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INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
NURSING THROUGH
KNOWLEDGE

Clinical Best
Practice Guidelines

REVISED DECEMBER 2010

Enhancing Healthy Adolescent Development

RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

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Greetings from Doris Grinspun,

Executive Director Registered Nurses' Association of Ontario

It is with great excitement that the Registered Nurses' Association of Ontario (RNAO) disseminates this revised guideline, *Enhancing Healthy Adolescent Development,* to the health-care community. Evidence-based practice supports the excellence in service that nurses are committed to delivering in our day-to-day practice. RNAO is delighted to provide this key resource to you.

RNAO offers its heartfelt thanks to the many individuals and institutions that are making our vision for Nursing Best Practice Guidelines (BPGs) a reality: the government of Ontario for recognizing our ability to lead the program and providing multi-year funding; Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines (IABPG) Programs and the Centre for Nursing Excellence, for her expertise and leadership in advancing the production of the BPGs; each and every Team Leader involved. For this revised BPG in particular, we thank Joyce Fox for her superb stewardship, commitment and, above all, exquisite expertise. Also thanks to Frederick Go, RNAO's IABPG Program Manager, for his intense work in leading the revision of this guideline. A special thanks to the BPG Revision Panel, as well as the original development panel; we respect and value your expertise and volunteer work. To all, we could not have done this without you!

The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the development, implementation, evaluation and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementation and evaluating the guidelines, and working toward a culture of evidence-based practice.

Successful uptake of these guidelines requires a concerted effort from nurse clinicians and their healthcare colleagues from other disciplines, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students require healthy and supportive work environments to help bring these guidelines to practice actions.

We ask that you share this updated guideline with members of your interdisciplinary team, as there is much we can learn from one another. Together, we can ensure that the public receives the best possible care each time they come in contact with the healthcare system. Let's make **them** the real winners in this important effort!

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How to Use this Document

This nursing best practice guideline is a comprehensive document that provides the resources necessary for the support of evidence-based nursing practice. The document must be reviewed and applied, based on the specific needs of the organization or practice setting/environment and the needs of clients. Guidelines should not be applied in a "cookbook" fashion; rather, they should be used as a tool to assist in decision-making for individualized client care, while ensuring that appropriate structures and supports are in place to provide the best care possible.

Nurses, other healthcare professionals and administrators who are leading and facilitating practice changes will find this document invaluable for the development of policies, procedures, protocols, educational programs, and assessment and documentation tools. It is recommended that the nursing best practice guidelines be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process used to develop the guidelines. However, it is highly recommended that practice settings/environments adapt these guidelines in user-friendly formats for daily use. Indeed, these guidelines contain suggested formats for such local adaptation and tailoring.

Organizations who wish to use the guideline may decide to do so in the following ways:

- Assess current nursing and healthcare practices using the recommendations in the guideline.
- Identify recommendations that address identified needs or gaps in services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

The RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story. Implementation resources will be made available through the RNAO website (www.rnao.org) to assist individuals and organizations in implementing best practice guidelines.

Purpose and Scope

Best practices are emerging guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific clinical circumstances (Field & Lohr, 1990). Given this definition, best practices are recommendations that may evolve, based on ongoing expert experience, judgment, perspective and continued research (Health Canada, 2008). Best practice guidelines are an accepted method of providing current evidence for nurses to use to guide their practice. These guidelines synthesize the current evidence, and recommend best practices based on the evidence. They offer nurses a reliable source of information, which can be used to make decisions concerning practice.

The nursing profession has long been considered a leader in the area of health promotion and disease prevention. The goal of this document is to assist nurses working with youth in a variety of practice settings, i.e. schools, public health units, community health centres, adolescent clinics, hospitals, and in family practice. Recommendations are inclusive of adolescent development across diverse contexts (e.g. cultural, socioeconomic, structural, political).

This guideline is intended for nurses who are not necessarily experts in the above-mentioned practice areas, and who work in a variety of practice settings across the continuum of care. It is acknowledged that individual competencies vary between nurses and across categories of nursing professionals. Individual competencies are based on knowledge, skills, attitudes, critical analysis and decision-making, which are enhanced over time by experience and education. It is anticipated that the information contained in this best practice guideline will reinforce the value of initiatives already being implemented and stimulate interest in incorporating additional approaches. Furthermore, it is intended that this guideline will be applicable to all domains of nursing, including practice, administration, policy, education and research.

While focusing on nursing practice, this guideline is relevant to all disciplines, and supports an interprofessional approach to enhancing healthy adolescent development. This approach is consistent with the primary healthcare framework promoted by the World Health Organization (2008). The intention is that by utilizing best and promising practices regarding youth development, nurses and others can make a difference more often, for more youth, across diverse settings.

Summary of Recommendations

Practice Recommendations

	RECOMMENDATION	*Type of Evidence
1	When working with youth, nursing interactions will be grounded in principles of respect, confidentiality, trust and transparency. Nurses will acknowledge youth's strengths and potentials while building on collaborative partnerships.	IV
2	Nurses working with youth will utilize a comprehensive, collaborative, multifaceted approach to promote therapeutic partnerships and enhance positive youth development.	III-IV
3	Nurses will employ youth engagement approaches to foster positive youth development.	III-IV
4	Nurses will apply the principles of positive youth development in working with youth and other members of the healthcare team to develop the necessary skills and knowledge needed to successfully transition care to the adult-oriented healthcare system.	III-IV
5	Nursing practice will be informed by evidence-based theoretical models.	IV
6	Nurses engaged in the design, implementation and evaluation of programs for youth will base decisions on evidence reflecting the elements of effective program planning and design.	III-IV

Education Recommendations

	RECOMMENDATION	
7	Nurses who work with adolescents will have specific knowledge and skills related to adolescent development, health and well-being.	III-IV

* Please refer to page 8 for details regarding Types of Evidence

** For those practicing outside Ontario, please check within your jurisdiction.

Organization & Policy Recommendations

	RECOMMENDATION	Type of Evidence
8	Organizations establish a culture that supports youths' active engagement in creating a healthy future for themselves and their community.	IV
9	Organizations establish internal policies and practices that support meaningful youth participation.	IV
10	Agencies and funders allocate appropriate staffing and material resources to enable implementation of comprehensive approaches to adolescent programming.	Ia, III-IV
11	Organizations provide educational opportunities for nurses to improve their understanding of adolescent development, health and well-being, and ways to engage youth in meaningful ways.	III-IV
12	Nurses work in partnership with youth to advocate for healthy public policy and the development, implementation and evaluation of programs that serve to enhance healthy adolescent development. Ministries responsible for health, community, education and recreation must dedicate resources to ensure the implementation and evaluation of services directed at improving the success and well-being of youth across the province.	IV
13	Nurses collaborate with a variety of community partners to promote the comprehensive school health model.	IIb-IV
14	Nursing best practice guidelines can be successfully implemented only when there are adequate planning, resources, organizational and administrative supports, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: ■ An assessment of organizational readiness and barriers to implementation. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Dedication of a qualified individual to provide the support needed for the education and implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. In this regard, a panel of nurses, researchers, and administrators developed the Toolkit: Implementation of Clinical Practice Guidelines based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline *Enhancing Healthy Adolescent Development.*	IV

BACKGROUND

Interpretation of Evidence

Types of Evidence

- Ia Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
- Ib Evidence obtained from at least one randomized controlled trial.
- IIa Evidence obtained from at least one well-designed controlled study without randomization.
- IIb Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.
- III Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
- IV Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

See Glossary, page 12, for definitions of terms.

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Glossary of Terms

Adolescence: The period of transition from childhood to adulthood, and can be divided into early (ages 11 to 14), mid (ages 15 to 17), and late (ages 18 to 21) adolescence.

Adult-Youth Partnership: Partnership that results "when youth and adults work together as a team to make decisions that affect their lives. Both adults and youth have the opportunity to make suggestions, decisions and recommendations." (Khanna & McCart, 2007, p.2)

Advocacy: To give a voice to youth's belief, values and wishes in all phases of health promotion – including program planning and evaluation – and networking with youth stakeholders.

Anticipatory Guidance: An approach that prepares youth and their families for expected stressful events before they occur. Nurses employing such an approach by provide counselling to parents and helping them understand the developmental challenges their adolescent may encounter as they move toward adulthood.

Asset Development/Developmental Asset: The relationships, opportunities and personal qualities that young people need to avoid risks and to thrive (Search Institute, 2006).

At-Risk Youth: A segment of the population that under current conditions has a low probability of growing into responsible adulthood. At risk youths experience difficulties with their family, in school and in the community; however, the factors that place these youth at risk are often not of their own doing (Youth Services Steering Committee, 2002).

Clinical Practice Guidelines/Best Practice Guidelines: Systematically developed statements to assist healthcare practitioner and patients to make decisions about appropriate health care under specific clinical (practice) circumstances (Field & Lohr, 1990).

Collaboration: A process used to create effective partnerships. Conditions critical for success include: early and continuing clarification of project goals and activities; mutual trust; commitment to community decision-making processes; commitment to mutual consultation; and maximization of local ownership opportunities.

Community Involvement: Involvement of young people in their community and the interaction between community members with youth. Creating opportunity for community involvement is a successful and innovative way of advancing community change (Restuccia & Bundy, 2003).

Comprehensive School Health: A framework to support improvement in students' educational outcomes while addressing school health in a planned, integrated and holistic way. Comprehensive school health (Joint Consortium for School Health, 2008):
- Recognizes that healthy young people learn better and achieve more.
- Understands that schools can directly influence students' health and behaviours.
- Encourages healthy lifestyle choices, and promotes students' health and well-being.
- Incorporates health into all aspects of school and learning.
- Links health and education issues and systems.
- Requires the participation and support of families and the community at large.

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Empowerment: "A multi-level construct consisting of practical approaches and applications, social action processes, and individual and collective outcomes. In the broadest sense, empowerment refer to individuals, families, organizations and communities gaining control and mastery, within the social, economic, and political context of their lives, in order to improve equity and quality of life." (Jennings, Parra-Medina, Messias, & McLoughlin, 2006, p.32)

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research provide the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigor with expedience, while privileging the former over the latter (Canadian Health Services Research Foundation, 2006, p.11).

Family: Whomever the person defines as being family. Family members can include parents, children, siblings, partners, neighbours, and significant people in the community.

Health Organization: Any agency, institution or facility with a mandate to provide health-related services and programs, including hospitals, public health units, community-based programs, primary care settings and correctional centre health clinics.

Health Promotion: The process of enabling people to increase control over, and to improve, their health. Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. The World Health Organization (1998) noted that participation is essential to sustain health promotion action, and identified six key strategies for health promotion: 1) building healthy public policy; 2) creating supportive environments; 3) strengthening community action; 4) developing personal skills; 5) reorienting health services; and 6) moving into the future.

Interdisciplinary: Refers to a range of collaborative activities undertaken by a team of two or more individuals from different disciplines applying the methods and approaches of their respective disciplines (Canadian Collaborative Mental Health Initiative, 2005). Approaches that analyze, synthesize and harmonize links between disciplines into a coordinated and coherent plan of care (Choi & Pak, 2006).

Mentoring: Involves a voluntary, mutually beneficial and usually long-term professional relationship (Canadian Nurses Association, 2005).

Organization and Policy Recommendations: Statements of conditions required for a practice setting that enable the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Participatory Evaluation: An evaluation process whereby young people actively collaborate with adults to examine the issues that affect their lives. They participate in all phases of the evaluation, build their capacities in evaluation skills, generate knowledge and make decisions that result in meaningful change in their communities (Suleiman, Soleimanpour & London, 2006).

Positive Youth Development: A set of strategies "which any program or program model can adopt to help guide youth on a successful transition to adulthood. It is an approach that provides youth with the broadest possible support, enabling them to attain desirable long-term outcomes, including economic self-sufficiency and engagement in healthy family and community relationships." (Restuccia & Bundy, 2003)

Practice Recommendations: Statements of best practice directed at the practice of healthcare professionals that are ideally evidence based.

Protective Factors: Attributes, both internal and external, that help to prevent youth from becoming involved in at-risk behaviours.

Resiliency: "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)

Risk Behaviours: Specific behaviours that are associated with increased susceptibility to a specific disease or ill health (Youth Services Steering Committee, 2002).

Risk Factors: Conditions or variables that lower an adolescent's likelihood of achieving positive outcomes and increase the likelihood of negative or socially undesirable outcomes (World Health Organization, 2004).

Social Determinants of Health: The economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole. Drawing from the Ottawa Charter for Health Promotion, the Public Health Agency of Canada (2008) identified 12 key issues regarding determinants of health: 1) income and social status; 2) social support networks; 3) education and literacy; 4) employment/working conditions; 5) social environments; 6) physical environments; 7) personal health practices and coping skills; 8) healthy child development; 9) biology and genetic endowment; 10) health services; 11) gender; and 12) culture.

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Strategy: A systematic plan of action to reach pre-defined goals.

Therapeutic Partnership: A youth-adult partnership structure grounded in support for one another while working toward an agreed-upon outcome. The therapeutic partnership is purposeful and directed toward advancing the best interest and outcome of the youth.

Youth-Centered Counselling: "A process through which one provider and a young client work together to explore and define the young client's problem, situation or challenge, set realistic goals for the counselling relationship and develop approaches to attain those goals." (Vega, Maddaleno, & Mazin, 2005, p.11)

Youth Diversity: Acceptance, understanding, and respect for youths' unique quality in the dimension of age, gender, race, sexual orientation, ethnicity, abilities, belief, and socioeconomic status.

Youth Engagement: Meaningful and sustained involvement of youths in an activity, with a focus outside of themselves (Centre of Excellence for Youth Engagement, 2003). Shen (2006) documented that youth engagement programs that emphasize access, equity and social justice can facilitate positive youth development by:
- providing opportunities for skill development and capacity building;
- providing opportunities for leadership;
- encouraging reflection on identity; and
- developing social awareness.

Background Context

Adolescence can be defined as the state or process of growing up (Merriam-Webster, 2004). Historically, the definition of the period of adolescence has not changed: It is a transitional period from dependence to independence within which the adolescent – having completed the stages of childhood – enters a phase of physical, sexual, intellectual and emotional growth, culminating in adulthood. The Canadian Paediatric Society (2003) maintains that a definition of adolescence based solely on chronological age is unjustified and impractical. Rather, the Society favours a more functional definition based on the biopsychosocial readiness of young people to enter adulthood.

In the literature, adolescence has been divided into early (10 to 14 years), mid (15 to 17 years) and late (18 to 21 years) stages with some researchers extending the final stage to as late as age 24. Setting the upper age boundary is difficult and is subject to cultural variability. In light of ongoing research in brain development, the suggestion that the adolescent brain is different than the adult brain corroborates with what nurses, who work with adolescents, have known clinically for some time— that adolescence is a truly distinct and identifiable period (Arnett, 2006). Throughout this document the terms 'youth' and 'adolescent' will be used interchangeably.

Adolescent Development

Adolescence is a time in one's life when significant biological, cognitive, emotional, social and ethical development occurs. Mastery of a series of interdependent developmental tasks is central to the concept of adolescence as a transition from childhood to adulthood.

Developmental Tasks of Adolescence (Lerner & Galambos, 1998)

1. Achieving increased independence
2. Adjusting to sexual maturation
3. Establishing cooperative relationships with peers
4. Preparing for meaningful vocation
5. Establishing intimate relationships
6. Developing a core set of values and beliefs

Adolescent development has also been characterized as a period during which competencies and assets are gained that will not only contribute to achieving full potential but also to building the foundation for a productive adulthood (Pittman, Irby, Tolman, Yohalem, & Ferber, 2003). The influences of social environment and the context in which adolescents are living have been acknowledged, as have the attributes of programs and settings, to contribute to adolescent development.

Trends in Adolescent Health Status

An increased emphasis on health promotion for adolescents is important for several reasons. According to a 2007 United Nations report on child welfare, Canada ranked twelfth out of 21 wealthy countries based on six factors: material well-being; health and safety; education; peer and family relationships; behaviours; risks; and young people's own subjective sense of well-being. Much of the morbidity and mortality during adolescence is related to unhealthy or risky behaviours (e.g. smoking, drinking and driving, unprotected sexual intercourse, illegal drug use, violence). Since many of these behaviours are

preventable, much research and clinical activity has focused on prevention. In addition, behaviours that begin during adolescence often continue into adulthood; thus, risky or unhealthy behaviours can result in long-term negative health outcomes. Finally, there is solid evidence that risky behaviours can have a cluster effect, i.e. adolescents who engage in one risky behaviour are more likely to engage in other risky behaviours (Alamian & Paradis, 2009). However, much work remains to build universal programs beyond early childhood, develop public policy and increase the focus on prevention in order to promote healthy adolescent development (Adlaf, Paglia-Boak, Beitchman, & Wolfe, 2007; Boyce, 2004; Minister of Public Works and Government Services Canada, 2000).

Historically, much effort has been focused on a deficit-based approach to working with adolescents, i.e. preventing and addressing the problems and risk behaviours of adolescents. It has now recognized that a more holistic adolescent development approach is needed to complement these initiatives and to achieve gains in the health of all adolescents (Eccles & Gooteman, 2002; Youngblade et al., 2007). In addition, a positive youth development approach to addressing adolescent health issues is critical, as it may produce a positive effect on population health outcomes.

Given that many organizational mandates are directed toward specific health issues, it is worthwhile to note the trends in health issues confronting the Canadian adolescent population. Significant health status findings for this population can be summarized as follows:

- Fewer youth identify themselves as having excellent or very good health (Adlaf et al., 2007).
- Although alcohol use has declined, risky practices (e.g. binge drinking) have increased (Canadian Council on Social Development, 2006).
- Tobacco use has declined significantly in younger youth but not to in older youth (Health Canada, 2009).
- Overweight and obesity has nearly doubled over the past two decades (Shields, 2004).
- One-third of youth aged 12 to 14 years report having a chronic condition (Health Canada, 2007).
- Mental-health-related issues are of concern, as one third of school-aged youth report psychological distress and have experienced bullying at school (Adlaf et al., 2007).
- Ten percent of youth report suicidal ideation (Adlaf et al., 2007).
- Aboriginal youth are at particular risk for suicide, with a suicide rate six times higher than that of the general population (Adlaf et al., 2007).
- The number of youth engaging in sexual intercourse has declined slightly, and age at first intercourse has risen slightly for females (Rotermann, 2007).
- Condom use has increased, but the rate for some sexually transmitted infections (STIs) has increased (Public Health Agency of Canada, 2009a).
- Teen pregnancy rates have declined, as have subsequent pregnancies (Rotermann, 2007).
- Lesbian, gay, bisexual and transgender youth remain at higher risk of health issues and are challenged to develop a healthy identify in the face of prejudice, often without support (Wells, 2006).
- Exposure to violence affects the lives of youth, and youth experience the highest rate of assaults reported to police (Nemr, 2009).

Additional information on these issues and data sources are provided in Appendix D.

A significant number of youth have a chronic health condition or a healthcare condition that may have a lifelong impact. Given this prevalence, attention must be paid to ensure that youth develop self-care and disease management knowledge and skills, as well as receives the support needed from the healthcare system. "Children with chronic diseases who live into adulthood have unique challenges. The transition to adulthood within the healthcare system, as well as accessing appropriate resources, can be frustrating." (Health Canada, 2007, p.149)

Influences on Adolescent Health: A Framework

Adolescent development and health status are influenced by multitude of factors, and may have either positive or negative impacts. These factors are interdependent and not only involve individuals themselves, but societal influences and resources, a framework based on a population health model; Figure 1 provides an overview of the important considerations regarding promotion of healthy adolescent development. This framework is founded on the social determinants of health as key underlying elements in adolescent development, and recognizes the underlying conditions that contribute to or impede development.

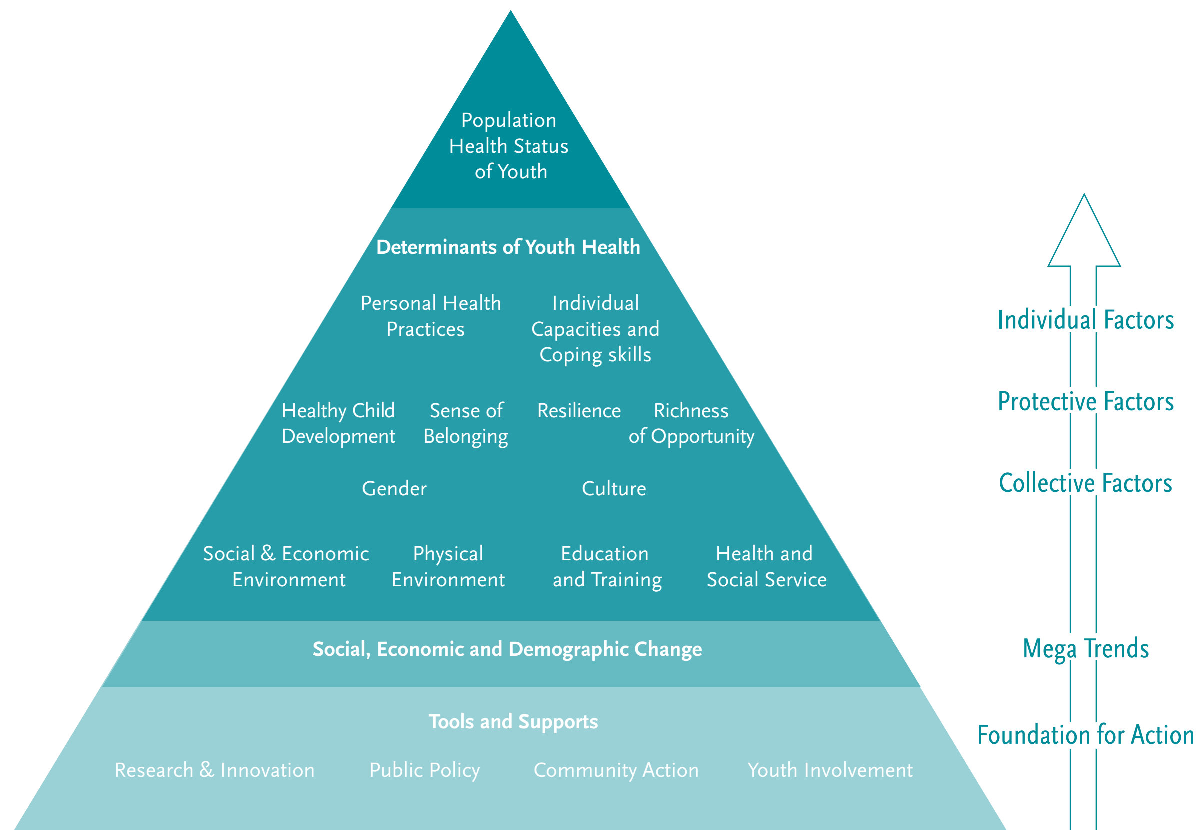

Figure 1: Conceptual Framework for Youth Health Status

(Reprinted with permission from Public Health Agency Canada)

Campbell (2000) described the framework thusly:

> "... a broad set of collective and individual factors, such as income and social status, employment and working conditions, education, social support networks, biological factors, child development, and personal health practices interact to influence health and disease processes directly and indirectly.

