July 2013

Connecting the Dots

How Ontario Public Health Units are Addressing Child and Youth Mental Health

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Public Health Ontario
PARTNERS FOR HEALTH

Santé publique Ontario
PARTENAIRES POUR LA SANTÉ

Toronto Public Health

Prepared by:

CAMH Health Promotion Resource Centre
Health Promotion and Prevention Team,
CAMH Provincial System Support Program
33 Russell Street,
Toronto, Ontario M5S 2S1
Telephone: 416 535-8501
www.camh.ca

Public Health Ontario
480 University Avenue, Suite 300,
Toronto, Ontario M5G 1V2
Telephone: 647 260-7100
www.publichealthontario.ca

Toronto Public Health
277 Victoria Street,
Toronto, Ontario M5B 1W2
Telephone: 416 338-7600
www.toronto.ca/health

ISBN PRINT	978-1-77114-163-5
ISBN PDF	978-1-77114-164-2
ISBN HTML	978-1-77114-165-9
ISBN ePUB	978-1-77114-166-6

How to Cite This Publication
Centre for Addiction and Mental Health; Ontario Agency for Health Protection and Promotion (Public Health Ontario); Toronto Public Health. Connecting the dots: how Ontario public health units are addressing child and youth mental health. Toronto, ON: Centre for Addiction and Mental Health; 2013.

CAMH Health Promotion Resource Centre
The CAMH Health Promotion Resource Centre provides system support, capacity building and access to evidence-based resources to inform programming and policy for Ontario health promotion and public health audiences related to substance misuse, mental health promotion and tobacco. The CAMH Health Promotion Resource Centre is situated in the Health Promotion and Prevention Team, Provincial System Support Program at the Centre for Addiction and Mental Health (CAMH). The Centre for Addiction and Mental Health is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the areas of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues. For more information about CAMH, visit *www.camh.ca*.

Public Health Ontario
Public Health Ontario is a Crown corporation dedicated to protecting and promoting the health of all Ontarians and reducing inequities in health. Public Health Ontario links public health practitioners, front-line health workers and researchers to the best scientific intelligence and knowledge from around the world.

Public Health Ontario provides expert scientific and technical support to government, local public health units and health care providers relating to the following:

- communicable and infectious diseases
- infection prevention and control
- environmental and occupational health
- emergency preparedness
- health promotion, chronic disease and injury prevention
- public health laboratory services

Public Health Ontario's work also includes surveillance, epidemiology, research, professional development and knowledge services. For more information about PHO, visit *www.publichealthontario.ca*.

Toronto Public Health
Toronto Public Health reduces health inequalities and improves the health of the whole population. Its services are funded by the City of Toronto, the Province of Ontario and are governed by the Toronto Board of Health. Toronto Public Health strives to make its services accessible and equitable for all residents of Toronto. For more information about Toronto Public Health, visit *www.toronto.ca/health/*.

Project Leads

This report is a collaboration between the Centre for Addiction and Mental Health (CAMH) Health Promotion Resource Centre, Public Health Ontario, and Toronto Public Health. The project leads are:

- Christie Collins-Williams, Manager, Health Promotion and Prevention Team, Provincial System Support Program, Centre for Addiction and Mental Health
- Phat Ha, Research Coordinator, Public Health Ontario
- Jan Lancaster, Manager, Mental Health Promotion Program, Toronto Public Health
- Dr. Chris Mackie, Medical Officer of Health and CEO, Middlesex-London Health Unit
- Tamar Meyer, Health Promotion Consultant, CAMH Health Promotion Resource Centre, Provincial System Support Program, Centre for Addiction and Mental Health
- Monica Nunes, Research Analyst, CAMH Health Promotion Resource Centre, Provincial System Support Program, Centre for Addiction and Mental Health
- Jessica Patterson, Health Promotion Consultant, Mental Health Promotion Program, Toronto Public Health

Acknowledgements

The project leads would like to thank the following individuals for their contribution:

- Julie Dénommé, Steering Committee member; Manager, School Health Promotion Team, Sudbury & District Health Unit
- Emma Firsten-Kaufman, Research Analyst, CAMH Health Promotion Resource Centre, Provincial System Support Program, Centre for Addiction and Mental Health
- Benjamin Leikin, Steering Committee member; Mental Health Project Officer, Ottawa Public Health
- Dr. Heather Manson, Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario
- Carol McDougall, Steering Committee member; Public Health Manager, Perth District Health Unit

The support of the Government of Ontario is acknowledged.

Table of Contents

EXECUTIVE SUMMARY

Momentum is building to promote the mental health of Ontarians including efforts to improve treatment options and services for children and youth with mental health concerns. For instance, with *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy,* the Ontario government is focusing the first three years of the 10-year plan on child and youth mental health. In addition to addressing improvements to clinical services, this strategy acknowledges the need to promote resilience and mental wellness.

In Ontario, the core business of public health encompasses illness prevention and health promotion. Mental health is increasingly considered to be a key component of overall health and wellbeing. However, the role of public health in mental health in Ontario has not been well-described. For instance, the *Ontario Public Health Standards* (which guides the work of public health units) lacks an explicit mandate to address mental health. Nevertheless, health units are required to respond to local health needs, which include mental health concerns.

This research project is a collaboration between the CAMH Health Promotion Resource Centre, Public Health Ontario and Toronto Public Health. The purpose was to understand the activities undertaken by public health units to address and promote mental health in children and youth. The research also sought health unit perceptions on barriers, enablers and opportunities for support and improvement.

Methods

This study consists of an online survey and a series of key informant interviews. Participants in both components were employees from Ontario health units with experience working in or overseeing mental health-related activities or initiatives. The survey was designed to identify activities that were conducted by health units to address the mental health of children and youth between the ages of 0 to 19. The key informant interviews were designed to provide insight into the strengths and challenges that health units experience when addressing the mental health of children and youth as well as to identify opportunities for support.

Findings

All 36 Ontario health units completed the online survey. A total of 325 activities and initiatives were reported, ranging from 1 to 32 per health unit. This survey data shows that a substantial amount of work is underway across a diverse array of approaches to promote and address mental health in children and youth. The key characteristics of these activities are highlighted below:

- The most common activities were programs delivered by public health units, followed by knowledge exchange and capacity building activities.
- The most common target age-group was 14 to 18 years, followed 7 to 13 and 0 to 6.
- The Ontario government is the most common activity funder, followed by local municipalities.
- The most common motivation for undertaking an activity or initiative is local need or in response to a specific request.
- The *Ontario Public Health Standards* and Guidance Documents are being used to guide activities.
- Partnerships (both formal and informal) are present in most activities and initiatives.
- Nearly half of all activities/initiatives were reported as being evaluated.

Key informant interviews were obtained from 31 of 36 health units. Many factors influence the role and actions of public health units in mental health promotion for children and youth. The most frequently identified enablers and barriers are presented below:

Enablers	Barriers
◗ partnerships ◗ embedded approaches to addressing child and youth mental health ◗ strong leadership and commitment within health units ◗ fundamental public health approaches, principles and frameworks ◗ health unit structure and size ◗ staff expertise	◗ lack of a provincial mandate contributing to unclear roles ◗ lack of dedicated resources ◗ coordination challenges among community partners ◗ lack of focus on mental health promotion and mental illness prevention ◗ stigma ◗ gaps in mental health service system/unmet needs

Conclusions and Future Opportunities

A substantial amount of work is already underway by Ontario public health units to address mental health in children and youth. Health units are responsive to local needs, are working with a variety of partners, and have shown resourcefulness in integrating mental health into existing programming. This research study also informs us on the enablers and barriers that have had a substantial influence on the current state of public health's collective efforts in child and youth mental health, as well as the overall role for public health in this area as it stands now. Participants also provided direction on the support they would like to receive, including:

- provincial guidance for public health's role in mental health (i.e., a clear mandate)
- identifying evidence on best practices
- establishing mental health indicators
- training public health staff
- knowledge exchange among public health units and community partners
- addressing larger mental health system service gaps

The overall question of the role of public health in mental health is not new, yet it remains largely unresolved in Ontario. The present research helps lay the foundation for answering this question. Future research may explore the interaction between health units and mental health stakeholders including service providers, community partners and government. Data on activities and initiatives targeting adults (e.g., young adults, middle-age, seniors) or priority populations would be helpful. Lastly, as innovative public health approaches to mental health are developed and disseminated, there will be many opportunities for evaluation of implementation and replication projects. ●

SOMMAIRE

La promotion de la santé mentale des Ontariennes et des Ontariens prend de plus en plus d'ampleur alors que se multiplient les efforts, entre autres, pour améliorer les options de traitement et les services offerts aux enfants et aux jeunes ayant des problèmes de santé mentale. Par exemple, dans le cadre d'*Esprit ouvert, esprit sain : Stratégie ontarienne globale de santé mentale et lutte contre les dépendances,* le gouvernement de l'Ontario met l'accent, pendant les trois premières années de son plan décennal, sur la santé mentale des enfants et des jeunes. Cette stratégie, en plus de viser l'amélioration des services cliniques, reconnaît le besoin de promouvoir la résilience et le mieux-être mental.

En Ontario, la prévention de la maladie et la promotion de la santé sont au cœur des activités de la santé publique. Or, la santé mentale est de plus en plus considérée comme un élément clé du bien-être et de l'état de santé global. Cependant, en Ontario, le rôle de la santé publique en santé mentale n'a pas été bien décrit. Ainsi, les *Normes de santé publique de l'Ontario* (qui régissent le travail des bureaux de santé publique) ne définissent pas un mandat explicite en matière de santé mentale. Néanmoins, les bureaux de santé sont tenus de satisfaire les besoins de santé locaux, qui englobent les problèmes de santé mentale.

Le présent projet de recherche résulte d'une collaboration entre le Centre de ressources de la promotion de la santé de CAMH, Santé publique Ontario et Santé publique Toronto. Il visait à mieux comprendre les activités qu'entreprennent les bureaux de santé publique pour promouvoir la santé mentale chez les enfants et les jeunes et pour traiter les problèmes en la matière. La recherche a aussi voulu savoir quels étaient, selon les bureaux de santé publique, les obstacles, les catalyseurs et les opportunités pour ce qui est de l'appui et de l'amélioration.

Méthodes

La présente étude est le résultat d'un sondage en ligne et d'une série d'entrevues avec des répondants clés. Dans les deux cas, les participants étaient des employés de bureaux de santé publique de l'Ontario ayant de l'expérience en santé mentale, soit qu'ils travaillent à des activités ou à des initiatives dans ce secteur ou y jouent un rôle de supervision. Le sondage voulait cerner les activités que font les bureaux de santé publique en lien avec la santé mentale des enfants et des jeunes âgés de 0 à 19 ans. Les entrevues avec des répondants clés visaient à mieux connaître les forces des bureaux de santé publique en matière de santé mentale des enfants et des jeunes et les défis qu'ils ont à relever et elles tentaient aussi de mettre en évidence les occasions de soutien.

Résultats

La totalité des 36 bureaux de santé publique en Ontario ont répondu au sondage en ligne. Au total, 325 activités et initiatives ont été déclarées ; elles varient de 1 à 32 par bureau de santé publique. Les données tirées du sondage prouvent qu'une somme considérable de travail est en cours et qu'une vaste gamme d'approches est utilisée pour promouvoir la santé mentale chez les enfants et les jeunes. Voici les principales caractéristiques de ces activités :

- Les activités les plus courantes des bureaux de santé publique consistent à offrir, dans l'ordre, des programmes, puis des activités d'échange de savoir et enfin, de renforcement des capacités.
- La principale tranche d'âge cible est de 14 à 18 ans, suivie de 7 à 13 ans puis de 0 à 6 ans.
- Le financement de ces activités provient surtout du gouvernement de l'Ontario et ensuite des municipalités locales.
- Une activité ou une initiative est le plus souvent entreprise en raison d'un besoin local ou à la suite d'une demande précise.
- Les *Normes de santé publique de l'Ontario* et les documents d'orientation sont utilisés pour mener à bien les activités.
- La plupart des activités ou initiatives profitent de partenariats (formels ou non).
- Près de la moitié de l'ensemble des activités ou initiatives serait évaluée.

Les entrevues avec des répondants clés ont été menées auprès de 31 des 36 bureaux de santé. De nombreux facteurs influencent le rôle et les actions des bureaux de santé publique en promotion de la santé mentale des enfants et des jeunes. Voici les catalyseurs et les obstacles qui ont été nommés le plus souvent :

Catalyseurs	Obstacles
◗ partenariats ◗ approches bien ancrées en matière de santé mentale des enfants et des jeunes ◗ solidité du leadership et de l'engagement dans les bureaux de santé publique ◗ approches, principes et cadres fondamentaux de santé publique ◗ structure et taille des bureaux de santé publique ◗ expertise du personnel	◗ absence de mandat provincial, d'où le manque de clarté des rôles ◗ manque de ressources distinctes ◗ défis de coordination parmi les partenaires de la collectivité ◗ manque de concentration sur la promotion de la santé mentale et la prévention de la maladie mentale ◗ stigmatisation ◗ lacunes dans le système de services en santé mentale/ besoins non satisfaits

Conclusions et occasions futures

Les bureaux de santé publique de l'Ontario abattent déjà une somme considérable de travail dans le secteur de la santé mentale des enfants et des jeunes. Les bureaux de santé publique comblent les besoins locaux, collaborent avec divers partenaires et ont fait preuve de débrouillardise en intégrant la santé mentale dans les programmes existants. Cette étude de recherche nous a également permis de connaître les catalyseurs et les obstacles qui influent beaucoup sur l'état actuel des efforts collectifs en santé publique axés sur la santé mentale des enfants et des jeunes et de constater le rôle d'ensemble que joue la santé publique dans ce secteur pour le moment. Les participants ont également donné des indications de l'appui qu'ils aimeraient recevoir, notamment :

- orientation de la province quant au rôle de la santé publique en santé mentale (c.-à-d. un mandat clair)
- détermination de données probantes sur les meilleures pratiques
- établissement des indicateurs de santé mentale
- formation du personnel en santé mentale
- échange du savoir parmi les bureaux de santé publique et les partenaires de la collectivité
- prise en compte des lacunes de service dans le système de santé mentale

La question générale du rôle de la santé publique en santé mentale n'est pas nouvelle, mais en grande partie elle n'est pas réglée en Ontario. La présente recherche permet de jeter des bases qui nous aideront à trouver des solutions. Les prochaines recherches pourraient porter sur l'interaction entre les bureaux de santé publique et les parties prenantes en santé mentale dont les fournisseurs de service, les partenaires de la collectivité et le gouvernement. Des données sur les activités et les initiatives visant les adultes (p. ex. les jeunes adultes, les gens d'âge moyen et les aînés) ou les populations prioritaires seraient utiles. Et, finalement, à mesure que sont établies et diffusées des approches novatrices de santé publique en santé mentale, se présenteront de nombreuses occasions d'évaluer leur mise en œuvre ainsi que les possibilités de réplication. ●

INTRODUCTION

Mental health is often a key mediator between the social determinants of health and various physical health outcomes (Raphael, 2009). However, mental health is more than a mediator for positive physical health outcomes. The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being; it is not simply the absence of disease or infirmity (WHO, 2003). If there is "no health without mental health," (WHO, 2004) it follows that public health has an important role in the promotion of positive mental health and prevention of mental illness.

Previous research has described the range of effective mental health promotion and mental illness prevention interventions for children and youth. However, the investigators are not aware of any existing work describing the range of activities undertaken by public health units in this area. Thus, the present research seeks to understand how public health units in Ontario are addressing the promotion of mental health and prevention of mental illness for children and youth in their community.

The focus on children and youth is aligned with the first three-year priority focus on children and youth outlined in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. It is also well-aligned with *Make No Little Plans: Ontario's Public Health Sector Strategic Plan*. This recently released strategic plan for the public health sector identifies a goal of focusing on "early childhood development, including mental wellness and resiliency" (Ministry of Health and Long-Term Care [MOHLTC], 2013, p. 14). Lastly, this research contributes to an emerging discussion articulated in Public Health Ontario's and the Institute for Clinical Evaluative Science's *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report*. This report describes the burden of mental illness and addictions in Ontario and calls for increased clarity in the role of public health in reducing this burden (Ratnasingham et al., 2012). Specifically, the report recommends conducting "jurisdictional scans to clarify and better understand the potential role(s) of public health in addressing mental illness and addictions."

Objectives

The primary objective for this project was to describe the range of child and youth mental health activities, initiatives, services and programming occurring in Ontario's public health units.[1] The project also explored how these were funded and the mandate for their deployment. Lastly, the research aimed to describe the enablers and barriers that public health units experience when implementing activities to promote mental health and prevent mental illness in children and youth. By meeting the stated objectives, this research will support public health units and other stakeholders to identify, understand, incorporate, and expand mental health promotion and mental illness prevention within public health programming.

Project Partners

The lead agencies for this project were the CAMH Health Promotion Resource Centre, Toronto Public Health (TPH) and Public Health Ontario (PHO). A steering committee guided the project and development of this report; committee members were from Perth District Health Unit, Ottawa Public Health, Sudbury & District Health Unit and Toronto Public Health. This project was funded by the CAMH Health Promotion Resource Centre; this centre is funded by the Ministry of Health and Long-Term Care to support public health and health promotion audiences in Ontario. Project leads from TPH and PHO and Steering Committee members provided in-kind support.

Background and Context

Historically, the role of public health in mental health in Ontario has not been well-described (this tendency is observed in other jurisdictions as well). Mental health promotion is a relatively new field and is not well understood in the context of public health's core business of illness prevention and health promotion. Nonetheless, public health units in Ontario are mandated to respond to local health issues which include mental health needs as well.

[1] In this report, these terms are often used individually to simplify the text; however, the inclusion of the entire range of terms is implied.

Ontario Public Health Standards

The *Ontario Public Health Standards (OPHS)* describes the minimum requirements for fundamental public health programs and services to be delivered by the 36 local public health units (also known as boards of health) in Ontario (MOHLTC, 2008). These standards "outline the expectations for boards of health, which are responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians" (MOHLTC, 2008, p. 1).

Despite the importance of child and youth mental health promotion for several program standards and protocols such as the *Healthy Babies, Healthy Children Protocol*, mental health is not a defined area of focus within the *OPHS*. However, specific mental health issues and protective factors are cited throughout the *OPHS*. For example, the Chronic Diseases and Injuries Program Standards contain references to mental health. There are also requirements related to risk and protective factors for mental health in the Chronic Disease Prevention and the Prevention of Injury and Substance Misuse standards. The former standard addresses "work stress" by creating supportive environments (MOHLTC, 2008, p. 19). Lastly, the Prevention of Injury and Substance Misuse subsection mentions creating supportive environments, policies, and public awareness to address "alcohol use and substances" (MOHLTC, 2008. p. 23); and suicide is identified as an area of "public health importance" in this subsection (MOHLTC, 2008. p. 23).

OPHS Guidance Documents

The Guidance Documents of the *OPHS* provide advice and support to local public health units in their implementation of the *OPHS*. In contrast to the *OPHS*, the Guidance Documents explicitly discuss mental health and its determinants. For example, the *School Health Guidance Document* (Ministry of Health Promotion [MHP], 2010a) acknowledges child and youth mental health as a priority:

> *The promotion of positive mental health of children and youth is recognized as fundamental to the development of healthy behaviours by children and youth. (p.17)*

In addition, the *Child Health Guidance Document* (MHP, 2010b) states that:

> *Promoting mental health can also lead to better educational performance, greater productivity, improved relationships within families and safer communities… it is important that an underlying principle of mental health promotion be incorporated in the implementation of all Child Health requirements. (p. 22)*

Mental health is also considered elsewhere in the Guidance Documents, including: *Child Health*, *Comprehensive Tobacco Control*, *Prevention of Injury*, *Reproductive Health*, *Prevention of Substance Misuse* and the recent *Healthy Babies, Healthy Children*.

National and Provincial Mental Health and Addictions Strategies

In Canada, mental health and mental health promotion have received more attention in recent years. For instance, the Mental Health Commission of Canada (MHCC) released, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada,* in 2012. This strategy recognizes the importance of the determinants of health and has recommendations to address the full spectrum of mental health issues and to build resiliency in individuals and communities (MHCC, 2012). Despite its breadth, the national strategy does not explicitly outline a role for public health in mental health.

At the provincial level, the Ontario government released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* in 2011. This strategy starts with a three-year plan that focuses on child and youth mental health, improving access to services, early identification, and closing service gaps for vulnerable children and youth (MOHLTC, 2011). *Open Minds, Healthy Minds* also recognizes the need to reach at-risk groups by fostering resilience, mental wellness and mental health literacy. Lastly, the strategy underscores the importance of providing mental health services in the community. As in the national strategy, a specific role for public health in the promotion of mental health and prevention of mental illness is not explicitly outlined (MOHLTC, 2011).

The Burden of Mental Illness and Addictions in Ontario

Public Health Ontario and the Institute for Clinical Evaluative Sciences released *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report* in 2012 (Ratnasingham et al., 2012). The report shows that the burden of mental illness and addiction is higher than infectious diseases and cancers in Ontario. While the study does not report on Ontarians less than 18 years, it underscores the importance of intervening in early childhood and youth. Many mental illness and addiction issues begin at times of critical life transitions such as the completion of school, entry into the workforce and involvement in relationships. The disruption of these major life transitions often has lifelong impacts. The report also highlights public health's role in reducing the burden of mental illness and addiction. Specifically, it highlights the tools and strategies used by public health such as partnership and collaboration, research and evaluation, and taking action on the determinants of health. Further, the report recommends performing jurisdictional scans to "...clarify the potential role(s) of public health and other partners in addressing the burden of MI&A...recognizing the principles of need, impact, capacity and collaboration" (Ratnasingham et al., 2012, p. 54).

Direction from the Chief Medical Officer of Health

In 2013, Dr. Arlene King released the 2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario entitled *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report, 2011*. This report identifies mental health as one of 12 priority public health indicators, selected because they were:

1. *worth measuring—that is, they had to address an important issue, worth discussing and measuring. We also considered if they were relevant to a life course discussion.*
2. *understandable by the public—we've made an effort to choose indicators that will be meaningful to the public and not just to a more specialized health care audience.*
3. *actionable—the indicators chosen have implications for government and health sector policy and practice. This also means that government and health sector policy and practice have the potential to influence the issues that the indicators highlight.*
4. *credible—the indicators must be appropriately defined, explained and supported by credible, relevant and appropriate data.*
5. *measurable—for each indicator we considered, we had to assess whether we could measure it and whether there were reliable, good quality data available. (King, 2013, p. 6)*

In the report, the Chief Medical Officer of Health, also calls for more attention on the burden of mental illness and addictions:

> *I would like to see more efforts to reduce the stigma associated with mental health and addictions, and a greater understanding that mental health and addictions must be recognized and understood as critically important health issues. I also would like to see more discussion of what role the public health sector could play in promoting and protecting mental health, managing stress, recognizing risk factors for mental health disorders and building resilience in communities. (King, 2013, p. 3)*

Most recently in 2013, the Chief Medical Officer of Health released *Make No Little Plans: Ontario's Public Health Sector Strategic Plan* to help Ontarians become the healthiest people in the world by working toward five strategic goals (MOHLTC, 2013, pp. 13-24):

1. *Optimize healthy human development.*
2. *Improve the prevention and control of infectious diseases.*
3. *Improve health by reducing preventable diseases and injuries.*
4. *Promote healthy environments—both natural and built.*
5. *Strengthen the public health sector's capacity, infrastructure and emergency preparedness.*

The first strategic goal reflects a holistic approach to health that considers both physical and mental health and is focused on early childhood development, including mental wellness and resiliency. The actions proposed to achieve this strategic goal include (MOHLTC, 2013, p. 14):

- *Building on current initiatives including Healthy Babies, Healthy Children (focusing on early childhood development) and THREE key government strategies:*
  - *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (children's mental health)*
  - *Great to Excellent: Launching the Next Stage of Ontario's Education Agenda (education)*
  - *No Time to Wait: The Healthy Kids Strategy (healthy eating, active living).*
- *Identifying and implementing evidence-based strategies that support early childhood development and maternal/child/youth health, mental wellness and resilience.*

Summary

The reports and strategies described above provide the context for Ontario's public health units in their work to promote and address mental health. This report contributes to this discussion by describing the current mental health promotion and mental illness prevention activities for children and youth in Ontario public health units, outlining barriers and facilitators and identifying future opportunities.

METHODS

This study had two components: an online survey and a series of key informant interviews covering all 36 Ontario public health units. Voluntary and informed consent was sought from the medical officer of health (MOH) from each public health unit via email. Participants in both components were employees from Ontario health units with experience working in or overseeing mental health-related activities or initiatives. These individuals were identified by an MOH or through the online directory of public health staff, maintained by the Association of Local Public Health Agencies. In most cases, the same individual participated in both the survey and interview on behalf of their health unit.

Online Survey

The survey (presented in Appendix A) was designed to identify activities that were conducted by health units to address the mental health of children and youth between the ages of 0 and 19. Participants could also identify activities targeting those beyond age 19 if applicable (e.g., activities targeting new parents). Survey respondents were asked to consult with staff in their health unit to better capture as many of the activities underway as possible.

To ensure that the reported activities were intended to promote or address mental health, it was required that "mental health" or at least one related mental health term (see Box 1) be explicitly mentioned in at least one of six areas, listed below:

1. Description
2. Goals/objectives
3. Outcomes
4. Service plan/work plan
5. Logic model
6. Indicators

BOX 1. Mental Health or Related Terms

- Infant, child or youth mental health
- Psychological health
- Emotional health
- Mental well-being
- Mental wellness
- Mental illness
- Mental health promotion
- Mental illness prevention
- Mental health literacy
- Body image or self-esteem
- Stress
- Resiliency
- Stigma reduction
- Suicide prevention
- Prevention of self-harm
- Bullying
- Violence
- Discrimination
- Crisis support or management

Note: These terms were developed with input from the Steering Committee members.

The inclusion of the related terms recognizes the broad scope of mental health activities in public health along the continuum of mental health promotion, mental illness prevention and care. This approach also recognizes the many ways that "mental health" is articulated, understood, and addressed by different public health units and professionals. The survey also identifies and captures information on key enablers, such as mandate, partnerships, funding and use of *OPHS* or Guidance Documents.

The survey was conducted using Fluid Surveys software. Data was exported to, and analysed, in SPSS predictive analytics software. Two research team members reviewed each open-text/fill-in entry and independently reassigned the entry or recoded it; these changes were compared and differences were reconciled. Publicly available health unit characteristics were obtained and merged into the final dataset; for example, peer-group category and population size as taken from Statistics Canada data (see Table C2 in Appendix C). Two researchers carried out a review of the activity descriptions to identify secondary activity categorizations based on primary function. Statistical tests were not conducted because of the descriptive nature of the survey.

Key Informant Interviews

The key informant interviews (presented in Appendix B) were designed to provide insight into the strengths and challenges that health units experience when addressing the mental health of children and youth as well as identify opportunities for support. The interviews were audio recorded and transcribed. The responses to the open-ended questions were themed and summarized by two research team members (including one who had conducted all the interviews) and reviewed by two different research team members.

RESULTS AND ANALYSIS

Survey Results

Surveys were received from 36 of 36 Ontario public health units (100%). Respondents included six directors, 23 managers, five health promoters or nurses and two unspecified participants. Participants received input from other public health unit (PHU) staff in most instances (30 of 36). Eleven PHUs reported having a dedicated mental health team or staff member; seven of the 11 PHUs had a team, department or division while four had a single staff position. Mental health was specified in the mission statement, values or vision of one PHU. The number of PHUs reporting mental health in their major goals, objectives, and balanced scorecard was five, four and two, respectively.

A total of 325 activities and initiatives were reported; this is an average of 9.0 per health unit, ranging from 1 to 32 with the majority of activities reported as ongoing (73.8%).

CASE STUDY

Student Support Leadership Initiative (SSLI)

The **Student Support Leadership Initiative** (SSLI) is an example of a comprehensive school health initiative involving local health units. This initiative is aligned with Ontario's Safe Schools Strategy and Ministry of Children and Youth Services report, *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (2006). SSLI is designed to build leadership within school boards and community organizations, strengthen local partnerships, and meet the needs of students and families through collaboration and referral to services. Many health units are participating in SSLI partnerships to develop guidelines to identify mental health issues early and for student referral, to develop mental health training modules, and to conduct scans of community mental health programs and services. SSLI was developed by the Ministries of Education and Children and Youth Services. ●

Table 1 presents the reported activity or initiative type. The most common type was a program delivered by the PHU (49.2%) followed by knowledge exchange or capacity building activities (16.3%). Among the "other" types of programs, respondents reported programs delivered in partnership with another organization and committee participation.

TABLE 1.
Type of Activity or Initiative Reported (N=325)

Type of activity or initiative	Percent	Count
Program delivered by the PHU	49.2	160
Knowledge exchange or capacity building	16.3	53
Communications	6.5	21
Planning	5.2	17
Policy or advocacy-related	2.2	7
Evaluation or research	1.5	5
Program delivered by another agency through a financial transfer from the health unit	1.2	4
Surveillance or population health assessment	0.6	2
Other*	17.2	56
Program delivered in partnership with another organization	13.2	43
Committee participation	1.8	6

*Only the top two write-in responses are presented below.

