development day with Gina Browne as a speaker.	June 2014

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	... exchanging knowledge with a deliberate commitment to sharing best and promising practices	The IIF initiative was presented at the Community Health Nurses Conference in June 2014. We had a professional development day with project partners to exchange information, learnings, barriers, etc.	Apply for an IPAC/ Deloitte Public Sector Leadership Award and present it at the International Council of Nurses Conference in South Korea in June 2015. Continue to have annual professional development days with partners. Submit an article to a nursing / social science journal.	Receive award and present at international conference. Offer regular annual professional development days.	June 2015 Summer 2015 Submit late 2014
	...other means?				
10. Does your initiative ensure that information and services provided are culturally appropriate, equitable and holistic by...	... facilitating access for parents and children to culturally relevant, supportive social networks?	We use interpretation services as needed both for individual and group interventions.	Offer at least one language-specific "Let's Talk" group series.	Promote this "Let's Talk" group series as an option with our project partners.	Dec. 2014
	... providing relevant information in an understandable and culturally appropriate manner?	From the qualitative findings of our previous research on "Let's Talk" groups, staff and clients saw our project as providing an opportunity to learn about Canadian systems and services, cultural norms and food, and as a place for participants to practise English: this experience helped them become more confident and comfortable being part of social networks and involved in the community.	Implement recommendations from the "Let's Talk" client evaluation.	Include project partners in implementing "Let's Talk" client evaluation recommendations and in further development of the "Let's Talk" initiative.	Dec. 2015

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What would you like your initiative to further achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
	... facilitating participation from minority groups?	"Let's Talk" groups are provided city-wide for clients in the IIF project living in at-risk neighbourhoods across Toronto. The "Let's Talk" group is culturally diverse.	Continue to offer "Let's Talk" across Toronto and increase participation in "Let's Talk" groups.	Engage project partners in recruiting "Let's Talk" participants.	Ongoing
	... considering the possible consequences to families who are socially disadvantaged?	Clients are referred to the project partners (TPH and PFR) by TESS and all receive social assistance through the Ontario Works program. Taking a comprehensive approach, all project partners offer home or community visits and participate in group interventions to address the needs of IIF families.	Work with our project partners to increase the number of referrals to public health nursing services and increase the number of "Let's Talk" participants.	Continue to have public health nurses lead group interventions and brainstorm recruitment strategies with our partners.	Dec. 2014
	... considering the person as a whole (taking into account the physical, emotional, spiritual, mental and social factors that affect their mental health)?	Public health nurses visit families, provide group intervention and conduct assessments to help clients set goals.	Increase the number of face-to-face contacts with families.	Develop marketing tools specific to the IIF project that reflect culturally and linguistically diverse communities.	June 2015
	... providing a holistic and integrative approach to dealing with mental health issues?	Qualitatitve research of clients and staff identified "Let's Talk" as filling a gap in the mental health support service system by addressing social isolation related to depression and anxiety. Group participants also gain strategies for coping with stress.	Focus on youth mental health issues and offer "Let's Talk" groups for youth in the IIF project.	Provide professional development opportunities to staff in the IIF project to enhance knowledge of youth mental health.	Dec. 2014
	... other means?				

Appendix 2

Glossary

Access/accessibility: A measure of the proportion of a population that can access appropriate health services. For example, cultural accessibility considers whether access to health services is hindered by cultural taboos, language or cultural beliefs and values.

Best practices: "Methods and procedures found to be most effective. Best practices are not rules, laws or standards which people are required to follow. . . . Best practices are to be used as a guide to help a person be aware of that which is known to work and that which has inherent pitfalls" (Association TransCommunication, n.d.).

Capacity and capacity building: Work that strengthens the capability of communities to develop their structures, systems, people and skills so that they are better able to define and achieve their objectives, engage in consultation and planning, manage community projects and forge partnerships. It includes aspects of training, organizational and personal development and resource building organized in a planned and self-conscious manner, reflecting the principles of empowerment and equality (Skinner, as cited in Bush, 1999).

Community capacity: The interaction of organizational resources and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community. Community capacity may operate through formal social processes and/or organized efforts by individuals, organizations and social networks that exist among them and between them and the larger systems of which the community is a part (Chaskin & Brown, 1996).