> Eliminating social and economic inequities helps to build factors that protect against disease and promote health and well-being. These protective factors, which include resilience (the ability to cope with adversity), meaningful participation in society and social cohesion (mutual caring and a sense of being responsible for one another's well-being), enable individuals to develop their personal resources and capacities to make healthy choices throughout life. The population health model also suggests tools for eliminating inequalities and maximizing population-wide benefits, including information, research and public policy.

Many of the issues facing youth in the future can be framed in relation to individual capacity and coping. In other words, what resources and supports will today's children and youth need in order to develop individual capacity and resilience to meet the challenges they will face in 10 to 20 years? The most critical issues facing youth in coming decades will revolve around broad determinants of health (income and social status, social and economic environment, education, physical environment, employment and working conditions.)" (p.1)

Considerations from the Framework: Social Determinants of Health

Social determinants of health are the economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole. Drawing from the Ottawa Charter for Health Promotion, the Public Health Agency of Canada (2008) identifies 12 key issues in determinants of health: 1) income and social status; 2) social support networks; 3) education and literacy; 4) personal health practices and coping skills; 5) gender; 6) social environments; 7) physical environments; 8) biology and genetics endowment; 9) culture; 10) health services; 11) healthy child development; and 12) employment/working conditions.

Income and Social Status

Income is a determinant of the quality of early life, education, employment, food, quality of housing, the need for a social safety net and social exclusion. It is an incontrovertible fact that poverty affects health; the inability to access such basic needs as food and shelter have profound effects on physical and mental health. People living on the street have the highest risk of premature death. Economic inequality is a significant determinant of health: as the gap widens the health status declines (Canadian Nurses Association, 2005). Regular family income results in good nutrition and a safe place to live. A shortage of food and a lack of variety or excess intake contribute to chronic malnutrition and such chronic diseases as diabetes and obesity (Wilkinson & Marmot, 2003). Emerging evidence demonstrates an association between family income and such aspects of well-being as physical activity levels and youth self-esteem (Abernathy, Webster, & Vermeulen, 2002).

Social Support Networks

Within the youth population, the social safety net encompasses not only those issues that affect the total population – i.e. access to welfare and medical care – but also those unique to adolescence, especially those youth who are homeless due to abuse or neglect, youth with mental health disorders and those who are sexually exploited, lesbian, gay, bisexual, transgendered and questioning (LGBTQ) and parenting youth. Youth services agencies should provide youth with a range of specifically developed services that are integrated, accessible, readily available and multisectoral (Youth Services Steering Committee, 2002). It is essential to engage youth and to value and acknowledge them as the experts regarding their own lives (Youth Services Steering Committee, 2002). Most adolescents transition well into adulthood, i.e. they develop positive relationships and show few adjustment difficulties as they approach and reach maturity; for

others, however, obstacles impede their progress and nurses must be cognizant of issues specific to the adolescent population (Bergman & Scott, 2001; Tilton-Weaver, Vitunski, & Galambos, 2001).

Education and Literacy

School plays a unique role in the lives of adolescents, as it provides not only an opportunity to learn and demonstrate academic achievement but also serves as a social setting. Evidence demonstrates that supportive schools with student-friendly environments can positively affect academic outcomes. Adolescents who do poorly in school or feel marginalized are at risk of dropping out and becoming unemployed, pregnant, or participating in a range of unhealthy behaviours (e.g. drinking, smoking, drug abuse (Canadian Institute for Health Information, 2005; Public Health Agency of Canada, 2010; Joint Consortium for School Health, 2008; Klinger & McLagan, 2008; World Health Organization, 2010; Youngblade et al., 2007).

Personal Health Practices and Coping skills

Personal health practices established during adolescence often continue into adulthood. Enhancing social and problem-solving skills and self-confidence can help prevent mental health problems (e.g. conduct disorders, anxiety, depression, eating disorders), as well as other risk behaviours, including those that relate to sexual behaviour, substance abuse, and violence (World Health Organization, 2010).

Gender

Sexual development and emerging sexual identity is a significant developmental task of adolescence. In today's society, the discussion of gender and sexuality reaches beyond male and female to include lesbian, gay, bisexual, transgendered and questioning youth. These youth are at higher risk for adverse health outcomes such as human immunodeficiency virus (HIV) and STIs, substance abuse and depression (University Institute for Social Research, 2006).

Social Environment

The neighbourhood or community in which an adolescent lives may determine the resources available for spending time constructively after school (e.g. recreational facilities, skill development programs in the arts, interest clubs). Some neighbourhoods are considered high risk due to a lack of resources and the prevalence of drug use/abuse and violence of all forms.

Social exclusion can result from racism, discrimination, stigmatization, hostility and unemployment (Wilkinson & Marmot, 2003). Youth who have been incarcerated, been in psychiatric hospitals, or are homeless are particularly vulnerable to addiction and social isolation. Victimization and bullying put youth at risk for anxiety, depression and somatic complaints. Bullying can be physical, verbal, indirect (e.g. being excluded or ignored by others), sexual (e.g. harassment), racial, religious, and/or electronic, i.e. cyberbullying (Craig & McCuaig-Edge, 2008).

Aboriginal youth are exposed to a barrage of risk conditions that have a profound effect on their health. These factors are associated with their circumstances and environments as well as the structures, systems and institutions that influence the physical, emotional, mental and spiritual dimensions of health. As determinants, they have been categorized as distal (historic, political, social, economic), intermediate (community infrastructure, resources, systems, capacities) and proximal (health behaviours, physical and social environments) (Reading & Wien, 2009). Social determinants not only have a differential impact

on health in general, but the ensuing health issues themselves create conditions that subsequently influence health, e.g. poverty in Aboriginal communities is associated with increased substance use/abuse, which can lead to stressful family environments and diminished social support, which in turn are linked to depression (Reading & Wien, 2009).

Family Supports

Real and perceived factors in the social environment have perhaps the strongest impact on adolescent health. Family supports and resources are crucial to healthy development. There is evidence that the qualities of family interaction (e.g. overall connectedness) are crucial to healthy development. These qualities are reflected in parenting styles and family cohesiveness (Canadian Institute for Health Information, 2005). More children in families with adequate financial resources appear to develop normally, regardless of family configuration. Of all the family factors, socioeconomic status reflected in family income and parental education has perhaps the most significant impact on child/adolescent development (Canadian Institute for Health Information, 2005). The national culture also influences adolescent health through its values, beliefs and policies. Human rights and social welfare policies influence adolescent values as well as their health (Yugo & Davidson, 2007). The shift toward assessing and promoting protective factors in positive youth development has highlighted the importance of adolescents' connectedness within their social contexts, which include both family and school (Yugo & Davidson, 2007).

The Changing Canadian Family

Canadian children are growing up in family environments that have changed dramatically over the past few decades. The traditional, nuclear family led by a male wage earner is no longer the prevalent model of family life. Today, children and youth experience a variety of family types that include married, common-law, same-sex parents, as well as lone-parent families and blended families. These changes are highlighted in a "family portrait" released by Statistics Canada using data from the 2006 census. The report examines developments in families, marital status, households and living arrangements between 2001 and 2006. The following information is drawn from this report (Statistics Canada, 2007):

- Married-couple families accounted for 68.6% of all census families in 2006, down from 70.5% five years earlier. The proportion of common-law-couple families rose from 13.8% to 15.5%, while the share of lone-parent families increased slightly from 15.7% to 15.9%. In 1986, common-law-couple families accounted for only 7.2% of all census families, while married-couple families represented 80.2%, and lone-parent families 12.7%. Since 2001, common-law couple families grew 18.9%, more than 5 times faster than growth for married couple families.
- The number of same-sex couples rose 32.6% between 2001 and 2006, five times the pace of opposite-sex couples (up 5.9%). In total, the census enumerated 45,345 same-sex couples, of which 16.5% were married couples. In 2006, same-sex couples represented 0.6% of all couples in Canada. About 9.0% of persons in same-sex couples had children aged 24 years and under living in the home in 2006. This was more common for females (16.3%) than for males (2.9%) in same-sex couples.
- Sixty two percent of all families have children living at home. Only 10% of all families have three or more children living at home. Most families consist of 2 or 3 persons. Among common-law families and lone-parent families, the majority is comprised of just 2 people. Female lone-parent families make up 80% of all lone-parent families, while male lone-parent families make up the remaining 20%.
- Married couples with children aged 24 and under were the only census family structure to experience a decline in numbers representing 34.6% of all census families in 2006 and 41.3% in 1996.

Transformations in the family have stimulated interest in studying the impact of changing family structure and composition on the health and well-being of children and youth. There is evidence to suggest that some changes (such as having more mature, dual-income parents with more human capital) have beneficial effects, while others (such as increasing instability in parental partnerships) have adverse effects. However, these outcomes are mediated by other significant socio-environmental factors such as economic and parenting resources (Beaujot & Ravanera, 2008; Brown, 2006). Further research is needed in this area.

Biology and Genetic Endowment – Adolescent Brain Development

Genetic endowment, the biological functioning of the human body and the processes of growth and development, are individual factors that interact with other factors to influence health.

Over the past decade, technological advances have allowed scientists to more closely examine the development of the human brain. Magnetic resonance imaging and other neuroimaging technologies have enabled scientists to map the developmental trajectories of neuroanatomy and physiology during childhood and adolescence. Longitudinal studies have revealed significant changes in grey and white matter densities during adolescence, which occur well into young adulthood (Giedd, 2008). According to Steinberg (2010), these and other findings indicate that "brain changes characteristic of adolescence are among the most dramatic and important to occur during the human lifespan. (p.110)" Certainly, they point to increased adaptability and plasticity of the brain during adolescence.

During childhood and adolescence, there is a prepubertal increase in grey matter (neuron cell bodies, dendrites, glial cells), followed by post-pubertal decline. The reductions in grey matter are thought to be caused by a selective pruning process that follows a non-linear pattern starting in the sensorimotor regions of the brain and developing in a back to front direction occurring last in the prefrontal cortex (Gogtay & Thompson, 2010). The losses follow a "use it or lose it" pattern, clearing out rarely used synaptic connections to make way for more efficient and speedier information processing (Johnson, Blum, & Giedd, 2009).

The density of white matter (axons and myelin) increases in a roughly linear pattern throughout childhood and adolescence into young adulthood (Johnson et al., 2009). This is thought to be due to increased axonal caliber and/or myelination (the formation of a fatty sheath of insulation around axons), increasing transmission speed and strengthening connectivity within and between the frontal cortex and other regions of the brain (Paus, 2010; Schmithorst & Yuan, 2010).

There is evidence of gender differences in neurodevelopment during adolescence (i.e. females reaching peak volumes of grey matter earlier than males); however, research addressing this and other areas of adolescent brain development –including the role of puberty, neurotransmission and genetic influences – is just beginning (Steinberg, 2010).

Implications

Studies of adolescent brain development have stimulated a great deal of interest in the connections between adolescent neurodevelopment and the real-world opportunities and vulnerabilities that young people experience. One area of concern is the long-term impact of exposure to commonly used substances such as alcohol and cannabis.

Recent research regarding alcohol use and the developing teen brain suggests that alcohol affects adolescents differently than adults. Adolescents are more vulnerable to the negative effects of alcohol in the areas of memory and learning, and heavy drinking during adolescence may adversely affect brain development and maturation, causing brain damage, structural alterations and cognitive deficits (Guerri & Pascual, 2010).

Researchers are also exploring the theory that cannabis use during the period of adolescent neurodevelopment may increase adolescents' vulnerability to the development of psychosis. While the data do not support a direct causal relationship, some evidence suggests that adolescents who use cannabis have a two-fold increase in relative risk for developing schizophrenia or schizophreniform disorder (Arsenault, Cannon, Witton, & Murray, 2004). Cannabis use elicits psychological responses (anxiety, panic attacks, depression, disorientation, impaired memory, disordered thinking, labile affect) that have personal and psychosocial implications for youth. There also appears to be a correlation between younger age of onset of cannabis use and younger age of onset of these responses (Dragt et al., 2010). It is more likely that cannabis use interacts with many other risk factors for psychosis, including environmental factors and genetic predisposition, and therefore contributes to – rather than causes – the onset of psychosis (Barkus & Murray, 2010; Henquet et al., 2005).

This emerging research points to the need for early intervention in substance abuse prevention and health promotion programming.

Little is known about the factors that guide the building up or withering away of connections between cells, although it is likely that the process is influenced by genetic and multiple environmental factors, including experience (Paus, 2010). Evidence indicates that adolescence is a time of considerable brain plasticity; there is also speculation that individual differences in brain structure and function could be linked to differences in experience (Steinberg, 2010). One implication is that this an ideal time for interventions directed at prevention and positive youth development.

Given that impulse control, planning and decision-making are largely prefrontal cortex functions that are still maturing during adolescence, researchers have hypothesized that the temporal gap between the development of the socio-emotional and cognitive control systems of the brain underlies some aspects of adolescent reckless behaviour and risk-taking (Johnson et al., 2009). This increased vulnerability will have different outcomes, depending on the environment or setting, available opportunities to engage in reward-seeking and the degree to which parents, other caring adults, schools, institutions and communities, are able to provide support for adolescent learning and self-regulation (Steinberg, 2010).

Many neuroscientists agree that further research is needed to fully understand brain development, empirical evidence for a causal relationship between brain biology and behaviour is lacking and precise applications to practice are still unclear. They indicate as well the need to ensure appropriate translation of research findings and to situate them within the broader context of other physiological systems and the socio-environmental factors that influence adolescent development and behaviour (Johnson et al., 2009; Steinberg, 2010). Given that research regarding adolescent neurodevelopment is evolving rapidly, nurses should continue to monitor new developments in this area.

Fast Facts on Teen Brain Development

- The brain matures from "back" to "front:"
  - Myelinzation of white matter occurs from 5 to 20 years of age.
- Adolescent decision-making behaviours are more influenced by the amygdala in the limbic system than the prefrontal cortex:
  - Decision-making is influenced by emotional and gut responses.
  - This is the "reactive" part vs. the "thinking" part of the brain.
- The pre-frontal cortex (the brain's "CEO") develops last (up to 25 years of age):
  - It is responsible for planning, strategizing, judgment, impulse control and regulation of emotions.
  - The region demonstrates a growth spurt at 11 or 12 years of age, then "prunes" away unused pathways and "hardwires" what is being used.
    - The result is increased response to emotional reward and less engagement in cognitive control.

(Barr & Sandor, 2010; Blakemore & Choudhury, 2006.)

Culture/Immigration

To promote the healthy development of all youth, attention must also be given to the strengths of and challenges faced by immigrant youth and their families. The ethnocultural and racial diversity of Canadian cities continues to grow with new immigrant source countries.

The following are some statistics reported by Citizenship and Immigration Canada (2008) pertaining to immigration and youth:

- Among those immigrating to Canada each year, 26% are children and youth under 24 years of age.
- In 2008, more than 4,800 youth aged 15 to 24 years came to Canada as refugees. It is estimated that 20% of Canada's youth under age 18 are immigrants or children of immigrants; by 2016, they will constitute 25% of Canada's children.
- Of the total immigrants (permanent residents), 33.4% report speaking neither French nor English.

A comprehensive, inter-sectoral approach – including the participation of health, social services, education systems and resettlement services – is required to facilitate the settlement of newcomer youth and their families in Canada (Khanlou et al., 2002). Nurses can assume leadership roles across various systems of influence in order to advocate and plan for health-promoting policies and strategies that are context-specific and encompass sensitivity to gender, culture, immigration and racial status.

Aboriginal Youth and Cultural Considerations

While public discourse tends to focus on the health challenges and risk behaviours of Aboriginal youth, researchers have urged governments, policymakers and service providers to take a holistic, strengths-based, culturally sensitive approach in promoting the health and well-being of Aboriginal children and youth. They point out the need to foster and build on the assets, protective factors and capacities for positive change that exist among Aboriginal youth and their communities. Particular to this approach is the need to embed programming in an Aboriginal worldview, seek the full and meaningful participation of youth, and form effective and appropriate partnerships with them and their communities (Crooks, Chiodo & Thomas, 2009).

"Health inequalities arise from variations in social, economic and environmental influences along the life course. Health promotion, particularly when it uses social and structural interventions developed by multi-disciplinary teams working with young people, not merely for them, has the potential to reduce health inequalities among young people immediately, and in their later lives... There are six promising elements to be combined in an evidence-informed approach to tackling inequalities: multidisciplinary teams working in partnership with the people they aim to help, to develop structural and social support interventions that adopt inclusive approaches to delivering and evaluating their processes and impact on health and inequalities." (Oliver et al., 2008, p.20)

Appendix E lists ten strategies and considerations to assist in the process of integrating cultural identity into a program.

Impact of Information and Communication Technologies

The rapid growth of information and communication technologies (ICTs) during the past decade has had a significant impact on the lives of young people. In a 2005 survey of 5,000 Canadian students in grades 4 to 11, 94% had regular access to the internet from their homes. By Grade 11, 51% of the students surveyed had their own internet-connected computer, 46% had their own cell phone and 31% had a web-cam. The survey also found that adolescents regard the internet as a space that blends seamlessly with the other spaces in their lives, strengthening their connections to the real world and enhancing their social interactions with peers (Media Awareness Network, 2005). One example of this is provided by the increasing participation of youth in social networking sites such as Facebook, MySpace and Twitter. In addition to the internet, adolescents make regular use of a variety of other electronic media, including cell phones, mobile devices, smart phones, text messaging, gaming consoles and portable gaming devices.

While it is clear that electronic media have created a new world of action and social networking for youth, there is debate in the literature about the nature and impact of these changes. Ongoing research regarding the meaning of the relationships and social connections that occur is needed to determine the role these technologies play in enhancing or harming young people's health and well-being (Wyn, Cuervo, Woodman, & Stokes, 2005). Concerns have also been raised about the discrepancies between those who have access to ICTs and the skills to use them and those who do not. This "digital divide" based on race, culture and socioeconomic factors may reflect or even augment existing material and economic inequalities in society (Looker & Thiessen, 2008).

Implications

Despite very real concerns about their impact, these technologies are proving to be powerful mechanisms for engaging and partnering with youth in health promotion approaches that focus on enhancing capacities (Flicker et al., 2008).

Evidence indicates that adolescents use the internet to access information about health. A survey by the Pew Research Center of 800 American youth aged 12 to 17, found that 31% of online teens get health, dieting or physical fitness information from the internet. Seventeen percent reported that they use the internet to gather information about health topics that are hard to discuss with others, such as drug use and sexual health (Lenhart, Purcell, Smith, & Zickuhr, 2010).

In a qualitative study conducted in Ontario (Skinner, Biscope, Poland, & Goldberg, 2003), youth reported that using eHealth technology (web-based health education applications) to locate health information can be difficult, and they look to health practitioners for support in finding and evaluating health information. As a result, new and expanding roles are emerging for health professionals to integrate eHealth applications into their practice. Theoretical models and frameworks are also being developed to guide practitioners in designing programs that use technology to engage youth in community health promotion (Flicker et al., 2008; Skinner, Maley & Norman, 2006).

As information and communication technologies are constantly evolving, it is essential for health professionals who engage and partner with youth in health promotion initiatives to take advantage of the opportunities presented by electronic media to reach out to and connect with youth in ways that are both meaningful and empowering for them.

Positive Youth Development Approaches

Youth engagement

Traditionally, nurses have worked with youth in the area of prevention and in response to problems. Often, young people play a passive role in the relationship and are viewed as "clients." Oftentimes, the programs and services are short-term or a one-time offerings, where nurses act as professionals or experts who work for young people rather than with them as equal partners. Youth engagement models and youth resiliency models operate under a youth-adult partnership structure while working toward an agreed-upon outcome in which youth are seen as partners rather than clients. It is this type of youth participation that leads to the development of the protective factors required for a long-term strategy of establishing a healthy lifestyle.

Building assets and/or resiliency in youth, as well as providing youth with opportunities to be engaged, are protective factors that promote positive youth development and prevent youth from engaging in risk-taking behaviours (Search Institute, 2006). Resiliency Initiatives (n.d.) has conducted research related to assets that emphasizes the positive aspects of individual differences in understanding the extrinsic and intrinsic strengths that contribute to optimal human development. Health Canada has defined resilience 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. Protective factors can buffer a person "in face of adversity and moderate ... the impact of stress on social and emotional well-being, thereby reducing the likelihood [that] disorders will develop." (Commonwealth Department of Health and Aged Care, 2000, p.13).

