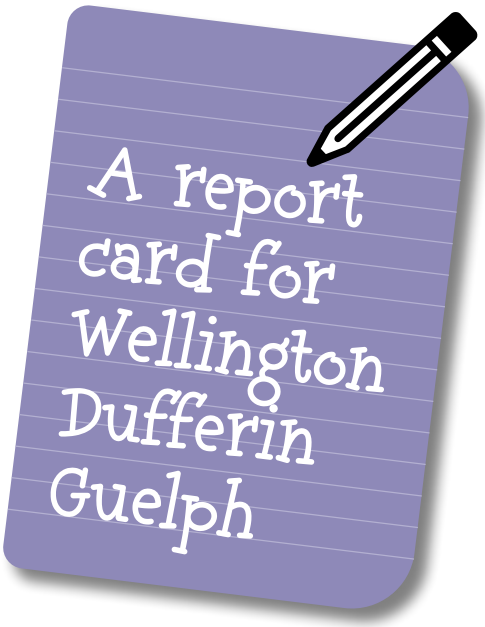
THE WELL-BEING OF YOUTH AGES 14 TO 18

A report card for Wellington Dufferin Guelph

THE WELL-BEING OF YOUTH AGES 14 TO 18



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Coordinator
Melissa Potwarka, Wellington-Dufferin-Guelph Public Health

Coalition Membership
Coalition membership includes the active involvement of personnel from several community organizations and service agencies for children, youth, and their families. They include:

- Canadian Mental Health Association Waterloo Wellington Dufferin – Jennifer Heaslip
- City of Guelph – Jenn Bucci, Rachel Guerin, Adam Rutherford, Jennifer Smith
- County of Dufferin Community Services – Jane Hall
- County of Wellington Child Care Services – Laura Coulman
- Conseil scolaire de district catholique centre-sud – Marie-Pierre Daoust
- Family and Children's Services of Guelph and Wellington County; Dufferin Child and Family Services – Shelley Welstead
- Guelph Community Health Centre, Ontario Early Years Centre – Lynn Bestari, Wendy de Gomez
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The Data Analysis Working Group (DAWG) is a sub-committee of the Coalition. The DAWG was responsible for preparing the data for the Report Card. Preparation included determining the most appropriate data sources for each indicator included in the Report Card, followed by gathering, analyzing and graphing and mapping the data.

Data Analysis Working Group Members
Lynn Bestari
Laura Coulman
Wendy de Gomez
Jane Hall
Auburn Larose
Wanzi Muruvi
Melissa Potwarka
Patrick Seliske
Jennifer Smith
Shelley Welstead

Principal writers
Auburn Larose, Melissa Potwarka

Editors
Jane Hall, Wanzi Muruvi, Shelley Welstead

Youth Groups

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- 2nd Chance Employment Counselling Wellington Inc.
- Guelph YMCA Leadership in Training Camp
- Give Yourself Credit
- Guelph Youth Council
- Mount Forest Youth Group
- Norwell District Secondary School
- Orangeville District Secondary School & Dufferin Child and Family Services
- Town of Orangeville Youth Camp
- West End Drop-In Centre
- West Willow Neighbourhood Youth Group
- Wyndham House Resource Centre

Photographs and Artwork

Justina Green created the artwork for the Wellington-Dufferin-Guelph Youth Charter of Rights.

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- Adrian Canonizado
- Miranda Hous
- Drucilla Gary
- Rachel Rodrigues

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Art Kilgour, writedesign.ca

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Ampersand.ca

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Planning Tables

- Wellington Children and Youth Services Planning Council
- Dufferin Coalition for Kids
- Growing Great Kids

Organizations

- Canadian Mental Health Association Waterloo Wellington Dufferin Branch
- Catholic Family Counselling Centre
- City of Guelph
- County of Dufferin
- County of Wellington
- Dufferin Child and Family Services
- Family & Children Services of Guelph and Wellington County
- Family Counselling and Support Services for Guelph-Wellington
- Guelph Community Health Centre
- KidsAbility-Centre for Child Development
- Ministry of Children and Youth Services
- United Way of Guelph & Wellington
- Upper Grand District School Board
- Wellington-Dufferin-Guelph Public Health
- Wellington Catholic District School Board

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Executive Summary

Introduction

Adolescents represent an increasingly diverse sub-population for which the patterns of transition into adulthood have changed drastically over the last century.[1] During these transitional years, many lifelong attitudes and behaviours are established that set the stage for future health and well-being.[2] However, certain segments of this population may face greater challenges that could affect their transition into adulthood and make them more vulnerable to particular health issues.[3] *The Well-Being of Youth Ages 14 to 18: A Report Card for Wellington-Dufferin-Guelph* presents information that increases our capacity to understand and evaluate the impact of certain factors or experiences on the overall health and well-being of youth and their transition into adulthood.

