Mental Health Promotion & Addictions Prevention
A Health Promotion Strategy

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EXECUTIVE SUMMARY

The purpose of this strategy is to examine the current status of mental health promotion and addictions prevention within the Western Region of Newfoundland and Labrador; identify priority areas, evidence informed programs, and best practices; as well as provide recommendations for action within the Region.

This strategy will include an environmental scan of current statistics and indicators as well as current initiatives and programs that support mental health promotion and addictions prevention. Strengths and gaps will be reviewed, best and evidence informed practices will be explored, and recommendations will be provided for enhancing mental health promotion and addictions prevention.

The Regional Addictions Prevention Consultant (RAPC) and Regional Mental Health Promotion Consultant (RMHPC) provide leadership for the following health promotion strategy. The RAPC and RMHPC provide support and consultation regarding resources, programs, and initiatives on substance use prevention, gambling prevention, mental illness prevention, and mental health promotion.

Promoting positive mental health is important for helping people live happier and more productive lives. It builds resilience, helps people cope with the challenges of everyday life, and helps those with chronic illness cope effectively with their illness. Promoting positive mental health also helps to prevent the onset of mental illness and addiction.

The mental health strategy for Canada, Changing Directions, Changing Lives, focuses on improving mental health for all Canadians (MHCC, 2012). This is the first mental health strategy for Canada. The following health promotion strategy for Western Health aims to support the mental health strategy for Canada, specifically, Strategic Direction 1: Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible (MHCC, 2012).

Prevention is one of the 5 policy directions in Working Together for Mental Health: A Provincial Policy Framework for Mental Health & Addictions Services in Newfoundland and Labrador. The framework emphasizes, in Policy Direction 1, “a responsive mental health and addictions system has to actively lead in prevention and early intervention approaches while supporting communities in the promotion of mental health” (Government of NL, 2005).

The Canadian Centre on Substance Abuse (CCSA) recognizes health promotion as a key factor in the prevention of substance use and abuse, as well as in addressing the social and personal impacts of substance use (CCSA, 2014). The CCSA identifies that prevention can have a significant cost-benefit savings. In fact, analysis has shown that there is a savings of $15 - $18 for every $1 spent on drug abuse prevention programs (CCSA, 2013). The CCSA developed A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (CCSA, 2012). This Approach recommends the development of a continuum of services and supports to
help prevent and respond to substance abuse and addiction. This is conceptualized as a tiered model which incorporates health promotion and prevention initiatives as the foundational level, as well as a component of each subsequent level.

A number of indicators are utilized in the development of a health promotion strategy for mental health and addictions. Mental Health & Addictions priorities in the Western Region are identified through annual Mental Health and Addictions Services referral statistics; data available through community health needs assessments, comprehensive school health assessments, and annual site visits; as well as a review of provincial and national health indicators. In addition, an overview of the professional services and existing programs supporting prevention and promotion will be reviewed.

The available data supports the need for continued prevention and promotion efforts to support the following priority areas:

- Stigma
- Stress
- Depression
- Anxiety
- Alcohol Use
- Youth Substance Use
- Suicide
- Violence

Best and evidence informed practices involve initiatives that target specific groups and settings, address risk and protective factors, set clear goals, support communities to take action, and are sustained over time. Better outcomes are achieved when needs are addressed in everyday settings such as homes, schools and workplaces. This approach also helps to reduce stigma (MHCC, 2012). This strategy will provide an overview of general best practices in mental health promotion and addiction prevention, as well as best practices specific to stages across the lifespan.

Recommendations for enhancing mental health promotion and addictions prevention include:

1. Enhance Collaboration and Coordination Across Sectors
2. Avoid Duplication of Effort
3. Ensure Outcome Measures and Continuity Planning are Integrated Into Promotion and Prevention Initiatives
4. Address Stigma
5. Promote Resiliency and Positive Coping
6. Address Alcohol Use
7. Address Youth Substance Use
8. Support Suicide Prevention
9. Support Violence Prevention
10. Incorporate Trauma Informed Practices
BACKGROUND

There are still some misconceptions about the terms mental health and mental illness (CIHI, 2009). Similarly, many people incorrectly define and misapply the terms substance use, substance abuse, substance dependence, and addiction (CCSA, 2009). Furthermore, substance dependence is often but not always included under the definition of mental illness. In *The Face of Mental Health and Mental Illness in Canada*, the Public Health Agency of Canada included substance dependence and gambling in their definition of mental illness (PHAC, 2006). However, in the strategy document, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* the Mental Health Commission of Canada noted the connection between addictions and mental health but did not identify substance dependence or gambling addiction as a mental illness (MHCC, 2012). The term concurrent disorder has been developed to refer to the unique experience and needs of individuals with co-occurring mental health and addiction issues. This is a common experience among Canadians, with more than half of those seeking services for addiction concerns also having a mental illness and 15-20% of those seeking services for mental health issues also living with an addiction (CCSA, 2009).

The terms mental illness and addiction are separated in this strategy to allow for increased clarity. However, substance abuse and mental health problems have common risk factors, such as stress, neglect, or exposure to violence. These risks can be buffered by increasing common protective factors, such as increasing resiliency and developing strong connections to family and community. Furthermore, promoting mental health is seen as a measure to prevent the development of mental illness and addiction issues. As such, prevention and promotion strategies may sometimes be referred to generally as mental health promotion (CCSA, 2009; CCSA, 2014; MHCC, 2012).

The terms mental health and mental illness are often used interchangeably but have very different meanings. A survey conducted by the Canadian Population Health Initiative revealed that 56% of Canadians thought that mental health and mental illness meant “about” or “exactly” the same (CIHI, 2009). However, “mental health is more than just an absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2014). The Public Health Agency of Canada takes a similar view and defines mental health as “the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face” (PHAC, 2006).

In contrast, mental illness refers to changes in thinking, mood or behaviour and is associated with distress and impaired functioning. Mental illness can take many forms and the symptoms vary from mild to severe (PHAC, 2006). There is no single cause of mental illness and mental illness will affect approximately 1 in 5 Canadians in every given year (Smetanin, Briante, Adair, Ahmad, & Khan, 2011). Everyone has some level
of mental health from poor to optimal but not everyone has a mental illness. Positive mental health creates a buffer from the stresses in our lives and can reduce the risk of developing a mental health problem or reduce the impact of the problem (MHCC, 2012). Therefore, mental health promotion aims to improve a person’s overall mental health and reduce the risk of mental illness.

The Mental Health Strategy of Canada, *Changing Directions, Changing Lives*, focuses on improving mental health for all Canadians (MHCC, 2012). This is the first mental health strategy for Canada. Strategic Direction 1: “Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible” (MHCC, 2012). This strategy recognizes the significant overlap in risk and protective factors for mental health and addiction, as well as that mental illness increases the risk of problematic substance use (MHCC, 2012).

Policy Direction 1 of *Working Together for Mental Health: A Provincial Policy Framework for Mental Health & Addictions Services in Newfoundland and Labrador* highlights the importance of prevention, stating that, “a responsive mental health and addictions system has to actively lead in prevention and early intervention approaches while supporting communities in the promotion of mental health” (Government of NL, 2005). To support this direction, the Province has hired Regional Addictions Prevention Consultant (RAPC) and Regional Mental Health Promotion Consultant (RMHPC) positions, implemented community-based grants for prevention and promotion efforts, developed mental health literacy and anti-stigma campaigns, and implemented the Youth Outreach Worker positions across the province to engage with youth in their own environments. Furthermore, a Provincial Mental Health and Addictions Advisory Council was established to advise the Minister of Health and Community Services on key mental health and addictions matters. The three issues on the Council’s Activity Plan for 2011-2014 were reviewing the 2005 Framework, addressing pervasive stigma, and addressing accessibility of services for youth in rural areas (Provincial Mental Health and Addictions Advisory Council, 2011).

Addiction is a commonly used term that is generally thought of as “compulsive use leading to physical symptoms of withdrawal when use is discontinued” (CCSA, 2008). It is commonly applied to the more specific continuum of substance use, substance abuse, and substance dependence, as well as to process dependencies and impulse control disorders, such as gambling (CCSA, 2008; PHAC, 2006). Accurate statistics on addiction can be difficult to obtain, in part due to the illegal nature of some commonly used substances resulting in individuals being untruthful about their use (PHAC, 2006). Furthermore, addiction statistics and research can be difficult to apply to program development due to the variety of substances and processes, such as gambling, that may be included or excluded. It is very important to carefully review documents utilizing this term to determine exactly what substances and/or processes are included.

Substance use refers to the use of any psychoactive substance that is taken primarily for its effects on consciousness, mood, and/or perception. Substance use may be beneficial or non-problematic in some circumstances, while in others it can create
difficulties. Substance use has been a social phenomenon for centuries and substances have been used for religious, medical, and personal purposes (CCSA, 2014; PHAC, 2006). The term substance abuse is commonly misapplied to substance use (CCSA, 2014). Substance abuse is defined as “a maladaptive pattern of substance use resulting in recurrent and significant adverse consequences related to the repeated use of a drug” (CCSA, 2008). Substance abuse occurs when substance use results in problems at home, at school, or in the community; becomes physically hazardous, or creates legal, social, or interpersonal problems (CCSA, 2008; CCSA, 2014). Substance dependence is defined as continued use despite severe distress resulting from the use, such as a cluster of cognitive, behavioural, and physiological symptoms (CCSA, 2008; CCSA, 2014).

Substance use is commonplace across Canada. The Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) is an annual population survey of alcohol and illicit drug use among individuals age 15 and older. Alcohol use was the most common substance, followed by cannabis. Use of psychoactive pharmaceuticals was also prevalent among the respondents. Of particular concern was the significant increase in reporting of abuse of such drugs, with abuse almost doubling from 2012 among users of pharmaceuticals. There has also been a significant increase in the use psychoactive pharmaceuticals among youth (Health Canada, 2013).

Gambling is the act of risking money, property or something of value on an activity with an uncertain outcome. Gambling is an increasingly popular recreational activity and a multi-billion dollar industry in Canada (CAMH, 2008). While gambling activity has been on the decline among the youth population in Newfoundland and Labrador it is still a concern, with almost half of youth gambling for money (Government of NL, 2012). Gambling occurs on a continuum from recreational or social use, which ranges from casual to serious use, along to problem gambling, which ranges from harmful involvement to pathological or compulsive gambling. Problem gambling is not solely about the monetary loss. Rather, it is about how gambling can affect the person's whole life through negative social, emotional, financial, and health consequences. Mental health and addiction problems increase the risk of developing a gambling problem and, conversely, gambling problems increase the risk of substance use problems and mental health struggles, including increased rates of depression and higher rates of suicide (CAMH, 2008).

When people think of addiction prevention, they most commonly associate it with preventing young people from experimenting with drugs. While this is an important and large aspect of prevention activities, addictions prevention encompasses much more than this. At the primary level, addiction prevention can be about trying to prevent people from starting substance use and gambling or about encouraging them to delay their use. Prevention can also be expanded to the larger community and may work to address some of the larger social and environmental factors, also known as risk and protective factors, which can contribute to people being more likely to use substances or engage in problematic gambling. At the secondary level, it can focus on the early stage of use or misuse and may include trying to encourage people to reduce their use; to use
in less risky manners; or to develop alternative activities, coping strategies, or positive peer or community involvement. At the tertiary level, addiction prevention can focus on the prevention of serious harm to individuals who have developed a substance use or gambling problem. This may include harm reduction approaches, treatment approaches, or enforcement strategies.

The Canadian Centre on Substance Abuse recognizes health promotion as a key factor in prevention of substance use and abuse, as well as in addressing the social and personal impacts of substance use (CCSA, 2014). The CCSA identifies that prevention can have a significant cost-benefit savings. In fact, analysis has shown that there is a savings of $15 - $18 for every $1 spent on drug abuse prevention programs (CCSA, 2013).

The Canadian Centre on Substance Abuse (CCSA) developed A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (CCSA, 2012). This Approach recommends the development of a continuum of services and supports to help prevent and respond to substance abuse and addiction. This is conceptualized as a tiered model which incorporates health promotion and prevention initiatives as the foundational level. The CCSA supports the use of a population health framework for substance use prevention and health promotion, with the majority of services being broadly available and generally offered at the community level. Comprehensive prevention and promotion services should be multidisciplinary and incorporate community outreach, primary care, and social services, rather than being a specialized sector. Further, promotion and prevention initiatives should be incorporated in aspects of each of the subsequent tiers and clients should be able to move between services or tiers as appropriate to their needs and preferences (CCSA, 2012).

Figure 1:
Health Promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health (WHO, 1997). Similarly, mental health promotion has been defined as “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health” (CIHI, 2009). According to the World Health Organization, “mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles” (WHO, 2009).

Promoting positive mental health is important for helping people live happier and more productive lives. It builds resilience, helps people cope with the challenges of everyday life, and helps those with chronic illness cope effectively with their illness. Promoting positive mental health also helps to prevent the onset of mental illness and addiction.

**Impact of Mental Illness / Substance Abuse**

Mental illness and addiction can have a significant impact on many aspects of a person's quality of life, including physical health, relationships, employment, and education (CCSA, 2008; CMHA, 2014). The individuals experiencing these issues are impacted but so are their families, friends, and supports, as well as the larger community and our social service systems (CCSA, 2014; PHAC, 2006). Furthermore, having a mental illness increases an individual's risk for developing problematic substance use. Similarly, substance abuse and dependence increase an individual's risk for the development of mental health issues and mental illness (CCSA, 2009; MHCC, 2012).

According to the Canadian Mental Health Association, people with mental illnesses are at higher risk of chronic medical conditions such as diabetes and cardiovascular disease (CMHA, 2014). The CCSA also identifies that substance use is associated with an increased risk of acute injuries and chronic illness (CCSA, 2008). Substance use during pregnancy increases the risk of various medical and obstetrical complications for the mother and baby (Finnegan, 2013). Problematic substance use increases the risk for death by suicide and mental illness is one of the leading risk factors for death by suicide and suicide attempts (CCSA, 2008; CMHA, 2014).

Living with a mental illness or addiction often prevents people from reaching their educational potential. “Without educational achievement and quality employment, individuals face poverty, alienation, and high levels of boredom, increased risk of addiction, isolation, and deteriorating mental and physical health” (CMHA and CAMH, 2010). Isolation from family, friends, and community can be a symptom of a mental illness, the result of increased tensions and interpersonal conflict associated with substance abuse, or associated with the discrimination and disadvantage that people with mental illness an addiction often encounter (CCSA, 2005; CCSA, 2011; MHCC, 2012).
Mental illness and addiction are also associated with poor outcomes for family members and caregivers. If we include the impact on family and caregivers, everyone in Canada is impacted by mental illness (CCSA, 2005; MHCC, 2012). The responsibility of providing care to a family member with a mental illness or addiction can be challenging and stressful. Frequently “a loved one’s mental health problem or illness impacts family, friends and supporters. Caring for a person living with a mental illness or addiction often creates emotional, physical, financial and social burdens for caregivers (CCSA, 2005; MHCC, 2012). In addition, almost half of people caring for someone with a mental health issue have been doing so for at least five years, increasing the risk of cumulative stress and burnout (O’Grady and Skinner, 2007). In 2012, the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) added questions about harms people have experienced in the past year due to someone else’s alcohol use and determined that, in the prior 12 months, one in seven Canadians had experienced harm as a result of another person’s drinking. Without support, the mental health of the caregivers can become compromised, leading to poor outcomes for both the caregiver and the person with the mental illness or addiction (MHCC, 2012). Furthermore, treatment for the individual does not necessarily equal a decrease in stress for the caregiver. In fact, family members may have increased worry, anxiety, and confusion as they experience the changes and difficulties that take place during their loved ones’ treatment process (Armstrong, S., Bubbra, S., Himes, A., Kelly, C., Shenfeld, J., Sloss, C., and Tait, L., 2009).

Parental substance use has significant negative effects for children. Fetal exposure to substance use is the leading cause of preventable birth defects in Canada. In Canada, estimates are that over 3000 babies are born with fetal alcohol spectrum disorder (FASD) every year. FASD is a spectrum disorder caused by fetal exposure to alcohol during pregnancy which results in development and cognitive delays. These can include brain damage, vision and hearing problems, slowed growth, and other birth defects. People with FASD are also at high risk of other disabilities, such as mental health issues, disrupted schooling, and alcohol and drug problems (PHAC, 2007). Children of parents with untreated alcohol use disorders are at far greater risk of developing their own problems with alcohol and other substances later in life (CCSA, 2013).

The Mental Health Strategy for Canada states that “in any given year, one in five people in Canada experiences a mental health problem or illness costing the economy of well in excess of 50 billion” (MHCC, 2012). Although the biggest proportion of costs are government departments such as healthcare, social services and income support, there is also a loss of $6 billion to businesses in loss efficiency including sick days, absenteeism, ‘presenteeism’ (coming to work even when the employee can’t work well), and lost productivity (MHCC, 2012).

The estimated yearly cost of substance abuse in Canada was about $39.8 billion in 2002 (CCSA, 2013). Healthcare is the biggest single direct cost associated with substance abuse. This includes the costs of acute care hospitalizations, as well as psychiatric and specialized treatment, ambulatory care, prescription medications, and doctors’ fees. The second biggest cost is law enforcement. Other costs include
workplace costs from direct services such as employee assistance programs and indirect costs such as lost productivity and turnover (CCSA, 2006).

People with mental illnesses and addiction issues often experience stigma, a negative stereotype that can lead to discrimination. In many cases, stigma can have an equal or more harmful effect than the mental health problem or illness on a person’s life (MHCC, 2012). Stigma is so pervasive that the fear of being labeled often prevents people from seeking the services they need to improve the quality of their lives (National Treatment Strategy Working Group, 2008; MHCC, 2009). Additionally, stigma and discrimination can affect all stages of the lives of people living with mental illnesses and addiction issues - dealing with friends, family, communities, and employers, as well as justice and health care systems. This impact seriously impedes their ability to participate fully in society and attain the best quality of life (CCSA, 2008; MHCC, 2009). Furthermore, people caring for family members with mental illnesses also experience the negative effects of stigma through association, which can lead to poor mental health consequences for caregivers (MHCC, 2009).

In 2020, it is estimated that there will be approximately 1.2 million suicides worldwide. In addition, 10-20 times more people than this will attempt suicide (Murray and Lopez, 1996 as cited in WHO, 2004). One of the most recognized risk factors for suicide is psychiatric disorders (WHO, 2004). The Mental Health Strategy of Canada recognizes that suicide has a devastating impact on individuals, families and communities. In 2011, the total number of Canadians that died by suicide was 3728. Males are significantly more likely to die by suicide than females, with 2781 males to 947 females in 2011. Suicide is also one of the leading causes of death among young people (PHAC, 2012; Statistics Canada 2012). It should be noted that of the nearly 4,000 Canadians who died as a result of suicide, most were confronting a mental health problem or illness (MHCC, 2012).

Health Promotion Framework / Population Health Promotion Model

Western Health has developed a Health Promotion Framework and has positions to support the implementation of population health promotion strategies in key areas, including mental health and addictions. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health (CCSA, 2014).

The Population Health Promotion Model incorporates health promotion and the determinants of health to create one comprehensive model to understand risk and protective factors and to develop a holistic strategy to promote optimal health for the individuals and communities we work with. Health Promotion initiatives are most successful when they incorporate and link the different concepts represented in this model. These concepts include not only focusing on the individual but also on the family and the community. The basis of the model includes evidence, decision-making, and
experimental learning. All initiatives presented in this strategy are based on research and best practices.

Figure 2:

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**Determinants of Health**

According to the Mental Health Strategy for Canada, poverty, inadequate housing, and problems finding work or getting an education put people at greater risk for developing mental health problems and illnesses (MHCC, 2012). The CCSA recognizes health promotion as a key factor in prevention of substance use and abuse, as well as in addressing the social and personal impacts of substance use (CCSA, 2014). The conditions that people face in their lives shape whether they feel safe, secure, and supported at home and in their communities. These factors collectively are referred to as the social determinants of health (MHCC, 2012). It is well known that when disparities exist, people who have higher education, valued employment, better social relationships, and economic means are more likely to have better mental health (MHCC, 2012). It has also been shown that addressing the determinants of health will help prevent substance use and improve outcomes for individuals who are engaged in problematic substance use and gambling (CCSA, 2014). The Mental Health Strategy for Canada recognizes that working to reduce disparities will involve efforts at many levels to change social and health policy in Canada (MHCC, 2012).

**Early Life:**

Parent-child interactions in early life form the foundation for a child’s social and emotional development (CCSA, 2011). According to the World Health Organization (2014) “secure attachment to the primary caregiver in the early years is of fundamental importance for the individual in buffering against anxiety and coping with stressors”. 
Risk factors experienced during infancy and early childhood that contribute to poor mental health and addictions outcomes include parental mental health and substance abuse issues, lower socio-economic status, parenting practices, and exposure to violence. Thus, efforts that are directed towards families with infants and young children affected by chronic stress offer long-term benefits especially when included in education or social services (CCSA, 2011; MHCC 2012).

Education:
Education is also an important social determinant of mental health. People with higher education tend to have better mental health outcomes than those with lower educational attainment. According to the Public Health Agency of Canada, mental health status improves with each level of education (PHAC, 2006). There are a couple of reasons why education leads to better mental health outcomes. First, education is associated with other social determinants of health such as employment, working conditions, and income security. In fact, according to the Public Health Agency of Canada (2006) “Education increases opportunities for income and job security and gives people a sense of control over their life circumstances - key factors that influence health. Second, education increases overall literacy so that one can promote one’s own health through individual action (Mikkonen and Raphael, 2010).

Employment:
According to the World Health Organization, poor quality employment, such as employment with short-term contracts and jobs with low reward and control at work, has significant impacts on mental health (WHO, 2014). As such, employers have a significant role in potentially reducing or exacerbating mental disorders among working age populations. Employers should institute better working conditions and better employment practices to ensure that their employees experience a higher reward and control balance at work (WHO, 2014). Strategies that reduce long-term unemployment and improve working conditions are vitally important in reducing the risk of mental disorders in adults. A recent report from the Institute of Health Equity suggests a correlation between job loss and symptoms of depression and anxiety. The report also demonstrates that these impacts are most profound for the long-term unemployed (WHO, 2014).

Income Security:
Income is a significant social determinant of mental health. Low income predisposes people to material and social deprivation. This deprivation contributes to social exclusion by making it harder to participate in cultural, educational, and recreational activities (Mikkonen & Raphael, 2010). According to the Public Health Agency of Canada, adequate income enables healthy living conditions, such as safe housing and the ability to buy sufficiently healthy food. It also provides opportunities that are unavailable to low-income individuals and families. Therefore, income has an impact on mental health due to its influence on a person’s ability to meet their basic needs, have control over their lives, and deal with unfortunate events (PHAC, 2006).
Housing:
There are many studies that support the fact that poor quality housing is a risk factor for the mental health of Canadians. Mikkonen and Raphael (2010) affirm, “Living in poor housing creates stress and unhealthy means of coping such as substance abuse”. According to this same report, there are a growing number of families and individuals in Canada with insecure housing as a result of factors such as lack of affordable rental accommodation and growth of part-time precarious employment that are both low paying and insecure. Further to this, without adequate housing, recovery from mental illness is challenging. According to the Mental Health Strategy for Canada, there is strong evidence that improved housing helps people do much better in recovery. Priority 3.5 of the Mental Health Strategy for Canada recommends increasing the availability of safe, secure, and affordable housing, with supports for people living with mental health problems and illnesses (MHCC, 2012).

Social Isolation:
Social isolation is a factor that has a profound influence on mental health. According to the Public Health Agency of Canada, several studies have shown social connections to be vital in influencing both mental and physical health (PHAC, 2006). In the Western region, 84.3% of people reported a sense of belonging to local community as strong or somewhat strong in 2011-2012 (Statistics Canada, 2013). Belonging to a supportive community contributes to positive mental health by providing support during crisis, grounding in one’s cultural roots, and providing opportunities for creativity, volunteering, and social involvement (PHAC, 2006).

Gender and Sexual Orientation:
The MHCC identifies that gender makes a person vulnerable to mental health problems and illnesses (MHCC, 2012). For example, women and girls are more likely to experience depression and anxiety and to attempt suicide at higher rates but men and boys are more likely to die by suicide. Further to this, women experience more negative aspects of the social determinants of health than men. Women are more likely to carry the responsibility for raising children and household duties. Women have more episodes of long-term disability and earn less than men as a result of lower wages and part-time work. However, men are more likely to be prone to accidents and extreme forms of social exclusion (Mikkonen and Raphael 2010).

There is also evidence that gay, lesbian, and transgendered individuals experience unique forms of discrimination and stigma, which leads to stress and poor mental health outcomes. According to Mikkonen and Raphael (2010) this is especially a problem when youth need to come to terms with their self-identity. This discrimination is also experienced when these individuals enter the workforce.

Health Promotion Strategies

The World Health Organization states that “Generally, prevention activities are more successful when different interventions are coordinated and sustained over a number of
years and if different stakeholders are mobilized and involved” (WHO, 2002). This is achieved through engaging communities, creating and maintaining partnerships, creating public awareness and the following strategies:

1. **Build healthy public policy** to ensure that policy developed by all sectors contributes to health-promoting conditions (e.g., healthier choices for goods and services, equitable distribution of income).

2. **Create supportive environments** (physical, social, economic, cultural, and spiritual) that recognize the rapidly changing nature of society, particularly in the areas of technology and the organization of work, and that ensure positive impacts on the health of the people. (e.g. healthier workplaces, clean air and water).

3. **Strengthen community action** so that communities have the capacity to set priorities and make decisions on issues that affect their health (e.g. healthy communities). People in healthy communities have the opportunity to develop the skills they need, learn how to access resources and develop and strengthen social networks.

4. **Develop personal skills** to enable people to have the knowledge and skills to meet life’s challenges and to contribute to society (e.g. life-long learning, health literacy).

5. **Reorient health services** to create systems which focus on the needs of the person and invite a true partnership among providers and users of the services (e.g. homecare, child development services).

**Health Promotion Strategies in Mental Health & Addiction Services**

The development of healthy public policies is a main component of health promotion. Western Health, in partnership with Corner Brook Regional High, made an important contribution to the work of substance use prevention in the Western region by developing a substance use and gambling prevention policy which includes health promotion, prevention, harm reduction, treatment and enforcement components. This policy moved to the Safe and Caring Schools Committee where the policy was combined with the current policy that adopts a new comprehensive policy approach to dealing with substance use and gambling in the school system.

Furthermore, Western Health supported the Western Regional Coalition to End Violence (WRCEV) in the development of PEACE (Promoting Equality and Accountability through Community Engagement). A representative from Western Health was part of the Steering Committee for this two-year process. The project included a needs assessment (focus groups, interviews) and a comprehensive regional strategy to address gender-based violence. The strategy was released in fall 2013 and reflects the needs, concerns, and lived experiences of women and girls. It also identifies gaps in services for victims of gender-based violence, as well as supports and services within Western Health for girls and women such as Sexual Assault Nurse Examiners, Sexual Abuse Community Services, and Youth Outreach Workers.
Supportive environments facilitate access to services, supports, and other resources. Creating supportive environments promotes mental health, prevents addictions, and has a positive impact on the health of the population. This can be fostered in schools, communities, and neighborhoods. Western Health currently offers various evidenced-based programs that are examples of creating a safe non-threatening environment and fostering participation in health, as well as promoting self-reliance. Some examples are Boys’ Council / Girls’ Circle and Challenges, Beliefs and Changes. Also, the No Stress Fest was developed and piloted in the Corner Brook area by the Mental Health Partners Working Group in November 2012. This has since been offered in Port aux Basques, Port Saunders, and Stephenville with plans underway for an event to be held in Pasadena in 2015.

Strengthening community action so that communities have the capacity to make decisions and set priorities in areas that affect their health has been achieved with the implementation of the Community Addictions Prevention Mental Health Promotion (CAPMHP) Fund and various Awareness Week Activity Grants. These grants are supported by the RAPC and RMHPC, as well as other Western Health employees, to enhance capacity building and promote utilization of evidence-based practices. The high number of prevention and promotion initiatives that have been delivered in the Western Region demonstrates a commitment to community development and capacity building. Evidence-based programs such as Strengthening Families for the Future, Strengthening Families for Parents and Youth, and the FRIENDS for Life anxiety prevention program focus on increasing the capacity of families, caregivers, schools, and community organizations to promote mental health and prevent addictions.

The CAPMHP and Activity Week funds have also supported a number of projects focused on violence prevention. For example, the Corner Brook Status of Women’s Council received funding from the CAPMHP Fund to support an Introduction to Trauma Informed Practice workshop for people working in the community. Additionally, The Family Outreach Resource Centre received an Awareness Week Activity Grant to support a Lunch and Learn session on the topic of victim blaming.

Developing personal skills gives people the ability to cope with everyday challenges and contribute to society. Again, programs such as Strengthening Families; FRIENDS for Life; Challenges, Beliefs and Changes; and Boys Council/Girls Circle  teach people skills that foster resiliency, such as positive coping, emotional regulation, and healthy relationships.

