Applying a Health Equity Lens to the Fourth R Programs, Research and Program Partnerships

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Overview of Report

This report describes our approach to applying a health equity lens within the evidence-based program, *The Fourth R*, the methods we apply in our research and evaluation, and our relationships with program partners. The field of prevention science has an ethical responsibility to develop programs that meet the needs of disadvantaged groups in an effort to improve overall population health while reducing health inequities in young people. In this report, we describe how health equity is understood from a public health perspective and the lack of evidence-based prevention programs for marginalized groups of youth. We provide a brief overview of the health disparities for Indigenous youth, LGBT2Q+ youth, and justice-involved youth and describe how the *Fourth R* has developed specific programming tailored to meet the needs of these marginalized populations. Next we briefly discuss health equity considerations in our research and evaluation approaches as well as within our partnerships. Finally, this report ends with a discussion of the future development of *Fourth R* programming for vulnerable youth and some overall considerations for applying a health equity lens to prevention programming.

What is Health Equity?

Health equity as it is understood in the public health literature is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health disparities or inequities, are types of unfair health differences closely linked with social, economic or environmental disadvantages that adversely affect groups of people (Brennan Ramirez, Baker, & Metzler, 2008). Since 1995, the Government of Canada has committed to using Gender-Based Analysis Plus, an analytical tool used to assess how diverse groups of women, men and gender-diverse people may experience policies, programs and initiatives to advance gender equality in Canada.

Health Equity and Evidence-Based Programs

The move towards endorsing evidence-based practices (EBP) in violence prevention and mental health promotion in general has been hampered by a lack of EBP, particularly for marginalized groups (Claussen, Exner-Cortens, Abboud & Turner, 2016). One major working group concluded that, “Little research has addressed the question of how transportable evidence-based interventions developed for one ethnic group are to a range of ethnic and cultural groups.” (O’Connell, Boat, Warner, & National Research Council, 2009, p. 336). This

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gap is problematic because many identifiable ethnic and cultural groups experience disproportionate rates of negative mental health and violence outcomes.

In our review of the state of gender-based violence prevention programs in Canada, for example, we concluded that virtually all EBPs were delivered either in high schools or postsecondary settings (Jaffe, Crooks, Dunlop, & Kerry, 2016). There was a stark lack of EBP for specific marginalized groups (including Indigenous women and girls, LGBT2Q+ youth and adults, and women with disabilities). Furthermore, there were no EBPs for vulnerable youth in specific settings, such as youth justice. There is clearly a need to develop programs that meet the needs of these populations within their unique settings for service delivery.

Health Equity and Fourth R Programs

Over recent years, the *Fourth R* team has focused on developing new programs by working closely with partners to adapt programming for particular settings and groups. In developing our programming, we have worked closely with our partners and stakeholders which include members of the marginalized group to better understand the needs of vulnerable youth and communities.

Health Disparities for Indigenous Youth

Collectively, Indigenous youth continue to face significant and disproportionate health and social disparities compared to their non-Indigenous counterparts. Canada's Indigenous youth experience higher rates of injury, suicide, obesity, violence, and health-related conditions at higher rates compared to non-Indigenous youth (Irvine, Kitty, & Pekeles, 2012). The multigenerational impact of colonization that lead to the loss of land, culture, language, tradition, and spirituality is now recognized for its negative health inequities and systemic inequity to Indigenous youth and their families (Truth and Reconciliation Canada, 2015). To address these disparities, researchers and community members have argued for the development of culturally appropriate programming for Indigenous youth.