The purpose of this Report Card is to provide access to a wide range of population-level health and well-being indicators that supports understanding of the status of youth health and well-being in our community. The hope is that service providers will use this Report Card to stimulate conversations, answer questions that they may have about youth, and to examine how effective their programs have been in supporting youth and their families in our communities. This will allow us to ensure that the supports, resources, and opportunities necessary for healthy youth development are available.

Using a *determinants of health* perspective, the Report Card is organized according to the Wellington-Dufferin-Guelph Youth Charter of Rights. Whenever possible, the local data presented is specific to youth, ages 14 to 18 living in Wellington, Dufferin, and Guelph. Highlights of the local data presented in each chapter are summarized below.

Chapter 1: A right to a voice in the issues that affect our lives

- The top five health issues that youth think are most important to them, in order of importance include: 1) depression, 2) healthy weight/body image, 3) healthy relationship, 4) alcohol use, 5) physical activity.
- The top five health issues that youth think are most important to their peers, in order of importance include: 1) suicide, 2) healthy weight/body image, 3) stress, 4) bullying, and 5) depression.
- Overall, 50% of the health issues that emerged in the top five for both youth and their peers were related to mental health (e.g., depression, suicide, body image, healthy relationships, stress, and bullying).
- More female grade 10 students reported volunteer activities without pay (48%), high levels of caring about others (20%), and stronger values of promoting equality and social justice (40%) when compared to male grade 10 students.
- More grade 10 students in the City of Guelph (38%) reported that they feel that they can make a difference in their community compared to students in Wellington (27%) and Dufferin (32%).

Chapter 2: A right to good health by having our social, emotional, mental, physical and spiritual needs met

- Overall, more male grade 10 students reported high levels related to positive mental health indicators (e.g., personal power, self-esteem) and lower levels related to negative mental health outcomes (e.g., risk for depression, and thoughts of self-harm).

- More male grade 10 students (55%) reported eating breakfast daily, while more female grade 10 students (21%) reported skipping breakfast during the school week.
- More male grade 10 students (53%) reported regular physical activity and active transport to or from school (25%). More grade 10 students in Dufferin (31%) reported active transport to or from school compared to Wellington (22%) and Guelph (20%).
- Overall, in Wellington, Dufferin, and Guelph, 21% of grade 10 students were considered to be overweight or obese.
- More male grade 10 students reported at least one episode of heavy drinking in the past 12 months (43%) and currently smoking cigarettes (12%) compared to females.
- Although their ranking varies by gender, mental health, injuries, and digestive conditions represent the top three causes of hospitalization among youth, ages 14 to 18 during 2005 to 2009.
- Overall, in Wellington, Dufferin, and Guelph, the average expenditure for emergency dental services through public health increased with age among youth, ages 14 to 17.
- The percent of youth, ages 14 to 18, who have up-to-date immunization records ranged from approximately 77% to 93% across all secondary schools in Wellington, Dufferin, and Guelph.
- Among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph, Chlamydia infections represented the highest rates of all reportable disease among this population (220 per 10,000).

Chapter 3: A right to a place to sleep, clothes to wear, food to eat and supportive friends and/or family

- The percent of youth, ages 13 to 17, receiving Ontario Works in both Wellington County (including Guelph) and Dufferin County, ranged from approximately 1.1% to 2.0% between January 2008 an March 2012. The majority of these youth are dependent (i.e., living with a parent or caregiver), rather than independent (i.e., living on their own).
- The percent of families living below the Low Income Cut-Off (LICO) before tax varied across each geographic area: 7.5% in Guelph; 5.5% in Dufferin; and 4.4% in Wellington. Overall, our local rates were lower than the rest of Ontario with 11.7% of families living below the LICO before tax.
- The Nutritious Food Basket for our area has increased by 5.7% since 2011 and by 14.5% since 2009.
- The percentage of children, ages 0 to 17, who access food banks in Wellington, Dufferin, and Guelph has remained fairly stable from 2009 to 2012.
- In Guelph CMA, 41.2% of tenant households spend 30% or more of their income on rent, and 18.0% spend 50% or more of their income on rent. These percentages are not available for Wellington and Dufferin.
- Wait times in subsidized housing depends on the size of the unit, the number of bedrooms, and where it is located. The wait times ranged from just under 2 years to more than 3 years in Dufferin, between 2 and 5 years in Wellington, and 3 to 9 years in Guelph. Youth can be eligible for subsidized housing at age 16.
- Among youth, ages 16 to 18 in Wellington, Dufferin, and Guelph, rates of emergency shelter and long-term transitional housing use have remained fairly stable during 2007 to 2011. The number of youth accessing these services ranged from 74 to 90 in Guelph and Wellington, and 35 to 48 in Dufferin.