The development of personal skills also includes improving mental health literacy, which contributes to people possessing the skills and knowledge they need to have control in their own health. Some of this knowledge can be acquired through Western Health’s website. Community members can access resources or request a presentation from Mental Health and Addiction Services by visiting the website: www.westernhealth.nl.ca/mha. The site promotes all available resources that can be borrowed, as well as access to a presentation request form. There are also links to other organizations and self-help resources regarding mental health.
Reorienting services means the responsibility of healthcare must be shared among individuals, community groups, government agencies, and health professionals (WHO, 1986). These changes in the organization of health services take into account a holistic approach to the delivery of services, which considers the needs of the whole person. Western Health, in partnership with the Canadian Mental Health Association, NL Division recently created a Seniors’ Mental Health Education Program for people who work with seniors. This Program is being piloted to Western Health’s long term care staff with a plan to expand the program to homecare workers who are involved with the care of seniors in the community. This Program recognizes that people who work with and support seniors have an important role to play in their mental health and supporting recovery from mental illness and addictions.

Furthermore, Western Health partnered with the Western School District in 2013 to train 18 staff to deliver FRIENDS for Life within elementary schools. This is in light of the fact that anxiety disorders are the most common mental health problem facing children today. More and more students are dealing with significant levels of anxiety and stress in the school, community and home settings.

ENVIRONMENTAL SCAN

Indicators

A number of indicators are utilized in the development of the health promotion strategy for mental health and addictions. Mental Health & Addictions priorities in the Western Region are identified through annual mental health and addictions services referral statistics, as well as data available through community health needs assessments, comprehensive school health assessments, annual site visits, and a review of provincial and national health indicators. In addition, an overview of the professional services supporting prevention and promotion, as well as existing programs, will be reviewed.

The available data supports the need for continued prevention and promotion efforts to support the following priority areas:

- Stigma
- Stress
- Depression
- Anxiety
- Alcohol Use
- Youth Substance Use
- Suicide
- Violence

Stigma

The stigma associated with mental illness may be more devastating than the illness (MHCC, 2012). Stigma can prevent people with a mental illness or addiction from talking to a loved one for fear of losing them. It can prevent people from telling their employer when they need adjustments to workload for fear of losing their job. It can prevent people from seeking medical help for fear of judgment. While 70% of adults living with mental illness say symptoms developed before they were 18 years old, the
fear of stigma often delayed them from seeking treatment (MHCC, 2013). Yet, not seeking treatment can have devastating results, such as loss of income, increased illness severity, hopelessness and suicide (Government of Newfoundland and Labrador, 2014).

**Stress**
Stress can result in negative health consequences and can contribute to behaviours such as substance use that may result in further negative health consequences. Stress is an especially relevant risk factor during adolescence, as this is a particularly vulnerable period for the development of mental health problems and substance use disorders (CCSA, 2009). In the 2012 Canadian Community Health Survey (CCHS), 23% of Canadians aged 15 and older reported that most days were ‘quite a bit’ or ‘extremely’ stressful with females more likely than males to report high stress. The percentage of residents in Newfoundland and Labrador that reported ‘quite a bit’ or ‘extremely’ stressful was lower than the national average, at 15.2% vs. 23% (Statistics Canada, 2012). Stress remained as one of the top three reasons for referral to Mental Health and Addiction Services at Western Health in 2013-2014. Similarly, stress was identified as a significant issue in the results of the Western Health’s Comprehensive School Health Assessment 2012 -2013.

**Depression & Anxiety**
Mood disorders, which includes depression and bipolar disorder, are among the most common forms of mental illness in Canada. In the recent Canadian Community Health Survey, depression was more common among Canadians than anxiety disorders with 4.7% of respondents meeting the criteria for a major depressive episode and 2.6% of respondents meeting the criteria for generalized anxiety disorder in the 12-month period (Statistics Canada, 2013). Females had higher rates of mood disorders and generalized anxiety disorder than males. In the Western Region, the top three reasons for referral to Mental Health Services are depression followed by anxiety and stress. These results from 2013-2014 referral data are consistent with the Canadian Community Health Survey. Furthermore, depressive symptoms increased significantly for high schools students in the Province with 8.4% of students in 2012 reporting ‘very elevated’ depressive symptoms compared to 4.7% in 2007. Females were also significantly more likely to report very elevated depressive symptoms than males (Government of Newfoundland and Labrador, 2012).

It is relevant to note that the presence of mental illness has repeatedly been associated with a mental health need. However, the rates of unmet needs were higher among those people meeting the criteria for mental illness, especially depression. According to the 2012 Canadian Community Health Survey – Mental Health (CCHS-MH), while counseling was the most common need reported in Canada, it was also the need most likely to not be met. Personal circumstances were given as one barrier to receiving services. However, 1 in 5 reported that the barriers were related to features of the healthcare system (Statistics Canada, 2013).

**Substance Use**
According to the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) conducted in 2012, alcohol was the most common substance used in Canada with
78.4% reporting using in the past 12 months. This was followed by cannabis, with 10.2% using in the past 12 months. Use of psychoactive pharmaceuticals is also very prevalent. While a portion of the 24.1% of respondent who reported using at least one psychoactive pharmaceutical in the past 12 month did so as prescribed by a medical professional, 6.3% of users reporting abusing this medication. This is up significantly from 3.2% reporting abuse in 2011. A significant segment of the population is also using other illicit drugs, with the use of at least one illicit drug (cocaine/crack, speed, ecstasy, hallucinogens, or heroin) in the past 12 months being reported by 2.0% of the respondents. When cannabis use is included in illicit drug use statistics, 10.6% of Canadians reported using illicit drugs. This is very closely mirrored in Newfoundland, with 11.1% of respondents reporting using one or more of illicit drugs. There is increased need for further attention and exploration of illicit drug use, as this has continued to increase from 8.4% in 2009 and 10.2% in 2010 (Health Canada, 2013).

Globally, the harmful use of alcohol is one of the main risk factors for poor health and the third leading risk factor for premature deaths and disabilities (WHO, 2010). Heavy drinking is a particular concern due to the high percentage of individuals who consume alcohol and the resulting negative health and social impacts of heavy drinking. Statistics Canada’s definition of heavy drinking is consuming five or more drinks on one occasion, at least once per month in the last year. Based on this definition, the Canadian Community Health Survey found that for 2011/2012, 18.2% of Canadians meet the heavy drinking definition. This compares to 26.2% of respondents in the Western Region, which is significantly higher than the national average. There are a significantly higher percentage of males engaged in heavy drinking compared to females, 39.8% and 13.2% respectively (Statistics Canada, 2013).

Substance use does not only affect the user; rather, the impacts are far-reaching. The National Treatment Indicators Project found that individuals seeking help due to a family member of close friend’s substance use accounted for over 10% of treatment episodes in 2011 – 2012 (Pirie, Jesseman, Di Gioacchino, & National Treatment Indicators Working Group, 2014). This does not include those who access services for stress, depression, or anxiety, which is later determined to be linked to a loved one’s substance abuse or mental health problems, a common experience reported by service providers in the Western Region. Prenatal exposure to alcohol is the leading cause of preventable birth defects and developmental delays in Canadian children (Public Health Agency of Canada, accessed online 2014). According to Statistics Canada’s Canadian Community Health Survey, between 2003 and 2010, women aged 25 to 34 experienced the fastest increase in risky drinking of any age group or gender. These women account for over 62% of births in Canada. When combined with women aged 18-24, this accounts for approximately 80% of births in Canada (Statistics Canada, 2011). This helps reinforce why it is so important to promote positive mental health and prevent addictions, as well as to educate women about the dangers of drinking alcohol or using other substances during pregnancy (CCSA, 2014). Males have higher rates of substance use disorders (Statistics Canada, 2013). However, women who use drugs and alcohol are more heavily stigmatized than males, especially pregnant women. Stigma increases reluctance to access services and negatively impacts the services these women do receive (Finnegan, 2013).
Youth Substance Use

On a broad socio-cultural level, youth live in a society where substance use is not only tolerated but also glorified. Youth are avid consumers of mass media and much of this further legitimates substance use and gambling behaviour. Adolescence is a risky period for experimentation. It is during adolescence that important physical, cognitive, emotional, and social development changes take place and substance use can interfere with these processes (CCSA, 2010). Youth are disproportionately more likely to use substances, engage in risky patterns of use, and experience harms from substance use. In fact, youth are five times more likely to experience harm because of drug use (CCSA, 2013). The Student Drug Use Survey requires that students actually be in school in order to respond to the survey administered on a particular day. As such, this report may not reach or reflect the realities of those who may be at the highest risk among the youth population (CCSA, 2010). While these are limitations to these reports, they provide the best snapshot of youth substance use in our communities and are very helpful in identifying trends and providing a general picture of the issues.

There has been a significant increase in the number of youth abstaining from substance use, up from 42.1% in 2003 to 53% in 2012. However, alcohol use is still concerning, with binge drinking occurring among almost one third and drunkenness among just over one quarter of students in the month prior to the survey. Decision making under the influence also requires special focus, including driving under the influence, being a passenger with a driver who has been drinking or used substances, and unplanned sexual activity after using substances. Use of almost all substances has decreased over the past 8 years. While ecstasy and cocaine use have shown an increasing trend, a relatively low percentage of students are using these substances compared to the others included in the survey (Government of Newfoundland and Labrador, 2007 & 2012). In addition to these substances, the use of pharmaceuticals among the youth population is a growing concern among service providers in the Western Region. This concern was supported by the Canadian Alcohol and Drug Use Monitoring Survey, which found that psychoactive pharmaceutical use among youth was up from 17.6% in 2011 to 24.7% in 2012. Furthermore, in 2012, 4.9% of youth aged 15 to 24 had abused pharmaceuticals. This concern is further heightened, as only 0.9% of those 25 years of age and older reporting pharmaceutical abuse (Health Canada, 2012).

Use of caffeinated energy drinks appears to be normalized among youth and the risks minimized, with advertisers marketing to youth and presenting these drinks as healthy choices. Almost two out of every three youth reported using caffeinated energy drinks (GNL, 2012). The health and social risks increase when alcohol and caffeinated drinks are combined, a practice four to five times more prevalent among youth and young adults than the general public (Brach, Thomas & Stockwell 2012).

Suicide & Suicide Rates

Suicide, in addition to being a mental health issue, is a public health issue and a health and safety priority. For these reasons, the Public Health Agency of Canada began consultations for the development of a federal framework to guide suicide prevention efforts (PHAC accessed online Aug 2014). Suicide is one of the leading causes of death among young people (PHAC, 2012; Statistics Canada, 2012) with 528 suicides among individuals under the age of 25 years in 2011. A recent survey conducted with high
school students in this Province revealed that suicidal ideation is increasing among students. The survey showed some alarming results, as 17% of students had seriously considered suicide, 14.1% made plans for suicide, and 8.4% attempted suicide (Government of Newfoundland and Labrador, 2012). The following table shows a breakdown of the number of suicides in Canada from 2007 – 2011 by age.

<table>
<thead>
<tr>
<th>Suicides and suicide rate by age group (Both sexes no.)</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages¹</td>
<td>3,611</td>
<td>3,705</td>
<td>3,890</td>
<td>3,951</td>
<td>3,728</td>
</tr>
<tr>
<td>10 to 14</td>
<td>33</td>
<td>25</td>
<td>25</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>15 to 19</td>
<td>185</td>
<td>208</td>
<td>202</td>
<td>198</td>
<td>198</td>
</tr>
<tr>
<td>20 to 24</td>
<td>290</td>
<td>255</td>
<td>277</td>
<td>288</td>
<td>301</td>
</tr>
<tr>
<td>25 to 29</td>
<td>282</td>
<td>256</td>
<td>258</td>
<td>271</td>
<td>261</td>
</tr>
<tr>
<td>30 to 34</td>
<td>235</td>
<td>257</td>
<td>298</td>
<td>292</td>
<td>283</td>
</tr>
<tr>
<td>35 to 39</td>
<td>325</td>
<td>316</td>
<td>332</td>
<td>343</td>
<td>288</td>
</tr>
<tr>
<td>40 to 44</td>
<td>403</td>
<td>452</td>
<td>431</td>
<td>365</td>
<td>354</td>
</tr>
<tr>
<td>45 to 49</td>
<td>486</td>
<td>468</td>
<td>491</td>
<td>502</td>
<td>432</td>
</tr>
<tr>
<td>50 to 54</td>
<td>410</td>
<td>418</td>
<td>476</td>
<td>484</td>
<td>443</td>
</tr>
<tr>
<td>55 to 59</td>
<td>307</td>
<td>337</td>
<td>371</td>
<td>386</td>
<td>375</td>
</tr>
<tr>
<td>60 to 64</td>
<td>203</td>
<td>224</td>
<td>241</td>
<td>272</td>
<td>245</td>
</tr>
<tr>
<td>65 to 69</td>
<td>115</td>
<td>145</td>
<td>138</td>
<td>152</td>
<td>150</td>
</tr>
<tr>
<td>70 to 74</td>
<td>102</td>
<td>114</td>
<td>122</td>
<td>117</td>
<td>128</td>
</tr>
<tr>
<td>75 to 79</td>
<td>103</td>
<td>100</td>
<td>82</td>
<td>103</td>
<td>101</td>
</tr>
<tr>
<td>80 to 84</td>
<td>76</td>
<td>67</td>
<td>73</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>85 to 89</td>
<td>42</td>
<td>42</td>
<td>54</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>90 and older</td>
<td>14</td>
<td>21</td>
<td>19</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

¹ "All ages" includes suicides of children under age 10 and suicides of persons of unknown age.


When we look at the suicide rates per 100,000 population in Newfoundland, it is important to note that suicide rates in the Western Region are higher than the provincial average and suicide rates in the Western Region have continued to increase from 2007-2009. The following table shows the provincial rates and rates for each Regional Health Authority.

<table>
<thead>
<tr>
<th>Annual Suicide Rates per 100,000 population by Regional Health Authority of Residence, 2007-2009. Ages 10 plus, Newfoundland and Labrador.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Death</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>2007</td>
</tr>
<tr>
<td>2008</td>
</tr>
<tr>
<td>2009</td>
</tr>
</tbody>
</table>

Data Source: Newfoundland and Labrador Centre for Health Information, suicide Database. (Note: Figures reflect data obtained from the Office of the Chief medical Examiner, Department of Justice, Government of Newfoundland and Labrador.)
Violence
The impact of violence is far reaching and impacts the individual, family, and society as a whole. “The consequences of violence on physical, mental, sexual and reproductive health often last a lifetime. Violence also contributes to leading causes of death such as cancer, heart disease and HIV/AIDS, because victims are at an increased risk of adopting behaviors such as smoking, alcohol and drug misuse, and unsafe sex” (WHO, 2014).

According to the Newfoundland & Labrador Violence Prevention Initiative – Taking Action Against Violence “violence continues in homes and communities in Newfoundland and Labrador. Its victims include women, children and youth, Aboriginal women and children, seniors, persons with disabilities and others who are victims of violence because of race, ethnicity, sexual orientation, or economic status (Government of Newfoundland and Labrador, No Date).

Violence against women continues to be prevalent in our society. While overall rates of violent crime against men and women are similar, women are more likely to experience certain forms of violence. For example, according to police-reported data, women were 11 times more likely than men to be sexually victimized and three times as likely to be stalked (Statistics Canada, 2013). Family violence makes up more than one-quarter of all violent crimes reported to police. In 2013, there were 59,725 female victims of family violence, representing 68% of all police-reported family violence victims. In fact the majority of victims were female in incidents where the perpetrator was the victim’s child (62%), parent (57%), extended family member (57%), or sibling (56%). The most common type of violence against women is intimate partner violence (Statistics Canada, 2013). Intimate partner violence has serious physical, emotional, social and economic consequences for victims, making this phenomenon a major public health issue (World Health Organization, 2013). As prevalent as violence against women is across Canada, it is further compounded for Aboriginal Women. According to the 2009 General Social Survey (GSS) on Victimization, the rate of self-reported violent victimization against Aboriginal women in the provinces was about 2.5 times higher than the rate for non-Aboriginal women. This was the case for spousal violence as well as violence perpetrated by other family members, friends, acquaintances, and strangers (Statistics Canada, 2013).

Victims of violence, including children, are often the most vulnerable members of society. According to Statistics Canada, 81% of children are victimized by someone known to them. More specifically, of those accused of violence against children and youth in 2013, over half (52%) were acquaintances or friends, while more than one-quarter (29%) were family members. Over the longer term, experiencing family violence during childhood can increase the risk of delinquent behavior in later years and has been shown to be linked to problems related to drug and alcohol consumption and mental health issues in adolescence and adulthood (Statistics Canada, 2013).

Physical disabilities and cognitive impairments make seniors a population who are also more vulnerable to violence. As with many countries, Canada is facing an aging population, especially over the next three decades as the baby boomer generation reaches the age of 65. According to police-reported data, nearly 8,900 persons aged 65
and over were the victims of a violent crime in Canada in 2013, which is a rate of 173.9 per 100,000 seniors (Statistics Canada 2013). It is important to note that violence against older people is often under reported. In fact, it was estimated by the General Social Survey on Victimization (2009) that two-thirds of violent victimizations that occur in Canada are not reported to police.

According to several studies, including the Adverse Childhood Experience (ACE) study, trauma is wide-spread, with 76% of Canadian adults reporting some form of trauma exposure in their lifetime (Van Ameringen et.al., 2008; Klinic Community Health Center, 2013). These statistics are even higher for those receiving treatment for addiction and mental health issues. An estimated 90% of mental health clients have been exposed to trauma and most of these clients have multiple experiences (Mueser et al, 2004). Likewise, a study of 6 women's treatment centres in Canada found that 90% of women interviewed reported childhood or adult abuse histories in relation to their use of alcohol (Jean Tweed Centre, 2013).

The Center for Addiction and Mental Health defines trauma as, “the emotional response when a negative event is overwhelming” (CAMH, 2012). Trauma affects everyone no matter what their age, gender, socio-economic background, religion, sexual orientation or education. The Trauma Informed Toolkit reports that, “Developmental Trauma, violence, abuse and other adverse childhood events are often among the root causes of many of the health and social problems that challenge our society today, problems such as poverty, homelessness, violence, addictions, mental illness, poor health outcomes and many physical and chronic illnesses, poor mental health, suicide, poor academic performance and lower efficiency and productivity” (Klinic Community Health Center, 2013).

The ACE study is an on-going collaborative research project initiated in 1998 that shows staggering proof of the health, social and economic risks that result from childhood trauma. The data from this study continues to be evaluated and it has produced numerous reports that show a very strong correlation between the number of adverse childhood events and the mental health challenges that the respondents faced as adults (Felliti et.al, 1998 as cited in The Trauma Toolkit, Klinic Community Health Center, 2013).

**Western Health, Mental Health and Addiction Services 2013-2014**

There has been a continuous growth in referrals to Mental Health & Addiction Services in the Western Region. Referrals increased another 8.6% in the 2013-2014 fiscal year with 3139 referrals received compared to 2890 in the previous year. Since 2006-2007, there has been a 131% increase in overall referrals to this program area (1358 referrals in 2006/2007).

The top three reasons for referral to Addiction Services remained unchanged from last year:

1. Alcohol use
2. Prescription drug use – opiates
3. Impaired driving assessment (There were 85 referrals for impaired driving assessments as compared to 77 referrals in the previous year).
The top reasons for referral to Mental Health Services were also unchanged:
  1. Depression
  2. Anxiety
  3. Stress

Furthermore, clinical consultation has identified that caregiver stress is a common underlying or complicating factor for many referrals to mental health and addiction programs. As well, many parents access services for support due to their children's mental health and addiction-related needs.

*Western Health, Community Health Needs and Resources Assessment 2012-2013*
Western Health’s *Community Health Needs and Resources Assessment* revealed some concerns related to mental health and addictions. The following table represents the mental health and addictions related concerns and the percentage of respondents that identified those concerns.

Table: Percentage of respondents who identified community concerns related to mental health and addictions.

<table>
<thead>
<tr>
<th>MH&amp;A Concern</th>
<th>Corner Brook &amp; Bay of Islands</th>
<th>Deer Lake &amp; White Bay</th>
<th>Bonne Bay &amp; Port Saunders</th>
<th>Bay St. George &amp; Area</th>
<th>Port aux Basques &amp; Burgeo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking &amp; Driving</td>
<td>78.9</td>
<td>62.1</td>
<td>53.7</td>
<td>80.2</td>
<td>67.4</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>75.8</td>
<td>45.3</td>
<td>52.6</td>
<td>78.1</td>
<td>63.2</td>
</tr>
<tr>
<td>Loneliness</td>
<td>69.5</td>
<td>70.5</td>
<td>66.3</td>
<td>54.2</td>
<td>57.9</td>
</tr>
<tr>
<td>Suicide*</td>
<td>14.7</td>
<td>4.2</td>
<td>1.1</td>
<td>29.2</td>
<td>16.8</td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td>67.4</td>
<td>41.1</td>
<td>11.6</td>
<td>59.4</td>
<td>38.9</td>
</tr>
<tr>
<td>Illegal Drug Use</td>
<td>76.8</td>
<td>66.3</td>
<td>62.1</td>
<td>76.0</td>
<td>71.6</td>
</tr>
<tr>
<td>Abuse of Prescription</td>
<td>72.6</td>
<td>42.1</td>
<td>32.6</td>
<td>67.7</td>
<td>36.8</td>
</tr>
</tbody>
</table>
Drugs
Abuse of Over the Counter Drugs 72.6 31.6 30.5 60.4 26.3
Gambling 68.4 42.1 40.0 52.1 52.6

* The question related to suicide was not consistently asked to all survey respondents. The question was omitted for the majority of surveys conducted. As a result, the data is not an accurate representation of community concern for this issue.

Western Health, Comprehensive School Health Assessment 2012-2013
Western Health’s Comprehensive School Health Assessment (CSHA) Summary Report indicated some mental health and addictions related issues among the school-aged population. More specifically, the issues of stress and alcohol/drug use were identified. Stress was identified as early as the elementary population. Similar to last year, stress was identified as a significant issue among both the junior and senior high students. However, the dramatic increase among the senior population was alarming. The issue of stress increased with student age. Stress was ranked as the #1 issue identified by Level III students at 43.1%, the #2 issue identified by Level II students at 36.8%, the #4 issue for Level I at 31.8% and Grade 9 at 27%. The following table outlines the percentage of students that identified stress as a problem at school. When all grade levels were combined, stress was identified as one of the top three issues (3rd place). This was consistent with the results from the previous year. However, according to the CSHA report, stress is not an issue that is currently in the school health policy and, therefore, it is not a topic that is routinely being addressed by the Community Health Nurses.

<table>
<thead>
<tr>
<th>Grade 7</th>
<th>Grade 8</th>
<th>Grade 9</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>15.30%</td>
<td>33.10%</td>
<td>27.00%</td>
<td>31.80%</td>
<td>36.80%</td>
</tr>
</tbody>
</table>

Alcohol/drug use was also a highly rated problem identified by students. The issues of alcohol/drug use also increased with student age. The topic of alcohol and drugs ranked fourth place as a topic that students wanted to learn more about. The following table outlines the percentage of students that identified alcohol/drug use as a problem at school. It is also interesting to note that the elementary students in the Stephenville and South Area identified alcohol/drug use as a problem in the school more than elementary students in the Corner Brook and Bays of Islands and Pasadena, Deer Lake and North
Areas. Stephenville and South had double the number of students indicating alcohol/drug use as a problem in the school.

![Alcohol/drug Use Issue Identified by Students](image)

Stress and alcohol/drugs were also identified as topics that students wanted to know more about.

![Topics that students wanted to know more about](image)

**Western Health, Mental Health & Addiction Site Visits**

The RMHPC and RAPC conduct annual visits with staff and key community partners at each of the Mental Health & Addiction Services sites. The purpose of the visit is to discuss trends in mental health and addictions issues in each of the areas, talk about available resources, and strengthen connection and collaboration among internal and external partners. Local partners invited to attend the site visit include Youth Outreach Workers, Mental Health & Addictions personnel, Community Health Nurses, Wellness Facilitators, Health Promotion staff, School Guidance Counsellors, police personnel, as well as any other relevant staff and community partners in the area.
Some consistent trends that were identified in the past few years are anxiety among young children and teens, significant alcohol use, social acceptance of alcohol and marijuana use, lack of parent engagement, driving under the influence of substances, increase in prescription drug use, and stigma. These trends are consistent with other available information regarding individuals living in the Western Region.

Newfoundland and Labrador 2012 Student Drug Use Survey

The Student Drug Use Survey was standardized in 1994 and monitors substance use trends in youth, as well as gambling activity, sexual behaviour, mental health, and help-seeking behaviour. Studies have been carried out approximately every four years. The Newfoundland and Labrador 2012 Student Drug Use Survey: Highlights Report is based on 2530 student responses from grades 7, 9, 10, and 12 with randomly-selected schools and classes across the province.

There have been some significant improvements in substance use among youth in the province. Almost half of youth surveyed (46.6%) having not used any substance in the previous year. This is an increase from 41.4% in 2007 and 36% in 2003. Furthermore, the use of alcohol and illicit drug use among youth are at their lowest since 1996. The age for first use of alcohol is slightly older, at 13.5 years-old in 2012 from 12.9 years-old in 2007. While cannabis use remained the same, the age of first use has increased from 13.5 years-old in 2007 to 14.2 years-old in 2012. There were also decreases reported in driving after using alcohol and drugs and in being a passenger with someone who had consumed alcohol. Youth gambling has decreased significantly from 61.7% of youth gambling for money in the 12 months preceding the 2007 survey to 48.5% for the 2012 survey. However, gambling is certainly still a concern, with almost half of youth gambling for money and 4.3% of youth respondents meeting the criteria for at-risk or problem gambling (Government of Newfoundland and Labrador, 2007 & 2012).

<table>
<thead>
<tr>
<th>No Use of Substances</th>
<th>46.6 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>47.0 %</td>
</tr>
<tr>
<td>Cannabis Use</td>
<td>30.0 %</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>16.4 %</td>
</tr>
<tr>
<td>Ecstasy Use</td>
<td>5.7 %</td>
</tr>
<tr>
<td>Caffeinated Energy Drinks</td>
<td>61.6 %</td>
</tr>
<tr>
<td>LSD</td>
<td>2.9 %</td>
</tr>
<tr>
<td>Psilocybin or Mescaline</td>
<td>3.7 %</td>
</tr>
<tr>
<td>Inhalants</td>
<td>2.3 %</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5.8 %</td>
</tr>
<tr>
<td>Gambling (at least one of nine activities)</td>
<td>48.5 %</td>
</tr>
</tbody>
</table>

Results by grade indicate that the mean age of initiation varied among respondents, with grade 7 students reporting a mean age of 11.4 for first use of alcohol and tobacco and 12.1 for cannabis. Given the increase in risk due to early onset of substance use, there is a concern with substance use occurring among grade 7 students. This report
supports the need to look at ways to prevent or delay the onset of substance use among elementary-age children (GNL, 2007; GNL 2012).

## Alcohol Stats

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>53%</td>
</tr>
<tr>
<td>Age of first use</td>
<td>13.5 years</td>
</tr>
<tr>
<td>Consuming 5 drinks or more in a single sitting</td>
<td>31.4%</td>
</tr>
<tr>
<td>Experiencing drunkenness</td>
<td>27.8%</td>
</tr>
<tr>
<td>Used alcohol twice a month or more</td>
<td>28.1 %</td>
</tr>
</tbody>
</table>

The top 3 substances used in the year prior to the survey were alcohol (47%), cannabis (30%) and tobacco (16.4%). Students in this province reported high rates of drunkenness (27.8%) and high rates of binge drinking, with 31.4% of respondents meeting this criterion. While the percentage of students using these substances remains relatively low, at 5.8%, the use of cocaine is at its highest since 1996. There was also an increase in the use of ecstasy (MDMA), from 2% in 2003 to 5.7% in 2012 (GNL, 2007; GNL 2012).

## Substance Use and Driving

<table>
<thead>
<tr>
<th>Driving after drinking alcohol</th>
<th>7.7 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passenger with a driver who had been drinking</td>
<td>11.5 %</td>
</tr>
<tr>
<td>Driving after consuming cannabis</td>
<td>16.1 %</td>
</tr>
<tr>
<td>Passenger with a driver who had been using cannabis</td>
<td>23.6 %</td>
</tr>
<tr>
<td>Driving after taking pain medication</td>
<td>2.8 %</td>
</tr>
</tbody>
</table>

High-risk behaviour and decision making under the influence are also concerns for youth in this province. While there was a decrease in the percentage of youth driving after using alcohol and drugs, 7.7% reported driving after consuming alcohol and 16.1% after using cannabis. Also, while there was a significant decrease in youth who reported being a passenger with a driver who had been drinking (11.5% in 2012 compared to 16.9% in 2007), the number of students who reported being a passenger with a driver who had been using cannabis increase slightly from 22.2% in 2007 to 23.6% in 2012. Furthermore, of the 38% of students that reported being sexually active, 36.5% reported having unplanned sex after using alcohol or other drugs (GNL, 2007; GNL 2012).
Depressive symptoms and suicidal ideation are increasing among students, with 8.4% of students reporting 'very elevated' depressive symptoms. This is a significant increase from the 4.7% reporting these symptoms in 2007. Further, 17% of students reported seriously considering suicide, 14.1% made plans for suicide, and 8.4% attempted suicide. Females were significantly more likely to report very elevated depressive symptoms and attempted suicide. There are also concerns about the discrepancy between those reporting needing help and those reporting receiving help for depression symptoms. Needing help for depression was reported by 20.3% of students, while only 6% received this help. Significantly more females than males reported needing help for depression. However, females were not significantly more likely than males to receive help (GNL, 2007; GNL 2012).

**CIHI Indicators**

Mental Health Indicators were first nationally reported last year by the Canadian Institute for Health Information. The following indicators are being monitored and the chart shows the key data for the Western region.