Community: "A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, [and] are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been

developed by the community in the past and may be modified in the future. They show some awareness of their identity as a group, and share common needs and a commitment to meeting them" (WHO, 1998, p. 15).

Community action: The collective efforts of communities directed toward increasing community control over the determinants of heath and thereby improving the health status of the community as a whole.

Community development: Any action that engages community members with the potential to positively transform local conditions. Community development should emphasize building social relationships and communication networks, and contribute to the social well-being of community members.

Community education (or health education in the community): Health education is concerned not only with communicating information, but also with fostering life skills, confidence and overall community health.

Community needs assessment: A process used to document community needs, concerns or issues in consultation with all parts of the community.

Determinants of health: Are based on the understanding that health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. The term usually refers to non-lifestyle factors such as income, shelter, peace, food and employment.

Equity/inequities: Equity in health status is the presence of the same levels of health even between groups with different levels of socio-economic status (e.g., wealth, power, prestige). Inequities in health are the differences in the health outcomes of specified populations that are "systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill" (Whitehead, 1992, pp. 429–445).

Health: "A state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities" (WHO, 1998, p. 1).

Healthy public policy: Characterized by explicit attention to health and equity in all areas of policy development, including non-health sector policies. Healthy public policy should be a collective effort across sectors, directed at creating healthy social and physical environments (WHO, 1988).

Initiatives: Include a broad range of mental health activities, including services, information, campaigns, strategies, research and evaluation.

Mental health promotion: The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity.

Programs: Include a broad range of mental health activities, including services, information, campaigns, strategies, research and evaluation.

Risk factors: Social, political, environmental or biological conditions that are associated with, or cause, increased susceptibility to a specific disease, ill health or injury (WHO, 1998). Risk conditions are usually a result of unhealthy public policy (i.e., substandard housing) and may be modified through collective action and social reform (PHAC, 2006).

Self-efficacy: Perceived self-efficacy is people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave (Bandura, 1994).

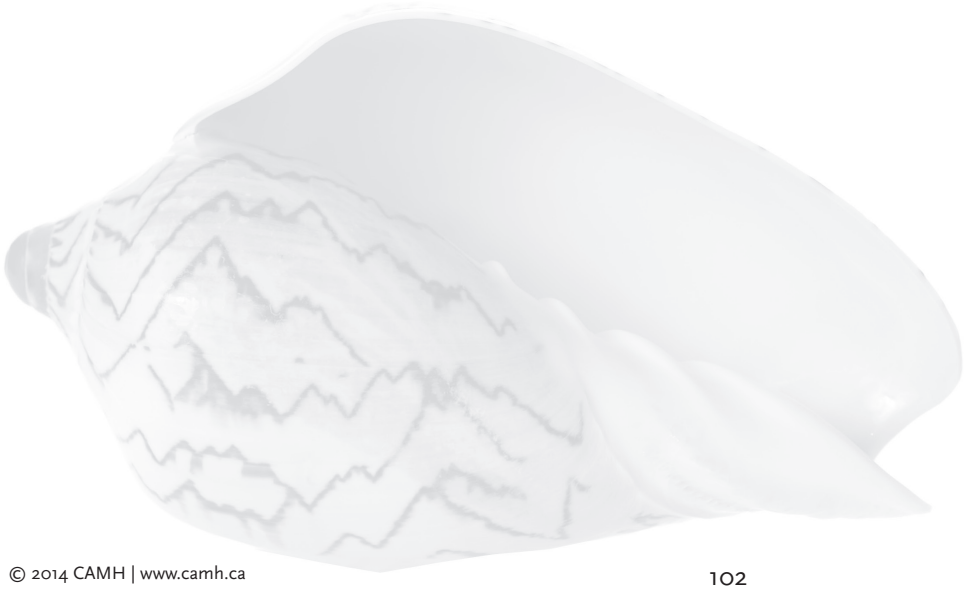
Social capital: Refers to "the resources available to people and to society that are provided through social relationships and networks. This fosters a sense of neighbourliness, mutual trust, shared values and cooperation amongst network members" (CMHA Ontario et al., 2012).

Social connectedness: Connections to family, school and community groups, clubs and organizations, as well as informal relationships with people—family, friends, teachers and youth workers.