Chapter 4: A right to affordable activities and programs, and safe places to hang out

- More grade 10 students in Guelph (48%) reported high levels of youth program involvement compared to Wellington (30%) and Dufferin (30%). Additionally, fewer grade 10 students in Guelph reported "never" participating in youth activities, such as attending a religious service and visiting the local library.
- More grade 10 females (29%) reported never playing on a sports team in the past 12 months compared to males (22%), while more males (42%) reported never visiting their local library

in the past 12 months compared to females (24%).
- Subsidies for a wide variety of recreation activities for children and youth exist within our community. Overall, the number of subsidies provided has increased over the recent years, along with the increasing demand.

Chapter 5: A right to education, training and opportunities that prepare us for our future lives

- Students who receive a level 3 or 4 score on the Education Quality and Accountability Office (EQAO) standardized testing are achieving or exceeding the provincial standard. For both 2011/2012 Academic and Applied Grade 9 math, the percentage of students receiving a score of level 3 or 4 is higher in Guelph (89% and 58%) compared to Dufferin (86% and 50%) and Wellington (81% and 41%). In Ontario, these percentages are 84% and 44% for Academic and Applied Grade 9 math, respectively.
- Guelph (86%) also had a higher percentage of first time eligible students who were successful for the 2011/2012 Ontario Secondary School Literacy Test, compared to Wellington (84%), Dufferin (81%) and Ontario (82%).
- Similar geographic trends related to academic achievement were also found in self-reported data about grades. More grade 10 students in Guelph reported usually getting A's (51%) in school, compared to Dufferin (37%) and Wellington (36%).
- More grade 10 students in Guelph reported high levels of *School Engagement* and *School Bonding* compared to Wellington and Dufferin.
- Female grade 10 students consistently reported higher levels of positive outcomes related to school, compared to male grade 10 students, including *School Engagement*, academic achievement (i.e., reporting that they usually get A's), and *School Bonding*.

Chapter 6: A right to quality time with our friends, family and/or other positive role models in our community

- More grade 10 students in Guelph (55%) reported high levels of *Positive Peer Influence* (55%), *Family Support* (56%), and *Positive Family Communication* (45%) compared to Wellington (46%, 50%, and 37%, respectively) and Dufferin (48%, 45%, and 39%, respectively).
- More female grade 10 students also reported high levels of *Positive Peer Influence* (57%), *Family Support* (56%), *Time at Home* (58%) compared to male grade 10 students (46%, 50%, and 50%, respectively).

Chapter 7: A right to be and feel safe in our homes, schools and communities

- The total number of protection investigations opened by Family and Children's Services of Guelph and Wellington (FCSGW) and Dufferin Child and Family Services (DCAFS) increased between 2007 and 2011. *Physical/Sexual Harm by Commission*, *Emotional Harm/Exposure to Conflict*, and *Caregiver Capacity* were the most common reasons for opening an investigation during that time period.
- In Guelph/Wellington there was an increase in the total number of children and youth served in care in 2009. The number of youth, ages 14 to 18, as a percentage of the total number of children in care remained fairly stable across each year, with an average of 40% during 2007 to 2011. In Dufferin this percentage was slightly higher at 44%.
- In Guelph/Wellington and Dufferin, the number of approved foster homes has decreased over the 2007 to 2011 time period.
- During 2007 to 2001, the referrals for parent-teen conflict declined for both FCSGW and DCAFS, while the investigations were increasing for both, meaning that despite the decline in referrals, more referrals are being investigated in Wellington, Dufferin and Guelph.
- More male grade 10 students reported being involved in criminal activities, including damaging or destroying something that did not belong to them (29%), carrying a weapon for the purposes of defending themselves or using it

in a fight (14%), selling drugs (12%), and being a part of a group that broke the law by stealing, hurting someone, damaging property, etc (21%) compared to females (10%, 3%, 4% and 10%, respectively).
- *Injuries and Poisonings* were the primary leading cause of hospitalization for males and the third leading cause of hospitalization for females in Wellington, Dufferin, and Guelph between 2005 and 2009.
- More grade 10 students in Guelph reported feeling safe at home, school, and in their neighbourhood (86%) and had high levels of family boundaries (i.e., the extent to which parents/guardians/caregivers are aware of their whereabouts and set/enforce clear rules and consequences) (48%) compared to students in Wellington (82% and 38%, respectively) and Dufferin (76% and 40%, respectively).
- More female grade 10 students (87%) reported feeling safe at home, school, and in their neighbourhoods and had high levels of family boundaries (i.e., the extent to which parents/guardians/caregivers are aware of their whereabouts and set/enforce clear rules and consequences) (53%) compared to males (80% and 35%, respectively).