Fourth R Programming for Indigenous Youth

Over the past decade, the *Fourth R* team has worked with youth, the local school board, and three local First Nations communities to develop and evaluate school-based, culturally-relevant, relationship-focused programming for Indigenous youth in grades 7 through 12 (Crooks & Dunlop, 2017). *The Fourth R: Uniting Our Nations* program comprises multiple components developed specifically for Indigenous youth (with the exception of the Indigenous Perspectives[1] *Fourth R*, which was adapted from the original *Fourth R* program). These programs share the *Fourth R*'s strengths-based, positive youth development framework, and focus on healthy relationships and social-emotional skill development, yet differ from the original *Fourth R* program in their emphasis on cultural identity development and mentoring, utilization of culturally appropriate teaching methods, and inclusion of Indigenous community members and locally relevant teachings. Over the past decade, the *Fourth R* team has worked in close, ongoing partnership with local community partners to co-develop, implement, and evaluate multiple initiatives and program components comprising *The Fourth R: Uniting Our Nations* program for Indigenous youth, including: 1) Elementary Mentoring Program, 2) Peer Mentoring

[1] This program was originally known as the Aboriginal Perspectives Fourth R, but the names of our program have evolved as preferred terminology has evolved. Indigenous is all-encompassing of first peoples in the same way that Aboriginal was intended to be, but has emerged as the preferred term.

for Secondary Students, 3) Cultural Leadership Camp, 4) FNMI Student Leadership Council, and 5) Indigenous Perspectives *Fourth R* (Crooks & Dunlop, 2017).

Health Disparities of LGBT2Q+ Youth

Sexual minority youth experience stigma, discrimination, and social rejection, and this stigma can have a variety of negative consequences throughout the lifespan (Meyer, 2003). Sexual minority youth are at increased risk for negative health outcomes, compared with their heterosexual peers. For example, one large Canadian study of almost 1000 transgender youth from across Canada found that transgender youth had a higher risk of reporting psychological distress, self-harm, major depressive episode, suicidal ideation, and suicide attempts (Veale, Watson, Peter, and Saewyc, 2017). Research in Canada and elsewhere have documented that LGBTQ youth are more likely to drink alcohol or use tobacco, marijuana, and other substances (Marshal et al., 2008) and a few studies report higher risk for teen pregnancy and higher rates of sexually transmitted infections (Saewyc et al., 2006). Almost all these health disparities have been linked to higher risk for further discrimination and violence, and lower levels of school safety and school connectedness (Saewyc, Poon, Kovaleva, Tourand, & Smith, 2016). When sexual minority youth experience safe and supportive schools, supportive families, and receive health promotion interventions in their school, some of these critical health gaps have been reduced (Saewyc et al., 2016). There continues to be a need for further development of specific interventions to promote positive mental health and reduce health programs among sexual minority youth.

Fourth R Programming for LGBT2Q+ Youth

In 2013, the *Fourth R* team recognized the need to adapt the Fourth R for LGBT2Q+ youth that could help schools narrow the health and mental health gap for these youth. The Healthy Relationships Program (HRP) for Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and Two-Spirit Youth (LGBT2Q+) was adapted from the Fourth R's Healthy Relationships Plus (HRP) Program. The HRP for LGBT2Q+ Youth is an 18-session program that promotes positive mental health and wellbeing, and healthy relationship development among LGBT2Q+ youth. The program was designed to affirm gender, sexual, and romantic minority identities and experiences, and enhance youth's ability to cope with sexual- and gender based oppression. Since there is a dearth of evidence-informed positive mental health programming for LGBT2Q+ youth (Craig, Austin, & McInroy, 2013; Heck, 2015), the HRP for LGBT2Q+ Youth fills significant programmatic gaps.

Health Disparities for Justice-Involved Youth

Youth involved in the justice system experience a number of adverse outcomes related to physical and mental health, poverty, homelessness, unemployment, all factors which may increase the risk of future offending. For example, Public Safety Canada (2012) reported that youth who live in poverty appear in court ten times more frequently than the general youth population. An extensive review of the literature suggests that the prevalence of mental illness among youth involved in the criminal justice system is significantly higher than the general population with estimates around 50-100% (Chitsabesan & Bailey, 2006) compared to the general youth population where estimates range from 10-20% (Canadian Mental Health Association, 2016). In addition to individual impacts, youth delinquency is associated with significant societal costs, including a strain on finances and resources (de Vries, Hoeve, Assink, Stams, & Asscher, 2015). The prevalence of youth offending, as well as the individual and

societal impacts of these behaviours highlight the importance of supporting the needs of these youth.

