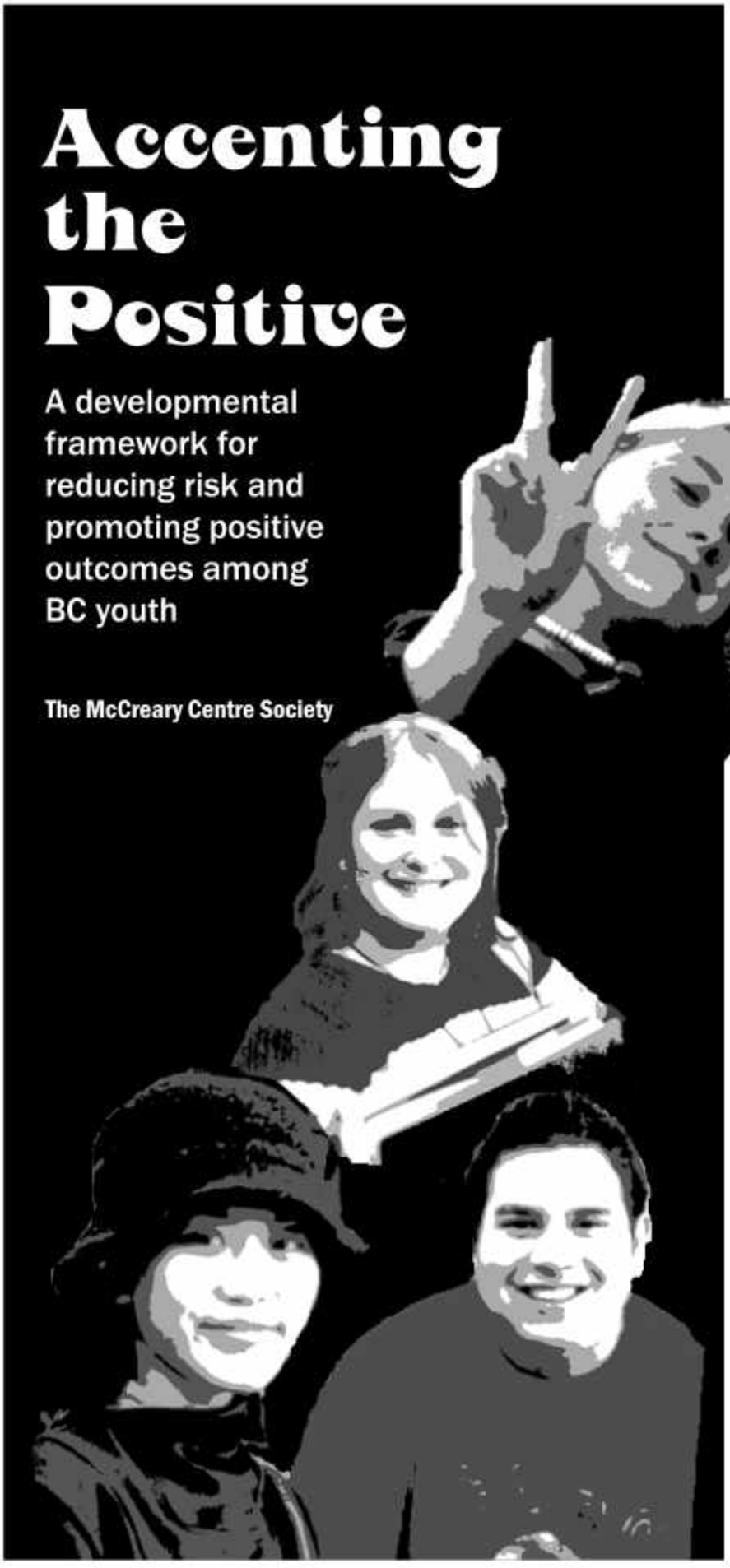
Accenting the Positive

A developmental framework for reducing risk and promoting positive outcomes among BC youth

The McCreary Centre Society



Accenting the Positive

A developmental framework for reducing risk and promoting positive outcomes among BC youth

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The McCreary Centre Society is a non-government, non-profit organization committed to improving the health of BC youth through research, education and community-based participation projects. Founded in 1977, the Society sponsors and promotes a wide range of activities and research to address unmet health needs of young people. Areas of interest include:

- health risk behaviours
- disease prevention and health promotion
- youth participation and leadership skills development

Dedication

Gordon May, a Director of The McCreary Centre Society from 1989 to 1994, passed away this year. He was an active, highly supportive and thoughtful contributor during these years and afterwards. It was during his tenure that the Adolescent Health Survey was conceived and launched. It was a risky venture for a small non-profit, but Gordon's support and commitment to the AHS was unwavering. Gordon was an educator and a skilled administrator. His last position before retirement was as principal at Killarney Secondary in the Vancouver School District. Gordon loved working with young people whether they were students or young professionals. He believed in their good judgement and resilience. We wish to honour Gordon's contributions to McCreary and to the young people in this province by dedicating this report to him.

Preface

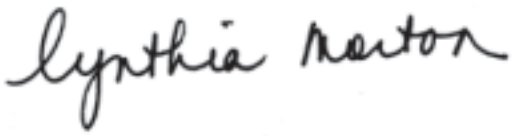
This latest report of The McCreary Centre Society is dedicated to promoting the development of public policies for youth that are evidence based and positive in approach and outcomes.

The report is based upon years of research, experience, and surveys of youth. It rightly points out the need for research and policies which are integrated to form a complete picture of cause and effect regarding health and reducing risk for youth. Further, the need for youth's involvement in the creation and implementation of such policies is a key to the success of the initiative as well as to the self-esteem of youth.

In British Columbia we are fortunate to have institutions such as The McCreary Centre who are dedicated to understanding the needs and voice of youth. But their work shows us that more is needed, and on a larger scale.

The research underway across Canada and the evidence it generates is a good start, but is not an adequate nor integrated response to understanding the full range of needs of adolescents in what is a critical period of growth, risk, and opportunity in the human lifecycle.

Many are calling for the creation of a Youth Foundation whose mandate would be the oversight of BC youth focused research. It would build research capacity, provide ongoing assessment of the public health determinants of youth health, and ensure the full participation and leadership of youth in setting a youth health agenda for our province. Through such a foundation we will spend our research time and money well, enhancing the usefulness of our policy and programs to youth.



Cynthia Morton
BC's former Children's Commissioner

Table of Contents

Introduction

This report is the product of an ongoing collaboration between The McCreary Centre Society (MCS) and the BC Ministry of Children and Family Development (MCFD). While the report was prepared specifically for MCFD, it will likely be of interest to other provincial ministries, to professionals who work with youth, and to community agencies concerned with the health and well-being of BC's youth. The report supports the premise that provincial strategies to address youth health concerns should be built on a solid understanding of adolescent development and should be positive—rather than punitive—in approach. Wherever possible, planners need to ensure that policies and programs are based on the latest knowledge, accurate data, and evidence of effectiveness in promoting healthy development.

In November 2001, McCreary hosted a planning institute to discuss the third provincial Adolescent Health Survey (AHS), scheduled to be conducted in 2003. The meeting brought together members of the AHS Advisory Group, including representatives of the provincial government, education sector, universities, and community agencies. To lay the groundwork for AHS III, and to keep youth issues on the provincial agenda, the Advisory Group suggested that McCreary use previously collected AHS data to prepare a special report focusing on risk and resiliency. Following the institute, the Ministry of Children and Family Development broadened the scope of the proposed report, contracting McCreary to include evidence and advice on "protective factors to mitigate factors that place youth at risk." The developmental framework proposed in this report is consistent with MCFD's strategic shift toward evidence-based practice and in support of capacity and resiliency building approaches.

The report provides evidence generated by the AHS II, conducted by MCS in 1998-99, and discusses its programmatic and policy implications. The survey involved about 26,000 Grade 7 to 12 students in schools throughout British Columbia. The survey was augmented by a series of smaller surveys of special populations such as street youth and youth who were in custodial facilities due to their involvement in criminal activities. Further information on the survey methodology and a list of reports is accessible at www.mcs.bc.ca

This report also draws upon relevant research literature on adolescence to suggest developmentally based frameworks for future provincial programs. The report incorporates the accumulated experience of the principal author and referenced academic health literature, as well as data from AHS and other McCreary studies, to create a positively-oriented framework for youth health policy. It suggests the principles upon which to base policy guidelines and key elements of policies affecting youth. However, it is not in the scope of this report to address specific Ministry programs or regional service issues. Nor does the report attempt to provide recommendations on service delivery models or specific Ministry strategies or regulations.