Chapter 8: A right to be accepted for who we are and what we believe without being discriminated against

- More female grade 10 students (38%) reported being bullied at school than males (32%).
- Guelph's population alone included 3,030 new immigrants (or 2% of the total population) between 2006 and 2011. This represents a 21% decrease in the number of new immigrants coming to Guelph compared to the number of people who immigrated between 2001 and 2006.
- The 2011 populations for Wellington and Dufferin Counties do not include as many new immigrants as the City of Guelph's population. One percent (1%) of Dufferin County's population and 0.50% of Wellington County's population represented new immigrants between 2006 and 2011. This translates to 510 new immigrants in Wellington County and 315 new immigrants in the County of Dufferin.
- In 2011, the percentage of the population that speaks languages other than English or French has remained fairly stable since 2006 at 9.7% of Guelph's population (n=11,460). The most prominent non-official language are Vietnamese, Chinese and Panjabi.
- In 2011, the percentage of the population that speaks languages other than English or French has decreased slightly to 5% of Wellington County's population (n=4,280). The most prominent non-official language were German and Dutch.
- In 2011, the percentage of the population that speaks languages other than English or French has decreased slightly to 1.8% of Dufferin County's population (n=1,025). The most prominent non-official languages are German and Polish.

Chapter 9: A right to access to quality and affordable child care, early education programs and/or parenting supports

- In Wellington County, the therapeutic abortion rate gradually increased as a proportion of pregnancies during 2007 to 2010. In 2007, more young mothers were having an obstetric delivery; by 2010, the therapeutic abortion rate was over two and a half times greater than the obstetric delivery rate.
- In Dufferin County, the obstetric delivery rate also declined as a proportion of the pregnancy rate during 2007 to 2010. By 2010, the therapeutic abortion rate was more than three and a half times that of the obstetric delivery rate.
- In contrast to the above trends, in the City of Guelph, the therapeutic abortion rate progressively declined between 2007 and 2010. In 2007, the therapeutic abortion rate was more than double the obstetric delivery rate; however, by 2010, the obstetric delivery rate was nearly one and a half times greater than the therapeutic abortion rate.
- In Wellington, Dufferin, and Guelph there are many supports available for young parents, including Michael House, Teen Age Parent

Program (TAPPS), Come Understand Parenting, Orangeville Young Parent Education Program, Early Years Outreach Program, Guelph Young Parent Education Program, Young Parent Program, Young and Parenting Program, Learning, Earning, and Parenting, Teen Canada Prenatal Nutrition Program.

Endnotes

1 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from http://publichealth.gc.ca/CPHOreport.

2 ibid

3 ibid


SO
speak out
WHAT?

Introduction

Defining "youth"

The concept of youth, adolescence, or even what constitutes young people varies significantly in different countries and contexts. Indeed, in many parts of the world, youth are not determined by age, but rather by a "biological marker" that spans a period between puberty and parenthood.[1] Other societies define adolescence to be the period of time from the onset of puberty to when the individual achieves economic independence.[3] Adolescence can also be defined in numerous other ways, taking into account factors such as physical, social, and cognitive development, in addition to age.[2]

The term "youth" is often used interchangeably with the term "adolescent", as adolescents are generally thought to be a subset of the youth category. According to the United Nations and the World Health Organization (WHO), youth are defined as individuals 15 to 24 years of age.[3, 4] The literature further indicates that the transition to adulthood has extended over the years, as most youth do not become independent adults until their mid-twenties and even early thirties.[5, 6] For the purposes of this Report Card, when using the term "youth", we are referring to individuals who are 14 to 18 years of age. As with previous Report Cards, whenever possible, we have provided local data and information specific to this age group.