<table>
<thead>
<tr>
<th>CIHI Indicators</th>
<th>2010-2011</th>
<th>2011-2012*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-Injury Hospitalization (Age standardization per 100 000) CIHI</td>
<td>123</td>
<td>100</td>
</tr>
<tr>
<td>2. Mental Illness Hospitalization (Age standardized rate per 100 000) CIHI</td>
<td>916</td>
<td>989</td>
</tr>
<tr>
<td>3. Mental Illness Patient Days (Age standardized rate per 100 000) CIHI</td>
<td>1322</td>
<td>1184</td>
</tr>
<tr>
<td>4. 30 Day Readmission Rate (Age standardization rate per 100 000) CIHI</td>
<td>14.1</td>
<td>12.2</td>
</tr>
<tr>
<td>5. Patients With Repeat Hospitalizations For Mental Illness (Age standardization rate per 100 000) CIHI</td>
<td>15.7</td>
<td>18.7</td>
</tr>
</tbody>
</table>

**Self-Injury Hospitalization Rate:**

Self-injury hospitalization is the result of suicidal or self-harming behaviors that require hospitalization. It can be used as a measure of how effective community-based services are in minimizing this type of behavior. Newfoundland and Labrador’s self-injury hospitalization rate is significantly higher than the national average according to Health Indicators (CIHI, 2013).

Health Indicators began reporting on socio-economic status (SES) for 13 health indicators including self-injury hospitalization in 2013. It is significant to note that this report concludes that by addressing SES, self-injury hospitalization has the highest potential rate reduction and would be 27% lower if all Canadians experienced the same rates as those living in the most affluent neighborhoods. The table shows a decrease from 123 in 2010-11 to 100 for 2011-12 for the Western Region.

**Mental Illness Hospitalization:**

This indicator can give a view of hospital utilization for mental health issues in an acute care setting. It provides valuable insight into the performance of mental health services
for people living with mental illness or poor mental health. There was an increase from 916 in 2010-11 to 989 the following year (2011-21) in the Western Region (CIHI, 2013).

**Mental Illness Hospitalization (30 DAY Readmission):**
Inpatient care for people living with mental illness aims to alleviate acute symptoms of mental illness. Once stabilized patients are preferably discharged with follow-up care provided through outpatient and community services. High rates of 30 day readmission could be an indicator of poor coordination of services after discharge. According to Health Indicators, “Reducing the need for readmission by ensuring care and support are coordinated and provided following discharge is beneficial for individuals and caregivers and reduces costs” (CIHI, 2011). In the Western Region, this rate decreased from 14.1 to 12.2 between 2010-11 and 2011-12 (CIHI, 2013).

**Patients with Repeat Hospitalization for Mental Illness:**
Another indicator for health performance is repeat hospitalizations. This indicator is considered an indirect measure of appropriateness of care. According to Health Indicators (2011), “exploring hospital utilization patterns for individuals admitted with mental illness may be useful to highlight the use and availability (or lack thereof) of outpatient community services”. The table shows this rate increased from 2010-11 to 2011-12 (15.7 to 18.7 respectively) in the Western Region.

**Patient Days:**
As reported by Statistics Canada (2012), mental diagnoses, whether co-morbid or not, were associated with a much longer hospital stay – more than two and a half times longer than stays not involving mental diagnosis. The report also states that this pattern was the same for patients of all ages. The patient days rate is a partial measure of hospital utilization in acute settings. For Western Health, there were 1184 per 100,000 mental illness patient days in 2011-12. This was a decrease from the previous year of 1322.

**Acute Care Hospital Days:**
The term alternate level of care (ALC) identifies patients who have completed the acute care phase of their treatment but who still occupy a bed because of the unavailability of supports in the community (Statistics Canada, 2012). These patients may stay in acute care hospitals for a longer period of time than patients without a co-morbid mental illness. According to a report by Statistics Canada, mental illness comorbidity was associated with a substantial increase in the average length of stay. The three co-morbid mental diagnoses that accounted for the largest number of days were organic disorders (1,404,000), mood disorders (600,000) and substance-related disorders (537,000) (Statistics Canada, 2012).

**Life Satisfaction:**
The Statistics Canada General Social Survey (GSS) and Canadian Community Health Survey (CCHS) have collected a great deal of information on the subjective well-being of Canadians. Evidence from all these years of data collection indicates that Canadians are able and willing to answer questions about their life satisfaction. In Newfoundland and Labrador, 92.5% of people reported being satisfied or very satisfied with life in general for 2011-2012. The Western Region is consistent with the provincial rate, with
92.3% reporting the same level of life satisfaction for the same year (Statistics Canada, 2013).

**Sense of Belonging:**
Social isolation is one of the determinants of health that can negatively impact a person's mental health. Research shows that a sense of belonging and social engagement are associated with better mental and physical outcomes, even when socio-economic status, age, and other factors are taken into consideration. According to Statistics Canada, people from rural communities and higher household incomes reported a somewhat or strong sense of belonging (Statistics Canada, 2013). In 2011-2012, 77.3% of people in the province of Newfoundland and Labrador reported a sense of belonging to local community as somewhat strong or very strong. In the Western region the rate is higher than the provincial rate with 84.3% reporting a sense of community belonging in 2011-12 (Statistics Canada 2013).

**Perceived Mental Health:**
Perceived mental health refers to a person's view of their own general mental health. It is reflective of a population's emotional or mental suffering that is not necessarily reflected in perceived health. In Newfoundland and Labrador, 73.2% reported perceiving their mental health as either very good or excellent for 2011-12. The Western region is comparable for 2011-12 at 72.2% reporting the same level of life satisfaction (Statistics Canada, 2013).

**Perceived Need for Mental Health Care:**
In the 2012 Canadian Community Health Survey – Mental Health (CCHS-MH) it states that one in six Canadians aged 15 or older perceived a mental health care need in the previous year. The most common was for counseling services; however, other perceived needs include medication and information. Also, having a mental disorder, chronic physical condition, or high levels of distress were positively associated with perceiving a mental health need (Statistics Canada, 2013).

**Professional Services Supporting Prevention & Promotion**

Prevention and promotion services are offered through Western Health’s, Mental Health & Addiction Services Program area, with staff responsibilities for prevention and promotion as well as designated positions for prevention and promotion.

**Internal Positions:**

**Regional Mental Health Promotion Consultant (RMHPC):**
As part of the mental health and addictions team, the RMHPC position provides leadership in the development, coordination, planning, and implementation of specialized mental health prevention/promotion. This position is also responsible for the effective evaluation of prevention initiatives and is instrumental in providing regional direction in the initiation of mental health prevention/promotion and in the establishment of community partnerships. The RMHPC assesses community needs, researches appropriate initiatives, and implements and evaluates programming.
Regional Addictions Prevention Consultant (RAPC):
As part of the mental health and addictions team, the RAPC will provide leadership in the development, coordination, planning, and implementation of specialized addictions prevention/promotion. This position is also responsible for the effective evaluation of prevention initiatives and is instrumental in providing regional direction in the initiation of addictions prevention/promotion and in the establishment of community partnerships. The RAPC assesses community needs, researches appropriate initiatives, and implements and evaluates programming.

Youth Early Intervention and Outreach Workers (YOW):
YOW’s provide support to youth aged 12 to 29 and their parents. There are 4 positions located throughout the region in Port aux Basques, Stephenville, Corner Brook and Bonne Bay. YOW’s provide confidential support to youth and their parents and help connect youth to appropriate services and supports as required. In addition to the direct support provided to youth, YOW’s offer a variety of prevention and promotion programming. The YOW positions have provided a unique opportunity for collaboration between community agencies and Western Health. The positions are placed in a way that they have provided tremendous support to the Prevention and Promotion Consultants and have added a layer of facilitation and program delivery that did not exist prior with competing demands between health promotion and clinical waitlist management.

Addictions Coordinators:
There are 2 Addictions Coordinator positions within Mental Health and Addiction Services: (1) Corner Brook and North and (2) Stephenville and South. These positions have clinical addictions responsibilities but also have designated responsibilities for prevention and promotion work. Recently, the positions have evolved to incorporate mental health promotion into the duties in recognition that mental health promotion and addictions prevention go hand and hand.

Prevention & Promotion Team:
The Prevention and Promotion team is a newly established team that consists of the following Mental Health and Addiction Services positions: Consultants, Youth Outreach Workers, Addictions Coordinators, and Mental Health and Addictions Manager. The team meets bi-monthly to ensure a coordinated approach to prevention and promotion in the Western Region.

Clinical Mental Health and Addictions Workers:
All Mental Health and Addictions staff share the responsibility of prevention and promotion work. However, clinical caseload and waitlist management must be considered when determining the amount of prevention and promotion work that clinical staff can support. This varies throughout the year and throughout the region.

Other Western Health Consultants & Staff:
The RMHPC and RAPC positions are located within the Mental Health and Addictions Services program area but work closely with Consultants and staff in other program areas such as Health Promotion and Primary Health Care and Community Health and Family Services. Positions such as the Wellness Facilitators, Parent & Child Health
Coordinators, Regional Sexual & Reproductive Health Consultant, Regional Health Educator, and Community Health Nurses are among the staff that the RMHPC and RAPC often partner with to support prevention and promotion initiatives. Wellness Facilitators consult regarding mental health and addictions issues and resource needs in their area. Community health nurses access resources to support the front line delivery of prevention and promotion initiatives in their schools and community.

**External Partners:**

Western Health also partners with various community-based agencies to support prevention and promotion programs and initiatives. Schools, women’s centres, youth centres, seniors clubs, Aboriginal organizations, and police are among some of the many partners in prevention and promotion. In addition, there are some community based organizations that specialize in mental health, addictions, and violence prevention.

**Community Mental Health Initiative Inc. (CMHI)**

CMHI is a non-profit charitable organization that is community-based and made up of representatives from professional agencies, community groups and consumers whose goal is to work together to address mental health needs in the Corner Brook, Bay of Islands and Deer Lake areas, with some initiatives extending across the entire western region. CMHI has subcommittees to address specific priorities such as the Mental Health Promotions Committee, Adult Mental Health Working Group, and Suicide Prevention and Awareness Committee.

**Suicide Prevention and Awareness Committee (SPAC)**

Formed in 2010, SPAC is a sub-committee of the Community Mental Health Initiative. The committee includes members from multiple community organizations and individuals whose lives have been affected by suicide. In an effort to raise awareness, educate the community, reduce stigma, and to remember those who have died by suicide, SPAC has been very active in various initiatives across the region. The committee organizes an annual World Suicide Prevention Day Walk on September 10th, a Tree of Memories each year in December in memory of lives lost to suicide, a BBQ grant available to community groups to promote key messages of suicide prevention and awareness, and distribution of warning signs posters and postcards, ‘life savers’ cards, ‘Help After Suicide’ pocket cards, and key chains throughout the Western region. The Committee also created a local video with hopes to send a powerful message to viewers about suicide. It can be viewed on the Western Health website and YouTube.

**Canadian Mental Health Association, Newfoundland and Labrador Division (CMHA-NL)**

CMHA-NL is a voluntary, non-profit, charitable organization established in 1964 to promote a better understanding of mental health and mental illness in the province. As a division of the national Canadian Mental Health Association, their mission is to facilitate access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness. This mission is accomplished through building capacity, influencing policy, providing services, and developing resources. CMHA-NL division’s head office is in St. John’s,
and they also have two new regional offices located in Grand Falls-Windsor (Central) and Stephenville (Western). They are governed by a volunteer board of directors from all over the province.

**Consumers’ Health Awareness Network of Newfoundland and Labrador (CHANNAL)**

CHANNAL is the only consumer-led mental health organization in the province. They are a provincial non-profit organization that exists to build and strengthen a self-help network among individuals who live with mental health issues. CHANNAL’s aim is to combat isolation for those living with mental illness, to provide a forum for mental health consumers’ concerns, to educate the public on issues relevant to mental health consumers, to offer advocacy, and to offer social and emotional support to mental health consumers. There are Regional Peer Support Positions located in St. John’s, Grand Falls and Stephenville as well as a Provincial Coordinator.

**Community Youth Network (CYN)**

CYN is a Provincial initiative whose mandate is to provide a variety of services for youth living in or at risk of poverty. Its inception resulted from a need to decrease barriers to education and/or employment, and improve the quality of life for young people. CYN sites provide youth 12-18 with recreational and educational opportunities, along with life management skills. CYN’s overall goal is to help youth to achieve their full potential in a safe, supportive, drug and alcohol free environment. In the Western Region, CYN has sites in Port aux Basques, Stephenville, Burgeo, and Corner Brook (including satellite sites for North and South Shore Bay of Islands).

**Status of Women Councils**

Working within a feminist framework, the Status of Women Councils are dedicated to the empowerment of all women. The Councils endeavor to promote peace, justice, and equality for women and their families through support, education, and advocacy. Goals of the councils are to improve the status of women, to eliminate discrimination on the basis of sex and marital status, to promote better opportunities for women, to encourage the development and improvement of services and facilities to meet the needs of women, and to promote awareness and acceptance of women rights on a personal and public basis. The three Councils in the Western Region are Gateway Status of Women Council in Port aux Basques, Bay St. George Status of Women Council in Stephenville, and Corner Brook Status of Women Council in Corner Brook. While services vary among sites, each site provides education and social programming, support and referral for women in crisis, and community meeting space.

**Schizophrenia Society of Newfoundland and Labrador (SSNL)**

SSNL is a charitable organization that works under the federation model with other provincial Schizophrenia Societies across Canada, as well as the Schizophrenia Society of Canada. Their mission is to improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy, and research. The main office is located in St. John’s with Family Support Workers located in St. John’s and Corner Brook.
Western Regional Coalition to End Violence (WRCEV)
WRCEV is one of ten Regional Coordinating Committees that work in partnership with the provincial Violence Prevention Initiative to increase awareness of all forms of violence and the structural context of inequality in which violence is rooted. Their role encompasses public awareness and education initiatives, community capacity-building, outreach, resource development, advocacy, and the coordination of partnerships and programs. The Coalition employs a full-time Executive Director, as well as a part-time Administrative Coordinator. There are three volunteer-based local coordinating committees operating under the umbrella of the WRCEV throughout Western Newfoundland, in Deer Lake, Bonne Bay North, and Bonne Bay South.

Southwestern Coalition to End Violence
The Southwestern Coalition to End Violence consists of representatives from the three local coordinating committees. Each of these three committees works to engage the support of stakeholders in their respective communities to address issues of violence. The three committees include: Peaceful Communities (Port aux Basques, the Codroy Valley and southwestern Newfoundland coastal communities), the HELP Committee (Burgeo), and the Bay St. George Coalition to End Violence (Bay St. George South, Stephenville, and the Port au Port Peninsula).

Northern Committee to End Violence
The Northern Committee Against Violence has at least one representative from each of the following departments in the region: Department of Health, Department of Justice, Department of Education, Department of Advanced Education and Skills, RCMP, St. Anthony Sub-Committee, Port Saunders Sub-Committee, Flower’s Cove Sub-Committee, Roddickton Sub-Committee, and three Community members. Their goal is to promote violence prevention in the St. Anthony – River of Ponds region through the promotion of community awareness, education, and policy development as it relates to the prevention of violence.

Prevention & Promotion Initiatives & Programs

Community Grants:
Western Health supports prevention and promotion efforts through the provision of community grants. Mental Health and Addiction Services administers the Community Addictions Prevention and Mental Health Promotion Fund in May and November with $15,000 available for each round of funding. In addition, smaller amounts of funding are available through Awareness Week Activity Grants. These grants provide a maximum of $150 per applicant to support activities in recognition of the following annual awareness week campaigns: Mental Health Week in May, Mental Illness Awareness Week in October, and Addictions Awareness Week in November.

Prevention and Promotion Resources:
The RMHPC and RAPC continue to develop and acquire new resources to support prevention and promotion efforts. Resources include toolkits, displays, print materials, presentations, workshops, and interactive resources. While sometimes considered ‘one-off’ initiatives, these prevention and promotion resources also build together to form one
branch of a coordinated and ongoing effort to strengthen connection between service
providers and the community. They are also tied together with consistent underlying
messages to build awareness and address risk and protective factors across the
lifespan.

The Consultants have made significant efforts to promote these available resources
through the development of a web link on the Western Health website and email
address for borrowing resources. The web link is www.westernhealth.nl.ca/mha and the
email address is mha@westernhealth.nl.ca. This email address links directly to the
Consultants and Administrative Support positions. A presentation request form was also
developed and available on the website for community to request a presentation from
mental health and addiction services. This form helps the Consultants direct
presentation requests to the appropriate area.

Existing Regional Programs and Initiatives:
There are a number of prevention and promotion programs and initiatives already
established in the Western Region. These programs and initiatives are being offered
through Western Health staff and other community agencies. They address a variety of
prevention and promotion issues, range in duration, and require varying human
resource and financial needs. Information about the following programs or initiatives can
be found in the Program Descriptions in the appendices of this Strategy or by contacting
the Mental Health and Addiction Consultants. The following programs and initiatives are
available in the Western Region and are considered evidence informed and best
practice based:

• **Addictions Prevention Tools, Addiction Prevention Centre**
  A program that aims to support youth to distinguish between true and false beliefs
  about substance use, develop understanding regarding the risks of substance use,
  and develop personal opinions related to alcohol and drug use. It has five interactive
  activities for youth related to areas of influence: (1) friend, (2) family, (3) life setting,
  (4) community, and (5) media.

• **An Introduction to Trauma Informed Practice Workshop, Corner Brook Status of
  Women**
  A 1-day introductory workshop that is offered to front-line workers or anyone in the
  community who interacts with those seeking help. The workshop covers various
  topics with a focus on developing an understanding of trauma and trauma informed
  practice guidelines. Participants are also given opportunities to practice applying this
  knowledge to their own practice.

• **Applied Suicide Intervention Skills Training (ASIST), Living Works**
  A 2-day interactive workshop intended for individuals who want to feel more
  comfortable, confident and competent in helping to prevent the immediate risk of
  suicide.

• **Boys Council, One Circle Foundation**
  Structured programs for boys that aim to promote boys’ natural strengths and to
  increase their options about being male in today’s world. The Council challenges
myths about how to be a “real boy” or “real man”. It engages boys in activities, dialogue, and self-expression to question stereotypical concepts and to increase boys’ emotional, social, and cultural literacy by promoting valuable relationships with peers and adult facilitators.

- **Challenges, Beliefs and Changes, Parent Action on Drugs**
  A peer education program that provides an atmosphere for young people to freely discuss concerns about teenage social issues and challenges related to substance use. This program helps adolescents: clarify and challenge their own personal beliefs and expectations about the use of alcohol and other drugs in high school; clarify "urban myths" and learn or reinforce information about alcohol, cannabis (marijuana and hashish), prescription drugs, caffeine (high energy drinks) and other drugs; address the issues of teenage drinking and drug use in our society and consider meaningful alternatives; apply the problem-solving process to their choices; and learn what options are available for help for youth both inside and outside their school community.

- **Families & Schools Together (F&ST)**
  A 2-year parent involvement and prevention program that supports families with children from birth to 12 years of age. The program consists of an 8-week facilitator-led program with structured weekly session, followed by monthly follow-up sessions organized by the families.

- **FRIENDS for Life Anxiety Prevention Program**
  The FRIENDS for Life program is an internationally recognized, school-based early intervention and prevention program that builds resilience and reduces the risk of anxiety disorders in children.

- **Girls Circle, One Circle Foundation**
  Structured programs for girls from 9-18 years that integrate relational theory, resiliency practices, and skills training in a specific format designed to increase positive connection, personal and collective strengths, and competence in girls.

- **Helping Skills Training Program, Canadian Mental Health Association-NL**
  A 14-module certificate program to improve communication skills and teach people how to better support others. This program has been successfully offered across the Western Region. Currently, the program is in re-development by CMHA-NL. Once revised, the program will be reviewed to determine appropriateness and feasibility to re-initiate in the Region.

- **Mental Health First Aid Canada, Mental Health Commission of Canada**
  A 2-day program that offers explanations of mental health, mental illness, and mental health problems; signs and symptoms of common mental health problems and crisis situations; information about effective interventions and treatments; and ways to access professional help.
• **No Stress Fest**
  A 1-day family wellness event which is focused on promoting positive mental health & overall wellbeing and includes interactive booths/sessions on variety of topics. Western Health developed this initiative in partnership with CMHI, CMHA-NL, and the Schizophrenia Society. A ‘How-To’ Guide is in development.

• **Prevent Alcohol & Risk Related Trauma in Youth (PARTY) Program, Sunnybrook Health Science Centre**
  A ½-day interactive program targeting youth aged 15 and older to recognize injury risks associated with substance use and make informed decisions to reduce these risks. For more information see the Injury Prevention Strategy developed by the Health Promotion and Primary Health Care Program, Western Health.

• **Peer Mentoring Program**
  Through discussion and fun engaging activities, students learn the basic but crucial skills to build healthy relationships and support each other, including communication, assertiveness, confidentiality, decision making, and conflict mediation.

• **Safer Bars**
  A regional initiative developed and delivered by a sub-committee of the Sexual Health Working Group. The goal of the initiative is to promote safer partying and harm reduction messages. Coasters and posters were developed for a social marketing campaign. The campaign’s messages range from the importance of condom use and sexual consent to responsible drinking. This initiative focused on prevention and reducing harm related to risky behaviors among the 19-29 year old youth population. The initiative specifically targeted youth attending bars and aimed to prevent negative unintended outcomes and reduce the negative health impacts or harms associated with decision making under the influence of alcohol and drugs. The Program Description can be found in the Sexual and Reproductive Health Strategy developed by the Health Promotion and Primary Health Care Program, Western Health. In addition to the bar campaign, a campaign involving taxis was added during the Fall 2014 round. The group is now considering how to effectively adapt the messaging to expand to secondary and post-secondary schools across the region.

• **Strengthening Families for the Future Program, Parent Action on Drugs**
  A 14-week substance use prevention program for families with children aged 7-11.

• **Strengthening Families for Parents & Youth Program, Parent Action on Drugs**
  A 9-week substance use prevention program for families with teens ages 12-16.

• **Suicide Prevention**
  Coordinated and collaborative suicide prevention efforts are continually ongoing in the Western Region. Two suicide awareness and prevention campaigns are currently underway. The first is directed at physician’s offices and emergency/outpatient clinics in the Western Region and includes distributing posters and postcards with warning signs of suicide in case someone they knew may be suicidal and encouraging patients to talk to their doctor if having thoughts of suicide. The
second is directed at youth and includes distributing postcards and a youth-focused poster to all secondary and post-secondary schools, as well as youth centres, in the Western Region.

Recognizing the growing trend of people seeking E-mental health services for emotional support such as live chat, texting, e-mail, social media, apps, and peer support, a recent addition to the MHA website has been a list of available on-line and self-help resources located in the suicide prevention section of the site. In addition, a suicide prevention e-learning module has been developed and submitted for implementation in the e-learning system for staff of Population Health. This training depicts various scenarios that a staff person in the Population Health Branch could encounter when contacted by a person displaying suicidal behaviour.

- **Tattered Teddies/Straight Talk, Centre for Suicide Prevention**
  Tattered Teddies is a workshop about preventing suicide in children. This ½-day workshop examines the warning signs in a child and intervention strategies. Straight Talk is a youth-focused suicide prevention workshop for people working with youth ages 12 to 24.

- **The Truth About Drugs, Foundation for a Drug Free World**
  A program that covers the truth about the most commonly abused street and prescription drugs. The program includes a variety of sessions with accompanying videos and handouts.

- **What’s With Weed**
  A peer education program to engage high school students in a discussion about the use of marijuana. This youth-driven program helps students identify not only risks and potential problems but also positive behaviour change and decision-making strategies that connect with marijuana use.

- **Youth Voices, Healthy Choices, The Sexual Health Working Group**
  Developed with funding from the Health Promotion and Primary Health Care Program, the project aimed to get youth involved as leaders in the promotion of healthy decision making. This project aims to support youth, parents and communities in working together to take action and work on addressing local sexual and emotional health priorities including responsibilities, self-esteem/body image, sexual identity, decision making, risky behaviours (ex: unprotected sexual activity, alcohol/drug use), and harm reduction. The Program Description is included in the Sexual and Reproductive Health Strategy developed by the Health Promotion and Primary Health Care Program, Western Health.

**BEST & EVIDENCE INFORMED PRACTICES**

Best and evidence informed practices involve initiatives that target specific groups and settings, address risk and protective factors, set clear goals, support communities to take action, and are sustained over time. Better outcomes are achieved when needs are
addressed in everyday settings such as homes, schools and workplaces. This approach also helps to reduce stigma (MHCC, 2012).

Approaches to promote mental health and prevent mental illness and addiction focus on increasing protective factors and decreasing risk factors. Protective and risk factors are things that protect a person from developing a substance, gambling, or mental health problem or put someone at risk for developing a problem. Programs should target modifiable risk factors and strengthen protective factors. Early intervention with risk factors often has greater impact than later intervention. The risk and protective factors listed in the first two tables below have an impact on mental health and mental illness. However, many of the same risk and protective factors also have an impact on the risk of suicide and problematic substance use (MHCC, 2012). This is evidenced by the third chart depicting risk and protective factors for developing substance use problems.

Mental health promotion efforts should support individual resilience, create supportive environments and address the broader determinants of mental health (CIHI, 2009). These components along with building protective factors and reducing risk factors across the lifespan are utilized in this health promotion strategy for mental health and addictions.

<table>
<thead>
<tr>
<th>Individual Factors</th>
<th>Family Factors</th>
<th>School Context</th>
<th>Life Events &amp; Situations</th>
<th>Community &amp; Cultural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy temperament</td>
<td>Supportive caring parents</td>
<td>Sense of belonging</td>
<td>Involvement with significant other person (partner or mentor)</td>
<td>Sense of connectedness</td>
</tr>
<tr>
<td>Adequate nutrition</td>
<td>Family harmony</td>
<td>Positive school climate</td>
<td>Availability of opportunities at critical turning points or major life transitions</td>
<td>Attachment to and networks within the community</td>
</tr>
<tr>
<td>Attachment to family</td>
<td>Secure and stable family</td>
<td>Prosocial peer group</td>
<td>Economic security</td>
<td>Participation in church or other community group</td>
</tr>
<tr>
<td>Above-average intelligence</td>
<td>Small family size</td>
<td>Required responsibility and helpfulness</td>
<td>Good physical health</td>
<td>Strong cultural identity and ethnic pride</td>
</tr>
<tr>
<td>School achievement</td>
<td>More than two years between siblings</td>
<td>Opportunities for some success and recognition of achievement</td>
<td></td>
<td>Access to support services</td>
</tr>
<tr>
<td>Problem-solving skills</td>
<td>Responsibility within the family (for child or adult)</td>
<td>School norms against violence</td>
<td></td>
<td>Community/cultural norms against violence</td>
</tr>
<tr>
<td>Internal focus of control</td>
<td>Supportive relationship with other adult (for child or adult)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social competence</td>
<td>Strong family norms and morality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good coping style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moral beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive self-related cognitions</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 1-1 Protective factors potentially influencing the development of mental health problems and mental disorders in individuals.

Many of these factors are specific to particular stages of the lifespan, particularly childhood; others have an impact across the lifespan, for example, socioeconomic disadvantage.