Key Considerations for a Youth Positive Policy Framework

Public policy, strategies, programs, and services designed to meet the needs of youth must:

- empower youth, their families, and their communities
- de-emphasize perceptions of youth as problems, and emphasize youths' ability to contribute to solutions
- be youth-friendly, participatory, and developmentally appropriate
- promote approaches that are protective rather than punitive
- identify and build upon individual assets and capacity
- support continuity of positive relationships (connectedness)
- encourage and reinforce the role of schools as social institutions
- be capable of serving all youth yet be adaptable to the needs of special populations of youth
- have the capacity to monitor changing patterns of risks, risky behaviours, and health-promoting behaviours
- have the capacity to monitor the effectiveness of programs and services
- be cost-effective

Elements of a youth positive policy framework, explored in this report, include:

1) **Targets**: targets for youth policy should encompass all youth "upstream" and high risk youth "downstream"

2) **Developmental Tasks**: youth policy must incorporate understanding of the important transitional goals of adolescence

3) **Developmental Strategies**: youth policy can benefit from knowledge about developmental phases and individual coping styles

4) **Resilience**: youth policy must build upon protective factors

5) **Schools**: youth policy should promote the capacity of schools as influential social institutions

6) **Youth Friendly Services**: youth policy must promote non-judgemental approaches that are acceptable to the targeted population

7) **Risks**: design of programs and services for youth must acknowledge the interplay of risk, environment, and individual behaviour

8) **Population Health**: policy must take into account the broader determinants of youth health

9) **Youth Participation**: policy should encourage meaningful youth involvement in the solution to issues

Terminology

The following describes terminology commonly used in adolescent health research:

Adolescence is that period of the life cycle that begins with puberty and concludes with the achievement of adult status. It is not a specific age group, because development initiates and progresses at differing times and rates in each individual.

Youth is a social concept which incorporates the adolescent phase of development but extends into both the middle childhood and young adult years. It is variably defined as ending at 19, 24, 29, and even 35 years of age.

At risk denotes vulnerability for negative outcomes based on external determinants such as economic status, ethnicity, or region of residence. Some populations of adolescents are at risk because of personal factors such as chronic health conditions or disabilities, lifestyle choices, or level of maturity.

Risky behaviours are engaged in as part of normal adolescent experimentation and development. They may or may not result in negative outcomes and are not necessarily perceived by youth as deliberate acts.

Risk taking behaviours are activities in which youth engage in deliberate acts that have a high risk of negative outcomes. These behaviours may or may not be socially sanctioned (e.g., involvement in risky sports may be socially acceptable, while street racing is not).

Problem behaviours is a concept originated by Jessor that identifies the clustering of behaviour outcomes (1). Some adolescents engage in a multiplicity of risk behaviours, and this mix is sometimes referred to as problem behaviour.

Negative outcomes are the results of a particular attribute or behaviour(s) that result in an undesirable physical, emotional, or social impact on present or future development.

Positive outcomes are the results of a particular attribute or behaviour(s) that result in personal growth and enhancement of physical, emotional, or social well-being.

1 Jessor R, Jessor S. Problem behavior and psychosocial development: A longitudinal study of youth. New York: Academic Press; 1977.

Shifting Focus: Youth Friendly Research. Policy. and Practice

A review of the academic research literature related to adolescence and youth health reveals an evolving emphasis from a focus on problem behaviours towards a better understanding of healthy development and the broader factors which impact on health. This evolution is also reflected in a shift in youth health policy and practice away from narrowly defined, categorical programs to emphasis on resilience and positive development.

Systematic studies of adolescent behaviours date back to the work of psychologist G Stanley Hall in 1904 and of anthropologists such as Malinowski and Mead in the 1920's. Violato provides a brief historical perspective of the evolution of adolescence since the early Greeks (1). The research literature specifically related to adolescent health issues is relatively recent but often very clinical in nature (2).

Limitations of a Problem-based Focus

Over the past several decades, much of adolescent health research has focused on documenting the prevalence and analyzing the correlates of specific risky behaviours. Similarly, most youth health education efforts have targeted problem prevention, protection against negative outcomes, or early intervention; examples include anti-smoking efforts, promotion of bike helmet use and emergency contraception for young sexually active early adolescents. These categorical or targeted programs often have proven costly, and not all have been shown to be effective.

Dryfoos, reviewing the research literature on evaluation of categorical health programs, documents their uneven performance, noting that "a few were even proved to have exacerbated the behaviours of high-risk youth" (3). Examples include:

- substance abuse prevention programs such as DARE (Drug Abuse Resistance Education) did not modify use of substances
- teen pregnancy prevention programs focused on sexual abstinence had no impact on pregnancy rates
- programs to prevent violent behaviour and promote non-violent conflict resolution were not effective (in some cases, the interventions were found to promote more aggressive behaviour)
- programs which exposed juvenile delinquents to hardened criminals resulted in an increase in negative behaviours

Dryfoos notes that programs that target only one category of behaviour "usually focus on problems, rather than individuals as a whole" and "do not always address the most pressing needs of their clients".

Categorical programs have few positive cross-over effects on other risky behaviours and may, in fact, give rise to introduction of other risks. Teen pregnancy interventions do not necessarily address risks of sexually transmitted infections. Programs to counter tobacco use by adolescents may inad-

vertently play a role in increased rates of obesity or experimentation with disordered eating. Programs directed at countering alcohol misuse may be a factor in relaxed attitudes towards marijuana and its increased use by early adolescents. Bike helmet legislation may increase use of protective equipment by serious cyclists; however, it may have the net result of discouraging healthy physical activity such as cycling among those youth who refuse to wear helmets. Thus, categorical programs, while they may be useful in achieving specific prevention or educational objectives, must be assessed in light of their overall impact on healthy development.

Focus on Positive Youth Development

Adolescent health professionals, mindful of the lack of strong evidence in support of categorical or problem-based programs, have begun to seek new approaches and to call for strategies based on solid evidence of effectiveness. They advocate for programs grounded in established principles of adolescent development and for policies that emphasize protection rather than punishment (4-8). These approaches promote healthy development and build capacity within a context which values youth and discourages blaming. In this type of approach, adolescent problems are de-emphasized in the belief that the frequency of their occurrence will diminish as a natural by-product of shifting the focus from adolescents as problems to adolescents as assets.

Generally, young people are not regarded positively in North American society. A recent public opinion poll conducted in the US showed that 71% of adults surveyed agreed that they viewed adolescents negatively (9). Some youth advocates have called for a new vocabulary for discussing young people. At a recent Society for Adolescent Medicine conference, delegates were encouraged to "get off the carousel of blame" and focus more on the assets inherent in youth. WT Grant Foundation's President Karen Hein reflects this when she writes "The Foundation wants to use its resources to persuade adults to view young people in a more positive light, as a way to help young people to reach their full potential."

International bodies such as UNICEF and the Pan American Health Organization (PAHO) have acknowledged the importance of a more developmentally based, resiliency promoting, and positive approach to youth health. Several authoritative international reports have been published recently. These reports stress the importance of building life skills and suggest frameworks for national action plans (10, 11). This emerging emphasis is derived from the pioneering work of Rutter (London) and the subsequent findings from research centres in Melbourne, Minneapolis, Gothenberg, and Boston. This collection of work demonstrates that focusing on adolescent development and promoting youth engagement is less costly and more beneficial than problem-based or categorical programs. The Ministry of Youth Affairs in New Zealand has taken a formal step towards child and youth development with the January 2002 release of its "Youth Development: Strategy Aotearoa" (available on-line at www.youthaffairs.govt.nz).

In Canada, a new federal/provincial/territorial document echoes this philosophy, and Health Canada's latest reorganization includes creation of a section that embraces the middle childhood and adolescent years (5). Health Canada funds a program of Centres of Excellence in Children's Well-being; one of the centres focuses on youth engagement, while program elements in three others include a youth dimension.

Schools have been shown to have great potential as enablers of positive youth development. Rutter et al. found that academic performance and positive behaviours were strongly associated with

school environments that focus on the school as a social institution and not only as a place to teach basic academic skills (12). Similarly, Patton et al. in Melbourne identified the powerful impact on school performance and risk behaviours of incorporating simple, positive messages into the schools' English classes (13). Dryfoos provides a cogent argument on behalf of schools as promoters of "safe passage" through adolescence, especially for high risk adolescents (3).

Parents, families and communities provide the sense of connectedness that reduces risk and enhances resilience. For example, Jessor and Jessor have demonstrated that strong family ties and high academic expectations are associated with lower rates of problem behaviours (14). Spivak reported a marked reduction in vandalism and violence in Boston when a community-wide youth positive developmental program was introduced (15). Stoneman, reporting on her work with high risk youth in east Harlem, identified the key strategy as being "approaching these youth in opposite manner to what they had experienced or expected ... and teaching them simple skills" (15).

This report advocates a philosophy that reflects the need for balance in our approach to adolescence. Acceptance of this philosophy requires us to shun moralizing or passing quick judgements about youth. It requires understanding that healthy development involves taking risks, sometimes making mistakes, and being given the chance to learn from experiences. The Search Institute builds on this type of philosophy and advocates an assets based approach to youth issues (16). The Institute approach has been used by the Boys and Girls Club in Summerland, BC and combines a simple research tool with an individual and community-based approach.