There is mounting evidence to suggest that young people who take active roles in organizations and in their communities have fewer problems, are better skilled and tend to be lifelong citizens (Irby, Ferber, Pittman, Tolman, & Yohalem, 2001). Programs operating within a youth engagement model have better uptake and outcomes for both participants and organizations. Adoption of the model facilitates a more youth-friendly environment, and allows organizations to create a better relationship with the communities they serve. Furthermore, current research indicates that youth engagement offers a variety of positive outcomes for youth, including lower rates of substance use, lower levels of depression, a significant reduction in dropout rates in school, higher academic performance and lower rates of conflict with the law, particularly for youth who have been categorized as "high risk" (Centre of Excellence for Youth Engagement, 2007).

Youth engagement is based on the understanding that, in order to make a successful and healthy transition from adolescence to adulthood, youth must possess certain skills and competencies. Youth engagement can be defined as "meaningful participation and sustained involvement of a young person in an activity with a focus outside of him or herself" (Centre of Excellence for Youth Engagement, 2003). The concept of youth engagement is relatively new and does not have a single universal definition. It is a framework that can be used within various practice settings to involve youth as valued partners in addressing issues and making decisions that affect them or that they believe are important. There is a wide variation in how this approach is applied in diverse settings; however, several key elements help achieve positive youth outcomes and health promotion objectives.

The Developmental Assets® Framework, which was developed through the Search Institute (2006), focuses on promoting positive adolescent development. This framework consists of 40 developmental assets, categorized into internal and external assets (Appendix F). Internal assets include commitment to learning, positive values, social competencies and positive identity; individual, family and community factors are included in this category. External assets (e.g. health-promoting features of the environment) include support, empowerment, boundaries and expectations, and constructive use of time. To learn more about youth asset development, visit Search Institute (www.search-institute.org) and The Canadian Centre for Positive Youth Development (www.thrivecanada.ca).

According to the National Adolescent Health Information Center (2004):

"No matter what health issue is being addressed, adolescents need specific knowledge regarding the issue; a specific set of skills that enable them to adapt and apply that knowledge to their own behaviour; motivation to use those skills; a family, school and community environment that supports use of the requisite knowledge and skills; and a policy environment that provides sufficient resources and political commitment for improving adolescent health and changing social norms. (p.2)"

Practice Recommendations

Principles and Practices in Working with Adolescents

RECOMMENDATION 1
When working with youth, nursing interactions will be grounded in principles of respect, confidentiality, trust and transparency. Nurses will acknowledge youth's strengths and potential while building on collaborative partnership.

Type IV Evidence

Discussion of Evidence

Program settings that encourage trusting relationships provide a warm, welcoming climate that conveys a sense of safety, security and confidentiality (Grant, Elliot, Di Meglio, Lane & Norris, 2008; Public Health Agency of Canada, 2008; Restuccia & Bundy, 2003). To effectively promote healthy adolescent development, programs must also provide youth with: a sense of meaningful participation; a sense of community involvement; c) challenges that build on skills; and d) encouragement related to relationship-building (Restuccia & Bundy, 2003).

Professionals who work with youth must be competent, committed and well-trained in the various determinants of health affecting adolescents. Practitioners build strong relationships with youth when the relationship is based on mutual trust and respect (Rew, Johnson, Jenkins & Torres, 2008). It is the individual professional who makes a program work, who draws participants back year after year, and who becomes known and trusted as the face of the organization in the community (Shen, 2006).

The following guiding principles and practice considerations should be considered to foster youth engagement and enhance the overall health of adolescents. They are neither mutually exclusive nor presented in order of priority (Canadian Institute for Health Information, 2005):

1. Adolescents are competent individuals with strengths and potential, and deserve to be viewed a such.
2. Adolescents are diverse in their developmental stages and their abilities to comprehend and respond to specific tasks and expectations.
3. Adolescent behaviour is meaningful to the adolescent.
4. Adolescents desire a sense of belonging, wish to participate in decisions, and have a voice about issues that affect their lives.
5. A supportive, nonjudgmental approach is best when assisting any adolescent.
6. The context of an adolescent's environment (i.e. family, school, peers, culture/ethnic group, neighbourhood and community) should always be considered.
7. Interventions that contribute to healthy development are comprehensive and address factors associated with multiple behaviours; create positive environments and opportunities; and that engage youth.
8. Supportive, protective factors for youth include: parental nurturing and monitoring school engagement; peer connectedness; inherent coping skills; and resilience.

Practice Considerations that Enhance Nursing Practice When Working with Adolescents

1. Utilize a theory-based approach, e.g. youth engagement, resiliency, anticipatory guidance, harm reduction
2. Be nonjudgmental, honest and transparent. Practice active listening and respect.
3. Respect consent to treatment and capability parameters.
4. Respect an adolescent's need and right to confidential care and interactions.
5. Take extra time to ensure youth are fully informed, and encourage their participation in all decisions.
6. Include strategies that are multifaceted, comprehensive, holistic, multisectoral and multidisciplinary (i.e. incorporating individual, families and communities).
7. Be flexible, timely, accessible and patient.
8. Participate in adolescents' use of technology, and use it as a form of communication and information-sharing when working with youth.
9. Focus on the antecedents of risk behaviours and utilize an informed harm reduction approach.
10. Be knowledgeable of adolescent brain development, particularly recent research on frontal lobe function, in understanding the motivation and abilities of youth regarding consequences and rewards.
11. Involve youth in all aspects of program development and evaluation.
12. Build on adolescents' strengths. Promote competence and potential.
13. Establish and nurture environments that youth perceive to be safe for their participation.
14. Provide continuity of practitioner to establish trust and rapport.

Comprehensive, Collaborative Approaches

RECOMMENDATION 2

Nurses working with youth will utilize a comprehensive, collaborative, multifaceted approach to promote therapeutic partnerships and enhance positive youth development.

Type III-IV Evidence

Discussion of Evidence

The current evidence provides strong support for a comprehensive, collaborative approach to programming and strategy development when working with youth (Pearlman, Camberg, Wallace, Symons & Finison, 2002; Public Health Agency of Canada, 2008; Scheve, Perkins & Mincemoyer, 2006). Critical to the accomplishment of a comprehensive, collaborative approach is the integration of asset-based approaches and risk reduction/prevention strategies (Duncan et al., 2007; Patersson & Panessa, 2007). According to Duncan et al. (2007), although risk reduction strategies seek to discourage youth from engaging in risky behaviour, asset-based approaches encourage youth to actively seek and acquire personal, environmental and social assets that are the building blocks of future success; thus, the pairing of both approaches is essential in facilitating positive youth development.

The incorporation of therapeutic youth partnerships into programs that have multiple components, settings and goals is essential to program success (Scheve et al., 2006). Therapeutic youth partnerships in program development, implementation and evaluation seek to promote positive youth development by

providing adolescents with opportunities to become active participants in the resolution of issues governing their community (Gambone & Connell, 2004).

Active participation of youth on decision-making committees and boards, as well as in planning school activities, promotes the development of internal and external assets. Specifically, it: facilitates youth skills and capacity building; encourages youth to reflect on their own social identity; develops social awareness; and helps build leadership skills (Shen, 2006).

In addition to establishing partnerships with youth, programs must include a focused assessment of global risk factors – in addition to individual risk behaviours – in order to ensure comprehensiveness. This emphasizes the importance of context to both problem behaviours and their prevention.

The following points summarize key themes from the literature related to a comprehensive, collaborative, multifaceted approach when working with youth:

- Comprehensiveness of a program entails assessment of youth developmental level, along with assessment of both risk and protective factors at the individual, family, peer, school and community levels (Lerner, 2005; Youngblade et al., 2007). Given that youth behaviours tend to cluster, programs that seek to target multiple risk factors may have a better chance of producing positive and more consistent effects (Canadian Institute of Health Information, 2005). Accordingly, programs must be designed to simultaneously reduce risk and promote protection by focusing on antecedents of high-risk behaviour, rather than the presenting behaviour itself (Canadian Institute of Health Information, 2005). Programs that promote family connection, communication, engagement and positive characteristics of the family and adolescent are all deemed effective in reducing negative outcomes and facilitating positive outcomes (Grossman & Bulle, 2006; Youngblade et al., 2007).
- Positive youth development programs should seek to achieve one or more of the following: bonding; resilience; social, emotional, cognitive, behavioural and moral competence; self-determination; self-efficacy; and, spirituality. These programs should foster belief in the future, pro-social norms and provide recognition for positive behaviour and opportunities for pro-social involvement, as well as development of clear and positive identity (Catalano, Berglund, Ryan, Loczak, & Hawkins, 2004).
- Interdisciplinary interventions and programs that involve family, peers, media, school board personnel, the public and private sectors, and the community are more likely to be successful and have an impact on adolescent behaviour (Community Health Nurses Association of Canada, 2008; Public Health Agency of Canada, 2008).
- Community-level strategies should create supportive and secure physical and social environments for youth that complement problem-focused or risk-reduction strategies in programs (Canadian Institute of Health Information, 2005). Critical to this decision-making strategy is the inclusion of all relevant stakeholders, i.e. clients, members and community partners. For youth to be and to feel included, they must be well-represented at the discussion table and their input considered at all stages of the decision-making process (Shen, 2006).
- Health cannot be pursued by the health sector alone. Health promotion demands coordinated action by numerous agencies and community partners (i.e. governments, health and other social and economic sectors, non-governmental and volunteer organizations, local authorities, industry and the media). Professional and social groups, and health personnel have significant influence in the pursuit of health and the interests of society (Ottawa Charter for Health Promotion, 1986).

- Health promotion strategies and programs should be adapted to local needs and available resources in each community or geographical region, taking into account differing social, cultural and economic systems (Ottawa Charter for Health Promotion, 1986).

PRACTICE BOX: Tips for Collaborating in Interdisciplinary Settings Across Sectors and Practice Settings When Providing Clinical Care in Collaboration with Youth and Family

- Identify all stakeholders within the circle of care (interdisciplinary healthcare team in both acute and community settings, youth and family, significant others, community partners, academic and spiritual supports).
- Identify essential stakeholders required to move the plan of care forward.
- Identify a key worker who will facilitate communication, goal-setting, implementation and evaluation of the plan. This role is usually fulfilled by a registered nurse,
- Invite identified stakeholders to participate in discussions about supporting and enhancing re-integration of youth back into the community.
- Develop a plan of care and support with specific goals for each stakeholder that will enhance re-integration, reduce risk and promote health, while maintaining the collaboration of all stakeholders involved.
- Implement the desired plan of care with ongoing evaluation and revisions as required.
- Ensure that follow-up planning is addressed and available as required.

Facilitation Role and Youth Leadership

RECOMMENDATION 3
Nurses will employ youth engagement approaches to foster positive youth development.
Type III-IV Evidence

Discussion of Evidence

Youth engagement is an emerging concept that does not currently have a single universal definition. It is an overarching framework often used within programs, organizations and communities (see Appendix I for a detailed description of the Youth Engagement Model). Youth engagement programs and approaches contribute to positive development by encouraging active citizenship among youth, instilling in them a sense of social responsibility that they will carry to adulthood (Shen, 2006).

Youth engagement entails the meaningful involvement and sustained participation of youth in activities that are external to their being (Pancer, Rose-Krasno, & Loiselle, 2002). The Center of Excellence for Youth Engagement (2007) identified full youth engagement as consisting of three components: 1) a behavioural component (e.g. spending time doing the activity); 2) an affective component (e.g. deriving pleasure from participating in the activity); and 3) a cognitive component (e.g. gaining knowledge about the activity). These three components are reflective of the following key features of vital engagement in a youth activity:

- the youth experiences "enjoyed absorption" in the activity that is sustained over time;
- the activity provides a link between the youth and the outside world; and
- the activity is felt to be meaningful and significant (The Center of Excellence for Youth Engagement, 2003).

It is critical for nurses working with youth to consider the above outlined activity features when implementing youth engagement programs and approaches. Such features strengthen youths' leadership potential and allow for greater achievement of social consciousness (Shen, 2006). Youth engagement is deemed to be an effective approach when working with young people regarding decisions for healthy living. Research regarding the effectiveness of youth engagement approaches is expanding rapidly.

PRACTICE BOX: Transforming Youth Leadership Potential

McGregor (2006) identified the following as actions that can help transform leadership potential in youth:

- Permit youth to self-select for participation in any leadership related activities.
- Respect and consider youths' power and experiences, relating these to their roles as leaders.
- Provide frequent and diverse leadership opportunities within the organization or community in which youth could engage.
- Involve high- or at-risk youth in school-based leadership roles.
- Develop an understanding of differences in cultural expression of leadership behaviours, incorporating this understanding into the youth leadership experiences.
- Allow youth to take on responsibilities and leadership roles without expectations of perfection.
- Recognize that leadership opportunities go beyond an elected formal position and encompass non-traditional leadership activities, such as volunteering or serving as a student assistant.
- Evaluate and explore one's own perspectives and beliefs about leaders and leadership.
- Engage youth in discussions related to leadership.

Closely related to the concept of youth engagement is positive youth development. This concept revolves around the ideology that young people need to develop the skills and competencies necessary to be healthy, caring and responsible, in order to successfully transition from childhood into adulthood (Dotterveich, 2009; Fiissel, Schwartz, Schnoll, & Garcia, 2008). For nurses working with youth, these essential skills and competencies can be facilitated by placing greater emphasis on the youth's assets and strengths as oppose to their problems (Dotterveich, 2009). Collaborative effort through active youth participation is key to appreciating and realizing the unique assets, capabilities and strengths of youth (Green & Parfrey, 2002). Appendix G outlines the key influences on youth health and development.

Youth participation is crucial to youth engagement. Hart (1992) introduced the Ladder of Youth Participation (Appendix H) to conceptualize the participation level of youth with adults when undertaking initiatives. The ladder serves as a tool to assess current levels of youth participation. It also helps set goals by aiming to work toward the rungs at the top of the ladder. Within this framework, youth participation involves nurses working with young people to achieve greater health outcomes and positive youth outcomes. As youth move up each rung of the ladder, a greater engagement and sense of empowerment are realized.

Jennings, Parra-Medina, Messias & McLoughlin (2006) identified the following as key to youth empowerment:

- a welcoming, safe environment;
- meaningful participation and engagement;
- equitable power-sharing between youth and adults;
- engagement in critical reflection on interpersonal and sociopolitical processes;
- participation in sociopolitical processes to affect change; and
- integration of individual and community level empowerment.

Ultimately, nurses must gain awareness of approaches necessary to effectively engage youth in issues related to their own health and the health of their communities. Appendix I summarizes the understanding and strategies that nurses require in order to effectively influence the health and development of youth.

PRACTICE VIGNETTE

A nurse practicing in a secondary school setting was seeing many girls with various health issues. Some would see the nurse to discuss healthy weight or self-esteem. Others found themselves in unhealthy relationships but couldn't find a way out. Some experienced anxiety, panic attacks, drug use and unplanned pregnancies. After a few months, the nurse determined that most of these girls did not participate in regular physical activity and were not connected to an after-school sports team.

Research has revealed that the more physically active young girls are, the less likely they are to: experiment with alcohol, drugs and tobacco; experience depression and anxiety; be in an abusive relationship; or have an unplanned pregnancy.

To engage these youth and empower them to make healthier choices, the nurse partnered with a health promoter. After conducting focus groups with the youth to determine what they wanted from a physical activity program, FUEL was developed. Named by youth, FUEL stands for Female Using Energy for Life and is a girls-only, after-school physical activity program that is non-competitive and where no one "gets cut from the team." The program's success is directly related to the fact that it was created by and for teenage girls.

With the nurse acting as an adult ally, student advisors played an active role in implementing the program. They were responsible for booking fitness instructors from the community. They explored Pilates, yoga, Zumba and body sculpting, among others. They also booked space and posted announcements to encourage their peers to attend. With the guidance of the nurse, they ensured that healthy refreshments were offered at each session. Most importantly, they helped create a supportive environment where every girl felt welcomed and accepted.

Implications

The nurse and other adults involved in this project provided an opportunity for students to take the lead in their school, resulting in student advisors who engaged and empowered FUEL participants. Within the youth engagement model, the nurse acts as mentor, role model and colleague. The nurse relinquishes control and listens to the youths' program needs. Through trusting relationships and strong facilitation skills, the nurse empowers youth to reach their objectives.

Youth with Chronic Health Conditions and Healthcare Transitions

RECOMMENDATION 4

Nurses will apply the principles of positive youth development in working with youth and other members of the healthcare team to develop the necessary skills and knowledge needed to successfully transition care to the adult-oriented healthcare system.

Type III-IV Evidence

Discussion of Evidence

It is estimated that between 14.8% and 18% of all youth in North America have a chronic health condition or a special healthcare condition (e.g. musculoskeletal impairments, speech defects, deafness and hearing loss, blindness and visual impairments; and diseases such as asthma and heart disease) that affect them and their families (Canadian Paediatric Society, 2006). Many of these youth have survived life-threatening illnesses which, until recently, had a high mortality rate (Canadian Paediatric Society, 2006). Technological and therapeutic advances in pediatric care have resulted in a new generation of adolescents surviving with chronic illness and disability. It is estimated that up to 98% of children with a chronic health condition may now reach the age of 20 years, depending on their condition (Van Dyck, Kogan, McPherson, Weissman, & Newacheck, 2004).

Chronic illness has been shown to significantly affect adolescent development (McDonagh, 2005). Adolescents with chronic conditions may be overprotected and socially delayed; however, they usually have the same aspirations as their adolescent counterparts with respect to relationships, school, careers and travel (Kennedy, Sloman, Douglass, & Sawyer, 2007). More recently, emphasis has been placed on developing the skills and competencies of youth with chronic conditions through active participation in the management of their health. As treatments for infants and children continue to improve, the prevalence of chronic conditions and disabilities among today's youth are expected to increase. As a result, as these youths approach their eighteenth birthday, they will graduate from the care of their pediatric providers and move into the adult healthcare system.

Transition, the term used to describe the movement from the pediatric healthcare system into the adult healthcare system, is defined as "the purposeful, planned movement of adolescents with chronic medical conditions from child-oriented to adult-oriented health care." (Blum, 2002, p.1302) The goal of transition is to provide health care that is uninterrupted, coordinated, developmentally appropriate and psychologically sound, before and throughout the transfer of youth into the adult health system (Canadian Paediatric Society, 2007). Transition programs promote an environment that supports the family, while empowering the youth to become interdependent (with family and society) and responsible for their own health care (Reiss, Gibson & Walker, 2005). By providing youth with developmentally appropriate knowledge and skills, and the opportunity to practice self-management skills, it is anticipated that they will learn to advocate for themselves, maintain health-promoting behaviours and use healthcare services into adulthood (Canadian Paediatric Society, n.d.).

Preparation for transition should begin early in the adolescent's experience with her/his condition. Many facilities and organizations are attempting to outline how transition preparation can be effective in influencing positive health outcomes (see the Resource Box).

Transition preparation has been promoted as an important component of high-quality health care. The movement away from pediatric care and into adult-oriented health care has been shown to cause stress, fear and anxiety among adolescents (Paone, 2000). Similar anxieties are experienced by parents, who may feel that their own needs are neglected or even abandoned by a perceived lack of parental consultation in the new system (Sawyer, Blair & Bowes, 2008).

Although transition preparation should be initiated by the pediatric system, it does not end once an adolescent has been transferred to the adult system. After leaving the familiarity of the pediatric system, and entering the adult system, the needs of young adults still require specific attention. There must be willingness on the receiving practitioner's part to accept young adults and provide care that is both developmentally appropriate and sensitive to their medical and educational needs, particularly with respect to the management aspects of the condition. Many resources are available to help nurses provide effective transition care, as outlined in the Resource Box below.

RESOURCE BOX:
Transition Resources for Nurses Caring For Youth with Chronic Health Conditions

Youth in Transition
www3.bc.sympatico.ca/steeksma/Medical/transition.htm

Good 2 Go Transition Program: The Hospital For Sick Children, Toronto, Ontario
www.sickkids.ca/good2go

Good 2 Go Transition Program: MyHealth Passport
www.sickkids.ca/myhealthpassport

Health Care Transitions: Institute for Child Health Policy, University of Florida
http://hctransitions.ichp.edu/

Healthy & Ready To Work: A Transition Service for Youth-Maternal and Child Health, United States http://www.hrtw.org

Ability Online
http://www.ablelink.org

Disability Resources on the Internet
http://www.disabilityresources.org

Principles of Effective Transition Promotion

1. Transition preparation should begin early in childhood, with the healthcare system encouraging families to be informed participants in their child's care, e.g. young children and their families can be taught developmentally appropriate self-management skills which, with continued encouragement, will grow into increased abilities and responsibilities as they move into their adolescent and youth adult years.
2. As children enter adolescence, they require support and encouragement, as well as opportunities to practice increased levels of responsibility and information regarding their condition and how to best manage it.
3. Adolescents, their families and care providers must work together to develop transition care that is effective in fostering health-promoting behaviours and in enhancing the long-term quality of the young adult's life.
4. Adolescents and their supports (e.g. family) must have a thorough understanding of the condition and its impact on various aspects of life at different developmental stages, e.g. adolescents require accurate and honest information regarding relationships, pregnancy, parenting and vocation options, and any limitations that may be imposed.
5. Transition efforts should be based on concepts central to positive youth development.
6. Collaboration among healthcare providers – including pediatric and adult specialists – is essential for successful transition from pediatric to adult care.