<table>
<thead>
<tr>
<th>Individual Factors</th>
<th>Family Factors</th>
<th>School Context</th>
<th>Life Events &amp; Situations</th>
<th>Community &amp; Cultural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal brain damage</td>
<td>Having a teenage mother</td>
<td>Bullying</td>
<td>Physical, sexual &amp; emotional abuse</td>
<td>Socioeconomic disadvantage</td>
</tr>
<tr>
<td>Prematurity</td>
<td>Having a single parent</td>
<td>Peer rejection</td>
<td>School transitions</td>
<td>Social or cultural discrimination</td>
</tr>
<tr>
<td>Birth injury</td>
<td>Absence of father in childhood</td>
<td>Poor attachment to school</td>
<td>Divorce &amp; family breakup</td>
<td>Isolation</td>
</tr>
<tr>
<td>Low birth weight; birth complications</td>
<td>Large family size</td>
<td>Inadequate behaviour management</td>
<td>Death of family member</td>
<td>Neighbourhood violence &amp; crime</td>
</tr>
<tr>
<td>Physical &amp; intellectual disability</td>
<td>Antisocial role models in childhood</td>
<td>Deviant peer group</td>
<td>Physical illness or impairment</td>
<td>Population density &amp; housing conditions</td>
</tr>
<tr>
<td>Poor health in infancy</td>
<td>Family violence &amp; disharmony</td>
<td>School failure</td>
<td>Unemployment</td>
<td>Lack of support services including transport, shopping, recreational facilities</td>
</tr>
<tr>
<td>Insecure attachment in infant/child</td>
<td>Marital discord in parents</td>
<td></td>
<td>Homelessness</td>
<td></td>
</tr>
<tr>
<td>Low intelligence</td>
<td>Poor supervision &amp; monitoring of child</td>
<td></td>
<td>Incarceration</td>
<td></td>
</tr>
<tr>
<td>Difficult temperament</td>
<td>Low parental involvement in child’s activities</td>
<td></td>
<td>Poverty, economic insecurity</td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td>Neglect in childhood</td>
<td></td>
<td>Job insecurity</td>
<td></td>
</tr>
<tr>
<td>Poor social skills</td>
<td>Long-term parent unemployment</td>
<td></td>
<td>Unsatisfactory workplace relationships</td>
<td></td>
</tr>
<tr>
<td>Low self esteem</td>
<td>Criminality in parent</td>
<td></td>
<td>Workplace accident/injury</td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>Parent substance misuse</td>
<td></td>
<td>Caring for someone with an illness or disability</td>
<td></td>
</tr>
<tr>
<td>Impulsivity</td>
<td>Parental mental disorder</td>
<td></td>
<td>Living in a nursing home or aged care hostel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harsh or inconsistent discipline styles</td>
<td></td>
<td>War or natural disaster</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiencing rejection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of warmth &amp; affection</td>
<td></td>
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</tr>
</tbody>
</table>


*Many of these factors are specific to particular stages of the lifespan, particularly childhood; others have an impact across the lifespan, for example, socioeconomic disadvantage.*
**Risk and protective factors potentially influencing substance misuse and abuse.**

<table>
<thead>
<tr>
<th>Life Area</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
</table>
| **Individual** | • Begins using at an early age  
• Impulsiveness and sensation seeking (risk taking)  
• Poor social and coping skills  
• Early childhood behaviour problems  
• Feeling alienated | • Well-developed social and problem solving skills.  
• A sense of self-esteem |
| **Family** | • History and patterns of use and attitudes toward drugs  
• Inconsistency in parenting, supervision, discipline and nurturing  
• Unclear family rules, expectations and consequences  
• Family is conflict ridden, experiencing disruption | • Good communication (in general and specifically about substance use)  
• Supervision of children and activities (including the selection of friends)  
• Rules are clear and consistently enforced  
• Child feels connected, valued and supported  
• Parents have expectations of child’s success (i.e. grades) |
| **Peer** | • Association with peers who use alcohol or other drugs or other drugs or who engage in risk taking behaviours | • Friends who do not use alcohol or other drugs and who do not support the behaviour.  
• One or more close friends  
• Form long lasting friendships  
• Rely on friends for emotional support |
| **School** | • Academic problems  
• Lack of commitment to school  
• Lacks a sense of belonging in the school community | • Success and commitment in school  
• Involvement in extra-curricular activities  
• School action/messages on drug use |
| **Community** | • Alcohol and other drugs are easily accessible  
• Community disorganization and low neighborhood attachment  
• Laws, norms and attitudes favor drug use | • Community sponsored activities  
• Strong social bonds, child feels connected  
• Community action/messages around drug use |

*Risk and protective factors are grouped by life area, but these factors are often connected. Examples are given for each life area or domain. Source: Addiction Services Nova Scotia (2015).*
The *Mental Health Strategy for Canada* provides considerable support for prevention and promotion efforts. The Strategy recognizes that treatment alone is not enough and, in an effort to reduce the impact of mental health problems, there is a need to promote mental health for the entire population and prevent mental illness where possible (MHCC, 2012).

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

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

The delivery of education and awareness, both at the general population level and among target groups, is a key component of mental health promotion. The following best practices have been developed for use in developing and delivering messaging for health-related behaviour:

- Use messaging tailored to the values, attitudes, and needs of explicit target groups
- Use multiple approaches
- Cultivate broad social responsibility
- Enhance social support
- Avoid moralizing behaviour
- Use positive messages
- Use branding to enhance public campaigns
- Proactively counter competing messages and norms

(Brach, Thomas & Stockwell, 2012)

Most informal care for older adults is provided by families. In addition, approximately 2% of Canadians over age 17 are providing care for a loved one who has been diagnosed with a mental health problem. Furthermore, almost half of these caregivers have been doing so for over 5 years (CAMH, 2008; O’Grady and Skinner, 2007). While providing care may offer a sense of fulfillment, many caregivers experience stress, frustration, and strain from trying to provide support for individuals with mental health and addiction issues (Armstrong, S., Bubbra, S., Himes, A., Kelly, C., Shenfeld, J., Sloss, C., and Tait, L., 2009; CAMH, 2008). Mental health promotion for caregivers should incorporate normalizing the strain caused by caregiving, as this can reduce guilt and stigma among caregivers, increasing their likelihood of accessing supportive services. Additional best practices to improve caregiver outcomes include increasing mental health literacy, promoting resiliency and coping skills, as well as increasing social support. CAMH (2008) highlights that, “Caregivers learn best while sharing their feelings with others who understand them”. Ensuring that caregivers are meaningful participants in planning...
and delivery of mental health promotion initiatives will help ensure goodness of fit for the initiative while also increasing connections among caregivers.

Due to the prevalence of trauma in our society and the evidence that supports how trauma contributes to poor mental health outcomes, service providers should assume that all people they encounter has experienced trauma. According to the Trauma Informed Toolkit, providing a trauma-informed service requires the recognition that genuine, authentic and compassionate relationships are at the foundation of service delivery. Furthermore, trauma informed services must utilize the following core principles:

• Acknowledgement – recognizing that trauma is pervasive
• Safety
• Trust
• Choice and Control
• Compassion
• Collaboration
• Strength-based

(Klinic Community Health Center, 2013)

Trauma-informed care is Standard 14 of the Provincial Addictions Treatment Standards (Government of Newfoundland and Labrador, 2015). The Standard outlines that disclosure of trauma is not required to implement trauma-informed practices. Rather, these practices can benefit all clients who are engaged in services. Applying this Standard to work in prevention and promotion requires:

• Establishing safety and trustworthiness by ensuring informed consent, providing clear information, and demonstrating consistency and transparency when working with colleagues, community partners, and the public;
• Ensuring a collaborative approach in working with community partners and stakeholders, addressing power imbalances, and promoting meaningful engagement and shared decision-making; and
• Supporting the development of new coping skills, focusing on resiliency and building strengths, at all opportunities (GNL, 2015).

Now, more than ever, Canada is a multicultural society. However, using a “one size fits all” approach is not only ineffective, it does not support the idea of multiculturalism in which all cultures are viewed as equal in value (CAMH, 2007).

Traditional mental health and addictions services are not considered to be effective in improving the circumstances of Aboriginal Peoples. According to the Provincial Framework for Newfoundland and Labrador: Working Together for Mental Health, the unique experiences of Aboriginal Peoples, including the high incidence of suicide, substance abuse, fetal alcohol spectrum disorders, violence, and family and band breakdowns, requires a customized approach to mental health issues in this population (GNL, 2005). The devastating impact of colonization, loss of land, residential schools, loss of identity, intergenerational trauma and the organization of power and governance as had a significant influence on the lives and health of this population. Efforts need to focus on emphasizing a holistic approach to wellness that creates balance and harmony between the physical, spiritual, and emotional components of life (GNL, 2005).
Ethno-cultural communities are defined as communities whose members have ethnic origins that are not French, British or Aboriginal. According to the Centre for Addiction and Mental Health, Canada has exceeded 200 ethnic groups. Ethno-cultural communities are vulnerable to mental health and substance use problems due to pre-migration trauma, economic and social disadvantages, isolation, racism, discrimination and cultural pressures (CAMH, 2007).

Cultural competence is the ability to relate effectively and respond to the unique needs of members of minority populations. When working with people of different cultures, it is important that service providers are aware of their own culture and how it has shaped their way of thinking and doing things. It is important to recognize that other people may have other ways of understanding, communicating, and learning. Best practice in enhancing service delivery with people of other cultures includes: putting aside assumptions, being flexible, listening more, talking less, and recognizing the possibility of misunderstanding rather than making judgments (CAMH, 2007). The Mental Health Strategy for Canada also supports cultural competency. Priority 4.2.of this strategy states that people from diverse backgrounds sometimes experience and explain mental health issues differently and this can be a challenge for service providers. “organizations and health professionals need to be attuned to those differences and work to modify services, treatments and supports to make them more welcoming and effective” (MHCC, 2012).

Collaboration among providers, within service sectors but also across service sectors, is established as a best practice to address mental health and addiction issues (CCSA, 2014). A significant majority of individuals affected by mental health and substance use problems do not use specialized services. However, they are accessing other healthcare services, as well as other social services and community-based programs, such as the Emergency Department, Public Health, Community Supports, the Department of Justice, and Newfoundland and Labrador Housing, as well as educational institutions, women’s shelters, youth centres, and peer-support programs, among others. Therefore, it is paramount that other systems and services collaborate and work to enhance mental health promotion and addiction prevention efforts (CCSA, 2014; National Treatment Strategy Working Group, 2008).

Furthermore, there is a need to improve general mental health and addiction knowledge, as well as early detection capacity, among these related health and human service providers. Enhancing their knowledge and capacity will improve health promotion and early intervention, as well as increase referrals to prevention programs, self-help supports, and/or professional services (CCSA, 2007 & 2014). Training for front-line service providers in the early identification of mental health problems to promote mental health and prevent mental illness and suicide where possible is a recommendation for action in the Mental Health Strategy for Canada (MHCC, 2012). CAMH identifies the GAIN Short Screener (GSS) as a good option for first-stage screening in primary care and other health and social services settings (CAMH, 2009). The GSS is made up of 20 items, takes 3 to 5 minutes to administer, and screens for mental health and substance use disorders, as well as crime/violence. The GAIN-SS has been validated for subjects aged 10 to 17, as well adults. A GAIN License must be obtained and each person using the GAIN must also complete a GAIN Usage Agreement. However, the GAIN offers an option for licensing for multiple agencies.
within a system or project. As such, this may be a cost-effective option for consistent screening (CAMH, 2009; Chestnut Health Systems, 2015).

Technology has become a part of everyday life for the majority, if not virtually all, Canadians. In fact, 83% of Canadian households have internet access at home and the majority of Canadians are using the internet on a daily basis (MHCC, 2014). For those without home access, schools, public libraries, and Community Access Program sites provide no-cost access in the community. The use of technology for mental health is commonly referred to as e-Mental health. E-Mental Health uses the internet and related technologies to deliver or enhance mental health services and information (MHCC, 2014). The *Mental Health Strategy for Canada* highlights that there are, “tremendous possibilities for new technology in promoting mental health and preventing mental health problems” (MHCC, 2012).

The Provincial Government, through the Department of Health and Community Services, began developing an E-Mental Health and Addiction Awareness Program in 2011. The Program aims to decrease the negative impact that stigma and discrimination have on people with mental illness and addiction issues. The program is founded on a multi-prong comprehensive model that includes community action, awareness, access, education, and knowledge exchange (Government of Newfoundland and Labrador, accessed online February 23, 2015).

People use technology to plan their day, communicate with friends and family, keep themselves entertained, check on the weather, as well as keep up with news and current events. Increasingly, technology is also becoming the main point of reference for research. The stigma that may prevent someone from coming to an awareness or education event is drastically reduced by technologies that allow the individual to access information in the comfort and privacy of their own home. Technology also allows for immediate access across time zones and in rural and remote areas. Because of these factors, technology has the potential to reach more people than we can ever hope to reach face to face. Technology is a beneficial mechanism that may be utilized for anti-stigma and awareness campaigns, promotion of initiatives and events, and provision resources and information to improve mental health literacy and help individuals make informed decisions about mental health and substance use (MHCC, 2014).

Evaluation is a key component of prevention and promotion and should be incorporated into the planning process when developing or implementing programs and initiatives. Evaluation assists providers in assessing the strengths and weaknesses of their initiatives, in order to engage in a continual improvement process and ensure services meet their needs and intended outcomes as best they can. Outcome indicators measure how well initiatives are accomplishing their intended results. They compare the result of an intervention to the situation beforehand. For example, if an initiative is aimed at building a skill, the outcome indicator may be to measure the participants’ confidence in the skill pre-and post-initiative to determine if positive change occurs. Likewise, pre- and post-initiative measures may be used to indicate changes in other objectives such as changing a risk or protective factor or enhancing knowledge or awareness. Process indicators measure how well activities are being run. They track how much is being
done and how well people like it. Examples include the number of participants, number of participants who take on a leadership role, number of meetings held to discuss a policy change or initiative development, or participant satisfaction survey responses (Ziegenspeck, Kobus-Matthews, Barr, Jackson, Magdeburg-Stendal, Jiwani, N., Easlick, Loconte, and Chow, 2010). The Monitoring and Evaluation Toolkit developed by the CCSA provides a workbook for developing and implementing an evaluation plan (CCSA, 2012). While focused on youth substance abuse prevention, these steps can be easily applied to other addiction prevention and mental health promotion initiatives.

**Infants, Children and Youth**

Efforts for infants, children, and youth should focus on building resilience and coping skills (assertiveness, refusal, and decision making skills), building supports, and the early identification of mental health problems. Children and youth are best reached at home, school or post-secondary institutions through universal programs that promote mental health for everyone, in addition to targeted programs for those at highest risk for reasons such as poverty, parent with a mental health or substance use problem, or family violence. Targeting efforts for families with infants and young children affected by chronic stress offers long-term benefits, especially when efforts are integrated in education or other social services (MHCC, 2012). The World Health Organization’s (2014) report Preventing Suicide: A Global Imperative states that addressing risk and protective factors, such as “emotional stability, an optimistic outlook and a developed self-identity assist in coping with life’s difficulties”, early in the life course may result in better mental health outcomes over time. Furthermore, developing a strong mental health focus in all child health programs is an approach that supports Policy Direction 1: Prevention and Early Intervention as outlined in the Provincial Framework for Mental Health & Addictions Services (Government of Newfoundland and Labrador, 2005).

Some of the strategic directions outlined in the Child and Youth Framework for Canada include:

- Provide education for teachers, students and parents/caregivers about mental health and mental illness through school-based curriculum and community programs.
- Provide support for youth-led mental health promotion activities in community, school and youth organization settings
- Deliver prevention programs designed to improve outcomes in at-risk populations in locations such as schools or community organizations.
- Provide targeted initiatives for transitional-age young people (e.g., 16 to 25).

(Evergreen Framework, 2010)

Similarly, the Mental Health Strategy for Canada recommends increasing comprehensive school health and post-secondary mental health initiatives, with targeted prevention efforts for those at risk. The strategy also recommends increasing the availability of family-centered and community-based mental illness prevention programs for children and youth most at risk. Again, programs like FRIENDS for Life, Strengthening Families for the Future, and Strengthening Families for Parents and
Youth are consistent with the recommendations of the *Child and Youth Framework for Canada* and the *Mental Health Strategy for Canada*.

The Centre for Addiction and Mental Health; the Centre for Health Promotion, University of Toronto; and Toronto Public Health developed best practice guidelines for mental health promotion programs aimed at children and youth. The author acknowledges that not all components will apply in all contexts and encourages health and social service providers to take into consideration their own level of resources and restrictions and apply what is relevant for their programming needs. The guidelines include:

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

(Ardiles, Boyko, Hale, Kobus-Matthews, Lavigne, Jackson, and Loconte, 2009)

Youth substance use prevention has consistently been identified as a priority in addressing substance use across the lifespan, as age of onset increases risk across the lifespan. Furthermore, youth are more likely to use substances, engage in risky use, and experience harms due to use (CCSA, 2007). The Canadian Centre on Substance Use identifies that public and school-based education campaigns are capable of increasing awareness and influencing attitudes. These campaigns have been shown to have limited effect in changing drinking behaviours in the short-term, especially when used in isolation. However, the evidence suggests that coordinated efforts across sectors and implemented over the medium- to long-term are able to shift cultural norms and reduce the potential harms (Brach, Thomas & Stockwell, 2012). The CCSA emphasizes the importance of goodness of fit between prevention initiatives and community readiness and capacity, working collaboratively across sectors and settings, as well as ensuring integrated and sustained prevention efforts (CCSA, 2010).

The Canadian Centre on Substance Use (2007) developed *A Drug Prevention Strategy for Canada’s Youth*. The Strategy outlines the importance of prevention efforts being focused on risk and protective factors, such as developing resiliency, with recommendations that messaging aimed at deterring or delaying substance use start with youth aged 10 or younger (CCSA, 2007). The 2012 *Newfoundland and Labrador Student Drug Use Survey: Highlights Report* also supports these recommendations and supports the need for early social and emotional development. The Report highlights
the importance of early development of skills that promote resiliency, such as assertiveness, refusal, and decision-making skills. Strengthening Families and Roots of Empathy are two programs highlighted by the Report which already have been successfully implemented within the Western Region. The Report also encourages consideration of the Promoting Alternative Thinking Strategies (PATHS) curriculum for students in Kindergarten to Grade 6 (Government of Newfoundland and Labrador, 2012). The Drug Prevention Strategy for Canada’s Youth explains that prevention efforts need to be coordinated across multiple sectors and address needs in schools, families, and larger communities. The Strategy also emphasizes the importance of applying the youth engagement model to ensure service providers develop effective partnerships with youth, as opposed to providing services to youth (CCSA, 2007).

In the Portfolio of Canadian Standards for Youth Substance Abuse Prevention, the Canadian Centre for Substance Use provides evidence informed guidance regarding planning, selecting, implementing, and evaluating prevention efforts across sectors and services. The Standards use a social ecological framework to understand the effects of risk and protective factors on youth substance use and abuse. Prevention efforts, therefore, need to be comprehensive, collaborative, and address factors across the community system. Specific guidebooks have been developed for prevention initiatives with school, communities, and families (CCSA, 2010). For school-based prevention, the CCSA advocates for a comprehensive school health approach that pays attention to all aspects of environment, policy, partnerships, and services. Addiction prevention should be integrated into the school’s core mission and linked to community initiatives that aim to improve youth’s well-being (CCSA, 2010). For community-based prevention, the CCSA advocates for a comprehensive long-term approach that shares prevention responsibility across sectors, service providers, community groups, and community members (CCSA, 2010). In line with the CCSA Standards, the Youth Outreach Worker positions are community-based and work over the long-term in collaboration with other providers and partners across sectors. For prevention with families, the CCSA advocates for the inclusion of family skills programming as a part of a comprehensive prevention initiative (CCSA, 2011). The Strengthening Families for the Future, Strengthening Families for Parents and Youth, and Families & Schools Together programs are examples of evidence-based programs that fit this approach and are currently being offered in the Western Region. The Standards provide checklists for planning and a toolkit to support monitoring and evaluation, helping service providers ensure that their initiatives are meeting the guidelines. All resources can be downloaded free of charge from CCSA’s website: http://www.ccsa.ca/Eng/topics/Children-and-Youth/Drug-Prevention-Standards/ Pages/default.aspx.

Due to the level of harm alcohol use can cause to physical and mental development in adolescence and early adulthood, the primary best practice for youth younger than 19 is ‘don’t drink’ or delay drinking alcohol for as long as possible. However, as it is a reality that many youth do drink alcohol, harm reduction approaches to prevention are seen as a best practice approach, which should be balanced with population-based approaches to promote reduction of use or total abstinence. Harm reduction takes a more neutral position on substance use, recognizing that it will take place and that users are not abnormal (CCSA, 2005).
An example of harm reduction approach to prevention is the promotion of specific Low-Risk Alcohol Drinking Guidelines (LRDGs) that have been developed to provide guidelines for alcohol consumption that could limit youth and young adults' health and safety risks. The guidelines recommend that youth who do decide to drink while under the legal drinking age speak to their parents about drinking, never have more than one or two drinks per occasion, and never drink more than one or two times during the week. For youth from the legal age to 24 years-old, the recommendation is for females to never have more than two drinks a day and ten drinks a week and for males to never have more than three drinks a day and fifteen drinks a week (CCSA, 2014). Another example of the harm reduction approach is the Party Safer presentation and accompanying promotion tools, such as postcards, magnets, and Safe Grad kits which were developed and promoted with youth in Grade 12 and older by the RAPC and RMHPC and Youth Outreach Workers.

Driving under the influence of substances is of particular concern due to the prevalence of driving under the influence and the misconceptions among youth about the effects and risks of driving under the influence, particularly under the influence of drugs. As with other youth-focused initiatives, the evidence supports the use of youth-centric, youth-created, and factual messaging for initiatives aimed at increasing knowledge and changing perceptions of driving under the influence, as well as teaching critical thinking, coping skills, life skills and refusal skills. Effectiveness is also increased when parents and communities are included in initiatives and when initiatives are timed to correspond with periods of critical age or critical events, such as before obtaining a driver's licence or before high school graduation (Holmes, Vanlaar, & Robertson, 2014).

Prevent Alcohol and Risk-Related Trauma in Youth (PARTY) is a program offered in the Western Region that is aimed at increasing awareness about potential risks associate with driving under the influence. While studies have shown mixed results, one study found that individuals involved in PARTY experienced less traumatic injuries compared to control groups. Evaluation of a higher-risk group of juvenile offenders found that participation modified attitudes toward risk-taking behaviours and participants experienced fewer traffic, alcohol, and drug-related offences, as well as fewer injuries compared to those who did not participate in PARTY (Holmes, Vanlaar, & Robertson, 2014). Ensuring that initiatives meet the local realities and needs in the Western Region requires that high-risk driving prevention initiatives incorporate not only traditional vehicles but also recreational vehicles, such as ATVs and snowmobiles.

Parental role-modeling, expectations, and engaging of children and youth in conversations about the effects and risks of alcohol use have been found to have potential to lower rates of alcohol-related problems among youth (CCSA, 2014). This supports the importance of working with parents to ensure they have the necessary knowledge and skills needed to positively impact youth substance use. Furthermore, The International Standards on Drug Use Prevention identifies that effective parenting skills and role-modeling are among the most powerful protective factors against youth substance abuse and other risky behaviours. Parenting programs associated with positive prevention outcomes enhance family bonding, support parents to take a more active role in children's lives, provide positive discipline, and provide role-modeling. Parenting programs should include activities for the parents, children, and whole family;
be delivered by trained individuals; include a series of sessions; and be organized in a way to make parent participation easy and appealing, with features such as accessible hours, meals, child care, transportation, and small incentives for completing sessions (United Nations Office on Drugs and Crime, 2013).

The *International Standards* also support the effectiveness of universal programming, for both children and adolescents, when these programs include a series of interactive structured sessions that are delivered by trained teachers, with a focus on improving a range of personal and social skills, including coping, decision making and resistance (UNODC, 2013). Further support for school-based programs comes from the *Child and Youth Framework for Canada*. Evidence supports the need for mental health programming to be incorporated into schools. Educators, with proper training and support, are positioned to challenge stigma, enhance mental health literacy and raise awareness of child and youth mental health (Evergreen Framework, 2010). An ideal example is the school-based FRIENDS for Life program, in which trained school personnel deliver this universal curriculum-based program within the classroom. FRIENDS for Life is an internationally recognized, early intervention and prevention program that builds resilience and reduces the risk of anxiety disorders in children. With over 15 years of comprehensive research evaluation and practice, this is the only anxiety prevention program acknowledged by the World Health Organization. FRIENDS for Life is also endorsed in the *Mental Health Strategy for Canada* (MHCC, 2012).

This evidence supports the need for programs such as Strengthening Families for the Future and Strengthening Families for Parents and Youth, and Families & Schools Together. In addition, Priority 1.2 of the *Mental Health Strategy for Canada* focuses on increasing the capacity of families, caregivers, schools, post-secondary institutions, and community organizations to promote the mental health of infants, children, and youth; prevent mental illness and suicide where possible; and intervene early when problems first emerge. This priority area offers a number of recommendations for action that are consistent with the need to offer more family-centered, community based programs for children and youth at risk, as well as comprehensive universal school health and post-secondary mental health promotion initiatives (MHCC, 2012).

**Adults**

For adults, efforts should focus on the early identification of mental health and substance use problems, as well as on building coping skills and supports. People who are unlikely to seek help risk compounding their mental health problems, increasing the risk of suicide that may otherwise have been prevented by early intervention (WHO, 2014). According to the World Health Organization, individuals at risk of suicide often reveal risk factors that identify them as vulnerable. A “gatekeeper” is anyone who is in a position to identify whether someone may be considering suicide. Key potential gatekeepers include: primary, mental, and emergency health providers; teachers; community leaders; police officers and other first responders; and managers and human resource staff (WHO, 2014). The Mental Health First Aid program is ideal to support this recommendation. This program is supported by the Mental Health Commission of Canada and endorsed in the *Mental Health Strategy for Canada*. Mental Health First Aid
offers education on signs and symptoms of mental health problems and illness, as well as how to provide initial help and guide a person to professional help (MHCC, 2012). Furthermore, improving the quality of care for people seeking help can ensure that early interventions are effective. The World Health Organization states that, “Improved quality of care is the key to reducing suicides that arise as a result of mental and alcohol use disorders and other risk factors (WHO, 2014).

Women with substance use problems are more likely than males to have co-occurring mental health problems and be victims of abuse and assault. Women who use drugs and alcohol are also more heavily stigmatized than males, especially pregnant women. Stigma increases reluctance to access services and negatively impacts the services they do receive. Addressing stigma among the larger community can help create a supportive environment in which women are able to more easily and comfortably access needed services, decreasing risks to themselves and their unborn children (Finnegan, 2013).

Consumption of alcohol at levels as low as one or two standard drinks per day has been causally linked to significant increases in cancer risk and numerous other serious medical conditions over the long-term. It is of utmost importance to ensure that Canadians are well-educated about the effects of alcohol use, given that alcohol advertising, cultural norms, and conflicting research published in the media create confusion about the risks of use and can actually encourage drinking in excess. The Low-Risk Alcohol Drinking Guidelines (LRDG’s) provide evidence-based advice to Canadians regarding how to minimize risks from their own and others’ drinking. The guidelines outline that one standard drink equates 12 ounces of beer, cider, or cooler with a 5% alcohol content; 5 ounces of wine with a 12% alcohol content; or 1.5 ounces of distilled alcohol with a 40% alcohol content. The guidelines recommend that adults plan non-drinking days every week, that women drink no more than 2 drinks per day most days and no more than 10 drinks per week, and that men drink no more than 3 drinks per day most days and no more than 15 drinks per week. Furthermore, they recommend that drinking take place in a safe environment and that zero alcohol be consumed under higher risk circumstances such as operating a vehicle, taking medicine or other drugs, being responsible for the safety of others, making important decisions, while living with a mental or physical health problem, or while pregnant or planning to become pregnant. The National Alcohol Strategy Working Group recommends that the Guidelines be widely disseminated and used to inform a variety of knowledge-exchange activities, as a component of a well-rounded cross-sectional approach that includes regulating price and availability of alcohol, early detection and brief intervention efforts, and the enforcement of drunk-driving laws (Butt, Bierness, Glikman, Paradis, & Stockwell, 2011).

Physicians are often the first point of contact with health services. People are more likely to consult their family physician about a mental health problem or illness than any other health care provider (MHCC, 2012). Therefore, campaigns targeting Physicians may offer a particularly effective opportunity to educate people about the early identification of signs and symptoms of mental health and substance use problems, as well as connect them to services, preventing the on-set or decreasing harms due to mental illness and addiction. The Screening, Brief Intervention, and Referral (SBIR)
intervention by physicians was found to effectively reduce alcohol consumption among high-risk drinkers (Giesbrecht et al, 2013). This intervention program was developed by the College of Family Physicians of Canada (CFPC) and the Canadian Centre on Substance Abuse and is intended for use with all young adults and adults, not only high-risk patients. Physicians and other health professionals can visit the website, [http://www.sbir-diba.ca/](http://www.sbir-diba.ca/), to access the clinical guide; guidelines for healthcare providers to promote low-risk drinking among patients; and resources on brief intervention, including videos illustrating key elements of a brief intervention. Family physicians are eligible to claim CME/CPD credits for reviewing the information as well as for documented clinical application of the SBIR (CFPC, 2012). Periodic screening of all women of childbearing age for alcohol and prescription and illicit drug use is an evidence-based recommendation by the Society of Obstetricians and Gynaecologists of Canada (Finnegan, 2013).

**Seniors**

The growing importance of aging issues has been acknowledged by national organizations such as the Mental Health Commission of Canada, Center for Addiction and Mental Health, Canadian Mental Health Association, and Canadian Coalition for Seniors’ Mental Health, who have undertaken research and have developed policy directions, publications, and educational materials related to improving seniors’ mental health. The Government of Newfoundland and Labrador has also acknowledged the importance of seniors’ mental health in their *Healthy Aging Policy Framework* and *Policy Framework for Mental Health & Addictions*. The Mental Health Commission of Canada (2011) offers key recommendations for comprehensive mental health services and incorporates the following elements:

- Recognize the diversity of seniors
- Focus on recovery, well-being, hope and choice
- Incorporate mental health promotion and prevention of mental health issues
- Promote anti-stigma and awareness about ageism and discrimination
- Encourage education not only for seniors, but also for health care providers, families/caregivers, and the public to increase their capacity to support them and create better communities.

The Centre for Addiction and Mental Health, University of Toronto, and Toronto Public Health (2010) developed best practice guidelines for mental health promotion for adults aged 55 and older. The author acknowledges that not all components will apply in all contexts and encourages health and social service providers to take into consideration their own level of resources and restrictions and apply what is relevant for their programming needs. The guidelines include:

1. Identify and address a specific population for your program/initiative;
2. Address and modify risk and protective factors, including determinants of health, that indicate possible mental health concerns for older people;
3. Intervene in multiple settings;
4. Support professionals and non-professionals in establishing caring and trusting relationships with older people;
5. Provide a focus on empowerment and resilience;
6. Promote comprehensive support systems;
7. Adopt multiple interventions;
8. Ensure that information and services provided are culturally appropriate, equitable and holistic;
9. Involve multiple stakeholders;
10. Address opportunities for organizational change, policy development and advocacy; and
11. Demonstrate a long-term commitment to program planning, development and evaluation

(Ziegenspeck, Kobus-Matthews, Barr, Jackson, Magdeburg-Stendal, Jiwani, N., Easlick, Loconte, and Chow, 2010).