Most health units are carrying out evaluated programs (33 of 36) with 21 PHUs reporting one to five activities evaluated in some form. Nearly half of the activities and initiatives reported had been evaluated (48.0%), although no further information on the evaluation is available. Table 1a presents a breakdown of the evaluations based on activity or initiative type. The most common activity being evaluated was a program delivered by the PHU (61.3%), followed by knowledge exchange or capacity building (47.3%). The majority of all reported evaluations involve these two activity categories (78.8% or 123/156).

TABLE 1A.
Evaluation Completed by Activity or Initiative Type (N=325)

Activity or initiative type	Percent	Count	N
Program delivered by the PHU	61.3	98	160
Knowledge exchange or capacity building	47.2	25	53
Other	39.3	22	53
Communications	23.8	5	21
Policy or advocacy-related	28.6	2	7
Planning	11.8	2	17
Program delivered by another agency through a financial transfer from your health unit	25.0	1	4
Evaluation or research	20.0	1	5
Surveillance or population health assessment	0.0	0	2
All	48.0	156	325

Note: Participants were also able to report 'don't know', 'not applicable' and 'no.'

A secondary categorization (Table 2) of the activities and initiatives was conducted to provide a different understanding of the types of activities identified in Table 1. To develop the categories in Table 2, the descriptions provided by survey participants were collaboratively analysed by two research team members in order to determine the primary function of associated activities. Based on the described functions of the activities, nine categories emerged. Reported activities were then assigned to each category accordingly. The majority of activities were school-based (32%), followed by parenting-related programs (23.1%). A full inventory of reported activities organized by the categories below can be found in Appendix D.

TABLE 2.
Secondary Categorization of Activities and Initiatives (N=325)

Category	Percent	Count
School-based programming (i.e., comprehensive school health programs, group activities, one-on-one student support, curriculum support and delivery)	32.0	104
Parenting supports and programs (i.e., pre- and post-natal health, early childhood development, general parenting)	23.1	75
Committees, networks and coalitions (i.e., for knowledge sharing around youth engagement, maternal and infant mental health, addictions, suicide prevention)	10.5	34
Direct services (i.e., screening, referrals, counseling, health clinics, treatment services)	8.0	26
Community-based youth skills-building programming	7.1	23
Communication and awareness-raising activities	5.5	18
Strategic planning and policy-related initiatives	5.2	17
Training and capacity building for PHU staff and/or service providers	5.2	17
Research and surveillance activities	3.4	11

Participants reported where "mental health," or an equivalent related term appears, within the activity or initiative documentation; Box 1 lists the related terms while Table 3 presents the results from this question. There is an apparent mismatch between the prevalence of these terms across the activity components. That is, if "mental health" is mentioned in the goals or objectives, it would be expected that it would appear in the logic model and indicators as well. However, it is possible that the drop-off in prevalence is simply because these elements (e.g., logic models, indicators) were not a part of the activity; it was not possible to make this distinction.

TABLE 3.
Documentation Where "Mental Health" or Related Terms are Mentioned (N=325)

Component	Percent	Count
Goals or objectives	81.5	265
Description	72.3	235
Outcomes	72.3	235
Service or work plan	48.3	157
Indicators	29.5	96
Logic model	25.2	82

Table 4 presents the target audience (or ultimate recipient) for the activities. Children and youth (62.5%) and parents, caregivers, and guardians (52.9%) were the most common target group. Education staff, public health professionals and service providers (i.e., social service, mental health and other health providers) were also targeted by many of the activities. About one in nine of the activities were targeted at the general public (11.4%). Other target audiences included volunteers, faith-based organizations, and law enforcement personnel (these are not shown in Table 4).

TABLE 4.
Target Audience for the Reported Activities and Initiatives (N=325)

Target audience	Percent	Count
Children or youth	62.5	203
Parents, care providers or guardians	52.9	172
Education	44.3	144
Public health staff	44.3	144
Social service providers	26.5	86
Mental health providers	20.6	67
Other health providers	18.8	61
General public	11.4	37
Government	8.9	29
Other	5.5	18

Table 5 presents the target age-groups for the activities and initiatives. The most commonly reported age-groups fall between 0 and 18; a sharp drop-off is seen in the 19 to 24 and 25+ age-groups. Between the 0 to 18 age group, the most commonly targeted age-group was the 14 to 18 group, followed by the 7 to 13 age group and the 0 to 6 age group. Most of the activities in this older range were targeted at the general public or parents and caregivers. It will be important in future studies to determine if there is a true programmatic gap among these two older age-groups (the current survey is only relevant for child and youth activities).

TABLE 5.
Target Age-Group among Activities and Initiatives (N=325)

Age-group	Percent	Count
0 – 6	47.2	154
7 – 13	57.4	187
14 – 18	64.1	209
19 – 24	25.8	84
25+	16.6	54

Table 6 presents the discrete age ranges among the initiatives. The 'variable' category includes activities with gaps in the age ranges; for example, 0 to 6 and 25+. These activities are typically targeted at parents/caregivers and children (but, not adolescents or youth). The single program targeting the 25+ age-group is a parent/caregiver activity. Lastly, the 23 activities targeting "all ages" were typically information campaigns for the general public.

TABLE 6.
Discrete Target Age-Range among Activities and Initiatives (N=325)

Age range	Percent	Count
0 – 6	16.3	53
0 – 13	4.9	16
0 – 18	12.3	40
0 – 24	1.8	6
7 – 13	9.8	32
7 – 18	15.7	51
7 – 24	2.5	8
14 – 18	13.2	43
14 – 24	4.0	13
19 – 24	0.9	3
0+	7.1	23
7+	2.2	7
14+	2.2	7
19+	1.2	4
25+	0.3	1
Variable	5.5	18

Note: These age range categories are mutually exclusive. The 'variable' category contains two or more, non-continuous age groups; e.g., both 0 to 6 and 19 to 24 age ranges. The '0+' category is interpreted as "all ages."

Table 7 presents the reported funding sources for the initiatives; the "All Sources" column presents all reported sources (i.e., "check all that apply") while the "Primary Source" column shows the primary source (i.e., "check one"). The Ontario government was a funder in nearly three-quarters of all activities (74.2%); it was also the primary funder for the majority the reported activities (63.1%). Overall, Ministry of Health and Long-Term Care (MOHLTC) and Ministry of Children and Youth Services (MCYS) were the primary funders for 43.1% and 8.0% of all reported activities, respectively.

Local municipalities were also a prevalent funding source (42.5%); however, they appear to be primarily providing supplementary funds as part of a collaborative effort (only 8.9% as primary funder). This finding may reflect the 75:25 split between provincial and local funding used in many health unit programs. User fees and non-governmental organizations (NGOs) were not substantial sources of funding for mental health promotion activities in Ontario. Other sources of funds were health unit operating budgets, grants, and school or school boards. Some initiatives were unfunded with support being provided in-kind.

TABLE 7.
Funding Sources for Activities and Initiatives (N=325)

Source	All Sources		Primary Source	
	Percent	Count	Percent	Count
Ontario government*	74.2	241	63.1	205
MOHLTC	53.5	174	43.1	140
MCYS	8.9	29	8.0	26
Unspecified	3.4	11	3.1	10
Ministry of Education	3.1	10	2.8	9
MOHLTC/MCYS	2.2	7	1.2	4
Local municipality	42.5	138	8.9	29
NGO	8.6	28	2.8	9
User fees	2.2	7	1.2	4
Don't know	9.8	32	6.8	22
Other*	32.6	106	17.2	56
PHU budget	12.0	39	4.9	16
No funds/ in-kind support	6.8	22	4.0	13
Grant	4.3	14	1.2	4
School or school board	3.4	11	1.5	5
Federal government	1.8	6	1.2	4

*The top five write-in responses are presented below.

Table 8 presents the impetus (or motivation) for the activities and initiatives. A specific local need was the most reported impetus (46.5%) followed by board of health (22.2%), school (16.0%), and external partner (14.2%). It is important to note that there is a local element within each of the top five reported impetuses; for instance, the board of health is a local body and the school boards were local boards (and not those from another municipality). The provincial and national mental health strategies were relevant for 2.8% and 0.3% of activities and initiatives, respectively. Among the written entries, participants reported that the activity was part of an existing program, a mandated program (e.g., Healthy Babies, Healthy Children), and that health unit leadership provided the motivational force. Overall, a specific local need or request from a local stakeholder was the primary motivating factor in most mental health promotion activities taking place in Ontario public health units.

CASE STUDY

Healthy Schools

The Ministry of Education's **Foundations for a Healthy School Framework** guides many school-based, physical and mental health programs and contributes to the physical, mental, emotional, social and spiritual health of the entire school community. The four components of this framework are quality instruction and programs, a healthy physical environment, a supportive social environment, and community partnerships. Across Ontario, Health Action Teams and Healthy School Committees have been established; they include teachers, school administrators, students, parents, public health service providers and community partners. Committees begin by identifying health topics of concern or interest to school communities. These topics would include healthy eating, physical activity, mental health, bullying prevention, substance misuse prevention, and healthy growth and development. Public health staff and school staff then identify or develop evidence-based resources, provide guidance to healthy school committees, and consult with school administrators and boards. Public health nurses, in collaboration with school social workers and guidance counsellors, may also offer small-group education sessions and one-on-one situational support to students. ●

TABLE 8.
Impetus for Activities and Initiatives (N=325)

Source	Percent	Count
Local need	46.5	151
Board of health	22.2	72
School or school board	16.0	52
External partner	14.2	46
City council	3.7	12
Ontario mental health and addictions strategy	2.8	9
National mental health strategy	0.3	1
Don't know	2.2	7
Other*	30.2	98
Mandated program**	8.0	26
Service gap	6.2	20
Part of existing program or plan	4.9	16
Consultation, report or review of evidence	4.0	13
Initiated by PHU or leadership	2.8	9

Note: *The top five write-in responses are presented below. **Mandated programs reported relate to the Best Start Initiative, Smoke-Free Ontario Strategy and Healthy Babies, Healthy Children.

Table 9 presents the types of partnerships related to the reported activities and initiatives. The vast majority of activities have some type of informal partnership (78.8%) while a smaller proportion had a formal partnership (49.5%). The most common partnerships were with schools and school boards, another department in the health unit, a mental health organization, and a local social service agency. Government, colleges and universities and businesses were less common partners. In all instances, except government, there is a drop-off when comparing informal to formal partnerships. For example, of the activities reported to be in partnership with another health unit department, 23.7% were informal partnerships compared to 5.5% were that formal partnerships; this discrepancy is less apparent for partnerships with schools and school boards. Most government partnerships

were with MOHLTC and MCYS, consistent with the high proportion of funding from these ministries. Other reported partnerships include local coalitions or networks, child protection services, health care providers, and faith-based organizations (not shown in Table 9).

TABLE 9.
Types of Partnerships Related to Activities and Initiatives (N=325)

Partner type	Informal		Formal	
	Percent	Count	Percent	Count
School or school board	35.7	116	24.9	81
Local social service agency	33.5	109	17.5	57
Mental health organization	27.4	89	11.7	38
Other department in health unit	23.7	77	5.5	18
Hospital or community health centre	17.8	58	11.4	37
Other municipal department	10.5	34	1.8	6
Other health unit	8.0	26	1.8	6
College or university	6.2	20	2.5	8
Government	4.9	16	6.8	22
Business	2.5	8	0.3	1
Other	23.4	76	14.5	47
One or more	78.8	256	49.5	161
None	21.2	69	50.5	164

Note: Formal and informal partnerships are not mutually exclusive.

Table 10 presents the proportion of activities employing the guidance of various *Ontario Public Health Standards (OPHS)* or Guidance Documents (GD). The mean number of *OPHS* or Guidance Documents in use was 2.64 (N=325) per activity or initiative, with a range of 0 to 13. Other Guidance Documents used include the *Healthy Babies, Healthy Children Protocol/Guidance Document* and the Sexual Health Program Standard (not shown in Table 10). Overall, mental health promotion activities are being guided by a wide range of documents, many of which do not directly deal with mental health.

TABLE 10.
Use of *OPHS* or Guidance Document to Guide the Activities and Initiatives (N=325)

OPHS or Guidance Document	Percent	Count
Foundational Standard	28.9	94
Chronic Disease and Injuries Program Standard	44.3	144
Family Health Program Standard	42.5	138
Infectious Diseases Program Standard	8.0	26
Environmental Health Program Standard	0.9	3
Emergency Preparedness Program Standard	0.3	1
School Health Guidance Document	38.2	124
Child Health Guidance Document	35.4	115
Healthy Eating, Physical Activity and Healthy Weights Guidance Document	19.7	64
Prevention of Substance Misuse Guidance Document	16.3	53
Prevention of Injury Guidance Document	14.5	47
Comprehensive Tobacco Control Guidance Document	4.9	16
Child Health Program Oral Health Guidance Document	1.8	6
Nutritious Food Basket Guidance Document	0.9	3
Other	7.1	23
None	3.7	12
Don't Know	3.7	12

Interview Results

Overall, 31 of 36 health units participated in an interview; one to five health unit staff participated in each interview, with one-third of interviews involving a single participant.

The interview results have been themed and summarized; five primary themes emerged:

1. Successes of health units in promoting mental health and/or preventing mental illness of children and youth
2. Enablers for health units to promote mental health, and/or prevent mental illness, in children and youth
3. Barriers to promoting mental health, and/or preventing mental illness, in children and youth
4. Suggested supports for promoting mental health and preventing mental illness in children and youth
5. Perceptions of public health's role

Theme 1: Successes of Health Units in Promoting Mental Health and/or Preventing Mental Illness of Children and Youth

Participants were asked about what they believed were the successes in promoting mental health and preventing mental illness in children and youth in their community. These successes included:

1.1 Engaging in specific activities/initiatives

1.2 "Starting the conversation" around child and youth mental health

CASE STUDY

Girls Talk

Girls Talk, developed by the Centre for Addiction and Mental Health, is an anti-stigma program for girls between the ages of 13 and 16 with a focus on depression. Health unit staff are leading discussions on mental health topics and the corresponding artistic or recreational activities. These sessions help young women develop resilience, self-awareness, coping strategies and critical thinking skills. ●

1.1 | Engaging in Specific Activities/Initiatives

Participants identified a large number of activities and initiatives, such as the training of health unit staff in suicide prevention (through ASIST and SafeTALK) and general mental health education. Youth engagement programs were also identified; examples include Youth Net and tobacco control programming through the Smoke-Free Ontario Strategy. Several participants felt that school-based initiatives and the presence of health unit staff in elementary and secondary schools were successes. Public health nurses provided one-on-one counselling, referrals and programming to prevent bullying, foster healthy relationships [e.g., Roots of Empathy and the Playground Activity Leaders Schools (PALS) Program], and promote self-esteem and healthy body-image. Health units also support teachers, principals and school boards with training and assistance in the development and delivery of curriculum on child and youth mental health. Participants also spoke about their health unit's support of comprehensive school health.

Programs for perinatal health, maternal mental health (e.g., pre-natal health, post-partum mood disorders), and early years were often cited as successes. Likewise, some participants also identified that their health units were supporting and building the capacity of teen parents, with a focus on positive discipline, healthy parent-child attachment, and early intervention in child behaviour problems. Frequent mention was made of Healthy Babies, Healthy Children and Triple P Positive Parenting Program.

Participants highlighted various research and surveillance initiatives in their health units. Similarly, some health units reported conducting surveys on mental health and illness in their communities in an attempt to identify best practices in mental health promotion (through literature reviews and environmental scans). Others mentioned strategic planning initiatives, including developing suicide intervention protocols and youth strategies that involve the health unit in community design.

Finally, health units were involved in broad community health initiatives that include child and youth mental health. Examples included screening and referral through clinical services for individuals with mental health and substance use concerns and raising awareness of mental health through events, campaigns and media.

CASE STUDY

Playground Activity Leaders in Schools

Playground Activity Leaders in Schools (PALS) is a playground leadership program for elementary schools. During recess and lunch breaks, children in grades four to six become Activity Leaders; they encourage participation and inclusion of younger students in games, regardless of age, gender or ability. The program builds leadership skills, increases physical activity, and decreases conflict and bullying on playgrounds. Public health nurses provide training to staff and students on implementing the program and provide ongoing support. ●

1.2 | "Starting the Conversation" Around Child and Youth Mental Health

In some cases, interview participants felt that their health unit had less established programming to report on. In these cases, participants identified "starting the conversation" to initiate discussions and set priorities around children and youth mental health as successes. These discussions were described as occurring at both the health unit level as well as the community level.

Theme 2: Enablers for Health Units to Promote Mental Health and/or Prevent Mental Illness in Children and Youth

The enablers that were identified by participants can be divided into six categories:

2.1 Partnerships

2.2 Embedded approaches to addressing child and youth mental health

2.3 Leadership and commitment within health units

2.4 Fundamental public health approaches, principles and frameworks

2.5 Health unit size and structure

2.6 Staff expertise

2.1 | Partnerships

Partnerships were felt to be a key factor in the success of the promotion of mental health and prevention of mental illness in children and youth. Participants described their partnerships as both longstanding and recently emerging from the issue of child and youth mental health. The most frequent partnership identified was with schools and school boards. Many participants spoke about community partnerships with mental health agencies, community health centres, family support groups, parent groups, social service providers, law enforcement and Ontario Works.

These partnerships facilitated information sharing and shared responsibility for the development and delivery of programming. Within these partnerships, health units facilitated project coordination, knowledge exchange, capacity building, networking, collaboration and coalition building. Several participants reported that their partnerships supported referrals for community members. One participant felt that the strength of their health unit was due to:

> *"…the ability of public health to understand that collaborative nature of our work; that we do have to work together with all the organizations in the community… that's why we're sort of successful in some of the programs. A lot of the programs that we're working on are always in combination with another organization."*

2.2 | Embedded Approaches to Addressing Child and Youth Mental Health

> *"Our work with mental health is, in some respects…it's not direct, it's indirect. And a large part of the work that we do does address mental health, but it's not specifically focused on mental health." — Participant*

Participants also identified promoting mental health and preventing mental illness in children and youth through embedded approaches and intertwined with the goals of existing programs. As an example, participants referred to their youth engagement efforts (as funded through the Smoke-Free Ontario Strategy), various school initiatives, and their support to enhance youth self-esteem and resiliency:

"Public health doesn't have a mandate within their standards for mental health. There are some things that can be linked with mental health and that we need to address, such as some of our Standards around nutrition and eating disorders. Eating disorders are a mental health issue."

"There's so many rich stories from individuals already working in public health, everyone from the nurse who visits [a] TB patient in the home to observe their medication treatment, you know they're providing support on mental health…it's just part of the way it is…the counselling that happens for the young person who comes to our sexual health clinic who then receives counselling about their concerns with gender identity. There are so many places where we engage with this work."

"If we look at, you know, reducing substance use, if we look at increasing academic achievement—if we look at all these areas that are currently within our OPHS and look at the many things we're mandated to do—we know from evidence that we can reach those outcomes in a more successful and efficient way if we address the underlying mental health of individuals."

Participants noted that Healthy Babies, Healthy Children (mandated by the *OPHS*) enables their health units to address child and youth mental health indirectly by promoting maternal mental health:

"One of the things that actually contributes to our ability to do the kind of work that we do is the fact that some of these things have been built into the work that we're doing…so you know thinking about the supports that have been provided to Healthy Babies, Healthy Children… the work that's being done there is actually fine-tuning the abilities of our public health nurses to contribute to positive mental health in families with young children."

Lastly, participants spoke about how they creatively integrated child and youth mental health components into their other work:

"Integrating the messaging, trying to leverage every opportunity, because there are many competing priorities—so, we try to be innovative and integrative as much as we can, and to break down silos as well."

2.3 | Leadership and Commitment

Health unit leadership and decision-makers (e.g., medical officers of health, directors) were considered to be enablers for mental health activities. Participants also felt that having managers that support work in this area was a key facilitator. Similarly, it was important to have staff members who were champions for child and youth mental health.

"We're hard-wired for mental health, and I think that perhaps in some areas, some health departments, they may have staff who are dedicated to this program, but it's really part of us."

2.4 | Fundamental Public Health Approaches, Principles and Frameworks

Participants highlighted several enabling frameworks, principles and approaches. For instance, health units sought to improve the social determinants of health as an upstream approach, focusing on the root causes of mental illness and poor health in general. Another approach was to view health holistically or to consider mental health as a component of physical health. There was an effort to leverage "evidence-based practice" or basing decisions on evidence, using best practice guidelines, and seeking input from experts and community partners. Other identified approaches included fostering resilience, engaging youth and responding to community needs.

2.5 | Health Unit Size and Structure

Participants praised being a part of multi-disciplinary teams that worked collaboratively and having Local Health Integration Network (LHIN) funded mental health and addictions teams within their health units. They also felt that working in smaller health units allowed them to form closer relationships with colleagues and that limited resources often forced them to collaborate. These smaller health units often had simpler administrative structures, which allowed them to respond to issues more quickly and to be more flexible in their approach. One respondent stated:

"We kind of describe ourselves as a little kayak on the river where it's easy to change direction."

In contrast, some participants felt that having a larger health unit, or being in a larger municipality, gave them a broader reach and ability to connect with partners that were doing related work.

2.6 | Staff Expertise

Participants noted that some colleagues received education and training on child and youth mental health, in particular through the Healthy Babies, Healthy Children (HBHC) program. Some felt that health unit staff had a thorough understanding of child and youth mental health issues and were aware of community resources:

> *"Through our HBHC programs we've had recent training in supporting maternal mental health, and that's been something the health unit has followed through as a directive from HBHC but has really embraced."*

Theme 3: Barriers to Promoting Mental Health and/or Preventing Mental Illness in Children and Youth

Participants identified the barriers for health units in promoting mental health and preventing mental illness in children and youth; these are listed and described further below:

3.1 Lack of a provincial mandate

3.2 Limited resources at the health unit level: Evidence and expertise

3.3 Coordination challenges among community partners

3.4 Lack of focus on mental health promotion and mental illness prevention

3.5 Public perceptions: Stigma and conceptualizations of mental health/mental illness

3.6 Gaps in the mental health service system/unmet needs

3.1 | Lack of a Provincial Mandate

Nearly all participants cited the lack of a provincial mandate as the primary barrier their health units face in promoting mental health and preventing mental illness in children and youth. In almost all cases, participants cited the absence of a program standard focusing on mental health and the lack of clear directions to address mental health in the *OPHS*. Participants also noted the lack of a provincial mandate or role clarity for public health units in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*.

CASE STUDY

FUEL (Females Using Energy for Life)

FUEL is a free after-school physical activity program for female youth that aims to increase girls' self-esteem and mental wellness. It engages girls in non-competitive fitness activities (e.g., yoga or strength training), builds physical skills, and is an opportunity to socialize and teach options for a healthy and active lifestyle. FUEL uses a youth engagement model where activities are determined and organized by a committee of female students with guidance from the school and health unit. In some locations, the program uses a nurse-guided health discussion on topics ranging from healthy eating to dating relationships. ●

Participants noted that the omission of a mandate in the *OPHS* meant that health units had limited staff and financial resources for mental health programming. With competing priorities (and without a mandate for mental health), some participants felt their health units were unable to allocate sufficient resources for child and youth mental health. Moreover, when resources were limited, priority was given to activities where health units were directly accountable (through provincial government accountability agreements).

Participants felt that their health unit was unable to address community needs or the expectations of community partners in a timely manner:

> *"I don't think we've kept up—you know, we've got standards for everything else, but mental health is nowhere there. People are talking about it more…it's almost like the floodgates have opened, and we're not—we can't respond to the volume…the work demand, we can't—it's like we haven't kept up."*

Lastly, participants recognize that their efforts are not uniform across Ontario because of the lack of a province-wide mandate.

3.2 | Limited Resources at the Health Unit Level: Evidence and Expertise

Participants cited barriers related to the availability of evidence and limited staff expertise. For example, health units may not have the surveillance data required to set priorities or measure outcomes for child and youth mental health. Participants were also unable to identify best practices from existing resources; some expressed difficulty in "knowing which direction to take" given the vast number of interventions possible in this area.

Similarly, participants felt that although there was some staff training available (i.e., training related to Healthy Babies, Healthy Children), overall there were limitations in staff expertise; for example, general knowledge of mental health, primary and secondary prevention of mental illness, and stigma reduction. Participants noted it was difficult to allocate resources for such training without a provincial mandate for mental health.

3.3 | Coordination Challenges among Community Partners

Participants cited that partnerships were a key enabler for addressing the mental health of children and youth; however, the work with community partners was often impeded by the lack of coordination and clear leadership. Several participants describe these efforts as being piecemeal, or as one health unit explains:

> *"We don't really have a well-defined community mental health promotion plan…we're doing bits and pieces… but it's not a well-coordinated effort with some priority activities…and nobody is really ready to take the lead in doing that."*

Some participants attributed the lack of coordination to the isolated pockets of funding available to their health units as well as to their community partners; others mentioned the need for stronger leadership and a mandate:

> *"When I think of this, I think of, again, whose mandate is it? And often people wait to see who's going to lead. I don't know if there's any leadership around this piece. We all do our little part it, but I don't know if it's coordinated in a way that there's prevention…We're there, we're at the table, but I don't think the community is saying, 'What can we all do together to do prevention and promotion?'"*

CASE STUDY

Triple P: Positive Parenting Program

Health units are employing **Triple P,** an evidence-based program developed in Australia that promotes positive, caring relationships between parents and children. It teaches parenting skills to prevent and manage emotional, developmental and behavioural problems without being coercive or punitive. The program provides community support, primarily reaching parents of children under 12 years old. Each parent receives a tailored program through topic-focused seminars, small group discussion forums, or one-on-one interventions by public health staff (either face-to-face or over the phone). One health unit reported the development of an online version of Triple P. ●

Another barrier identified was the lack of role clarity. Participants felt that there was a mutual uncertainty with community partners on the role of public health in mental health. Some participants felt that health units should focus on upstream determinants through mental health promotion and mental illness prevention initiatives. This perspective may contribute to the tension with some community partners, particularly among treatment providers. One participant described their health unit's challenges and unmet expectations with partnerships:

> *"You know that what you need to be doing…as public health…is supposed to be upstream and doing prevention and health promotion, so it's a struggle… people often have a different expectation of what it is that public health should be doing, so in the absence of really having that formal standard language that you can say 'here's where our role is'…you're challenged."*

Another participant described the apparent "disconnect" with community partners:

> *"…there's often a disconnect in what we're doing in terms of our Standards and what we feel our role is and what community partners feel the need is…they know we have nurses working here and they're not sure why we're not doing mental health assessments or having clinics…so it's understanding what public health is and where we fit in the continuum of care."*

Participants also discussed the impact of provincial mental health strategies. It was noted that the role of public health was not specified in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* and public health was excluded during the roll-out of mental health nurses through the Community Care Access Centres. One participant reflected on these omissions:

> *"I think we've got a number of really good initiatives happening around the province right now that are meant to address system issues; that are meant to identify where some of the concerns are existing…for example, the Open Minds, Healthy Minds strategic direction …However, when you look through that document, you recognize that there are key players that have not been involved in the development of that, or there are aspects that are not even addressed…there's only passing mention of parenting education as one potential way of promoting mental health and, you know, everything else was about treatment… There's very little in there that talks about the role of primary care or public health, which are two huge sectors involved in the promotion of mental health, and they're precisely who families go to on the front-line ..."*

System-level mandates were also felt to contribute to the disconnection between public health and community partners. For example, health units have a mandate to work with schools, but schools do not have a similar mandate to work with public health. For participants, the absence of a shared mandate and the lack of role clarity were significant barriers in addressing mental health issues among children and youth.

CASE STUDY

Sexual Health Clinics

Health units are using **sexual health clinics** to address child and youth mental health. Confidential counselling, by public health nurses, provides an opportunity for young people to discuss and obtain referrals and support for sensitive issues. These issues include substance abuse, eating disorders and body image, bullying, relationship problems, and self-harm or suicide. ●

3.4 | Lack of Focus on Mental Health Promotion and Mental Illness Prevention

Overall, participants were concerned with the lack of focus on mental health promotion and mental illness prevention. Participants acknowledged the ongoing effort to improve access to mental health services underway in their community and outlined in provincial strategies. However, the absence of a focus on mental health promotion is still an issue; in particular, to build resiliency, support children and youth through life transitions, and support for parents and caregivers. One participant noted:

> *"…the backbone stuff around resiliency and youth asset development and positive mental health promotion… is one area that we think maybe isn't being as well addressed because the focus is so much on treatment, and access to the service."*

Participants also felt that stronger efforts were needed to address the social determinants of health, such as low income, poor housing and unemployment. It was expressed that these determinants impact the mental health of families, children and youth; however, they are not uniformly distributed and thus impact some groups more than others.