A new approach may require adjusting our language to reflect a shift in attitude. Lerner identifies the "6 C's" of positive youth development as being: competence, confidence, connection, character, caring/compassion, and contribution (17). These attributes do not require any reference to negative outcomes such as teen pregnancy, smoking and drug use, juvenile crime or violence. Indeed, evaluative research indicates that the prevalence of undesirable and risky behaviours can be markedly lowered in communities whose youth are supported to achieve the "6 C's."

1 Violato C. History of adolescence. In Friedman SB, Fisher M, Schonberg SK, editors. Comprehensive adolescent health care. St. Louis: Quality Medical Publishing; 1992. p. 3-6.

2 Rutter M. Changing youth in a changing society: Patterns of adolescent development and disorder. London: The Nuffield Provincial Hospitals Trust; 1979.

3 Dryfoos, JG. Safe passage: Making it through adolescence in a risky society. New York: Oxford University Press; 1998.

4 World Health Organization. Young peoples' health-A challenge for society. WHO Technical Report Series No. 731; 1986.

5 The opportunity of adolescence: The health sector contribution. Federal Provincial Territorial Advisory Committee on Population Health. Ottawa: Health Canada; 2000.

6 Plan of action for health and development of adolescents and youth in the Americas 1998-2001. Washington (DC): Pan American Health Organization; 1998.

7 Burt MR. Why should we invest in adolescents? Washington (DC): Pan American Health Organization; 1998.

8 Celebrating success: A self-regulating service delivery system for children and youth. A discussion paper for the Federal Provincial Territorial Group on mental health and well-being of children and youth; 2000.

9 Public Agenda. Kids these days '99: What Americans really think about the next generation. New York: Public Agenda; 1999.

10 UNICEF. Youth health - for a change: A UNICEF notebook on programming for young people's health and development. New York: UNICEF; 1997.

11 Mangrulkar L, Whitman CV, Posner M. Life skill approach to child and healthy human development. Washington (DC): Pan American Health Organization; 2001.

12 Rutter M, Maughan B, Mortimore P, Ouston J. Fifteen thousand hours: Secondary schools and their effects on children. Cambridge (MA): Harvard University Press; 1979.

13 Patton GC, Glover S, Bond L, Butler H, Godfrey C, Di Pietro G, Bowes G. The Gatehouse Project: A systematic approach to mental health promotion in secondary schools. Aust N Z J Psychiatry 2000;34(4):586-593.

14 Jessor R, Jessor S. Problem behavior and psychosocial development: A longitudinal study of youth. New York: Academic Press; 1977.

15 Spivak H, moderator; Hammond Rev. RA II, Stoneman D, Lerner R, Mogul J, panelists. Building healthy communities for adolescents. Panel presentation at The Society for Adolescent Medicine Annual Meeting; 2002 Mar 6-10; Boston, Massachusetts.

16 Samples P, editor. Healthy communities-healthy youth tool kit. Minneapolis: Search Institute; 1998.

17 Lerner RM. Adolescence: Development, diversity, context, and application. Upper Saddle River (NJ): Prentice-Hall; 2002.

Elements of a Youth Positive Framework

The following sections of this report discuss the underlying philosophy, contributing concepts, evidence for, and implications of these key elements for consideration in a youth positive policy framework:

- Targets
- Developmental Tasks
- Developmental Strategies
- Resilience
- Schools
- Youth Friendly Services
- Risks
- Population Health
- Youth Participation

Table 1

Selected school populations.

	% of Total
Aboriginal	6%
Always speaks non-English at home	6%
Does not currently live with adult relative	2%
Not 100% heterosexual	8%
Chronic illness or disability	13%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

Targets

Philosophy

Policies, to be effective, must address the needs of the majority of adolescents as well as those with a specific problem. Universal programs that address the needs of most youth are most effective when applied "upstream," or before problem behaviours have appeared or become entrenched. Some youth require policies and programs that are more targeted "downstream" to entrenched or multiple risk situations. Programs must have the capacity to discriminate between the developmental needs of differing groups of youth. This capacity requires a population based framework that is both inclusive and specific.

Concepts

While BC's adolescent population includes many sub-groups (e.g., see Table 1), all young people face the same developmental challenges. Not all respond to these challenges in the same way, and some are overwhelmed by the tasks before them. However, for most young people, progress towards healthy development is possible and likely despite challenges. For example, of the many thousands of young people who experience emotional health difficulties, most do not attempt suicide, and of those who do, only a minority die (1).

Some sub-populations of adolescents—for example Aboriginal youth, gay youth, and street youth— have special sets of needs. These youth constitute a significant part of the total adolescent population but often are considered vulnerable or marginalized. As such, they are frequently placed outside the scope of traditional policies and programs. Others—such as rural youth, immigrant youth, or youth with chronic health conditions—may have inadequate access to adolescent-oriented services due to barriers of geography, language, or mobility. Understanding that these sub-populations belong within our provincial "map" is an important consideration for policy development and can counteract the tendency to adopt fragmented approaches.

Evidence

The AHS collects data largely from mainstream (or upstream) adolescents, while a number of MCS reports provide evidence on sub-populations of concern (downstream) such as street youth. Within the mainstream population, students can be grouped according to the extent to which they engage in risky behaviours. This analysis identifies the behavioural characteristics of "no or low risk" and of "multiple risk" students.

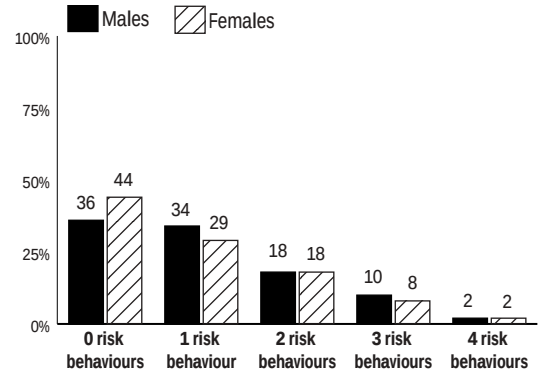
By looking at a selection of risk behaviours (experimenting with hard drugs, skipping school, involvement in physical fights, and seriously considering suicide), the AHS provides evidence that between 10-12% of students engage in multiple risk behaviour (see Figure 1). In other words, most adolescents in BC are either not experimenting in risky behaviours or are limiting their behaviour to one or two chosen activities (see Figure 2).

Implications

The evidence suggests that a minority of youth would benefit greatly from early recognition/intervention programs. The larger group's needs can be met by less costly universal programs delivered through family, school, peer, and community based interventions. It is important to understand the profile of the entire adolescent population, not just the minority of "headline grabbers" described in negative media reports.

Figure 1

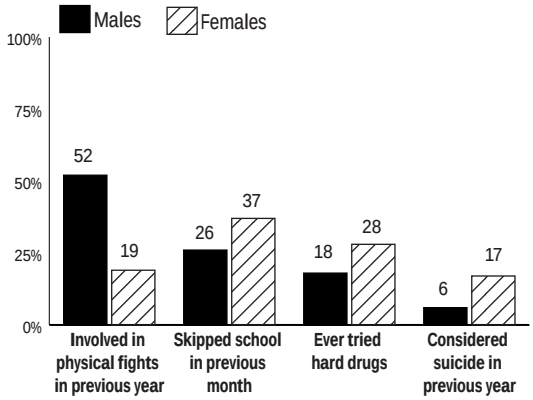
Gender comparisons among school youth for engagement in multiple risk behaviour.



Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

Figure 2

Distribution of behaviours for youth who engaged in only one risk behaviour.



Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

Communities and policy-makers also need to develop the capacity to monitor changes in adolescent behaviour and "early warning" systems for identifying new trends in risky behaviours. Such a capacity is especially important for the small percentage of youth who engage in multiple high risk behaviours. Strategies should include mechanisms to involve parents, peers, and schools in dealing with emerging issues.

Resources to address specific issues must be allocated in an appropriate manner, such that we "do not scratch where there is no itch." Responses should be based on evidence of the nature, extent, and potential impact of the problem. For example, evidence shows that street youth in smaller communities are more likely to remain connected to family, school, and caring community agencies, whereas those who migrate to major urban streets are disconnected (except to their street family) and more severely entrenched in extreme behaviours and high risk situations (2). Such information can be used in ways that allow for interventions in the upstream rather than in the more costly and more challenging downstream end.

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1 The McCreary Centre Society. Violence in adolescence: Injury, suicide, and criminal violence in the lives of BC youth. Burnaby: The McCreary Centre Society; 2002.

2. The McCreary Centre Society. No place to call home: a profile of street youth in British Columbia. Burnaby: The McCreary Centre Society; 2001.