Social inclusion: This means "feeling you belong, are valued and respected and able to take part in your community and benefit equally from what your community has to offer" (CMHA Ontario et al., 2012).

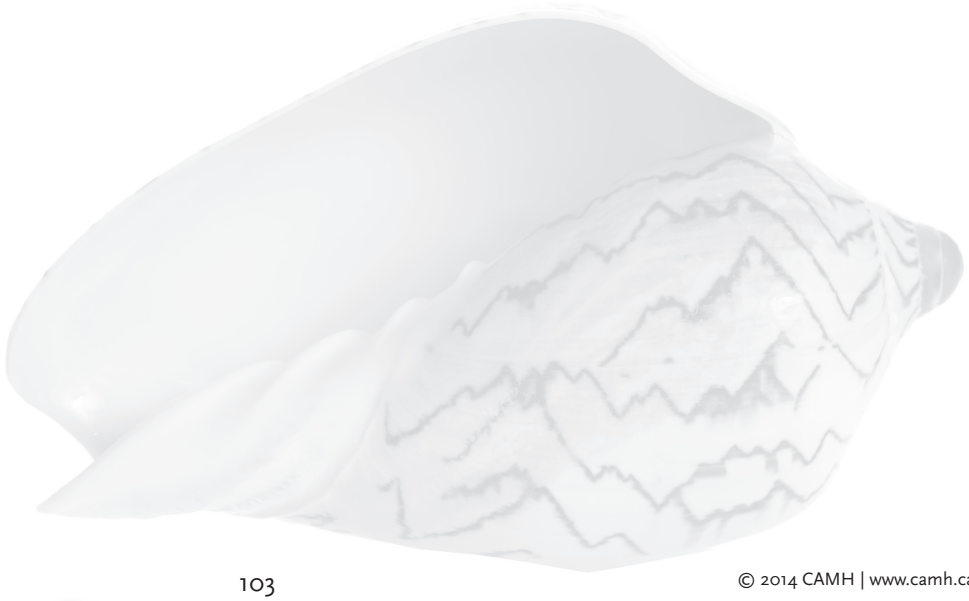
Social support networks: Assistance available to individuals from friends, family, co-workers and others within the community that can provide a buffer against adverse life events and living conditions and can provide a positive resource for enhancing quality of life (WHO, 1998).

Stigma: Negative attitudes and stereotypes held against a group of people, often because of their gender, sexual identity, ethnic or racial background, ability or mental health status.



References and bibliography

This section includes a reference list of works cited in this document, and a separate bibliography of other works that were consulted in developing this material.



References

Association TransCommunication. (n.d.). Best practices. In *Glossary of Terms Related to Phenomena*. Retrieved from http://atransc.org/theory/terms_a-l.htm

Bandura, A. (1994). Self-efficacy. In V.S. Ramachaudran (Ed.), *Encyclopaedia of Human Behaviour* (Vol. 4) (pp. 71–81). New York: Academic Press.

Barankin, T. & Khanlou, N. (2007). Enhancing resilience: Environmental factors. In *Growing Up Resilient: Ways to Build Resilience in Children and Youth* (pp. 69–84). Toronto: Centre for Addiction and Mental Health.

Barnaby, L., Penn, R. & Erickson, P.G. (2010). *Drugs, Homelessness & Health: Homeless Youth Speak Out about Harm Reduction—The Shout Clinic Harm Reduction Report, 2010*. Toronto: Wellesley Institute. Retrieved from www.wellesleyinstitute.com/wp-content/uploads/2010/02/homelessyouthspeakout_shoutclinic2010_v2.pdf

Boak, A., Hamilton, H.A., Adlaf, E.M. & Mann, R.E. (2013). *Drug Use among Ontario Students, 1977–2013: OSDUHS Highlights* (CAMH Research Document Series no. 37). Toronto: Centre for Addiction and Mental Health. Retrieved from www.camh.ca

Bond, L., Glover, S., Godrey, C., Butler, H. & Patton, G. (2001). Building capacity for system-level changes in schools: Lessons from the Gatehouse Project. *Health Education and Behavior, 28*, 368–383.

Bush, R. (1999, October). *Achievements, Experiences and Opportunities for the Future: Capacity Building and Public Health*. Presentation at a New South Wales health capacity-building forum, Sydney, Australia.