Model or Theoretical Framework

RECOMMENDATION 5
Nursing practice will be informed by evidence-based theoretical models.

Type IV Evidence

Discussion of Evidence

The factors that influence adolescent health are complex and interrelated. Well-grounded theories and models address this complexity and provide frameworks for effective program development and implementation. The empirical evidence to support these frameworks is more established for some than for others. There are, however, a multitude of well-grounded theoretical frameworks available to the practitioner.

Examples of sound theoretical approaches to consider are included in Appendix I. This list is not exhaustive, but is reflective of promising theories that are well-documented in the literature.

Program Design and Implementation

RECOMMENDATION 6
Nurses engaged in the design, implementation and evaluation of programs for youth will base decisions on evidence reflecting the elements of effective program planning and design.

Type III-IV Evidence

Discussion of Evidence

Decision-making pertaining to the design and implementation of programs for adolescents should be grounded in evidence gathered from studies with sound methodologies. This approach involves reviewing, appraising and integrating new research findings into practice settings – a daunting task for nurses who deal with the everyday realities of organizational mandates, funding limitations and time constraints. Fortunately, a large number of systematic reviews, best practice documents and evaluation reports specific to youth health are available and provide evidence regarding effective programming for prevention and risk reduction (see Appendix J).

As important as it is to base program design and implementation on evidence, it is also critical to evaluate new initiatives using sound study methodologies. A number of authors emphasize the importance of involving youth in such evaluation. Specifically, they recommend using qualitative methodology to identify and assess their experiences with respect to a new program, and using participatory action research to actively engage youth in the research process and facilitate youth empowerment (Flicker et al., 2008; Lind, 2007; Suleiman, Soleimanpour & London, 2006; Winkleby et al., 2004).

Participatory evaluation by youth is quite different from traditional or conventional evaluation processes, in that young people actively collaborate with adults to examine the issues that affect their lives. They participate in all phases of the evaluation, build capacity in evaluation skills, generate knowledge and make decisions that result in meaningful change in their communities (Suleiman et al., 2006). As a result, youth contribute to the development of programs that are better able to meet their needs, while enhancing their knowledge and skills and increasing their capacity to make healthy choices (Suleiman et al., 2006).

Health promotion and positive development approaches involving adolescents take place over time and are subject to multiple contextual and societal factors during that time. Effective evaluation of such programming depends on long-term commitment to tracking changes in life experiences and asset development, as opposed to measuring only efficacy outcomes. Some researchers have applied a unified approach, combining both qualitative and quantitative methods and procedures in the evaluation of long-term, youth development programs (Montgomery et al., 2008). Such mixed methods designs contribute to a better understanding of complex issues, allow for cross-validation of research findings and compensate for the limitations inherent in each study design (Holt, 2009).

It is well-established that programs reported as successful in the literature should be implemented as designed in order to remain effective. However, when designing interventions, practitioners must find a balance between what the research says works vs. feasibility in their specific settings and communities (National Adolescent Health Information Center, 2004).

PRACTICE BOX:

Participatory Evaluation with Culturally Diverse Youth

Nurses who work with culturally diverse groups of youth should consider the following elements during program evaluation.

- ***Getting organized*** by assuring that youth evaluation leaders and committee members represent the social and cultural diversity of the population.
- ***Enlisting "bridging persons,"*** which are those young people who work easily across cultural boundaries and who are able to bring diverse individuals together.
- ***Strengthening social and cultural knowledge***, especially of key groups whose characteristics might affect the methods selected.
- ***Representing diverse interests*** in all steps of evaluation: from asking questions, to gathering information, to sharing the findings.
- ***Selecting methods of gathering information*** by identifying the methods –interviews, focus groups, surveys – that fit the class, race or gender of the young people.
- ***Increasing intergroup dialogue*** by enabling group members from diverse backgrounds to talk and listen effectively with one another.
- ***Dealing with conflict*** by recognizing it as a normal part of multicultural participation in a diverse democracy.

Source: Checkoway & Richards-Schuster, 2004, p.10

Education Recommendation

Practice Skills in Various Settings

RECOMMENDATION 7
Nurses who work with adolescents will have specific knowledge and skills related to adolescent development, health and well-being.

Type III-IV Evidence

Discussion of Evidence

The various contributions that nurses make when working with adolescents require diverse skill sets and knowledge, and the ability to apply them with the adolescent population. Knowledge and skill development should be a component of nursing undergraduate education and ongoing professional development. The following list identifies specific areas of skill development and knowledge for different settings when working with adolescents.

Required Competencies

- Adolescent brain development (Giedd, 2004; Giedd, 2008; Johnson et al., 2009)
- Adolescent developmental milestones (Gambone & Connell, 2004; Restuccia & Bundy, 2003)
- Adolescent mental health (Public Health Agency of Canada, 2008; Shepherd et al., 2002)
- Adolescent trends (American Psychological Association, 2002)
- At-risk youth and priority populations (Centre of Excellence for Youth Engagement, 2003; Youth Service Steering Committee, 2002)
- Case management (Youth Service Steering Committee, 2002)
- Communication, assessment and interview skills that are open, honest, and nonjudgmental (Duncan et al., 2007; Norris, 2007; Vega, Maddaleno & Mazin, 2005)
- Community partner engagement (Gambone & Connell, 2004)
- Health promotion and education (International Union For Health Promotion and Education, 2009; Shepherd et al., 2002; Stewart-Brown, 2006)
- Healthy sexuality/LGBTQ (Frankowski, 2004; Hoffman et al., 2009)
- Mentoring (Dubois & Silverthorn, 2005; Herrera, Grossman, Kauth, Feldman & McMaken, 2007)
- Policy development (Health Council of Canada, 2006; Naudeau, Cunningham, Lundberg, McGinnis & World, 2008; Shen, 2006)
- Relationship building (Ayres, 2008; Grossman & Bulle, 2006; Public Health Agency of Canada, 2008)
- Social media and technology (Flicker et al., 2008; Grossman & Bulle, 2006)
- Understanding the impact of school culture (IUHPE, 2009; Public Health Agency of Canada, 2008; Shepherd et al., 2002)
- Understanding youth diversity (Public Health Agency of Canada, 2008)
- Understanding youth values and peer influence (Shepherd et al., 2002)
- Youth engagement, adult ally and advocacy (Paterson & Panessa, 2008; Scheve et al., 2006; Shen, 2006)
- Youth-specific developmental assets (American Psychological Association, 2002; Search Institute, 2006)

PRACTICE VIGNETTE

This vignette originated from an interaction between an Ontario public health nurse and a student.

Scenario: Sam is a 17-year-old high school student in his senior year. He is a high achiever; has excellent grades, excels at sports, is very popular and has many friends. Sam seems to have it all!

At the beginning of the school year, however, Sam's performance and behaviour changed significantly. He was very angry, and was verbally and physically abusive to his friends and his girlfriend.

Sam was referred to the school nurse.

When the nurse met with Sam and created a comfortable, open environment, he felt ready to tell his story. Sam's home life was very difficult. His mother often told him he was no good and that he would amount to nothing. Sam would often argue with his stepfather, which often degenerated into physical fights.

The nurse listened to his story and empathized about how difficult it was at home, thereby validating his feelings. She offered contact information for a crisis line for immediate and confidential assistance,

should the need arise. The nurse's assessment identified that Sam was using substances regularly, was experiencing sleeplessness and irritability, and that his violent, abusive home situation was a key factor in his anger and lashing out behaviour at school.

Later, in the semester, Sam got into another physical fight with his stepfather and mother, and was forced out of the home. He was homeless for several days but, with a friend's help, he found the Ontario Works program and applied for assistance.

During the weeks that followed, Sam grew depressed, due to his circumstances and the fact that he could not see his sister in the family home. He felt more and more isolated and overdosed with pills. He was found by a friend and taken to hospital. Sam agreed to a follow-up appointment with the nurse the next week.

Although Sam was not at school for the next few weeks, the nurse connected with school staff and his friends to learn more about his current situation. The nurse learned that Sam's life was in turmoil: He was running out of money each month and could not afford to buy food; he was experiencing insomnia due to his worries about his life circumstances; his coach was threatening to kick him off the team because he had missed so many practices; he was arguing with his friends and his girlfriend; teachers complained that he was behind in his assignments and not attending class, and when he did attend he was a disturbance in the classroom; finally, Sam's use of alcohol and drugs had increased.

The nurse collaborated with the in-school multidisciplinary team, which resulted in a plan for counselling by the nurse and the guidance head. During the interview and mental health assessment, the nurse assessed Sam as being at risk for high-risk behaviours, feeling isolated and not supported, feeling that he did not have someone to talk to and not feeling a connectedness to his school or peers. Sam admitted to thoughts of suicide; he said no one cared about him, and he refused to speak to the Crisis Line social worker. The nurse understood the value of peer influence in someone of Sam's age, and that someone with a close and trusting relationship could connect with Sam. With Sam's consent, the nurse invited Sam's girlfriend and best friend in during the session. Sam's mood started to lift, and he realized that they were worried about him and that they wanted to support him.

Afterward, Sam was willing to speak with the social worker from the Crisis Line, and continued to receive support and counselling from the social worker. He connected with family members in the city and decided to live with them. The nurse maintained a good relationship with Sam; she touched base with him in the school regularly to assess his mood, ensure he was following through with counselling and show him that she cared.

Before Sam left the school, the nurse saw that he was rested, nourished and had a big smile on his face. He had done well in his classes, and expressed a connectedness to his school. He was positive about his decision to move in with other family members in the city and he had a hopeful attitude toward his future. The nurse connected him with a community support worker for ongoing support, career development and education opportunities as he transitioned to life after high school.

Implications:

Utilizing the knowledge and skills of youth development, nurses working with youth must:

- Build good rapport and establish a trusting relationship with youth.
- Be open and receptive to the youth's perspective and opinions.
- Understand the value of peer influence and school connectedness.
- Convey a nonjudgmental attitude and provide a confidential, comfortable environment during discussion.
- Collaborate with an interdisciplinary team to develop a plan of action.
- Be familiar with community resources and engage agency partners.
- Apply their clinical knowledge and judgment in assessing the health of the youth.

Permission obtained from Haldimand-Norfolk Health Unit. The above story was adapted from Morris, D. (2009). *Mental Health Report with a Focus on Suicide: Haldimand-Norfolk Stats*. Simcoe, Ontario: Haldimand-Norfolk Health Unit.

Organization and Policy Recommendations

The following recommendations reflect those elements in an organization that are fundamental to supporting nursing practice as described in this best practice guideline.

Creating Opportunities for Youth Involvement

RECOMMENDATION 8

Organizations establish a culture that supports youths' active engagement in creating a healthy future for themselves and their community.

Type IV Evidence

Discussion of Evidence

Organizational Commitment

Youth engagement represents a major shift in how some health organizations traditionally operate, and therefore requires significant organizational buy-in and change to incorporate into nursing practice. Support must come from the top and exist throughout all levels of the organization (Zeldin, Larson, Camino & Connor, 2005). Everyone needs to be on board – including board members, internal stakeholders and external partners.

To successfully engage youth, an organization should:

- Create youth-friendly environments that are receptive to the opinions of young persons.
- Allocate funds when needed.
- Create training opportunities for all agency staff regarding youth working within the organization (not just for those working directly with youth), and staff who work directly with youth.
- Establish clearly defined goals and methods to measure effectiveness.

Resource
Evaluation Toolkit for Building an Organization's Capacity to Engage Youth. Toronto, ON: Laidlaw Foundation Retrieved October 29, 2010, from: www.laidlawfdn.org/sites/default/files/resources/youth-eval-toolkit.pdf

Stability

Many factors within an organization add to the stability of a program:

- Organizations that host youth engagement projects must be safe and free from harmful behaviour.
- Health units and other health organizations can be ideal places to host youth engagement initiatives, as they are generally safe environments and are stable fixtures in the community.
- Program structure is needed to help youth feel safe and secure, as well as to provide a framework for them to work within. However, a balance between structure and flexibility must be struck, as too much structure can potentially inhibit youths' creativity and motivation.
- Funding and adult support are key to the stability of any program.
- Compensation for youth is important when building stability. Youth are busy individuals with complex lives that are constantly changing. They are often balancing many responsibilities, such as school, extracurricular activities, work, social life and family responsibilities. Thus, where possible, youth should be compensated for their time. The Youth Action Alliance in Ontario found that the paid component led to lower youth turnover (Fiissel et al., 2008). If financial compensation is not possible, then community service hours are another option; however, bear in mind that sometimes when youth have reached their required hours, they move on and that youth asset is lost. Additional incentives for youth participation include: the opportunity to develop leadership skills, interpersonal skills, life skills and healthy relationships; provision of certificates of merit, school credits, honoraria, gift certificates, or letters of recommendation; and the opportunity to gain valuable experience.
- Networks are key to the stability of any program. Research has shown that youth are more motivated to participate when they know that other youth who are doing similar work will be available for support and to act as a resource (Fiissel et al., 2008). Youth are more inspired and motivated when they feel that they are part of a movement, e.g. the Youth Action Alliances in health units in Ontario provides an extensive network of youth doing the same work in their local communities; opportunities to exchange ideas and work collaboratively were made available through the regional youth coalition and the annual province-wide youth conference.

PRACTICE VIGNETTE

Youth engaging

A local public health unit was developing a process to conduct a community needs assessment to inform planning for programs and policies that will positively impact the community's health. The staff responsible for planning this community assessment has affirmed youth engagement as an underlying principle and priority for their work. The Promotion of Youth Engagement is one activity identified in the operational plan.

A Photovoice model was used to engage youth in capturing a snapshot

of "ways my community makes it easier, or not, for me to be healthy." This included issues such as healthy eating, physical activity, tobacco use/exposure, substance and alcohol misuse, mental health and injury prevention. These observations will be used to inform the community needs assessment and plan for community mobilization toward policy development.

Photovoice is a participatory, qualitative methodology used with difficult-to-reach or marginalized groups of people (specifically for this project, youth aged 15 to 19 years). Through the use of photographs, it gives a voice to the people who most often aren't heard. It is a research technique based on the idea that, when attempting to understand community issues, local people – not outside professionals – are the experts.

Flexible meeting times were key

Youth compensated

Invitations for youth to participate were issued through the health unit website, at youth centres and other youth venues. Along with the opportunity to influence their community, volunteer hour credits were offered as an incentive. Groups were established in each local health unit office to ensure they were accessible to a variety of youth from different communities. The youth groups each determined the best time for them to meet over a six- to eight-week period. Public health nurses served as facilitators for each youth groups in the project. Their role was to establish a respectful and safe environment, encourage youth to discuss issues of concern, foster participation from all youth and assist them to think critically about the issues in their community.

Adult support via public health nurses

To prepare youth for the task, photography training was provided by a professional photographer, and session were held on ethics in photography and the "consent to be photographed" process. Youth took pictures to illustrate their perceptions of their community in the six areas of interest. They shared their pictures with the group, engaged in discussion about the meaning of the photographs and identified common themes. The group then selected the photos they believed best represented their issues and assigned captions to those photos.

Training provided

Safe, stable environment at health unit

The themes that arose from youth through this process will be incorporated into the community needs assessment and priority-setting exercises, so that their needs will be better supported through programs, projects and initiatives. Involving youth in planning for and implementing change in policies and programs will be the next step in creating improvements within the community.

RECOMMENDATION 9
Organizations establish internal policies and practices that support meaningful youth participation.
Type IV Evidence

Discussion of Evidence

Engagement in youth development requires healthcare organizations to operate based on the principle that young people need meaningful choices and roles in the activities in which they are involved, shifting from receiving knowledge to creating knowledge, and from being service recipients to being program planners and deliverers (Pittman et al., 2003). This translates into a healthcare organization's commitment to inclusion of youth in all aspects of decision-making, including, programming, funding, personnel and governance. Young people are often participants in organizations, but are not consistently seen as problem solvers (Irby et al., 2001).

To increase youth participation, healthcare organizations must move away from "things done to or for youth," and move toward combining program objectives with youth-development outcomes. Such integration can result not only in the attainment of agency goals, but also the development of youths' personal assets and relationships with nurses, as well as their respective organization.

Working with youth in a more participatory and meaningful way can facilitate a broader focus that goes beyond health issues. Adults in power "must approach relationships with young people with an intention of increasing transparency, accessibility and inclusivity of the organizations and agencies that serve the public." (Bynoe, 2006, p. 5). It is time to be intentional in our expectations and measure what we want them to do, not just what we do not want them to do (Pittman et. al., 2003).

PRACTICE BOX

Principles to Help Promote Youth Development

Pittman, Irby and Ferber (2000) outlined nine major principles to help promote youth development. These principles and the relevant agency policy considerations are outlined here:

Principle	Organizational Policy Considerations
1) Broaden the outcomes: beyond prevention and academics	■ Include positive development and assets gained by youth, not just prevention of problem behaviours or knowledge gained, as program/service outcome indicators
2) Broaden the inputs: beyond services	■ Assess service provision using youth-friendly guidelines and parameters ■ Consider planning models that involve youth in shaping service provision or as active contributors in achieving the agency mandate
3) Broaden the time frame: beyond quick fixes	■ Plan for and put resources in place to support long-term goal achievement of asset development with lasting benefits

RECOMMENDATIONS

4) Broaden the settings: beyond schools	■ Engage with youth in a variety of settings where they are comfortable ■ Create youth-engaging work environments, spaces and equipment
5) Broaden the times: beyond the school day	■ Adjust staff work hours, to be available when it is convenient for youth to access service or fully contribute ■ Consider the importance of work/school/life balance for youth
6) Broaden the actors: beyond professionals	■ Include youth and community stakeholders who value the contributions youth can make to achieving outcomes
7) Broaden youth roles: beyond recipients	■ Include youth as active and equitable members of the healthcare team, not simply recipients of service ■ Blend agency parameters with a youth-led framework. Honour agency standards honouring youth's creativity and culture
8) Broaden the targets: beyond labelling	■ Think beyond "at-risk" to promoting positive youth development through engaging youth in developing solutions
9) Broaden the numbers: beyond pilots	■ Recognize that short-term funding and repeated pilot projects discourage youth from participating and devalue the importance of youth health initiatives. ■ Assign a specific annual budget to youth initiatives

Integration of a youth development model in health organizations' practices requires organizational readiness in order to create successful experiences. In clinical settings, organizations can achieve this through utilization of strengths-based assessments, e.g. Duncan et al. (2007) suggested enhancing office interactions with the knowledge and best practices from the field of positive youth development by modifying the application of the Home, Education/Employment, Activities, Drugs, Sexuality, Suicide (HEADSS) assessment to identify strengths. "This means modeling respect and kindness toward adolescents and conveying the belief that adolescents have the ability to continue their positive health behaviours or to make a behaviour change when needed. An office visit is not just an occasion to assess for and champion the idea of strengths; it is also an opportunity to directly promote strengths in adolescents." (Duncan et al p. 531) Furthermore, organizations should plan and structure programs based on evidence-based findings related to features of positive development settings (Eccles & Gooteman, 2002). Tools are also available (Appendix K) that can help identify the extent to which existing services within an organization are youth friendly (Senderowitz, 1999, Senderowitz, 2002).

Funding and Resources Allocation

RECOMMENDATION 10
Agencies and funders allocate appropriate staffing and material resources to enable implementation of comprehensive approaches to adolescent programming.
Type Ia, III-IV Evidence

Discussion of Evidence

Organizational policies ensure that supports for youth are established and a quality practice environment is provided for nurses. Staffing practices and resources needed to adequately implement comprehensive approaches to adolescent programming include:

- Ensuring staffing assignments that support consistency and continuity of relationships between nurses and youth/youth groups (Shen, 2006).
- Providing adequate staffing for meaningful opportunities for interactions between nurses and youth and availability of staff at times convenient for youth (Shen, 2006).
- Allocating resources to support youth participation through the provision of financial support for transportation, facility rental in appropriate locations for youth participation, food, materials and supplies for initiatives, recognition, as well as honoraria (Public Health Agency of Canada, 2008; Scheve et al., 2006; Shepherd et al., 2002).
- Allocating funding for programming over time so that programs of appropriate length and rigorous design can be implemented and evaluated (Gambone, Yu, Lewis-Charp, Sipe & Lacoe, 2006).

Supports for Skill and Knowledge Development

RECOMMENDATION 11
Organizations provide educational opportunities for nurses to improve their understanding of adolescent development, health and well-being, and ways to engage youth in meaningful ways.
Type III-IV Evidence

Discussion of Evidence

The complexity of working with adolescents and the skill set needed by nurses requires that agencies:

- Provide various opportunities for nurses' professional development to enhance skills and knowledge regarding communication, facilitation, negotiation, cultural awareness, and current youth issues and concerns.
- Offer mentoring of new staff by experienced staff to contribute to the maintenance of organizational values and culture that reflect youth engagement and the development of expert practice (Grossman & Bulle, 2006; Shen 2006).
- Ensure access to adequate, current information and research to support nursing practice, including adolescent development theory, health-promoting strategies, youth empowerment strategies, youth engagement strategies, positive youth development strategies and systematic reviews (IUHPE, 2009; Jennings et al., 2006; Restuccia & Bundy, 2003).

Policy Recommendations

RECOMMENDATION 12

Nurses work in partnership with youth to advocate for healthy public policy and the development, implementation and evaluation of programs that serve to enhance healthy adolescent development. Ministries responsible for health, community, education and recreation must dedicate resources to ensure the implementation and evaluation of services directed at improving the success and well-being of youth across the province.

Type IV Evidence

Discussion of Evidence

Building on the Ottawa Charter, the World Health Organization describes healthy public policy in the following way:

> *"Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. It makes social and physical environments health-enhancing."* (WHO, n.d.)