Developmental Tasks

Philosophy

Adolescence is a time of transitions, first from middle childhood to adolescence and then from adolescence to young adulthood. The effectiveness of adolescents' passage through these transitions is measured by the extent to which they have achieved developmental milestones, including physical maturation, progress towards education or employment goals, and establishment of significant relationships. Achievement of these milestones follows a variable course at a variable rate and in individual cases can even be either delayed or precociously advanced.

Concepts

Several interconnected conceptual frameworks which refer to the developmental tasks of adolescence are available to inform policy, program and practice. While these tasks may vary somewhat, they are more similar than different and can be regarded as universal challenges for adolescents throughout the world, regardless of era or cultural background (see Table 2). For health and social service professionals, these developmental tasks inform our interactions with adolescents, provide guidelines for focus of problem intervention, and are a useful basis for assessment tools (1, 2).

Evidence

With only a few exceptions, the AHS reveals that health and risk behaviours affecting adolescent development were very stable in BC during the 1990's. However, the AHS does show that gender, ethnicity, and region of residence—among other factors—demonstrate consistent patterns of influence on adolescents' achievement of their developmental tasks. Age of puberty may also be an important factor as the AHS reveals that whether youth think they look older, younger, or the same age as their peers is associated with emotional health, decisions on risky behaviours, and risk of abuse (see Table 3).

As adolescents become older and progress through school, their perception of themselves as students, their future academic goals, and their school attendance changes in ways that reflect their developmental maturity. Similarly, the age at which adolescents experiment with risky behaviours (while influenced by peers and society) show age/stage appropriateness (see Table 4). Each of these pieces of evidence reinforces the central importance of understanding the concept of developmental tasks.

Table 2

Developmental tasks (milestones) of adolescence.

1. Accepting one's physique & using it effectively.
2. Developing appropriate sex roles & achieving adult sexuality.
3. Achieving emotional & economic independence, especially from the family.
4. Developing appropriate peer relationships.
5. Preparing for an adult lifestyle and vocation.

Source: College of Family Physicians of Canada. Task Force on Adolescent Health. From an acorn to an oak tree: It's not easy being young. Mississauga: CFPC; 1993.

Table 3

Relationship between health and how girls in school look compared to their same-aged peers.

	Look older than peers	Look same age as peers
Emotionally distressed in previous month	13%	7%
Smokes regularly	19%	8%
Ever tried alcohol	73%	57%
Ever tried marijuana	49%	35%
Ever had sex	32%	19%
Ever been sexually abused	21%	11%
Injured in fight in previous year	3%	1%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

Table 4

Age comparisons in health and risk behaviour among youth in school.

	13 years old	15 years old	17 years old
Thinks of self as above average student	42%	36%	34%
Has plans for post-secondary education	74%	74%	77%
Skipped school 3+ times in previous month	5%	11%	18%
Attempted suicide in previous year	6%	7%	5%
Smokes regularly	3%	12%	17%
Ever tried marijuana	20%	48%	58%
Ever had sex	9%	23%	42%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

Implications

Developmental tasks of adolescence include learning to become responsible consumers of helping services. Young people, as they seek support for physical or emotional health concerns, are learning to become independent of family in this regard. However, adolescents may not be transparent in their search for support. Where sensitive or confidential matters prompt help seeking behaviour, adolescents may present themselves at clinics or community service agencies by selecting a "safe" reason for their visit. Programs and services for youth should be aware of their role within the developmental context.

It is especially important for professionals who work with youth to recognize that the presenting issue may not be the individual's real reason for seeking help. Establishing rapport is an essential first step in addressing an adolescent's concerns but should always be followed by a comprehensive assessment of the individual's developmental status.

Instruments such as the HEADSS exam (see Table 5) enable professionals to make a simple, quick assessment of each adolescent's strengths and weaknesses. By identifying the individual's placement on a developmental trajectory, the helping professional can better develop a strategy for helping the adolescent to move forward.

1 MacKenzie RG. Considerations in developing a system of health care for adolescents. Baillieres Clinical Pediatrics 1994;2:215-226.

2 Tonkin R. The future needs of Canada's youth. 11th Ross Conference-Child and Youth Health Care in the 21st Century; 1997; Ottawa, Canada.

Table 5

HEADSS exam – the psychosocial adolescent history.

H = Home
Who lives there, how do they relate, what are the conflicts, recent losses or stresses

E = Education
What grade, enjoyment, accomplishment, attendance, plans for future

A = Activities
Peer relations, best friends and dating experiences, in/out of school involvement, job, vocational plans, interests, hobbies, skills

D = Drugs
Legal and non-legal, parental awareness, type-frequency-setting of use, age of onset, relation to emotional state

S = Sex
Orientation, age of onset, safe sex practices, negative experiences, number of partners

S = Suicide
Mood, poor school performance, withdrawal from friends & family, prior attempts, thoughts about suicide, close contact with suicide or death

Source: MacKenzie RG. Considerations in developing a system of health care for adolescents. Bailliere's Clinical Pediatrics 1994;2:215-226.

Developmental Strategies

Philosophy

To be effective in working with adolescents, programs and professionals must avoid stereotyping and recognize that the adolescent population is a heterogeneous mix.

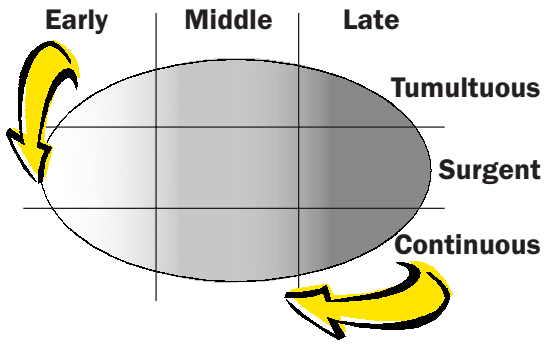
Concept

A second useful framework is that illustrated in Figure 3. In Offer's framework (1), adolescent development consists of 3 phases each with specific developmental challenges or tasks. Adolescents respond to these challenges with one of three coping styles. Based on these features, adolescents can be grouped according to the combination of developmental phase and coping style into 9 subsets within a matrix which embraces all youth. These sub-populations vary in their behaviours and in their service needs. The outcomes of these various behaviours and needs are influenced by the appropriateness of the strategies and interventions provided.

For example, an adolescent of a category described within this matrix as "early maturing and tumultuous" may be seen as conflicted, acting out, rebellious, elusive, and defiant. By contrast, a type of mid-to late adolescent described in the matrix as "continuous" may be perceived as steady going; emotionally stable; high achieving; and strongly connected to family, school, and community. The former type of youth will likely be frequent users of alternative health services, youth workers, police, and possibly the courts; the latter will, when indicated, be users of family physicians, coaches, and guidance counsellors. The former will rely more on help from peers whereas the latter will also consult parents, teachers, and other health professionals.

Figure 3

Coping with developmental challenges.



Source: Offer D, Offer J. Three developmental routes through normal male adolescence. Adolesc Psychiatry 1975; 4: 121-141.

These subsets may also be subject to the influence of local trends or to unanticipated crises. For example, the "early maturing tumultuous" youth may be at risk for addiction or sexual exploitation in the presence of a drug or sex trade. The adolescent with a "continuous" coping style may not fall victim to drugs or sexual exploitation but may feel overwhelmed by stresses at home or school and compensate by becoming eating disordered. In such instances, continuity of relationships and connectedness to family and school are not only protective but also foster resilience in the face of adversity.

Evidence

Adolescents vary in the extent to which they seek help. Those who need help may not know where to go for it, may delay seeking help, or may be non-compliant or elusive in response to the help offered. The front line in adolescent help-seeking behaviour continues to be the family or peers; only a minority of adolescents turn to professionals (see Table 6). This front line role for peers and families may be seen by youth as being more accessible and more acceptable than professional

Table 6

Age comparisons among youth in school for preferred sources of help with problems.

	14 years and under	15-16 years old	17 years old and older
Depression			
Parent	40%	25%	21%
Other family member	5%	5%	4%
Friend of same age	32%	44%	49%
Adult friend	1%	2%	3%
Health professional	0%	1%	1%
Teacher/School staff	1%	1%	1%
Religious leader	0%	1%	#
No one	13%	17%	16%
Not sure	6%	5%	4%
Abuse			
Parent	43%	33%	27%
Other family member	4%	5%	4%
Friend of same age	12%	20%	23%
Adult friend	5%	6%	6%
Health professional	5%	7%	8%
Teacher/School staff	4%	4%	3%
Religious leader	1%	1%	1%
No one	9%	9%	10%
Not sure	17%	16%	18%
STDs			
Parent	39%	27%	20%
Other family member	3%	3%	3%
Friend of same age	8%	11%	11%
Adult friend	2%	3%	2%
Health professional	22%	35%	45%
Teacher/School staff	1%	1%	1%
Religious leader	#	0%	#
No one	7%	6%	7%
Not sure	18%	14%	12%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

# denotes insufficient data.

Table 7

Services identified by street youth as "very much needed" in their community.