A time of transition

"Young Canadians represent an increasingly diverse sub-population and the life transition patterns of youth and young adults have changed significantly over the last century."[7] This unique period of development is often a time of good health, but there are also many important changes occurring that impact youths' health, including biological, psychological, economic and social transitions.[8] By the time young people reach the late adolescent stage (i.e., between the ages of 15 and 19), they have gone through many of the major physical changes, while their brains are continuing to develop and reorganize themselves, constantly enhancing their capacity for analytical and reflective thought.

During these transitional years, many lifelong attitudes and behaviours are established that set the stage for future health and well-being.[9] Although youths' ability to evaluate risks and make conscious decisions increases during this time, certain risk behaviours, such as cigarette smoking and experimentation with drugs and alcohol, are often embraced and carried through into later adolescence and adulthood.[10]

Despite these risky behaviours, and their associated health-related consequences, late adolescence is also a time of opportunity for positive life experiences and challenges. It is during these years that young individuals can transition into healthy adult roles and responsibilities; making their way into the working world, opting for further education, developing and settling into their own identities, and taking an active role in shaping the world around them.[11] However, certain segments of this population may face greater challenges that could affect their transition into adulthood and make them more vulnerable to particular health issues.[12]

Youth and identity: The psychology of adolescence and identity formation

Youth is a critical time in human development, as it is the time in which individuals begin the process of establishing their own identities.[13] The pressure to conform to a certain group, 'gang', or social circle is very strong during this time. This is also a time when youth are thinking and making decisions about what they believe in, what they want to do and be, and what kind of a person they are and are becoming.[14]

The modern account of adolescent psychology can be traced back to the early 20th century, where Psychologist G. Stanley Hall defined adolescence as a period of "storm and stress." This is characterized by "intergenerational conflicts, mood swings and an enthusiasm for risky behaviour."[15] The second classic psychological account of adolescence is derived from the work of Erik Erikson.[16] According to Erikson, the "identity crisis" that adolescents face is a combination of physical, cognitive, and social changes that occur during this critical period in their lives, in addition to the serious and important life choices that they need to make, such as choosing their occupation, sexual identity, and possible life partners.[17] The "crisis" in this case does not necessarily mean a profound uncertainty or doubt, but rather a time where they can address and challenge their values and ideals.[18] Through this journey of self-reflection and self-definition, adolescents come to an "integrated, coherent sense of identity" which maintains over time.[19]

Youth not only begin to overcome the "uncertainty experience" in their earlier years of development, but also become more aware of their strengths and weaknesses, and become more confident in their unique qualities and abilities.[20] This is both a psychological process and a function of general cognitive development. Resolving the "identity crisis" allows youth to progress to early adulthood and build intimate relationships, which is one of the key tasks of adolescence.

From the moment children are born, they are being shaped by the language they speak at home, their family's customs and beliefs, and the culture to which they belong.[21] When children reach the adolescent stage, they start to make their own choices, whether it is to accept or reject parts of the identity that has been pre-determined for them, or whether it is to explore new roles as they build their unique identity.[22]

Erikson further acknowledges that identity formation can occur through interaction with peers and caregivers.[23] This is an important notion, because although identity is developed by an individual, it needs to be recognized and confirmed by others. Erikson also argues that adolescence is a period when teenagers negotiate their separation from their families and develop independent social competence, such as participating in a certain "clique" or group of peers, which exerts its own influences.[24]

During this transition, young individuals may experiment with different identities, and indeed may engage in risky behaviour in order to mould into their own individual and unique identity.[25] Today, more than ever, we see more evidence (e.g., documentation through social media, including Facebook) that youth create their own subcultures and identities. As a result, they have an increasingly complex array of potential identities that go beyond the traditional "jock" or "geek" identities.[26] Their image is also influenced by a variety of races, cultures, and ethnicities that they come across in their everyday lives in both local and global contexts.[27]

The sociology of youth

From a sociological perspective, there are many complex social factors, such as poverty and inequality, which can have an impact on the healthy transition from one developmental stage to the next.[28] Aligned with the social determinants of health, sociologists believe that different social contexts, particularly relating to social class, gender, and ethnicity, determine the nature and health-related outcomes of youth in a significant way.[29] For example, marginalized or unprivileged social groups who are usually seen as a "social problem" or "at-risk", are particularly vulnerable to particular health outcomes and may face greater challenges throughout the developmental stages.[30, 31] Depending on the individual, the complex interaction between the social determinant of health (e.g., education, literacy, income, employment, etc.), will influence the times and rates of which adolescents progress into the next life stage.[32] It is important for service providers to recognize these social influences, as adolescents are facing a unique transition from being dependents in a parental home to becoming independents in the labour market.[33]