The United Nations Convention on the Rights of the Child, which came into force in 1990, identified in Article 12 that children and youth have the right to be involved in decision-making processes that involve them. Canada is a signatory to this document (Canadian Children's Rights Council, 2010).

Through application of the principles of youth engagement and positive youth development, nurses can serve as allies and mentors for youth as they develop leadership skills and competencies to actively advocate for change within youth serving organizations, communities, systems such as school boards, and government. The following chart depicts how young engagement flows on a continuum from interventions to systemic change. The intent of this recommendation is for nurses to actively partner with youth to achieve systemic change.

Youth Engagement Continuum

Intervention	Development	Collective Empowerment	Systemic Change	
Youth Services Approach	**Youth Development**	**Youth Leadership**	**Youth Organizing**	**Civic Engagement**
▪ Defines young people as clients ▪ Provides services to address individual problems and pathologies of young people ▪ Programming defined around treatment and prevention	▪ Provides service and support, access to caring adults and safe spaces ▪ Provides opportunities for the growth and development of young people ▪ Meets young people where they are ▪ Builds young people's individual competencies ▪ Provides age-appropriate support ▪ Emphasizes positive self-identity ▪ Supports youth adult partnerships	Includes components of youth development approach plus: ▪ Builds authentic youth leadership opportunities within programs and organizations ▪ Helps young people deepen historical and cultural understanding of their experiences and community issues ▪ Builds skills and capacities of young people to be decision-makers and problem-solvers ▪ Youth participate in community projects	Includes components of youth development, youth leadership and civic engagement plus: ▪ Builds a membership base ▪ Involves youth as part of core staff and governing body ▪ Engages in direct action and political mobilization ▪ Engages in alliances and c oalitions	Includes components of youth development and youth leadership plus: ▪ Engages young people in political education and awareness ▪ Builds skills and capacity for power analysis and action around issues young people identify ▪ Begins to help young people build collective identity of themselves as social change agents ▪ Engages young people in advocacy and negotiation

Funders' Collaborative on Youth Organizing (2003). An Emerging Model for Working with Youth Community Organizing + Youth Development = Youth Organizing. p.10. Retrieved October 26, 2010, from http://www.fcyo.org/media/docs/8141_Papers_no1_v4.qxd.pdf.

According to Periera (2007), youth participation and opportunities for influencing organizations can be supported in the following ways:

- Incorporate a youth voice into board structures.
- Form advisory committees for programs and services development and evaluation.
- Consult through ad hoc committees.
- Establish a reference or advisory group.
- Offer peer-to-peer support as a component of programs.
- Integrate peer educators into program delivery.
- Engage youth as researchers through participatory action research methods.

Youth activism is referred to within the literature as civic engagement or youth organizing. Through their efforts, young people identify issues, analyze problems and determine how to influence power structures to create policy or social change (Funders' Collaborative on Youth Organizing, 2010; Lesko & Tsourounis; 1998; Schulman, 2006; Yee, 2008). Civic activism and youth development are complementary – not competing – approaches to youth work. Youth action strengthens youth by encouraging the active engagement of young people in their communities (Funders' Collaborative on Youth Organizing, 2003; Irby et al., 2001).

"For marginalized youth, who are most isolated and frequently discriminated against, youth organizing has particular utility. Within youth organizing, marginalized youth find companionship, structure, and a critical framework for studying and understanding the world around them – connecting their public and private life. By helping young people see how their individual experiences, both positive and negative, are shared by others, young people participate in group efforts that lead to building collective power." (Funders' Collaborative on Youth Organizing, 2003, p. 9)

Through youth organizing, youth develop competencies in six areas: 1) cultural, 2) personal, 3) civic, 4) political, 5) cognitive and 6) social. Youth have addressed a range of issues through their own efforts, including substances use, sexual health, community safety, school system reform and recreation opportunities available (Bradley et al., 2004; Funders' Collaborative on Youth Organizing, 2003; Holden et al., 2005).

In a toolkit for youth activism, the Innovation Center for Community and Youth Development (2004) identified best practices in developing youth leadership that reinforce each other as part of a developmental process:

- Personal leadership: Tied to identity formation.
- Organizational leadership: Expands on the role of young people as decision-makers.
- Community leadership: Focuses on youth organizing as a catalyst for community change.

COMMUNITY LEADERSHIP: PROMISING PRACTICE CHECKLIST

In supporting youth leadership in community, nurses should provide consistent and structured activities for youth to deepen their knowledge of and commitment to the community, including

- Help youth understand the community context.
- Learn the community issues that are meaningful and important to young people.
- Use the community as the arena for applying young people's skills.
- Foster a relationship-based approach to community leadership.
- Draw on youth-organizing strategies – education, advocacy and direct action – to engage youth as leaders in their communities.

Innovation Center for Community and Youth Development (2004) p.68

Government Actions and Policy Development

The nursing community has a responsibility to engage in advocacy initiatives on behalf of those who are unable to advocate for themselves. Adolescent development is a critical time in the maturation of humans; as such, it is deserving of appropriate supports in public policy decisions. Nurses must advocate for a youth voice in government policy decision-making processes, and support youth to advocate for their own needs in this environment. Nurses are encouraged to partner with youth to lobby for expansion of government services and policies that will contribute to supporting the healthy development of children and youth throughout their developmental years. Critical outcomes of this effort are the acquisition of long-term funding to support effective programming for positive youth development and the creation of communities that are supportive to youth development.

A review of youth policy models undertaken by United Way Toronto (2008) revealed that a youth policy framework (national, regional, or local) can "provide clarity around a government's long-term priorities and goals related to youth. An outcomes-based framework is connected to a longer-term strategy with positive youth outcomes as a goal." (p.9)

Provincial youth policy models that reflect the features supportive of youth development have also been developed. The province of Quebec has developed the most comprehensive youth policy framework to date. A Youth Secretariat was created, which reports directly to the Premier of the province; the Secretariat is responsible for ensuring the consistency of all government policies and initiatives relating to youth. Municipalities are also actively involved with youth – particularly with respect to youth health and safety – through police services, schools, transportation, housing and recreational services (Government of Canada, 2010). In British Columbia, a youth policy guides the delivery of youth services within the Ministry for Children and Families (Government of British Columbia, 2000). Alberta has given youth issues priority through a coordinated, government-wide effort called the Alberta Children and Youth Initiative; one key outcome is: "Youth are successful in the transition to adulthood." (Government of Alberta, 2007)

In Ontario, the provincial government has embarked on a youth engagement initiative through the Ministry of Infrastructure "to find solutions to urban growth issues using their own communities as their laboratories." (Government of Ontario, 2010) The Ministry of Health Promotion and Sport provided public health units with funding to hire youth peer leaders to take action on tobacco issues from 2005 to 2009. Upon the termination of this funding, the Ministry established a Youth Engagement Task Group to determine future directions for youth engagement strategies (yet to be announced). In a report to this task group, Pollara (2009) identified that the youth in these Youth Action Alliances were successful in influencing policy decisions, specifically:

> "At the community or broader scope, nearly all respondents acknowledged without prompt that they were able to make a difference in their community through the Youth Action Alliance program. Some of the examples cited were by-law changes to create smoke-free parks, the banning of chew tobacco in a high school, smoke-free car legislation, federal-level work against flavoured tobacco and other municipal by-law changes pertaining to smoking. Participants drew a direct connection between their work and these changes." (p.10)

Youth also reported gaining personal skills and confidence in their abilities, drawing a link between youth asset development and youth leadership, youth organizing and civic engagement.

The Practice Resources table below provides a number of tools to assist youth, nurses and government in engaging youth in creating change within organizations and their community, and developing government policy to achieve positive developmental outcomes for youth.

PRACTICE RESOURCES

For Youth

Youth! The 26% Solution

A guide for youth on the how-to's of getting organized and taking action.
www.youthactivism.com/26PercentSolution/Youth26Solution2008-Web.pdf

Mental Health: A Guide to Action

A Canadian resource guide written by youth for youth on the issues and potential actions.
www.teenmentalhealth.org/images/resources/MH_GUIDE_006.pdf

For Nurses

Learning and Leading: A Toolkit for Youth Development and Civic Activism

This toolkit Includes a description of key concepts, a set of promising practices, checklists, a list of resources, vignettes illustrating practical lessons and workshops or activities that have been used successfully in young people's groups. www.theinnovationcenter.org/files/learningandleading_toolkit.pdf

Maximum Youth Involvement! The Complete Game Plan for Community Action

This resource manual includes guiding principles and ideas for those exploring the feasibility of collaborating with youth or trying to expand the role of young people as community problem-solvers, particularly in the public policy arena.
www.youthactivism.com/freedownload/maximumyouthinvolvement/maximumyouthinvolvement!completeguidetocommunityaction.pdf

Say Y.E.S. to Youth: Youth Engagement Strategies

A resource package to assist in engaging youth within your team and organization.
http://downloads.cas.psu.edu/4h/yesbookweb.pdf

Adult Allies

A Canadian guide to being an effective ally for youth engagement.
www.engagementcentre.ca/files/alliesfinal_e_web.pdf

Allies In Action

A workshop manual to assist adults in embracing the notion that young people have a right to participate and that adults need to be comfortable in sharing power so as to enable youth to become meaningfully engaged related in addressing sexual health issues.
www.engagementcentre.ca/files/Allies_e.pdf

For Organizations

Hear by Right: The United Kingdom response to the UN Convention on the Rights of the Child
A series of tools and guides to assist in embedding youth participation across all levels of services, including standards and performance indicators, which can be effectively used at both strategic and operational levels across partnerships, departments and single organizations.
www.nya.org.uk/quality/hear-by-right/download-resources

Hear by Right in Health Services: Children and Young People's participation in PCTs, Hospitals And Other Health Settings
An overview of involvement of youth in service development.
http://nya.org.uk/dynamic_files/hbr/sharedresources/Hear%20by%20Right%20in%20Health%20Services.pdf

For Government

Investing in Youth: Evidence from Policy, Practice and Research
This document proposes a framework for analyzing public policy. The framework is a tool for reflection and its main goal is to help guide youth policy discussions in various sectors of government activity. It is intended to facilitate defining or revising government objectives in relation to policy research, and the development and evaluation of policies and programs.
http://policyresearch.gc.ca/2010-0017-eng.pdf

RECOMMENDATION 13
Nurses collaborate with a variety of community partners to promote the comprehensive school health model.

Type IIb-IV Evidence

Discussion of Evidence

Schools play a critical role in adolescent health and well-being. Adolescent health behaviours, their perceived social and emotional connectedness, as well as their mental well-being, are greatly influenced by their school environment (Auseum, Mesters, Van Breukelen, & De Vries, 2004; Cohall, Nshom & Nye, 2007; Joint Consortium for School Health, 2008; Robinson, 2006). According to the Joint Consortium for School Health (2008), the concept of health and education are interdependent: healthy students are better learners and a better-educated adolescent is healthier. It is, therefore, important for nurses to understand all aspect of the life of the school community in order to adequately promote the health of this population (IUHPE, 2009).

The term "comprehensive school health" is widely used in Canada. It is defined as an "internationally recognized framework for supporting improvements in educational outcomes while addressing school health in a planned, integrated and holistic way." (Joint Consortium for School Health, 2008, p.1)

Nurses working with adolescents must have an understanding of the Public Health Agency of Canada's model of comprehensive school health (Appendix L) and the critical role schools play in the healthy development of children and youth. When working with youth in other settings, awareness of the aspects

of school life that affect their health is essential. These include, but are not limited to: school connectedness, peer relationships and influence, quality of relationships with teachers and other adults, physical environment of the school, environmental supports and policy, bullying, academic success and self-perception (Ayres, 2008; Cohall et al., 2007; Grossman & Bulle, 2006; Public Health Agency of Canada, 2008; Streng, 2007; Youngblade et al., 2007).

Promoting the Comprehensive School Health Model while working in partnership with educators, families, community agency partners, acute care settings and mental health providers is a key aspect of the nurse's role while working with adolescents. For more information regarding this model, refer to the Joint Consortium for School Health website (www.jcsh-cces.ca).

PRACTICE VIGNETTE

A grade 10 student who sits on a Health Action Team at a health-promoting school became a lead on a subcommittee exploring healthier food choices in the school cafeteria. The youth recruited three other youths to join the subcommittee. A public health nurse assigned to the school, a cafeteria representative and a teacher were also on the subcommittee, all of whom supported the youth with the plans that they wanted to initiate within the school cafeteria.

The administration at the school was supportive of the youths exploring this issue and assigned dedicated space for them to hold meetings. The public health nurse took meeting minutes. The youth worked with the cafeteria lead on the committee to develop a healthy food item that they wished to feature for a few days in the school cafeteria. The public health nurse was instrumental in supporting the youth by engaging other stakeholders who could support the event (e.g. a dietitian from the local health unit). The teacher liaised with the administration to keep them informed of the progress of the committee. The public health nurse assisted the youth with a marketing campaign that followed a health promotion framework. This included the nurse assisting the youth with identification of key times and places to market the new idea, supporting the development of key messages and working with youth, cafeteria administrators and school administration to ensure that the healthier food was affordable.

The students decide to offer healthy wraps as the food item to be featured for the healthy nutrition days being marketed at the cafeteria. The events took place and went very well. Many students, teachers and administration staff had healthy wraps for lunch at a price point that was affordable for all. Following the event, the subcommittee reconvened to debrief. The youths all felt the event went well, and that they had learned and developed important social and leadership skills. The school felt that the decision-making with the youth involved was positive and that it was also an excellent strategy. The final outcome was that the cafeteria permanently added this item to the school menu.

At the suggestion of the nurse, the students who were involved in the initiative were rewarded by being granting community hours and a certificate that identified their leadership role.

The youth were excited about this opportunity as they had heard about a similar event happening at another local school. The feedback from the youth was as follows: they liked having the responsibility to execute this task; guidelines for the decisions that they could make were very clear from the outset; and the environment of the committee was youth friendly.

Implications

In this practice example, the nurse utilized the following knowledge and skills to effectively implement the comprehensive school model:

- health promotion and education;
- mentoring;
- relationship-building;
- understanding youth values and peer influence;
- understanding impact of school culture; and
- youth engagement / adult ally/ advocacy.

RECOMMENDATION 14

Nursing best practice guidelines can be successfully implemented only when there are adequate planning, resources, organizational and administrative supports, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to implementation.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Dedication of a qualified individual to provide the support needed for the education and implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, a panel of nurses, researchers and administrators developed the *Toolkit: Implementation of Clinical Practice Guidelines* (2002) based on available evidence, theoretical, perspectives and consensus. The Toolkit is recommended for guiding the implementation of the revised RNAO guideline *Enhancing Healthy Adolescent Development*.

Type IV Evidence

Discussion of Evidence

A critical initial step in the implementation of guidelines is their formal adoption and evaluation. Organizations must consider how to formally incorporate guideline recommendations into their policy and procedure structures (Graham, Harrison, Brouwers, Davies & Dunn, 2002). One example of such a formal adoption process would be integration of the guideline into existing policies and procedures. This initial step paves the way for general acceptance and integration of the guideline into such systems as the quality management process.

A commitment to monitoring the impact of the implementation of the *Enhancing Healthy Adolescent Development* best practice guideline is a key step that must be taken if there is to be an evaluation of the impact of the efforts associated with implementation. It is suggested that each recommendation to be adopted be described in measurable terms, and that the health-care team be involved in the evaluation and quality monitoring processes. A suggested list of evaluation indicators is provided on page 56.

New initiatives, such as the implementation of a best practice guideline, require strong leadership from nurses who are able to transform the evidence-based recommendations into useful tools that will assist in directing practice. In this regard, the RNAO – through a panel of nurses, researchers and administrators – has developed the Toolkit: Implementation of Clinical Practice Guidelines (2002) based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO best practice guideline *Enhancing Healthy Adolescent Development*. Appendix M provides a description of the Toolkit.

Research Gaps and Future Implications

In reviewing the evidence during the revision of this guideline, the development panel identified several gaps in the research literature related to enhancing healthy adolescent development.

The issues identified below, although in no way exhaustive, represent an attempt to identify and prioritize the research gaps in this area. Some of the recommendations in this guideline are based on evidence gained from qualitative or quantitative research, while others are based on consensus, reports or expert opinion. Further substantive research is required in some areas to validate the expert opinion and impact knowledge that will lead to improved practice and outcomes related to enhancing healthy adolescent development.

Recommendations for areas of new or expanded research include:

- Evaluation of effectiveness of programs addressing multiple risk factors.
- Integration of multiple risk factors in a program.
- Effective strategies for youth engagement for younger, middle and older youth (not just 15 to 19 years): do they differ?
- Can programs designed for specific groups of youth affect determinants of heath?
- The relationship between adolescents and healthcare providers.
- The role that nurses, and others, play in influencing adolescents' access to and utilization of healthcare services, and the quality of those services.
- The role of communities and neighbourhoods in adolescent health and development.
- The role of comprehensive school heath programs in promoting youth asset development.
- A comprehensive school health model, which highlights the nurse's role
- Evidence regarding the benefits of a nurse's role within the school setting.
- Development of youth assets through youth engagement opportunities.
- Health organization policies supporting youth engagement.
- Methods of successful youth engagement and sustainability.
- Methods of successful parent engagement to enhance healthy youth development.
- Implications of adolescent brain development for practice in health promotion and harm reduction.
- Adolescent use of information and communication technologies, and how they influence adolescent health status.

Evaluation/Monitoring of Guideline

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation, and its impact, will be monitored and evaluated.

The following table, based on a framework outlined in the RNAO Toolkit: Implementation of Clinical Practice Guidelines (2002), illustrates some specific indicators for monitoring and evaluation of the guideline *Enhancing Healthy Adolescent Development*. The Toolkit provides an example of how this matrix may be used.

Objective: Evaluate the supports needed, process involved and impact of the recommendations related to enhancing healthy adolescent development.

LEVEL OF INDICATOR	STRUCTURE (What you need)	PROCESS (How you go about it)	OUTCOME (What happens)
System	Adolescent development and behaviours are considered within the context of their family, school, peers, culture, neighborhood and community.	Educational opportunities are available for all healthcare professionals related to the principles underlying enhancing healthy adolescent development and youth engagement. Environment supports healthcare professionals in providing youth centered care that addresses multiple levels of influence and is grounded within the principles of youth engagement and therapeutic partnership with youth. A youth engagement model is utilized in the development and implementation of youth-specific programs.	Health professionals achieve greater understanding of factors affecting adolescent development and behaviour, e.g. social determinants of health. Health professionals provide culturally sensitive care/programming. Youth-specific programs are successful in promoting the assets and capacities of adolescents. Adolescents' strengths, potentials and leadership skills are enhanced. Adolescents are more involved in youth-specific programs.
	Nursing education programs embed theoretical and practical concepts related to adolescent development and health promotion within the curricula.	Curricula content development includes adolescent development, youth engagement approaches, therapeutic partnership with youth, principles of anticipatory guidance, resilience, philosophy of empowerment and creation of youth-friendly environments. There is ongoing dialogue between Schools of Nursing and organizations offering youth-specific services.	Nurses will have knowledge and skills related to adolescent development, health and well-being. Enhanced partnerships between Schools of Nursing and organizations offering youth-specific services.

LEVEL OF INDICATOR	STRUCTURE (What you need)	PROCESS (How you go about it)	OUTCOME (What happens)
Organization	There is organizational support for comprehensive collaborative approaches in programming and strategy development when working with youth.	Nurses, interdisciplinary colleagues, and youth are involved in the creation of policies related to positive adolescent development. Nurses promote and participate in Comprehensive School Health approaches while working in partnership with educators, families, community agency partners, acute care settings, mental health providers and others.	Policies positively affect youth development, health and well-being. An increase in number of schools and school communities participating in youth-specific health promotion activities.
	There is organizational support for meaningful youth participation in program development, implementation and evaluation.	Youth are provided with opportunities to participate in organizational initiatives that are geared toward promotion of adolescent health and well being.	Evidence that youth have opportunities provided for active involvement in and contributions to organizational decisions, e.g. youth committees, peer mentoring.
	Best practice guideline recommendations are reviewed by organizational structures (e.g. committees, programs) responsible for youth programs and services	Policies and procedures are consistent with recommendations to enhance healthy adolescent development and the values of youth-friendly services.	There is evidence that principles of enhancing healthy adolescent development and youth-friendly services are integrated and adopted within the program processes.
	Commitment to ensure continuity of adolescent programming.	Organizational mission that supports a youth-friendly environment. Dedicated workspace is provided, with appropriate tools for youth to meet and to work. Evaluation and implementation of recommendations are planned and resourced.	Formal recognition of the commitment to youth engagement by the organization Youth friendly work environment created equivalent to adult space. Successes and barriers to implementation are identified.
	Organizations provide evidence based professional development programs.	Organizations develop and deliver continuing professional development activities, orientation and mentorship programs that integrate evidence based positive adolescent development strategies.	Number of education sessions focused on adolescent development. Availability of mentors for development of youth specific programs and approaches.