Job training	29%
School program for street youth	22%
Dental services	21%
Youth clinic	21%
Youth detox	18%
Street nurses	17%
Alcohol and drug counselling	15%
Mental health services	15%

Source: The McCreary Centre Society. No place to call home: A profile of street youth in British Columbia. Burnaby: The McCreary Centre Society; 2001.

help. However, there is also evidence that adolescents frequently desire more help from professionals than they actually receive (e.g., see Table 7). Specific services such as crisis lines, emergency departments, pharmacies, and Internet-based information resources are either underutilized or inappropriately used by adolescents with problems.

Implications

When a youth presents with a problem, irrespective of its nature, the professional assessment and prescription for response need to recognize the developmental stage, coping style, and family/social context of the individual client. Adolescents will benefit most from service programs that offer an opportunity to connect with a professional who can establish rapport and who has specialized experience and skill in working with adolescents.

1 Offer D, Ostrov E, Howard KI, Atkinson R. The teenage world: Adolescents' self-image in ten countries. New York: Plenum Press; 1988.

Resilience

Philosophy

A sense of connection to family, to non-family adults, to school and community, promotes positive development and enables individuals to successfully deal with problems or crises. Resilience does not imply the avoidance of difficulties but rather an ability to face challenges and emerge with a stronger sense of self-confidence and coping capacity.

Concept

Adolescent development and connectedness are best served by programs that promote stability at home, in school, and in the community. This concept embraces the need for continuity of relationships and a sense of safety within those relationships. While these attributes are often lacking in health and human services programs, policies that do promote resilience are protective for development, for recovery from negative life experiences, and for effective transitioning.

Evidence

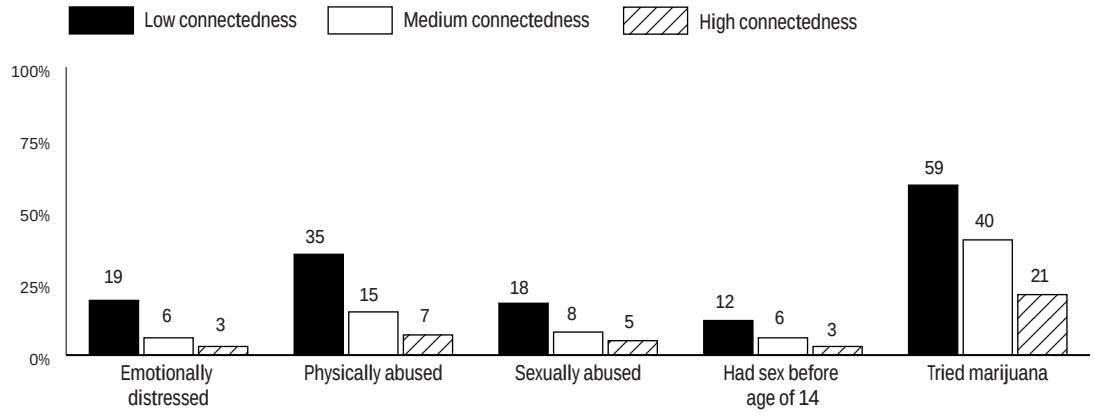
Steinhauer provides an analysis of the application of resiliency theory to clinical services and makes the case for its cost benefits (1). The AHS measured resilience from the perspective of a student's connectedness to family or school. In general, students who were strongly connected to family and/or school showed more positive health status and fewer risky behaviours (see Figure 4 and Figure 5). Family connectedness was demonstrated to be protective against emotional distress among students who had been abused (see Figure 6); school connectedness was protective against suicidality for those who had been bullied. Adolescents in high risk situations were more likely to report low levels of connectedness (see Table 8).

Implications

Policies and services which promote connectedness and continuity of youth/non-youth relationships are strategically sound and cost-effective. However, merely saying to parents, peers, schools, and community organizations that "what you do is important" is not enough. These

Figure 4

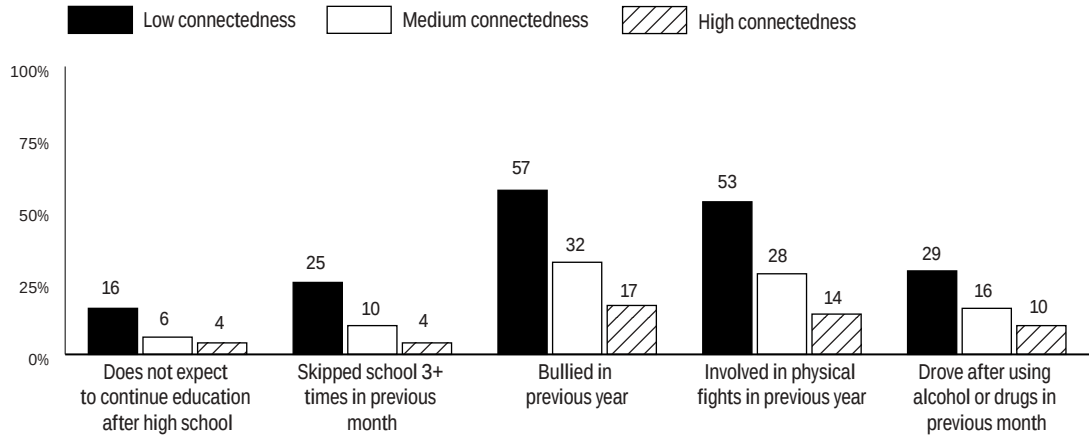
Family connectedness and risk among school youth.



Source: The McCreary Centre Society. Healthy connections: Connectedness and BC youth. Burnaby: The McCreary Centre Society; 2000.

Figure 5

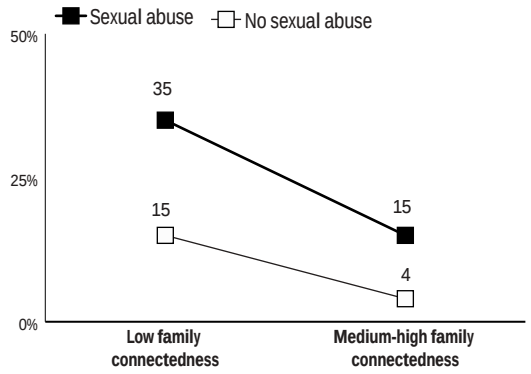
School connectedness and risk among school youth.



Source: The McCreary Centre Society. Healthy connections: Connectedness and BC youth. Burnaby: The McCreary Centre Society; 2000.

Figure 6

Percentage of school youth with emotional distress.



Source: The McCreary Centre Society. Healthy connections: Connectedness and BC youth. Burnaby: The McCreary Centre Society; 2000.

Table 8

Connectedness levels for school, custody, and street youth.

	School	Custody	Street
Family connectedness			
Low	15%	25%	96%
Medium	72%	69%	4%
High	13%	6%	0%
School connectedness			
Low	13%	37%	60%
Medium	74%	57%	40%
High	13%	7%	0%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in school (1998), on the street (2000), and in custody (2000).

potential supports for youth must also receive adequate information, resources, and recognition to enable them to proceed. Such an approach can be low-cost and low-tech and can be particularly appropriate in times of fiscal restraint or community instability.

1 Steinhauer PD. Clinical and service applications of the theory of resiliency with particular reference to adolescents. Int J Adolesc Med Health 2001;13 (1):53-73.

Schools

Philosophy

Schools are extremely important in the lives of adolescents. They play many roles, even for adolescents who are not currently in school. Schools are not just about teaching a curriculum, nor are they simply convenient vehicles for delivering health-promoting education or services. Schools are primarily significant as socializing institutions in which adolescents explore and struggle with each of their developmental tasks.

Concept

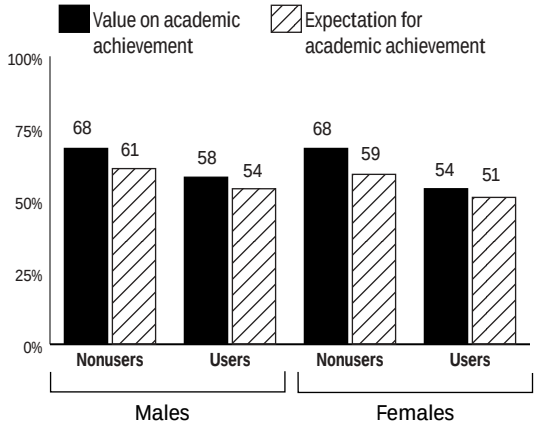
Schools are vital social influences in the lives of young people. As advocated by Rutter, Dryfoos, and demonstrated by Patton et al. what schools do—or don't do— makes an important difference in youth development. To be effective, schools need to focus on empowering and respecting students. Engaging students in school and in after-school activities, and engaging their parents/families in the school as community, has a powerful impact on increasing self-esteem, decreasing negative behaviours, and promoting positive development and responsible citizenship.