Canadian Council on Social Development. (2006) *The Progress of Canada's Children and Youth 2006*. Kanata, ON: Author. Retrieved from www.ccsd.ca/resources/ProgressChildrenYouth/pdf/pccy_portrait.pdf

Canadian Institute for Health Information. (2009). *Improving the Health of Canadians: Exploring Positive Mental Health*. Ottawa: Author. Retrieved from https://secure.cihi.ca/free_products/mh_report_13Feb2009_e.pdf

Canadian Mental Health Association (CMHA) Ontario. (2009). *What is Mental Health and Mental Illness?* Retrieved from http://wmhp.cmhaontario.ca/workplace-mental-health-core-concepts-issues/what-is-mental-health-and-mental-illness#_ftn3

Canadian Mental Health Association (CMHA) Ontario, Centre for Addiction and Mental Health, Ontario Lung Association & OPHEA. (2012). *YouThrive: Supporting Communities to Create Places Where All Youth Thrive*. Retrieved from www.youthrive.ca

Canadian Public Health Association. (1998). *Documenting Projects, Activities and Policies in the Field of Mental Health Promotion in Association with CMHA.* Ottawa: Author.

Caxaj, S. & Berman, H. (2010). Belonging among newcomer youths: Intersecting experiences of inclusion and exclusion. *Advances in Nursing Science, 33* (4), E17–E30.

Centre for Addiction and Mental Health (CAMH). (2012). *Mental Health Promotion for Youth in Canada*. Retrieved from www.hclinkontario.ca/images/Youth_MHP_Report_FINAL.pdf

Chaskin, R. & Brown, P. (1996). Theories of neighborhood change. In R. Stone (Ed.), *Core Issues in Comprehensive Community-Building Initiatives* (pp. 1–15). Chicago: Chapin Hall Center for Children, University of Chicago.

Commonwealth Department of Health and Aged Care (CDHAC). (2000). *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*. Canberra, Australia: Commonwealth of Australia. Retrieved from www.health.gov.au

Craig, W. & McCuaig Edge, H. (2008). Bullying and fighting. In W. Boyce, M. King & J. Roche (Eds.), *Healthy Settings for Young People in Canada* (pp. 91–104). Retrieved from www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/yjc/ch5_105_108-eng.php

Craig, W. & McCuaig Edge, H. (2011). Bullying and fighting. In J.G. Freeman, M. King & W. Pickett (Eds.), *The Health of Canada's Young People: A Mental Health Focus* (pp. 167–184). Retrieved from www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/hbsc-mental-mentale/bullying-intimidation-eng.php

Derevensky, J. & Gupta, R. (1999). Youth gambling problems: A new issue for school psychologists. *Nova Scotia Psychologist, 12* (11), 8–11.

Elton-Marshall, T., Leatherdate, S. & Burkhalter, R. (2011). Tobacco, alcohol and illicit drug use among Aboriginal youth living off-reserve: Results from the Youth Smoking Survey. *Canadian Medical Association Journal, 183* (8), E480–E486. doi: 10.1503/cmaj.101913

Epp, J. (1986). *Achieving Health for All: A Framework for Health Promotion*. Ottawa: Health and Welfare Canada. Retrieved from www.hc-sc.gc.ca

Freeman, J.G., King, M., Pickett, W. & Craig, W. (2011). *The Health of Canada's Young People: A Mental Health Focus*. Retrieved from www.phac-aspc.gc.ca

Government of Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada 2006*. Ottawa: Author. Retrieved from www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php

Government of Ontario. (2009). *Every Door Is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy—A Discussion Paper*. Toronto: Author. Retrieved from www.health.gov.on.ca

Government of Ontario. (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Toronto: Author. Retrieved from www.health.gov.on.ca

Health and Welfare Canada. (1988). *Mental Health for Canadians: Striking a Balance*. Ottawa: Supply and Services Canada.

Health Canada. (2000). *Risk, Vulnerability, Resilience: Health System Implications*. Ottawa: Supply and Services Canada.