LEVEL OF INDICATOR	STRUCTURE (What you need)	PROCESS (How you go about it)	OUTCOME (What happens)
Nurse	Nurses and non-nursing staff with theoretical and practical knowledge of positive adolescent development are available. Range of partnerships with youth and others (interprofessional and multisectoral) are established to plan and deliver youth health services and address issues of concern to youth.	Nurses and non-nursing staff identify their learning needs or proportion of nurses demonstrating personal reflection on the application of required knowledge and skills in working with youth and areas for growth Nurses champion and promote the utilization of this best practice guideline in their daily practice. Educational resources related to positive adolescent development approaches are available. Nurses' and non-nursing staff's self assessed knowledge of the importance of: ■ Youth-friendly services and practice. ■ The use of theory to guide youth engagement practice. ■ Assessing healthy adolescent asset development. ■ Documenting healthy adolescent asset development. ■ Developing a facilitative approach to working with adolescents as partners. ■ Understanding the facilitators, challenges and barriers to successful implementation of the guideline.	Completion of educational programs related to strategies and approaches for enhancing healthy adolescent development. Percent of nursing and non-nursing staff that report being actively involved in the implementation process. Percent of nurses and non-nursing staff self-reporting: ■ The degree of adolescent involvement in developing, implementing and evaluating programs. ■ Adequate assessment of an adolescent's desire to be an active partner. Nurses apply theory and evidence to their practice with youth as partners.
Adolescents	Adolescents have a voice in the programs and activities affecting their own health and well-being. Contributes ideas for improvement in agency facilities to be more youth-friendly. Demonstrates commitment to involvement over time in initiatives.	Adolescent are provided with the necessary resources and tools that allow them to become full participants. Adolescent self-assessed perception of youth friendly services and factors affecting their health and well-being. Youth engaged to actively contribute to decisions and participate in evaluation of initiatives.	Improved adolescent satisfaction and involvement. Adolescents report being included as full partners in the program. Adolescents feel they are being listened to. Youth report increased assets, knowledge and skill in areas relevant to an initiative/service.

LEVEL OF INDICATOR	STRUCTURE (What you need)	PROCESS (How you go about it)	OUTCOME (What happens)
Financials Costs	Provision of adequate financial resources for the level of staffing needed for a model of service based on working with adolescents as partners. Provision of adequate time, resources, education, training and development of skills for youth. Provision of incentives and recognition for youth achievements.	Development of evaluation process for resource allocation. Process is created for inclusion of stakeholders regarding resource allocation. Costs for education, other interventions and on the job support for nurses and youth. Office/facility planning to accommodate youth volunteers/staff workspace. Specific budget allocation to support youth engagement initiatives and modify facilities to be youth-friendly.	Optimal investment of resources related to promotion of positive adolescent development and youth engagement. Youth report appropriate work and service delivery space and needed tools available. Youth report contributions are valued and acknowledged.

Implementation Strategies

The Registered Nurses' Association of Ontario and the guideline revision panel have compiled a list of implementation strategies to assist healthcare organizations or healthcare providers who are interested in implementing this guideline. A summary of these strategies follows:

- Have at least one dedicated person such as an advanced practice nurse or a clinical resource nurse who will provide support, clinical expertise and leadership. The individual should also have good interpersonal, facilitation and project management skills.
- Conduct an organizational needs assessment related to enhancing healthy adolescent development to identify current knowledge base and further educational requirements.
- Initial needs assessment may include an analysis approach, survey and questionnaire, group format approaches (e.g. focus groups), and critical incidents.
- Establish a steering committee comprised of key stakeholders and interdisciplinary members committed to lead the change initiative. Identify short term and long term goals. Keep a work plan to track activities, responsibilities and timelines.
- Create a vision to help direct the change effort and develop strategies for achieving and sustaining the vision.
- Program design should include:
  - target population;
  - goals and objectives;
  - outcome measures;
  - required resources (human resources, facilities, equipment); and
  - evaluation activities.
- Design educational sessions and ongoing support for implementation. The education sessions may consist of presentations, facilitator's guide, handouts, and case studies. Binders, posters and pocket cards may be used as ongoing reminders of the training. Plan education sessions that are interactive, include problem solving, address issues of immediate concern and offer opportunities to practice new skills (Davies & Edwards, 2004).

- Provide organizational support such as having the structures in place to facilitate the implementation. For example, hiring replacement staff so participants will not be distracted by concerns about work and having an organizational philosophy that reflects the value of best practices through policies and procedures. Develop new assessment and documentation tools (Davies & Edwards, 2004).
- Identify and support designated best practice champions on each unit to promote and support implementation. Celebrate milestones and achievements, acknowledging work well done (Davies & Edwards, 2004).
- Organizations implementing this guideline should adopt a range of self-learning, group learning, mentorship and reinforcement strategies that will, over time, build the knowledge and confidence of nurses in implementing this guideline.

In addition to the strategies mentioned above, the RNAO has developed resources that are available on their website. A Toolkit for implementing guidelines can be helpful if used appropriately. A brief description regarding this Toolkit can be found in Appendix M. A full version of the document in PDF format is available at the RNAO website (www.rnao.org/bestpractices).

Process For Guideline Review and Update

The Registered Nurses' Association of Ontario proposes to update this best practice guideline as follows:

1. Each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area every three -five years following the last set of revisions.

2. During the period between development and revision, RNAO program staff will regularly monitor for relevant literature in the field.

3. Based on the results of the monitor, program staff may recommend an earlier revision period. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guidelines earlier than the planned schedule.

4. Three months prior to the review milestone, the program staff will commence the planning of the review process by:
   a) Inviting specialists in the field to participate in a Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b) Compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c) Compiling new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research, and other relevant literature.
   d) Developing detailed work plan with target dates and deliverables.

5. The revised guideline will undergo dissemination based on established structures and processes

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Appendix A: Original Guideline Development Process (2000–2002)

Since 1999, the Registered Nurses' Association of Ontario (RNAO), with funding from the Government of Ontario, has established a program of nursing best practice guideline development, evaluation, dissemination, implementation and support for uptake. One area of emphasis early in the program was identification of multiple strategies that would direct nursing practice in enhancing healthy adolescent development. Consequently, a guideline entitled Enhancing Healthy Adolescent Development was developed by a panel of nurses convened by the RNAO. This work was conducted independent of any bias or influence from the Ontario Government.

In 2000, a panel of nurses with expertise in practice, education and research, from hospital, community, and academic settings, was convened under the auspices of the RNAO. The panel discussed the purpose of their work, and achieved consensus on the scope of the best practice guideline. Subsequently, a literature search for clinical practice guidelines, systematic reviews, relevant research studies and other types of evidence was conducted.

A review and critique was conducted of approximately 60 studies and various frameworks supported by the literature that articulated principles and practices in working with adolescents. Through a process of evidence gathering, synthesis and consensus, a draft set of recommendations was established. This draft document was submitted to a set of external stakeholders for review and feedback; an acknowledgement of these reviewers is provided at the front of this document. Stakeholders represented various healthcare professional groups. External stakeholders were provided with specific questions for comment, as well as the opportunity to provide overall feedback and general impressions. The result were compiled and reviewed by the development panel; discussion and consensus resulted in revisions to the draft document.

A pilot implementation practice setting was identified through a Request for Proposal process. Practice settings in Ontario were asked to submit a proposal if they were interested in pilot testing the guideline recommendations. These proposals were then subjected to a review process, from which a successful practice setting was identified. A twelve-month pilot implementation was undertaken to test and evaluate the recommendations. Further refinement of the guideline was undertaken after the pilot implementation period (please refer to acknowledgement at the front of the document).

Appendix B: Revision Process (2009/2010)

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this best practice guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each published guideline.

In February 2009, a panel of nurses with expertise in adolescent health from a range of practice settings (including institutional, community and academic sectors) was convened by the RNAO. The group was invited to participate as a review panel to revise the Enhancing Healthy Adolescent Development guideline originally published in July 2002. This panel was composed of members of the original development panel, those with experience implementing the guideline and other recommended specialists.

The panel members were given the mandate to review the guideline, focusing on the currency of the recommendations and evidence, and maintaining the original scope of the document. This work was conducted as follows:

Planning

- Search terms were generated with input from the panel team leader for each recommendation in the guideline.
- A literature search was conducted by a health sciences librarian.
- A structured website search was conducted by program staff, focusing on recently published clinical guidelines.

Critical Appraisal

- Search results were reviewed by a research assistant assigned to the panel. The review included examining abstracts with respect to inclusion and exclusion criteria (see Appendix C for a detailed description of the search strategy).
- Studies that met the inclusion and exclusion criteria were retrieved. Quality appraisal and data extraction were conducted by the research assistant. The results were then summarized and circulated to the panel.

Panel Review

- Panel members reviewed the data extraction tables, systematic reviews and, where appropriate, original studies and clinical guidelines.
- Recommendations for additional search strategies were identified to address gaps in the evidence.
- Through a process of consensus, recommendations for revision to the guideline were identified.

Appendix C: Process for Literature Review/Search Strategy

The search strategy utilized during the revision of this guideline focused on two key areas: 1) The identification of clinical practice guidelines published on the topic of adolescent development; and 2) A literature review to identify primary studies, meta-analyses and systematic reviews published in this area from 2001 to 2010.

Step 1: Database Search

A database search for existing evidence related to healthy adolescent development was conducted by a health sciences librarian using search terms generated in consultation with the panel lead. The search strategy utilized by the Cochrane Effective Practice and Organization of Care group was used to formulate the final search strategy. An initial search of the Cochrane Database of Systematic Reviews, MEDLINE, ProQuest, CINAHL, WebScience, PsychInfo, Embase and Ageline databases for guidelines, primary studies, and systematic reviews published from 2001 to 2010 was conducted using the following search terms: "Adolescent;" "adolescent development;" "adolescent – supports;" "adolescent – family;" "school;" "peer group;" "community;" "health promotion;" "adolescent practice guidelines;" "adolescent practice guideline;" "adolescent development clinical practice guideline;" "youth;" "youth development;" "asset development;" "youth engagement;" "peer education;" "peer (or youth) led models;" "mentorship;" "positive youth outcomes;" "youth organizing;" "meaningful youth participation;" "nurturing strength and abilities of youth;" "youth engagement & health outcomes;" "youth services;" "youth capacity;" "youth leadership;" "youth contributions;" "youth civic activism (engagement);" "positive youth development;" "risk & resiliency;" and "mental health promotion."

As directed by the panel, the need for additional literature searches was identified and conducted to supplement the results of the review report.

STEP 2: Structured Website Search

One individual searched an established list of websites for content related to the topic area in April 2009. This list of websites was compiled based on existing knowledge of evidence-based practice websites, known guideline developers and recommendations from the literature. The presence or absence of guidelines was noted for each site searched, as well as the date searched. Some websites did not house guidelines, but directed readers to another website or source for guideline retrieval. Guidelines were downloaded if full versions where available, or ordered by telephone or email.

- Alberta Heritage Foundation for Medical Research: www.ahfmr.ab.ca/publications
- Agency for Healthcare Research and Quality: www.ahrq.gov
- Alberta Medical Association Clinical Practice Guidelines: www.albertadoctors.org
- Annals of Internal Medicine: www.annals.org
- Bandolier Journals: www.medicine.ox.ac.uk/bandolier
- British Columbia Office of Health Technology Assessment: www.chspr.ubc.ca
- British Columbia Council on Clinical Practice Guideline: www.bcguidelines.ca/gpac
- Canadian Coordinating Office for Health Technology Assessment: www.ccohta.ca
- Canadian Institute for Health Information: www.cihi.ca
- CMA Infobase: Clinical Practice Guidelines: www.mdm.ca/cpgsnew/cpgs/index.asp
- Cochrane Reviews: www.cochrane.org/reviews

- Commission on the Future of Health Care in Canada: www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/romanow-eng.php
- CREST: www.crestni.org.uk
- Database of Abstracts of Reviews of Effectiveness: www.crd.york.ac.uk/crdweb
- Evidence Base on Call: www.eboncall.org
- European Observatory on Health Care for Chronic Conditions, World Health Organization: www.who.int/chronic_conditions/en/
- Guidelines Advisory Committee: www.gacguidelines.ca
- Guidelines International Network: www.g-i-n.net
- Health Canada: www.hc-sc.gc.ca
- Health-Evidence: www.health-evidence.ca
- Institute for Clinical Evaluative Sciences: www.ices.on.ca
- Institute for Clinical Systems Improvement: www.icsi.org
- Joanna Briggs Institute: www.joannabriggs.edu.au
- Medic8.com: www.medic8.com/ClinicalGuidelines.htm
- Monash University Centre for Clinical Effectiveness: www.monash.edu.au/healthservice/cce/evidence
- National Guideline Clearinghouse: www.guidelines.gov
- National Institute for Clinical Excellence: www.nice.org.uk
- New Zealand Guidelines Group: www.nzgg.org
- NHS Centre for Reviews and Dissemination: www.york.ac.uk/inst/crd
- US Department of Health & Human Services National Institutes of Health Consensus Development Program: www.consensus.nih.gov
- NIHR Health Technology Assessment Programme: www.ncchta.org
- Royal College of General Practitioners: www.rcgp.org.uk
- Royal College of Nursing: www.rcn.org.uk/index.php
- Royal College of Physicians: www.rcplondon.ac.uk
- Scottish Intercollegiate Guidelines Network: www.sign.ac.uk
- SUMSearch: www.sumsearch.uthscsa.edu
- The Qualitative Report: www.nova.edu/ssss/QR
- Trip Database: www.tripdatabase.com
- Virginia Henderson International Nursing Library: www.nursinglibrary.org

Step 3: Website Guidelines Search

In addition, a website search for existing practice guidelines related to healthy adolescent development and youth engagement/leadership was conducted via the search engine Google (www.google.com), using key search terms. One individual conducted this search, and noted the results of the search, the websites reviewed and date found. This search yielded no guidelines pertaining to this topic area.

Step 4: Hand Search/Panel Contribution

Panel members were asked to review their personal archives to identify guidelines not previously found via the search strategies noted above. No guidelines were identified from this search.

Search Results

The search strategy described above resulted in the retrieval of 1,621 abstracts on the topic of adolescent development. These abstracts were then screened by a research assistant in order to identify duplications and assess for inclusion and exclusion criteria established by the panel. A total of 74 abstracts were identified for article retrieval and critical appraisal. No clinical practice guidelines were identified pertaining to healthy adolescent development in the context of youth engagement and youth leadership.

Appendix D: Health Status of Adolescents

In 2003, 67% of Canadian youth aged 12 to 24 years identified that they are in excellent or very good health, a decrease from 73% in 1998 (Canadian Council on Social Development, 2006). This decrease in percentage is significant and must be addressed. It is therefore critical to understand those issues central to adolescent health, in order to effectively promote the well-being of this population. Summarized below are issues that affect adolescent health.

Alcohol and Drug Use

The Centre for Addiction and Mental Health conducted annual surveys in 2009 of Ontario students in grades 7 through 12 related to alcohol and drug use. Ten-year trends in alcohol use among the students surveyed identified a decrease from 66.0% in 1999 to 58.2% in 2009 (Paglia-Boak, Mann, Adlaf, & Rehm, 2009). Despite this reduction, risky drinking behaviours of youth aged 12 to 19 years has increased significantly over the 10-year period (Public Health Agency of Canada, 2010).

Of the ten drugs (including cannabis) asked about in the survey, illicit drug use among students in grades 7 through 12 decreased significantly between 1999 and 2009. In particular, drug use among students declined to 27.9% in 2009 from 32.3% in 1999 (Paglia-Boak et al., 2009).

Tobacco Use

Tobacco use has declined significantly for youths aged 15 to 19 years, but remains high among those aged 20 to 24 years. In 2008, the Canadian Tobacco Use Monitoring Survey provided data on the long-term trends of smoking prevalence across Canada. The survey documented a downward trend in smoking rates for youth: In 1999, 31% of youth aged 15 to 24 years smoked tobacco; by 2008, the rate had declined to 21% (Health Canada, 2009). Despite this positive outcome, the prevalence of smoking by youth aged 20 to 24 years remained high, dropping from 34% in 1999 to 27% in 2008 (Health Canada, 2009). However, smoking by youth aged 15 to 19 years of age dropped significantly to 15% in 2008, down from 28% in 1999 (Health Canada, 2009).

Obesity

The epidemic of overweight and obesity has become a major issue for 2- to 17-year-old Canadians. Indeed, obesity rates rose from 15% in 1978 to 26% in 2004 (Shields, 2004). According to Raine (2004), youth in low-income families, youth of ethnicity, and youth who live in urban neighbourhoods are at higher risk of obesity. Aboriginal children are also at higher risk for obesity and being overweight (Raine, 2004).

Chronic Diseases

Chronic diseases affect the lives of many young Canadians. Based on the report entitled The Health of Canada's Children: A CICH Profile (2000), the Canadian Institute of Child Health identified that approximately one-third of all children between ages 12 and 14 reported having a chronic condition (Canadian Institute of Child's Health, n.d.). Chronic conditions include allergies, asthma, emotional disorders, neurological disorders and mobility disabilities. The report also documented the following:

- Youth who have chronic conditions generally experience some form of limitations in activity and are therefore less active.
- Youth who have chronic conditions are more likely to smoke cigarettes, consume alcohol, and/or be involved in physical fights.

The prevalence of chronic conditions cannot be ignored. A Health Canada report (2007) noted that 1,300 children and youth in Canada develop cancer ever year, 16% suffer from asthma; moreover, a staggering 33% of Canadian children born today will develop diabetes.

Research regarding the relationship between clustering of behavioural risk factors and chronic disease demonstrated that 65% of Canadian youth had two or more risk factors, with older youth and those in lower socioeconomic families having multiple risk factors (Alamian & Paradis, 2009).

Mental Health and Well-being

According to a mental health and well-being survey conducted in 2007 by the Ontario Student Drug Use and Health Survey (OSDUHS), the majority of students rated their health as excellent or very good (Adlaf et al., 2007). These students also reported getting along with their parents and experiencing a positive school climate (Adlaf et al., 2007). In addition, none of these students reported internalizing or externalizing their problems (Adlaf et al., 2007). However, a significant minority reported impaired well-being or functioning:

- One-third of students reported elevated psychological distress, and being bullied at school.
- One in five students reported visiting a mental health professional and setting something on fire.
- One in eight students reported poor personal health, delinquent behaviour and concern about personal safety at school.

"Eighty percent of all psychiatric disorders emerge in adolescence and are the single most common illness that commence in the adolescent age group." (Health Canada, 2007, p. 5) Indeed, in the ODSUHS survey, 10% of students reported suicidal ideation and low self-esteem (Adlaf et al., 2007). The same survey also documented that 5% of students reported having used prescribed medication to treat their feelings of depression and/or anxiety; 5% of these students reported depressive symptoms, had attempted suicide and/or had taken part in a gang fight (Adlaf et al., 2007).

Suicide is a leading cause of death for Canadian adolescents, with attempted suicide outnumbering completed suicide four to one (Adlaf et al., 2007). This issue is of particular concern in First Nations adolescents, where the number of suicide deaths is approximately six higher than the general adolescent population (Adlaf et al., 2007)

Another mental health issue affecting the adolescent population is eating disorders, which can lead to serious physical and mental health issues. According to a 2002 survey, 1.5% of Canadian women aged 15 to 24 years had an eating disorder (Government of Canada, 2006).

Sexual Practices and STIs

Engaging in sexual intercourse at a young age, having multiple partners and having unprotected sex put youth at risk for STIs and unwanted pregnancy. In 2005, 43% of youth aged 15 to 19 reported having had intercourse at least once, a decrease from 47% in 1996/1997 (Statistics Canada, 2008). Condom usage increased overall between 2003 and 2005, with use more common among youth 15 to 17 years of age than those 18 to 19 years of age (Rotermann, 2005).

Approximately one-third of the 15- to 24-year-olds who had had sexual intercourse in the past year had done so with more than one partner (Public Health Agency of Canada, 2009a). While condom use can reduce the likelihood of acquiring an STI, the incidence of some STIs has risen considerably.

Rates of STIs per 100,000 population	Year	Age 15–19 years	Age 20–24 years
Chlamydia (Public Health Agency of Canada, 2009a)	1991	623.4	621.6
	2008	989.4	1,342.7
Gonorrhea (Public Health Agency of Canada, 2009b)	1991	86.0	100.6
	2008	127.2	166.0

Teenage Pregnancy

Between the year 1993 and 2003, Rotermann (2007) reported that teenage pregnancy in Canada had declined from 4.8 to 2.4 births per 1,000 15- to 19-year-old girls. However, despite this decline, teenage pregnancy continues to persist in our society, negatively affecting the health and well-being of many girls. It has been documented that "early childbearing can have serious consequences for both the babies and their mothers. Infants born to teenagers are more apt to experience adverse birth outcomes and die during their first year of life than are infants born to older women." (Rotermann, 2007, para. 7) Furthermore, education and employment opportunities of teen mothers are often affected by their pregnancy, leading to lowered income. Of particular concern are those teens who have more than one baby, as they are likely to be at even greater disadvantage (Rotermann, 2007).

Sexuality

In a 2004 survey involving Canadian youth aged 13 to 29 years, 3.5% of the participants identified their sexual orientation as lesbian, gay, bisexual or transgender (LGBT) (Wells, 2006). Homosexual youth face health risks and social problems at greater rates than their heterosexual counterpart. This can be directly attributed to the chronic stress that many LGBT youth experiences, primarily as a result from coping with society's negative responses and stigmatization. These youth often reported fear of being rejected or being victims of violence if they are known to be homosexual (University Institute for Social Research, 2006; Wells, 2006). In addition, these youth are at higher risk of contracting HIV/AIDS, being victims of violence and/or being unemployed, all of which can contribute to premature mortality (University Institute for Social Research, 2006).

Exposure to Violence

Exposure to violence can have long-term impacts on an individual. The 2007 OSDUHS found that 30% of Ontario students reported being bullied at school, while 25% reported that they had bullied others (Adlaf et. al., 2007). In addition, about 40% of women who reported spousal abuse identified that their children had heard or seen the occurrence of abuse (Adlaf et al., 2007). Similarly, another study has shown that three to five students in every classroom have witnessed domestic violence (BC Yukon Society of Transition Houses, 2007).