3.5 | Public perceptions: Stigma and conceptualizations of mental health/mental illness

Participants reflected on the role of stigma and the lack of knowledge of mental health issues among some community partners. Participants reported that stigma prevents children and youth from accessing services provided by health units. It was suggested that stigma may also impact the work of service providers by inhibiting any discussion of mental health issues with clients or not prioritizing mental health promotion. Lastly, stigma was identified as contributing to discriminatory treatment by service providers towards children and youth with known or apparent mental health issues.

In addition to stigma, participants noted that the concepts of mental health were not always well understood among health unit staff that work with children and youth in the education system and community. Mental health was not conceptualized as a positive concept and the impact of the social determinants of health on mental health was not fully appreciated. One participant highlighted that:

"I mentioned that relationship between the determinants of health and promoting positive mental health, and I think there's a lack of knowledge or lack of awareness about that."

Some participants felt that attention was directed to treatment interventions because of the overlap of mental health with language about mental illness rather than creating space to explore opportunities for the promotion of positive mental health and prevention of mental illness.

For instance, one health unit described this dissonance as a barrier when working with community partners by stating that:

"There is a lack of understanding when we go forward to engage our partners in talking about mental health promotion. They nod, but then we're a little out of sync… right now there's a lot of activation in the area of children and youth with no core definition and public health influence on that definition."

3.6 | Gaps in the Mental Health Service System and Unmet Needs

Health units provide many one-on-one services, directly to clients; as such, health units may encounter barriers if the mental health service system becomes underfunded. For instance, participants described how children and youth in their community were struggling with depression, anxiety, eating disorders, substance use problems, and suicide or suicidal ideation. Participants then discussed the gaps resulting from underfunding, including the inaccessibility of services due to long wait lists, shortage of specialists, lack of community-based services, fees associated with mental health assessments and treatments, and a gap in the transition between services. Participants also identified gaps when reaching out to groups that may be facing multiple, systemic barriers; these groups may include First Nations, Inuit and Métis youth and children and youth from newcomer groups. Health units are often identifying clients in need of support services, thus, the limits on services often inhibit early intervention.

CASE STUDY

Regional Suicide Prevention Coalitions

Health units are the primary partners in several **regional suicide prevention coalitions** that aim to reduce suicide rates. These coalitions raise public awareness about suicide and the risk factors and improve services for intervention and support to reduce the impact of suicide on individuals, families and communities. Coalitions are developing regional suicide strategies and action plans. They are also involved in advocacy and education initiatives, and develop and disseminate suicide prevention resources. ●

Theme 4: Suggested Supports for Promoting Mental Health and Preventing Mental Illness in Children and Youth

Participants spoke about the need for additional support to enable their health units to better promote mental health and prevent mental illness in children and youth; five primary categories were discussed:

4.1 Provincial guidance and coordination

4.2 Identifying evidence on best practices

4.3 Establishing mental health indicators

4.4 Training public health staff

4.5 Knowledge exchange among public health units and community partners

4.1 | Provincial Guidance and Coordination

Participants consistently said that guidance and coordination by the provincial government and a provincial level mandate (on the role of public health in mental health) was a primary need. Many participants envisioned this mandate as a new program standard within the *OPHS* that would create accountability for health units to address mental health. In general, additional guidance or clarity on the role of public health in addressing mental health was felt to be useful. For instance, a guidance document on mental health may provide direction in this area. One participant cited the *School Health Guidance Document* to demonstrate how the inclusion of mental health within the *OPHS* might impact their work:

"The impetus for developing a School Health Team was really the OPHS and I feel our health unit really works that way, like our Board of Health provides direction to the MOH and it's very based on the Standards. Like it's really, really based on the Standards. So I think it would just provide a gateway to staff—permission to staff to be able to address it, and the guidance documents provide a lot of direction in terms of what activities we should be looking at. It also helps define our role as a community partners."

Additional reflection was provided on the rationale for a provincial mandate. First, guidance from the province would enable health units to allocate limited to Ontario government resources toward dedicated staff and training to address and promote child and youth mental health. Participants often cited that additional funding would be necessary to address mental health and that an immediate investment would assist with long-term planning. For instance, one participant described the impact of early childhood development programs on long-term gains:

"We used to get early years money and all the attention our health unit put on that because the Ministry was providing extra money and there were expectations and reporting that went along with it. We did a whole lot of work, and even though now the money is gone, we've been able to sustain that work because we had a really good foundation."

Secondly, participants felt that a province-wide mandate or guidance document would help coordinate divergent approaches to mental health occurring provincially and locally. A province-wide direction was cited as a mechanism to provide practical guidance to health units, clarify the role of public health and the specific support that public health can offer and reduce duplication in efforts among partners.

4.2 | Identifying Evidence on Best Practices

Participants spoke about improving access to evidence for best practices in addressing mental health; in particular, toolkits and summaries of effective interventions.

"I can see that if someone else could do a systematic review of effective approaches—public health approaches to the mental health of children and youth—we would certainly uptake the results of that, if it were well done… It would be wonderful if someone at the provincial level could do something for all of the public health units. Again, with a focus on a more population health approach and more upstream, because we are moving away from direct service…So promoting mental health rather than band aids for mental illness."

4.3 | Establishing Mental Health Indicators

An additional support cited was improved mechanisms to track mental health outcomes including surveillance data and indicators to measure the status of mental health over time. For example, one participant stated the need for:

"…assistance in what to measure when trying to measure the mental health of children and youth…if we were clear on what the indicators were and health units were expected to collect certain information, analyze certain information—or if it was part of a surveillance strategy for the province—it's easier to make a case."

4.4 | Training for Public Health Staff

Participants felt that training was essential to improve knowledge and skills among health unit staff. The specific areas mentioned include: basic concepts of mental health and mental illness, practical approaches to building resiliency, training for parenting programs, connections between the social determinants of health and mental health outcomes, and suicide prevention. Moreover, basic mental health awareness training should be available to all divisions in a health unit, including those not directly associated with mental health (e.g., staff working in oral health). Participants acknowledged the expense associated with training, but also noted the benefit of using standardized training for health units to improve consistency in delivery. For example, several participants spoke highly of the Healthy Babies, Healthy Children NCAST training, which equips public health nurses to deliver mental health promotion programming for mothers.

"The training that's been provided at HBHC with the NCAST system is very expensive, but…the payoff's going to be huge. The ability to access things like training for parenting programs is not inexpensive, but the payoff can be huge because there's consistency of practice."

4.5 | Knowledge Exchange among Public Health Units and Community Partners

Participants reflected on the potential value of discussion and information sharing with community partners; through a dialogue, a community of practice, or a network focusing on mental health in public health. It was felt that information could be shared with other public health units to facilitate the coordination of initiatives and promote efficiency. However, participants also suggested that all relevant stakeholders be included in these networking efforts because the work of public health is often done in partnership with other community partners. An improved network could be used to disseminate common messaging, decrease the impact of stigmatization, and provide support for early intervention efforts. As one participant emphasized:

"Just the whole concept of having common understanding and definitions of what is mental health promotion, mental wellness and not only within public health, but also from the broader health care system and community partner organizations…"

One participant described the potential impact of dialogues in articulating the role of public health in mental health:

"In terms of common understanding, definitions to begin with and understanding of role, really requires some provincial level dialogue, and I think it needs to involve a broad cross-section of public health staff, so that it's not strictly an MOH conversation for example…we need to be able to see ourselves and others need to be able to identify us as part of the overall system plan and I think that can happen through various forums for dialogue."

Knowledge exchange opportunities could also be a medium to share evidence and research in this emerging field. For instance, participants suggested it would be ideal to share work completed or underway on literature reviews, environmental scans or best practices. This is important because of the varying capacities for research among health units. As one participant noted:

"What does the research show that actually works? Can we get this research easily and disseminate it to different health units and share it with one another?"

Theme 5: Perceptions of Public Health's Role

The majority of the participants felt that public health does indeed have a role in mental health, but that this role required greater clarification. This clarity was needed to improve the responsiveness of their health unit to community needs and to avoid duplication of existing efforts. Many participants felt that their health unit needed to address mental health in order to achieve their overall objectives. One participant reflected on the intersection between physical health and mental health:

"I think public health has to look at the mental health of children and youth —that it cannot reach its goals without doing that…We just can't look at physical health and sexual health and nutrition in isolation from the mental component of a person's growth and development."

CASE STUDY

Roots of Empathy

Roots of Empathy is an evidence-based classroom program for children from kindergarten to grade eight that builds empathy and social and emotional competence. A parent and their infant are observed by students in the classroom over the course of the school year; particular attention is focused on the infant's development and emotions. By teaching children to understand their own feelings and those of others, they learn to care for other people and the likelihood of aggression is decreased. Health unit staff are either serving as instructors or providing training and support to facilitators. ●

Participants frequently stated that health units should facilitate upstream, health promotion- and prevention-oriented approaches in their communities. This approach would align with other prevention and health promotion efforts underway. Some examples of this approach include building resiliency in children and youth to reduce the potential impact of exposure to risk factors. Participants also spoke about their health units taking a leadership role in community discussions to ensure the inclusion of health promotion approaches. This was seen as an opportunity to address a neglected area of mental health with one of the strengths of health units:

> *"We think our role in public health, especially as public health nurses, is to really focus on health promotion, mental health promotion, and on skill-building in relation to resiliency and managing stress... A lot of things that are being done are early detection-focused and mental illness-focused, with regards to treatment, but there's really not anyone working on the prevention end and the promotion end."*

Participants also felt that public health units could take on a strong liaison and coordinating role among community partners. This role would be a natural progression from the roles that health units are already serving.

> *"I think we should be coordinating just like we do with all our other areas: coordinating expertise, ensuring gaps don't exist. And if they do, you know, trying to help cement system changes to improve that. I mean, I guess I would see as just any other program, such as tobacco or healthy eating. I mean, it's our role."*

CASE STUDY

SafeTALK, ASIST

Two suicide prevention training programs were reported by health units. First, **SafeTALK** workshops (where TALK stands for *tell, ask, listen and keep safe*) increase participants' awareness and understanding of suicide risk factors, prepares them to identify people with thoughts of suicide, and enhances their ability to provide appropriate and timely referrals to suicide first aid resources. Health units are providing this training to staff but also funding workshops for youth, parents and vulnerable groups in their communities. Secondly, **Applied Suicide Intervention Skills Training** (ASIST) provides two days of practice-oriented workshops and is offered to various front-line professionals and interested community members. Both SafeTALK and ASIST are developed by LivingWorks Inc. ●

DISCUSSION

The aim of this study was to document the activities and initiatives undertaken by public health units in Ontario to promote mental health and prevent mental illness in children and youth (including characteristics related to mandate and funding). The research also sought health unit perceptions of barriers, enablers and opportunities for support and improvement.

The survey data shows that a substantial amount of work is already underway across a diverse array of approaches to promote and address mental health in children and youth. A total of 325 activities and initiatives were reported, ranging from 1 to 32 per health unit. Several characteristics of these activities are worth highlighting to establish a clear, system-level perspective of the state of public health-led efforts to address child and youth mental health in Ontario; these are described below:

- The most common activities were programs delivered by public health units, followed by knowledge exchange and capacity building activities (Examples of specific activities are presented in Appendix D).
- The most common target age-group was 14 to 18 years, followed 7 to 13 and 0 to 6.
- The Ontario government is the most common activity funder, followed by local municipalities.
- The most common motivation for undertaking an activity or initiative is local need or in response to a specific request.
- The *Ontario Public Health Standards* and Guidance Documents are being used to guide activities.
- Partnerships (both formal and informal) are present in most activities/initiatives.
- Nearly half of all activities/initiatives were reported as being evaluated.

The key informant interviews provide deeper and more nuanced insight into the successes and challenges facing public health in this area. Many factors shape and influence the role of public health units, both individually and collectively. Some of these are supportive in nature (e.g., strong partnerships) while others present barriers (e.g., the lack of a clear mental health mandate); the most frequently identified enablers and barriers are presented in Table 11.

TABLE 11.
Enablers and Barriers to Addressing Mental Health in Public Health Identified from the Key Informant Interviews

Enablers	Barriers
◗ partnerships ◗ embedded approaches to addressing child and youth mental health ◗ strong leadership and commitment within health units ◗ fundamental public health approaches, principles and frameworks ◗ health unit structure and size ◗ staff expertise	◗ lack of a provincial mandate contributing to unclear roles ◗ lack of dedicated resources ◗ coordination challenges among community partners ◗ lack of focus on mental health promotion and mental illness prevention ◗ public perceptions: stigma and conceptualizations of mental health ◗ gaps in mental health service system/unmet needs

These enablers and barriers have had a substantial influence on the current state of public health's collective efforts in child and youth mental health, as well as the overall role for public health in this area as it stands now. It is worth looking more closely at those that were the strongest and most frequently identified as having the greatest impact in order to orient the discussion towards creating opportunities for moving forward in the future.

Enablers: What Is Working

As previously noted, public health units are undertaking a large number and wide spectrum of activities to address mental health in children and youth. Every public health unit in Ontario is engaged in this area to varying degrees. This is a positive finding and a clear indication that public health has identified (or at least accepted) a role in mental health based on local need. Many participants expressed interest in the project's outcome and specifically in the desire to better define the role of public health in addressing mental health.

A number of factors have contributed to the current level of activity, interest and collective success. These include partnerships, integration of mental health, alignment with evidence, leadership and evaluation of efforts.

Partnerships

Partnerships were found to be a key incentive and facilitator in the delivery of mental health activities by public health units. Since a principle of the *OPHS* is "partnership and collaboration" (MOHLTC, 2008), it is reasonable that health units are engaging with other stakeholders to carry out mental health-related work. Previous research on mental health promotion in public health demonstrates the importance of facilitating partnerships, community support and collaboration (Barry, 2007). Specifically, cross-sector engagement promotes a greater understanding of positive mental health and its contribution to an individual's overall well-being and quality of life; this engagement also reduces the stigma of mental illness among diverse stakeholders (Barry, 2007). Promoting mental health also requires addressing multiple health determinants, including those at the environmental, interpersonal and individual levels. Finally, where budgets are limited, partnerships enable the sharing of resources (Freeman et al., 2010). Thus, the diverse range of partnerships identified in this study (e.g., education, criminal justice, clinical sectors) may lead to comprehensive approaches to address the mental health of children and youth (Herrman & Jané-Llopis, 2012).

Integrating Mental Health

An additional facilitator was the integration of mental health promotion and mental illness prevention efforts into existing health unit programs and services. For example, many health units reported activities that fall within the scope of the *Ontario Public Health Standards* despite the lack of a standard explicitly related to mental health. Such integration is certainly one way of addressing the lack of dedicated resources for mental health and the absence of an explicit mental health mandate for public health. However, research from Jané-Llopis, Saxena and Hosman (as cited in Herrman & Jané-Llopis, 2005) also suggests that it is more efficient to integrate components of mental health promotion within existing health promotion activities, particularly if they already exist in the community. The World Health Organization (WHO) endorses the integration of mental health and physical health strategies; this approach can lead to positive overall health, social and economic outcomes such as savings in public expenditures (WHO, 2004). An integrated approach is also important because mental illness is associated with many risk factors that public health is already addressing, such as alcohol use, physical inactivity and smoking (Strine et al, 2008). Further, these integrated efforts are promising as emerging evidence shows there is association between positive mental health and improved health outcomes(Perry et al., 2010) and a lower prevalence of chronic disease among those with good mental health (Keyes, 2005). An example of integrating mental health promotion with chronic disease prevention is evident in *No Time to Wait: The Healthy Kids Strategy* recently developed by the Healthy Kids Panel to advise the Ministry of Health and Long-Term Care on the issue of childhood obesity. Specifically, this report recommends inclusion of mental health promotion activities for children and youth as part of efforts to address healthy weights (The Healthy Kids Panel, 2013).

Alignment with Evidence

To the extent of our review, the reported activities appear to be well-aligned with documented best practices in mental health promotion. For instance, Herrman & Jané-Llopis (2012) highlight the impact and cost-effectiveness of embedding mental health promotion into whole-school health approaches that include changes to the culture, teacher training, parent engagement and partnering with external agencies. This approach is shared by several initiatives reported by health units; one in three activities (32%) were categorized as "school-based programming"

including comprehensive school health programs, group activities, one-on-one student support, curriculum support and delivery. Also, effective parenting interventions have been described as "the single most important factor contributing to a healthy start in life and hence to mental health" (Herrman & Jané-Llopis, 2012, p. 8); nearly a quarter of all activities (23%) were categorized as "parenting supports and programs" including pre- and post-natal health, early childhood development and general parenting programs.

The *Science Advisory Report on Effective Interventions in Mental Health Promotion and Mental Disorder Prevention* produced by the Institut National de Santé Publique du Québec (INSPQ) in 2008 recommends several child- and youth-focused measures for consolidation in public health services and programs. These include home-visiting for at-risk families, mental health promotion programs in schools and interventions to improve mental health literacy (INSPQ, 2008). These findings support a 2007 review by the British Columbia Ministry of Health, which identified many of the same measures as core public health functions; additional measures included physical activity programs for children and post-partum support programs (Balfour, 2007).

More research is needed to identify the types of child and youth mental health activities that may be best administered by public health. However, it is encouraging to find that the reported activities are generally aligned with best practices.

Leadership

Participants highlighted the important enabling function of leadership within public health, at all levels (i.e., staff, management, director and medical officer of health). The findings revealed a high level of interest within Ontario health units, inspiring pioneering, promising and innovative practices to promote and address child and youth mental health. Public health units through leadership at various levels have embedded mental health language in health unit mission statements, values, strategic goals, and incorporated it in objectives and balanced scorecards. Future discussions might consider the necessary support to enhance the leadership function.

Evaluating Activities and Initiatives

Almost half (48%) of reported activities have been evaluated in some form with programs that are delivered by the health unit having the highest proportion of evaluation (61%). In addition, nearly 30% of the reported activities included "mental health" or a related term in the activity's indicators.

On a broader level, the appeal to recognize mental health as a priority public health indicator was articulated in the Chief Medical Officer of Health's report *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report, 2011* (King, 2013). By embedding mental health as an indicator in specific public health activities, these activities are seen as meaningful to the public, actionable, credible, measurable, and worth measuring (King, 2013). However, as Dr. King notes, there are many challenges associated with the priority indicators identified in the annual report, and mental health could feasibly be at the top of that list (2013). In order for mental health indicators (among others) to have meaningful health impacts in public health, they require:

> *…coordinated, government-wide and multisectoral approaches. In many instances, the activities underway related to each of the indicators the indicators will need to be identified and aligned "vertically" (at federal, provincial, regional and local levels) and "horizontally" (across health and non-health sectors). It is only then that we'll be able to identify the full scope and breadth of what is being done to address the challenges, determine if there is any duplication and identify were there may be gaps that could be filled. (King, 2013, p. 3)*

Barriers: Facing the Challenges

The findings show that public health units are heavily engaged in mental health promotion and prevention work and are able to identify factors that have contributed to their ability to carry out these activities. However, this study also uncovers specific barriers that health units are faced with; several of these are described below.

Lack of a Specific Mental Health Mandate

Participants reported that a lack of a provincial mandate in mental health is the most pressing obstacle for health units. In particular, there is no specific strategy or framework at the system or provincial level that directs public health units in Ontario to address mental health in children and youth. Likewise, mental health is not a part of the provincial accountability framework that health units adhere to (i.e., the *Ontario Public Health Standards*). As a consequence, health units may be faced with corresponding factors such as deficits in dedicated financial resources, staff training and professional development. Respondents also said there was uncertainty about their health unit's role in mental health. The lack of a clear mandate contributed to challenges in coordination efforts and partnerships with community stakeholders.

A provincial mandate or public health framework for action would help clarify the roles for public health units in addressing mental health. This would facilitate the allocation of dedicated financial and staff resources, support collaboration with partners, and allow the impact of interventions to be measured. One example of a plan is the Centers for Disease Control and Prevention's (CDC) *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention (CDC), 2011–2015* (CDC, 2011). This action plan has eight strategies for integrating mental health promotion and mental illness prevention with chronic disease prevention efforts in public health. As noted in *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report, 2011,* having clear goals and indicators are essential in the prevention of health problems and promotion of health, including mental health outcomes (MOHLTC, 2013). While many current public health unit activities do align with the goals outlined in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, without a coordinated and comprehensive public health approach including clear outcomes and indicators, public health units are left without clear direction to address and promote child and youth mental health.

Unmet Needs and Other System Challenges

Participants identified unmet needs and system-wide challenges as key barriers in promoting and addressing child and youth mental health in public health. Some examples included long waiting lists for youth and their families in accessing mental health treatment, a shortage of mental health specialists, gaps in the transition between services, and insufficient services for youth with complex needs. Also, participants described how public health was often called upon by schools and other community stakeholders to directly respond to children and youth experiencing mental health concerns. In fact, direct services such as screening, referrals, counselling and treatment accounted for one in 12 activities (8%) reported by participants. This finding underscores the system support role public health professionals and units have in addressing child and youth mental health and mental illness in their communities. Health units were also responsive to community crises such as acts of violence and youth suicide (e.g., 16 activities were initiated due to community concerns of youth suicide or self-harm).

The participation of public health in addressing child and youth mental health has led to more community dialogue and increased awareness. It also resulted in some unique, coordinated strategies between public health, municipalities and other local stakeholders. Despite these successes, participants were concerned that public health response to mental health was too reactionary. In responding to the dynamic mental health needs of the community, some public health units were compelled to try to bridge gaps at the mental health services system level. For some health units, it further compounded the challenges in allocating the resources and capacity to work on the promotion and prevention side of mental health.

Currently stakeholders across Ontario are working to improve access and coordination of services in the mental health and addictions treatment system. As partners in this work, public health can contribute to this discussion in order to address the pressures they face in this area with the aim to contribute to a more coordinated and integrated system.

Stigma

Finally, the impact of stigma was also cited as a significant barrier to promoting and addressing child and youth mental health. At the community level, stigma can prevent children, youth and their families from accessing mental health services—across the spectrum from promotion and prevention efforts to treatment and care. Among service providers, stigma may inhibit discussion of mental health and contribute to a lack of priority to pursue mental health promotion. At the public health unit and system level, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* states that "jurisdictional challenges have been compounded by the stigma that has kept discussion of mental health issues out of the public arena for far too long" (MHCC, 2012, p. 6). By including mental health in all levels of planning (i.e., program, health unit, system), we can begin to change public and practitioner perceptions, and help reduce stigma and discrimination.

Limitations

There are several limitations with the survey and interview findings. The number and description of activities and initiatives reported in the survey are likely incomplete (although, the intent of this study was never to produce a census of activities). In the data cleaning process, some records were removed because of incompleteness. Some larger programs were reported as either the larger combined program or as individual components (e.g., Healthy Babies, Healthy Children). It is also likely that some participants were unable to take the necessary time to complete the survey in full. Some questions may not have been detailed enough, such as the evaluation area. A systematic document analysis (rather than participant investigation and recall) would have yielded more complete and precise data, particularly on funding, structure and partnerships. However, this approach would have been beyond the scope of the present project.

With respect to the key informant interviews, the views of the participants do not necessarily represent those of the health unit as a whole. As well, definitions for "mental health promotion" or "mental illness prevention" were not provided. There may be different interpretations of these concepts, which may have impacted the responses. Lastly, the interviews were conducted by telephone which may have impacted how interview participants understood and reported on the questions (compared to in-person interviews).

CONCLUSION: OPPORTUNITIES FOR MOVING FORWARD

This report provides new insight on the range of child and youth mental health activities, initiatives, services and programming undertaken by Ontario public health units. We now have a better understanding of the key enablers and barriers public health professionals and health units face when implementing these activities in their community. Health units are responsive to local needs, are working with a variety of partners, and have shown resourcefulness in integrating mental health into existing programming; this is a necessity given the lack of clarity for the role of public health in mental health.

Participants also provided insight on the types of support they would like to receive. These are described in the key informant interview results section and include provincial guidance and coordination for public health's role in mental health (i.e., a clear mandate), and identifying evidence on best practices. Participants also mentioned the need to train public health staff, provide additional knowledge exchange opportunities, and establish mental health indicators (to be included in accountability frameworks). These suggested supports complement the recent call for a review of effective interventions for mental health promotion and mental illness prevention, as described in *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report* (Ratnasingham et al., 2012).

Additional research may further explore the interaction between health units and mental health stakeholders including service providers, community partners and government. This would provide more insight into the facilitators and barriers described in this report and perhaps lead to a framework for improved collaboration between the public health and mental health sectors in Ontario. It may also be beneficial to have similar data on activities and initiatives targeting adults (e.g., young adults, middle-age, seniors) or priority populations. As innovative public health approaches to mental health are developed and disseminated, there will be many opportunities for evaluation of implementation and replication projects. The broad, survey nature of the findings may be also complemented with the in-depth analysis of a number of activities.

Lastly, the larger question of the role of public health in mental health is not new, yet, it remains underdeveloped in Ontario. The present research contributes to this understanding but is still cursory in nature—we certainly hope this work stimulates further discussion towards meaningful outcomes on this important issue.

References

Balfour, K. (2007). Evidence review: Mental health promotion. British Columbia: Population Health and Wellness, Ministry of Health. Retrieved on June 27, 2013 from: *www.health.gov.bc.ca/public-health/pdf/Mental_Health_Promotion-Evidence_Review.pdf*

Barry, M.M. (2007). Building capacity for effective implementation of mental health promotion. *Australian e-Journal for the Advancement of Mental Health, 6*(2). Retrieved on June 27, 2013 from: *http://www.nuigalway.ie/health-promotion/documents/M_Barry/2007_ja_building_capacity_guest_ed._aejamh_692.pdf*

Centers for Disease Control and Prevention. (2011). *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015.* Atlanta: U.S. Department of Health and Human Services. Retrieved on June 27, 2013 from: *http://www.cdc.gov/mentalhealth/docs/11_220990_Sturgis_MHMIActionPlan_FINAL-Web_tag508.pdf*

Freeman, E., Presley-Cantrell, L., Edwards, V.J., White-Cooper, S., Thompson, K.S., Sturgis, S., et al. (2010). Garnering partnerships to bridge gaps among mental health, health care, and public health. *Preventing Chronic Disease, 7*(1). Retrieved on June 27, 2013 from: *http://www.cdc.gov/pcd/issues/2010/jan/pdf/09_0127.pdf*

Healthy Kids Panel. (2013). *No Time to Wait: The Healthy Kids Strategy.* Toronto: Queen's Printer for Ontario. Retrieved from: *http://health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf*

Herrman, H. & Jané-Llopis, E. (2005). Mental health promotion in public health. *Promotion & Education, 12*(42). Retrieved on June 27, 2013 from: *http://ped.sagepub.com/content/12/2_suppl/42.full.pdf+html*

Herrman, H. & Jané-Llopis, E. (2012). The status of mental health promotion. *Public Health Reviews, 34*(2), 1-21.

Insitut National de Santé Publique du Québec. (2008). Science advisory report on effective interventions in mental health promotion and mental disorder prevention. Retrieved on June 27, 2013 from: *http://www.inspq.qc.ca/pdf/publications/1116_EffectiveInterMentalHealthPromoMentalDisorder.pdf*

Jané-Llopis, E., Saxena, S. & Hosman, C. (2004). Next generation of preventive interventions: Need for a global perspective. *Journal of the American Academy of Child and Adolescence Psychiatry, 1*, 5-6.

Keyes, C. L. M. (2005). Chronic physical conditions and aging: Is mental health a potential protective factor? *Ageing International, 30*(1), 88-104.

King, A. (2013). *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report, 2011.* Toronto: Queen's Printer for Ontario. Retrieved on June 27, 2013 from: *http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_13/cmoh_13.pdf*

Mental Health Commission of Canada. (2012). *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*.

Calgary, AB: Author. Retrieved on June 27, 2013 from: *http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf*
Ministry of Health and Long-Term Care. (2008). *Ontario Public Health Standards.* Toronto: Queen's Printer for Ontario. Retrieved from: *http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf*

Ministry of Health and Long-Term Care. (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Toronto: Queen's Printer for Ontario. Retrieved on June 27, 2013 from:*http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf*

References Continued

Ministry of Health and Long-Term Care (2013). *Make No Little Plans: Ontario's Public Health Sector Strategic Plan*. Toronto: Queen's Printer for Ontario. Retrieved on July 3, 2013 from *http://www.health.gov.on.ca/en/common/ministry/publications/reports/make_no_little_plans/docs/make_no_little_plans.pdf*

Ministry of Health Promotion. (2010b). Child Health Guidance Document. Toronto: Queen's Printer for Ontario. Retrieved on June 27, 2013 from: *http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/ChildHealth.PD*F

Ministry of Health Promotion. (2010a). School Health Guidance Document. Toronto: Queen's Printer for Ontario. Retrieved on June 27, 2013 from: *http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf*

Perry, G.S., Presley-Cantrell, L.R., & Dhingra, S. (2010). Addressing mental health promotion in chronic disease prevention and health promotion. *American Journal of Public Health*, *100*(12), 2337-9. Retrieved on June 27, 2013 from: *http://www.publichealthreviews.eu/upload/pdf_files/12/00_Perry.pdf*

Raphael, D. (2009). Restructuring society in the service of mental health promotion: Are we willing to address the social determinants of mental health? *International Journal of Mental Health Promotion, 11*(3), 18-31.