International Centre for Youth Gambling Problems and High-Risk Behaviors. (2013). *Public Health and Prevention*. Retrieved from www.youthgambling.com

Jané-Llopis, E. & Barry, M. (2005). What makes mental health promotion effective? *Global Health Promotion, 12* (2), 47–54. doi: 10.1177/10253823050120020108

Joubert, N. & Raeburn, J. (1998). Mental health promotion: People, power and passion. *International Journal of Mental Health Promotion, 1* (1), 15–22.

Joubert, N., Taylor, L. & Williams, I. (1996). *Mental Health Promotion: The Time Is Now*. Ottawa: Health Canada.

Kirmayer, L., Boothroyd, L., Laliberte, A. & Simpson, B.L. (1999). *Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities*. Montreal: Institute of Community and Family Psychiatry, Jewish General Hospital. Retrieved from www.mcgill.ca/files/tcpsych/Report9_Eng.pdf

Klinger, D., Mills, A. & Chapman, A. (2011). School. In J. Freeman, M. King & W. Picket (Eds.), *The Health of Canada's Young People: A Mental Health Focus* (pp. 47–66). Retrieved from www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/hbsc-mental-mentale/school-ecole-eng.php

Lalonde, M. (1974). *A New Perspective on the Health of Canadians*. Ottawa: Minister of Supply and Services Canada.

McCreary Centre Society. (2007). *Not Yet Equal: The Health of Lesbian, Gay, and Bisexual Youth in B.C.* Vancouver: Author. Retrieved from http://mcs.bc.ca/pdf/not_yet_equal_web.pdf

Mental Health Commission of Canada. (2012). *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. Calgary, AB: Author. Retrieved from http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf

Ogrodnik, L. (2010). *Child and Youth Victims of Police-Reported Violent Crime, 2008.* (Statistics Canada catalogue no. 85F0033M, no. 23). Ottawa: Minister of Industry. Retrieved from www.statcan.gc.ca/pub/85f0033m/85f0033m2010023-eng.pdf

Paglia-Boak, A., Mann, R.E, Adlaf, E.M., Beitchman, J.H., Wolfe, D. & Hamilton, H.A. (2011). *OSDUHS Highlights: The Mental Health and Well-Being of Ontario Students, 1991–2011.* Retrieved from www.camh.ca

Public Health Agency of Canada (PHAC). (2006). *The Human Face of Mental Illness and Mental Health in Canada*. Retrieved from www.phac-aspc.gc.ca

Shaffer, H., Hall, M. & Vander Bilt, J. (1999). Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health*, *89*, 1369–1377. doi: 10.2105/AJPH.89.9.1369

Shayka, Y.B., Khanlou, N. & Gonsalves, T. (2010). *Determinants of Mental Health for Newcomer Youth: Policy and Service Implications.* Retrieved from http://accessalliance.ca

Solin, P. (2006). The determinants of mental health: A qualitative analysis of health policy documents. *International Journal of Mental Health Promotion, 8* (2), 3–11.

Statistics Canada. (2010). Children and youth. In *Canada Year Book 2009*. Retrieved from www41.statcan.ca/2009/20000/cybac20000_000-eng.htm

Statistics Canada. (2012). *The Canadian Population in 2011: Population Counts and Growth. Population and Dwelling Counts, 2011 Census*. (Catalogue no. 98-310-X2011001). Retrieved from www12.statcan.gc.ca/census-recensement/2011/as-sa/98-310-x/98-310-x2011001-eng.pdf

Statistics Canada. (2013a). *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit. National Household Survey 2011.* (Catalogue no. 99-011-X2011001). Retrieved from www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.pdf

Statistics Canada. (2013b). *Immigration and Ethnocultural Diversity in Canada. National Household Survey 2011.* (Catalogue no. 99-010-X2011001). Retrieved from www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf

Taylor, C., Peter, T., McMinn, T.L., Elliott, T., Beldom, S., Ferry, A., . . . Schachter, K. (2011). Every Class in Every School: The First National Climate Survey on Homophobia, Biphobia, and Transphobia in Canadian Schools: Final Report. Toronto: EGALE Canada. Retrieved from http://egale.ca/wp-content/uploads/2011/05/EgaleFinalReport-web.pdf

Totten, M. (2009). Aboriginal youth and violent gang involvement in Canada: Quality prevention strategies. *IPC Review, 3*, 135–156. Retrieved from http://sciencessociales.uottawa.ca/ipc/fra/documents/IPCR3Totten.pdf

Waddell, C., McEwan, K., Peters, R.D., Hua, J.M. & Garland, O. (2007). Preventing mental disorders in children: A public health priority. *Canadian Journal of Public Health, 98* (3), 174–178.