Stigma and misconceptions regarding mental health and addiction problems are very prevalent among seniors, as well as those that provide care to this population. Many people normalize substance use among seniors as a pleasant and harmless activity to avoid loneliness or boredom. Age discrimination has also been shown to contribute to programs not considering or meeting the needs of older clientele. Education regarding the unique experiences and needs of seniors is important to ensure that service providers are knowledgeable, competent, and confident in responding to the needs of older persons. The invisibility of seniors in promotion and prevention initiatives may increase their sense of internalized stigma and shame (CAMH, 2008). Promotion initiatives aimed at seniors, as well as those who provide care to older adults, offer an opportunity to raise awareness and normalize the needs of this population. This will help reduce and combat the negative effects of ageism and stigma. The Centre for Addiction and Mental Health (2008) emphasizes the importance of a holistic collaborative approach and advocates for prevention and health promotion measures that address common risk factors. Recommended activities include education in relaxation techniques, exercise, and nutrition; recreation opportunities; emotional and social supports; and engaging older adults in meaningful activity in the community.

Suicide in seniors is a significant concern, with older adults having among the highest rates of suicide worldwide. Furthermore an estimated 3 million seniors in Canada experience major depression at some point in their lives (Canadian Coalition for Seniors’ Mental Health, 2009). It is important that staff and residents at long-term care facilities, home care workers, and those who interact socially with seniors are educated about mental health issues among seniors, risk factors and warning signs of suicide in older adults, and to know what to do if a senior they interact with is at risk of suicide.

Western Health, in partnership with Canadian Mental Health Association-NL, recently developed a Seniors’ Mental Health Education program for people who work with seniors. This program will provide education regarding a range of mental health and addictions topics. It is directed at those who work with seniors or who provide care to a senior family member. The program is being piloted with Western Health’s Long Term Care staff over the winter of 2014 and will be revised as necessary. A plan to continue delivery in the Western Region and to launch the program provincially will be established.
Workplaces

Priority 1.3 of the *Mental Health Strategy for Canada* is to create mentally healthy workplaces. This priority area offers recommendations which support the need for better employment practices that are cohesive to mentally healthy workplaces (MHCC, 2012). Further to this, the Strategy cites barriers that keep people with mental health problems and illnesses out of work must be removed and supports that help people to obtain competitive employment should be increased (Latimer et al, 2006 as cited in MHCC, 2012).

The Mental Health Commission of Canada has reported that in any given year one in five Canadians will experience a mental health problem or illness, costing the economy well in excess of 50 billion dollars (MHCC, 2013). Colleagues and employers are best able to recognize the signs and symptoms of mental health problems in their co-workers. However, many employees and employers are not well informed about how to provide appropriate help to their co-workers or recognize the symptoms of a mental health problem. Offering Mental Health First Aid in the workplace increases mental health literacy and teaches people how to provide support to their colleagues until professional help is attained (MHCC, 2013).

It should also be noted that stigma is a barrier to help seeking behavior associated with mental health and addictions problems which increases the risk of suicide. Reducing the stigma associated with mental illness is one of the goals of the Strategy and of Mental Health First Aid (MHCC, 2013).

The workplace can be a stressful environment contributing to the development of mental health problems such as depression and anxiety (MHCC, 2012). The Mental Health Commission of Canada is one of the leaders behind the development of the *National Standard for Psychological Health & Safety in the Workplace*, which was released in 2013. The Standard is a guide that offers organizations a logical approach to develop and sustain a workplace that addresses risks and promotes mental health through supportive work environments (BNQ, CSA Group, & MHCC, 2013). The Standard identifies 13 key workplace factors affecting psychological health and safety:

- organizational culture,
- psychological and social support
- clear leadership and expectations
- civility and respect
- psychological competencies and requirements
- growth and development
- recognition and reward
- involvement and influence
- workload management
- engagement
- balance
- psychological protection
- protection of physical safety

(MHCC, 2012)

Implementing the Psychological Health and Safety Standard in private and public sectors is one of the recommendations for action cited in the *Mental Health Strategy for Canada* (MHCC, 2012).
RECOMMENDATIONS

1. Enhance Collaboration and Coordination Across Sectors

- All relevant Western Health staff and community partners should have basic understanding of mental health and addictions issues, as well as capacity and a protocol for routine first-stage screening and referral to specialized services. The Consultants will incorporate discussion of the benefit and options for education and referral protocols during the annual site visits. To further support this goal, Mental Health and Addiction Services workshops and presentations, such as Understanding Mental Health & Addictions, The Fundamental Concepts in Addiction, and Youth & Substance Use, should continue to be provided to Western Health staff, as well as community partners and government agencies. The Mental Health and Addictions Prevention and Promotion website should be promoted annually to all Western Health staff and a distribution list of community and government agencies. Promotional materials, such as rack cards and business cards, should continue to be promoted and available.

- The RMHPC and RAPC are available and should be accessed, as needed, by Western Health staff and community partners for consultation and support in mental health promotion and addictions prevention initiatives.

- All relevant Western Health staff and community partners should display or provide promotional material, such as the rack cards, postcards, business cards, and other handouts, at all appropriate health promotion programming and initiatives.

- When new programs are being developed, ensure a collaborative team approach is utilized in which all stakeholders are meaningfully engaged participants and share responsibility in the development process.

- It is critical for stakeholders to include individuals with lived experience, as well as their families and supports, and not only service providers.

- In order to ensure effective collaboration, engagement and relationship building among stakeholders should be incorporated into prevention and promotion development initiatives (teambuilding, discussion of roles and services, etc.).

2. Avoid Duplication of Effort

- Ensure that programs and initiatives that have already been supported and delivered within the Region are reviewed for appropriateness and applicability prior to researching or developing a new program or initiative. These are listed in the Existing Regional Programs and Initiatives section of this Strategy, on page 35-38, or on the Prevention and Promotion website (www.westernhealth.nl.ca/mha). Detailed Program Descriptions for many programs are available in the Appendices of this Strategy.

- Consult or include the RMHPC and RAPC during the planning process to ensure utilization of relevant evidence-based practices.
3. Ensure Outcome Measures and Continuity Planning are Integrated Into Promotion and Prevention Initiatives

- Outcome indicators should be identified during the planning process and measures should be used to determine effectiveness of the program or initiative, such as pre- and post-tests and participant feedback. The RMHPC and RAPC are available for consultation and assistance. In addition, the Monitoring and Evaluation Toolkit developed by the CCSA (2012) provides a workbook for developing and implementing an evaluation plan. While focused on youth substance abuse prevention, these steps can be easily applied to other addiction prevention and mental health promotion initiatives.

- Sustainability should be considered and incorporated in planning wherever possible. When a project has a finite timeframe, continuity should be incorporated in other ways, such as consistent messaging, coordination with other initiatives, and connection to support services.

4. Address Stigma

- Address myths and stereotypes, not only in mental health and addictions initiatives but also in everyday language and conversation. Each individual has a potential to initiate change by watching their own behaviour and ensuring the use of holistic and positive language.

- When initiatives target development of resiliency and coping skills, facilitators should promote strengths and build upon existing capacity.

- Ensure inclusion of the target population and caregivers/support persons in the planning and delivery of mental health and addictions promotion and prevention initiatives.

- Promote resiliency and stress management for the general population, as opposed to targeted populations. This will help to normalize the experience of stress and benefit of positive coping skills, as well as provide a non-intimidating and non-stigmatizing environment for individuals to access supports and learn about more targeted services. The No Stress Fest is an example of this approach. The Program Description is available in the appendices of this Strategy.

- Promote mental health literacy among parents, caregivers, Western Health staff, and community partners. Understanding will enhance supportive environments and allow for informed decision making. Presentations available to support this include Myths of Mental Illness, Stigma, and Understanding Mental Health & Mental Illness. The Government of Newfoundland and Labrador has also developed the Understanding Changes Everything website (www.understandnow.ca) focused on combating stigma and increasing the understanding of mental health and addictions issues among the public.

5. Promote Resiliency and Positive Coping

- Incorporate resiliency and positive coping as a component of other health promotion initiatives wherever possible, across the lifespan and across all populations.
Many skills focused on other health issues are transferable. For example, self-awareness, critical thinking, effective decision-making, and assertiveness skills utilized in physical health initiatives will also support positive mental health and prevent substance misuse and abuse. These links should be explicitly highlighted during these initiatives.

- Partner with Community Health Nurses to address stress and promote mental health coping skills.
  As stress is a key concern among students in the Western Region, there is an opportunity to promote mental health coping skills in schools. Coping skills can also be promoted in Lifestyle Clinics. Resources available from the RMHPC and RAPC to support this endeavor include the Recreation for Mental Health Toolkit, No Brainer Container, No Stress Fest Manual, and Cleaver Catch Balls, as well as displays and presentations such as Coping with Stress, Relaxation, and Self-Esteem, among other resources.

- Advocate for school based policy on resiliency
  Promote the development of a policy or position statement regarding resiliency and coping skills, as well as a plan to implement resiliency and coping skill development within the school curriculum. FRIENDS for Life meets the objective of developing these skills and is currently being offered by school personnel across the Western Region. Western Health and the NL English School Board, Western District, are working on a proposal to train additional personnel and confirm financial support for this program. A policy or position statement will strengthen the commitment to the Program and help ensure sustainability.

6. Address Alcohol Use

- Promote the Low-Risk Alcohol Drinking Guidelines at all opportunities.
  It is of utmost importance to ensure that Canadians are well-educated about the effects of alcohol use, given that alcohol advertising, cultural norms, and conflicting research published in the media create confusion about the risks of use and can actually encourage drinking in excess. The Low-Risk Alcohol Drinking Guidelines provide evidence-based advice to Canadians regarding how to minimize risks from their own and others' drinking. There are general guidelines for adult men and women, as well as additional guideline for specific populations. The guidelines, brochures, posters, and other handouts to support the dissemination of this information can be found on the CCSA website (http://www.ccsa.ca/eng/topics/alcohol/drinking-guidelines/Pages/default.aspx) or by contacting the RAPC.

- The Screening, Brief Intervention, and Referral (SBIR) intervention program should be utilized by relevant Western Health staff with all young adults and adults, not only high-risk patients.
  Physicians and other health professionals can visit the website (http://www.sbir-diba.ca/) to access the clinical guide; guidelines for healthcare providers to promote low-risk drinking among patients; and resources on brief intervention, including videos illustrating key elements
of a brief intervention.

- Relevant Western Health staff should engage in periodic screening of all women of childbearing age for alcohol and prescription and illicit drug use and complete referrals to Mental Health and Addiction Services as needed.

7. **Address Youth Substance Use**

- Support and deliver programs and initiatives that enhance early development of skills that promote resiliency, such as assertiveness, refusal, and decision-making skills.
  
  Strengthening Families and Roots of Empathy are two programs that are supported by the *Newfoundland and Labrador 2012 Student Drug Use Survey: Highlights Report* and have already been successfully implemented in the Western Region. In addition, the Promoting Alternative Thinking Strategies (PATHS) curriculum should be explored, in collaboration with the Western School District, for goodness of fit with the needs and capacities of primary and elementary schools in the Western Region.

- Support and deliver programs and initiatives that specifically address decision making under the influence, including driving under the influence, being a passenger with a driver who has been drinking or used substances, and unplanned sexual activity after using substances.

  Several programs addressing these factors have been successfully implemented in the Western Region, including The Youth Voices, Healthy Choices program, developed in the Western Region by the Sexual Health Working Group; The Challenges, Beliefs, and Changes Program, developed by Parent Action on Drugs and supported by the *Newfoundland and Labrador 2012 Student Drug Use Survey: Highlights Report*; and PARTY (Prevent Alcohol and Risk Related Trauma in Youth), a program being overseen by the Regional Health Educator. The Program Description for Youth Voices, Healthy Choices can be found in the Sexual and Reproductive Health Strategy developed by Health Promotion, Western Health. The Program Description for Challenges, Changes, and Beliefs can be found in the Appendices of this Strategy. More information on the PARTY program can be found in the Injury Prevention Strategy developed by Health Promotion, Western Health. Furthermore, The Safer Bars campaign is in the process of being revamped with a revised focus on youth. Campaigns in secondary and post-secondary institutions are planned for the 2015-2016 school year. More information on this campaign can also be found on the website (www.clubcode.ca and the Program Description for the original campaign can be found in the Sexual and Reproductive Health Strategy developed by Health Promotion, Western Health. In addition, Mental Health and Addictions staff have access to a supply of condoms, which should be distributed to youth, along with the Condom On condom usage cards, as needed. Additional evidence-based programs are also available. More details can be found in the Existing Regional Programs and Initiatives listing and
Program Descriptions in this Strategy. The RMHPC and RAPC are available for consultation about implementing these or other programs across the region.

- Incorporate harm reduction approaches to substance use with youth. While the primary best practice for youth younger than 19 is ‘don’t drink’ or delay drinking alcohol for as long as possible, as it is a reality that many youth do drink alcohol, harm reduction approaches should be balanced with population-based approaches to promote reduction of use or total abstinence. Harm reduction recognizes that it will take place and that users are not abnormal. An example of harm reduction approach to prevention and promotion is the promotion of specific *Low-Risk Alcohol Drinking Guidelines* (LRDGs). The youth-specific guidelines can be accessed on the CCSA website ([http://www.ccsa.ca/Resource%20Library/CCSA-Youth-and-Alcohol-Summary-2014-en.pdf#search=low%20risk%20drinking%20guidelines%20youth](http://www.ccsa.ca/Resource%20Library/CCSA-Youth-and-Alcohol-Summary-2014-en.pdf#search=low%20risk%20drinking%20guidelines%20youth)). Another example of the harm reduction approach is the Party Safer presentation and accompanying promotion tools (postcards, magnets, and Safe Grad kits) developed and promoted by the RMHPC, RAPC, and Youth Outreach Workers.

- Enhance effective parenting skills and role-modeling. Parenting programs that are associated with positive prevention outcomes enhance family bonding, support parents to take a more active role in children’s lives, provide positive discipline, and provide role-modeling. Parenting programs should include activities for the parents, children, and whole family; be delivered by trained individuals; include a series of sessions; and be organized in a way to make parent participation easy and appealing, with features such as accessible hours, meals, child care, transportation, and small incentives for completing sessions. Families and Schools Together, Strengthening Families for the Future, and Strengthening Families for Parents and Youth, are examples of evidence-based programs that have been successfully implemented in the Western Region.

- Ensure that public and school-based education campaigns use a youth engagement model, incorporate coordinated efforts across sectors and settings, and are implemented over the medium- to long-term, as well as that there is a goodness of fit between prevention initiatives and community readiness and capacity. The evidence suggests that longer-term initiatives are able to shift cultural norms and reduce potential harms. The Youth Outreach Worker positions are a great example of long-term programming focused on youth engagement with targeted groups of youth. Youth Voices, Healthy Choices is an example of a program that uses a youth engagement model. When the program is implemented as an ongoing annual initiative, it builds awareness and education over the long term.

- Utilize evidence-informed guidance when planning, selecting, implementing and evaluating addiction prevention efforts with youth.

The *Portfolio of Canadian Standards for Youth Substance Abuse*
Prevention are specific guidebooks which have been developed for prevention initiatives with school, communities, and families. The Standards provide checklists for planning and a toolkit for monitoring and evaluation to help service providers ensure that their initiatives are meeting the guidelines. All resources can be downloaded free of charge from CCSA’s website: http://www.ccsa.ca/Eng/topics/Children-and-Youth/Drug-Prevention-Standards/Pages/default.aspx.

8. Support Suicide Prevention

- Relevant Western Health staff and community partners should have basic understanding of the warning signs for suicide risk and how to access supports, both immediate and longer-term services.
  
  “A “gatekeeper” is anyone who is in a position to identify whether someone may be considering suicide. Key potential gatekeepers include: primary, mental and emergency health providers, teachers, community leaders, police officers and other first responders, human resource staff, and managers. The Suicide Prevention E-Learnings, or an equivalent, should be made a mandatory education for all relevant Western Health staff. The Suicide Prevention presentation should continue to be offered to community partners and other human services agencies. In addition, Mental Health First Aid, ASIST, Tattered Teddies, and Straight Talk should continue to be promoted by the RMHPC and RAPC when offered by community partners.

- Currently, many Western Health staff members are involved in suicide prevention efforts and key partnerships already exist. However, it is important that Western Health continue to support community efforts and continue to embark on partnerships with key stakeholders to address this important issue.

- Warning sign posters and postcards should continue to be distributed widely and available upon request. These can be viewed and requested through the Prevention and Promotion website (www.westernhealth.nl.ca/mha) or requested through the Community Mental Health Initiative (www.communitymentalhealthinitiative.ca).

- The Suicide Prevention Partnership Meeting should become an annual or biennial meeting to continue to enhance collaboration and capacity across sectors in the Western Region.

9. Support Violence Prevention

- Currently, there are many Western Health staff members involved in violence prevention efforts and key partnerships already exist. However, it is important that Western Health continue to support community efforts and continue to embark on partnerships with key stakeholders to address this important issue.

  There should be Western Health staff identified and actively involved in violence prevention efforts throughout the Western Region, as well as representation on each of the three existing Coalitions to End Violence.
10. **Incorporate Trauma Informed Practices**

- All frontline Mental Health and Addiction Services staff, as well as any other Western Health staff or community partners working with vulnerable populations, should assume that all people they encounter have experienced trauma and incorporate trauma-informed practices.
  
  This is based on the evidence that 76% of Canadian adults and 90% of mental health and addiction treatment recipients report trauma exposure, while recognizing the impact of trauma on mental health and addictions (Klinic Community Health Center, 2013; Mueser et al, 2004; Van Ameringen et al., 2008).

- Relevant Western Health staff and community partners should establish competency in trauma-informed care.
  
  Western Health staff can access resources through Mental Health & Addiction Services and the Western Health Regional Library, as well as the Trauma Informed Practices presentation. Community partners can access the Corner Brook Women’s Centre’s 1-Day Trauma Informed Practices workshop.

- Ensure environment, messaging, and approach to development and delivery of health promotion and prevention efforts are supportive, collaborative, and strengths based, regardless of target population.

- Establish safety and trustworthiness by ensuring informed consent, providing clear information, and demonstrating consistency and transparency when working with colleagues, community partners, and the public.

- Ensure collaborative approach in working with community partners and stakeholders, addressing power imbalances and promoting meaningful engagement and shared decision-making.

- Support the development of new coping skills, focusing on resiliency and building strengths, at all opportunities.
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APPENDIX A:

Prevention and Promotion Resources

The Regional Mental Health Promotion and Addictions Prevention Consultants provide support and consultation regarding resources, programs, and initiatives on mental health promotion and mental illness prevention, as well as substance use, gambling, and addictions prevention.

The Mental Health Promotion and Addictions Prevention Consultants have developed a website (www.westernhealth.nl.ca/mha) to provide Western Health staff and community partners with easy access to a variety of prevention and promotion resources. Individuals, families, communities, organizations, and professional groups can email mha@westernhealth.nl.ca for more information or to borrow resources.

The following Prevention and Promotion Services are available to individuals, families, communities, organizations, and professional groups:

1. Resource Development & Access to Resources:
   a) Print Materials
      o Print materials are available free of charge. Images of print materials are available on the website for review. Examples include Mental Health & Addiction Services rack cards, crisis and helpline cards and magnets, suicide prevention postcards and magnets, and Party Safer postcards and magnets.
b) Informational Displays
  o Over 40 displays on various mental health and addiction topics are available for short-term loan or can be printed directly from the website. Topics include Coping with Stress, Peer Pressure, Suicide Prevention, Party Safer, and Talking With Your Teen About Drugs, among many others.

c) Interactive Resources
  o Various games, books, DVDs, and other resources are available for short-term loan, such as The Choice Is Yours Activity Cards, Emotion Mania Thumball, Drugs and Alcohol Clever Catch Ball, Just for the Health of It – Health Curriculum Activities, and Raising Healthy Teens in an Age of Overindulgence.

d) Best Practice Information
  o The RMHPC and RAPC are available for consultation and can provide various mental health and addictions best practice information. Detailed information on specific commonly requested topics has been posted on the website, including Suicide Prevention, Stress Management & Relaxation, Low-Risk Alcohol Drinking Guidelines, and Fetal Alcohol Spectrum Disorder.

e) Presentations, Workshops, and Programs
  o Many presentations, workshops and programs have already been developed or purchased. A full listing is available on the website. Additional presentations may be developed upon request. A variety of presentations, workshops, and programs are offered on rotation by Mental Health and Addiction Services staff. Presentations, workshops, and programs may also initiated by community partners, in consultation or collaboration with the RMHPC and RAPC.

f) Toolkits
  o A variety of prevention and promotion toolkits have been developed by Mental Health and Addiction Services and community partners, such as Body Image, Recreation for Mental Health, Impaired Driving, and Standard Drink.

2. Awareness Workshops & Presentations:
  o A presentation request can be completed to have a Mental Health and Addictions staff member present a workshop or presentation to an interested group. The Presentation Request form is available on the website. When appropriate, these can also be provided to Western Health staff and community partners for their own facilitation. Some examples of awareness topics include Myths of Mental Illness, Prevent Suicide, Understanding Mental Health & Addiction, Stigma, Gambling Awareness, The Fundamental Concepts in Addiction, and Addiction & The Family.
3. Skills Development Workshops & Presentations:
   o A presentation request can be completed to have a Mental Health and Addictions staff member present a workshop or presentation to an interested group. The Presentation Request form is available on the website. When appropriate, these can be provided to Western Health staff and community partners for their own facilitation. Some examples of skill development topics include Coping with Stress for Teens, Creative Compromise, Life-Work Balance, Motivational Interviewing, and Working with Addictions Issues.

4. Prevention Training:
   o A presentation request can be completed to have a Mental Health and Addictions staff member provide prevention training to an interested group. The Presentation Request form is available on website. When appropriate, these can be provided to Western Health staff and community partners for their own facilitation. Some examples of prevention training include Prevention and Promotion 101, Second Hand Effects of Alcohol, Schools and Substance Use, and Suicide Prevention.

5. Research & Project Consultation:
   o The RMHPC and RAPC are available for consultation and can provide information regarding best and evidence-informed practices, local trends, past project successes and challenges, and partnership and funding opportunities.

6. Community Addictions Prevention & Mental Health Promotion (CAPMHP) Fund:
   o The CAPMHP Fund is an initiative the Department of Health and Community Services and is administered by the four regional health authorities. All individuals, not for profit community groups, and organizations in the four health regions of Newfoundland and Labrador, who are interested in preventing addictions issues and promoting mental health to community members, are eligible to apply for project funding through their regional health authority. More information is available on the website or by contacting the RMHPC or RAPC.

7. Awareness Week Activity Grants:
   o A limited number of Awareness Week Activity Grants are available to Mental Health and Addiction Services Staff, Community Health Nursing Staff, and Community Partners, including Mental Health Week – May, Mental Illness Awareness Week - October, and Addictions Awareness Week - November. More information is available on the website or by contacting the RMHPC or RAPC.
APPENDIX B:
Program Description
Addiction Prevention Tools Program (APT)

Introduction:
The Addictions Prevention Tool (APT) Program is an evidence-based addiction prevention program for youth age 12-18. It consists of two streams: (1) non-users or users who have only experimented and (2) occasional, regular, or abusive substance users. The program raises awareness of risk and reduces risk based on informed, responsible use of substances. It is intended for facilitators working with youth in various settings such as schools, youth centers, or community or sport settings.

APT is highly structured and supported by comprehensive training. The program is based on scientific evidence and developed using best practice in addiction prevention. APT has also been found to be a program appreciated by young people.

Background:
Developed with financial support received from Health Canada as part of its Drug Strategy Community Initiatives Fund, the APT program is the result of a major study conducted over a three-year period (2005-2008) in Quebec and the Maritimes. The APT program was developed based on the following key observations:

- Young people are consuming psychoactive substances (alcohol, cannabis, and other drugs) at increasingly younger ages and they tend to trivialize consumption.
- Young people today are exposed to contradictory messages about substance use and the risks associated with it (e.g., television commercials tell them that it is fun to drink beer, while public-service campaigns warn of the potentially fatal consequences of impaired driving).

Purpose:
The purpose of the program is to develop young people’s ability to correct risky beliefs and reinforce protective beliefs that they may have about substance use.

Objectives:
1. To delay the average age of initial substance use; in the case of youth who are not using
2. To reduce the risk related to substance use for youth that are using
3. To develop a personal opinion on issues related to drug and alcohol use
Target Audience:
The program is aimed at young people aged 12 to 18. There are two profiles of young people that this program targets. Profile A includes young people who do not use substances or use occasionally, typically 12-15 year olds. Profile B includes regular or abusive substance users, typically 15-18 year olds.

Description of Activities:
Each activity has two main parts, including a description of the activity and the steps to be followed, as well as the teaching materials required to complete the activity (scenario cards, posters, charts, and fact sheets; harmonized messages; set of arguments; and control sheet).

A major aspect of preparing for the activities is the choice of the participants’ substance use profile. In order to meet the specific needs and characteristics of different groups of participants, the APT provides for two different substance use profiles; A & B. Profile A is for young people who do not use or occasionally use and Profile B is for regular or abusive users.

The APT program is made up of five interactive activities, each of which lasts about an hour and deals with one of the following five spheres of influence on young people: friends, family, life setting, community, and media. The activities all have a common structure that includes a group discussion and debate.

The following is an example of how the scenarios are presented depending on whether the group is in profile A or B.

<table>
<thead>
<tr>
<th>“A” Scenario</th>
<th>“B” Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situations involve non-consumption or experimentation</td>
<td>Situations involve occasional, regular or abusive consumption</td>
</tr>
<tr>
<td>Aim at risk elimination by non-consumption</td>
<td>Aim at risk elimination by informed, responsible consumption</td>
</tr>
<tr>
<td>Often depicts situations of substance use involving a friend (rather than the participants him or herself). The participants assess the situation as an observer.</td>
<td>Often depicts situations of substance use by participant him or herself.</td>
</tr>
<tr>
<td>Situations are aimed mainly at younger participants</td>
<td>Situations are aimed mainly at older participants (driving while intoxicated, initiation parties, polysubstance use)</td>
</tr>
<tr>
<td>Represent low-risk consumption behaviors (tasting alcohol)</td>
<td>Represent riskier consumption behavior (drinking contests, mixing substances)</td>
</tr>
</tbody>
</table>
**Budget:**
The cost to purchase this program, consisting of a Facilitator’s Guide, access to e-learning on the website and the book *Drugs: Know the Facts*, is $480.00 (not including shipping and handling fees). However, copies of this program are available at no cost by contacting the Mental Health Promotion Consultant or Regional Addiction Prevention Consultant.

**Evaluation:**
This program was developed using best practice in addiction prevention and is based on scientific evidence. It is one of the few addiction prevention programs for youth that has been scientifically validated in Canada. The program was implemented concurrently with each of the four age group categories (236 subjects in total) so as to evaluate the quality of implementation and its outcomes with young participants in school and sports settings. Based on the outcomes of this testing phase, modifications to the tools and how they were used were changed to be more effective.

More information about research can be found by obtaining the scientific research paper on their website (www.cldq).

**Indicators:**
- Pre and post questionnaire for participants
- Activity evaluation questionnaire for participants
- Real-time observation

**Requirements to Support Staff:**
The training for this program is provided with the use of three training tools as well as telephone and on-line support. The three tools are the Addiction Prevention website (www.cqld.ca) and e-learning, the Facilitator’s Guide, and the book *Drugs: Know the Facts*. This program has been purchased by Western Health and can be requested from the Regional Mental Health Promotion Consultant or Regional Addiction Prevention Consultant. Time for staff to complete this on-line training would need to be supported. However, the e-learning is conducted on an individual basis, so staff can study at their own pace and according to availability.

**Timeline/Action Plan:**
1. Request program tools (user name and password, Facilitators Guide and *Drugs: Know the Facts*) from Mental Health Promotion or Addiction Prevention Consultant
2. Use training guide and e-learning to prepare to deliver this program
3. Coordinate time and venue to deliver program
4. Advertise program, if needed
5. Prep teaching materials for each session (scenario cards, posters, chart and fact sheets, harmonized messages, set of arguments, control sheet) and ensure you are proficient with set of arguments
6. Deliver program in 60-75 minute sessions using program resources and website

**Program Structure:**
Each activity includes presentation of the activity, team discussion based on scenario card, group debate, conveying the harmonized message and wrap-up. Each session runs for approximately 60-75 minutes.

<table>
<thead>
<tr>
<th>Activity 1</th>
<th>More or Less Risky? Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity 2</td>
<td>Let’s Talk About it! Family</td>
</tr>
<tr>
<td>Activity 3</td>
<td>Decisions? Life Setting</td>
</tr>
<tr>
<td>Activity 4</td>
<td>You’re the Expert! Community</td>
</tr>
<tr>
<td>Activity 5</td>
<td>Media Influences? The Media</td>
</tr>
</tbody>
</table>
APPENDIX C:

Program Description
Boys Council

Introduction:
Boys Council is a structured program for boys that aim to promote boys’ natural strengths and to increase their options about being male in today’s world. Boys and young men are given the opportunity in a safe environment to address masculine definitions and behaviors.

When boys have an opportunity to express ideas, identify and normalize a full range of emotions, and make decisions in a safe, nonjudgmental community, their resiliency is strengthened.