Ratnasingham, S., Cairney, J., Rehm J., Manson, H. & Kurdyak, P.A. (2012). *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report*. Toronto: Institute for Clinical Evaluative Sciences and Public Health Ontario. Retrieved on June 27, 2013 from: *http://www.publichealthontario.ca/en/eRepository/Opening_Eyes_Report_En_2012.pdf*

Strine, T.W., Mokdad, A.H., Balluz, L.S., Gonzalez, O., Crider, R., Berry, J.T. & Kroenke, K. (2008). Depression and anxiety in the United States: Findings from the 2006 Behavioral Risk Factor Surveillance System. *Psychiatric Services, 59,* 1383–1390.

World Health Organization. (2003). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, NY, June 19-22, 1948 and entered into force on April 7, 1948. Retrieved on June 27, 2013 from: *http://www.who.int/about/definition/en/print.html.*

World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options.* A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: World Health Organization. Retrieved on June 27, 2013 from: *http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf*

Appendix A
Survey Questions

APPENDIX A. SURVEY QUESTIONS

Survey of Ontario's Public Health Units: Activities to Promote and Address the Mental Health of Children and Youth

Introduction

We are pleased to invite you to participate in our project: **Survey of Ontario's Public Health Units: Activities to Promote and Address the Mental Health of Children and Youth**. This provincial survey aims to measure the range and extent of mental health activities/initiatives for children and youth currently occurring across Ontario's 36 public health units. The project leads for this initiative are the **Centre for Addiction and Mental Health (CAMH)** Resource Centre, the Mental Health Promotion Program at **Toronto Public Health**, and the Health Promotion, Chronic Disease and Injury Prevention Program at **Public Health Ontario**. Funding has been provided to CAMH by the Health Promotion Division, Ministry of Health and Long-Term Care. This project, including the development of this survey, is being overseen by a steering committee, with representation from four public health units from across the province.

This survey aims to identify mental health activities/initiatives *currently* in progress across your public health unit that promote and/or address the mental health of children and youth.

In terms of collecting this data from your public health unit, we would like to receive **one completed online survey**. However, in order to capture the full range of activities/initiatives we ask that you consult your colleagues about activities/initiatives falling outside of your program area. As such, we are providing participants with both an online version of this survey and a Word version; except for formatting, these versions are identical. Please share the Word version with your colleagues to gather their knowledge on activities to address and/or promote the mental health of children and/or youth. You may wish to share this document via email and then host a meeting to gather this information from your colleagues. We ask that you complete a single version of the entire survey online representing all data from your health unit, incorporating information from colleagues via the link available here:

_____.

We ask that you please complete this survey by **January 31, 2013.**

In the following pages, you will find a Frequently Asked Questions (FAQ) file that will help you determine the scope of this survey and the most relevant person in your health unit; a participant information and consent form; and the three sections of the survey.

In **Section 1**, we ask you to provide information about your public health unit.

In **Section 2**, we ask you to identify each activity/initiative in your health unit to promote and/or address the mental health of children and/or youth (see FAQ for examples of types of activities/initiatives).

In **Section 3**, we ask you concluding questions.

Section 1: Introductory Questions

This section asks questions about your public health unit and your professional role within your public health unit.

1. What is the name of your public health unit?

2. Please provide your name, title and email. This will help us to follow up to gather consent if we wish to request your permission to publish specific information from your responses. If you choose not to provide this information, we will still include your responses as part of aggregated data in our report, and will not publish any specific information from your responses.

   NAME:

   TITLE:

   EMAIL:

3. Is "mental health" (or the following related terms such as "psychological health," "emotional health," "mental well-being," "mental wellness" and/or "mental illness," *as well as "mental health promotion" and/or "mental illness prevention"*) explicitly articulated in your public health unit's current strategic plan or other strategic planning/accountability documents (e.g., balanced scorecard)?

   ❍ YES ❍ NO

   If Yes, please indicate where mental health (or the following related terms such as "psychological health," "emotional health," "mental well-being," "mental wellness" and/or "mental illness" as well as *"mental health promotion" and/or "mental illness prevention"*) is mentioned:

   ❍ Mission, vision or values

   ❍ Major goals (highest level)

   ❍ Detailed objectives (for example, at the level of specific, measureable, achievable, realistic, time-limited objectives)

   ❍ Balanced scorecard indicators

4. Is there a dedicated mental health team, department or staff at your public health unit?

   ❍ YES ❍ NO

   If Yes, please indicate if this role belongs to a:

   ❍ An individual staff member ❍ A team, department or division

   Please indicate how many people work in this team

   Please indicate which professional designation best matches those with this role and how many staff have this role:

   (Check all that apply)

   ❍ **Health Promoter** – Number of staff in this role

   ❍ **Consultant** (Planning, policy, research) – Number of staff in this role

   ❍ **Nurse** – Number of staff in this role

   ❍ **Epidemiologist** – Number of staff in this role

   ❍ **Educator** – Number of staff in this role

   ❍ **Public Health and Preventive Medicine Physician** – Number of staff in this role

   ❍ **Psychiatrist** – Number of staff in this role

   ❍ **Psychologist** – Number of staff in this role

   ❍ **Social Worker** – Number of staff in this role

   ❍ **Other, please specify** – Number of staff in this role

Section 2: Activities/Initiatives to Address and/or Promote the Mental Health of Children and Youth.

This section will ask you to identify each activity/initiative that promotes and/or addresses the mental health of children and/or youth. Please complete one full "Section 2" for each relevant activity/initiative in which your health unit is engaged.

Please complete this section after consulting with colleagues outside of your program area if appropriate.

Note: The range of activities/initiatives that could be considered relevant to mental health is very broad. Virtually all of the determinants of health play a role in mental health. For the purposes of this survey, we are interested in those activities that are most specific to mental health and/o r are intended to impact mental health.

The activities/initiatives that we would like you to report are those that use at least one of the terms listed below in the activity/initiative's description, goals, objectives, outcomes, service plan, work plan, logic model or indicators. You may complete a "Section 2" for as many activities/initiatives as your public health has that relate to the terms of interest below.

Terms of interest for this scan:

- Mental health
- Infant, child or youth mental health
- Psychological health
- Emotional health
- Mental well-being
- Mental wellness
- Mental illness
- Mental health promotion
- Mental illness prevention
- Mental health literacy
- Body image/self-esteem
- Stress
- Resiliency
- Stigma reduction
- Suicide prevention
- Prevention of self-harm
- Bullying
- Violence
- Discrimination
- Crisis support/management

Review Checklist

To review, below is a checklist to guide you in determining which activities/initiatives to include in this survey. If your activity/initiative satisfies all three points, please include it in this survey. If you are unsure, please contact Monica Nunes (416 535-8501 ext 33935; *monica.nunes@camh.ca*) or Jessica Patterson (416 338-7867; *jpatter2@toronto.ca*).

✓ This activity/initiative intends to promote and/or address the mental health of children and youth (aged 0-19).

✓ Your health unit is currently participating in, partnering on or planning this activity/initiative.

✓ This activity/initiative includes at least one of the Terms of Interest listed above in the activity/initiative's description, goals, objectives, outcomes, service plan, work plan, program plan, logic model or indicators.

Section 2: Questions

1. Name of activity/initiative

2. Please indicate where "mental health" and/or its related terms identified in the list above are located: (Please check all that apply)
   - ❍ Description
   - ❍ Goals/objectives
   - ❍ Outcomes
   - ❍ Service plan/work plan
   - ❍ Logic model
   - ❍ Indicators

3. Which category best describes this activity/initiative? (Please select the one category that is the best fit)
   - ❍ Program activity/initiative delivered by your PHU
   - ❍ Program activity/initiative delivered by another agency through a financial transfer from your health unit (e.g., to NGOs or other agencies)
   - ❍ Policy or advocacy-related activity/initiative
   - ❍ Communications activity, including:
     - ◗ distribution of print or web-based information resources, such as fact sheets or brochures
     - ◗ social marketing
   - ❍ Surveillance or population health assessment activity
   - ❍ Evaluation or research activity
   - ❍ Planning activity
   - ❍ Knowledge exchange or cap city building activity including;
     - ◗ training of health unit staff
     - ◗ within other organizations
   - ❍ Other. If other, please specify:

4. Please provide a brief description of the activity/initiative (i.e., what are the goals, objectives): (Word limit = 350 words; feel free to use less)

5. Activity/initiative URL (if applicable):

6. We would like to know about which age category of children/youth is the primary beneficiary of this activity/initiative.
   For example, if you were referring to a parenting program involving parents of infants, you would check on the "6 and under" box.

   Please choose the most applicable age range of children/youth that this activity/initiative intends to benefit. (If the activity/initiative benefits children/youth across all ages, then check all of the boxes)
   - ❍ 6 and under
   - ❍ 7-13
   - ❍ 14-18
   - ❍ 19-25
   - ❍ 26 and over
   - ❍ Please provide comments on age range if necessary:

7. We would like to know who the main participants of this activity/initiative are. For example, if you were referring to a parenting program involving parents of infants, you would check on the "Parents/Caregivers/Guardians" box.

   Please identify the main participants in this activity/initiative: (Check all that apply)

   - ❍ Children and youth
   - ❍ Parents/ caregivers/ guardians
   - ❍ Educators
   - ❍ Government
   - ❍ Public health staff
   - ❍ General public
   - ❍ Mental health providers
   - ❍ Other healthcare providers
   - ❍ Social service providers
   - ❍ Other. If Other, please describe who the intended audience is:

8. Are there external partners that are involved in this activity/initiative?

   ❍ YES ❍ NO ❍ Not applicable

   If Yes, please indicate if the partners are one of the following groups. Please respond in the appropriate box depending on the formal/informal nature of the partnership.

   Please indicate types of formal partnerships (i.e. a contract or memorandum of understanding/ agreement exists between partners): (Please check all that apply)

   - ❍ Another department within your public health unit
   - ❍ Another public health unit
   - ❍ Another municipal department (e.g. Parks & Recreation)
   - ❍ Government. Please specify:
   - ❍ School/school board
   - ❍ Mental health organization
   - ❍ Local social service agency
   - ❍ Hospital/community health centre
   - ❍ Business
   - ❍ College/university
   - ❍ Other, please specify:

   Please indicate types of informal partnerships here (i.e. there is no contract or memorandum of understanding/agreement between partners): (Please check all that apply)

   - ❍ Another department within your public health unit
   - ❍ Another public health unit
   - ❍ Another municipal department (e.g. Parks & Recreation)
   - ❍ Government. Please specify:
   - ❍ School/school board
   - ❍ Mental health organization
   - ❍ Local social service agency
   - ❍ Hospital/ community health centre
   - ❍ Business
   - ❍ College/university
   - ❍ Other, please specify:

9. What best describes this activity/initiative:

   - ❍ Time limited

   If time limited, please indicate if the time span of the activity/initiative is:

   - ❍ A one-time event
   - ❍ Lasting from 1 month to 6 months
   - ❍ Lasting from 6 months to 1 year
   - ❍ Lasting from 1 year to 2 years
   - ❍ Lasting more than 2 years. Please specify length of time:
   - ❍ Ongoing
   - ❍ Don't know
   - ❍ Not applicable

10. Which of the following Ontario Public Health Standards or Guidance Documents does your public health unit use to guide this activity/initiative? (Please check all that apply)

Ontario Public Health Standards:

- ❍ Foundational Standard
- ❍ Chronic Disease and Injuries Program Standards
- ❍ Family Health Program Standards
- ❍ Infectious Diseases Program Standards
- ❍ Environmental Health Program Standards
- ❍ Emergency Preparedness Program Standard

OPHS Guidance Documents:

- ❍ Comprehensive Tobacco Control Guidance Document
- ❍ Healthy Eating, Physical Activity and Healthy Weights Guidance Document
- ❍ Nutrition Food Basket Guidance Document
- ❍ Prevention of Injury Guidance Document
- ❍ Prevention of Substance Misuse Guidance Document
- ❍ School Health Guidance Document
- ❍ Child Health Guidance Document
- ❍ Child Health Program Oral Health Guidance Document
- ❍ None
- ❍ Don't know
- ❍ Other. If other, please specify:

11. What was the primary impetus for implementing this activity/initiative at your public health unit? (Please choose one if possible and a maximum of two)

- ❍ Mandate from Board of Health
- ❍ Mandate from City Council or Regional Council
- ❍ Provincial 10-year mental health strategy from the Ministry of Health and
- ❍ Long-term Care: Open Minds, Healthy Minds
- ❍ Federal mental health strategy from the Mental Health Commission of Canada:
- ❍ Changing Directions, Changing Lives
- ❍ Local need/community crisis. Please specify:
- ❍ Request from the local school board
- ❍ Request from an external partner other than school board
- ❍ Don't know
- ❍ Other. If other, please specify:

12. We are interested in whether this activity/initiative is partly or fully funded outside of the standard operating budget of your public health unit. Please describe the source(s) of funding for the activity/initiative. (Please check all that apply)

- ❍ Within funding envelope for Ontario Public Health Standards (including 100% funded programs such as Healthy Babies, Healthy Children and Surveillance)
- ❍ Provincial ministry or agency outside of OPHS

Please identify ministry or agency:

- ❍ Local government
- ❍ Federal ministry or agency

Please identify ministry or agency:

- ❍ Funding from non-governmental organization (e.g. Trillium Foundation, local community foundation, charitable organizations such as Kiwanis or Rotary Clubs)

Please identify ministry or agency:

- ❍ Don't know
- ❍ Not applicable
- ❍ Other. If Other, please describe:

13. Has this activity/initiative been evaluated with current or past participants? (Program evaluations conducted by external consultants for your public health unit should be considered)

- ❍ Yes. Please describe the evaluation method and indicators used to measure the success of this program. If possible, please share a link to more information or report if possible. (Word limit = 350 words)

- ❍ No, but we have plans to evaluate in the future

Please describe the plans for evaluation and indicators that will be used to measure the success of this program.

- ❍ No, we have not evaluated this activity/initiative, nor do we have plans to
- ❍ Not applicable
- ❍ Don't know

14. What source of evidence supports this activity/initiative? (Please check all that apply)

- ❍ Primary interventional research (e.g. controlled trials)
- ❍ Systematic review or meta-analysis
- ❍ Narrative review
- ❍ Grey literature
- ❍ Environmental scan
- ❍ Field tested in the community (e.g. feedback surveys, focus groups, interviews)
- ❍ Other. If Other, please describe:

15. Please share any additional comments about this activity/initiative (limit = 200 words)

Section 3: Concluding Questions

Please note: These questions are to be answered only once, at the end of reporting on and describing mental health activities/initiatives for children/youth at your public health unit.

1. Were there any activities that should have been included in this survey but did not match the inclusion criteria outlined at the start of Section 2 (i.e., they did not relate to any of the terms of interest for this scan)? If so, please provide a brief overview of these activities/initiatives.

2. Was this survey completed by:

- ❍ An individual with limited input from others. Number of individuals who provided input
- ❍ An individual with substantial input from others. Number of individuals who provided input
- ❍ Multiple staff or a team

3. Any additional comments about the information provided in this survey?

Appendix B
Interview Questions

Connecting the Dots:

How Ontario Public Health Units are Addressing Child and Youth Mental Health

APPENDIX B. INTERVIEW QUESTIONS

1. Please provide the name of your health unit. This is the only mandatory question in the interview.

2. Please provide your name, title and email address to be linked with your responses. This is optional; its use here will be to follow up with you in case we wish to ask for your specific permission to use your quotes in our reports, and to notify you when our report is publicly available. If you do not provide this information, we will accept your data anonymously.

   NAME:

   TITLE:

   EMAIL

3. In terms of promoting mental health and/or preventing mental illness of children and youth in your community, in which areas do you feel your public health unit is doing well?

   a) Why do you think your PHU has these strengths?

4. What are the most important issues related to promoting mental health and/or preventing mental illness of children and youth in your community that are not currently being well addressed?

5. What barriers exist for you and/or your public health unit in promoting mental health and/or preventing mental illness of children and youth in your community?

6. What additional supports does your public health unit require in better promoting mental health of and/or preventing mental illness in children and/or youth in your community?

7. Do you have any other comments about the role of public health in addressing the mental health of children and youth?

Appendix C
Supplementary Findings from the Public Health Unit Survey

Connecting the Dots:

How Ontario Public Health Units are Addressing Child and Youth Mental Health

APPENDIX C. SUPPLEMENTARY FINDINGS FROM THE PUBLIC HEALTH UNIT SURVEY

TABLE C1.
Mean number of reported activities or initiatives by various health unit characteristics (N=325)

Health unit characteristic	Mean	Count/#HU
Presence of a mental health team or staff		
Mental health team or staff	10.2	112/11
No mental health team of staff	8.5	213/25
Health unit region		
Central West	13.1	92/7
Northeast	10.2	51/5
Central East	9.2	66/7
Northwest	8.5	17/2
Eastern	7.3	44/6
Southwest	6.1	55/9
Health unit peer group		
Urban centres	13.2	119/9
Sparsely populated urban rural mix	9.3	65/7
Urban-rural mix	7.3	109/15
Mainly rural	6.4	32/5
Health unit population size		
< 100,000	8.7	52/6
100,000 to < 200,000	7.0	112/16
200,000 to < 1,000,000	12.1	133/11
1,000,000 +	9.3	28/3
Total	**9.0**	**325/36**

Notes: The health unit peer groups and population sizes are taken from Statistics Canada. Toronto was combined with Central East. 'Metro centres' was combined with 'urban centres.' 'Rural northern regions' was combined with 'mainly rural.'

TABLE C2.
Proportion of activities or initiatives primarily funded by the provincial government or local municipality by various health unit characteristics

Health unit characteristic	Provincial government		Local municipality		N
	Per cent	Count	Per cent	Count	
Presence of a mental health team or staff					
Mental health team or staff	66.1	74	9.8	11	112
No mental health team of staff	61.5	131	8.5	18	213
Health unit region					
Northwest	70.6	12	5.9	1	17
Northeast	70.6	36	0.0	0	51
Southwest	63.6	35	1.8	1	55
Eastern	61.4	27	6.8	3	44
Central East	58.0	42	13.6	9	66
Central West	57.6	53	16.3	15	92
Health unit peer group					
Sparsely populated urban rural mix	73.8	48	1.5	1	65
Mainly rural	65.6	21	0.0	0	32
Urban-rural mix	64.2	70	5.5	6	109
Urban centres	55.5	66	18.5	22	119
Health unit population size					
< 100,000	57.7	30	0.0	0	52
100,000 to < 200,000	68.8	77	5.4	6	112
200,000 to < 1,000,000	61.7	82	12.0	16	133
1,000,000 +	57.1	16	25.0	7	28

Notes: The health unit peer groups and population sizes are taken from Statistics Canada. Toronto was combined with Central East. 'Metro centres' was combined with 'urban centres'. 'Rural northern regions' was combined with 'mainly rural'. The 'provincial government' and 'local municipality' response categories are mutually exclusive.

TABLE C3.
Detailed local need impetus for activities and initiatives (N=151)

Detailed local need	Percent	Count
Consultation or report	13.2	20
Service gap: Parents and caregivers	11.9	18
Concern: Suicide or self-harm	10.6	16
Service gap: Youth mental health	9.3	14
Concern: Bullying	7.9	12
Unspecified service gap	6.0	9
Concern: Girl's mental health	5.3	8
Concern: Eating disorders and body image	4.6	7
Direct service request	4.6	7
Service gap: Perinatal mental health	4.0	6
Unspecified community need	2.6	4
Based on or follow-up to existing program	2.0	3
Concern: Teen pregnancy	2.0	3
Alcohol misuse	0.7	1
Concern: Health inequities	0.7	1
Service gap: Families	0.7	1
Service gap: Sub-population	0.7	1
Service gap: Target population	0.7	1
No additional detail	12.6	19

TABLE C4.
Mean number of partnerships by activity or initiative type

Activity or initiative type	Mean		N
	Informal	Formal	
Policy- or advocacy-related	2.86	0.86	7
Program delivered by your PHU	2.05	1.50	160
Other	2.02	0.95	56
Program delivered by another agency through a financial transfer from your health unit	2.00	1.50	4
Planning	1.82	0.35	17
Knowledge exchange or capacity building	1.79	0.72	53
Communications	1.48	0.76	21
Surveillance or population health assessment	0.50	0.50	2
Evaluation or research	0.40	3.20	5
All	1.94	0.99	325

TABLE C5.
Mean number of partners per activity or initiative by various health unit characteristics

Health unit characteristic	Mean		N
	Informal	Formal	
Presence of a mental health team or staff			
Mental health team or staff	1.96	1.22	112
No mental health team of staff	1.92	0.86	213
Health unit region			
Central East	2.30	0.77	66
Eastern	2.18	0.75	44
Central West	1.98	1.39	92
Northeast	1.78	0.82	51
Southwest	1.64	0.98	55
Northwest	1.06	0.76	17
Health unit peer group			
Urban-rural mix	2.24	0.88	109
Urban centres	2.02	1.18	119
Sparsely populated urban rural mix	1.66	0.85	65
Mainly rural	1.16	0.91	32
Health unit population size			
< 100,000	1.34	0.71	52
100,000 to < 200,000	1.79	0.93	112
200,000 to < 1,000,000	2.26	1.12	133
1,000,000 +	2.04	1.11	28

Notes: The health unit peer groups and population sizes are taken from Statistics Canada. Toronto was combined with Central East. 'Metro centres' was combined with 'urban centres'. 'Rural northern regions' was combined with 'mainly rural'.

TABLE C6.
Evidence used to support the activities and initiatives (N=325)

Evidence source	Percent	Count
Field testing	42.8	139
Systematic review or meta-analysis	35.1	114
Grey literature	30.8	100
Environmental scan	27.4	89
Primary intervention research	20.9	68
Narrative review	17.2	59
Other	13.8	45
Don't know	18.2	56

Appendix D
Activity List

Connecting the Dots:

How Ontario Public Health Units are Addressing Child and Youth Mental Health

APPENDIX D: ACTIVITY LIST

Appendix D presents a list of all 325 activities and initiatives reported by the survey participants; these are organized by the categories outlined in Table 2 (page 11). This information provides more detail on the range and types of activities occurring in Ontario public health units to address and promote mental health in children and youth. Each activity identified includes a description, identifies the target age group, and provides a generic web-link where available. To develop the categories, the descriptions provided by survey participants were collaboratively analysed by two research team members in order to determine the primary function of associated activities. Based on the described functions of the activities, 9 categories emerged. Reported activities were then assigned to each category accordingly. For the purposes of this appendix, subcategories were created to provide further detail on the 9 categories. The activity names and descriptions have been edited for clarity and to remove words that may link a specific activity to a health unit.

Category/subcategory page

SCHOOL-BASED PROGRAMMING

- *Small group programming (including parents/teachers as audiences)*

Roots of Empathy

Target age: 0 to 13. Reported 5 times.

Roots of Empathy is an evidence-based classroom program in which health unit staff either serve as instructors or provide training and support to facilitators. The program builds empathy and social/emotional competence by bringing an infant and parent into the classroom over the course of the school year and having the students observe the infant's development and emotions. By teaching children to understand their own feelings and the feelings of others, they learn to care for others and the likelihood of physical, psychological and emotional aggression is decreased.

http://www.rootsofempathy.org/en/where-we-are/ontario.html

P.A.L.S. - Playground Activity Leaders in Schools

Target age: 0 to 13. Reported 4 times.

P.A.L.S. is a playground leadership program designed for elementary schools. Public Health Nurses provide training to staff and students on how to implement the program and provide ongoing support at program sites. During recess and lunch breaks, older children act as Activity Leaders, encouraging participation and inclusion of younger students in interactive games, regardless of age, gender or ability. The program serves to build children's leadership skills, increase physical activity, and decreasing conflict and bullying on playgrounds.

Girls Talk

Target age: 7 to 18. Reported 2 times.

Girls Talk is an eight-session anti-stigma program for girls developed at the Centre for Addiction and Mental Health that aims to educate about and prevent depression. Discussions on mental health topics and corresponding artistic or recreational activities are led by health unit staff.

http://www.camh.ca/en/education/about/camh_publications/Pages/girls_talk.aspx

F.U.E.L. (Females Using Energy for Life)

Target age: 14 to 18. Reported 3 times.

F.U.E.L. is a free after-school physical activity program for female youth. It engages girls in non-competitive fitness activities, such as yoga or strength-training, building physical skills, allowing an opportunity for socializing, and teaching them options for living a healthy, active lifestyle. The program aims to increase girls' self-esteem and mental wellness.

Youth Net

Target age: 14 to 18. Reported 2 times.

The Youth Net program, originally developed in 1994 by Dr. Ian Manion and Dr. Simon Davidson from the Children's Hospital of Eastern Ontario, is a mental health promotion program that provides a forum for youth to express, explore and discuss their concerns about mental health issues, including topics such as mental illness, stress management or coping strategies. It also offers an opportunity to identify youth at risk of suicide and connect them with help. Discussion groups are 90 minutes (or adjusted to classroom period length) and offered predominately in secondary schools.

Can You Feel It?

Target age: 7 to 18. Reported 2 times.

The Can You Feel It program is a multi-faceted tool designed to help students and school communities build the necessary life skills to manage and cope with stress in their everyday lives. By helping students understand how their bodies react to individual stresses, the goal of this resource is to help students recognize that stress comes and goes, both good and bad kinds, and to enable them to develop control over how they react to it.

Gay Straight Alliance Support

Target age: 14 to 18. Reported 2 times.

Gay Straight Alliances (GSAs) are groups formed in schools to improve the feelings of safety of sexual minority students and to prevent incidents of homophobic violence. Public health nurses employed by the local health unit may provide support to the GSA in the following ways: School-wide education and awareness

events on homophobia; teacher in servicing on GSAs and LGBT youth issues (such as family disownment, bullying and harassment, depression, anxiety, substance misuse, suicide, etc.); and general support for the creation and continuation of thriving GSAs.

Talking About Mental Illness (TAMI)

Target age: 14 to 18. Reported 3 times.

Talking about Addictions and Mental Illness (TAMI) is an anti-stigma program often offered in conjunction with Youth Net over two consecutive days. Trained volunteers from the Canadian Mental Health Association (CMHA) speak with youth about their personal experiences with mental illness. These presentations are paired with an educational session by an agency (partnering agencies include CMHA, the Centre for Addiction and Mental Health, the Schizophrenia Society of Ontario, and ADAPT) staff member. Presentations cover a range of topics - depression/anxiety, concurrent disorders and psychosis. TAMI presentations are offered in Secondary schools during a classroom period.

Girl Talk

Target age: 7 to 13.

Girl Talk follows a peer-support group model and is based on an earlier program entitled Every BODY is a Somebody (EBIS). Local public health practitioners trained by Gail McVey and colleagues facilitate sessions with small groups of middle school girls, within the school setting. The intervention was designed to help girls reverse negative peer pressures and adopt positive health promoting behaviours. Outcome based studies conducted on the EBIS curriculum revealed promising results, whether delivered in the classroom or nurse-facilitated peer support group setting. Specifically, improvements were shown in global self-esteem, body image satisfaction, body esteem, and disordered eating among girls attending middle school.

Healthy Transitions

Target age: 7 to 13.

Healthy Transitions is a mental health promotion program for young adolescents (grades 7-8), their parents and teachers. It is designed to enhance protective factors known to support positive developmental outcomes in youth. The program was developed in partnership with professionals representing community and hospital mental health, education and public health, led by the Children's Hospital of Eastern Ontario (CHEO). The program objectives are: 1) Enhance individual capacity of young adolescents through increased knowledge, positive attitudes about mental health (de-stigmatization), and behaviours supportive of mental health; 2) To enhance teacher and parental skills, strategies, and knowledge in order to strengthen their capacity to meet the needs of their children during early adolescence; and 3) Strengthen links between schools and community agencies to support the mental health of young adolescents. The Healthy Transitions program was evaluated by CHEO, and the results indicated that the young adolescents who participated in the program had lower levels of stress and worry after the program, an increased knowledge of positive mental health, increased awareness of personal mental health status, and increased use of positive coping strategies (Croll, Langill, and Pisterman, 2006). The program is currently being implemented in grade 7-8 classes in four publicly funded school boards by a Public Health Nurse and a Youth Facilitator.

http://child-youth-health.jimdo.com/english/publications-and-resources/healthy-transitions/

Come As You Are

Target age: 14 to 18.

