



Knowledge Summary

The Healthy Relationships Plus Program: National Implementation Study

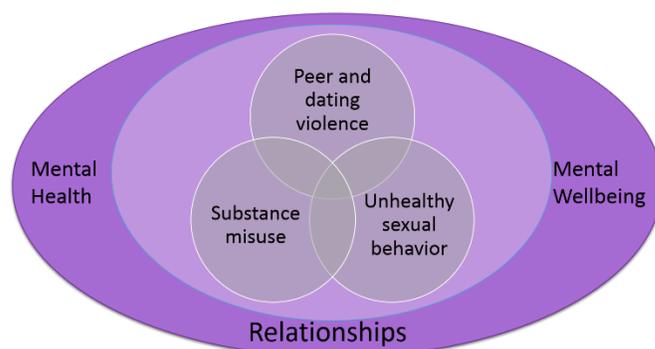
What you need to know

The Healthy Relationships Plus (HRP) program is a small groups program designed to promote healthy relationships increase positive mental health, and decrease dating and peer violence. It is an offshoot of the evidence-based Fourth R programs. The HRP consists of 14 one-hour sessions for youth aged 13-17 years. The HRP was delivered in more than 136 groups in 82 settings in four provinces and territories over the course of a two-year national implementation study. The study looked at the implementation and impact of the HRP in diverse settings and real world contexts. Youth completed pre- and post- intervention surveys and facilitators completed training feedback forms and implementation surveys. Results showed decreases in anxiety and depression for many youth, increased awareness of help-seeking, and decreased acceptance of stigma beliefs. Facilitators liked the program and observed benefits among youth participants, but also reported implementation challenges.

What is the issue?

There is a clear need for evidence-based approaches to promote mental health and prevent violence among youth. These programs need to be flexible enough to be implemented in diverse settings. Ideally, they would also address multiple outcomes at once. We know that there is a significant overlap among violence, substance misuse, and unhealthy sexual behaviour (i.e., the adolescent risk triad). These problem behaviours are linked in several ways: they co-occur, they share risk factors, and they frequently emerge within the context of dating and peer relationships. More recently, researchers have identified mental health as an issue that overlays all of these other issues (see figure 1 below).

Figure 1. *The adolescent risk triad within the context of relationships and mental health*



The Healthy Relationships Plus program was designed to address these overlapping issues through engaging and interactive sessions. It is a small groups program designed to promote healthy relationships and positive mental health. It is also intended to reduce dating and peer violence. It is an offshoot of the evidence-based Fourth R programs that are delivered within health curriculums in schools. The HRP is similar to the Fourth R in that it focuses on healthy relationships, emphasizes skill development, and takes a positive youth development approach. It is different in that it is intended to be delivered in small group or in the classroom, has a stronger mental health focus, and has more flexibility in how it is delivered (i.e., length and spacing of sessions). It can be offered by one facilitator or two co-facilitators. Although optimal group size is considered 10-15 youth, it has been used successfully with entire classes.

Why is this important?

Adolescence is a time of many important changes. Peer and dating relationships become very important influences on youth. It is also a time when many mental health challenges emerge. Many adolescents experience clinical levels of anxiety and depression, and many others experience anxiety and depression is subclinical, but still interferes with functioning. These symptoms are linked to mental health challenges and other negative outcomes in adulthood. It is easier and more cost-effective to prevent problem behaviours and promote mental well-being than to address problems once they are entrenched. It is important to equip youth with skills to recognize mental health challenges among their peers and respond in supportive ways, because youth most often turn to their peers for help. Teaching youth to help their friends also means teaching them when a situation is serious enough to require help from an adult. Creating safe spaces for youth to talk about mental health and other challenging situations gives them the opportunity to share ideas with each other, develop skills, and be more prepared when these situations arise in real life.

What did the researchers do?

The HRP was implemented in a wide range of settings over two years, including schools, community organizations, and camp settings. All together there were 138 groups run in 87 sites across four provinces and territories (although not all groups participated in all research components). Youth participants completed pre- and post-intervention surveys measuring mental health, stigma beliefs, and other related behaviours. A number of focus groups were conducted with youth; some of these focus groups had a specific focus on understanding adolescent help-seeking and the extent to which the program decreased help-seeking barriers and increased skills. Group facilitators completed a feedback survey after their initial training and an implementation survey after they finished their groups.

Our research team analyzed data in a number of ways. We conducted a latent class group analysis with year 1 groups ($n = 74$ groups; 748 youth) to identify groups of youth based on pre- and post- anxiety and depression scores. We also conducted a multi-level model to look at group-level predictors of individual change. We looked at stigma beliefs within a multi-level model using year 2 data ($n=21$ groups due to missing data) because we did not assess stigma beliefs in year 1. Focus groups from both years were coded and themed qualitatively. We used SPSS to look at descriptives of the implementation surveys. It is important to note that we did not have a comparison group, so we cannot claim that the program *caused* the observed changes of anxiety or depression. However, it is worth noting that significant reductions in moderate-severe depression are not typically observed in this age group in longitudinal research.

What did the researchers find?

Youth Outcomes

In focus groups, youth described learning important relationships skills, as well as critical information about mental health and related risk behaviours.

“I learned to be respectful and assertive when apologizing, ending relationships / friendships, and when not agreeing with peer pressure. I also learned how to be a good listener.”

“I learned what to do for a friend in suicidal situations.”