Background:
Boys Council is the counterpart to Girls Circle founded by Beth Hossfeld and Giovanna Taormina. They were motivated to develop Girls Circle programs due to the severe national epidemics of depression, body image problems, dating violence, self-harming behaviors, relational aggression, etc. among female youth.

In 2006, they partnered with experienced male and female facilitators to develop the Boys Council model, in recognition of the need for healthy male role models. According to research, boys need a gender-specific group program to have a safe, protected, and focused place to address an array of harsh realities and to create healthy options for growing up male today. Findings of recent studies tell us that boys are not faring well in areas of education, mental health, health care access, bullying, violence, or substance abuse in this new millennia. The structured group model recognizes and builds upon inherent strengths and interests of boys and young men, challenges unhealthy masculinities, and connects youth in solidarity and community.

Boys Council programs has been successfully implemented in the Western Region and supported through the provision of community grants such as the Community Addictions Prevention and Mental Health Promotion Fund. The program has been delivered by community agencies and within schools. Feedback from these programs is positive.

Purpose:
To purpose of this program is to promote boys’ and young men’s safe and healthy passage through pre-teen and adolescent years.

Objectives:
The goal of this program is fulfilled by exploring:
• Relationships
• Education
• Leadership
• Diversity
• Media messages
• Personal values
• Integrity
• Future goals

**Target Audience:**
The target audience for this program includes boys ages 13-18 years.

**Description of Activities:**
Each week, a group of six to ten boys of similar age and development meet with one or two facilitators for 1.5 to 2 hours. These meetings are held for ten weeks or more, depending on the capacity of the setting.

The group format includes warm up activities, a “council” type check in opportunity, experiential activities that address relevant topics, and a reflection and group dialogue component. The focused activities may include group challenges, games, skits or role plays, arts, and so on. Topics may address:
  • competition
  • the male “box”
  • bullying
  • valuing diversity
  • safe expression of emotions
  • defining power from multiple perspectives
  • influences of mentors and role models
  • rejecting violence
  • becoming allies with girls and women
  • mentoring and making a difference with others
  • making safe and healthy decisions for themselves
  • finding and living with value in difficult times

Boys are free to participate at their own pace. Participants can express a range of ideas and emotions with peers and can expect respect and high regard from one another.

**Budget:**
Delivering the program within budgetary constraints is possible due to the in-kind contribution of other agencies that may also support these clients. The budget includes resource material from the One Circle Set (Boys’ Council), activity supplies, space rental, snacks, transportation, program incentives, and childcare.
Past Sample Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small honoraria for volunteers ($50 x 2)</td>
<td>$100</td>
</tr>
<tr>
<td>Transportation (offered after school based on 18 taxi trips x $10)</td>
<td>$180</td>
</tr>
<tr>
<td>Materials (Bristol board, markers, mural paper, cards, pens, crayons, flip sheet paper, etc.)</td>
<td>$100</td>
</tr>
<tr>
<td>Snacks</td>
<td>$100</td>
</tr>
<tr>
<td>Program Incentives</td>
<td>$100</td>
</tr>
<tr>
<td>Equipment &amp; space rental</td>
<td>In-Kind</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$580</strong></td>
</tr>
</tbody>
</table>

Requirements to support staff:
The human resource component consists of staff time for preparation and the delivery of this program. The Mental Health Promotion Consultant and the Addiction Prevention Consultant are also available for consultation and support throughout planning and running the program.

Evaluation:
Results from two studies found significant increases in boys’ school engagement, positive impact on boys’ masculinity beliefs and high rates of satisfaction. [https://onecirclefoundation.org/research-TC.aspx](https://onecirclefoundation.org/research-TC.aspx)

Indicators:
This program is evaluated using the Council Evaluation Packet. The packet includes instructions, forms and public domain scales as well as author-permitted scales for the The Council program evaluation.

Sample Timeline/Action Plan:

- **Step One:** Order materials
- **Step Two:** Recruitment of participants including parental consent
- **Step Three:** Review facilitator manuals
- **Step Four:** Purchase program materials and supplies
- **Step Five:** Program delivery
- **Step Six:** Evaluation
### Sample of Activity Plan – Standing Together: A Journey into Respect

<table>
<thead>
<tr>
<th>Week</th>
<th>Theme</th>
<th>Activity</th>
<th>Required Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Creating Our Council</em></td>
<td>Develop Opening and Closing Ritual</td>
<td>Items to be used in ritual like a drum or chime. Council format handouts, flip chart, and markers</td>
</tr>
<tr>
<td>2</td>
<td><em>Similar and Different</em></td>
<td>Are We More Alike or Different? &amp; If I were a…..</td>
<td>Masking tape or rope, soft Nerf type balls, or bean bags-one per each pair of boys</td>
</tr>
<tr>
<td>3</td>
<td><em>Put Downs – Part 1</em></td>
<td>Dude! A Quick Drama and Team Building Game: Put Down &amp; Build Up Role-Plays</td>
<td>White board or flip chart, pens, and paper</td>
</tr>
<tr>
<td>4</td>
<td><em>Put Downs – Part II</em></td>
<td>Keeping Each Other Afloat &amp; Balloon Bash</td>
<td>Lots of deflated balloons, markers, and poster board,</td>
</tr>
<tr>
<td>5</td>
<td><em>Space Invaders</em></td>
<td>Physical Boundaries</td>
<td>Large unobstructed space for activity</td>
</tr>
<tr>
<td>6</td>
<td><em>Boys’ Rights</em></td>
<td>My Boundaries &amp; Charter to Protect and Respect Boundaries</td>
<td>A backpack with items typical to the age group, ie. Wallet with $1, ear phones, a folded note, bag of chips or snack</td>
</tr>
<tr>
<td>7</td>
<td><em>E-motions – Part I</em></td>
<td>Who's Feeling is that Anyway? &amp; My Most Common Emotions</td>
<td>Pens or pencils, white board or flip chart, markers, drawing paper and art supplies</td>
</tr>
<tr>
<td>8</td>
<td><em>E-motions – Part II</em></td>
<td>Storytelling and Role-Playing Feelings</td>
<td>“Contrasting Feelings” cutout, paper, pens, pencils, “Feeling Situations” Handout, and “Feeling Words” Handout</td>
</tr>
<tr>
<td>9</td>
<td>Boys &amp; Power</td>
<td>Aces and Deuces</td>
<td>A deck of playing cards</td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
<td>-----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>10</td>
<td>Community Recognition</td>
<td>Group acknowledgment</td>
<td>½ sheets of paper, pens, colored markers, and program feedback forms</td>
</tr>
</tbody>
</table>
APPENDIX D:
Program Description
Challenges, Beliefs and Changes

Introduction:
The basic concept of the Challenges, Beliefs and Changes (CBC) Peer Education Program is that young people will listen to other young people when they have something significant to say. By using the peer educator team approach in the classroom, the CBC Peer Education Program seeks to provide an atmosphere whereby young people will freely discuss concerns about teenage social issues and challenges related to substance use. The CBC program is based upon best practice principles for drug education for youth. The CBC program provides information and problem solving strategies that promote healthier choices.

Background:
Parent Action on Drugs initiated its first peer education program on substance use and abuse in 1985 in a single high school in Scarborough, Ontario. Now in its 27th year of delivery, it is the longest, continuously running, peer-delivered program on drug education for youth in Ontario, and likely in Canada. As of 2012, they have worked with 235 different schools throughout the province and delivered 450 training sessions.

Purpose:
Challenges, Beliefs and Changes (CBC) is a peer education program delivered by senior high school students to address decisions about alcohol and other drugs and assist the transition to high school for junior high students. The program helps adolescents clarify and challenge their own personal beliefs and expectations about the use of alcohol and other drugs in high school; clarify “urban myths”; and learn or reinforce information about alcohol, cannabis, prescription drugs, caffeine (high energy drinks), and other drugs.

Objectives:
The goals of the CBC program are met by reaching the following objectives:
- CBC program provides information and problem solving strategies that promote healthier choices. It is important to acknowledge the experimentation with alcohol and other drugs that statistics show occurs in the transition to high school.
- The program is intended to be as non-judgmental as possible in order to promote an accepting environment where youth can voice their different opinions.
- The program provides an opportunity for peer educators and their younger peers to participate within the guidelines of the program, regardless of their personal
beliefs and experiences.

Target Audience:
The target audience is grade 8 and 9 junior high school students.

Description of Activities:
Using the Activity Guide and Activity Resources, the coordinator and peer educator teams will decide which activities they want to deliver to the younger students. It is important to deliver all of the Core Activities and then choose from the Optional Activities, based upon how much time the receiving school has allowed. For each activity there needs to be a leader, while the rest of the team supports them by handing out papers, writing on the board, or working with the students. Each activity should have a new team leader to allow all members of the peer educator team to develop leadership skills. Some schools allow for a full half day or two separate days of delivery. Other schools may request a three day delivery with a 60 minute curriculum per day.

Budget:
Program materials were funded through the Western Injury Prevention Coalition. The budget to deliver this program consists of pens, markers, flipchart paper, and labels, as well as a small stipend for peer educators/leaders. It is important to use the Standard Drink and Impaired Driving Kits to demonstrate the impact of alcohol and marijuana use on driving any type of motorized vehicle.

Evaluation:
The CBC Program is based upon best practice principles for drug education for youth. CBC is consistently reviewed and revised to incorporate new information about current drug use, social pressures, and evolving technology, as well as respond to suggestions from the peer educators.

Indicators:
This program is evaluated by administering a pre- & post-test as well as a peer educator feedback form.

Sample Timeline:
Step One: Recruit peer leaders
Step Two: Secure materials needed to deliver the program (i.e. Standard Drink Kit and Impaired Driving Kit)
Step Two: Train peer leaders
Step Three: Ensure peer educators understand instructional duties
Step Four: Administer pre-test and deliver program over 2-4 sessions
Step Five: Deliver post-test evaluation

Program Structure

<table>
<thead>
<tr>
<th>First Session</th>
<th>Second Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Introduction</td>
</tr>
<tr>
<td>Peer Educators Introduction</td>
<td>Thumbs Up, Thumbs Down</td>
</tr>
<tr>
<td>Tool Box</td>
<td>Tool Box</td>
</tr>
<tr>
<td>Establishing Ground Rules</td>
<td>The Decision Making Process</td>
</tr>
<tr>
<td>25 Questions-The Game</td>
<td>Four Corners</td>
</tr>
<tr>
<td>What Drug Am I?</td>
<td>Teen Strengths and Challenges</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Conclusion</td>
</tr>
<tr>
<td>Who Uses What and Why?</td>
<td>Fortune Teller Exercise</td>
</tr>
</tbody>
</table>
APPENDIX E:

Program Description
Families and Schools Together (F&ST)

Introduction:
Families and Schools Together (F&ST) is a proven parent involvement and family support program designed to help children succeed academically and socially. Facilitated by a team of professionals, the program is built around the principles that parents are the primary prevention agents in their children's lives. The activities have been developed based on family systems theory and other valid research to maximize impact for parents and their families. Positive connections are made by parents with school administration and staff that last throughout the child's school life. Families are introduced to community resources in a non-intimidating environment and a network of families is built through participation in the F&ST program. This network is continued with previous F&ST families through monthly follow up meetings called F&STWORKS.

Background:
F&ST was originally developed and implemented in Madison, Wisconsin by Dr. Lynn McDonald in 1988. The program is now available in 2000 schools internationally including the United States, Canada, Australia, Austria, England, and Germany. F&ST for elementary aged children has been successfully delivered in both the Bonne Bay and Bay St. George areas in the Western Region.

Purpose:
The purpose of F&ST is to foster feelings of affiliation, mutual respect, and reciprocity among the various players in the children’s family, neighborhood, school, and community environments.

The Goals of the program are:
1. Enhance family functioning
   - Strengthen the parent-child relationship
   - Empower parents, to help them become the primary prevention agents for their children
2. Prevent the child from experiencing school failure
   - Improve the child’s behavior and performance in school, both short-term and long-term
   - Empower the parents in their role as partners in the educational process
   - Increase the child’s and family’s feeling of affiliation toward their school
3. Prevent substance abuse by the child and the family
   - Increase the family’s knowledge and awareness of substance abuse, and the
impact of substance abuse upon child development
  • Link the family to appropriate assessment and treatment services as needed

4. Reduce the stress that parents and children experience from daily life situations
  • Develop an ongoing support group for parents of at-risk children
  • Link the family to appropriate community resources and services as needed
  • Build the self-esteem of each family member

Target Audience:
F&ST is a 2-year parent involvement and prevention model that supports children from birth to 12 years of age. There are four programs to support various age groups: Baby F&ST (0-3 Years), Early Childhood F&ST (3-5 Years), Elementary F&ST (5-9 Years), and Middle Years F&ST (9-12 Years).

Description of Activities:
F&ST consists of 8-10 weekly 2 ½ hour meetings for the whole family to attend and participate in. These sessions include opening and closing traditions, a family meal that is prepared in turn by each family in the group, structured family activities, parent mutual-support time, kids’ time and parent-child one-on-one time with the child originally identified as needing the program. The program ends with a graduation ceremony, during which the school principal presents the participating families with a certificate of completion.

The core F&ST Team consists of a minimum of 4 partner roles: (1) a parent partner* from the school community; (2) a partner from a community-based public/not-for-profit mental health agency; (3) a partner from a community-based public/not-for-profit substance abuse agency; and (4) a school partner from the school staff. The F&ST Team operates as a trained “team of coaches”. In addition, there are tasks that can be fulfilled by volunteers from the community (e.g., kitchen/meal helpers, childcare helpers, and recreation/activity helpers).

*After the first 8-week cycle, a graduate parent becomes the parent partner. S/he will be the team member to whom parents can relate most easily for support/assistance with program needs and so forth. The parent partner should be someone who is outgoing and assertive, comfortable approaching other parents by phone and face-to-face; a person who can advocate/support/assist parents with questions and concerns, as well as refer them to community resources as needed. This position is awarded a $500 honorarium.

Following the eight week intensive program, parents have the option of participating in F&STWORKS, a 2-year follow-up program consisting of monthly parent meetings. F&STWORKS is designed to maintain an active social network for the parents and further develop parent community involvement.
**Budget:**
The following is a sample budget for the F&ST program based on the participation of 12 families

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small honoraria for volunteers</td>
<td>Volunteers are invited to participate in the evening meal, and are given certificates of appreciation at graduation 1 Parent Partner @500 or 2 Parent Partners @ $250 each</td>
<td>$400/$500</td>
</tr>
<tr>
<td>Travel for participants</td>
<td>Transportation for families (TAXI) provided if families don’t have access to own transportation</td>
<td>$768</td>
</tr>
<tr>
<td>Materials</td>
<td>Family baskets (50 per family) x 12 families Family flag materials/Kids Time supplies/craft supplies/graduation supplies</td>
<td>$600/$400</td>
</tr>
<tr>
<td>Food</td>
<td>Family Meal Preparation Incentive ( $40 per family x 12 families) Weekly Meals Supplements (250 per week x 7 weeks Graduation Meal</td>
<td>$480/$1,050/$250</td>
</tr>
<tr>
<td>FASTWORKS</td>
<td>22 months x $25 per activity or month</td>
<td>$550</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$4,998</strong></td>
</tr>
</tbody>
</table>

**Evaluation:**
F&ST has undergone several evaluations in both the United States and Canada. These evaluations indicate that the program is effective at improving children’s social skills, decreasing externalizing behaviors and improving academic performance. It is also associated with improvements in family adaptability and parent’s feelings of social isolation. The F&ST approach has been named “Best Practice in Preventing Substance use Problems Among Young People” (Health Canada, 2001).

**Short term outputs:**
- Families demonstrate positive communication strategies
• Increase in the number of positive interactions among family members.
• Pre-adolescents have improved behavior (home and school) and performance in school.
• Physical activities (for children and pre-adolescents) incorporated into program sessions.
• Healthy meals provided at each family session.

Long term outcomes:
• Prevention of school failure among pre-adolescents
• Pre-adolescents have improved behavior (home and school) and performance in school
• Prevention of addictions by pre-adolescent and family.
• Reduced impact of stress and social isolation on parent and pre-adolescent.
• Enhanced family bonds (cohesion) and communication skills that encourage family discussions

Indicators:
FAST uses national pre and post evaluation tools. In order to measure the effect of F&ST on participating families, several surveys are administered before the program begins and again after its conclusion.
• The Behavioral and Emotional Rating Scale (BERS). This is a standardized scale designed to assess children’s behavioral and emotional strengths.
• The Family Adaptability and Cohesiveness Evaluation Scale III (FACES III). This scale consists of two subscales, one of which measures family adaptability while the other measures family cohesiveness.
• Parental Involvement Survey (PIS). This survey consists of a series of questions that ask parents about their involvement in schools and community activities.

In addition, a Family Information Sheet is used to gather some basic information about families, and the Program Evaluation Form asks families some open-ended questions about the impact of F@ST. Finally, feedback from teachers and administration are also used to evaluate this program.

Requirements to Support Staff:
The human resource component consists of staff time for preparation and the delivery of this program. The Mental Health Promotion Consultant and the Addiction Prevention Consultant are also available for consultation and support throughout planning, facilitator training, participant recruitment, and running the program.

Sample Timeline/Action Plan:
Step One: Contact partners and establish team (e.g. a parent, a school professional, RCMP officer, health professionals, and other
community partners). Recruit volunteers.

Step Two: Bring team together for planning and assignment of responsibilities

Step Two: Identify funding sources. May need to submit proposals and/or funding applications.

Step Three: Recruit 10-12 families from the school are recruited to participate in the program. Complete home visits with each family. distribute and complete pre-program evaluation tools. Invite all members of the at-risk child’s family are to attend a series of eight weekly team-led multi-family sessions.

Step Four: Acquire program resources (meal vouchers, side meals, and snacks, family baskets).

Step Five: Program delivery (weekly sessions).

Step Six: Graduating families join FASTWORKS Group.

Step Seven: Distribute and complete post-program evaluation tools.

Sample Elementary Program Session Agenda

5:30 PM Welcome Hello’s and Sing-Along Meal

6:15 PM Scribbles Feelings Charades

6:45 PM Buddy Time and Parent Group Kids’ Time

7:30 PM Special Play

7:45 PM Picking a Winning Family

7:55 PM Closing Circle / Rain

8:00 PM Departure

The Session Schedule differs to include Making Family Flags on Week 1 and a Presentation of Substance Abuse Prevention on Week 5. A Graduation Ceremony and celebrations are included in the final session.

Mental Health Promotion & Addictions Prevention Strategy
APPENDIX F:

Program Description
FRIENDS for Life Anxiety Prevention Program

Introduction:
Anxiety disorders are the most common mental health problem in Canada, facing up to 20% of children and teenagers today. If left untreated, childhood anxiety may become a prolonged problem with the potential to develop into more severe anxiety and depression in adulthood. The FRIENDS for Life program is an internationally recognized school-based early intervention and prevention program that builds resilience and reduces the risk of anxiety disorders in children.

Background:
FRIENDS originally stems from the research work of psychologist Phillip Kendall in the United States who developed Coping Cat workbook in the late 1980’s. This program was designed to treat children with a diagnosis of over anxiety, separation anxiety, or avoidant disorder. His work was adapted and extended by Dr. Paula Barrett in Australia. In 1998 Coping Koala was refined by Dr. Barrett to reflect a user friendly early intervention and prevention format and was expanded into two groups – FRIENDS for children 7-11 years, and FRIENDS for Youth – 12-16 years.

In late 1999, a third edition of FRIENDS for Children was completed, which included research feedback designed to tailor the program toward an even more teacher friendly, school based intervention. In late 2004 and early 2005, a major review to both the Children and Youth programs was undertaken to ensure FRIENDS remains at the cutting edge of quality in anxiety prevention and treatment. The new edition incorporates the latest research and advances in childhood anxiety, depression, and resiliency. A new general title for the program “FRIENDS for Life” was introduced to reflect the life-long benefits of the program.

The FRIENDS for Life program was first introduced in British Columbia in 2004 in support of the Child and Youth Mental Health Plan in British Columbia. It has been implemented in 18 other countries internationally. In 2013, Western Health partnered with the Western School District to have an on-site training delivered to approximately 16 guidance counselors in the Western region. The FRIENDS for Life program has been successfully implemented in the Western region since this training.

Purpose:
FRIENDS for Life aims to reduce the incidences of anxiety and depression, emotional distress, and impairment in social functioning by teaching children and youth how to cope with and manage anxiety now and later in life.
The **Goals** of the program are:
- Increase participants ability to recognize and regulate one’s own emotions
- Build skills in empathy
- Provide strategies for making constructive and respectful choices about personal behavior and social interactions
- Improve competencies for establishing and maintaining healthy relationships
- Develop skills to prevent and treat mental health concerns
- Enhance resilience skills to overcome challenges

**Target Audience:**
FRIENDS for Life is typically implemented in grades 4 and 5 (ages 9-11).

**Description of Activities:**
FRIENDS has been specifically designed for use in the schools to be delivered in a group based, non-clinical format as a universal preventative program run by teachers during normal class time. Teachers delivering this program must be certified to deliver this program. Children are given the opportunity to model positive behavior and have their own fears and worries normalized. Children are positively reinforced for desired behavior.

The FRIENDS program involves ten weeks of 1 to 1.5 hour sessions to be run during class time, with corresponding homework tasks for each session so the skills can be practiced at home with families. Schools may also choose to complete the program by conducting shorter sessions over a longer period of time. At the conclusion, there is also the option to run two booster sessions via homework tasks, where the students can review their progress and re-visit the FRIENDS management plan.

The parent component gives parents the opportunity to support their children and learn more about FRIENDS themselves by attending two parent sessions that may be arranged by the school. In addition, handouts are provided to supply parents with further information.

**Budget:**
The budget to deliver this program consists of a group leader’s manual for the facilitator and activity books for participants. The cost of the workbook is $16.00 per participant and the cost of the group leader’s manual is $54.00.

This program can only be delivered by professionals who have been certified to deliver the FRIENDS for Life program through attendance at a one day on-site training session. Eligibility for training includes professionals who work with children, such as teachers, social workers, guidance counselors, and nurses. On site trainings can be offered to groups of 16-30 participants. The cost of an on-site training consists of $180.00 per participant and a FRIENDS kit (including a leader’s manual and one activity book) that
costs $70.00. There are also travel costs for the trainer including accommodations, meals, and travel. Training costs can be obtained by contacting contactus@friendsrt.com.

**Evaluation:**
This program has been extensively evaluated and is considered a best practice program. It has been recognized by the World Health Organization for its more than 12 years of comprehensive validation and assessment across several countries and languages. FRIENDS has proven to be effective at all levels of intervention; as a treatment protocol for children diagnosed with anxiety disorders, as an early intervention program for children at risk, and as a universal anxiety prevention program.

Research and evaluation of FRIENDS, including independent replication studies, continues today throughout Australia and overseas. Within Australia, several large scale school-based trials in Western Australia, New South Wales, and Queensland have confirmed the program's ease of use, social acceptability, and appropriateness as a universal prevention approach.

Overseas trials in Germany, Norway, Finland, the Netherlands, and Mexico have shown the effectiveness of FRIENDS when translated into other languages. Research from the United States, the United Kingdom, and Canada also show effectiveness in these cultures.

**Indicators:**
To evaluate this program there is a pre and post-test evaluation. The program is also be evaluated through informal observation and the assigned homework.

**Short term outputs:**
- Enhances self-esteem
- Builds confidence
- Enhances the ability to effectively cope with stress, challenges and difficult life events
- Helps build friendships

**Long term outcomes:**
- Reduces a child’s risk of developing an anxiety disorder for up to six years.
- Children with normal levels of worry benefit by acquiring resilience to emotional stress.

**Requirements to Support Staff:**
In 2013, the Mental Health Promotion Consultant, in partnership with the Western School District, organized an on-site FRIENDS for Life training with Austin Resilience Development Inc. The Mental Health Promotion Consultant and the Addiction
Prevention Consultant are also available for consultation and support throughout planning and running the program.

**Sample Timeline/Action Plan:**

**Step One:** Decide what grades/ages will receive the program and add the program to the curriculum

**Step Two:** Purchase program manuals for the teachers responsible for and trained to deliver the program and order workbooks required for the number of participants (one per student)

**Step Three:** Encourage parents to be involved with the program by attending an optional parent session

**Step Four:** Deliver the program using the teacher’s manual and workbooks

**Step Five:** Complete post evaluation

**Step Six:** Offer optional booster sessions

**Program Structure:**

*FRIENDS for Life Children – 6th Edition*

<table>
<thead>
<tr>
<th>Children’s Session</th>
<th>Skills and Techniques Taught</th>
</tr>
</thead>
</table>
| Session #1 *Understanding Feelings in Ourselves and Others* | *•* Getting to know each other better  
*•* Working in groups  
*•* Appreciating difference  
*•* Setting personal goals  
*•* Identifying happy experiences |
| Session #2 *Introduction to Feelings* | *•* Understanding feelings in ourselves, others and animals  
*•* Understanding non-verbal communication (body language)  
*•* Learning to pay attention to positive cues using our senses |
<table>
<thead>
<tr>
<th>Session #3</th>
<th>Introduction to Body Clues and Relaxation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Learning to cope with our feelings in helpful ways</td>
</tr>
<tr>
<td></td>
<td>• Developing empathy and helping others</td>
</tr>
<tr>
<td></td>
<td>• Identifying our body clues for different feelings</td>
</tr>
<tr>
<td></td>
<td>• Learning ways to relax and calm ourselves down</td>
</tr>
<tr>
<td></td>
<td>• Engaging in fun activities to relax and feel good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #4</th>
<th>Paying Careful Attention – Helpful (“Green”) and Unhelpful (“Red”) Self-Talk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Paying attention to positive, happy, calm things around us</td>
</tr>
<tr>
<td></td>
<td>• Focusing on the positives to feel more confident</td>
</tr>
<tr>
<td></td>
<td>• Understanding how thoughts and feelings affect behavior</td>
</tr>
<tr>
<td></td>
<td>• Learning “green” thoughts make us feel braver and happier whereas “red” thoughts make us feel scared and upset</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #5</th>
<th>Changing Unhelpful Thoughts Into Helpful Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Learning to think in more helpful ways</td>
</tr>
<tr>
<td></td>
<td>• Paying attention to positive thoughts and cues</td>
</tr>
<tr>
<td></td>
<td>• Using “yellow” thought challenger questions for “red” thoughts</td>
</tr>
<tr>
<td></td>
<td>• Changing “red” thoughts into more helpful “green” thoughts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #6</th>
<th>Introduction to Coping Step Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Exploring ways to cope with difficult situations</td>
</tr>
<tr>
<td></td>
<td>• Using Coping Step Plans to face difficulties/reach goals</td>
</tr>
<tr>
<td></td>
<td>• Breaking down difficulties/goals into graduated steps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #7</th>
<th>Learning from Our Role Models And Building Support Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Identifying role models in our lives</td>
</tr>
<tr>
<td></td>
<td>• Identifying support people we can turn to in good/bad times</td>
</tr>
<tr>
<td></td>
<td>• Identifying the qualities of a good friend</td>
</tr>
</tbody>
</table>
APPENDIX G:

Program Description
Girls Circle

Introduction:
Girls Circle is a structured 8-12 week program for girls ages 9-18 years. The program integrates relational theory, resiliency practices, and skills training in a specific format. It is designed to increase positive connections, personal and collective strengths, and competence in girls.

When girls have the opportunity to voice their ideas and opinions in a safe environment it strengthens their confidence and promotes self-esteem. It also encourages them to think more critically about their behavior and choices. By exploring cultural expectations in a supportive environment, girls gain a greater awareness of their options and strengthen their ability to make choices that are consistent with their values, interests, and talents.

Background:
Founders Beth Hossfeld and Giovanna Taormina were motivated to develop the Girls Circle program due to the severe national epidemics of depression, body image problems, dating violence, self-harming behaviors, relational aggression, etc. among female youth.

Inspired by positive feedback from the Girls Circles, the first Girls Circle facilitator training was held in 1997. The gender based model has received recognition from mental health, child welfare, schools, and community based programs. In 2006, they partnered with experienced male and female facilitators to develop the Boys Council model in recognition of the need for healthy male role models.

This program has been successfully implemented several times in the Western Region and supported through the provision of community grants such as the Community Addictions Prevention and Mental Health Promotion fund. It has been delivered by community agencies and within schools. Feedback from these programs is positive.

Purpose:
Girls Circle aims to counteract social and interpersonal forces that impede girls’ growth and development by promoting an emotionally safe setting and structure within which girls can develop caring relationships and use authentic voices.

Goals:
- Create a safe space to address risky behaviors
• Build on protective factors
• Improve relationships

Target Audience:
The target audience includes all girls and young women ages 9-18 years.

Description of Activities:
The Girls Circle guide offers step-by-step instructions to lead a support circle. The Girls Circle is usually held for 1-2 hours once a week. Each week, the facilitator leads the participants through a format that includes each girl taking turns talking and listening to one another respectfully about their concerns and interests. The participants have the opportunity to express themselves creatively through role playing, drama, journaling, and other activities. Gender specific themes are introduced including being a girl, trusting ourselves, friendships, body image, and drugs and alcohol, among others.

Budget:
Delivering the program within budgetary constraints is possible due to the in-kind contribution of other agencies that may also support clients in other program areas. The resources to deliver this program can be borrowed from Western Health. The budget may include activity supplies, space rental, snacks, transportation, program incentives and childcare.