"Come as you are" is an initiative that addresses the stress and anxieties that students experience as they transition to high school. It sends the message to students that all students belong to the school community and that they should feel welcome and valued as they are. A focus group was done (grade 10 and 11 students) and students were asked what their main stressors were on the first day/ week of school. The majority had stated that their primary concerns were getting lost, "being freshied," making friends, and standing out. Students were asked for their input and participated in planning the activities for the first day/week of school. Main components of the Come as You Are campaign were the Ambassador Program (grade 9 orientation activities), message campaign and video (message to my grade 9 self), grade 9 survival guide booklet (included all tips of the do's and don'ts, and school map), and message board. Promotional items for this project included message pens, button, T-shirt, lanyards and a grade 9 survival guide booklet. All

items were branded and had the "Come as You Are" logo which was designed by a local artist. A big banner with the "Come as You Are" logo that was made by students and a local artist was posted on the front lobby on the first day of school. On the first day of school, all grade 9 students reported to the gym for the welcoming assembly. Approximately 50 ambassador students were present and each ambassador was assigned to students to do grade 9 orientation activities (escort students to their first class, ice breakers, etc.) All ambassador students wore a "Come As You Are" T-shirts so that they are more visible, teachers wore buttons and lanyards. During the assembly, a message to my grade 9 self video (tips for grade 9 on the first day of school), was shown. All grade 9 students were given the grade survival booklet, and a message pen. Throughout the week, orientation activities were done and included breakfast assembly at mid-week and stress management and positive coping mechanisms discussed (media was invited)

101 Things You Need to Know Before Leaving High School

Target age: 14 to 18.

"100 Things..." is an interactive workshop that can be run within the time frame of a 75 minute school period. The topics covered include time management, money management, partying, drugs and alcohol, stress and coping, dealing with diversity, and where to go for help. Research highlights the need for targeted supports for this developmental stage and a pilot-test of the workshop found students benefited from participation.

Challenges, Beliefs and Changes (CBC)

Target age: 7 to 18.

Challenges, Beliefs and Changes (CBC) is a peer mentoring program developed by the Parent Action on Drugs. CBC engages senior high school students as volunteers, providing leadership development training, accurate information and messaging about tobacco, alcohol and other drug use as well as intentional insights about the challenges many students face entering secondary school including peer pressure, stress etc. These Peer Leaders then travel to grade 8 classrooms to deliver two ninety minute interactive sessions exploring the challenges of high school and encouraging younger students to make well informed decisions.

At Home Alone

Target age: 7 to 18.

At Home Alone is a two hour interactive workshop for parents and their 10-14 year olds, to help prepare them to stay home alone safely. This workshop helps open up lines of communication and assists families in working together to develop a home alone safety plan. Topics in this family workshop include assessing if you are ready to be home alone, learning about safety, organizing your home, negotiating an agreement and evaluating how things are going.

Body Wize

Target age: 7 to 13.

The teaching resource, "Body Wize: forget the size", is designed to help teachers address several Healthy Living curriculum expectations. Students are encouraged to forget about body size, and focus on developing or maintaining a healthy lifestyle including healthy eating, physical activity, and a positive body image. Teachers do a number of activities with students related to personal coping strategies and caring for themselves, and a culminating activity is done by a public health nurse on the topic of stress. Students also have the chance to make and enjoy a healthy snack together.

Breathe Free

Target age: 14 to 18.

Tobacco cessation program including short-term group work and discussions on stress.

Be A Verb Bullying Prevention Initiative

Target age: 0 to 13.

Be a Verb, developed in collaboration with the local School Board, aims to raise awareness among elementary school students about what bullying is, how to recognize bullying, and how to take action when confronted with bullying of oneself or others.

Youth in Control Program and What's With Weed Program

Target age: 14 to 18.

Youth In Control is a program to prevent the misuse of alcohol and other drugs, using a variety of interactive activities that are initiated, planned and implemented by peer-leaders and supported by a school/agency staff advisor and public health nurse. What's With Weed is peer leadership education program based on a harm reduction model to engage youth in identifying issues they or their friends may be having with the use of marijuana and to inform them of effective ways to reduce problems associated with marijuana use. A local youth support worker is linked to the school to offer counselling to students who seek help.

Wellness Week Pilot

Target age: 7 to 18.

Wellness Week is a public health nurse-facilitated event taking place in a school setting and using a comprehensive school health approach. It is an adapted version of the 'Can you feel it?' program. The week of activities involves guest speakers, yoga classes, massage therapy and provision of healthy smoothies. There is a student leadership piece as well.

Vibrant Faces

Target age: 7 to 18.

Vibrant Faces helps females develop some of the skills necessary to overcome barriers to physical education, sport and physical activity participation and to lead active, healthy lifestyles.

HEY (Healthy Empowered Youth) committees

Target age: 7 to 13.

The purpose of HEY is to promote student ownership of health topics that relate to students, such as healthy eating, physical activity, self-esteem, personal safety and injury prevention. HEY committees encourage leadership and critical thinking and provide an opportunity for students to create change within their schools, express their opinions and creativity, and contribute meaningfully to their community. Students are taught how to locate, access, and write grants to support their plans (e.g. through grants such as Student Voice, Dare to Dream, and other local service clubs).

Take Charge Leadership Day

Target age: 14 to 18.

Take Charge is a one-day youth engagement and leadership event that includes training and key note speakers. Small grants are provided to students to run initiatives in their own schools.

Teen Esteem

Target age: 7 to 18.

The Teen Esteem program is designed to "raise the awareness of students and the school community to the critical decisions youth face". It is a series of seven sessions during the lunch hour, open to students in both the Public and Catholic School Boards. Trained volunteers meet with girls in middle school to share their experiences with careers and life choices. Volunteers facilitate discussion and lead students in interactive games and activities to engage them in learning about topics such as self-esteem, body image, peer pressure, bullying, coping with stress, social media, and healthy relationships. The last week is a celebration for the volunteers and students where they join together for pizza, crafts and certificate presentations. A public health nurse is present at every session and meets with the school prior to the sessions to ascertain their specific needs or concerns.

The Drug and Alcohol Package

Target age: 7 to 18.

This is a package of programming and education for youth that have experienced drug and alcohol charges while on suspension from school. It is now being re-developed for an online activity.

Thrive Workshop

Target age: 7 to 13.

Thrive is a 90 minute workshop involving five to seven activities which engage youth in identifying stress in their lives and provides tools for developing positive coping mechanisms.

Undercookstruction

Target age: 7 to 18.

Undercookstruction is a six-session program focused on food skills-building and positive messaging related to resiliency and self-esteem. Youth participants learn to create meals with food bank items and how to shop effectively and read food labels, all in a communal setting.

Healthy Buddies

Target age: 7 to 13.

Healthy Buddies is a 21-week comprehensive peer education program for elementary schools. It focuses on healthy eating, physical activity, and positive self-image. The intermediate grades are taught the content, which they then teach to the primary grades.

Mental Health Matters - Youth Summit

Target age: 7 to 18.

Based on a successful Youth Summit for grade 7 students held in 2012, a Summit will be offered to student reps from grades 7, 8, 9, along with parents and teachers.

Self Esteem and Body Image Programming

Target age: 7 to 13.

This program is part of a comprehensive approach to mental health and healthy weights promotion with a unique focus on body image, self-esteem, relationships and healthy lifestyle choices. It is a support group for girls, not just an educational session. The goals are to promote healthy eating and physical activity, reduce preoccupation with weight and size, and support girls through normal changes associated with puberty. This program is best delivered as part of an approach which includes education and training to all staff of the environment (e.g. school or recreation setting) and includes an environmental scan of the supports and potential barriers for nurturing positive mental health.

Party in the Right Spirit (post-secondary institutions)

Target age: 19 to 24.

PITRS (Party In The Right Spirit) is a health promotion and education program that trains student peer educators on topics related to safer substance use and safer partying and supports them in sharing the information with their peers on campus. The focus, using a harm reduction model, is on reducing risks in three main areas: personal safety, impairment from drugs and alcohol, and host liability. The peer educators conduct workshops, displays, walkabouts and other creative methods to relay messaging to their peers. Public health nurses provide outreach to post-secondary schools to engage students and staff, consult with Campus Health Educators (nurses, physicians, health promoters), train peer educators on workshop content, support peer educators at events as needed, and provide resources.

Pens and Paints

Target age: 14 to 18.

Pens and Paints is a school-based, weekly, eight-session group designed for marginalized youth who are at risk of mental health issues. Each 1.5 hour session focuses on a specific theme and is coupled with an artistic activity. Themes include stress, healthy relationships, self-esteem, conflict resolution, substance use, diversity, and violence. Sessions are led by two facilitators who are public health unit staff. The objectives of the program are to encourage youth to explore and discuss issues in a safe and supportive environment, to provide youth with an opportunity to develop and foster artistic skills, and to identify youth at risk and make appropriate referrals.

Mental Health Literacy

Target age: 14 to 18.

Initiatives are based on school/community need and altered to fit what is trending at the school level. The literacy campaign often consists of a basic Mental health literacy presentation using a person with lived experience (TAMI speaker) followed by a series of lunch and learn activities around specific knowledge gaps related to mental health. These presentations often include opportunities to engage youth in the school/community with regards to learning, teaching or initiatives at the school/community level.

Promoting Healthy Body Image Project

Target age: 7+.

The Promoting Healthy Body Image project involves several elements. The Dressing Room Project, created by Emerging Women Projects, is a series of interactive workshops for girls in grades seven and eight in which they learn and discuss the ways in which images in the media influence how we see ourselves and others. Each girl creates an inspirational positive body image postcard empowering herself to appreciate her natural size and shape. Messages created by girls in the workshops have been developed into a social media campaign targeting girls and women of all ages. The Promoting Healthy Body Image project also includes workshops and resources for educators, coaches, parents and young athletes, such as presentations from BodySense (Canadian Centre for Ethics in Sports). The health unit lending library provides curriculum-matched resources to promote positive body image, and the health unit is involved in health fairs and other community and school events (e.g. Happy to Be Me day).

Risky Business Workshop

Target age: 7 to 13.

Risky Business is a peer-led workshop in which students are led through 4-6 stations themed around bullying, harm reduction, resiliency and injury prevention. Students learn knowledge and skills to help them make responsible choices, respect one another and cope in a variety of situations.

Recess Ambassadors on the Playground (RAP)

Target age: 0 to 13.

The RAP program provides students with the opportunity to be leaders for younger students (JK/SK to grade 3), fostering leadership skills and promoting physical activity at the same time. Students who choose to be RAP leaders are trained to develop leadership and problem solving skills, as well as provided with outdoor equipment and games to run peer led recess physical activity for younger students. RAP leaders receive training and ongoing support as needed (e.g. booster meetings or refresher training) from the public health nurse and school lead. Public health nurses provide training for all co-facilitators (school staff who choose to be leads for the program) and students participating in the RAP program.

Rebounding: A Resiliency Program with Open Doors

Target age: 7 to 13.

Rebounding is a school-based resiliency building program that runs one hour per week for five weeks, with follow-up activities for teachers to lead during the week. Each community hosts a parent night for all schools that includes a workshop on parenting and mental wellness. The presenters are from Open Doors and Public Health.

The Dressing Room Project

Target age: 7 to 18.

The Dressing Room Project is a universal-selective secondary prevention program for female students for 90-120 minutes within their school. The objectives for students are: to learn to be critical of the media and the influences it brings, to build positive self-esteem/body-esteem and resiliency, to build positive social relationships, to prevent disordered eating and understand the body's resistance to dieting, and to define beauty and be involved in the communication of positive messages to self and others. Part I of each workshop is an interactive discussion and Part II invites students to create artistic positive message cards for themselves or to give to someone. Part II is incorporating some of their positive messages into a broader community-wide health promotion campaign.

Elements

Target age: 7 to 18.

The Elements program is for boys in Grades 7 and 8. It takes place during lunch-hour sessions within the school. The program is based on a mentorship model: male volunteers from the community come in and share experiences about their own careers and life choices. The sessions include games, crafts and group discussions. Topics covered include handling anger, violence, stereotypes, self-discovery, self-esteem, healthy relationships, and future goal setting.

Fourth R

Target age: 7 to 18.

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

http://www.youthrelationships.org/

Friends for Life

Target age: 7 to 13.

Friends for Life is a ten week program targeting grades 4-6 that uses cognitive-based therapy (CBT) for early intervention in anxiety and depression. The program is delivered by accredited facilitators within the school or community setting. Youth are provided a workbook and facilitators follow a leader's manual based on research and best practices. The program also includes a parent education session.

G.I.R.L.S. Power Camp

Target age: 7 to 18.

G.I.R.L.S. Power Camp is a three day camp program available to girls in Grade 8. This unique weekend camp experience is facilitated by young women volunteers aged 16-27. The goals of camp are: to build self-esteem and confidence among the participants; to raise the girls' awareness about young women's issues such as body image, peer pressure and sexism; to develop critical thinking skills among girls and young women in order that they may make informed choices; and to illustrate the links between young women and the community. Camp focuses on healthy choices, body image, self-esteem, healthy eating and active living, healthy relationships, personal safety, and transition to high school.

Girls Conference for Young Women

Target age: 14 to 18.

This conference is held annually for all grade 9 females attending a particular school. The goal is to encourage: 1) "Taking Care of your Mental Health" - through group activities, participants learn about the impact of mental health on overall wellbeing and identify appropriate and effective strategies to cope with stress; 2) "Team Building" - activities stress the importance of getting to know peers, making new friends and creating a positive school environment; and 3) "Healthy Relationships" - discussions are facilitated on what abuse looks like, healthy relationships and effective community responses that makes women and children safe from any kind of abuse.

Girls Groups, Lucy Project, All Girls Assembly

Target age: 14 to 18.

Groups led or co-facilitated by the school nurse promote physical health, positive body image and self-esteem, healthy relationships, and healthy decision making and empower girls with regard to current issues such as sexting, social pressure, social media, and portrayal of females in the media.

Mental Wellness Presentation

Target age: 14 to 18.

Following several suicides over a short period of time, school and community partners came up with a plan to educate students (grades 9/10) on Mental Health, Mental Wellness and where to go for support and other community resources.

Mindfulness

Target age: 0 to 18.

Students who practice mindfulness meditation and other mind/body focused exercises have the potential to improve academic achievement, mental health (e.g. anxiety, emotional reactivity), and personal relationships. When we pay attention to the present moment, we become aware of negative thought patterns which then allow us to create better ways to respond to life's challenges. Research in brain science shows evidence

to support the use of mindfulness in education. Health unit activities consist of: Conducting a literature review of research related to Mindfulness in school education; participation in an external Mindfulness in Education Committee; Assistance with developing mindfulness resources, delivering support to schools and community, and developing program evaluations.

www.mindfulschools.org,
www.mindfulnessstudies.com

More to Me Than What You See

Target age: 7 to 13.

More to Me Than What You See is a school-based, non-curriculum program that runs for 6 consecutive weeks during the lunch hour. The program creates an environment where children build social skills, positive values, positive identities and a sense of belonging. The program targets girls in grades 4 – 6 by providing them with an opportunity to talk with peers and adult facilitators about body image, self-esteem, relationships, healthy eating, active living, feeling good about themselves, and changes associated with puberty. It may be facilitated by PHNs, Child and Youth Councilors, Social Workers, teachers, or other group facilitators. It is based on a program developed in 1993 called Mood, Food, and You.

NicoTEEN Prevention Workshop

Target age: 7 to 13.

The 'NicoTEEN Prevention' workshop is facilitated by peer leaders under the guidance of a school health nurse, with the goal of educating their fellow peers regarding dangers of tobacco use. Along with the workshop, teachers are encouraged to utilize various tobacco resources and activities available through the Health Unit in their classrooms. The initial ½ day session consists of interactive training for 10 students in grades 6 through 8. They participate in a variety of pit stops which include games, a power point presentation and a demonstration of pig's lungs. The subsequent session is a workshop for students in grades 4 and up, developed on a class by class basis. The workshop is designed to work in conjunction with the Healthy Living Strand of the new Health and Physical Education Ontario Curriculum.

Nutrition Tools for Schools

Target age: 0 to 13.

As part of the essential elements for creating a healthy school nutrition environment, positive role modeling and promoting positive body image and self-esteem is integrated into one of many action guides in Nutrition Tools for Schools. After completing a school assessment checklist, a school nutrition action committee works through action guides with public health support.

◗ *One-on-one student support*

Tragic Event Response Support Team/Crisis Intervention Team

Target age: 0 to 18.

A Tragic Event Response Support Team is available for each school within the school board. This team also explores training opportunities regarding tragic events and networks with school boards and community agencies regarding professional roles in crisis situations.

Mental Health Liaison Nurse Junior Program

Target age: 7 to 13.

The Mental Health Liaison Junior Program is delivered to youth in grades 6-8 by Mental Health Liaison Nurses (MHLNs) who are employed by the regional health department. This program is free, confidential and anyone can make a referral. The following services are offered within the program: mental health and early risk assessment; consultations with parents, schools, community and health professionals to access timely mental health services; brief supportive counselling and/or specific therapeutic intervention; referral to appropriate health care services and community resources; and liaison between student, family, school communities and other professionals. Common issues for referral include anger, disconnect from friends, anxiety, depression, issues with sleep, loss of interest in school, mood disturbances, bullying, and challenges with the law/challenging authority figures. Mental health promotion is also a large part of the Mental Health Liaison Junior role including activities such as providing mental health

literacy and mental health presentations to educators, parents, and community partners (e.g. on anxiety, depression, self-esteem, etc.)

Secondary School Based Individual Counselling

Target age: 14 to 18.

Public health nurses provide individual counselling in high schools related to mental health issues and they promote positive mental health. They are available to students on a weekly basis for a variety of health related reasons, and students can self-refer (PHNs do not require parental consent), or be referred through school and support staff.

School-based Public Health Nurse Program

Target age: 0 to 18.

Working with school staff and parents, School-based Public Health Nurses encourage students to recognize their own strengths and use them in their everyday lives. They provide supportive counselling in a safe, accepting, non-judgmental environment to enhance learning and promote healthy growth and development. Working at school or in the homes of students, they provide confidential counselling for individuals and groups, advocate for students, provide information and consultation, hold student workshops, provide parent education, strengthen communication between school and home, and link students and their families to other community health and social services.

High School Based Clinics

Target age: 14 to 18.

Public Health Nurses offer clinics in the high schools. The clinics offer birth control options, STI testing and treatment, pregnancy testing, option counselling and the Emergency Contraception Pill (ECP). These services often provide a venue for students to discuss substance abuse, body image, bullying, relationship issues/concerns and self-harm with a health professional. These clinics are often the first point of contact for students and many referrals are made to Mental Health workers or Social Work.

School Based Sexual Health Clinics

Target age: 14 to 18.

Confidential counselling services provided by public health nurses provide a venue for young people to discuss and obtain referrals and support for issues such as substance abuse, eating disorders and body image, bullying, relationship problems, and self-harm or suicide.

Comprehensive school health programming

Healthy Schools Initiatives.

Target age: 0 to 18. Reported 12 times.

The Ministry of Education's Foundations for a Healthy School Framework is the guiding document for many school-based physical and mental health programs. The four components of this framework are: quality instruction and programs, a healthy physical environment, a supportive social environment, and community partnerships. The purpose of the framework is to contribute to the physical, mental, emotional, social and spiritual health of the entire school community. In order to do this, across Ontario Health Action Teams and Healthy School Committees are being established, comprised of teachers, school administrators, students, parents, public health service providers and community partners. Committees begin by identifying health topics that school communities are interested in or concerned about. Topics may include areas such as healthy eating, physical activity, mental health, bullying prevention, substance misuse prevention, and healthy growth and development, among others. School Health Units and resource staff operating within public health develop comprehensive, evidence-based program materials and provide guidance to school-based public health nurses, in addition to providing tailored consultation to interested school administrators and school boards. Depending on the location, public health nurses offer small group education sessions and one-on-one situational supports to students in collaboration with school social workers and guidance counsellors.

School Health Team Climate Committee

Target age: 7 to 18.

The Climate Committee tracks resources in order for School Health Public Health Nurses (PHNs) to link and refer school staff. School Health PHNs deliver training to educational staff and reinforce the link between Healthy Eating and Physical Activity to promoting positive mental health. Bullying lesson plans were created and distributed to schools for teachers as a curriculum resource. This resource is also available online. Playground Activity Leaders in Schools (PALS) Program continues to be implemented in schools across both school boards. This resource is also available online. Youth leadership guidelines are currently under development to assist school staff and community organizations when working with Youth Leaders. Currently, School Health PHNs support Student Wellness/Health Committees in schools in the region.

Comprehensive School Health Consultations

Target age: 0 to 18.

The School Health unit provides interested schools with consultations regarding the Foundations for a Healthy School Framework, which include mental health as a topic area. Public Health staff work collaboratively with the school community (and community partners) to address specific issues within the school community, with a focus on addressing issues in a comprehensive, evidence-based manner.

School Based Services delivered/ supported/facilitated by Public Health Nurses using a Comprehensive School Health Framework

Target age: 0 to 24.

The School Program uses the Foundations for a Healthy School Framework to guide School Based health interventions and service delivery. A comprehensive plan is developed with each Health Promoting School to address identified issues. This is done with Health Action Teams comprised of school administration & staff, students, parents, community partners and Public Health Services. The role of public health within this model is to provide evidence-based programs and information/ guidance to inform school based intervention. Resource staff within Public Health Services develops materials and programs to support the school PHNs to work within this Comprehensive School Health Model.

Supporting Caring Schools Program

Target age: 0 to 13.

An evidence-based, multi-strategy program for elementary schools designed to support a safe and caring school environment. This program is facilitated by the school Public Health Nurse and involves the entire school community, including administration, staff, students and parents. Based on an evaluated, two year pilot project in elementary schools, this program has demonstrated promising results. Participating schools have reported decreases in suspensions, absenteeism and a more positive environment. This program is available to Public Health Services - Health Promoting Partnership Schools only.

Support for Secondary Student Groups

Target age: 14 to 18.

The Public Health Unit provides support to existing secondary school committees such as: Safe Schools, Health & Wellness Councils, Students Council, Safe Grad Committees, Gay-Straight Alliances, Social Justice, and Ontario Students against Impaired Driving. Support may include attending meetings, providing resources, bringing in displays, offering financial assistance with projects, and assisting with grant writing. The level of involvement in these groups varies greatly between schools and within each committee. Some committees are completely self-sufficient. Other committees request more support from the Public Health Nurse.

School Health Team

Target age: 7 to 18.

A newly formed school health team have PHNs assigned to a group of schools to provide a comprehensive school approach to identifying and addressing topics of public health importance including mental health promotion, bullying, and self-esteem. We collaborate with school boards, staff and a group call support4northernkids. This could involve delivering programs (e.g. Girl Talk), supporting training for staff, connecting to other available resources, services. There would be a focus on developmental assets, resiliency. This also links with our substance misuse program initiatives. As part of this school team model we also have community health workers who work on youth engagement activities using principles of youth engagement.

School Health Secondary Nurse Program

Target age: 14 to 18.

The secondary school nurse works collaboratively with the school and teachers to deliver education on: body image, mental health and mental illness, stigma reduction, bullying, substance misuse prevention, support systems, asking for help, sexual health and decision making, sexual assault and violence awareness and prevention. The school nurse also sees students individually for brief assessment, counselling and referral to mental health or other community agencies.

COMPASS - Community Partners with Schools

Target age: 0 to 18.

There are 9 COMPASS Community School teams across the county. Local schools and the local community service providers meet to: share relevant best practice/ program/school resources and information; bring forward school and community issues; identify and participate in opportunities for collaboration; share leadership between school and community in coordinating a response; disseminate information, activities and issues within member organizations; and advocate within member organizations for resource/personnel allocation and programming priorities based on issues identified.

Student Support Leadership Initiative

Target age: 0 to 24 Reported 6 times.

The goal of S.S.L.I., developed by the Ministries of Education and Children and Youth Services, is to build leadership within and across school boards and community organizations, to strengthen local partnerships, and to improve the ability to meet the needs of students and families through collaborative work and referrals to services. Some examples of projects being undertaken by local SSLIs are the development of guides for early identification of mental health issues and student referral, the development of mental health training modules and scans of community mental health programs and services.

Education support and curriculum delivery

A Tool for Every Teacher

Target age: 7 to 18. Reported 2 times.

This guide explores frequently asked questions about role modeling and teaching to positively impact students in grades K to 8. Topics included in the guide: media literacy, healthy eating, physical literacy, physical activity, healthy weights, healthy body image and eating disorders.

Bulletin Boards in a Bag

Target age: 7 to 18.

Posters with positive messages to go on school bulletin boards. One poster is focused on resiliency.

Caught Caring

Target age: 7 to 13.

Caught Caring week is a health promotion program developed to help promote positive mental health through character development. This resource was developed for elementary school teachers.

Anti-bullying approach in the school

Target age: 0 to 18.

Because schools and community police are raising concerns over bullying taking place in and out of schools, public health is looking at ways to implement a comprehensive school health approach. Partners have agreed to work with our agency in planning the best interventions and programs to address this. Currently in its preliminary stage: reviewing of literature on best practice and evidence based evaluated approaches and how to best approach this issue with community partners.

Sexual health classes in grades 8 and 9

Target age: 14 to 18.

Classroom presentations on healthy relationships give students information on recognizing healthy/unhealthy/abusive relationship, on decision-making in relationships and the importance of building, positive self-esteem. Partnerships with other community agencies are used for some aspects of the lessons.

Healthy Choices, Transitions, 4th R

Target age: 7 to 18.

Public Health Nurses go into grade 7 and 8 classrooms with curriculum and activities that address Risky Behaviours, Mental Health, Skill Development, Decision Making, and Problem Solving. There is follow up throughout the year with classroom teachers to create a comprehensive strategy (usually using lesson plans from either the Healthy Transitions or 4th R curriculum).

Curriculum Supports Grade 1-8

Target age: 7 to 13.

Presentations are made in classrooms on substance misuse, growth and development, and body image/self-esteem in line with the Ontario Curriculum from the Ministry of Education. Goals and objectives are outlined for each course/presentation.

Teaching components of the Ontario Health curriculum in local schools

Target age: 7 to 18

Public Health Nurses teach provincial curriculum to public and separate school students on request basis. The curriculum includes lessons on body image, self-esteem, and discrimination/bullying.

PARENTING SUPPORTS AND PROGRAMS

◗ *Prenatal health*

Canada Prenatal Nutrition Programs

Target age: 0 to 6, 14 to 24. Reported 4 times

CPNP is a federal program providing access to health and social supports for pregnant women and new mothers facing challenges that put their health and the health of their infants at risk. It is delivered at the community level in the format of 9 weekly groups and is targeted to community needs and priorities. Clients include women facing challenges such as teen pregnancy, poverty, lack of social support, recent arrival in Canada, alcohol or substance dependency and family violence.

Feelings after Birth Parent Support Group

Target age: 0 to 6.

Feelings after Birth is a parent support program targeted to women with children less than two years of age who self-identify or are diagnosed with postpartum mood disorder. The object of this group is to mitigate the impact of postpartum mood disorder on young children. This is a collaborative program with shared space, responsibility and facilitators from the community and Public Health. Program coordination and childcare is provided by the county. Two groups operate on a weekly basis with 6 – 8 women per group.

In-class Prenatal Education

Target age: 0 to 6.

In-class prenatal education is provided in six 2 hour classes or two 6 hour classes. Prenatal education is offered for the public across the region as part of the Reproductive Health Program. Topics addressed that relate to child mental health/wellness include: healthy lifestyle and role modeling for children (e.g. alcohol and pregnancy, stress management, nutrition, exercise), maternal mental health (e.g. prenatal and postpartum depression), preparation for parenting (e.g. role transitions, attachment related information, children's healthy brain development). Addressing healthy pregnancy and overall lifestyle, mental well-being, parental relationships, and early parenting concepts within the context of prenatal education classes has the potential to positively impact emotional, cognitive, and behavioural development in childhood and beyond.

Information and Referrals for Maternal Mental Health

Target age: 0 to 6.

This program includes provision of information and referral to women and partners related to emotional health during and after pregnancy, development of and training related to best practice guidelines for supporting women with postpartum depression and anxiety, partnership with a local hospital to provide community-clinic assessment, and referral and support.

Teen Prenatal Education Classes

Target age: 0 to 6, 14 to 24.

The Teen Prenatal Education Classes are designed to empower participants to: adopt healthy lifestyles; make informed decisions regarding their care during pregnancy, childbirth and early parenting; advocate for their physical, emotional and mental health and the health of their families; and build supportive networks within their communities. All childbearing families have the opportunity to access free prenatal education regardless of their age, education, culture, ethnicity, race, socio-economic status, gender identity, developmental disability and financial status. The objectives of the Teen Prenatal Education Classes include: increased knowledge, confidence and coping skills to make informed choices about their pregnancy, birth experience and transition to parenting; recognizing healthy lifestyle choices including breastfeeding; recognizing ways to meet the physical and emotional needs of their infants; developing an understanding of the importance of and the skills involved in breastfeeding; enhancing family relationships through communication with partners and supports; enhancing communication with health care providers; recognizing that any pregnant or new mother can experience a postpartum mood disorder and being aware of the symptoms and resources available; exploring realistic expectations about parenthood; increased awareness of the value of fathering in a child's life; and making connections with other parents and community resources.

Teen Prenatal Supper Clubs (TPSC)

Target age: 0 to 6, 14 to 24.