Developmental assets and youth resilience

Although there are multiple factors that can place a young person at risk, there are several others that can help protect them, even in adverse and challenging circumstances, such as poverty.[3] Resilience is important, not only because it reduces the impact of risk, but also because it promotes competence in youth and strengthens their developmental assets.[34] A considerable amount of research has been done linking developmental assets with positive outcomes in children and youth.[35] The developmental assets are grounded in evidence-based literature that identifies personal attributes and environmental factors contributing to children's well-being, such as school climate, family communication, achievement motivation, commitment to learning, social competencies, positive identity, and safety. This research finds that the more developmental assets a young person has, the more likely the individual will be able to cope with challenges and adversities, and the more competent the individual will be in navigating health and social resources.[36] These youth are also less likely to engage in risk-taking activities, such as tobacco use and alcohol consumption,[37] drug abuse, and violence.[38]

The Search Institute is an organization that provides free lists of Developmental Assets, which are easily accessible to service planners.[39] These Developmental Assets are one part of the Search Institute's complex model for children and youth that is both theoretically-driven and empirically-tested.[40] Developmental theorists, service planners, and service providers tend to agree that a profound contribution of the Developmental Assets approach is that it has the potential to move our considerations of children and youth away from being deficit-based to strength-based, which is achieved by a specific focus on the importance of intentional and meaningful relationships with youth.[41]

Research has established three principles that protect young people from engaging in risk behaviours by helping them to succeed through building their strengths, and protecting them from social, emotional, and physical harm. These principles include: 1) caring relationships; 2) high expectations; and 3) opportunities for participation and contribution.[42] Thus, by nurturing young people and providing them with meaningful opportunities to acquire assets, we are preparing them to achieve important developmental milestones that will, in the long-term, improve their mental and physical heath, and overall well-being.[43]

Endnotes

1 United States Agency International Development. (2006). Youth and conflict: A brief review of available literature. Sommers, M. Retrieved from **http://www.gsdrc.org/go/display&type=Document&id=3599**

2 American Psychological Association. (2002). Developing adolescents: A reference for professionals (No. U93MC00105). U.S. Department of Health and Human Services. Retrieved from **http://www.apa.org/pi/families/resources/develop.pdf**

3 United States Agency International Development. (2006). Youth and conflict: A brief review of available literature. Sommers, M. Retrieved from **http://www.gsdrc.org/go/display&type=Document&id=3599**

4 United Nations Educational, Scientific and Cultural Organization. (2012). Acting with and for youth. Retrieve from **http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/**

5 United Way of Calgary and Area. (2010). Environmental scan: Extended age definition for youth 15-24. Douchette, K. Retrieved from **http://www.calgaryunitedway.org/main/sites/default/files/environmental_scan_extended_age_definition.pdf**

6 National Children's Alliance. (2004). Why Canada needs a national youth policy agenda. Kidder, K., & Rogers, D. Retrieved from **http://www.nationalchildrensalliance.com/nca/pubs/2004/youthpolicypaper.htm**

7 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from http://publichealth.gc.ca/CPHOreport.

8 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from http://publichealth.gc.ca/CPHOreport.

9 ibid

10 Wright, H.K., Hébert, Y. (2008). Proceedings from Rethinking Youth Culture and Identity Symposium. Vancouver, BC.

11 ibid

12 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from http://publichealth.gc.ca/CPHOreport.

13 Centre for the Study of Violence and Reconciliation. (2004). Youth and identity. South Africa, Barclay, H. Retrieved from **http://www.csvr.org.za/index.php?option=com_content&view=article&id=1529%3Ayouth-a-identity&Itemid=1**

14 ibid

15 Buckingham, D. (2008). Introducing identity: Youth, indentity and digital media. The John D. And Catherin T. MacArthur Foundation Series on Digital Media and Learning, 1-24. doi:10.1162/dmal.9780262524834.001

16 ibid

17 Vincent, C., Moffat, M., Paquet, M., Flynn, R. & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. Ontario Association of Children's Aid Societies, 52(2), 2-5.