“...made me realize that back in high school I used to drink a lot, and my friends did too, but I was drinking in an abusive way... that third person perspective made me see it in that different way.”

Youth were also able to describe specific ways that they would reach out to friends who might be struggling, including ways to encourage a friend to seek adult assistance.

“I learned how to approach someone who many have a mental health illness and what to say to them.”

When we looked at patterns of depression and anxiety from before to after the group, we identified a group of youth who were highly depressed at the start of the intervention and showed significantly decreased depression over the course of the program. Interestingly, there was no group of highly depressed youth who maintained the same level of depression. The youth with the highest levels of anxiety at outset did not show a significant decrease, but there was a group of youth experiencing moderate-high anxiety symptoms who showed a significant improvement. Our multilevel models looked at a range of group variables that might be expected to affect outcomes, including group size, community versus youth settings, the average amount of high risk behaviour demonstrated by the group, and group age. Surprisingly, the group level factors did not predict individual change in anxiety or depression, suggesting that the program was equally successful in different types of groups. Our multilevel model looking at stigma beliefs showed a reduction over the course of the program. There was some evidence of increased help-seeking, particularly within the focus groups. We did not see changes in self-reporting coping styles or cooperative behaviour.

Facilitator Training Outcomes

Facilitators participated in either half-day or full-day training. Training includes relevant background information, an orientation to the program, and instruction (and practice) in facilitating the activities. We had 120 completed training feedback forms over the first two years of the project. During year 3 of this project our online training became available. We are currently collecting feedback from participants who do the online training, but the results in this summary refer only to participants who were trained in person.

Facilitators indicated that the training taught them the relevant information and skills, and reported perceived gains in knowledge, skills, and self-efficacy. When asked to reflect on their pre- and post-training levels of knowledge and self-efficacy, facilitators reported significant increases in both. In addition, 98% of participants felt the training increased their capacity to promote positive relationships skills among youth. Participant comments reflected satisfaction with the training and with the HRP resources.

“I enjoyed the practical elements, anecdotes, and multimedia involved in the training.”

“Great review of information, I liked going over the activities to get an idea of how they work.”

“Fantastic materials, engaging, great activities.”

“The manual looks easy to follow.”

Participants were also asked how prepared they felt to implement the HRP. Overall, 79% of facilitators reported that they felt prepared to implement the HRP. Of the 21% who did not feel well prepared, all but one participant reported feeling neutral (i.e., neither well-prepared nor unprepared) and one felt unprepared.

Participants were also asked about potential implementation concerns they harbored. Some of the potential concerns were time constraints, youth participation, and logistics (e.g., overly small or large class size, poor physical space).

“There is a lot of content to get through in the classroom time slot.”

“Our students do not attend consistently and therefore may not all receive the 14 sessions.”

“Space is my biggest concern.”

Facilitator Implementation Feedback

Facilitators enjoyed the program and identified numerous benefits for youth.

“I really enjoyed how relevant it appeared to be to the students. Some students experienced a lot of the situations and they stepped up... spoke to the importance or practicality of some of the lessons, leading the way in discussions for less “mature” (for lack of a better term) students.”

“It really helped because the kids used the skills they learned in the HRPP to label the actions in those scenarios. They would say, ‘They could delay, they could negotiate, they could refuse’ or, ‘It would be difficult to be assertive there.’ So I was really impressed that the knowledge could transfer.”

When asked about challenges, many facilitators noted that timeframes were difficult to meet. Facilitators described having to cut off important conversations among youth due to time constraints, and also running out of time because of other situations or competing events that appeared.

“Time constraints were the main issue – virtually never got to the exit statement due to the length of time with the games. Changed games several times due to the large size of the group.”

The most consistent recommendation for new facilitators was to be well prepared with the materials and to think about how the program might need to be modified to fit a particular group of youth.

“It is an amazing and rewarding program to facilitate! Plan ahead by pre-reading sessions and if you need to make modifications do – every group is different and come from different environments – make HRP relevant to them!”

How can you use this research?

This project has demonstrated the success of combining healthy relationships and mental health promotion into a small groups program for youth.

There are several lessons in this research for those implementing similar programs.

1. Youth welcome the opportunity for a safe space to discuss critical issues like relationships and mental health. They find the topics engaging and appreciate the opportunity to develop skills and awareness.
2. Developing a high quality training program is a critical part of preparing for success. Also, while most facilitators felt prepared to implement the program following training, a smaller group was unsure about their preparedness. Additional opportunities for booster training might enhance the confidence of all program facilitators.
3. It is important to match programs to the structure of the setting to the fullest extent possible. Different challenges arose for school versus community settings. The biggest implementation challenge for school-based groups arose when facilitators were not given adequate time to implement the program. Community-based groups experienced other challenges such as consistency of attendance for youth.
4. Mixed methods research approaches are important for getting a full picture of a program. It can be difficult to measure gains in protective factors through self-report stories, but quantitative data can be augmented with clear stories and examples from focus groups.

Educators and community service providers wishing to learn more about the HRP can go to the Fourth R website at youthrelationships.org. There are a number of training options available, including in-person and online.

About the Author:



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Keywords

Adolescence; mental health; health promotion; depression; social and emotional learning; school mental health; implementation

Additional Resources

The Fourth R: <https://youthrelationships.org/>

Centre for School Mental Health, Western University:
<https://edu.uwo.ca/csmh/>

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