Sample Past Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Honoraria (2 Respect Team members to assist with delivery of program) $50 each</td>
<td>$100</td>
</tr>
<tr>
<td>Materials (mural paper, markers, Bristol board, string, balloons, art supplies, pens, glue sticks, buttons, etc.)</td>
<td>$100</td>
</tr>
<tr>
<td>Snacks</td>
<td>$200</td>
</tr>
<tr>
<td>Program Incentives</td>
<td>$100</td>
</tr>
<tr>
<td>Equipment &amp; space rental</td>
<td>In-Kind</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$500</strong></td>
</tr>
</tbody>
</table>

Requirements to support staff:
The human resource component consists of staff time for the preparation and delivery of this program. The Mental Health Promotion Consultant and the Addiction Prevention Consultant are also available for consultation and support throughout planning and running the program.
Evaluation:
Research conducted in 2007 on this program (available from http://girlscircle.com/research.aspx) suggests increases in skills were developed over the short term and that improvement in long-term outcomes was statistically significant.

Short term outcomes:
- Finding things in common with a new person
- Trying to see beyond girls’ reputations
- Telling adults what they need
- Feeling good about their body
- Picking friends that treat them the way they want to be treated
- Telling people how much they mean to them

Long term outcomes:
- Increase in self-efficacy
- Decrease in self-harming behaviors
- Decrease in rates of alcohol use
- Increases in attachment to school
- Increases in positive body image
- Increases in social supports

Indicators:
Girls Circle: The Rosenberg Self-Esteem Scale (SES) is administered with participants as a pre and post measure. It is a 10-item self-report measure of global self-esteem that consists of 10 statements related to overall feelings of self-worth or self-acceptance. It is in the public domain and free of charge.

An evaluation and feedback form can also be developed to ask the participants about their satisfaction with the group and the various activities.

A Sample Timeline/Action Plan:
Step One: Recruitment of participants including parental consents
Step Two: Arrangement of childcare for Mother’s night
Step Three: Purchase Supplies
Step Four: Running of Program for 8-12 consecutive weeks. Administer pre-test
Step Five: Evaluation of the program and Celebration
<table>
<thead>
<tr>
<th>Week</th>
<th>Theme</th>
<th>Activity</th>
<th>Required Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A Friendly Place</td>
<td>Group Guidelines, Posters, and Name</td>
<td>Poster paper and markers</td>
</tr>
<tr>
<td>2</td>
<td>Being My Own Friend First</td>
<td>“The Qualities I Possess” Activity</td>
<td>Paper (color, white), scissors, yarn, markers, glue, and copies of cut-outs</td>
</tr>
<tr>
<td>3</td>
<td>Being Included, Being Left Out</td>
<td>Pair Sharing, Group Sharing</td>
<td>Paper and pens or markers</td>
</tr>
<tr>
<td>4</td>
<td>Same and Different</td>
<td>Questions sheets, Drawings</td>
<td>Questions sheet handout and crayons</td>
</tr>
<tr>
<td>5</td>
<td>The Whole is Greater than All the Parts</td>
<td>Mini-Group Posters and Whole Group Mural</td>
<td>Posters, mural paper, and markers</td>
</tr>
<tr>
<td>6</td>
<td>Feuds, Followers, and Fairness</td>
<td>Role-Plays</td>
<td>Situation Sheet, white board or poster paper, and markers</td>
</tr>
<tr>
<td>7</td>
<td>Our Qualities &amp; Strengths</td>
<td>Chain of Strengths</td>
<td>Colored index cards, markers, string, and hole puncher</td>
</tr>
<tr>
<td>8</td>
<td>Appreciation Celebration</td>
<td>Flower Petals</td>
<td>Colorful construction paper, scissors, felt pens, treats, and evaluation forms</td>
</tr>
</tbody>
</table>
APPENDIX H:

Program Description
No Stress Fest

Introduction:
No Stress Fest is a project initiated by the Mental Health Partners Working Group. This group consists of key mental health and addictions organizations including: Community Mental Health Initiative (CMHI), Canadian Mental Health Association – NL Division (Western Office), Schizophrenia Society of Newfoundland and Labrador (Western Office), CHANNAL, and Western Health (Mental Health & Addiction Services).

No Stress Fest is a one day event that promotes positive mental health and promotes healthy lifestyles while promoting mental health resources that are available in the community. The first No Stress Fest was implemented in the Corner Brook on November 8, 2012. It has also been implemented in other areas in the region including Port Aux Basques, Stephenville and Port Saunders.

Purpose:
1. Engage individuals, families, and community groups in learning ways to promote healthy lifestyle and positive mental health.

2. Create awareness of mental health and addictions resources available to individuals, families and community groups

Goals:
Short term goals:
- Increase participant knowledge about what mental health and addiction services and resources are available in their community
- Encourage participants to think about how they currently manage stress and new ways to manage stress

Long term goals:
- Increase the probability that participants will access mental health services when they are in need
- Increase participants’ own tools for managing stress

Target Audience:
The target audience is universal, including individuals, families and community groups of all ages.
Description of Activities:
A one day event that consists of a combination of interactive booths from various organizations and agencies that promote healthy lifestyles and positive mental health. Activities can include relaxation methods, healthy recipes, making a stress ball, music, exercise such as yoga or Zumba, massage, and therapeutic Art.

Budget:
The budget for this program may consist of facility rental, promotional materials, food demo supplies, prizes, and honorariums. Delivering this program within budgetary constraints is possible due to in-kind support of other agencies and businesses within the community.

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room/Space Rental</td>
<td>$300 (Lion's Club)</td>
</tr>
<tr>
<td>Materials:</td>
<td></td>
</tr>
<tr>
<td>Paper $55</td>
<td>$280</td>
</tr>
<tr>
<td>Mocktails $30</td>
<td></td>
</tr>
<tr>
<td>Stress Ball Materials $40</td>
<td></td>
</tr>
<tr>
<td>Craft Supplies $80</td>
<td></td>
</tr>
<tr>
<td>Prop Supplies $50</td>
<td></td>
</tr>
<tr>
<td>Facial Scrub Supplies $10</td>
<td></td>
</tr>
<tr>
<td>Cups, Napkins, Plates $15</td>
<td></td>
</tr>
<tr>
<td>Trail Mix Supplies $40</td>
<td>$160</td>
</tr>
<tr>
<td>Chicken Wrap Supplies $40</td>
<td></td>
</tr>
<tr>
<td>Fruit Kabobs $40</td>
<td></td>
</tr>
<tr>
<td>Water $20</td>
<td></td>
</tr>
<tr>
<td>Juice $20</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous expenses</td>
<td>$60</td>
</tr>
<tr>
<td>Homemade jewelry, photocopying,</td>
<td>In-Kind</td>
</tr>
<tr>
<td>resources, camera and printer and</td>
<td></td>
</tr>
<tr>
<td>table cloths (In-kind), door prize,</td>
<td></td>
</tr>
<tr>
<td>community basket, donations from</td>
<td></td>
</tr>
<tr>
<td>local businesses</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$800</strong></td>
</tr>
</tbody>
</table>

Evaluation:
There as overwhelming positive feedback that this event accomplished its short term goals of increasing participant knowledge about what mental health and addiction services and resources are available in their community, as well as encouraging thinking about how they currently manage stress and new ways to manage stress.

Further evaluation is needed to determine the effectiveness of the No Stress Fest in meeting the program’s long term goals of increasing the probability that participants will
access mental health services when they are in need and increasing participants’ own tools for managing stress.

**Indicators:**
Evaluation includes recording the number of participants that attended. There is also a participant feedback survey to complete that includes six open-ended questions such as “Are you more aware of the available Mental Health & Addiction Services than before?” and “Did this event help you think about new ways to manage stress?”

**Requirements for Staff:**
The Mental Health Promotion Consultant and Regional Addiction Consultant provide support in a consultative role regarding how to plan a successful No Stress Fest. The Mental Health Partners Working Group is currently working on a Toolkit that includes a Planning Guide. Staff from Mental Health & Addiction Services participates in this event by setting up a booth to promote services and may also assist with set-up, delivery and take-down as this event, which can be quite labor intensive.

**Time-line/Action Plan (Sample):**

**Step One:** Form a planning committee. If possible have a member from each mental health organization within your community.

**Step Two:** Choose a date based on what may work for your community so that all family members have the option to participate.

**Step Three:** Choose a location

**Step Four:** Promote the event with posters, PSAs, etc.

**Step Five:** Acquire booth materials from Wellness Facilitator and/or Mental Health & Addiction Services

**Step Six:** Prepare a budget

**Step Seven:** Solicit prizes

**Step Eight:** Recruit volunteers

**Step Nine:** Create a checklist of required materials for the event

**Sample of Activities**

**Schedule of Events**

1:00 – 1:30  Guided Relaxation
1:45 – 2:15  Music (Sherman Downey)
2:30 – 3:00  Massage & Self-Massage
3:15 – 3:45  Therapeutic Art
4:00 – 4:30  Homemade Hand/Facial Scrubs (Lorraine Poole)
4:45 – 5:15  Hands-on Food/Healthy Lunch Box Demo
5:30 – 6:00  Musician (Daniel Payne)
6:15 – 6:45  Comedy (Theatre Newfoundland and Labrador)
6:45 – 7:30  Zumba (YMCA)

**Kids’ Zone – Schedule of Events (CMHI to lead)**

- Face Painting
- Worry Warriors
- Puppet Show
- Kite Making
- Other Children’s Health Festival Activities
- Scavenger hunt with prizes for kids
- Gus & Isaac Book Reading
- Kids Have Stress Too Stretches

Note: Information booths remain set-up throughout the day and mocktails, smoothies, and fruit lollipops are served throughout event. Sample solicited prize: 2 Nights @ Delta
APPENDIX I:

Program Description
Strengthening Families for Parents and Youth Program

Introduction:
Strengthening Families for Parents and Youth (SFPY) is a 9-week program for youth, ages 12-16, and their parents and other caregivers. SPFY is a shortened, adapted version of the successful 14-week Strengthening Families for the Future program developed by Dr. Karol Kumpfer of the University of Utah.

Background:
SFPY was supported through funds from Health Canada (2009-2011). It was adapted by Parent Action on Drugs as an effective strategy for the prevention of substance abuse in youth by means of improving parenting skills and positive family functioning for families involved with diverse youth serving agencies in Toronto, Ontario. This program was piloted in Corner Brook from October – December 2012 and has continued to be implemented in the Western Region.

Purpose:
The aim of the Strengthening Families for Parents and Youth program is to increase resiliency among at-risk youth, ages 12-16, through family participation in a skill-building family change program.

The Goals of the program are to:
- Increase positive parenting practices
- Increase in youth resiliency
- Increase in family functioning
- Increase the likelihood of non-use of illicit drugs by the use of youth participating in the program

Target Audience:
The target population is at-risk youth (age 12-16) and their families. The program is appropriate for youth at risk due to mental health and substance abuse concerns, high levels of family conflict or other environmental factors.

Description of Activities:
The Strengthening Families for Parents and Youth program is presented in nine consecutive weekly sessions. Sessions last about three hours and include a family meal. Parents and youth meet together to share a meal at the beginning of each
session. This is followed by separate one-hour sessions for youth and parents. Finally, families come together where they build on skills they explored in their individual sessions.

**Budget:**
The budget for delivering this program is less than the Strengthening Families for the Future due to the decrease in length of time to run the program from fourteen to nine weeks. The budget consists of family meals and supplies, transportation, crafts and supplies, program incentives (parent and youth), and volunteer appreciation. Delivering the program within budgetary constraints is possible due to the in-kind contribution of other agencies that may also support clients. Development of a financially sustainable plan is based on financial support from Western Health.

The ability to plan, prepare, and cook the meals also contributes to budgetary savings as the cost of meal preparation is usually the highest expense of running this program ($160.00 x 9 weeks). Catering is typically more expensive and would require more money in the budget. A higher budget for food is also based on meeting school health food guidelines. A typical budget usually ranges between $3000-3500.

**Past Sample Budget**

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small honoraria for volunteers</td>
<td>$250</td>
</tr>
<tr>
<td>Supplies (paper plates, napkins, cutlery, garbage bags, foil wrap, plastic wrap, etc.)</td>
<td>$150</td>
</tr>
<tr>
<td>Travel for participants (Gas cards/taxis)</td>
<td>($750 in-kind from another source)</td>
</tr>
<tr>
<td>Room/space rental</td>
<td>In-kind</td>
</tr>
<tr>
<td>Materials (manuals, arts and crafts, and journals)</td>
<td>(Printing of facilitator manual in-kind)</td>
</tr>
<tr>
<td></td>
<td>$250 Materials for activities</td>
</tr>
<tr>
<td>Food ($160 per week x 9 sessions)</td>
<td>$1440</td>
</tr>
<tr>
<td>Other program incentives for parents</td>
<td>$780</td>
</tr>
<tr>
<td>(grocery cards - $5 each session with a $20 bonus at completion - $65 x 12 families)</td>
<td></td>
</tr>
<tr>
<td>Program incentives for youth (iTunes gift cards $10 x 12)</td>
<td>$120</td>
</tr>
<tr>
<td>Graduation (food and drinks)</td>
<td>$150</td>
</tr>
<tr>
<td>Weekly grocery bag giveaways ($25 x 9)</td>
<td>$225</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3365</strong></td>
</tr>
</tbody>
</table>

**Evaluation:**
This program has undergone extensive evaluation and has been designated as “best practice”. Parent Action on Drugs contracted Lutra Group to complete a two-year research project consisting of 69 families. This involved implementing & evaluation of
the adapted 9-week curriculum in 8 different trials. These trials were evaluated & data analyzed according to standardized measurements used for international applications of Strengthening Families programs in consultation with the program’s originator, Dr. Karol Kumpfer.

Short term outcomes:

- Parenting outcomes: significant improvement shown in parenting skills, supervision, efficacy, parental involvement, depression, and decrease in parental substance use
- Family outcomes: reduction of targeted risk factors of family conflict and positive impacts on communication skills, family strengths and resilience.
- Child behavior outcomes: significant improvements shown in overt aggression, social skills, concentration, depression, covert aggression, social skills, hyperactivity, and overall child cluster.

Long term outcomes:

- Desired outcomes shown for positive parenting, family functioning and youth resiliency. SPFY has also been extremely effective in reducing substance misuse in youth.

Indicators:

To evaluate this program, families complete a mid-program evaluation and final evaluation. The Parenting Relationship Questionnaire is completed at week one and week nine, to be scored by a psychologist and analyzed by Quality Research and Management at Western Health. Facilitator feedback is provided at week nine.

Requirements to Support Staff:

In order to support staff to deliver this program, staff time for training, preparation, and the delivery of this program must be allotted. The Mental Health Promotion Consultant and the Addictions Prevention Consultant are also available for consultation and support throughout planning, facilitator training, recruitment, and running the program.

The plan also includes the availability of other funding sources, such as the Community Addictions Prevention and Mental Health Promotion Fund, to support community-based programming.

Timeline/Action Plan (Sample):

In order to implement this program from beginning to end, the following logistical steps should be taken to ensure the program runs smoothly.

- Step 1: Secure program funding and maintain budget
- Step 2: Develop and distribute promotional materials
Step 3: Network with community agencies (partners)
Step 4: Recruit families, volunteers, and facilitators
Step 5: Secure appropriate location
Step 6: Develop and deliver facilitator training
Step 7: Develop program forms
Step 8: Support family intake
Step 9: Determine incentives and purchase materials
Step 10: Arrange for transportation
Step 11: Assemble resource bins and family incentives
Step 12: Complete meal planning
Step 13: Complete program implementation
Step 12: Complete Evaluation
Step 13: Consult on program changes

**Program Structure**

<table>
<thead>
<tr>
<th>Session One</th>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Two</td>
<td>Positive Attention/Praise</td>
</tr>
<tr>
<td>Session Three</td>
<td>Communication</td>
</tr>
<tr>
<td>Session Four</td>
<td>Expectations/Goals</td>
</tr>
<tr>
<td>Session Five</td>
<td>Limits, Consequences/Behavior, Choices</td>
</tr>
<tr>
<td>Session Six</td>
<td>Stress and Anger</td>
</tr>
<tr>
<td>Session Seven</td>
<td>Substance Use</td>
</tr>
<tr>
<td>Session Eight</td>
<td>Problem Solving/Getting Support</td>
</tr>
<tr>
<td>Session Nine</td>
<td>Making a Commitment to the Future/Graduation/Evaluation</td>
</tr>
</tbody>
</table>
APPENDIX J:

Program Description
Strengthening Families for the Future

Introduction:
Strengthening Families for the Future is modelled on a successful program developed in 1988 by Dr. Karol Kumpfer, of the University of Utah. While the Strengthening Families program was originally developed as a prevention program to target children who were at risk of developing alcohol and other drug problems due in part to their parent’s substance abuse, the program is applicable to families with other environmental risk factors.

The program is a promising intervention for fostering significant improvements in family functioning, parenting, and children’s psychosocial functioning. This program has undergone extensive evaluation and has been listed as a best practice program by Health Canada.

Background:
Strengthening Families has been implemented in the United States, Australia, Europe, Central America, and Canada. With input from treatment agencies in Ontario, CAMH has updated the original program to make it more relevant to Canada.

In 2004, the Oxycontin Task Force was set up to examine concerns around the abuse of Oxycontin in this province. The Task Force released a report, which made a number of recommendations to address substance use issues in the province. At the time, there was a Substance Abuse Prevention and Education Committee put in place to look at how to disseminate Oxycontin specific information to schools. A sub-committee of the Prevention and Education Committee was set up to explore the issues around at-risk youth and to make programming suggestions. A review was undertaken of best practices in prevention with the at-risk youth population. Based on the guidelines a number of family focused prevention programs were reviewed. Strengthening Families for the Future was one of the programs that seemed to fit criteria for effective prevention.

Following the recommendations of this report, a decision was made by Western Health to pilot the Strengthening Families program in Corner Brook area in the fall of 2008; however, implementation was delayed due to staff turnover. The program was piloted from January – April 2009 at C.C. Loughlin School, with partnering agencies including Child, Youth and Family Services and Western School District. Based on the information collected, the program was a success. Since the pilot, the program has been successfully implemented in the Western Region with grants being awarded through the CAPMHP fund.
**Purpose:**
The purpose of the Strengthening Families for the Future program is to reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance.

The **Goals** of the Program are to:
- Reduce children’s or adolescents’ intention to use alcohol and/or other drugs, and reduce behavioral problems
- Increase children’s resilience and life skills
- Increase positive and effective parenting
- Increase family communication

**Target Audience:**
The target population is school aged children, ages 7-11, who may be at risk for substance use or mental health issues and their parents

**Description of Activities:**
The Strengthening Families program is presented in 14 consecutive weekly sessions plus a booster session. Sessions last about three hours and include a communal meal. Parents and children meet together to share a meal at the beginning of each session. This is followed by separate one-hour sessions for parents and children. Finally, the families come back together for the family session, where they practice skills they learned in their separate sessions. The sessions are fun and activity based.

**Budget:**
Delivering this program within budgetary constraints is possible due to in-kind support of other agencies and businesses within the community. Development of a financially sustainable plan is based on financial support from Western Health. The budget for this program usually consists of the following: welcome table, family meals, transportation, crafts and supplies, program incentives (child and parent), volunteer appreciation, graduation, and booster session.

The ability to plan, prepare and cook the meals also contribute to budgetary savings as the cost of meal preparation is usually the highest expense of running this program ($150.00 x 14 weeks). Catering is typically more expensive and would require more money in the budget. A higher budget for food is also based on meeting school health food guidelines. Although the budget varies depending on in-kind support and the number of participants, the typical budget to deliver this program is $4500-$5000.
Past Sample Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome Table $20 x 14 weeks</td>
<td>$280</td>
</tr>
<tr>
<td>Family Meals</td>
<td></td>
</tr>
<tr>
<td>Food $150 x 14 weeks = $2100</td>
<td>$2520</td>
</tr>
<tr>
<td>Meals Supplies $30 x 14 weeks = $420</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>$670</td>
</tr>
<tr>
<td>Taxis for families as required</td>
<td></td>
</tr>
<tr>
<td>Crafts Supplies/Kid Time Supplies $20 x 14 weeks</td>
<td>$280</td>
</tr>
<tr>
<td>Program Incentives</td>
<td></td>
</tr>
<tr>
<td>Child Incentives $250</td>
<td>$500</td>
</tr>
<tr>
<td>Parent Incentives $250</td>
<td></td>
</tr>
<tr>
<td>Volunteer Appreciation</td>
<td></td>
</tr>
<tr>
<td>Gifts for Volunteers</td>
<td>$250</td>
</tr>
<tr>
<td>Facilitators</td>
<td></td>
</tr>
<tr>
<td>Graduation Materials, supplies</td>
<td>$200</td>
</tr>
<tr>
<td>Space Rental</td>
<td></td>
</tr>
<tr>
<td>In-Kind</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4700</strong></td>
</tr>
</tbody>
</table>

Evaluation:
This program has undergone extensive evaluation. Results show that the Strengthening Families Program is a promising intervention for fostering significant improvements in family functioning, parenting, and children’s psychosocial functioning.

Short term outcomes:
- Positive effects over time have been shown in child behavior outcomes, including substance use, conduct problems, school related problem behaviors, peer resistance, and affiliation with antisocial peers
- Reduction was shown in targeted risk factors including family conflict, disorganization, and disengagement

Long term outcomes:
- Positive impacts on the family and the child such as: quality time spent together and enjoyed, reasonable consequences, scheduled regular play time, family monthly meetings, improved communication, and improvements in family problems.

Indicators:
To evaluate this program, parents complete a mid-program evaluation in week eight and a final evaluation is completed in week fourteen. A post-evaluation is completed during the booster session, six weeks after the end of the program.
There is also qualitative data from the Parental Stress Index, administered week 1 and week 14, which is scored by psychologist and analyzed by Quality Research and Management at Western Health. The Parental Stress Index is a clinical self-report instrument designed as a screening and diagnostic assessment technique to identify stress in parent-child relationships. It identifies where dysfunctional parenting may take place and predicts the potential for parental behavior problems and child adjustment difficulties.

As well, there are parent/volunteer feedback forms completed and observational data noted by volunteers, coordinators, and facilitators throughout the program.

Requirements to Support Staff:
Based on the recommendations of the Strengthening Families Final Report (August 2009), a financial stability plan was developed to support ongoing delivery. The stability plan consists of a financial and human resource commitment from Mental Health & Addiction Services to support the program.

The human resource component consists of staff time for training, preparation and the delivery of this program. The Addiction Prevention Consultant provides the facilitator training. The Mental Health Promotion Consultant and the Addiction Prevention Consultant are also available for consultation and support throughout planning, facilitator training, recruitment, and running the program.

Timeline/Action Plan:
In order to implement this program from beginning to end the following logistical steps should be taken to ensure the program runs smoothly.

- Step 1: Secure program funding and maintain budget
- Step 2: Purchase materials and supplies
- Step 3: Develop and distribute promotional materials
- Step 4: Network with community agencies (partners)
- Step 5: Recruitment (families, volunteers, and facilitators)
- Step 6: Secure appropriate location
- Step 7: Develop and deliver facilitator training
- Step 8: Develop program forms
- Step 9: Support family intake
- Step 10: Assemble resource bins and family incentives
Step 11: Meal Planning
Step 12: Evaluation Plan
Step 13: Consultation on Program Changes

**Program Structure:**

<table>
<thead>
<tr>
<th>Session One</th>
<th>Intro, group building, administer Parental Stress Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Two</td>
<td>What are Families? Developmental Stages</td>
</tr>
<tr>
<td>Session Three</td>
<td>Conversation Skills, Rewards</td>
</tr>
<tr>
<td>Session Four</td>
<td>Praise, Achieving Wanted Behavior</td>
</tr>
<tr>
<td>Session Five</td>
<td>Feelings and Communication</td>
</tr>
<tr>
<td>Session Six</td>
<td>Cooperation and Contribution</td>
</tr>
<tr>
<td>Session Seven</td>
<td>Managing Anger</td>
</tr>
<tr>
<td>Session Eight</td>
<td>Alcohol/Drugs and Families, Mid Program Evaluation</td>
</tr>
<tr>
<td>Session Nine</td>
<td>How to Say No and Stay Out of Trouble, Prevention: the Parent’s Role</td>
</tr>
<tr>
<td>Session Ten</td>
<td>Directions and Consequences</td>
</tr>
<tr>
<td>Session Eleven</td>
<td>Seeking Help, Consequences vs Punishment</td>
</tr>
<tr>
<td>Session Twelve</td>
<td>Problem Solving</td>
</tr>
<tr>
<td>Session Thirteen</td>
<td>Criticism and Helpful Comments, Managing Stress</td>
</tr>
<tr>
<td>Session Fourteen</td>
<td>Wrap-Up, Graduation Celebration, Administer Parental Stress Index, Final Evaluation</td>
</tr>
</tbody>
</table>
APPENDIX K:

Program Description
The Truth about Drugs

Introduction:
The Truth About Drugs was developed by the Foundation for a Drug-Free World. The program contains practical tools to educate young people about substance abuse. It provides effective fact-based drug education aimed at reaching young people before they start experimenting with drugs.

Background:
The Foundation for a Drug-Free World is a non-profit public benefit corporation that empowers youth and adults with factual information about drugs so they can make informed decisions and live drug-free.

No one, especially a young person, likes to be lectured about what he or she can or cannot do. This educational program provides the facts that enable youth to choose not to take drugs in the first place. Also, the campaign consists of activities that youth can participate in which promote drug-free living. These activities are simple, effective, and can involve people of all ages.

Through a worldwide network of volunteers, 50 million drug prevention booklets have been distributed, tens of thousands of drug awareness events have been held in some 180 countries, and the award winning public service announcements have been aired on more than 500 television stations. These materials and activities have helped people around the world learn about the destructive side effects of drugs and, thereby, make the decision for themselves to not use them.

Purpose:
The main purpose of this program is to reach youth with effective fact-based drug information before they start on drugs.

Target Audience:
The program is aimed at 11-year-olds and above in a classroom, group instruction, or community learning setting.

Description of Activities:
The program consists of a documentary (1 hour 42 minutes) entitled The Truth About Drugs: Real People- Real Stories. The documentary is supplemented by 13 drug information booklet that describes how drugs work and their mental and physical
effects. The program also includes award winning public service announcements. *The Truth About Drugs* education package contains practical tools to aid the person delivering the program, including lesson plans, assignments, and classroom activities that capture and retain young people’s attention and foster participation in the program.

A typical lesson may include: homework review from the previous session, an introduction to the current lesson, viewing and discussing a PSA, class discussion, in-class assignment, and assigning homework.

**Budget:**
The educational package to deliver this program can be ordered from the Foundation for a Drug-Free World. There are also downloadable resources available on the website free of charge. There are no mandatory costs associated with this program.

**Evaluation:**
Drawing on government reports and official studies, the Foundation for a Drug-Free World’s educational materials are research based and specifically oriented to young people.

**Indicators:**
A pre-program and post-program student questionnaire is provided for assessment. Students should fill out the pre-program questionnaire before starting any discussion, activity program and before playing the documentary or PSA’s in the curriculum. There is also an educator and student post-program survey. All evaluation tools are sent to the Foundation for a Drug-Free World.

**Requirements to Support Staff:**
Staff would require enough time to view the DVD, read the educational booklets, prep for each lesson, and to deliver the program. Staff may also require travel depending on what location the program is being delivered.

**Timeline/Action Plan:**

Step 1 Watch the DVD – Creating a Drug-Free World

Step 2 Read the drug education booklets

Step 3 Order *The Truth About Drugs* Education Package at no cost ([www.drugreeworld.org](http://www.drugreeworld.org)). This includes an Educator’s Guide with lesson plans, a DVD with *The Truth About Drugs* documentary and 16 public service announcements, booklets and posters.
Step 4  Implement *The Truth About Drugs* program in school, youth organizations or the community

Step 5  Document your event with photos and videos in order to show others what has been done and gain support for more activities.

Step 6  Review with the class the various activities they can do as covered in the Additional Projects and Activities as outlined in the Educator’s Guide. They can visit drugfreeworld.org for more information and to get help in starting various activities.

**Program Structure**

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Topic</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesson 1</td>
<td>Why is Drug Education Necessary</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 2</td>
<td>Our Drug Culture</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 3</td>
<td>Why Do People Take Drugs</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 4</td>
<td>How Do Drugs Work and How Do They Affect the Mind?</td>
<td>(55 min)</td>
</tr>
<tr>
<td>Lesson 5</td>
<td>The Truth about Marijuana</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 6</td>
<td>The Truth about Alcohol</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 7</td>
<td>The Truth about Ecstasy</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 8</td>
<td>The Truth about Cocaine</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 9</td>
<td>The Truth about Crack Cocaine</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 10</td>
<td>The Truth about Crystal Meth. And Methamphetamine</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 11</td>
<td>The Truth about Inhalants</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 12</td>
<td>The Truth about Heroin</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 13</td>
<td>The Truth about LSD</td>
<td>(55 min.)</td>
</tr>
<tr>
<td>Lesson 14</td>
<td>The Truth about Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Lesson 15</td>
<td>The Truth about Painkillers</td>
<td></td>
</tr>
<tr>
<td>Lesson 16</td>
<td>The Final Word</td>
<td></td>
</tr>
<tr>
<td>Lesson 17</td>
<td>Putting the Use about Drugs to Use</td>
<td>(165 min)</td>
</tr>
<tr>
<td>Lesson 18</td>
<td>End of Program Class and Graduation</td>
<td>(70 min.)</td>
</tr>
</tbody>
</table>
APPENDIX L:
Program Description
What’s With Weed?