18 Buckingham, D. (2008). Introducing identity: Youth, indentity and digital media. The John D. And Catherin T. MacArthur Foundation Series on Digital Media and Learning, 1-24. doi:10.1162/dmal.9780262524834.001

19 ibid

20 ibid

21 Centre for the Study of Violence and Reconciliation. (2004). Youth and identity. South Africa, Barclay, H. Retrieved from **http://www.csvr.org.za/index.php?option=com_content&view=article&id=1529%3Ayouth-a-identity&Itemid=1**

22 ibid
23 ibid
24 ibid
25 ibid
26 United Nations Children's Fund. (2011). The state of the world's children 2011: Adolescence an age of opportunity . New York, NY. Retrieved from **http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf**
27 National Children's Alliance. (2004). Why Canada needs a national youth policy agenda. Kidder, K., & Rogers, D. Retrieved from **http://www.nationalchildrensalliance.com/nca/pubs/2004/youthpolicypaper.htm**
28 ibid
29 ibid
30 ibid
31 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from http://publichealth.gc.ca/CPHOreport.
32 ibid
33 National Children's Alliance. (2004). Why Canada needs a national youth policy agenda. Kidder, K., & Rogers, D. Retrieved from **http://www.nationalchildrensalliance.com/nca/pubs/2004/youthpolicypaper.htm**
34 American Psychological Association. (2002). Developing adolescents: A reference for professionals (No. U93MC00105). U.S. Department of Health and Human Services. Retrieved from **http://www.apa.org/pi/families/resources/develop.pdf**
35 Vincent, C., Moffat, M., Paquet, M., Flynn, R. & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. Ontario Association of Children's Aid Societies, 52(2), 2-5.
36 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from http://publichealth.gc.ca/CPHOreport. Centre for the Study of Violence and Reconciliation. (2004). Youth and identity. South Africa, Barclay, H. Retrieved from **http://www.csvr.org.za/index.php?option=com_content&view=article&id=1529%3Ayouth-a-identity&Itemid=1**
37 Vincent, C., Moffat, M., Paquet, M., Flynn, R. & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. Ontario Association of Children's Aid Societies, 52(2), 2-5.
38 Act for Youth: Upstate Centre of Excellence. (2002). Identity formation in adolescence. Ithaca, NY. Retrieved from **http://www.human.cornell.edu/actforyouth**
39 Search Institute (2012). Developmental assets: What are developmental assets? Minneapolis, MN. Retrieved from **http://www.search-institute.org/developmental-assets**
40 Rose, H. (2006). Asset-based development for child and youth care. Reclaiming Children and Youth, 14(4), 236-240.
41 Weigel, D.J., Lowman, J.L., & Martin, S.S. (2007). Language development in the years before school: A comparison of developmental assets in home and child care settings. Early Child Development and Care, 177(6 & 7), 719-734.
42 Vincent, C., Moffat, M., Paquet, M., Flynn, R. & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. Ontario Association of Children's Aid Societies, 52(2), 2-5.
43 ibid

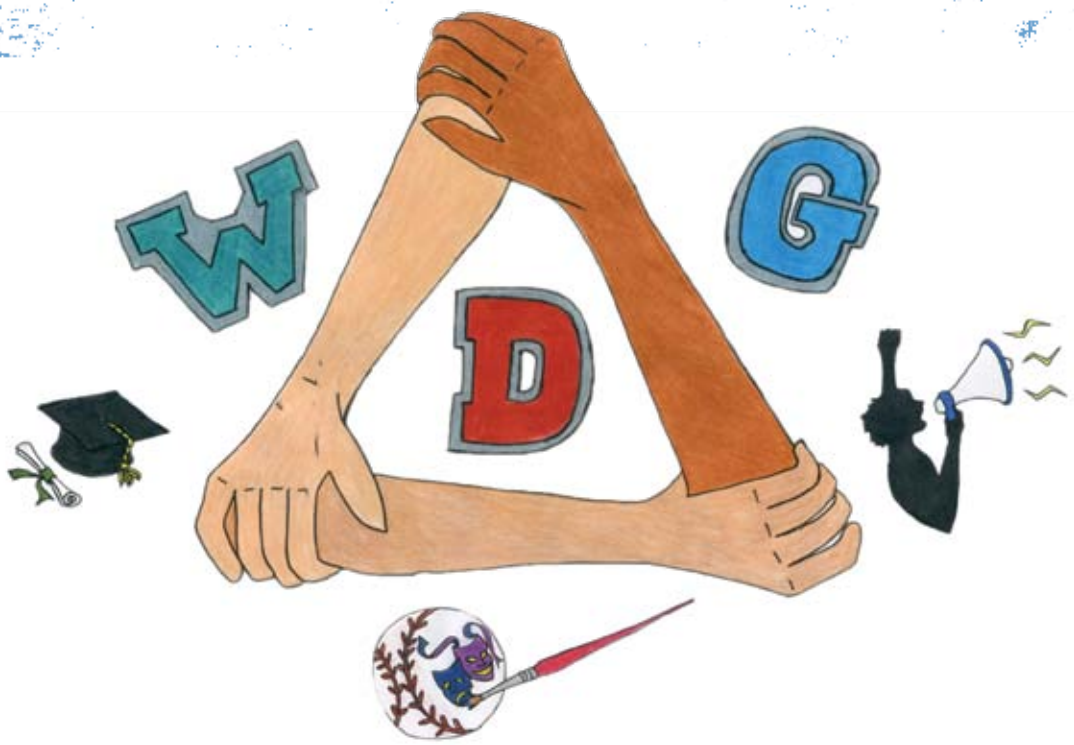
What is the purpose of the Report Card on the Well-Being of Youth?