Evidence

The AHS examines the impact of schools on adolescent development through correlates of school performance and risky behaviour and through the analysis of school connectedness (see Table 9). The AHS findings parallel those of Jessor (1) and of Rutter (2) that demonstrate the connections between good academic behaviour and low risky or problem behaviour (e.g., see Fig-

Figure 7

Mean scores on academic achievement variables for nonusers and users of marijuana.



Source: Jessor R, Jessor S. Problem behavior and psychosocial development: A longitudinal study of youth. New York: Academic Press; 1977.

Table 9

Risk behaviour and school environment.

	Binge-drank in previous month	Injured in fight in previous year	Attempted suicide in previous year	Smokes regularly
Feel that teachers care about me				
A little	38%	7%	11%	16%
Some	27%	3%	5%	10%
Quite a lot	16%	2%	4%	5%
Feel like I am a part of my school				
Disagree	42%	9%	14%	21%
Agree	23%	3%	4%	7%

Source: Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in grades 7-12. 1998.

ure 7). Rutter's analysis includes identification of which aspects of schools made a positive difference on student outcome (see Table 10).

Implications

Communities and school boards can reinforce the importance of the local school as a social institution. Such an approach involves recognition of characteristics which make a difference to the school environment and to the students individually and collectively. This approach may translate into less emphasis on regulations and testing procedures and more opportunities for schools and school districts to individualize their programs. It does not mean that a school is expected to become a "full service" facility for youth, but rather that the school becomes part of a "full service community." One example of the successful integration of school and social services is the Britannia Centre in Vancouver which provides multiple recreational, social, health, and educational services in one accessible location.

1 Jessor R, Jessor S. Problem behavior and psychosocial development: A longitudinal study of youth. New York: Academic Press; 1977.

2 Rutter M, Maughan B, Mortimore P, Ouston J. Fifteen thousand hours: Secondary schools and their effects on children. Cambridge (MA): Harvard University Press; 1979.

Table 10

School process variables associated with outcome.

Degree of academic emphasis
Teachers creating a cooperative, productive classroom atmosphere
Availability of incentives and rewards
Good conditions for students (feel comfortable approaching staff for help, etc.)
Extent to which students were able to take responsibility

Source: Rutter M, Maughan B, Mortimore P, Ouston J. Fifteen thousand hours: Secondary schools and their effects on children. Cambridge (MA): Harvard University Press; 1979.

Youth Friendly Services

Philosophy

Adolescent-adult interactions are often conflicted and tentative. This seems especially true in the case of early adolescents with a tumultuous coping style. Many health professionals express discomfort or lack of confidence in working with adolescents. In addition, adolescents are usually inexperienced consumers of health services and unaware of their rights to consent, confidentiality, and privacy under The United Nations Convention on the Rights of the Child (1).

Concept

The World Health Organization has outlined its concept of what constitutes youth friendly health services and in the process embraces important elements of the UN Convention (2). Essential components of such services are active listening, respect for confidentiality, provision for informed consent, and assuring accessibility to developmentally appropriate, competent care.

Evidence

Several projects conducted by The McCreary Centre Society address the issue of youth-friendliness in health and social services. Of particular relevance is the Doctor Project, in which youth who were part of BC's Youth in Care Network were surveyed about their issues in accessing confidential medical care (see Table 11). As well, surveys of youth in custody and street youth inquired about the helpfulness of programs and services (see Table 12 and Table 13). The National Training Initiative in Adolescent Health (NTIAH), a skills-development program for professionals who work with youth, includes a training module on Youth Friendly Care (3). In this module, Brandon describes what "youth friendly" meant to youth themselves as determined by focus groups carried out by YouthNet (see Table 14). More information is available at www.ntiah.org

Implications

The majority of adolescents are healthy individuals at low risk of significant developmental problems. However, this does not preclude their occasional need to use ambulatory services such

Table 11

The views of youth in care about their medical care.

	Regular doctor	Walk-in clinic	Hospital	Other
Felt their doctor listened to them and responded to their health concerns on their last visit to the doctor	98%	91%	56%	93%
Felt their doctor gave them an explanation of the health problem and how it is treated on last visit to the doctor	88%	77%	67%	79%
Were very satisfied with how the doctor examined them and with the treatment they received on their last visit to the doctor	52%	27%	21%	47%
Felt their regular doctor kept their conversations confidential	62%	NA	NA	NA
Felt their regular doctor allowed them to decide and give consent for medical treatments	67%	NA	NA	NA

Source: The McCreary Centre Society. The doctor project. Burnaby: The McCreary Centre Society; 1998.

as an emergency department, a walk-in clinic, a street clinic, a diagnostic service, a pharmacy, or a family planning clinic. Some adolescents will require institutional care in a hospital inpatient unit, a youth custody centre, or a rehabilitation facility. Wherever possible in such cases, the length of time that a youth is out of his or her home and community should be minimized; this may call for trying innovative models and using alternative therapeutic approaches.

Table 12

Custody youth who found programs and services helpful (of those who have used the service).

Health care	51%
Alcohol and drug programs	41%
Mental health services	41%
Chaplain services	53%
School	60%
Life skills programs	54%
Work programs	46%

Source: The McCreary Centre Society. Adolescent Health Survey of BC youth in custody. 2000.

Table 13

Street youth who found programs and services helpful (of those who have used the service in the past year).

Doctor/nurse	65%
Street nurse	54%
Alcohol and drug counsellor	41%
Mental health worker	29%
Social worker	44%
Youth worker	64%
Police	30%
Probation officer	41%
Financial aid worker	36%
Housing worker	37%

Source: The McCreary Centre Society. No place to call home: A profile of street youth in British Columbia. Burnaby: The McCreary Centre Society; 2001.

While most health and social service programs are not exclusively designed to meet the needs of adolescents, programs should be capable of offering youth-friendly care. Individual professionals and organizations which serve youth have a responsibility to be competent and appropriate in their care of young people. In some situations, such as programs for street youth, services should also be delivered in a setting and style that encourages attendance of the targeted population and is respectful of their life experiences.

1 Convention on the rights of the child. New York: United Nations; 1989.

2 Tonkin RS. WHO global consultation on adolescent friendly health services-Technical paper. Geneva: WHO; 2001.

3 Brandon S. Youth friendly care. In National Training Initiative in Adolescent Health, editor. Focus on youth health workshop workbook. Burnaby: NTIAH; 1999. Appendix B p. 9-12.

Table 14

Characteristics of youth friendly care.

- Active listener
- Understanding
- Positive personality traits (i.e. sociable, dynamic, sense of humour, approachable, positive attitude)
- Non-judgemental
- Helpful
- Cool/like youth (closer in age to youth, or at least youthful in their attitude)
- Confidential
- Youth aware
- Competent
- Like a friend
- Not condescending
- Honest/direct

Youth Net Focus Group Results 1997-1999 N=3185, Eastern Ontario, Western Quebec. Cited in Brandon S. Youth friendly care. In: National Training Initiative in Adolescent Health, editor. Focus on youth health workshop workbook. Burnaby: NTIAH; 1999. Appendix B p. 9-12.

Risks

Philosophy

While it is neither possible nor desirable to eliminate all risk in the lives of adolescents, it is necessary to have strategies that prevent negative outcome to certain risks. (Such negative outcomes could include injury resulting from risky behaviours, unintended pregnancy, or physical or emotional abuse.)

Concept

The Haddon's matrix, developed for use in the public health field, reflects the interplay between host, agent, and environment in various life events (1). In the youth health field, this interplay involves: youth as the susceptible host; the risks posed by external agents (such as cigarettes, alcohol, sexually transmitted diseases); and the physical and social context as the environment (such as home, school, peer group, community). In the original Haddon matrix, the life event of a car crash can be divided into pre-crash, crash, and post crash phases. The Haddon's matrix is particularly valuable in looking at issues in adolescent development. For example, youth sexual activity can be understood as incorporating a decision or readiness phase before the beginning of sexual activity, the situation of having sex, and the physical, emotional, and social effects of becoming sexually active (see Table 15). This framework, when applied to any youth health issue, can help identify strategies for health promotion, prevention of negative outcomes and, where required, rehabilitation.

Evidence

The AHS provides some evidence to demonstrate the influence of various risk reduction factors upon health outcomes. For example, the introduction of bicycle helmet laws produced an increase in use of helmets by adolescent cyclists (see Figure 8). Other reports authored by MCS document the improvement in mortality and hospital morbidity related to injury (especially from car crashes) among BC adolescents (see Figure 9 and Figure 10). In a 20 year retrospective, the MCS data reflects on the various elements of the

Table 15

The Haddon Matrix - Sexual Intercourse Adaptation.