Introduction:
What’s With Weed is a peer-led secondary school program that is delivered by senior high school students to help students in grade 9 or 10 recognize and reduce, avoid, or prevent problems with marijuana use.

This program provides secondary schools with effective tools to address marijuana use with its students. It helps students identify not only potential problems but also positive behavior change strategies connected with marijuana use.

What’s with Weed supports a harm reduction approach and follows a stages of change model to encourage users to move from pre-contemplation to action to avoid, reduce, or prevent problematic marijuana use.

Background:
Parent Action on Drugs initiated the project Youth to Youth, The Risks and Realities of Marijuana Use in conjunction with youth treatment and health promotion partners. The goal of the project was to reduce problematic marijuana use among Ontario youth ages 15-18.

In the first year of the project, a program model “What’s With Weed” was piloted at seven high schools in Ontario. The model included developing activities and resources to support the program goals and to engage high school youth in discussions about risks, potential problems, and ways to reduce, avoid, or prevent these problems. Problematic marijuana use was defined as any use which is causing problems for the user including problems with friends, family and school work. In Year Two, communication tools were developed based on the information received from youth in Year One.

In 2012, the Motor Vehicle Injury Prevention Committee, a sub-committee of the Western Injury Prevention Coalition, submitted a proposal to the Western Regional Wellness Coalition to purchase this program for delivery in Bonne Bay, Port aux Basque, Burgeo, Stephenville and Corner Brook.

Purpose:
The Goals of this program are:

- Increase awareness of the potential for problematic marijuana use with teens
- Provide effective youth-to-youth strategies for addressing the risks and realities of marijuana
• Promote a stages of change model as a support for users who want to reduce potential risks

**Target Audience:**
This program is aimed towards youth in Grades 9 and 10. The program is unique, as it is meant to be inclusive of both users and non-users of marijuana. The program supports a preventive education approach that allows every individual to choose a course of action for themselves and identify strategies to reduce, avoid, or prevent problems.

**Budget:**
This program has been purchased by the Western Injury Prevention Committee (a subcommittee of the Western Injury Prevention Coalition with a grant from the Western Regional Wellness Coalition. The program delivery budget may include lunch and peer incentives for the training day for peer educators, nutrition breaks and incentives for the youth workshop, and program materials (paper, pens, etc). The cost to deliver this program should not exceed $200.

**Evaluation:**
All aspects of the program have been evaluated. It has been tested and evaluated in seven schools in urban and rural settings in Ontario. The full report and evaluation results are available from [www.parentactionondrugs.org](http://www.parentactionondrugs.org). Key findings from the Ontario pilot project include:
- 38% of senior students reported that the program changed their minds about the risks of marijuana use “a little” to a “great deal”
- 66% of Grade 9 students reported that their assembly and workshop had changed their minds about the risks of marijuana use “a little” to “a great deal”
- Over 70% of Grade 9 students reported satisfaction with the classroom workshops run by peer educators
- Grade 9 students’ awareness of specific helping supports in school and in the community was increased significantly

**Indicators:**
- Pre- and Post-Test for participants of the workshop
- Peer Educator Feedback form.
- Observation by Peer Educators of younger participants during workshop

**Requirements to Support Staff:**
This program is listed on the Western Health website ([www.westernhealth.nl.ca/mha](http://www.westernhealth.nl.ca/mha)) and can be borrowed. The human resource component consists of staff time for training, preparation, and delivery of this program. The program is usually delivered by Mental Health Promotion & Addictions Prevention Strategy
Youth Outreach Workers in the Region. The Mental Health Promotion Consultant and Regional Prevention Addiction Consultant are also available to consult and support implementation and delivery of this program.

Description of Activities:
What’s with Weed is a program designed to engage students in a youth-to-youth marijuana prevention program within a school community. The successfully delivery of this program involves key individuals including (1) Program Coordinator, who will take the lead for all activities and deliver the training workshop for the peer educators (a teacher, support person at the school, youth counseling staff, etc.); (2) Stages of Change Facilitator, who will provide support to youth who want to talk about problematic marijuana use; and (3) Peer Educators, who should be interested senior students who are recruited through the volunteer recruitment assembly.

The program model includes a strategy for recruiting senior students as peer educators and a training day for the senior educators, which will provide instructions on delivering a 75 minute workshop to their younger peers about the real risks of marijuana use and ways to reduce the risk.

Timeline/Action Plan:
The program model has eight phases. Each of the eight phases is outlined in detail in the Coordinator’s Guide. It is recommended that all steps be implemented. It is important to take the time up-front to explain the program to administration, staff, and parents and to complete a full training with peer educators.

Phase One: Initial meeting with school administration: Discuss local Statistics and supports, core value of the program, potential dates for parent meeting, staff meeting, senior recruitment day, etc.

Phases Two/Three: Staff and/or parent meeting: Appendices # 2 and # 3 in the Coordinator’s Guide have been prepared to support these meetings. It is important during these meetings to explain that this is a harm reduction program and ensure they understand the implication of this. Handouts for staff and/or parents can be distributed at this meeting.

Phase Four: Senior student recruitment to identify the peer educator volunteers: This occurs in order to explain the program to senior students in a special assembly. They are then invited to volunteer to be What’s With Weed peer educators.

Step Five: Training day with peer educators: If possible this day should be planned away from the school at a local community center, church
hall, etc. Lunch should be provided for this day.

Step Six: Review and practice time for peer educators: It is important that the peer educators have time to review and practice the activities. The three activities associated with this phase include: review the workshop, practice time, and review for the junior assembly.

Step Seven: Assembly for younger students, involving the peer educators: This phase is to introduce younger children to the program, the peer educators and plans for the workshop. There is a peer educator script included in the Coordinator’s Guide.

Step Eight: Workshop for younger students delivered by peer educators: This is a 75 minute workshop. A package of resources to support the activities is given to the peer educator teams.

Sample Outline of Peer Training Day

<table>
<thead>
<tr>
<th>Introductions</th>
<th>Nametags; PowerPoint presentations (on CD Disk) “Problems and risk with week” and “Strategies to reduce problems/risks with weed”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm-up/Icebreaker</td>
<td>Copies of Marijuana Medley activity sheets; small group work</td>
</tr>
<tr>
<td>Knowledge about marijuana</td>
<td>Open ended discussion to identify the risks that are commonly recognized by this group of Peer Educators</td>
</tr>
<tr>
<td>Attitudes about marijuana use</td>
<td>4 Corners activity – to provide a non-judgmental forum for differing opinions and values about marijuana use</td>
</tr>
<tr>
<td><strong>BREAK</strong></td>
<td>Continue to compile a clear list of the risks and safety strategies that have been discussed and agreed to by the majority of Peer Educators; ensure Peer Educators know the changes when they come back from break</td>
</tr>
<tr>
<td>The Stages of Change</td>
<td>Open-ended discussion to discuss problem solving and to identify common strategies and resources to reduce, avoid or prevent problems; define the Stages of Change Facilitator’s role.</td>
</tr>
<tr>
<td>Choosing key risks, key strategies and key messages</td>
<td>Based discussion so far, what will the key messages be? (form consensus so Peer Educators can take ownership)</td>
</tr>
</tbody>
</table>
### LUNCH

<table>
<thead>
<tr>
<th>Facilitation Challenges – Skills for working with younger children</th>
<th>Skill-building on how to handle the challenge of classroom work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing teams and speakers for junior assembly</td>
<td>Give copies of Peer Educator scripts for junior assembly; Peer Educators take ownership for the format of their workshop and junior assembly</td>
</tr>
<tr>
<td>Review of Grade 9 Workshop outline</td>
<td>Skills development for delivery of the workshop for younger students</td>
</tr>
<tr>
<td>Introduction to new activities</td>
<td>Practice activities for their workshop presentations that were not already discussed or practiced</td>
</tr>
<tr>
<td>Review of workshop for younger children</td>
<td>Copies of &quot;Roles and Responsibilities Record&quot;; Teams identify activity leaders</td>
</tr>
<tr>
<td>Promoting the key message and Stages of Change Facilitator</td>
<td>Team-building to empower Peer Educator Teams to develop a tool to market the key message and ways to promote the Stages of Change Facilitator</td>
</tr>
<tr>
<td>Closing and reminder of next steps</td>
<td>Set a date and time for the review and practice time</td>
</tr>
</tbody>
</table>

---

**Sample Outline of workshop with students presented by peer educator teams**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Introduce Peer Educator Team and the key messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting group rules</td>
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<tr>
<td>Knowledge (give them the facts)</td>
<td>“Marijuana Medley” handout; get in groups and answer questions about marijuana in two minutes.</td>
</tr>
<tr>
<td>Attitudes (discuss their opinions)</td>
<td>“4 Corners” activity to challenge and draw forth reflections based on opinions.</td>
</tr>
<tr>
<td>Skills</td>
<td>Discuss way to REDUCE, AVOID, OR PREVENT problems; small group exercise “Design a Student”</td>
</tr>
<tr>
<td>Closing</td>
<td>Complete Evaluations</td>
</tr>
</tbody>
</table>
APPENDIX M:
Community Addictions Prevention and Mental Health Promotion Fund
Application Form

The Community Addictions Prevention and Mental Health Promotion Fund is an initiative of the Mental Health and Addictions Division of the Department of Health and Community Services. This fund supports projects and programs that seek to reduce problematic substance use, promote mental health, address stigma, and provide effective prevention, harm reduction, treatment and enforcement strategies by focusing on the following priorities:

- Increasing Awareness and Understanding of Problematic Substance Use and/or Gambling
- Reducing Alcohol-Related Harms
- Developing Supportive Communities
- Promoting Mental Health
- Providing Recreational Activities
- Supporting Child / Parent / Family Development

The Community Addictions Prevention and Mental Health Promotion Fund is being administered by the four regional health authorities: Labrador-Grenfell Health, Western Health, Central Health and Eastern Health.

All individuals, not for profit community groups, and organizations in the four health regions of Newfoundland and Labrador, who are interested in preventing addictions issues and promoting mental health to community members, are eligible to apply for project funding through their regional health authority. The maximum amount of funding that may be requested for one specific project may vary by region. You are encouraged to reach your regional contact (see page 4) for further details.

To receive funding, the project must cover one of the following priority areas. Your application must identify which of these priority areas it covers.

- Increasing Awareness and Understanding of Problematic Substance Use and/or Gambling
  - Individuals and community groups may benefit from an enhanced understanding of problematic substance use and/or gambling. Educational and awareness resources can be useful in working with youth and adults to help them better understand the risks associated with substance use and gambling. Increasing awareness and understanding can help correct common misperceptions about the nature of problematic substance use, its prevalence and how to reduce associated risks and harms. Activities can include addictions awareness and educational resources, information
displays, training and awareness events, media and social marketing campaigns, etc.

- **Reducing Alcohol-Related Harms**
  - Despite real concerns about the harms of illicit drug use, alcohol remains the main drug of choice for most adults and youth in this Province. Alcohol consumption can result in fatalities and serious injury through motor vehicle collisions, violence, and other risk-taking behaviors. Youth and adults who engage in binge drinking patterns put themselves at extreme risk which can result in serious harm to themselves or others. Among other things, activities to help reduce alcohol-related harms may include impaired driving prevention programs, enforcement of minimum legal drinking age restrictions, alcohol server intervention training, and awareness programs to prevent and reduce the risks and harms associated with alcohol use.

**Developing Supportive Communities**
- There is a need for communities to mobilize and work together to prevent addictions, promote positive mental health, and improve the health of the community. Individuals can come together to make their communities ones in which healthy choices are easier to make and are supported by the environment around them. Communities can help create supportive environments by giving attention to community policies and processes that support health and reduce risky patterns of substance use or poor mental health. Specific activities may include: community youth programs, volunteer and civic engagement opportunities, alcohol and drug-free community events and activities, and youth mentoring and leadership programs.

**Promoting Mental Health**
- Promoting positive mental health on a population/community level is an important component of mental health promotion. Components of positive mental health include the ability to enjoy life, dealing with life events, the ability to experience and regulate emotions, maintaining spiritual values and a sense of spirituality and/or meaning, social connections and respect for culture, equity, social justice, and personal dignity. Mental health promotion is about enhancing the capacity of individuals and communities to take greater control over their lives and improve their mental health. Specific activities may include: awareness resources around positive mental health, skill building sessions to support problem solving and emotional coping, programs or groups to support or enhance social connections, and programs to support work-life balance, anti-violence and discrimination, and access to economic resources.

- **Providing Recreational Activities**
  - An important protective factor indicated by youth is the need for alternative
activities, flexible programming, and after school programs. People in communities often indicate that lack of social networking, groups or associations is problematic and can lead to unhealthy behaviours. Activities focused on recreation and leisure are important elements of substance use prevention and mental health promotion. Providing opportunities for community members to come together on a regular basis allows individuals to interact and create a sense of belonging without engaging in potentially harmful activities. Specific activities may include but are not exclusive to: sports events/teams, games nights, book clubs, walking clubs, drama, writing, painting, and/or youth nights.

- **Supporting Child / Parent / Family Development**
  - Families play a vital role in the development of healthy children and young adults. Parents can help shape and promote positive mental health in their children and provide a strong foundation to help prevent risky behaviors such as problematic substance use or gambling. Parent education, support and family skill building programs can play an important role in supporting parents and families. Early childhood programs, parenting education and support groups, and family skill based programs are all examples of specific activities that can support parent and family skill building.
Application Guidelines

Applications can be hand-written or typed.

The application form must be fully completed; incomplete applications will not be considered.

A budget, outlining all associated costs of the project / program is required.

Eligible expenses include but are not limited to:

- Honoraria, speaking fees, travel and expenses for resource people will be considered on a case by case basis and must clearly demonstrate sustainability in project/program enhancement, skill building or community development
- Meals, travel or accommodations for participants or community members
- Resource material (e.g. educational / instructional materials)
- Advertising, publicity, printing
- Purchase of small recreational activity materials/equipment

Ineligible expenses include:

- Contributions to annual fundraising drives
- Core operating expenses (e.g. heat, light, staff, etc.)
- Capital expenditures (e.g. building renovations, office furniture, etc.)
- Projects which are a clear duplication of existing activities in your community.
- Individual scholarships or bursaries
- Membership fees

All successful funding recipients are required to return a completed activity tracking form (provided by your regional health authority) and receipts upon completion of the project that was funded.

Deadlines for Grant Applications will be announced by each regional health authority.

Please send applications to the contact in your region:

**Labrador-Grenfell Health:**
Tina Coombs  
Regional Addictions Prevention/Mental Health Promotion Consultant  
Mental Health and Addictions  
Charles Curtis Hospital  
178-200 West Street  
Labrador Grenfell Health  
St. Anthony, NL A0K 4S0  
Tel: 709 454-0521  
Fax: 709 454-4041  
Email: tina.coombs@lghealth.ca
Western Health:
Tracey Wells-Stratton
Regional Addictions Prevention Consultant
Mental Health & Addiction Services
Western Health
133 Riverside Drive, P.O. Box 2005
Corner Brook, NL        A2H 6J7
Tel: (709) 634-4921 / 634-4171
Fax: (709) 634-4888
E-mail: traceywells@westernhealth.nl.ca

Central Health:
Lauren Josselyn
Regional Addictions Prevention Consultant
Mental Health and Addictions Services
Grand Falls- Windsor Community Health Building
50 Union Street
Grand Falls-Windsor A2A 2E1
Tel. (709) 489-4389
Fax. (709) 489-8182
E-mail: lauren.josselyn@centralhealth.nl.ca

Eastern Health:
Wayne Bishop
Addictions Prevention Consultant
Mental Health and Addictions Program
Eastern Health
30 Ropewalk Lane, P.O. Box 13122
St. John’s, NL
A1B 4A4
Tel: (709) 752-4030
Fax: (709) 777-5170
Email: wayne.bishop@easternhealth.ca

Vanessa McEtegart
Regional Mental Health Promotion Consultant
Mental Health and Addictions Services
Eastern Health
38 Ropewalk Lane, P.O. Box 13122
St. John’s, NL
A1B 4A4
Tel. (709) 752-6846
Fax. (709) 777-5170
E-mail: vanessa.mcentegart@easternhealth.ca

Tracey Sharpe-Smith
Addictions Prevention Consultant - Rural Avalon & Peninsulas
Mental Health & Addictions Services
Eastern Health
P.O. Box 719
Bay Roberts, NL
A0A 1G0
Ph: (709) 786-5230
Fax: (709) 786-5221
Email: tracey.sharpe@easternhealth.ca
## SECTION 1: APPLICANT INFORMATION – PLEASE FILL IN ALL FIELDS

<table>
<thead>
<tr>
<th>Applicant(s):</th>
<th>Date:</th>
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<th>Agency or Committee Name:</th>
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<tr>
<th>Brief Description of Agency or Committee:</th>
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<table>
<thead>
<tr>
<th>Contact Information:</th>
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<tbody>
<tr>
<td>Name:</td>
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<td>Telephone #:</td>
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<tr>
<td>Address:</td>
</tr>
<tr>
<td>Fax #</td>
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<td>Email:</td>
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</table>

## SECTION 2: PROJECT DESCRIPTION

<table>
<thead>
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<th>Project/Program Name:</th>
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<tr>
<th>Brief Description of Project/Program:</th>
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<th>Total Amount Requested:</th>
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<tr>
<th>Priority Areas Covered: (please check all that apply)</th>
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<tbody>
<tr>
<td>☑ Increasing Awareness and Understanding of Problematic Substance Use</td>
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<tr>
<td>☑ Reducing Alcohol-Related Harms</td>
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<tr>
<td>☑ Developing Supportive Communities</td>
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<tr>
<td>☑ Promoting Mental Health</td>
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<tr>
<td>☑ Providing Recreational Activities</td>
</tr>
<tr>
<td>☑ Supporting Child / Parent / Family Development</td>
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### Project Details

**Who?**

Target Population: Who is the project/program for?

What is the total number of people expected to take part for the duration of the project, program, or event?

Partnerships: What partnerships do you already have or plan to make in order to make this project work?

### What?

What is the project about? Please give a detailed description, including a statement about how this project/program/event will enhance current prevention/promotion programming currently being offered through your agency or in your community.

### Sustainability

How will this project build lasting skills among participants? Please explain.
Why?
Why do you want to do this project (what is your main goal) and how does it meet a need?

<table>
<thead>
<tr>
<th>When?</th>
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<tr>
<td>Project start date:</td>
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</table>

Project Work Plan
Please indicate all the steps you will take to conduct this project. Please include who will be responsible for each step, and the expected timeline for each activity.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Person Responsible</th>
<th>Timeline</th>
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</table>
**Evaluation Plan**

How are you going to determine if this project has been a success? Please outline your goals, actions, expected outcomes, and measurement of expected outcomes.

- **Goals** = Final outcome you want to achieve
- **Actions** = How are you going to achieve your goal?
- **Expected outcomes** = What do you hope to achieve from the action?
- **Measurement of expected outcomes** = How are you going to measure the outcomes? (# of participants, feedback forms, pre-test/post-tests, etc)

An example of an evaluation plan:

<table>
<thead>
<tr>
<th>Goal: Increase awareness of harms of alcohol use</th>
<th>Actions</th>
<th>Expected Outcomes</th>
<th>Measurement of Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold a workshop educating on the harms of alcohol use.</td>
<td>Participants will have an increased knowledge of the harms associated with alcohol use.</td>
<td>Have participants fill out a questionnaire before and after the session to gauge their knowledge on the harms of alcohol use.</td>
<td></td>
</tr>
</tbody>
</table>

If you have any questions about the evaluation plan, please contact your regional consultant from page 4.
<table>
<thead>
<tr>
<th>Evaluation Plan Table</th>
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</thead>
<tbody>
<tr>
<td><strong>GOAL:</strong></td>
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<tr>
<td>Actions</td>
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<td><strong>GOAL:</strong></td>
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<td><strong>GOAL:</strong></td>
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</table>

Mental Health Promotion & Addictions Prevention Strategy
## SECTION 3: COSTS

Please list all items you require, costs, and other sources of funding you may be able to use if this fund cannot cover all items. Please be specific with all items listed.

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Details</td>
<td>Requested in current application</td>
</tr>
<tr>
<td>Small honoraria for volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel for participants</td>
<td>(E.g. # of taxis x $ ____ x # of trips = $; cost for bus for 30 participants)</td>
<td></td>
</tr>
<tr>
<td>Room/Space Rental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>E.g. program manuals, mocktail supplies, arts and crafts, journals, etc…)</td>
<td></td>
</tr>
</tbody>
</table>
Food
(E.g. # of participants x $ ____ x $ ---- = $ ____;
nutrition break supplies: fruit tray $ ____,
water $ ____,
etc...)

<table>
<thead>
<tr>
<th>Other</th>
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<th>Total</th>
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</table>

**Other Funding Requested or Received**

Have you requested funding from any other source? If yes, please specify all potential funding sources.

Have you received funding from any other source, or do you have access to any in-kind funding? If yes, please specify amount and source of funding.

**For Office Use Only:**

Application Received By: __________  Date: __________

Application Reviewed By: __________  Date: __________

Application Approved By: __________  Date: __________

Amount Awarded: __________
APPENDIX N:

Mental Health & Addiction Service
Programs and Services Listing

Mental Health Services
Mental Health Services is a community based service which provides promotion, education and prevention services, consultation, assessment, and counseling services to children, adults, families, groups, and communities for mental health/mental illness-related issues. Mental Health Services accept self-referrals or referrals from other agencies.

Mental Health Services has offices in Port aux Basques, Stephenville, Burgeo, Corner Brook, Deer Lake, Norris Point (traveling clinics to Cow Head), and Port Saunders. Telehealth services are provided to additional communities as appropriate.

Addiction Services
Addiction Services is a community based service which provides education, assessment, counselling and consultation to people with substance use and/or gambling issues, as well as those affected by someone else's alcohol/drug use or gambling behaviours. Services like impaired driving programs, after care, follow-up, and referrals to other services are provided to individuals, families, and in group settings.

Addiction Services has offices in Port aux Basques, Stephenville, Burgeo, Corner Brook, Deer Lake, Norris Point (traveling clinics to Cow Head), and Port Saunders. Telehealth services are provided to additional communities as appropriate.

Blomidon Place
Blomidon Place is an interagency counseling service that provides mental health promotion, education, and prevention services, consultation, coordination, assessment, and counseling services to children, youth (under age 19 years), and their families who have mental illness, or mental health or addiction issues.

This mental health service accepts self-referrals or referrals from other agencies on various issues. Referrals cover a wide range of issues including, eating disorders, phobias, obsessive-compulsive disorders, parenting issues, family of origin issues, pervasive developmental disorders, behavioral disorders, depression, anxiety, personality disorders, trauma, suicidal ideation, self-injury, substance abuse, addiction, and grief.

Blomidon Place serves the Corner Brook, Bay of Islands, and Pasadena area. This service was established in partnership with the Community Mental Health Initiative Inc. (CMHI) in 1996.
**Case Management Program**
The Case Management Program provides coordination of care and living supports necessary for individuals aged 18 years and older with severe and persistent mental illnesses. An assessment is required prior to admission into the program. Currently available in Stephenville, Port au Port Peninsula, Port Aux Basques, & Bonne Bay.

**Mental Health Rehabilitation**
This outpatient service located in Corner Brook provides supportive care to individuals with mental illness and their families. This support is offered through individual or group counselling as well as a weekly Neuroleptic clinic.

**Early Psychosis Program**
The Early Psychosis Program is located in Corner Brook but provides some outreach service and consultation to other areas of the region. This program is designed to meet the needs of people who are diagnosed with a first episode of psychosis. Individuals must be 16 years or older and be in their first three months of treatment for psychosis.

The goals of the Early Psychosis program are:
- Early recognition and identification of individuals experiencing psychotic symptoms
- Comprehensive assessment, intervention and support for individuals and families
- Promotion of recovery and prevention of relapse
- Provision of education to individuals, families, health workers and the community

**Sexual Abuse Community Services (SACS)**
Sexual Abuse Community Services, is located in Stephenville and provides education, assessment, and counseling services to children and adults affected by sexual abuse, as well as to children under age 12 who have sexually intrusive behavior. SACS also promotes community awareness and sensitivity to issues related to sexual abuse and provides consultation services. This service is offered in partnership with the Western School District, the Department of Education, and Department of Justice.

**Contact Information for Mental Health & Addiction Services Offices**

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port aux Basques</td>
<td>Mental Health &amp; Addiction Services&lt;br&gt;3-9 Barhaven Drive, P.O. Box 100&lt;br&gt;Port aux Basques, NL  AOM 1CO</td>
<td>Telephone: &lt;br&gt;(709) 695-6250</td>
</tr>
<tr>
<td>Location</td>
<td>Address</td>
<td>Contact</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Stephenville</td>
<td>Mental Health Services &amp; Sexual Abuse Community Services Rehabilitation Annex 127 Montana Drive Stephenville, NL A2N 2T4</td>
<td>Telephone: (709) 643-8740</td>
</tr>
<tr>
<td>Burgeo</td>
<td>Mental Health &amp; Addiction Services Calder Health Care Centre P. O. Box 614 Burgeo, NL AOM 2H0</td>
<td>Telephone: (709) 886-2185</td>
</tr>
<tr>
<td>Corner Brook</td>
<td>Adult Mental Health &amp; Addiction Services (age 19 &amp; over) 35 Boone's Road PO Box 2005 Corner Brook, NL A2H 6J7</td>
<td>Telephone: (709) 634-4506</td>
</tr>
<tr>
<td></td>
<td>Blomidon Place (age 18 &amp; under) Mental Health &amp; Addiction Services 133 Riverside Drive PO Box 2005 Corner Brook, NL A2H 6J7</td>
<td>Telephone: (709) 634-4171</td>
</tr>
<tr>
<td>Deer Lake</td>
<td>Mental Health &amp; Addiction Services 20 Farm Road Deer Lake, NL A8A 1J3</td>
<td>Telephone: (709) 635-7830</td>
</tr>
<tr>
<td>Norris Point</td>
<td>Mental Health &amp; Addiction Services Bonne Bay Health Centre P. O. Box 70 Norris Point, NL AOK 3V0</td>
<td>Telephone: (709) 458-2381, Ext. 266</td>
</tr>
<tr>
<td>Port Saunders</td>
<td>Mental Health &amp; Addiction Services Rufus Guinchard Health Centre P. O. Box 40 Port Saunders, NL AOK 4HO</td>
<td>Telephone: (709) 861-9125</td>
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</table>

**Humberwood Treatment Centre**

The Humberwood Treatment Centre is a provincial inpatient addictions program located in Corner Brook. This program offers services to individuals with a substance abuse and/or gambling addiction. Humberwood Centre operates from a philosophy that views the treatment of addiction from a holistic perspective. The Centre’s approach addresses the individual’s physical, social, psychological, and spiritual health. The overall goals of the Humberwood program are to help individuals reduce their risk of relapse and achieve healthy, balanced lifestyles.

Admission to Humberwood Centre is voluntary. The service is available to men and women over the age of nineteen who are experiencing a substance abuse or gambling problem. Individuals must be referred to the program by an addictions counselor or other community professional who will complete an assessment that explores the extent...
of the addiction and treatment goals. A medical assessment is also required.

Program activities include:

- Group and individual therapy
- Education sessions
- Stress management
- Relaxation
- Spirituality
- Nutrition
- Leisure planning
- Active living
- Relapse prevention
- Self help
- Family education day (for family members)

**Assertive Community Treatment Team (ACTT)**

The Assertive Community Treatment Team is a comprehensive community-based treatment team working with individuals living with severe and persistent mental illness (mainly bipolar disorder and schizophrenia) in achieving their recovery goals and enhancing quality of life. This service is available to individuals residing in Corner Brook and the Bay of Islands, up to and including Deer Lake. An assessment is required prior to admission into the program.

**Mental Health Unit at WMRH**

The Mental Health Unit is a 23 bed Acute Care Service at Western Memorial Regional Hospital that serves as the only Mental Health Unit in the Western Region. The admission criteria includes all diagnosis covered in the DSM IV, including alcohol and drug detoxification, with admission being arranged by a physiciatrist or general practitioner. A safe, therapeutic, and caring environment is provided through a multi-disciplinary team approach to individuals experiencing emotional, behavioral, or concurrent disorders.

**West Lane Recycling**

West Lane Recycling is a community-based occupational therapy program in Corner Brook for individuals living with a mental illness. Through work activity and contact with the public, participants of West Lane are given an opportunity to increase their self-esteem and confidence, learn new skills, and develop strategies to maintain health. Recycling is recognized as a valuable community service and West Lane offers individuals a working role and an opportunity to place structure and support in their daily lives.

To qualify for the program, individuals must be 19 years or older, have a diagnosis of psychosis, mood disorder, or anxiety disorder, and be able to identify and work towards goals. Individuals may self-refer or be referred by a community professional, family member or support person. All potential clients must be assessed by the Occupational Therapist to ensure that the West Lane program can meet their needs.
Other components of West Lane include:

- Active living
- Case management
- Health promotion
- Independent living skills
- Supportive counseling
- Therapeutic cooking
- Therapeutic group sessions
- Vocational rehabilitation

**Community Trauma Response Teams**

The goal of the Community Trauma Response Teams is to help people and communities cope with tragedies and their effects. Each team includes representatives from different Community and Government Agencies who work together to respond to the needs of community members who have experienced a traumatic event.

Support and services can be accessed by calling the closest Mental Health & Addiction Services office.