The TPSC program offers prenatal education, confidential counselling, nutrition counselling and support, as well as on-site referrals to the HBHC program. The overall goal is to reduce the incidence of low birth weight babies by offering free comprehensive services that promote the healthiest pregnancies possible, including health education, nutrition, and social support to childbearing women and their families. TPSC program supports high risk pregnant and parenting teens throughout their pregnancy and up to three months after the birth of their children. Participants enjoy a healthy snack, followed by a nutritious meal and receive free prenatal vitamins, food vouchers and bus tickets. All the clients are referred to the assigned HBHC PHN but have the option to decline the service. The HBHC PHN prioritizes client referrals based on risk factors, while keeping the clients' due dates in mind. They are admitted to the HBHC program as capacity to accept new clients allows. Initial nursing assessments may be done at the TPSC site or in the home, depending on client needs. The supper clubs aim to give young women increased knowledge, confidence and coping skills to make informed choices about their pregnancy, birth experience and transition to early parenting.

Online Prenatal Education

Target age: 0 to 6.

Online prenatal education is available to the public as part of the health unit's Reproductive Health Program. The Gift of Motherhood online prenatal education program enables parents-to-be to access prenatal education at a pace that suits their needs via an internet connection. Topics addressed that relate to child mental health/wellness include: healthy lifestyle (e.g. alcohol and pregnancy, stress management, nutrition, exercise), maternal mental health (e.g. prenatal mental health and postpartum depression), and preparation for parenting (e.g. role transitions, attachment related information). Addressing healthy pregnancy and overall lifestyle, mental well-being, parental relationships, and early parenting concepts within the context of prenatal education has the potential to positively impact emotional, cognitive, and behavioural development in childhood and beyond.

Early childhood development

Active Playgrounds

Target age: 7 to 13.

For children, play is about having fun! Children enjoy hopping, skipping, jumping, running, bending, balancing, throwing, catching, chasing and hiding. Play is also a way for them to express themselves, to learn social skills and to work out the stress in their daily lives. The benefits of physical activity go beyond fun. Adopting an active lifestyle at a young age can decrease the chances of developing heart problems, hypertension, osteoporosis, Type 2 diabetes and cancer. Regular physical activity strengthens bones, builds muscle, works the heart and contributes to a healthy body weight and lifestyle. Playing with peers gives children an opportunity to integrate their racial, ethnic and cultural awareness. Games allow them to practice teamwork and leadership skills through decision making, communication, time management, problem solving, conflict resolution and goal setting. Learning these skills builds a feeling of confidence, which encourages them to engage in new challenges.

Active Start: Developing Physical Literacy through Play

Target age: 0 to 6.

Developing Physical Literacy through Play is a workshop that provides participants with additional tools and resources to foster physical literacy in children. The workshop includes: the definition of physical literacy and why it's important; fundamental movement skills and sport skills; why ECE's play an important role in the development of physical literacy; a review of the Physical Activity and Sedentary behaviour guidelines for early years and children (5 years); and tools and resources for ECE (this includes electronic and hard copy activities ECE's can use to support the development of physical literacy).

Healthy Weights Communication and Media

Target age: 0 to 13.

This initiative involves promotional communications campaigns/awareness-raising related to the internal Balanced Approach philosophy (which includes component of psychological well-being, self-esteem, and body image). Mediums used include, but are not limited to, radio, newsletters, posters, television, social media, print materials, and website information.

Baby Talk (Parent and Baby Drop In)

Target age: 0 to 6.

Baby Talk is a well-baby drop in support group for parents with infants 0-12 months of age. The goal is to provide social and emotional support to parents, positively affecting infant attachment, maternal mental health, infant health and mental health and safety.

Infant and Child Development Program (ICDP)

Target age: 7 to 13.

ICDP provides support to families and children aged 0-6 and case management for families with children who have developmental disabilities. Many of the families struggle with or are at risk for mental health issues. A common intake is done with other service providers on the system (there is "no wrong door") and regular consultation takes place with the children's mental health agency in the community.

Healthy Babies, Healthy Children Program (HBHC)

Target age: 0 to 6. Reported 19 times.

HBHC is a free program falling under the Family Health Standard (Reproductive and Child Health Guidelines) of the Ontario Public Health Standards that is facilitated by public health nurses in collaboration with designated Family Home Visitors. The goal of HBHC is to promote children's optimal physical, cognitive, communicative and psychosocial development through effective prevention and early intervention. In addition, the program is meant to strengthen the bond between infants and their caregivers and to assist caregivers with developing positive interactions with their infants.

http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/health/index.aspx

Maternal Sensitivity Intervention

Target age: 0 to 13.

The purpose of the maternal sensitivity intervention is to prevent impaired psychosocial and emotional development in children by improving the quality of interactions between mom and baby. Interactions between mom and baby are video recorded, and then shown back to mom so that she can see the interactions and initiate change. The 5 principles of the program are: early treatment of depressive symptoms, early preventative treatment, strengthening the social support, improvement of the quality of the parent-baby interaction and home visits.

◗ *Postpartum*

Good Beginnings Parent & Infant Support Program

Target age: 0 to 6, 25+.

The Good Beginnings home support program provides weekly visits from trained volunteers to new mothers who need support and respite in the day to day care of their young infant. Many of the mothers and infants receiving support are dealing with postpartum depression. This is viewed as a valued service by Public Health Nurses who provide ongoing programming to these families and by Physicians and front-line service providers who also refer to Good Beginnings.

Postpartum Mood Disorder (PPMD) support group

Target age: 0 to 6.

The Health Department provides ongoing weekly group support sessions facilitated by two public health nurses. These group sessions provide clients with the opportunity to talk with people who understand, to share their experiences, and to learn from others in a safe and supportive environment.

Postpartum Mood Disorder Parent Support Group

Target age: 0 to 6, 14 to 24.

A public health nurse co-facilitates the Postpartum Mood Disorder group at the Community Health Centre. The group is open to mothers of children one year or less who have been pre-screened by a Social Worker and have symptoms or a diagnosis of depression, anxiety and/or obsessive thoughts and who are able to participate in a group forum. The group is open to 10 women who participate in a weekly session at no charge. Child Care is provided by the Ontario Early Years.

Postpartum Mood Disorder Group

Target age: 0 to 6.

The Postpartum Mood Disorder (PPMD) Program provides information, resources and education to families and service providers. The program coordinator is hired by Public Health. The goal of the program is to ensure that families at risk for or experiencing PMD have access to a comprehensive and sustainable continuum of services in the community. Our aims are to raise awareness of PMD, decrease stigma, educate service providers and families, and enhance services and accessibility for our diverse community. Our current initiatives include: 1) A website providing information, education, skill development, research links and resources for service providers and families in the region; 2) The Postpartum Family Support Line ; 3) Peer Education through "Adjusting to Life After Baby" Workshops; 4) Peer Support Groups offered at 5 Ontario Early Years Centres; and 5) Guideline/Pathway for Family Health Nurses.

Postpartum Mood Disorder Screening

Target age: 0 to 6.

All expectant mothers up to one year postpartum are assessed for perinatal mood disorders using routine standard questions. Supports are put in place and referrals are made if screening is positive.

Provision of mental health consultation to Healthy Families staff that work with new and at risk mothers

Target age: 0 to 6, 19+

Consultation focuses on developing relationships with individuals with postpartum mood disorders or other mental health problems in order to influence positive child development. Mental Health Nurse Consultants (MHNCs) are based in all offices across the area where Healthy Families teams are located. The consultation work is done primarily with staff from HBHC, Family Home Visitors and Invest in Families. MHNCs provide support working with challenging clients who present with mental health problems and intimate partner violence. The consultation is strength based using a narrative model.

Best Start Postpartum Depression Initiative

Target age: 19+.

The Postpartum Depression Initiative is funded as one component under the Best Start Initiative. It is comprised of a number of interventions, some of which have a population health focus, others of which have a targeted population or individual intervention focus. Interventions are aimed at raising awareness of perinatal mental health and its impact on the mother, infant and family, on improving access to supports and services and on optimal infant and family development.

Teen Education and Motherhood (TEAM) and Parenting and Catholic Education (PACE)

Target age: 0 to 6, 19+.

The goal of PACE is to provide an alternative learning environment in which young women who are pregnant or parenting can work towards completing their educational goals, learn the skills required to become capable and confident parents, and gain important social and life skills that will benefit them in their future endeavors. The objectives are: to motivate students to return to secondary or post-secondary school, and/or to pursue work/career goals; to offer support which promotes positive attitudes towards school and successful educational experiences including regular school attendance; to provide an atmosphere where the young women can hone their life skills, develop strong social networks and learn from one another; to deliver prenatal health education to improve the health and well-being of both mother and baby; to teach positive parenting skills that empower young parents and that benefit their children's growth and development; and to connect students with valuable community programs and services.

General parenting

Triple P Positive Parenting Program

Target age: 0 to 6, 14 to 24. Reported 9 times.

Triple P is an evidence-based program developed in Australia that is being facilitated widely across Ontario by health unit staff. The program provides community support for raising children and aims to build competence and confidence in parenting abilities, reducing the stress of parenting. Furthermore, it aims to promote positive, caring relationships between parents and children and to build positive behaviours in children and youth by teaching parents skills to prevent and manage emotional, developmental and behavioural problems without being coercive or punitive. The program is designed to be tailored to each individual parent.

http://www.triplepontario.ca/en/home.aspx

Nobody's Perfect Parenting Program

Target age: 7 to 13. Reported 2 times.

Nobody's Perfect is a parenting education and support program for parents or caregivers of children from birth to five years of age. It is designed for parents who are young, single, or living in a rural area, or for those who have few people to talk to, a limited formal education or a low income. Pregnant teens, non-custodial parents, and parents with difficulty learning/comprehending/reading are welcome to attend Nobody's Perfect. Many participants face multiple challenges in their lives. The overall goal of the program is to improve parents' capabilities to maintain and promote the health of their young children. The program aims to help parents recognize their strengths and to find positive ways to raise healthy, happy children. Within this general goal, the specific objectives of the program are: to increase participants' knowledge and understanding of their children's health, safety and behaviour; to effect positive change in the behaviour of participants in relation to their children's health, safety and behaviour; to improve participants' confidence and self-image as parents; to improve participants' coping skills as parents; and, to increase self-help and mutual support among parents. The program is offered free of charge to reduce barriers to access. Parent books, snacks and child care are provided, and assistance with transportation is available. Program delivery is flexible; most common is an eight-session format where trained co-facilitators lead weekly two-hour group sessions using a participant-centered, experiential model. Participants cover topics of their choice involving children's health, safety, development, behaviour and care. Specific topics include attachment, child's feelings, child/parent self-esteem, and child/parent anger. Participants also learn problem-solving and life-skills such as mood management, and about resources and supports in the community. The group setting provides opportunities for social interaction and mutual support.

Strengthening Families for the Future

Target age: 7 to 13. Reported 2 times.

This is a prevention program for families with children between 7-11 who may be at risk for substance misuse, depression, violence, and school failure. The goals of the program are to reduce behaviour problems, reduce child's intention to use alcohol/drugs, increase resiliency skills, and to increase positive parenting and family communication.

Parenting Education - classes and workshops

Target age: 0 to 6, 14 to 24.

Parenting education classes and workshops are offered to the general public, divided into ages 1-4, 5-12 and teens. They are offered in either weekly classes or short workshop formats. The classes currently use the Active Parenting series curriculum.

ADHD/HOPE Parent Support Group

Target age: 0 to 18.

This support group for parents of children with Attention Deficit Hyperactivity Disorder (ADHD) meets several times over 3 weeks. Session topics are identified and guest speakers are often brought in. The group uses a support format and provides links to community based resources.

Attachment Program

Target age: 0 to 6.

The attachment program promotes healthy attachment between parent and child by informing and educating parents with babies and use of videotaping. This program targets the priority populations in the HIV program.

Young Parents Place

Target age: 0 to 6.

Young Parents Place is a drop-in program for pregnant teens, young moms and dads (under 25) and their children. Meals are provided and it is an opportunity for social interaction and engagement with peers, along with informal group discussions on various topics. Transportation is provided if needed.

Truth & Consequences - Grade 9 Drug and Alcohol Awareness Conference

Target age: 14 to 18.

Truth & Consequences is an interactive conference which addresses the substance use and abuse expectations of the Grade 9 Healthy Living Strand. It offers an innovative way to engage students in learning about drug and alcohol misuse and related issues. Partnership with local community agencies is an integral part of the conference, and strengthens the link between school and community. Truth and Consequences was developed as a collaborative effort among partners dedicated to teaching young people the information they need to know to make healthy choices about drugs, alcohol and life in general.

Kids Have Stress Too!

Target age: 0 to 13.

Kids Have Stress Too! is a 2-3 session program for parents, guardians and caregivers of children 4-9 years of age to help parents better understand stress in children and teach them ways to support their children in managing stress. Each session is approximately two hours in duration. It is not intended for families in crisis. The activities are designed to build and strengthen parental and caregiver skills to assist children in coping with stress. Sessions are interactive with free handouts, healthy snacks and are facilitated by a trained public health nurse. The program was created by the Psychology Foundation of Canada.

Investing in Families

Target age: 0 to 18.

The Public Health Unit in partnership with other municipal departments is working together to support families in vulnerable communities to promote a healthy lifestyle, increase personal resiliency, improve physical and emotional health and enhance social and community supports.

Kids Line

Target age: 0 to 6.

Kids Line is a telephone parent support line, staffed by Public Health Nurses to discuss any parenting concern/question from preconception to children 13 years of age. PHNs answered over 250 calls in 2012 in which the primary reason for the call was children's mental health or perinatal mood disorders in mothers. PHNs provide support, education, and referral to community services for families who call with questions regarding children's mental health.

Making the Connection

Target age: 0 to 6.

Making the Connection is a child development program to foster secure attachment, social and emotional growth. Parents learn how to develop a strong and loving relationship with their baby.

Me, My Baby, Our World

Target age: 0 to 6, 14 to 24.

A group intervention was designed by Dr. Ruth Stirtzinger with the objective of "testing the effectiveness of an adolescent parenting course in changing adolescent depression and negative parenting attributions". This program was implemented within a community-based organization aimed at assisting adolescents that are pregnant or with young children in continuing their high school education. The primary goal of this program was to interrupt the course of maternal depression, child abuse and neglect which is so prevalent in the adolescent mother-

infant dyad. The program used an interactive engagement model which provided an active, power-based role for the adolescent reflections to the parent/child videos and live observations (Stirtzinger, 2000). Research outcomes from the original program included a significant decrease in depressive symptoms compared to the control group and a greater decrease in negative attributions and associated emotions than control group. This program targets young mothers aged 14-20 with infants 0-18 months of age. It uses the Beck Depression Inventory as a pre-assessment tool. The revised Me, My Baby, Our World program includes 12 sessions, 1 ½-2 hours weekly and 3 components: Music circle (parent child interactions, observation and picture taking, highlighting moments of attunement), Psycho-education (interactive play video, experiential modules), Scrapbooking (reinforces the ideas and theories presented, provides a tool for future reference).

Parenting Basics

Target age: 0 to 13.

Parenting Basics is a 10 week parenting support and education group delivered free of charge to residents who are clients of Children's Aid Society (CAS). Sessions are 1.5 hours in length. Child-minding, transportation and healthy snacks are provided. Upon completion, participants receive a letter verifying their attendance and a certificate if they attend at least 8 sessions. Trained facilitators include parent/child therapists, parent educators, public health nurses, CAS case workers and addictions counsellors. Many of the parents attending this series would be in a place of challenge, darkness, upset, anger, chaos or turmoil in their lives. Given this understanding, the session content was written to reach out and respond to persons finding themselves focused on addressing what Abraham Maslow (1954) referred to as their "basic needs" – physiological, safety, belonging/love and esteem. Each session provides a single parenting "gem" for participants to ponder, analyze and perhaps remember and apply to their lives. The concept of the "parent in the lead" echoes throughout the series and provides context for the various "gems" and eases applicability to the individual needs and circumstances of the participants. Basic parenting messaging is presented through discussion and play-based activities as to engage participant interest and consolidate learning. Topics include: knowing your child, being a parent in the lead, temperament, safety, loving parent/child relationships, routines, discipline, play, healthy living and self- esteem.

Proposal for Transitioning to Post-Secondary Program

Target age: 14 to 24.

A 40 minute talk on transitions to post-secondary transitions, including how to create balance with workload, manage stress, etc. 50 minute presentations for parents on transitions, common struggles, how to help students prepare and where to go for help will pilot at four schools in spring 2013.

Child Health Parenting Programs and Supports

Target age: 0 to 13.

Child Health parenting programs and supports include: delivery of Triple P (Positive Parenting Program) classes and seminars; delivery of Make the Connection group; delivery of topic-based parenting programs as requested; parent talk line; web based resources and information; print materials (i.e. Parent Resource Guides); and Twitter.

Community Based Positive Parenting Initiatives

Target age: 0 to 6.

Our community based positive parenting initiatives are provided to parents and key community stakeholders through education session, positive parenting series (classes) or one time education events. The focus for Family Health parenting initiatives is for parents, caregivers or community partners working with families from prenatal to age six. Education sessions, written materials or web information is based on building positive relationships with infants and children through positive interactions to enhance attachment. The focus of our initiatives is to strengthen emotional health and mental well-being, build self-esteem in children (and caregivers) for mental health promotion and mental illness prevention.

Cool Kids and Chilled Anxiety Groups

Target age: 7 to 18.

These anxiety groups are CBT (Cognitive Behavioural Therapy) based and are offered in a series of 10 sessions. The goal for participants is to develop skills and knowledge to identify their anxiety and manage it so that it does not interfere with everyday life (e.g., going to school, social situations, and relationships). It also includes effective communication skills (e.g. Style of Communication). The "Chilled" program address "big emotions & big reactions" and suicide prevention. Both programs provide parents with knowledge and skills to effectively support their son/daughter.

Families First Program

Target age: All.

Families First is a program for sole support parents who receive Ontario Works Assistance. It offers employment, health, and childcare services to parents as well as recreation for their children. Support is provided through a focused and coordinated approach to helping sole support parents become independent. This is achieved through the collaboration of Ontario Works, Children's Services, and the PHU. The Public Health Nurses (PHNs) in the Families First program conduct regular home visits and support client health through teaching, supportive counselling, advocacy, and case management. PHNs on the team address clients' physical, mental, and emotional health issues; document client interactions; obtain health resources and information for clients; and work with internal staff, community agencies, and health professionals in order to facilitate and improve clients' well-being. Clients also have access to an employment service worker, who works individually with clients to support their movement towards employment.

Family Drop-in

Target age: 0 to 18.

This is a group format drop-in program to address issues families may be having. Drop-in is carried out in collaboration with CAS, the local public library and an Ontario Early Years centre.

Fathering Workshops

Target age: 0 to 18.

Workshops are designed for fathers that have experienced violence. The program includes parenting groups, self-help, and peer to peer support. Participants get to ask questions and get answers.

Neighbourhood Groups

Target age: 0 to 6.

This program seeks to provide opportunities for isolated parents to socialize with other caregivers and engage in age-appropriate play with children 0-6 years. At the present time we have seven neighbourhood groups. Groups are consistent in that they are drop-in programs targeting neighbourhoods where a significant number of children are developmentally vulnerable, there is limited access to other early years programs, or there is significant social isolation due to mental health challenges, financial barriers or language barriers. While they often have similar characteristics to drop-in groups at an Ontario Early Years Centre, the support provided is enhanced and attention is paid to providing individualized support to families as well as group experiences to enhance knowledge, develop skills and access other community resources. All programs operate when schools are running (i.e. no programs on snow days, PD days, school holidays, etc.).

COMMITTEES, NETWORKS AND COALITIONS

- *Youth engagement related*

The Youth Engagement Network (Youth Engagement and Development Community of Practice)

Target age: 7+.

The Youth Engagement Network seeks to foster a collaborative approach to youth engagement and development. Network meetings are designed to identify useful training and resources, share "tricks of the trade", problem-solve through common youth engagement challenges, highlight development opportunities for youth,

and foster community partnerships. Membership includes youth serving organizations, including those related to children's mental health.

Youth Adult Partnership

Target age: 14 to 18.

This program works with vulnerable youth and looks at the youth perspective on violence and abuse.

Youth Action Alliance

Target age: 7+.

The Youth Action Alliance is a youth-led, adult-supported coalition with four committees across the district interested in promoting healthy lifestyles. Youth meet once a month after school to identify priorities related to tobacco prevention and other correlated risk factors, which can include mental health directly. Once youth identify their priority, they develop a health promotion campaign. A youth development approach is used to foster resiliency and positive youth outcomes (i.e., achievement, developmental and prevention) among youth leaders and their peers. The goal is to enhance protective factors and reduce risk factors.

Youth Engagement Initiative

Target age: 0 to 18.

A committee working to address youth supports with a large focus on mental health.

Mental Health Youth Engagement Committee

Target age: 14 to 18.

Description not provided.

Youth steering committee

Target age: 14 to 24.

The Youth Steering Committee is specifically looking at high rates of STI's and unplanned pregnancy among at-risk youth. Funding for this was provided from the Public Health Agency of Canada (PHAC) and an HIV/AIDS related community organization. This is an initiative that involves mulitple community agencies and also the Ministry of Children and Youth Services. In reach, along with their partners our health unit would deal with youth that experience mental health issues on a regular basis. This activity is considered a onetime event due to funding restrictions and time lines. Funding was released April 1, 2012 and expires March 31, 2014.

Perinatal, maternal and infant mental health/addictions related

Perinatal Mental Health Coalition

Target age: 0 to 6, 14+.

The purpose of this Coalition is to provide a forum for identification of perinatal mental health issues and to provide strategic direction for collaborative planning, implementation and evaluation of interventions, programs and services for child-bearing families in the city. Our vision is that all families in the city who are potentially at risk/or experiencing perinatal mental health concerns will have access to a variety of integrated services.

Perinatal Mood Disorders Coalition

Target age: 0 to 6.

The purpose of this coalition is to provide a forum for identification of perinatal mental health issues and to provide strategic direction for collaborative planning. Objectives of the coalition are to provide strategic direction in the development/revision of programs and services to families with perinatal mental health concerns by: establishing and monitoring strategic indicators for perinatal mental health in the community; developing a collaborative community continuum of service system encompassing care pathways and service coordination components; identifying and implementing mechanisms to obtain consumer feedback about perinatal mental health programs and services in the community; identifying gaps in service and develop a plan to address these gaps in service; and identifying potential funding sources to address gaps. The coalition also aims to facilitate opportunities for collaborative planning for service delivery amongst perinatal care providers in the community by: identifying barriers impeding access to perinatal mental health services; facilitating opportunities for problem solving effective strategies to overcome them

(i.e. language barriers); and exploring opportunities for outreach to isolated families; identifying opportunities for education, research and evaluation. The coalition aims to increase awareness of postpartum mental health issues by linking with appropriate agencies and care providers.

Postpartum Mood Disorder (PPMD) Coalition

Target age: 0 to 6.

The PPMD Community Coalition is a group of community agencies which are involved in program or service delivery to mothers experiencing postpartum mood disorders and their children. This coalition has evolved over time from a group of service providers who were facilitating support groups for women, to a group which is more focused on knowledge exchange and capacity building. There is currently representation from various community organizations. Every year, an educational presentation is organized for community professionals who work with women with PPMD. Topics include suicide prevention, fathers' role in supporting their partner's recovery, and identifying PPMD. In addition to decreasing the stigma of mental illness, the coalition supports promotion through publication of new educational materials such as "The Fathers' Role in PPMD".

Postpartum Mood Disorder (PPMD) Network

Target age: 0 to 6.

We provide membership to 2 local PPMD networks. These networks are currently working on developing a northern strategy for PPMD.

Early Years Mental Health Committee

Target age: 0 to 6.

The Early Years Mental Health Committee is an interagency committee. Its purpose is to develop an integrated approach to early years mental health service delivery in the region. The target populations are families with infants and young children (age 0-6) who are at risk for developing mental health concerns in their early years. The committee objectives are: 1) To ensure a coordinated, collaborative and integrated system of early years mental health services and supports exists in the region; 2) To ensure a flexible continuum of services and supports exists for young children and their families throughout the region; and 3) To enhance staff knowledge and skills with respect to relationship-based principles and infant mental health. Overarching Goals: 1) To ensure a coordinated, collaborative and integrated system of early years mental health services and supports exists in the region; 2) To ensure a flexible continuum of services and supports exists for young children and their families throughout the region; and 3) To enhance staff knowledge and skills with respect to relationship-based principles and infant mental health. 2012 Objectives: 1) To complete a scan of existing messages relating to early years mental health and healthy caregiver-child relationships; 2) To identify baseline competencies required for staff working in the area of Early Years; 3) To evaluate the implementation of the EYMH Guideline across current programs; 4) To make recommendations for Sustainable orientation, training and support across programs; 5) To assess readiness and feasibility of expanding EYMH committee membership; 6) To identify linkages between with other related regional initiatives; and 7) EYMH Training using existing training modules to key interested partners (e.g. CAS).

Suicide Prevention & Mental Health related

Suicide Prevention Coalition

Target age: 7+.

The Coalition aims to provide support and encourage collaboration in accomplishing the goals set out by the individual committees. We envision a community that is able to prevent suicide deaths by being a community that understands, recognizes, intervenes and supports people. Principles: 1) Mobilize the community by collaboration within in order to promote general awareness; recognize a shared responsibility across organizations, the community at large as well as including the contribution of people who have been directly affected by suicide. 2) Provide tools to enable individuals to make life-affirming choices. 3) Respect choices of all individuals. 4) Effective solutions come out of working together. 5) Initiatives must be inclusive, respecting the diversity of our community, including cultural and linguistic, sexual orientation, socio-economic class, gender, age, ability, etc.

Suicide Prevention Coalition

Target age: 7+.

The Suicide Prevention Coalition is a collaboration of individuals and organizations. We work together to provide leadership, advocacy, and education in the areas of suicide awareness, suicide prevention, suicide intervention, and suicide postvention. The first coalition meeting in May, 2004 identified needs and gaps in services around suicide prevention. Meetings that followed led to a structure for the coalition and priorities for the community's suicide prevention needs. An Action Plan was approved in 2006 and updated in 2007. The Coalition is led by a Steering Committee, which includes representatives of the Health Department, the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), the Schizophrenia Society of Ontario, the hospital sector, and citizens affected by suicide (also known as survivors of suicide and interested Individuals). The Education and Awareness Committee includes individuals interested in promoting awareness and education about suicide related activities. Other committees or working groups are established as required. The Coalition has an annual meeting and workshop, sponsors other educational meetings, and is involved in networking and advocacy with community organizations. Along with our website, the Coalition has a several print posters and brochures available to promote awareness and education about suicide related issues. A display focusing on suicide prevention is available for community events. The Coalition is interested in future initiatives to further the goals of its Action Plan and the priorities suggested at its annual meetings. The Coalition has been fortunate to receive funding from the municipality, as well as in-kind services through the Health Department. There has also been a significant commitment of volunteer time from steering committee and other committee members. The Coalition received its first community donation in 2010. The steering committee is seeking additional ongoing and/or project funding to meet the goals of the action plan.

Suicide Prevention Coalition

Target age: 7+.

The purpose of the Suicide Prevention Coalition is to work toward the development of a coordinated Suicide Prevention Strategy with the ultimate goal of suicide reduction. We envision a community that is compassionate, caring, informed, and educated and supports the well-being and safety of all people. Believing that every person has the right to be supported in living a healthy, positive life, our mission is to reduce suicidal behaviour and its impact on individuals, families, and communities. Functions include: Collecting and documenting current community resources; development and dissemination of resources; organization and facilitation of public community forums for stakeholder feedback; the development of proposals, as required, to provide resources for activities of the coalition; and conducting public consultation on issues related to suicide.

Reach Out Now

Target age: 7+.

The Suicide Prevention Coalition works in partnership with the community to develop and support comprehensive strategies to prevent suicide. The Coalition is comprised of a Steering Committee and three Work Groups in the areas of suicide prevention, intervention and postvention. Our commitment is to look at how we can minimize the harmful consequences of suicide and create a suicide safer community.

Maternal Infant Mental Health and Addictions Task Group

Target age: 0 to 6, 25+.

To address the deficit of access and availability of mental health services for mothers, children and youth in collaboration with Care Connections Child and Adolescent Mental Health and Addictions Steering Committee.

Internal (PHU) Mental Health Promotion Working Group

Target age: All.

The mental health promotion committee meetings provide a forum for sharing of information and educational opportunities within the health unit in order to provide a coordinated approach within programs. Research, best practices and current evidence will be incorporated into planning to increase staff awareness and provide a community wide approach to mental health and wellness. Issues that impact the delivery of public health programs will be discussed so that mental health and wellness will be considered to improve program delivery at the Health Unit. Members include coordinators, Managers, representatives from sexual health, nutrition, family health (child/repro), chronic disease/injury prevention and other programs as assigned. The chair will be an identified member from the Chronic Disease and Injury Prevention (CDIP) program.

Let's Open Our Minds Mental Health and Addiction

Target age: 14 to 24.

This is a partnership initiative between Champions for Youth Advisory Committee and the Drug Action Committee. The next event is a workshop for professionals who work with youth.

Youth Mental Health Partnership

Target age: 7 to 18.