	Pre-Event	Event	Post Event
Human Factors	Universal sex education Identify at-risk youth	Alcohol/drug-free sex Safe sex practices	Peer supports Access to information via Internet and public health
Environment	Confidential services: • family planning • physicians • pharmacists	Availability of: • condoms • oral contraceptives	Emergency contraception STD clinics Teen parenting programs
Social	Connectedness to family and schools	After school programs Safe grads	Education and training for teen parents Early childhood education
Legal	Child protection Age of consent	Right to access reproductive health services Drug controls • date rape • ecstasy	Primary care: • confidential • accessible Information consent Child welfare

Haddon matrix that might have played a role in the noted improvements (2).

Implications

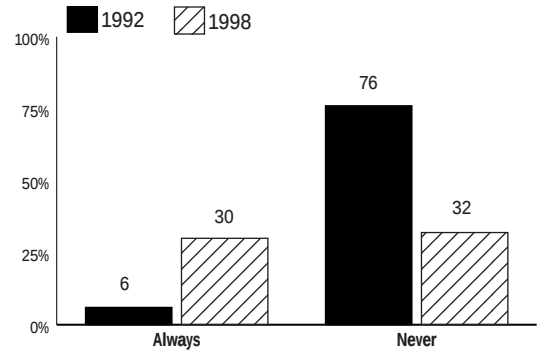
Youth health policies which recognize the interplay of risk, environment, and individual behaviour can reduce negative outcomes related to risk. Frameworks which provide for multiple intervention strategies hold the most promise for effecting change. Policies that emphasize a single approach to a youth health issue are less likely to demonstrate sustained effectiveness. The Haddon matrix can be a useful tool in policy and program planning to achieve a balanced approach and avoid reliance on "magic bullets" or "one size fits all" strategies.

1 Haddon Jr W. Conference on the prevention of motor vehicle crash injury. Israel J Med Studies 1980;16:45-68.

2. The McCreary Centre Society. Violence in adolescence: Injury, suicide, and criminal violence in the lives of BC youth. Burnaby: The McCreary Centre Society; 2002.

Figure 8

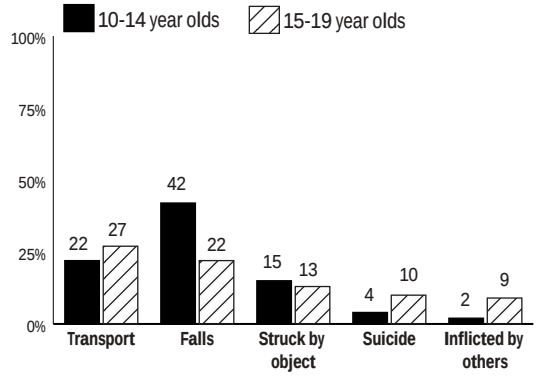
Helmet use among youth in school.



Source: The McCreary Centre Society. Healthy connections: Listening to BC youth. Burnaby: The McCreary Centre Society; 1999.

Figure 9

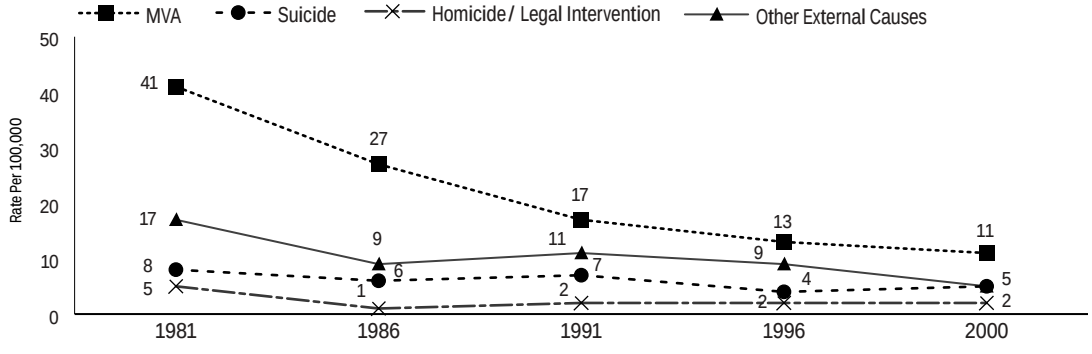
Cause of injury-related hospitalizations in BC in 1999/2000.



Source: Morbidity database, Information Support, BC Ministry of Health Planning and BC Ministry of Health Services, Health Data Warehouse, Release date: March 2001.

Figure 10

Death Rates of Youth in Care Compared to Provincial Population; 15-18 Year Olds 1985/86-1999/00 (Rate per 10,000).



Source: Office of the Provincial Health Officer. Children And Youth In Care: An Epidemiological Review of Mortality, British Columbia, April 1974 to March 2000. Victoria: BC Ministry of Health and Ministry Responsible for Seniors; 2001.

Population Health

Philosophy

The population health approach is grounded in a body of research which shows that the interaction of certain socio-economic and environmental factors has a "determining" influence on the health of populations and of sub-groups within populations. Youth health strategies must take into consideration these broader determinants of health.

Concept

Health Canada has identified twelve key determinants of health—including social and economic status, education, culture, gender, and biology—which impact on an individual's health and development (1). Unfortunately, most health indicators reflect the absence or presence of measurable disease (death, illness, disability, disaffection) in the adult population. Markers or indicators of adolescent health are even less satisfactory and less systematically collected.

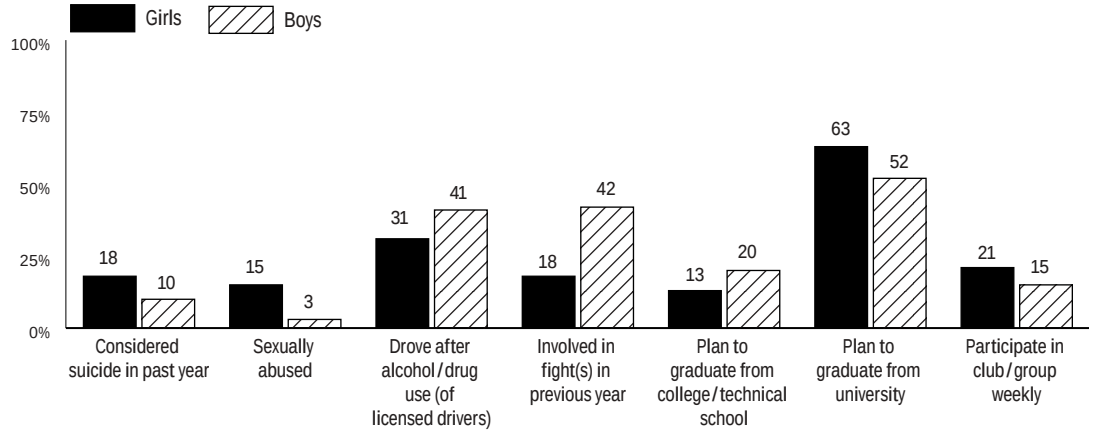
Evidence

The recent MCS report "Violence in Adolescence" employs mortality and hospitalization rates for BC adolescents to identify issues. Rates of violence and injury in this analysis were relatively low. However, reliance on death and hospitalization statistics provides only limited information about the youth population as a whole and indicates a need for current, regionally representative data on a larger population of adolescents.

The AHS provides a much broader measurement of adolescent health status than that available through collection of vital statistics. AHS I and AHS II covered a range of behaviours, health-influencing factors, and correlates (see Figure 11 and Table 16). AHS III will further increase the quantity and depth of data available on a broad range of health-determining factors. Response to dissemination of previous AHS results confirms interest in and usefulness of BC specific, regionally defined data sets on adolescents (2) (see Figure 12). Programs such as the Next Step have

Figure 11

Gender comparisons for youth in school.



Source: The McCreary Centre Society. Girls' report: The health of girls in BC. Burnaby: The McCreary Centre Society; 2001.

Table 16

Key findings for Aboriginal youth in school.

Signs of progress:

- Most Aboriginal students rate their own health as good or excellent.
- Most feel strongly connected to their family and school.
- Nearly two-thirds want to continue their education beyond high school.
- Aboriginal students are waiting longer to have sex.
- Rates of violence have remained stable.
- Sexual abuse of Aboriginal females appears to be decreasing.

Room for improvement:

- Aboriginal students continue to experience sexual and physical abuse.
- About a quarter are regular cigarette smokers.
- Many Aboriginal students drink and drive.
- Many think about or attempt suicide.
- More Aboriginal students are using marijuana.
- Aboriginal students are more likely to experience racial discrimination.
- Aboriginal girls experience more violence than non-Aboriginal girls.

Source: The McCreary Centre Society. Raven's Children: Aboriginal youth health in BC. Burnaby: The McCreary Centre Society; 2000.