Exposure to violence has detrimental effects on the adolescent's overall well-being. The BCYukon Society of Transition Houses (2007) documented that youth who are exposed to violence are at greater risk of experiencing the following problems:

- emotional issues;
- poorer academic performance;
- difficulty in paying attention;
- stress-induced illnesses; and
- may act out or become quiet and withdrawn.

Assault

Many situations of assault are not reported to police. The rate of police-reported assaults in 2007 are highest for youth aged 12 to 17 years, with sexual assault occurring at the rate of 295 per 100,000 population and physical assault at the rate of 1333 per 100,000. The majority of assaults were committed by an acquaintance (55%) or family member (30%) (Nemr, 2009).

Appendix E: Aboriginal Cultural Identity – Ten Considerations and Strategies

Reprinted with permission from: Crooks, C., Chiodo, D. & Thomas, D. (2009). *Engaging and Empowering Aboriginal Youth: A Toolkit for Service Providers*. Toronto, ON: Centre for Prevention Science, Centre for Addiction and Mental Health. Retrieved November 2, 2010, from http://youthrelationships.org/research_consulting/toolkit.html

Integrating culture into a program is an ongoing process. Similarly, establishing a sense of cultural identity is an ongoing process for the youth and adults involved. The following considerations and strategies are offered as starting points.

1. **Awareness of cultural identity needs to be woven into every step of our activities.**
   Cultural identity is woven through the very fabric of our work. It is not merely a lesson in a curriculum or an activity in a program. It is also about using teachable moments to help youth explore positive and healthy notions of culture and what it means to be a First Nations or Métis or Inuit youth. Incorporation of cultural identity must be considered during every step of program development, implementation, delivery, assessment practices and evaluation.

2. **Positive role models from youth cultural groups are an incredible asset in developing a healthy cultural identity.**
   All youth turn to their peers for issues of identity, and this process is amplified among youth who are not part of the dominant culture. Positive peer role models are incredible assets in this regard.

3. **Culturally relevant teachings are best identified through community partners.**
   Community partners, cultural advisors, and elders are best able to determine the cultural teachings that should be incorporated into a program. Strong and equal relationships with these people provide the foundation for this transfer of knowledge.

4. **Cultural identity needs to be reflected in the environment of the setting.**
   All youth need to see themselves reflected in positive ways in the media around them. For example, Aboriginal students need to see posters in the hallways that reflect their heritage. These culturally diverse posters should not be simply for issues related to culture, but for any positive images (such as work placements, student leaders, etc.).

5. Cultural competence needs to be fostered among professionals.

Non-Aboriginal youth and adults working with Aboriginal youth have an obligation to become educated about history, culture, and current events. Program deliverers must be culturally sensitive to effectively respond to the needs of the individual and community. This professional and personal development can include formal activities such as attending conferences, ceremonies, cultural events and reading books, but it is also achieved through informal learning with partners.

6. Traditions and symbols are important components of cultural identity (but they are not the sum of it).

There is an important place for rituals and symbols, but incorporating these into your program does not mean you have met your obligation to culturally enhance your services. Utilizing these symbols needs to be done carefully, as misappropriating a tradition or symbol is disrespectful.

7. Different ways of knowing need to be incorporated into programs.

Culture is also about process in terms of traditional ways of knowing. Notions of teacher and student and learning are different than in the more narrowly defined roles held by Western cultures. For example, the use of a sharing circle reflects equality in some First Nations and Inuit cultures, and may be more appropriate for Aboriginal youth than a lecture format.

8. Holistic worldviews are an integral part of most indigenous cultures.

One way to make almost any activity or program more culturally relevant is to incorporate a more holistic worldview with respect to health and balance. Attending to intellectual, emotional, spiritual, and physical needs will make a program more consistent with traditional Aboriginal values in general. A holistic program strives to incorporate a wellness model that balances all four areas. Spirituality in particular (often misunderstood as religion) is frequently absent from programs.

9. Youth need access to culturally relevant material, but also the opportunity for self-reflection.

Incorporating cultural information is not simply about providing youth with particular materials and experiences. It is also about providing them with opportunities to reflect and consider the traditional teachings and to consider the relevance and role of these teachings in a personal way.

10. Historical and contemporary cultural images must be balanced.

Too often, attempts to integrate cultural information and images rely solely on antiquated characterizations that reinforce stereotypes. A balance must be maintained between historical and contemporary representations of Aboriginal people.

Appendix F: Forty Developmental Assets

(for adolescents aged 12 to 18 years)

Search Institute has identified the following building blocks of healthy development that help young people grow up in a healthy, caring and responsible manner.

EXTERNAL ASSETS

Support	1. Family support- Family life provides high levels of love and support. 2. Positive family communication- Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents. 3. Other adult relationships- Young person receives support from three or more non-parent adults. 4. Caring neighbourhood- Young person experiences caring neighbours. 5. Caring school climate- School provides a caring encouraging environment. 6. Parent involvement in schooling- Parent(s) are actively involved in helping young person succeed in school.
Empowerment	7. Community values youth- Young person perceives that adults in the community value youth. 8. Youth as resources- Young people are given useful roles in the community. 9. Service to others- Young person serves in the community one hour or more per week. 10. Safety- Young person feel safe at home, school, and in the neighbourhood.
Boundaries & Expectations	11. Family boundaries- Family has clear rules and consequences and monitors the young person's whereabouts. 12. School boundaries- School provides clear rules and consequences. 13. Neighbourhood boundaries- Neighbours take responsibility for monitoring young people's behaviour. 14. Adult role models- Parent(s) and other adults model positive, responsible behaviour. 15. Positive peer influences- Young person's best friends model responsible behaviour. 16. High expectations- Both parent(s) and teachers encourage the young person to do well.
Constructive Use of Time	17. Creative activities- Young person spends three or more hours per week in lesson or practice in music, theatre, or other arts. 18. Youth programs- Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community. 19. Religious community- Young person spends one or more hours per week in activities in a religious institution. 20. Time at home- Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

Commitment to Learning	21. Achievement motivation- Young person is motivated to do well in school. 22. School engagement- Young person is actively engaged in learning. 23. Homework- Young person reports doing at least one hour of homework every school day. 24. Bonding to school- Young person cares about her or his school. 25. Reading for pleasure- Young person reads for pleasure three or more hours per week.
Positive Values	26. Caring- Young person places high value on helping other people. 27. Equality and social justice- Young person places high value on promoting equality and reducing hunger and poverty. 28. Integrity- Young person acts on convictions and stands up for her or his beliefs. 29. Honesty- Young person "tells the truth even when it is not easy." 30. Resposibility- Young person accepts and takes personal responsibility. 31. Restraint- Young person believes it is important not to be sexually active or to use alcohol or other drugs.
Social Competencies	32. Planning and decision making- Young person knows how to plan ahead and make choices. 33. Interpersonal competence- Young person has empathy, sensitivity, and friendship skills. 34. Cultural competence- Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds 35. Resistance skills- Young person's can resist negative peer pressure and dangerous situations. 66. Peaceful conflict resolution- Young person seeks to resolve conflict nonviolently.
Positive Identity	37. Personal power- Young person feels he or she has control over "things that happen to me." 38. Self-esteem- Young person reports having high self-esteem 39. Sense of purpose- Young person reports that "my life has a purpose." 40. Positive view of personal future- Young person is optimistic about her or his personal future

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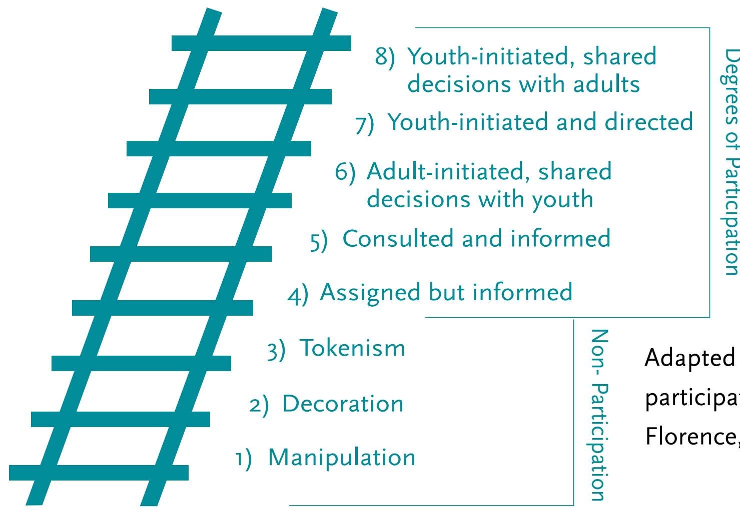
Appendix G: Key Influence on Youth Health and Development

Source: Youth Service Steering Committee (2002). Guidelines for provisions of youth services. Vancouver, BC: Ministry of Children and Family Development. Retrieved October 25, 2010, from www.mcf.gov.bc.ca/youth/pdf/guidelines_provision_of_youth_services.pdf. Reprinted with permission.

Appendix H: Hart's Ladder of Youth Participation

©2008. Adam Fletcher for The Freechild Project. Located online at www.freechild.org



Adapted from: Hart, R. (1992). Children's participation from tokenism to citizenship. Florence, Italy: UNICEF Innocenti Research Centre.

8) Young people-initiated, shared decisions with adults.

This happens when projects or programs are initiated by young people and decision-making is shared between young people and adults. These projects empower young people while simultaneously enabling them to access and learn from the life experience and expertise of adults. This rung of the ladder can be embodied by youth/adult partnerships.

7) Young people-initiated and directed.

This step is when young people initiate and direct a project or program. Adults are involved only in a supportive role. This rung of the ladder can be embodied by youth-led activism.

6) Adult-initiated, shared decisions with young people.

This step occurs when projects or programs are initiated by adults but the decision-making is shared with young people. This rung of the ladder can be embodied by participatory action research.

5) Consulted and informed.

This step happens when young people give advice on projects or programs designed and run by adults. The young people are informed about how their input will be used and the outcomes of the decisions made by adults. This rung of the ladder can be embodied by youth advisory councils.

4) Assigned but informed.

This step is where young people are assigned a specific role and informed about how and why they are being involved. This rung of the ladder can be embodied by community youth boards.

3) Tokenism.

This step occurs when young people appear to be given a voice, but in fact have little or no choice about what they do or how they participate. This rung of the ladder reflects adultism.

2) Decoration.

This step happens when young people are used to help or "bolster" a cause in a relatively indirect way, although adults do not pretend that the cause is inspired by young people. This rung of the ladder reflects adultism.

1) Manipulation.

This step happens when adults use young people to support causes and pretend that the causes are inspired by young people. This rung of the ladder reflects adultism.

Appendix I: Examples of Theoretical Approaches

Example A: Youth Development Approach

This information was compiled by Sierra Health Foundation in partnership with the Youth Development Network. Reprinted with permission from the Sierra Health Foundation.

Youth development is the process by which all young people seek ways to meet their basic physical and social needs and to build competencies (knowledge and skills) necessary to succeed in adolescence and adulthood.

Youth development is also an approach to working with young people that intentionally helps them meet developmental needs, builds their capacity and provides relationships and connections needed for their success.

The youth development approach not only includes youth building their skills to prepare themselves for adulthood, but also youth working to transform their community to address the social, physical, educational and cultural challenges that impede youth growing up successfully. This includes youth serving roles as leaders, civic advocates and community mobilizers.

The youth development approach is based on more than 40 years of research in the youth development, asset development and resiliency fields.

The Youth Development approach is based on the following set of principles:

Problem free is not fully prepared. We need to do more than prevent youth problems; we also need to ensure youth are prepared to take on adult roles and responsibilities.

Single-focus strategies don't work. Developing the whole child requires that we use comprehensive and collaborative approaches that address the full range of competencies we want youth to have civic, social, vocational, cognitive, creative/cultural and physical. Since no one person or agency can supply all of what youth need to succeed, we need to collaborate to create a web of support around youth to ensure they get the full range of supports and opportunities to help them develop.

Development happens across all settings. Youth are developing 24/7. By ensuring every setting has what we know youth need to succeed, we can help youth develop in positive ways. Everyone has a role in developing youth.

All young people need the same supports and opportunities. We know through research that youth need supports and opportunities to succeed. Some youth have less access to these supports and opportunities, but all youth need the same supports and opportunities.

Youth are resources, not just recipients of services. Youth have much to contribute if adults give them a chance to be part of the solution. Being engaged is critical to their development, as well as to making programs more relevant and communities more youth-friendly.

Framework for Practice

Sierra Health Foundation's REACH youth program uses the framework for change developed by Gambone, entitled *Finding Out What Matters for Youth*. Her research shows that children and youth who have certain supports and opportunities are more likely to achieve positive developmental outcomes. These outcomes include: being productive (graduating, becoming employed or going to college); being able to navigate (solve problems, know where to get help, manage living situations) and being connected (have healthy relationships, contribute to the community, and belong to groups).

The framework identifies the following key supports and opportunities that contribute to the developmental outcomes:

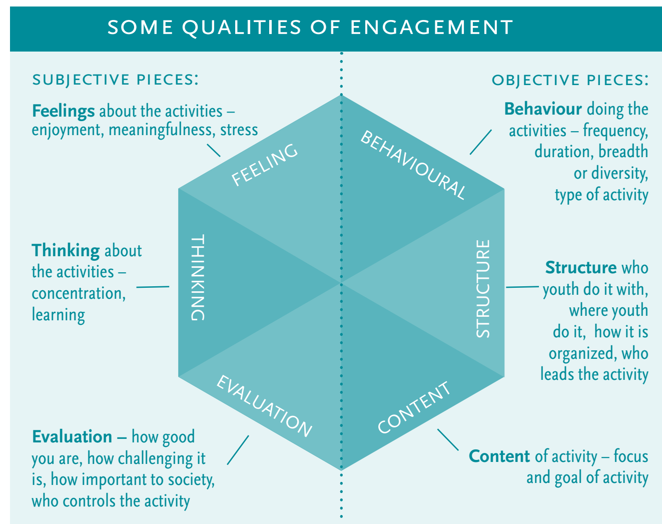
- Access to basic nutrition, shelter and health.
- Access to emotionally and physically safe environments.
- Multiple supportive relationships with adults and peers.
- Meaningful opportunities for youth voice, group membership and leadership.
- Meaningful opportunities to be involved in the community, impact the community and transform the community.
- Challenging, relevant and engaging activities and learning experiences.

Agencies can create high-quality experiences and programs through practices, policies and environments that offer youth these supports and opportunities. Organizational practices that support high-quality youth development approaches include: low staff-to-youth ratios, continuity on staff to ensure relationship building with youth, clear and fair standards of behaviour, use of multiple teaching modalities, staff training on youth development, structures and policies in organizations that include youth in decision making and leadership, collaboration and partnership with the community and families, cultural competency, flexible funding, evaluation and continuous learning.

Communities can create policies that ensure youth have access to environments and experiences that provide youth the supports and opportunities they need to succeed, i.e. more safe places after school, mentors for any child who wants one, inclusion, cultural competency and community-based services to ensure access and relevancy, opportunities for youth to engage in service to community, more youth on decision-making bodies, program evaluations that include youth voice and perspective/youth-led evaluations, adult training on how to engage with youth, and developing policies that support a stable and well-trained youth worker workforce.

Example B: Youth Engagement model: a Conceptual Model

Note: The Youth Engagement Conceptual Model is continually evolving as more is learned about youth engagement. However, the main structure of the model is complete and can be used as a framework for understanding youth engagement and health outcomes.



The Model– Under Construction

There are many ways to represent youth engagement. Our goal is to start with some key questions that invite others to share their own views about engaging youth. Through an ongoing process of inquiry, discussion, and practice we hope to build collective knowledge. Let us start the inquiry with some questions:

WHAT INITIATES ENGAGEMENT?

Part of our model is concerned with how youth first become involved in an activity. This initiating process may be different for each person and each type of activity or engagement.

We represent initiating process in our model with a "bubble", like this

FIG. 1

Some of the things that may help youth become involved include:

1. Individual or "self" factors. There are characteristics such as values, temperament, and interests, and

2. Social factors. For example, some youth report that they become involved in order to be with their friends or because a teacher asked them.

We represent these two initiating processes as a two-layered bubble. We consider that people exist as (1) individuals who (2) have important relationship with other people...

FIG. 2

A person's decision to get involved also may be influenced by

3. Systems. For example, the schools, organizations, communities, and countries in which he or she lives and works.

FIG. 3

We add a third layer to represent (3) system processes that may influence whether youth become involved or not.

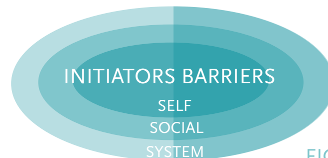


FIG. 4

Think of the resulting bubble as what gets engagement started or hinders it – at a personal level, in terms of relationships with others, and the systems in which we live and work.

We can connect the layered bubble and the engagement circle with an arrow. The arrow shows that initiating factors may **lead** to engagement.

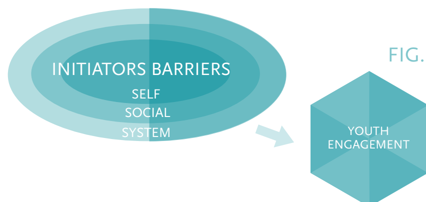


FIG. 5

WHAT SUSTAINS ENGAGEMENT?

Once the youth are involved in an activity, they may decide to keep doing it – or to stop doing it. Similar to the initiating process, sustaining factors may be different for each person and for each type of activity or engagement.

The sustaining process may be layered, since a person's decision to stay involved may be influenced by personal characteristics, other people, and the system in which the person live and works.

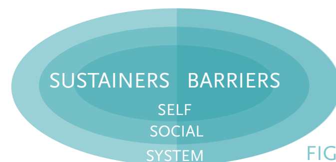


FIG. 6

So, in our model, we put in a bubble called " *Sustainers/ Barriers*" to represent the things that affect whether a person stays involved or not. This bubble has layers, just like the initiating bubble.

Think of this bubble as what keeps engagement going and what discourages it – at a personal level, in terms of relationships with others, and the systems in which we live and work.

The arrows show that initiating factors may lead to the beginning of engagement, and that sustaining factors may lead to continued engagement.

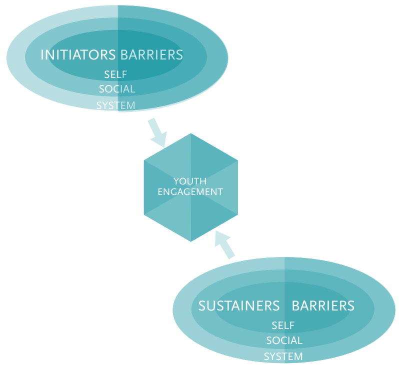


FIG. 7

ENGAGEMENT AND OUTCOMES?

Another question is whether engagement leads to positive outcomes.

Outcomes may be layered since engagement could lead to personal benefits, as well as improved social relationships, and even improvements in the systems (schools, organizations, communities, towns, provinces, countries) in which we live and work.

So, the connection between engagement and positive outcomes may be different for each person, type of activity and type of outcome.

FIG. 8

In our model, we have a bubble for "outcomes". This bubble has layers, just like the other bubbles and indicated the potential for both positive outcomes (the left side of the bubble) and negative outcomes (the right side).

Think of this bubble as what the benefits of engagement may be – at a personal level, in terms of relationship with others, and the environments we live in.

We also consider whether engagement may sometimes lead to outcomes that are not so positive – such as frustration or stress.

Thus, in our model, engagement may lead to specific outcomes.

ENGAGEMENT DEVELOPS

In our model, the factors and processes that engage youth or prevent them from being engaged operate over time.

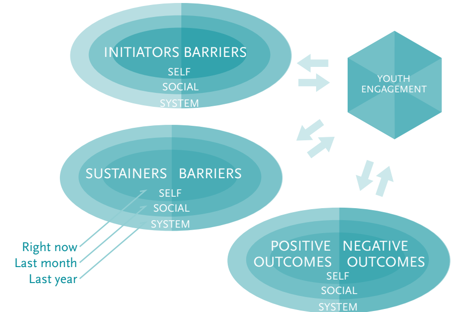
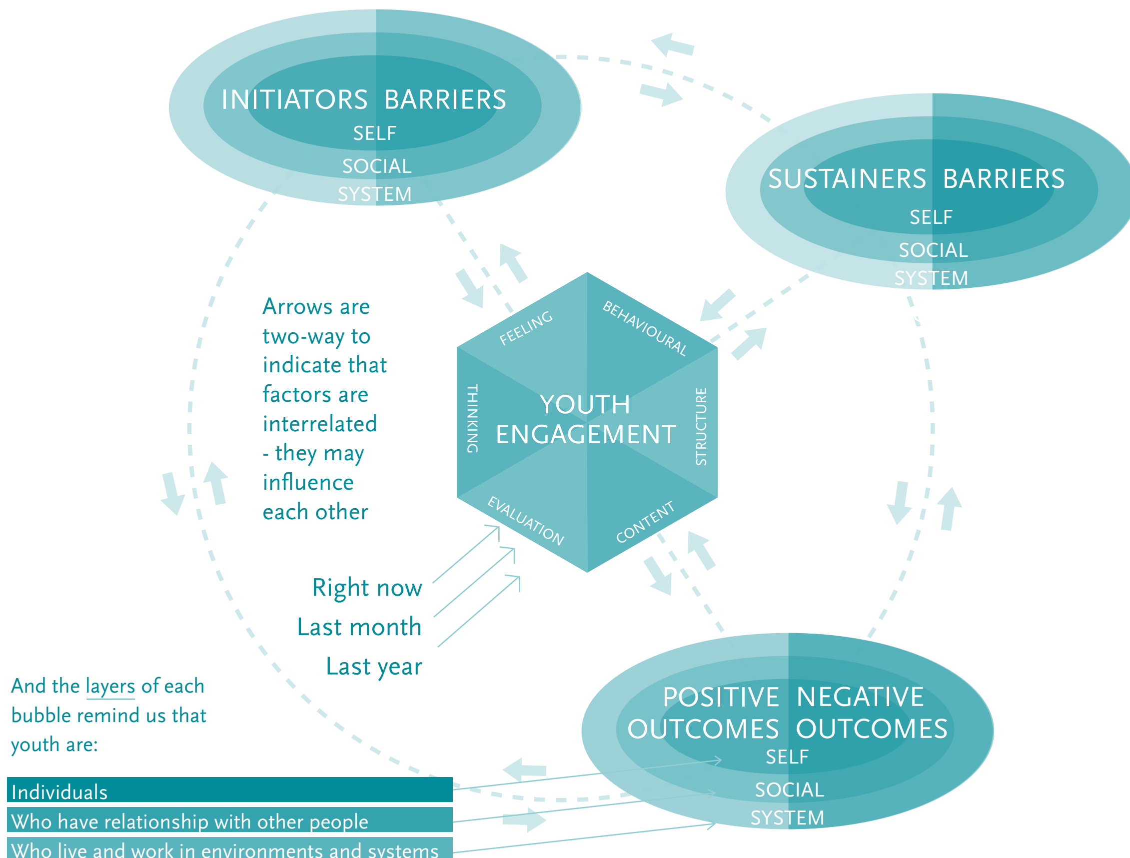


FIG. 9

THE MAIN PARTS OF THE MODEL

Together, the bubbles capture the main parts of our model:

- What initiates or hinders engagement?
- What are the many different qualities of engagement?
- What sustains or discourages engagement?
- What are the potential outcomes?