The Youth Mental Health Partnership is a network that was established by the school boards in the region. The goals are to share information and activities with respect to youth mental health, among key providers, including school administrators, youth mental health agencies, parents groups and others, with a focus on schools.

Local Health Integration Network Care Connections: Child and Adolescent Mental Health and Addictions Steering Committee

Target age: 0 to 24.

The Child and Adolescent Mental Health and Addictions Steering Committee is a multi-sectoral collaboration to align and address collaborative initiatives in the district. The Committee has developed a plan to address key issues identified, linking to existing initiatives and developing plans where no current actions exist. This committee is a part of the overall Care Connections initiative.

Community Partnership - Adolescent & Youth Mental Health

Target age: 7 to 18.

In November 2012, a partnership of 10 organizations involved in mental health was formed to determine mental health supports and services available in the county. It was determined that there are many services and supports that target youth and it seems to be fairly balanced in terms of Promotion, Prevention, Intervention and Treatment/Crisis. Many group members were surprised at the amount of work being done by the various players to support young people. A mapping activity identified far fewer services and supports that target the Adult community (Parents/Caring adults). Discussion also arose around the Community 'myth' respecting a perceived lack of services and how adults in the community would not necessarily be aware of what was being targeted for young people.

Child and Youth Mental Health Network

Target age: All.

Community partnership and collaboration to plan around the mental health of children and youth in the community. The membership is mostly working on System Improvement Through Service Collaboratives (SISC) work at present.

School Mental Health Coalition

Target age: 7 to 18.

School Boards have major concerns about children and youth mental health. There are many initiatives from different ministries with no coordination of activities or knowledge exchange. Discussion are taking place about public health taking on the role of bringing all the stakeholders together to share what their roles and objectives are, how we can work together to ensure that proper referrals are done efficiently and quickly, identify what the fundamental factors are and work together to plan prevention strategies and mental health promotion with youth, parents and community. We are waiting for school boards to complete their hiring process and will then put the coalition in place. CCAC already contacted us and will be presenting what their mandate is and the activities that they will be doing in schools.

Safe School Action Team Advisory Group

Target age: 7 to 18.

All schools within the School Board must create a bullying prevention/intervention action plan. These must include bullying prevention/intervention strategies that foster a positive learning and teaching environment, that support academic achievement for all students, and that help students reach their full potential. To accomplish this, schools develop a Safe School Action Team (SSAT) that comprises of the principal, teacher, students, parents and a community member. The Public health Nurse often represents the community member on this committee and helps to support the school with the development and implementation of the initiatives. The PHN brings the perspective of creating a comprehensive plan to address bullying in the school in which we look at the all the pillars of the foundations of a healthy school. The School Board also developed an advisory group to help support individual school SSAT committees. This advisory group, called Safe Schools Action Team Advisory Group (SSATAG) is comprised of various education disciplines such as social workers, child and youth counsellors, curriculum consultants, as well as parents and other community reps such as Public health nurses. This type of education or support that is provided to each school aligns well with the Accepting Schools Act (Bill 13), specifically in the area of training and awareness-raising.

Our Kids Network - Bullying Prevention Task Force

Target age: 0 to 18.

The Our Kids Network School Years Committee identified the need for a Bullying Prevention Task Force to build a more coordinated and strategic community approach for bullying. The intent of the Tasks Force's work is to address bullying issues that exist within the early years and among school aged children and youth based on recommended practices. The Task Force is currently developing a strategy based on information gathered to date.

University Mental Health Strategy Committee

Target age: 14+.

This committee's purpose is to create and provide continuing oversight on a comprehensive mental health strategy for a post-secondary institution that aims to develop and maintain a campus environment that sustains mental health and wellbeing for all members to succeed. Through decision-making, policies, systems, pedagogy, structures and delivery of education and services, the strategy will align with the University's mission, the academic plan, diverse knowledge bases, campus cultural centers and external strategies. The committee also provides advocacy for mental wellness, and leadership in the eradication of stigma, "sanism" and mental health discrimination on campus.

Parenting related

Positive Discipline Coalition

Target age: 0 to 18.

This coalition promotes a community of awareness through the development and implementation of a communication plan on positive discipline. Print and web resources are developed and distributed to increase knowledge and skills of parents/caregivers related to the benefits of positive discipline, both physically and emotionally.

Positive Parenting Community Working Group

Target age: 0 to 6.

The Positive Parenting Working Group is a subcommittee of and accountable to the Growing Great Kids Children's Planning Table. The group seeks to improve child health outcomes by creating a culture of positive parenting in our community. In 2013 this group will bring Triple P parent education program training to the community and conduct a survey of parent programs in the community for positive parenting elements.

Other

Working with Priority (Strong) Neighborhood Committee Involvement

Target age: All.

Mental Health Nurse Consultants participate in various planning groups in the city's Strong Neighbourhoods initiative. Committee focus can range from developing support and services that promote youth mental health to developing and participating in crisis protocols following gun violence.

Safe and Silver Alliance

Target age: 19 to 24.

The PHU is involved in youth initiatives through the Safe and Silver Alliance, providing support to alcohol and suicide prevention strategy work. A youth group has evolved from this work with the participation of public health nurses.

Representation on Community Organizations

Target age: 7 to 18.

The School Board provides a wealth of professional development opportunities to assist teachers, support staff and administration in managing student behaviour, particularly related to bullying prevention and intervention. An example of this professional development is the ABC Network (Anti-Bullying Collaborative), a network of teachers who meet regularly to discuss bullying prevention and intervention and share resources. The network is funded by Staff Development & School Support Services and the Internet Safety Committee, which is comprised of representatives from a variety of community groups in the region. The group's mandate is to monitor present and emerging internet related issues that may affect the citizens of the region. In addition, the committee advises on strategies that support continuing education and prevention programs that assist in protecting our citizens from the risks of internet use and related digital media. The School Health Team from the PHU sits on the School Board's Bullying Symposium for Parents Planning Committee. The School Health Team has also been requested to participate in workshop delivery to parents on building resiliency in children, connection between physical activity and healthy eating to improved mental health and wellbeing, and delivering results of our Student Health Assessments (completed 2011).

Ontario Early Years Centres Partnership/Public Health Unit Service Model

Target age: 0 to 6.

Public Health Nurses support the Ontario Early Years Centres (OEYCs) in 2 ways: (1) by providing support to parents through co-facilitation of sessions on public health topics and one-to-one support to parents as needed; (2) by exchanging knowledge with OEYC staff through in-service sessions on public health topics and sharing information from public health such as data and reports.

Service Providers Planning Committee

Target age: All.

The purpose of the planning committee is to provide education, opportunities for networking, and support to service providers who work with Low German Speaking families. The goal of the committee is to improve service provider ability to provide supports and services. This planning group seeks to bolster understanding among a wide range of service providers including educators, social service, child protection staff, primary care providers, police and public health staff, of the impact of cultural imperatives, migration, and poverty on this unique population in our community. The group plans and hosts

education and networking meetings 1-2 times per year, with interactive learning on subjects such as: Mental health and the LGS community: 101 for Service Providers - how providers can help individual and families facing mental health challenges; Mental Health and the LGS Community: Supporting Children and Youth; Community resource sharing; and Exploring Cultural Taboos and Sensitivities.

Domestic Violence Coordinating Committee

Target age: All.

We provide membership to this committee. Membership is comprised of sexual assault team at hospital, children's aid society, women/family shelters, social service agencies, and police. Information sharing venue and awareness raising regarding domestic violence and its impact on family and the community.

DIRECT SERVICES

Screening & Referrals

Working Together for Kids Mental Health

Target age: 0 to 18.

Mental health screening of children and youth with referral for further assessment for identified individuals. Developed care pathways.

Violence and Threat Risk Assessment (VTRA)

Target age: 14 to 18.

VTRA provides mental health information, assessment and plans of care.

Growing Great Kids System of Care

Target age: 0 to 6.

Growing Great Kids System of Care is a partnership of organizations providing a coordinated continuum of services to children, birth to age six, in the community. The System of Care has one point of access provided to parents and professionals. Growing Great Kids service providers practice inter-professionally with the goal of ensuring that the right service is offered by the right professional at the right time. Public Health provides KIDS LINE intake for the partnership and coordination of the intake and referral process. In terms of children's mental health, PHNs assess, refer and facilitate referrals for children's mental health services.

Mental Health Assessments at Child & Youth Walk in Clinic

Target age: 7 to 18.

This is a partnership between the health unit and a community health provider to support their child and youth walk in clinic. The Mental Health Liaison Nurse supports that walk in through mental health assessment and clinical consultation.

Social Media/Family Health Information Line (FHIL)

Target age: All.

Nurses provide comprehensive, research-based information, support and counselling over the phone and by email on topics including child and youth mental health. Public health nurses also offer support to parents online through the website, Twitter, and a parenting blog, with Facebook soon to come. FHIL is not restricted only to parents and the general public. It is also a great service for professionals across the region. Physicians and other health providers, school professionals and child care professionals receive access to evidence-based information and resources for patients and families, and information about the Health Department's programs.

Parent and Teacher Support Line

Target age: 0 to 18.

A phone line to provide referrals and support for parents and teachers (not a crisis line) is in development.

Parent Talk Line

Target age: 0 to 18.

The Parent Talk Line is a telephone-based information service provided to parents in the community. Callers speak with a public health nurse about any parenting issue or concern. Nurses provide assessment, education and necessary referrals/recommendations.

Pregnancy Options Counselling

Target age: 14+.

Clients may contact this program by phone or in clinic if they are seeking information and support related to a suspected or confirmed unplanned pregnancy. Clients who are concerned about an unplanned pregnancy may be offered a counselling appointment with a PHN in sexual health which can include assessment of pregnancy, assistance with decision-making and options counselling to assist clients to explore options and to make informed decisions. Counselling interventions are client centered and needs based, conducted in an interactive manner through the use of open-ended questions and active listening focused on developing objectives and strategies with the client.

Routine Universal Screening Tool Implementation (RUCS)

Target age: 19 to 24.

RUCS is a screening tool used to detect abuse in women. Our goal is to screen every client at every contact when she is seen alone. The screening tool is designed to introduce questions regarding family abuse in order to a) make asking the questions part of the clinical routine and b) determine if a client or patient may be a victim of family violence or other abuse.

Clinical Information - service at Health Unit

Target age: All.

Clinical information is a service provided by a PHN at the Health Unit. This PHN is often the first point of contact for clients (by telephone, walk-in and email). The PHN provides information about community resources to clients and facilitates referrals to community agencies and health unit programs/services. Clients in need of support related to their mental health would receive information about community services and agencies to help them and may receive referrals.

Connections Service Resolution Committee

Target age: 7 to 13.

Connections is a service resolution committee brought together to address the needs of complex families. Several community agencies and the School Boards are also represented. Connections helps children, youth and families with finding the right service when they are experiencing stress. Services available include: 1) Information Services, such as verbal consultations and requests for print information; 2) Referral Services; 3) Assessment using psychological and educational tools; 3) Behaviour Management; 4) Counselling; 5) Crisis Intervention; 6) Day Treatment; 7) After School Programs; 8) Residential Services; 9) Parenting support; and 10) Services for individuals with developmental disability.

NutriSTEP Screening and Related Community Programming

Target age: 0 to 6.

Nutrition screening tool with accompanying parental education materials and workshops. Does have components that focus on psycho-social feeding environments and parents' perception of weight, shape and food, which greatly influence a child's psychological wellbeing and perception of self-worth later in life

Early Years Screening Program

Target age: 0 to 6.

Our PHU has partnered with two community organizations to pilot an integrated early years French and English screening program for children ages 18 months - 4 years. In collaboration with Early Child Health PHNs, the program provides enhanced early identification of developmental, mental, social, and emotional issues in young children, for quicker intervention to reduce the percentage of children who are not ready for school. A developmental screening tool analyzes the child's skills in the following areas: vision, hearing, speech, language, communication, fine motor skills, overall motor skills, cognitive functions, social and affective skills and personal autonomy. NutriStep® enables early identification of potential nutrition problems in children and education and referral to community resources for parents. A Postnatal Depression Scale enables identification of potential postpartum depression. An additional tool used has been designed to assist in the management and planning of services to children from birth until three years old to achieve permanency, inclusion, and healthy development. It incorporates commonly-used clinical and diagnostic markers from the fields of psychology, pediatrics, and obstetrics. We also do an assessment of resilience in preschoolers ages 2 to 5 with social and emotional problems or significant behavioural concerns. The GED (grille d'évaluation du développement) makes it possible to assess the child's development in three areas: cognitive, motor and socio-affective. The CHAT (Checklist for Autism in Toddlers) is an assessment tool for children ages 16 to 30 months that makes it possible to screen for pervasive developmental disorders. The First Words check list is a tool for assessing whether a child has developed the expected language skills for his age group. These are combined with immunization record assessments.

External Mental Health Consultation

Target age: 0 to 6.

Mental Health Nurse Consultants provide weekly consultation to Child Protection Agencies (Children's Aid Society and Catholic Children's Aid Society). MHNCs attend weekly High Risk Committee meetings to assist CCAS with challenging cases. MHNCs meet on individual basis with workers from CAS. In both situations the purpose is to identify cases where there might be mental health problems that effect parenting with a child and, using a strength based approach, to assist workers in dealing with these cases and refer to appropriate agencies for increased support for the parent and child.

Family Connections at Local Food Bank

Target age: 0 to 6.

Drop-in support service at a local food bank to meet with a public health nurse that addresses various determinants of health and health related issues/concerns. Links/ referrals to community support services are provided.

Family Home Visiting

Target age: 0 to 18.

Provision of assessment, referral, consultation and home visit support to parents in our community for variety of reasons, including mental health.

Nurse Family Partnership

Target age: 0 to 6, 14 to 24.

The Nurse-Family Partnership (NFP) is an intensive, evidence-based pregnancy and early infancy home visiting intervention for young, low income, first time mothers. A 2013 goal for the NFP Team is that members achieve proficiency in recognition of Teen Mental Health concerns and implementation of effective programming to reduce barriers to mental health services. An ongoing goal is to assist the young mother in building a positive relationship with her infant that fosters optimal development.

◗ *Counselling and Health Clinics*

Youth Harm Reduction Drop-in

Target age: 14 to 24.

According to the 2011 Enhanced Street Youth Surveillance (ESYS) report, information on safer drug use is a priority topic for street-involved youth and 2/3 of those surveyed felt that there are significant barriers to accessing health services. With increasing numbers of injection and non-injection drug users (12% and 91% respectively) and HIV and Hepatitis C rates in street youth at an all-time high, the need

for harm reduction specific information was clear. The Harm Reduction Drop-In (HRDI) was created as a response to the gap in service needs identified in the ESYS report and is run weekly as a partnership between the Site Needle and Syringe Program (via the PHU) and the Hepatitis C Team. The HRDI provides high risk youth with an access point for blood-borne pathogen and sexually transmitted infection testing as well as safer drug information, vein and wound care and referrals to community resources. The Hepatitis C Team is led by peers who organize weekly activities for youth engagement, such as painting, craft making and music, as well as offering counselling on Hepatitis C and risk reduction. Additionally, the PHU has launched a safer piercing kit available to youth who attend the drop-in that provides the necessary tools and information to reduce the risk of blood-borne pathogens and serious infections associated with 'at-home' piercings. To date, the HRDI has had over 500 encounters with high risk youth, completed more than 30 HIV, Hep C and Chlamydia/ Gonorrhea tests and distributed 175 piercing kits.

Sexual health counselling

Target age: 7+.

As part of the Sexual Health Clinic, PHNs provide sexual health and healthy relationship counselling and support to clients. This support often involves aspects or elements of mental health (as indicated in the Terms of Interest). Nurses often provide referrals to clients in need of support related to mental health.

School based and community sexual health clinics

Target age: 14+.

Public Health offers confidential and non-judgmental sexual health services through sexual health clinics located in 6 communities. Services include: free and confidential sexually transmitted infections (STI) counselling, testing, and treatment; pregnancy testing and low cost emergency contraception (Plan B) for all women; contraception at reduced cost for women under age 19 years, and for some women aged 19 through 24 years; PAP testing for all women under the age of 19, and for women 19 years and older who do not have a regular health care provider (e.g. a family doctor or nurse practitioner). Sexual Health Clinics also see a wide range of mental health concerns. The PHNs assess the situation and intervene based on the need.

Young Adult Clinic

Target age: 7 to 24.

The Young Adult Centre is a drop-in centre where teenagers can talk to a public health nurse about any health-related issue. Everything you say is confidential and you will never be judged.

Mother and Young Child Clinic

Target age: 0 to 6.

This nurse practitioner lead clinic is focused on mothers and young children from the Amish and Mennonite communities to improve their access to health care. Appointments are often drop-in. Translation services are available for low German speakers and wellness care is provided. The clinic is especially for those who don't receive regular medical care because they don't have a doctor, OHIP, don't speak English, or find travel difficult.

Treatment Services

Community Mental Health Services

Target age: 14+.

Direct supports for individuals 16 and older dealing with severe mental illness service are provided in a place of consumer choice in the community. Flexible support to encourage independence focuses on individuals' strengths.

Child and Youth Psychiatry Program

Target age: 7 to 18.

The program offers psychiatric assessment and diagnosis services, mental health support and education, parenting enhancement and support, and linkages to ongoing therapy and community services.

Child and Adolescent Services

Target age: 7 to 18.

We are an outpatient Children's Mental Health Centre funded by the Ministry of Children and Youth Services. Our staff includes Child and Youth Workers, Clinical Therapists, Psychometrists (specialists in psychological testing), Marriage and Family Therapists, a Psychological Associate and Social Workers. We offer family therapy,

individual counselling, play therapy, psychotherapy, psychological testing and consultation to community agencies and facilities. Our Forensic Unit offers services for those in trouble with the law (assessments for fire setters, sex offenders, Young Offenders and post dispositional treatment for Young Offenders). We also offer specialized treatment services for trauma and dissociation.

Early Intervention in Psychosis

Target age: 14+.

The Early Intervention in Psychosis service provides education, assessment, counselling and psychiatric service to individuals age 14-35 who are experiencing their first episode of psychosis. It provides treatment for people 14-35 years with less than six months or no previous treatment who are currently experiencing psychosis. The multidisciplinary team will provide: psychiatric assessment; ongoing education to the client and his/her family about psychosis and medications; identification and support of goals for the client; and symptom monitoring. Anyone can make a referral, but the family doctor must be willing to continue with treatment recommendations.

COMMUNITY-BASED YOUTH SKILLS-BUILDING PROGRAMMING

- *Youth engagement programming*

School and Community Youth Engagement Initiatives

Target age: 7 to 18.

The goal of youth engagement in school/community based initiatives is twofold: 1) it is a mechanism to gather youth input into health unit programming related to healthy eating, food access, physical activity and active transportation; and 2) it is an effective way to support positive developmental assets in youth. This will lead to healthy choices and better health (including mental health) outcomes for youth. Examples of such initiatives include: 1) Girl Friends Club - focuses on girls' self-esteem and positive body image through physical activity and healthy eating activities; 2) SPARK Initiative - Based on the work of John Ratay, this high school based program is designed to influence school practices related to physical activity and healthy eating to support brain development in youth and optimize health and academic outcomes; 3) Food Security Initiatives - youth engagement into community garden initiatives; and 5) Active Transportation Initiatives - youth engagement into AT initiatives.

Youth Speakers Training

Target age: 14 to 18.

Youth interested in telling their story of struggle about overcoming tobacco and other substance use were engaged with a series of training sessions to build comfort and skills with public speaking as well as fostering peer support and resilience.

The New Mentality/Disable the Label

Target age: 14 to 18.

The local health unit has partnered with the New Mentality to host the Disable the Label conference. This is a "by youth for youth" initiative designed to empower youth to develop their own mental wellness committees and activities at their home schools.

Tobacco Cessation and Initiation of Cessation

Target age: 19+.

Tobacco cessation and initiation are a part of mental health in both adults and child/youth. TCAN has done work on tobacco cessation for health and social care providers which is predominately but not exclusive to adults and is targeted towards helping the HCP help people quit. There is discussion that Youth Engagement (YE) is a part of this but it needs to be considered within the local context. Any time spent on other activities can't be included in our reports and ultimately takes away from our required work under the program guidelines. Mental health is an aspect of tobacco initiation/cessation and YE activities would need to focus on tobacco related to mental health, not youth mental health in general.

Youth Engagement Symposium (YES)

Target age: 14 to 18.

The goal of YES is to build resiliency within youth and the community. YES is meant to engage, enlighten, challenge and prepare both youth and professionals through youth lead workshops. The four main topics are: Friendships, Dating Relationships, Parent-Child Relationships, and Peer Pressure and Substance Use. Each workshop will focus on one of the four topics.

Photovoice

Target age: 14 to 18.

The goal of this initiative is to use the Photovoice approach to gather input from youth to answer the question " Does my community make it "easier" – or not – for me to be healthy? Initially the project asked youth to answer the above question related to six priority areas: healthy eating, physical activity and sport, tobacco use/exposure, alcohol and substance misuse, injury prevention and mental health promotion. The project then went on to focus on active transportation with the question being "Does my community take it "easier" - or not - for me to use active forms of transportation. The project included: Recruiting, training and working with youth volunteers from community or high school settings to engage in the Photovoice project; youth going into the community to take picture of things they feel make it easy or not to use active forms of transportation in their community; youth, as a group, selecting a set number of photos, creating a short description of what the photo means to them; and finally finding avenues to share their input (i.e. municipal council deputations, presentation to active transportation committees).

Youth Engagement Tobacco Control Initiatives

Target age: 14 to 18.

We are working with youth to implement tobacco related health promotion activities and to support and advocate for youth engagement across all health unit programs and community youth serving agencies. This includes: 1) Creating and implementing a youth volunteer model for the Chronic Disease Prevention – Tobacco Program; 2) Recruiting, training, and working with youth volunteers for the TCAN Regional Youth Coalition; 3) Learning about, using, and applying the Health Equity Impact Assessment Tool when recruiting youth; 4) Working with the Child, Youth and Family Services Youth Engagement Core Group to build capacity for youth engagement and advocating amongst youth serving community partners to use a youth engagement approach; 5) Continuing to support youth engagement activity across all programs; and 6) Creating a positive youth engagement culture with the PHU and community partners.

CDIP Youth Engagement Strategy

Target age: 14 to 18.

The Chronic Disease and Injury Prevention directorate aims to work with youth and youth serving agencies within a youth engagement framework. Research indicates that Youth Engagement enhances resiliency. CDIP activities are planned with youth with the intent to further develop youth's internal and external strengths with the intended outcome of insulating youth from risk and helping youth to thrive and cope with adversity.

Youth Engagement Program for Tobacco Prevention

Target age: 7 to 24.

Youth take action to protect their health and contribute to sustainable changes in their communities. Foster effective grassroots health promotion outcomes in communities for tobacco control and other correlated risk factors (injury prevention, sexual health, substance use, etc.) through youth engagement and leadership. Youth (defined as ages 12-24yrs old) in the community will gain knowledge (resiliency), skills and resources necessary to be leaders within the PHU and their communities to enhance the education and awareness of their peers and communities around chronic disease, injury prevention, substance use, sexual and mental health.

Youth Engagement

Target age: 7 to 24.

Youth Engagement Principles: inclusiveness; positive youth development; accountability; transparency; sustainability of resources; space for youth; strengths-based approach; flexibility and innovation; cross-sector alignment; collaboration; and commitment to operational

practices. Operational practices may include: adults as allies/partners with youth; youth-led and/or peer-to-peer initiatives; approaches that provide opportunities to youth for meaningful action; recognition of mutual benefit for adults and youth; and demonstration that youth contribution is valued.

Youth Engagement - Tobacco Use

Target age: 7 to 24.

Funding for youth engagement through Smoke-Free Ontario.

Impact Youth Engagement Leaders

Target age: 14 to 24.

Impact is a youth-led action group that educates youth about making healthy choices and works to create positive changes in the community. The purpose of Impact is to provide youth with knowledge and skills to increase the overall health of themselves, their families, their peers and their communities, as well as to provide a chance for youth to develop leadership skills and build confidence. Youth Engagement Leaders connect with youth in the community to promote health by running programs and campaigns on various topics such as tobacco control, chronic disease and injury prevention.

Youth Engagement Theatre

Target age: 14 to 18.

Youth engagement theatre is a peer to peer knowledge sharing initiative with core messages in theatre style presentations. Forum theatre is part of the Ontario drama curriculum and is organized by the United Nations Educational Scientific and Cultural Organization. Under the guidance of a communication specialist and program facilitator, drama presentations are conceived and performed for student audiences. Audiences are encouraged to re-write the scenes to help the characters make healthy choices in worst case scenarios. Students are also invited to step into scenes. This assists in solving conflicts and making decisions.

Skills building

Pre-teen Esteem Girls Program

Target age: 7 to 13.

This program is comprised of six sessions: Session 1: 1) To stress how self-esteem affects a person's ability to make sound decisions and healthy choices; 2) To help girls develop an understanding of self-esteem; how individuals can build self-image and self-confidence; 3) To use group activities and brainstorming to help girls build and nurture their own self-esteem, even in the face of criticism. Session 2: 1) To help students realize that having a positive body image is about maintaining a healthy body weight, as well as having a positive attitude and accepting who you are; 2) To encourage the girls to make friends with their body, instead of trying to conform to unrealistic and unattainable images of women portrayed in the media. Session 3: 1) To enhance life skills (decision making and problem solving) and personal strengths in peer relationships; 2) To challenge the girls to recognize the problems of cliques, gossip and rumours; 3) To help students respond to peer pressure. Session 4: 1) To help the girls realize that life is forever changing and requires them to be flexible when setting life & career goals and working to meeting them; 2) To leave the girls with a feeling that change is a good thing and opportunities can be found in all situations. Session 5: 1) To inspire the girls to think about how their interests and talents could be useful in a variety of careers; 2) To stimulate the girls to think about what is required for different careers, through the sharing of co-facilitators personal career paths and experiences; 3) To encourage the girls to think about different types of careers, including entrepreneurial, traditional and non-traditional focus. Session 6: 1) To bring the philosophy and lessons learned in the Pre-Teen Esteem program into practice in everyday life; 2) To foster a sense of program completion and inspire the girls to think about the adventures and wonderful things to come in their futures; 3) To express gratitude for the time that the group has been able to spend together.

Go Girls! Healthy Bodies, Healthy Minds

Target age: 7 to 18.

"Go Girls! Healthy Bodies, Healthy Minds" is designed to provide girls aged 12-14 with information to help them make informed choices about healthy active living and support them in dealing with the emotional, social, and cultural issues they may face. In addition, the program provides girls with the tools they need to implement this healthier and happier lifestyle. Go Girls was started in 2001 by Ophea (Ontario Physical and Health Education Association). In 2004, Ophea partnered with Big Brothers Big Sisters in Ontario to deliver the Go Girls! program in nine communities. Go Girls! is a mentor-lead, seven session program that incorporates fun, educational games and activities designed to stimulate self-reflection and group discussion. Each session addresses the topics of active living, balanced eating, and feeling good. Participants and mentors also complete a personal journal at the end of each session.

STEPS Program

Target age: 14 to 24.

Engaging community partners and at- risk youth to provide prevention-level healthy recreation and leisure programs for at-risk youth in order to facilitate community integration, provide leadership opportunities, and promote healthy decision making. Objectives: 1) Increased opportunities for safe and healthy physical activity for at-risk youth; 2) Engagement of community partners and youth around this issue by strengthening networks and reducing overlap of services creating new pathways into community supports and services; 3) Increased capacity for participation, leadership, and healthy decision making in participants; 4) Increase social interaction for socially isolated and marginalized individuals in a sport and recreation environment; and 5) Improve the emotional and physical wellbeing of participants including self-esteem and feeling of self-worth.

Pride and Prejudice Group geared to GBLTQ youth

Target age: 14 to 18.

Partnership in our community with the AIDS committee. Offers a support group and activities for youth who identify as GBLTQ.

Craving Change

Target age: 19+

Craving Change is a series of activities and discussions developed for use with groups or individuals. The program employs a practical, evidence-based approach to address emotional eating by focusing on the "why" of eating. It helps to normalize problematic eating and encourages self-efficacy and self-management. Participants reflect on the bio-psycho-social factors that influence eating behaviours – physiological, conditioned, and environmental and increase awareness of their personal eating triggers and patterns. By applying the cognitive-behavioural approach, participants unlearn their behaviours and learn skills and strategies to change their triggers and eating responses.

Dynamic Youth

Target age: 14 to 18.

The Municipality would like to foster an environment for its youth which would facilitate healthy lifestyle choices and encourage a positive development. The youth group would be an opportunity for youth ages 13-18 to gather in a asocial environment composed of their peers to partake in physical activity, learn about healthy eating and discuss issues which could lead to unhealthy mental health.

Minding Our Bodies Youth in Action Forum

Target age: 14 to 24.

Youth In Action Forum is a one-day knowledge exchange event to explore the role of physical activity and healthy eating in youth mental health promotion and recovery from mental illness hosted by Minding Our Bodies (an initiative of the CMHA and partners). Health Unit physical activity and nutrition staff were involved in planning and presenting at the forum.