Westerhof, G.J. & Keyes, C.L.M. (2009). Mental illness and mental health: The two continua model across the lifespan. *Journal of Adult Development, 17*, 110–119. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2866965/

Whitehead, M.M. (1992). The Concepts and Principles of Equity and Health. *International Journal of Health Services, 22* (3), 429–445.

Willinsky, C. & Anderson, A. (2003). *Analysis of Best Practices in Mental Health Promotion across the Lifespan: Final Report*. Toronto: Centre for Addiction and Mental Health & Toronto Public Health.

World Health Organization (WHO). (1986). *Ottawa Charter for Health Promotion*. Geneva, Switzerland, & Ottawa: WHO & Canadian Public Health Association. Retrieved from www.phac-aspc.gc.ca

World Health Organization (WHO). (1988, April). *Adelaide Recommendations on Healthy Public Policy: Proceedings from the Second International Conference on Health Promotion*. Adelaide, South Australia. Retrieved from www.who.int/healthpromotion/conferences/previous/adelaide/en/index.html

World Health Organization (WHO). (1998). *Health Promotion Glossary*. Geneva, Switzerland: Author. Retrieved from http://whqlibdoc.who.int/hq/1998/WHO_HPR_HEP_98.1.pdf

World Health Organization (WHO). (2009). *Milestones in Health Promotion: Statements from Global Conferences*. Geneva, Switzerland: Author. Retrieved from www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf

World Health Organization (WHO). (2014). *Strengthening Our Response*. (Fact sheet no. 220). Geneva, Switzerland: Author. Retrieved from www.who.int/mediacentre/factsheets/fs220/en/

Bibliography

Boyce, W.F., King, M.A. & Roche, J. (2008). *Healthy Settings for Young People in Canada*. Ottawa: Minister of Health. Retrieved from www.phac-aspc.gc.ca

Centre for Addiction and Mental Health (CAMH). (2007). *Challenges and Choices: Finding Mental Health Services in Ontario*. Toronto: Author. Retrieved from www.camh.ca/en/education/about/camh_publications/Pages/Challenges_Choices.aspx

Centre for Addiction and Mental Health (CAMH). (2012). *Culture Counts: A Roadmap to Health Promotion*. Retrieved from www.camh.ca/en/hospital/about_camh/health_promotion/culture_counts/Pages/culture_counts_roadmap_health_promotion.aspx

Criminal Intelligence Service Canada. (2006). General trends. In *Annual Report 2006*. Ottawa: Author. Retrieved from www.cisc.gc.ca/annual_reports/annual_report_2006/general_trends_2006_e.html

Dupéré, V., Lacourse, E., Willms, J.D., Vitaro, F. & Tremblay, R.E. (2007). Childhood behavioral profiles and adolescents' affiliation to youth gangs: The moderating impact of neighborhood and family environmental adversity. *Journal of Abnormal Child Psychology, 35*, 1035–1045.

Economic and Social Development Canada. (2013). *Canadians in Context: Aboriginal Population*. Retrieved from www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=36

GermAnn, K. & Ardiles, P. (2009). *Toward Flourishing for All... Mental Health Promotion and Mental Illness Prevention Policy Background Paper.* Retrieved from www.utoronto.ca/chp/mentalhealthpdffinal/Toward%20Flourishing%20Background%20Paper%20Final%20Apr%2009.pdf

Health Canada. (2002). *A Statistical Profile on the Health of First Nations in Canada*. Ottawa: Author. Retrieved from www.hc-sc.gc.ca/fniah-spnia/intro-eng.php

Moukas, E. (2004). A review of selected literature on effective best practices in suicide prevention. In *Mental Health Promotion Compendium*. Toronto: Toronto Public Health.

Public Health Group (Australia). (2006). *Evidence-Based Mental Health Promotion Resource*. Melbourne, Australia: Author. Retrieved from www.gwhealth.asn.au/data/mental_health_resource.pdf