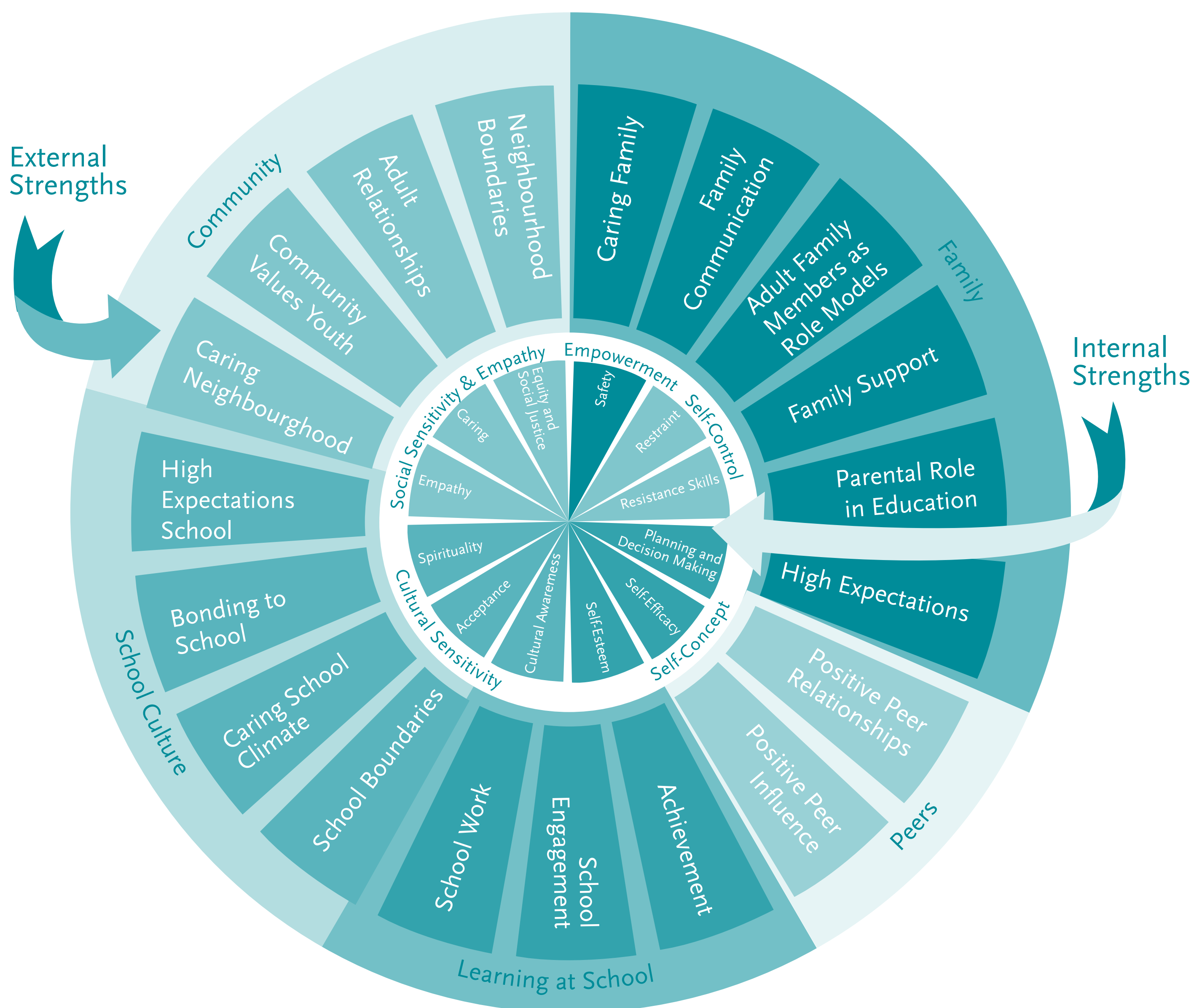


Source: Centre of Excellence for Youth Engagement (2007). Youth Engagement: A Conceptual Model. Available online at www.engagementcentre.ca. Reformatted and reprinted with permission.

Example C: Youth Resiliency Framework

Reprinted with permission from Dr. Wayne Hammond of Resiliency Initiatives (2001), www.resiliencyinitiatives.ca

The foundation of the Youth Resiliency Framework is based on the child, youth, and adult resiliency assessment and developmental protocols which promote a strength-based approach and holistic framework for understanding the major components that contribute to individuals becoming both productive and responsible.



Youth Developmental Strength
Understanding Youth Resiliency in Your Community

Resiliency Factor	Developmental strength	Description
Family support	Caring family	Family provides a nurturing, caring, loving home environment
	Family communication	Youth can communicate with family openly about issues/concerns
	Adult family role models	Family provides responsible role models
	Family support	Family provides trust, support, and encouragement regularly
Family Expectations	Family role in education	Family is active in providing help/support with education
	High expectations	Family encourages youth to set goals and do the best he/she can
Peer Relationships	Positive peer relationships	Friendships are respectful and viewed positively by adults
	Positive peer influence	Friendships are trustworthy and based on positive outcomes
Community Cohesiveness	Caring neighbourhood	Youth live in a caring and friendly neighbourhood
	Community values youth	Adults in the community respect youth and their opinions
	Adult relationships	Adults try to get to know the youth and are viewed as trustworthy
	Neighbourhood boundaries	Neighbours have clear expectations for youth
Commitment to Learning At School	Achievement	Youth works hard to do well and get the best grades in school
	School engagement	Youth is interested in learning and working hard in the classroom
	Homework	Youth works hard to complete homework and assignment on time
School Culture	School boundaries	School has clear rules and expectations for appropriate behaviour
	Bonding to school	Youth cares about and feels safe at school
	Caring school climate	School environment and teachers provides a caring climate
	High expectations	School/teacher encourages goal setting and to do the best he/she can

Resiliency Factor	Developmental strength	Description
Cultural Sensitivity	Cultural awareness	Youth has a good understanding and interest in other cultures
	Acceptance	Youth respects others beliefs and is pleased about cultural diversity
	Spirituality	Youth's strong spiritual beliefs/ values play an important role in life
Self-Control	Restraint	Believes that it is important for him/her to restrain from substance use
	Resistance skills	Is able to avoid or say "no" to people who may place he/she at risk
Empowerment	Safety	Youth feels safe and in control to his/her immediate environment
Self-Concept	Planning and decision-making	Youth is capable of making purposeful plans for the future
	Self-efficacy	Youth believes in his/her abilities to do many different things well
	Self-esteem	Youth feels positive about his/her self and future
Social Sensitivity and Empathy	Empathy	Youth is compassionate with others and cares about other people's feelings
	Caring	Youth is concerned about and believes it is important to help others
	Equity and social justice	Believes in equality and that it is important to be fair to others

Appendix J: Evidence-based Resources

Health-evidence.ca, is a free, searchable online registry that provides systematic reviews on the effectiveness of public health and health promotion interventions. The registry is updated quarterly and allows practitioners to register to receive quarterly notices with only the evidence that is relevant to their area(s) of interest. Adolescent health is one of the searchable options that a registered user may select among a wide range of topic areas. The site also provides tools to support evidence-informed decision making.

Other evidence-based, online resources include:

- The Cochrane Collaboration: www.cochrane.org;
- The McMaster University Centre for Evidence-based Practice: http://hiru.mcmaster.ca/epc/;
- The Centre for Excellence and Outcomes in Children and Young People's Services (a United Kingdom-based site that distills the best academic research and combines it with effective frontline practice): www.c4eo.org.uk/; and
- Evidence-Based Nursing (an international digest of pre-appraised evidence from a wide range of international medical journals): http://ebn.bmj.com

In addition to the above resources, listed below are some more generic resources that nurses can use when reviewing, appraising, and integrating new research findings into their practice settings:

- The Health Planners Toolkit: Evidence-Based Planning, www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_3.pdf

- TEIP Program Evidence Tools - a set of guidelines and worksheets that provide support in identification and application of relevant sources of evidence toward local health promotion and chronic disease prevention program: http://teip.hhrc.net/docs/tools/d._Program_Evidence_Tools/TEIP_Program_Evidence_Tools.pdf

- The Canadian Best Practices Portal (CBPP) - a compendium of community interventions related to chronic disease prevention and health promotion that have been evaluated, and have the potential to be adapted and replicated by other health practitioners working in similar field: http://cbpp-pcpe.phac-aspc.gc.ca/

- The Health Communication Unit online, an evidence-based health program planner that includes a workbook, worksheets, evidence to support decision-making, practical tips and recommended resources for each step: www.thcu.ca/ohpp/

This site also provides a comprehensive list of hot linked resources related to evidence-informed practice, www.thcu.ca/infoandresources/resource_display.cfm?resourceID=1205&translateto=English

- The IDM Evidence Framework, a tool to help practitioners/decision makers address health promotion issues more effectively by incorporating evidence from research and evaluation into daily practice. It also includes values and theories and understanding of the environment, and emphasizes how all these factors interact with each other: www.utoronto.ca/chp/download/IDMmanual/IDM_evidence_dist05.pdf

Furthermore, a number of Canadian organizations and agencies disseminate information about evidence-based best practices in program development and evaluation. Much of this information is oriented to specific fields of practice, e.g. the Centre for Addiction and Mental Health provides a web-based resource for practitioners that identifies ten best practice guidelines for mental health promotion interventions directed at children and youth.

Appendix K: Characteristics of and Assessment of Youth-friendly Services

Example A: Characteristics of Youth-Friendly Services Checklist

Provider Characteristics

- ❒ Specially trained staff
- ❒ Respect for young people
- ❒ Privacy and confidentiality honoured
- ❒ Adequate time for client and provider interaction
- ❒ Peer counsellors available

Health Facility Characteristics

- ❒ Separate space and special times set aside
- ❒ Convenient hours
- ❒ Convenient location
- ❒ Adequate space and sufficient privacy
- ❒ Comfortable surroundings

Program Design Characteristics

- ❒ Youth involvement in design and continuing feedback
- ❒ Drop-in clients welcomed and appointments arranged rapidly
- ❒ No overcrowding and short waiting times
- ❒ Affordable fees
- ❒ Publicity and recruitment that inform and reassure youth
- ❒ Boys and young men welcomed and served
- ❒ Wide range of services available
- ❒ Necessary referrals available

Other Possible Characteristics

- ❒ Educational material available on site and to take away
- ❒ Group discussions available
- ❒ Delay of pelvic examination and blood test possible
- ❒ Alternative ways to access information counselling and services

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Example B: Assessment of Youth Friendliness

For more information regarding this assessment tool, please refer to:

Senderowitz, J. (2002). *Clinic assessment of youth friendly services: A tool for assessing and improving reproductive health services for youth.* Washington, DC: Pathfinder International. Retrieved October 25, 2010, from www.pathfind.org/site/DocServer/mergedYFStool.pdf?docID=521.

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1. Location	Method	Answer	Comments/Recommendations
How far is the facility from public transportation?	E, IS, IC		
How far is the facility from places where adolescents spend their free time?	E, IS, IC		
How far is the facility from schools in the area?	E, IS, IC		
2. Facility Hours			
What time is the clinic scheduled to open?	IS, IC		
What time is the clinic scheduled to close?	IS, IC		
Does the facility have separate hours for adolescents?	IS, IC		
Is there a sign listing services and clinic working hours?	E		
What times are convenient for adolescents to seek services?	IS, IC		

3. Facility Environment	Method	Answer	Comments/Recommendations
Does the facility provide a comfortable setting for adolescent clients?	E, IC		
Does the facility have a separate space to provide services for adolescent clients?	E, IC		
Does the facility have separate waiting room for adolescent clients?	E, IC		
Is there a counselling area that provides both visual and auditory privacy?	E, IC		
Is there an examination room that provides visual and auditory privacy?	E, IC		
Are both young men and young women welcomed and served, either for their own needs or as partners	IS, IC, R		
4. Staff Preparedness			
Are providers trained to serve adolescent clients in reproductive health?	IS		
Did all staff members (e.g. receptionist) receive at least an orientation about adolescent clients? What type of orientation was this and how long was it?	IS		
Do providers show respect for the adolescent client during counselling and consultations?	IS, O, IC		
Are there job aids available to help service provides in their daily work (i.e. flipchart, posters that remind them of key messages, clients right etc.)?	IS, O		

5. Services Provided	Method	Answer	Comments/Recommendations
Is counselling on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention provided (including dual protection?	IS, IC, P		
What contraceptive methods are offered (including EC)?	R, IS, IC, P		
Are condoms provided to both males & females?	IS, IC, O, P		
Are supplies (condoms, other contraceptive methods, and drugs) sufficient to meet the need?	IS, IC		
Is there sufficient equipment for the provision of RH services for young people (small size speculum, scale, sphygmomanometer, syringe, needles, etc.)?	IS, E		
Is pregnancy testing offered?	R, IS, IC, P		
Is STI testing available? What type is available?	R, IS, IC, P		
Do young people request RH services other than the one offered? Which ones?	IS, IC		
Are referrals made for services not provided at the clinic (e.g. sexual abuse)? Please give examples	R, IS, IC, P		
Is there a formal referral system, including tracking and follow-up in place?	IS, IC, P		
6. Peer Education/Counselling Program			
Is a peer education/ counselling program available? If so, please describe.	IS, IC, O		
How many peer education/ counsellors are working with the facility?	IS		
How many hours a week do they each spend at the facility?	IS		
Is there a system for supervising and monitoring counsellors? If so, what kind of system?	IS, P		

APPENDICES

7. Educational Activities	Method	Answer	Comments/Recommendations
Are educational materials available on-site (A/V, computers, printed material?) which one?	IIS, IC, E		
Are there educational posters displayed?	IS, IC, E		
Are there posters or brochures that describe the clients' right?	S, IC, E I		
Are there print materials available for clients to take? Describe materials and comment.	S, IC, E		
In what languages are information, education and communication materials available?	IS, IC, E		
Are group discussions held? Please describe.	IS, IC, O		
Are there ways clients can access information or counselling off-site (telephone hotline, website, materials sent by mail)? Please describe.	IS, IC, E		
8. Youth Involvement			
What ways can adolescents suggest/ recommend change to make services more comfortable and responsive?	IS, IC, E, P		
Are adolescents currently involved in decision-making about how programs are delivered? How?	IS, IC, P		
How could adolescents be more effectively involved in decision-making at the facility?	IS, IC		
What other roles can adolescents play in clinic operations or guidance?	IS, IC		

9. Supportive Policies	Method	Answer	Comments/Recommendations
Do clear written guidelines for serving adolescents exist? Please describe.	IS, P		
Do written procedures exist for protecting client confidentiality? Please describe.	IS, P		
Are records stored so that confidentiality is assured?	IS, E, P		
Are there any contraceptive methods that adolescents cannot receive? Which ones?	IS, IC, P		
Is parental or spousal consent required? Which type and under what circumstances?	IS, IC, P		
Is there a minimum age requirement for adolescents to receive services? If yes, why and for what service?	IS, IC, P		
Are adolescent client served without regard to their marital status?	IS, IC, P		
Are pelvic exams routinely required? For what reasons? Can they be delayed?	IS, IC, P		
Do policies or procedures exist that pose barriers to youth friendly services?	IS, IC, P		

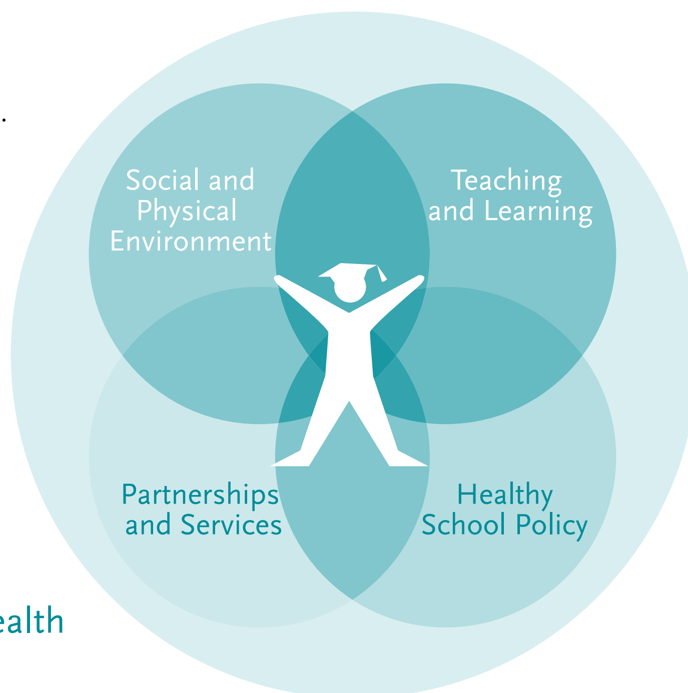
10. Administrative Procedure	Method	Answer	Comments/Recommendations
Is the registration process private so that other waiting clients cannot overhear the conversation?	IS, IC, E, P		
Can adolescent clients be seen without an appointment?	IS, IC, P		
If appointments are required, can they be expedited for adolescent clients?	IS, IC, P		
How long would an adolescent client wait, on average, to see a provider?	IS, IC		
What is the average time allowed for client/provider interaction?	IS, IC, O, P		
11. Publicity/ Recruitment			
Does publicity about the clinic identify services offered and stress confidentiality?	IS, IC, E		
Are there staff or volunteers that do outreach activities? If so, what type?	IS, IC, O		
12. Fees			
How much are adolescents charged for specific methods and services?	IS, IC, P		
Are these fees affordable by adolescents in the catchment area?	IS, IC		

E = Examine clinic layout and environment
IC = Interview clients
IS = Interview clinic managers and staff
O = Observe provider-client interaction
P = Review clinic policies and procedures
R = Review clinical records

Improvement Needed	Action Required	ResourcesNeeded	Person Responsible	Date Planned/Completed	Potential Obstacle

Appendix L: Comprehensive School Health Model

Reprinted with permission from the *Joint Consortium for School Health* (2008). Source: Joint Consortium for School Health (2008). What is Comprehensive School Health? Retrieved November 1, 2010, from www.jcsh-cces.ca/index.php?option=com_content&view=article&id=40&Itemid=62.



Pillars of Comprehensive School Health

When we say ...	We mean ...
Social and physical environment	The social environment is: ■ The quality of the relationships among and between staff and students in the school.
	■ The emotional well-being of students.
	■ Influenced by relationships with families and the wider community.
	The physical environment includes: ■ The buildings, grounds, play space and equipment in and surrounding the school.
	■ Basic amenities such as sanitation and air cleanliness.
Teaching and learning	■ Resources, activities and provincial/territorial curriculum where students gain age-appropriate knowledge and experiences, helping to build the skills needed to improve their health and well-being.
Healthy school policy	■ Management practices, decision making processes, rules, procedures and policies at all levels that promote health and well-being, and shape a respectful, welcoming and caring school environment.
Partnerships and services	Partnership are: ■ The connections between the school and students' families.
	■ Supportive working relationships within schools (staff and students), and between schools and other community organizations and representative groups.
	■ Health, education and other sectors working together to advance school health.
	Services are: ■ Community and school-based services that support and promote student and staff health and well-being.

Appendix M: Description of the Toolkit

Best practice guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative support, and appropriate facilitation. In this light, the RNAO – through a panel of nurses, researchers and administrators – has developed the *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of any clinical practice guideline in a healthcare organization.

The *Toolkit* provides step-by-step directions for individuals and groups involved in planning, coordinating and facilitating the guideline implementation. Specifically, the Toolkit addresses the following key steps in implementing a guideline:

1. Identifying a well-developed, evidence-based clinical practice guideline.
2. Identifying, assessing and engaging stakeholders.
3. Assessing environmental readiness for guideline implementation.
4. Identifying and planning evidence-based implementation strategies.
5. Planning and implementing evaluation.
6. Identifying and securing required resources for implementation.

Implementing guidelines that result in successful practice changes and positive clinical impact is a complex undertaking. The Toolkit is a key resource for managing this process.

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GUIDELINES

TRANSFORMING
NURSING THROUGH
KNOWLEDGE

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