Newcomer Program

Target age: 0 to 6.

This program exists to provide support to women and young children in the Low German Speaking Community. It operates from 9am – 1pm weekly during the school year and multiple community partners participate in program provision. A public health nurse acts as program lead and coordinates partners. Mental health challenges related to stress, poverty, isolation, substance abuse, and postpartum adjustment are common and addressed by staff in this program. For Adult Participants, the program serves: 1) to increase literacy levels and English language proficiency; 2) to increase basic life skills and parenting skills; 3) to reduce social isolation and provide opportunities for women to network with women of their own culture; 4) to increase knowledge regarding health; 5) to increase awareness of and ability to access community resources; 6) to provide modeling of positive adult/child interaction; 7) to provide the program in a supportive learning environment; 8) to reduce language and cultural barriers to participation in this community; 9) to ensure cultural sensitivity is incorporated into planning and implementation of all aspects of the program; and 10) to provide collaborative opportunities that promotes healthy lifestyles. For child participants, the program serves to enable all children to attain and sustain optimal health and development potential by: 1) assessing infant and child developmental and provide referral to appropriate community resources; 2) offering school readiness programs for preschoolers; and 3) providing the program in a supportive learning environment. The program also provides pre-employment and mentoring experience to adolescents working as child care workers.

Building Resilient Youth Project

Target age: 14 to 18.

The PHU is developing a plan to support secondary schools in addressing topics relating to PISM through a youth engagement approach. Resilient youth have skills for coping with stress, optimism when handling challenges and a sense of belonging. When youth are engaged in planning activities it helps build resiliency. Through youth engagement youth develop important life skills and are empowered to make a difference in their community. Through this youth engagement project youth will learn skills to apply to their lives such as how to cope better or make healthy social connections. They will learn more about resiliency and experience the benefits of empowerment, while making a difference in their community. This experience will contribute to positive youth development while helping us reach our objective of increasing awareness of the importance of building resilience in youth.

The RACE Against Drugs

Target age: 7 to 13.

The RACE Against Drugs is a community based drug and alcohol awareness program offered to Grade 5 students across the county. The RACE (Respect, Action, Courage, and Excellence) has been designed to deliberately reflect the character values and curriculum taught within the local school boards. The primary objective of this drug education initiative is to utilize the sport of auto racing to capture the attention of young people and communicate with them as they move and interact through each pit stop to learn key messages about the importance of (choosing) a drug and alcohol free lifestyle. In accordance with best practices for children of this age, this event will enable the students to identify sources of influence surrounding drug and alcohol use. The pit stops have been developed to encourage the students to learn about and make healthy lifestyle choices through interactive activities. The interactive pit stops provide information and messaging that coincides with best practice recommendations on building resiliency in youth. The RACE also provides the students with the opportunity to be engaged with the community partners staffing the pit stops. The event focuses on the protective factors that promote positive youth development and prevent youth from engaging in risk taking behaviours. The students will also learn short and long term effects of drugs and alcohol, refusal skills and resistance techniques.

COMMUNICATION AND AWARENESS-RAISING ACTIVITIES

Healthy, Happy Kids Campaign (e-bulletin)

Target age: 0 to 13.

The Healthy, Happy Kids campaign is part of the health unit's Healthy Weights for Children and Youth Strategy. This strategy follows a balanced approach philosophy for promoting healthy weights (i.e. balanced lifestyle changes for improving health, not for weight loss/healthy bodies come in all shapes and sizes). The campaign is designed for parents with children aged 4-12 and offers easy, affordable tips on how they can help their children eat well, be active and feel good about themselves. The campaign involves a monthly e-bulletin sent out to approximately 800 parents across the district have signed up to receive it. As well, a display is set up at community and school events where resources are distributed. Mental health topics that the e-bulletin has covered include: bullying, relationships/friendships, positive body image, self-esteem/confidence, the importance of connecting with your child, stress, positive parenting/discipline, physical activity and mental health, media literacy, sleep, tolerance/acceptance of others.

Online Adolescent/Parent Resiliency Resource

Target age: 14 to 18.

A resource for parents is being developed to address adolescent resiliency and coping. The objective is to increase awareness of factors that enhance resiliency, including supportive social networks, positive thinking, and healthy coping. It also aims to empower families/parents to increase the adoption of healthy living practices (physical activity, healthy eating, relaxation, sleep, and making good decisions around substance) and skills that assist in coping with challenges (dealing with stress, coping with loss, empathy, dealing with change, positive thinking). We are planning to use social media channels to meet these goals and objectives.

Our Minds Matter

Target age: 7 to 18.

Our Minds Matter is a project being led by one full time PHN in collaboration with a PHN in substance misuse and our Youth Engagement Coordinator. This is a communication campaign to encourage resilience among youth and reduce stigma around mental health issues. A component that will target parents is being planned as part of this initiative as well as policy for schools and tools for healthy emotional transitions of youth. We see youth resiliency as the primary prevention tool for risk taking behaviour associated with tobacco use, alcohol, drugs, etc. We are also working on some research with our schools on efficacy of teachers and staff to manage behavioural and mental health issues within their classrooms/schools. This was done through survey with a response rate of approx. 30%. Results are currently being analyzed.

Online parenting videos

Target age: 0 to 18.

Online parenting videos corresponding to specific developmental stages of children and youth to promote positive family relationships, increase resilience of all family members, and lessen stress in the home.

Parenting teenager videos

Target age: 7 to 18.

Videos to support parents in parenting teenagers. Multiple videos have a direct focus on promoting mental wellness. Topics include: How to support your child when they've been diagnosed with a mental illness; Promoting mental wellness; Getting help with mental health concerns; Recognizing the signs of mental illness; Risk and protective factors for mental illness; and Talking with your teen about mental health.

Me Mag

Target age: 14 to 18.

Me Mag has been developed in consultation with teens across the area. Our goal is to provide straight-forward, accurate information on general health issues and other topics that relate to teens. Me Mag does not provide personal health advice.

Cares Website

Target age: 7 to 18.

Website includes provides information on disorders and supports. Phase Two will include piece on resiliency and health promotion.

Kids Can Resiliency Campaign/Resource

Target age: 0 to 6.

Kids Can is a colourful, interactive resource, available online or in magazine format. It provides information and activities for parents and caregivers to help young children learn skills that will help them bounce back from stress and challenges. The goal is to increase resiliency related to personal health practices, coping skills and social support networks in parents and children 0-6. The objectives are: to increase awareness of factors that build resiliency in children 0-6; to increase the awareness of the importance of caregiver influence on building resilient in children 0-6; and to increase adoption of practices that build resiliency in children 0-6.

Healthy Babies, Healthy Brain promotion

Target age: 0 to 6.

Promoting Healthy Baby Healthy Brain Best Start campaign/website (campaign through Best Start).

Parent Bullying Event

Target age: 0 to 18.

Engaged a keynote speaker with a community expert panel for parents, teachers, and administrators with focus on bullying and how to address it within the school setting.

Public Health's Role in Mental Health

Target age: 25+.

Our Health Unit provided front-line staff with a brief description of Public Health's role in mental health. We also provided this description to community partners.

Child Health Operational Plan Activity # 5 - Public Awareness

Target age: 0 to 6.

This operational plan activity shall increase public awareness of healthy family dynamics. This will include adapting and/or supplementing a provincial communication strategy.

Digital Communications Strategies

Target age: All.

Our various digital communications strategies include: School Health E-News, Physician's web-pages, Parent Subscription (online newsletter), Pre-natal App, Online Prenatal, BFI website, and Parents: social media including Twitter, Facebook and blogs on Wordpress. All of these initiatives communicate messaging about mental health in various forms from referral information and community resources, to providing commentary through blogs and social media avenues such as Twitter. Messaging linked to Mental Health is intentional.

Eating Disorder Awareness Week Programming

Target age: All.

During Eating Disorder Awareness Week (and as opportunities arise) the health unit disseminates resources to encourage and build capacity for sensitivity re: weight issues, promoting positive body image and self-esteem. Resources may be sent to health care professionals, educators, recreation staff, and the public.

It Begins with Family Health Communication Campaign

Target age: 0 to 6.

The It Begins with Family health communication campaign is targeted at parents of children 0-6 years of age to increase their awareness of the importance of family in building resilience. The message is supported with a health education resource that provides parents with strategies to promote resilience in children 0-6 years.

E-Mental Health

Target age: All.

eMentalHealth.ca is a non-profit initiative of the Ontario Centre of Excellence for Child and Youth Mental Health that is dedicated to improving the mental health of children, youth and families. Founded by Dr. Michael Cheng, Child and Family Psychiatrist at the Children's Hospital of Eastern Ontario (CHEO) in 2005, in collaboration with Amy Martin, Clinician at Crossroads Children's Centre, the site contains a variety of mental health resources. These include: A Find Help Directory; Mental Health Screening Tools; Mental Health Info Sheets; a Mental Health Events Calendar; and related news stories.

Family Lending Library

Target age: 0 to 18.

A $10 000 Parent Reaching Out Grant paid for resources and bookshelves to add to the health unit's resource centre. The library is for parents and caregivers, with resources signed out by schools using a courier system. Lending is anonymous so parents can maintain their privacy. A diverse range of topics are available, including mental health.

Mental health/suicide awareness and education

Target age: All.

Mental health/suicide awareness materials are provided to the public, to community groups and to agency staff through health unit communications (i.e. Healthy Schools Newsletters distributed to all families with children in elementary school, as well as Healthy Workplaces Newsletters distributed to all interested workplaces).

STRATEGIC PLANNING AND POLICY-RELATED INITIATIVES

Healthy Community Design: Policy Statements for Official Plans

Target age: All.

This resource is a series of suggested policy statements and implementation activities related to land use, community design and public health. The Health Unit offers these suggestions for policy direction to municipal planners and elected officials in hope that communities adopt them as part of their Official Plans and work programs to improve the overall health and well-being of their residents.

Active and Safe Routes to School

Target age: 7 to 13.

To create safer streets in the school community, the PHU is working on increasing the number of students walking and cycling, promoting a healthy lifestyle to parents and students, and raising awareness of the benefits of an active lifestyle.

Changing Futures: Community Prevention Framework

Target age: All.

The intent of this project is to bring together stakeholders in the region through a two day youth prevention/health promotion symposium. Day one will be comprised of presentations on the risk and protective factors influencing youth substance misuse and mental health, as well as information on evidence based approaches. This will include an overview of effective prevention and health promotion efforts along the age continuum. The second day of the symposium will be a facilitated community session of key informants and decision/policy makers from ministries, organizations, agencies, committees, and councils who have a stake in youth substance misuse prevention and mental health promotion. This day will be dedicated to the development of a coordinated community plan built on the foundation of evidence based practices presented on day 1. This process will identify gaps in programming that respective councils, committees or

stakeholders can adopt into their future work. The overall goals of this two day symposium are: 1)A strengthened community awareness and level of knowledge of evidence based substance misuse prevention and mental health promotion practices; 2)The development of a coordinated, feasible and measureable community plan to guide interventions. All community partners will understand their role and take evidence based action, optimizing effective use of scarce resources; and 3) Strengthened networks of community agencies/committees addressing these issues.

Mental Health Initiative

Target age: 14 to 24.

The goal of the Mental Health Initiative is to foster the development of policies and system practices that support positive mental wellbeing and resiliency among all residents. This group is working to identify indicators for a community/municipality that supports mental well-being. Within the Healthy Communities Partnership, the PHU is working with municipalities on the development of an Asset Inventory Tool (AIT) which can be used by municipalities to identify their strengths and areas for improvement. The topic areas for the introduction of this tool are recreation and healthy eating. The addition of a well-being component will be a 'next step' in the roll out of this plan which includes a Healthy Communities Charter. The initial phase of this component of the AIT is directed at the well-being of youth. Activities so far include: identification and recruitment of partners; strategic planning; information gathering; and choice of framework. Next Steps: Identify indicators; gather resources for municipalities to support their efforts to be communities that support well-being; develop the Well Being section of the AIT; focus test this section of AIT; finalize AIT; and promote AIT to all municipalities in the region.

HIGH FIVE® Framework

Target age: 7 to 13.

HIGH FIVE® is a framework committed to assisting children along the path of healthy child development by: Ensuring that recreation and sport practitioners develop a high level of knowledge and expertise in child development; Helping parents to make informed choices and; Providing practitioners with the tools for enhancing and maintaining a high level of program quality The HIGH FIVE® Quality Framework identifies fours areas of organizational effectiveness that are essential to the delivery of quality programs for children. Within each area, HIGH FIVE® provides a support system of specialized training, innovative tools, resources and support to help organizations move toward the goal of quality assurance and accreditation.

Integrated Drugs Strategy

Target age: 14+.

Youth have been identified as a priority population within the integrated drugs strategy. Youth that are involved with drug use may also be homeless or at risk of homelessness, pregnant or at risk for pregnancy and also may be involved in sex trade work. There are formal partnerships involved with this initiative because this population often experiences concurrent disorders, both addiction and mental health issues.

System Improvement through Service Collaboratives (SISC)

Target age: 7 to 24. Report 2 times.

Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy commits to the transformation of mental health and addiction services for all Ontarians. The Strategy begins with a three-year plan that focuses on children and youth. Systems Improvement through Service Collaboratives (SISC) is one initiative encompassed within the Strategy. The goal is to create 18 Service Collaboratives that will improve services Ontarians experiencing mental health and addictions issues by focusing on transitions: between hospital and community settings; health and justice systems; and youth and adult services.

Healthy Living Division Youth Engagement Strategy

Target age: 14 to 24.

The strategy is currently in the development stage. Its focus is on capacity-building steps within the division to enhance current youth engagement activities through collaboration, training for staff on the theory and principles of youth engagement, and the development of a resource manual to support use of a youth engagement framework.

Memorandum of Understanding with CCAC Mental Health and Addictions Nurses in Schools Program

Target age: 7 to 18.

The purpose of this Memorandum of Understanding (MOU) is to outline the partnership between the Health Unit Healthy Schools Program and the Community Care Access Centres (CCAC) Mental Health and Addictions Nurses (MHAN) in Schools Program for supporting mental health in schools. In particular, the memorandum will articulate the communication and collaboration required between the two agencies in order to further plan and implement children and youth mental health supports for students, families and schools in the region.

Mental Health Promotion

Target age: 0 to 18.

From the Child Health (School-Age) Operational Plan: Engage in mental health promotion visioning as a team; Collaborate with school boards on mental health promotion and suicide prevention strategies; Provide mental health promotion to schools as requested and as resources allow.

Social Determinants of Health Initiative: Personal Health Practices and Coping Skills of Children and Youth

Target age: 7 to 18.

Health Units were mandated in the 2008 Ontario Public Health Standards to address the issue of mental health if identified locally. The Health Unit identified a need to work with community partners in addressing mental health programming and identifying the role of the Health Unit. Children and youth mental health was identified as a priority theme related to addressing the social determinants of health. Our PHU has assigned a public health nurse to work in the area of child and youth mental health promotion. This has resulted in the formation of an internal Mental Health Task Group (members include a health promoter working in the area of youth engagement, public health nurses and coordinator) to plan and implement activities specific to mental health. A literature review and summary of best practices has been completed. Our PHU initiated a formal planning process through The Health Communication Unit (THCU). We are working on the THCU Step II, to engage stakeholders in the planning process.

Suicide Risk Protocol

Target age: 0 to 18.

In 2009, a task group of interested individuals representing educators, hospitals and community mental health agencies in our region was formed to develop a local community protocol to effectively respond to the needs of children and youth who are at high risk for suicide. Funding was obtained through the Student Support Leadership Initiative. The High Risk Suicide Protocol for Youth is the result of the task group's work. The protocol and a report recommending a pilot implementation of the protocol in our community were presented to the Child Youth and Family Services Coalition in November 2009.

Strategic Priority to Develop a Mental Health and Addiction Strategy

Target age: All.

The health unit is planning to develop school-based mental health promotion recommendations based on a review of current services and best practices. Plans to look at this work in the post-secondary context are also underway. This will involve an environmental scan of the community.

Resilience Model

Target age:7 to 18, 25+

A resilience model is incorporated into all of the health unit's program planning and program delivery models. All programs are now required to indicate how building resilience in the population is built into program development and delivery. We have conducted division-wide training and have a Youth Strategy focused on resilience. Resilience is also discussed in our Seniors Strategy report, and part of our CDP social marketing campaign and messaging.

Sexual Health Philosophy and Guiding Principles

Target age: All.

This philosophy does not specifically mention "mental health" but has been developed to frame all of our work to promote healthy sexual expression. Internalized negative feeling towards one's sex, gender, sexual orientation, body image etc. has an impact on emotional development that impacts the basic needs for touch and intimacy that affect mental health. Sexuality is an important part of every human being, encompassing not only how we act, but also how we think and feel. It is strongly shaped by our experiences, attitudes, values and beliefs. Over the lifespan, sexuality may include the basic needs for touch, intimacy and connection, emotional expression, love, and pleasure. People make sexual choices within a complex set of social systems. Sexual expression and decision making takes many diverse forms. Healthy sexuality cannot be separated from basic human rights - freedom from discrimination, harassment and violence.

Addiction & Mental Health Program

Target age: 19+.

Our Health Unit has a unique situation in that is it one of only two PHU to offer an Addiction & Mental Health Program within its services. The program offers awareness and information on Mental Health issues, stigma, and services available. Further to these preventative tactics the program also offers individual and group counselling in secondary school programs, partnerships, social recreation, and case management. The main objectives focus on harm reduction, coping mechanisms, life skills building (social recreation component), and working with clients to enable them to be as productive as possible within their lives and society.

PHU STAFF/SERVICE PROVIDER TRAINING AND CAPACITY BUILDING

ASIST and SafeTALK workshops.

Target age: 14 to 18. Reported 3 times.

SafeTALK workshops developed by LivingWorks Inc. (in which TALK stands for tell, ask, listen and keep safe) increase participants' awareness and understanding of suicide risk factors, prepares them to identify people with thoughts of suicide and enhances their ability to provide appropriate and timely referrals to suicide first aid resources. Applied Suicide Intervention Skills Training (ASIST) is another LivingWorks program that is comprised of two days of practice-oriented workshops offered to various front-line professionals and interested community members.,*http://www.livingworks.net*

Mental Health First Aid

Target age 7+. Reported 3 times..

Mental Health First Aid is a training program offered by the Mental Health Commission of Canada that several health units have required their staff to attend. The program aims to improve mental health literacy and to provide skills and knowledge to better identify, prevent escalation of, and intervene in mental health problems.

http://www.mentalhealthfirstaid.ca/EN/Pages/default.aspx

Developmental assets training and awareness raising

Target age: 0 to 18.

Developmental assets training workshops have been provided for internal health department and children's services staff who work with children and youth. Workshops and awareness-raising presentations have also been provided to many community groups, agencies, and schools, with participants including staff, children and youth, and parents. Our Region's School Years Program follows Search Institute's DA framework and workshop guidelines. The goal of promoting DA within the community is to promote healthy behaviours (both physical and mental health) and to reduce high risk behaviour by children and youth. Search Institute's description of DA: The Developmental Assets® are 40 common sense, positive experiences and qualities that help influence choices young people make and help them become caring, responsible, successful adults. Because of its basis in youth development, resiliency, and prevention research and its proven effectiveness, the Developmental Assets framework has become one of the most widely used approach to positive youth development in the United States. The DA framework is woven into all aspects of the School Years Program work e.g. parenting, comprehensive school health, and community engagement

Building community capacity to build assets in children and youth

Target age: not provided.

In partnership with our local children's planning table we have been working to raise awareness of developmental assets and provide practical tools and resources to build capacity in those that work with children and youth to build assets using the Search Institute's framework.

Weight Bias Training

Target age: 7 to 18.

It is important educate all professionals who interact with children and youth to increase awareness and knowledge of: weight bias; evidence-based strategies for promotion of healthy weight, positive body image and self-esteem for various age groups and genders; and local resources available for the identification and treatment of Eating Disorders.

Healthy Weights Knowledge Exchange and Professional Development

Target age: 0 to 18.

Provision of education and skill building related to healthy weights sensitivity for community partners, social service providers and public health staff. This includes components of mental health promotion, body image, and self-esteem of the adult influencer. The intention is to increase the capacity of staff to promote healthy eating, active living, healthy weights, mental health and wellbeing and positive body image.

Annual Adolescent Care Workers Networking event

Target age: 0 to 18.

An annual networking event for child and youth workers who work in the local school boards was hosted by the health unit. Guest speakers covered issues related to mental health and the health unit did presentations on Wellness Week and Food Skills - Undercookstruction.

Information on Resiliency for Educators

Target age: 0 to 18.

Schools are well positioned to foster resilience in students. They reach and support the largest number of children, as children spend most of their wakeful hours in school. Resiliency "is a combination of skills and positive attributes that people gain from their life experiences and relationships. These attributes help them solve problems, cope with challenges and bounce back from disappointments" (The Psychology Foundation of Canada, 2009). When schools address resiliency they can strengthen students' competence, confidence, self-regulation, and sense of control. A pamphlet has been developed for educators and resiliency web content was developed and is available online. A resiliency PowerPoint was also developed for public health nurses to use with educators who have identified resiliency as a topic of interest and are prepared to begin addressing resiliency in their school.

Internal Positive Mental Health Presentation

Target age: All.

A presentation on positive mental health and resilience was developed and shared with management and the Chronic Disease Program. Topics included: key concepts and terms used to understand positive mental health/ illness (flourishing, resilience), protective and risk factors, determinants of mental health, and public health actions. Key resources and tools from the World Health Organization, VicHealth, NICE, CAMH, etc. were referenced. A background document was prepared to inform community partners of the relationship between recreation and the social determinants of health and social inclusion.

Social Determinants of Health/ Health Equity Training Staff Education Training Sessions

Target age: All.

Three hour interactive education sessions will be provided for all health department public health staff as a key component of the health department's plan to address health equity and better meet the needs of priority populations. Priority populations include people living with mental health and addictions, inclusive of children and youth with mental health and addictions and their families. One of the objectives for the session is to provide participants with an opportunity to explore personal views and assumptions related to issues such as poverty, culture and mental health and addictions, and explore what values and experiences shape their practice so that they are able to align their actions with social justice values and beliefs, which include mentalism and other forms of stigma and discrimination. Secondly, a "People with Mental distress or illness (and addictions)" summary sheet was created as a resource for health department staff. This resource summarizes how key informants in the district describe how mental distress/illness (and addictions) interacts with the social determinants of health.

Internal Stigma Reduction Awareness

Target age: All.

We have to inform our staff of what mental health is, means, and implies. Much stigma is attached to mental health and only with informing and educating can we do this. We decided to start with our personnel.

Internal and Community Promotion of Equity-focused Health Impact Assessment

Target age: 0 to 25.

Promotion, support and capacity building re: the application of Equity-focused Health Impact Assessment with both internal PH staff and external community partners. One component of EfHIA includes assessment of projects/initiatives on mental health/resilience/stigma etc.

Workshop on Social Determinants of Health and Mental Well-being

Target age: All.

In the planning stages to organize a workshop to explore social determinants of health and mental well-being and to explore collaboration amongst various community partners.

RESEARCH & SURVEILLANCE

Embedding a Strengths-Based Approach in Public Health Practice research project

Target age: All. Reported 2 times.

The Health Unit is a co-applicant in the Locally Driven Collaborative project funded by Public Health Ontario entitled, "Embedding a Strengths-Based Approach in Public Health Practice". The project's research questions include: 1.What is the current and the required capacity of public health staff to embed a strengths-based approach in their practice? 2.What are the essential steps a public health organization should undertake to embed a strengths-based approach? 3. How can public health organizations nurture strengths-based approaches in their community? Resiliency Initiatives was hired to conduct a mixed methods design using qualitative and quantitative measures with public health staff at 4 public health units. This included pre and post questionnaires to measure personal perception of resilience, understanding of strengths-based practice, current engagement and the degree to which their work setting supports strengths-based practice, as well as focus groups, expert interviews and reflection sessions with public health staff to explore implications, challenges and potential opportunities to embed a strengths-based approach. Staff also received full day training on the theory, principles and strategies of strengths-based practices. Resiliency Initiatives will outline a potential roadmap strategy for professional capacity building within Public Health Units that provides a common language and a strengths-based framework for public health practice.

Surveillance - Student Health Survey and Report

Target age: 7 to 18.

We conducted a local survey of youth which included questions related to self-esteem, body image, bullying and mental health.

School, Health, Action Planning and Evaluation System (SHAPES) survey and report

Target age: 7 to 18.

Nearly 3500 high school students in grades 9 to 12 across the District were asked a series of questions about their mental fitness, physical activity, tobacco use and eating behaviours. The results of the survey were compiled into a report called, Snapshot: Looking at Teen Health in the District. The report highlights some of the key results and recommendations that were revealed through the SHAPES survey. The report was distributed to schools and community partners encouraging them to use the information to work together towards creative solutions to improve overall student wellness.

Ontario Youth Screening Project - GAIN SS (Global Assessment of Individual Needs Short Screener)

Target age: 14 to 24.

The aims of this project are: To build collaboration amongst youth service providers across sectors by enhancing community-based networks; to use a common screening tool with youth seeking services; to enhance identification and treatment planning for youth with mental health and substance use concerns; to obtain feedback from service providers re: feasibility and utility of the GAIN-SS as a screening tool; to examine the effectiveness of a cross-sectoral collaboration as a knowledge translation strategy; and to inform planning processes within agencies with regards to identifying commonalities and differences in youth seen and identifying gaps in continuum of services.

Positive Parenting: Exploring a Comprehensive Approach

Target age: 0 to 18.

The Positive Parenting: Exploring a Comprehensive Approach project was created to address gaps in meeting positive parenting requirements as listed in the Ontario Public Health Standards and to explore community interest in a community-wide, comprehensive approach to positive parenting to better meet the needs of families with young children. The ultimate goal is to create a comprehensive approach to positive parenting in the region.

Resiliency Rocks

Target age: 7 to 18.

A survey has been distributed to all primary grade teachers, elementary school principals and vice-principals. We are looking for feedback from the staff to determine their need for mental health resources pertinent to this age group.

Wraparound Project

Target age: 7 to 24.

Wraparound is a demonstration project with longitudinal research component focused on moving youth out of poverty. These youth come from disadvantaged homes and often have mental health issues. The project is based on literature and best practices and is overseen by a Steering Committee and Evaluation Committee. It designed to engage up to 300 Grade 7 & 8 students over a 3 year period. A hired Community Development Coordinator performed needs assessment with students, families and staff, finding that over 80% of children and their families in grade 7 had not been engaged in school or community activities. A logic model was developed with the main components being: youth engagement, positive mentorship (link to a caring adult), parent-school engagement, community partnerships, and links to employment. The focus is to successfully transition youth during the most important years (grade 8 to grade 9) and out of secondary school either to the workforce or into post-secondary.

Public Health Physical Activity and Healthy Eating Grants

Target age: 7 to 18.

The Public Health Unit is committed to improving the health of the region's children by ensuring a supportive social and physical environment that encourages physical activity and healthy eating. With this, our PHU is offering one-time grant opportunities to eligible schools that want to initiate or enhance their school-based strategies to support students in these priority areas. Public Health Nurses will support grant schools, using the Healthy Schools Approach, which is consistent with school improvement planning processes. These include: Conducting an assessment of the school environment to determine if any changes are needed; Identifying facilitators and barriers to the specific issues and/or policies that are in place; Identifying internal and external partners to support change; Developing goals, objectives, and strategies for action; Taking action and implementing the developed strategies; Monitoring, evaluating, and reporting on the progress of the identified strategies; and celebrating successes!

Grieving and Resilience Experiences of Youth Who have lost Families and Friends to Gun Violence: A Research-based Project

Target age: 14 to 24.

This youth-led, action research is conducted to understand the trauma and resilience experiences of youth ages 14-25 who are grieving the loss of loved ones (friends and family members) to gun violence. The overall aim of this proposed project is to develop a basis of knowledge about risks and protective factors among these youth. Using research-based documentary, the project is intended to meet these objectives: 1) increase opportunities for self-expression for grieving youth; 2) engage youth in a process of skill building and knowledge dissemination; and 3) explore the influence of skill development on youths' coping ability and 4) identify decision-makers' perception of research-based documentary to enhance service delivery for grieving youth. Fifteen youth will receive skill building workshops in grief support (e.g. vicarious trauma), documentary filming and editing, and peer leadership. Using new skills, youth will video record their own unique experiences with grief, coping and resilience in distinctive ways, develop a documentary, analyze discourses and disseminate the findings primarily through a youth-led knowledge exchange symposium.

Mental health teacher survey

Target age: 0 to 18.

School boards were approached in spring 2012 to administer a teacher survey to look at frequency of mental health concerns and efficacy and capacity of teachers to deal with these issues within the school. The survey was administered in both the Public and Catholic board with a 33% response rate. Survey results will be discussed with the school boards to develop a plan of action to increase capacity and support for teachers in the area of mental health.

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Ontario
Agency for Health Protection and Promotion
Agence de protection et de promotion de la santé

Toronto Public Health

4822 / 07-2013