Fourth R Programming for Justice-Involved Youth

In 2015, we partnered with Manitoba Corrections to address the gap in health equity for justice-involved youth by examining the feasibility and fit of the *Fourth R* classroom-based program and *HRP* in youth correctional facilities, known as the HRP- Enhanced (HRP-E). It was understood that the programs were not designed specifically for youth offenders and the existing programs would require adaptations to make the content more applicable to the youth justice population and the constraints of a correctional setting. During the first year, the original programs were piloted to examine feasibility and fit and subsequently make program adaptations based on facilitator and administrator feedback. Results of this pilot indicated that, although the content was a fairly good fit for the needs of the participants, the *HRP* was a better fit for the setting than the classroom-based version. Subsequent revisions to the program added higher risk scenarios, increased cognitive-behavioural restructuring activities, and added a trauma-informed lens. The revised program is currently being piloted in five correctional settings in Manitoba and Ontario. The HRP-E is also being used in some community mental health settings and specialized education settings.

Future Directions of Fourth R Programs for Marginalized Groups

We have applied for additional funding from the Public Health Agency of Canada to develop an HRP for Newcomer youth. London Ontario is the third largest city of settled refugees behind Ottawa and Toronto. Relationships with local partners and schools have identified a need to develop healthy relationship programming for refugee and immigrant youth. Refugee and immigrant youth face multiple pre- and post- transition challenges and risk factors that affects many outcomes such as schooling, mental health, family and peer relationships, and positive adjustment. We have proposed to undertake widespread consultation with youth and community organizations to develop the adaptations of the HRP for this particular target group of youth. In addition, the consultation process will involve determining where best these groups should be offered, who should facilitate programming, and what sort of evaluation frameworks would best be suited for this work.

Health Equity Considerations in Research and Program Partnership

In addition to using a health equity lens to develop and implement healthy relationship programming for marginalized youth, we utilize a similar approach in our research and program partnerships. In research for example, we implement equity-sensitive data collection methods and surveys. We have found that it is far more effective in collecting data in the form of sharing circles with Indigenous and LGBT2Q+ youth than it is to administer a standardized survey. When we do administer a survey for research with marginalized youth, we ensure that it is a tool that has been tested and used with that particular population of youth. For some marginalized youth, we recognize that their literacy and comfort level completing a survey could be a concern and so we ensure that we can administer the survey orally to minimize any additional barriers to youth. We prepare plain language summaries quickly to share data back with our partners.

The Fourth R and their partners recognize that eliminating health disparities cannot be accomplished by a single stakeholder or organization. We also recognize that the causes of

health disparities among youth are complex and multifactorial and must also take into account the social determinants of health (i.e., the conditions in which youth are born, grow, live, work, and age). As such, we spend considerable time establishing sustainable partnerships among government agencies, the education sector, community organizations, and youth with lived experience to exemplify the importance of collaborative engagement needed to accomplish this goal.

Conclusions

What have we learned and where do we go from here? During the past decade, the *Fourth R* has used a health equity lens to develop, implement, and evaluate a number of healthy relationship programming for marginalized youth. Our team has approached the development of these programs and the relationship with our program partners with some important considerations. First, health equity doesn't mean equal programming for youth. In fact, health equity looks differently for different populations of youth and our programming reflects this understanding. Developing and implementing programming for marginalized youth has taken significant time and engagement with our stakeholders to develop the relationships necessary for this type of work. The positive impact on facilitators and young people who have participated in our HRP adapted programming have experienced benefits and opportunities that they might not otherwise have. Recognizing that the social conditions of marginalized youth do not change quickly, providing programming that meets their unique needs is one important step in reducing inequity and helping to promote the health and wellbeing of these marginalized groups.

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