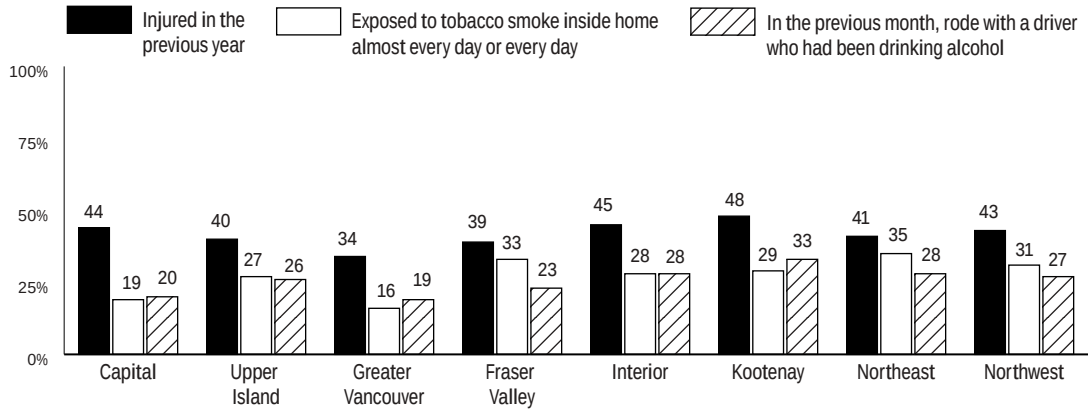
demonstrated the utility of this data, enabling youth and their communities to reflect on the AHS findings, determine their priorities, and define action plans (see Table 17 on page 28). Various national data sets on youth health are available for comparison (3).

Implications

The ability of a system to develop and implement effective youth health policy and services requires an ongoing process to monitor, evaluate, and adapt. Support is needed to sustain the research capacity to identify useful indicators, to ensure accurate and timely data collection, and to match evidence with program priorities. This requires a commitment to the development of a specific provincial research capacity related to youth health, based on the principles of population health. The AHS offers a unique mix of community/adolescent/academic/governmental collaboration and has a proven track record as a useful instrument in population health research.

Figure 12

Regional comparisons for youth in school.



Source: The McCreary Centre Society. Listening to BC Youth: Vancouver/Richmond region. Burnaby: The McCreary Centre Society; 2000.

Table 17

Next Step priorities.
Substance use
Sexual health
Mental and emotional health - depression, suicide, stress
Drinking and driving
Abuse and exploitation
Discrimination, racism, homophobia

Source: The McCreary Centre Society. Our communities-Our health: Young people discuss solutions to their health issues. The next step report. Burnaby: The McCreary Centre Society; 2001.

1 Jamieson K, Simces Z. Creative spice: Learning from communities about putting the population health approach into action. Vancouver (BC): Social Planning and Research Council of BC; 2001.

2 Tonkin RS, Murphy A. Knowing the constituency. In Hayes MV, Foster LT, editors. Too small to see, too big to ignore: Child health and well-being in British Columbia. Western Geographical Series 39:219-232. Victoria: University of Victoria; 2002.

3 King AJC, Boyce WF, King MA, Trends in the health of Canadian youth. Ottawa: Health Canada; 1999.

Youth Participation

Philosophy

Adolescent development includes learning about self-care, personal responsibility, and citizenship. The life skills and emotional maturity acquired during this learning process build self-esteem and foster independence. This process is facilitated if the learning is active and the adolescent feels empowered and engaged. Policies and programs that promote active youth involvement are more likely to be effective in serving the adolescent's needs and to foster healthy lifestyles.

Adults, including parents and professionals, often see adolescent behaviour as a problem, whereas the adolescent sees his or her behaviour as a solution—an appropriate response to the challenges of development. Youth engagement offers adults the opportunity to work together with youth to discover the opportunities for further growth within each challenge.

Concept

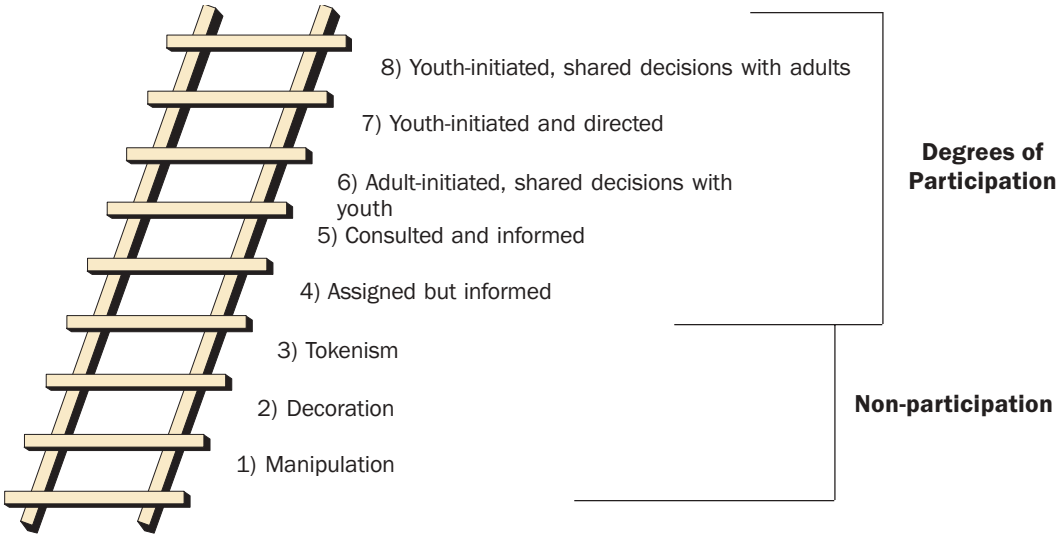
Hart's ladder of participation (see Figure 13) offers an excellent metaphor for youth empowerment (1). Empowering youth engages them in becoming part of the solution to youth issues, rather than being the problem.

Evidence

Rutter has demonstrated that students' involvement in their schools enhances academic performance and promotes positive social and emotional behaviour (2). Other studies show the value of participation in after-school and community activities. The McCreary Centre Society has had considerable experience with youth participation. This has included a range of activities that are youth driven as well as others that involve youth to non-youth interactions (for more details visit www.mcs.bc.ca). For example, The B4 (Breaking Barriers and Building Bridges) Conference organized by the McCreary Youth Advisory Council (YAC) aims to provide youth with the

Figure 13

Ladder of participation.



Source: Hart, RA. Children's participation: From tokenism to citizenship. Florence (Italy): UNICEF International Child Development Centre; 1992.

knowledge, skills, and confidence that will better enable them to participate in their schools and communities. In a follow-up evaluation of the B4, participants felt more empowered when they left the conference and experienced other positive outcomes (3) (see Table 18). The federally-sponsored Centre of Excellence for Youth Engagement is researching the characteristics of successful youth participation and exploring the role of youth in policy formulation. Other examples of youth participation in Canada (YouthNet, Cyberisle, CHN-Youth Affiliate) and links to their program web-sites are available on the MCS web-site.

Implications

Sound youth policy and effective programs for adolescents cannot afford to overlook the perspective of the adolescent consumer. Meaningful, properly mentored, and non-tokenistic participation of youth enhances the likelihood of effectiveness of strategies to promote positive youth development. Participation is especially important for the development of useful programs targeting those special, often elusive, sub-populations that engage in multiple risky behaviours.

Table 18

B4 participants...	
who gained skills through participating in activities, workshops, or interacting with others	74%
who were influenced in seeking other opportunities (e.g., career, volunteer, school)	57%
who took part in new projects or joined councils or groups after the B4	37%

Source: The McCreary Centre Society. Looking into the B4: A report assessing the impact of the 2002 Breaking Barriers and Building Bridges (B4) conference on participants, adult support people, and youth organizers. Burnaby: The McCreary Centre Society; 2002.

MCS has designed and submitted for government consideration a Youth Participation Strategy (YPS), including a proposed web-site, that could serve as a first step towards effective participatory programming for the various youth serving organizations and ministries in BC.

1 Hart RA. Children's participation: From tokenism to citizenship. Florence (Italy): UNICEF International Child Development Centre; 1992.

2 Rutter M, Maughan B, Mortimore P, Ouston J. Fifteen thousand hours: Secondary schools and their effects on children. Cambridge (MA): Harvard University Press; 1979.

3 The McCreary Centre Society. Looking into the B4: A report assessing the impact of the 2002 Breaking Barriers and Building Bridges (B4) conference on participants, adult support people, and youth organizers. Burnaby: The McCreary Centre Society; 2002.

McCreary Centre Society Publications

AHS Reports

Provincial Report for AHS II

Healthy Connections: Listening to BC Youth (1999). Burnaby, British Columbia: The McCreary Centre Society.

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Keeping Fit: Physical Activity Among BC Youth

Marijuana: Use Among BC Youth

Healthy Connections: Connectedness and BC Youth

Mirror Images: Weight Issues Among BC Youth

Silk Road: Health of Chinese Youth in BC

Lighting Up: Tobacco Use Among BC Youth

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For more information about The McCreary Centre Society and plans for the third Adolescent Health Survey to be conducted in BC schools in spring 2003, please contact:

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