The purpose of the Report Card is to raise the profile of youth in our communities by examining and reporting on the state of their health, development, and overall well-being. *The Well-Being of Youth Ages 14 to18: A Report Card for Wellington-Dufferin-Guelph* is a comprehensive review of the many factors that have an impact on our youth's well-being: health, learning, and development. This Report Card focuses on youth ages 14 to 18 years and their families, who are living in Wellington County, Dufferin County, and the City of Guelph.

The Report Card does not include recommendations or service delivery priorities that could be informed by the data presented in each chapter. The information provided in the Report Card is contextual, and considerations for how services are delivered in our communities often depend upon a spectrum of information that goes beyond the scope of data provided in this Report Card, such as service delivery mandates and priorities, and availability of resources.

In the last decade, we have experienced an increased emphasis on collaborative service planning in Ontario, which has influenced the collaborative work of local planning tables for activities, programs, and services for children and families in our communities. This movement has helped to increase our local capacity for understanding the value of high quality data for developing supports for children and families in a more effective way. Collaboration is more than sharing funding and capital resources; collaboration is also knowledge exchange. In the process of service planning, whether it is within a single organization or alongside others in the community who are working to meet broader goals greater than those which a single organization can achieve on its own, our hope is that service providers will use this Report Card:

- at the *beginning* of the service planning process to stimulate conversations as a means of developing more effective services for youth and their families;
- in the *middle* of service planning to answer questions that they may have about youth and families in our community – such as, "What are the trends in youth mental health that we need to be considering in this decision?" or "Are there differences in the rates or the kinds of injuries for which youth are treated for in Dufferin, compared to Wellington and Guelph?"; and
- *over time* to examine how effective their programs have been in supporting youth and their families in our communities. Many of the data sources presented in the Report Card are likely to remain stable as we continue to publish versions of the Report Card throughout the coming years, making us better able to determine how youth health, development, and well-being have changed. With the development and provision of effective activities and programs for youth and their families, we should see that there are positive changes in youth health, development, and well-being.



Wellington-Dufferin-Guelph Youth Charter of Rights

All youth in Wellington-Dufferin-Guelph have a right to:

- A voice in the issues that affect our lives;
- Good health by having our social, emotional, mental, physical and spiritual needs met;
- A place to sleep, clothes to wear, food to eat and supportive friends and/or family;
- Affordable activities and programs, and safe places to hang out;
- Education, training and opportunities that prepare us for our future lives;
- Quality time with our friends, family and/or other positive role models in our community;
- Be and feel safe in our homes, schools and communities;
- Be accepted for who we are and what we believe without being discriminated against;
- Access to quality and affordable child care, early education programs and/or parenting supports.

All youth deserve basic rights and freedoms. A fair share of society's resources must be devoted to ensuring this. While families are responsible for raising their children, all levels of government, in partnership with communities, have a duty to support families by putting the health and well-being of children first.

What is the Wellington-Dufferin-Guelph Youth Charter of Rights?

The Wellington-Dufferin-Guelph (WDG) Youth Charter of Rights is a document that outlines a vision to make Wellington, Dufferin, and Guelph better places for youth and families. It includes a series of statements that outline the responsibilities that our communities have for ensuring healthy development and bright futures for all of our youth.

In 2006, the Wellington Children's Services Council and the Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children led to the development of a Wellington-Dufferin-Guelph Children's Charter of Rights. This charter was made unique to our community and is based on the United Nations Convention on the Rights of the Child. There was an overwhelmingly positive response towards the Children's Charter of Rights, with over 58 organizations in Wellington, Dufferin, and Guelph endorsing the Charter. These endorsements represent an organization's commitment to act in accordance with the values and principles of the Charter. Given the success of the Children's Charter of Rights, the Coalition decided that an important component of the work necessary to prepare a Report Card for Youth Ages 14 to 18 was a Youth Charter of Rights developed by youth in our community.

The Wellington-Dufferin-Guelph Youth Charter of Rights and the Youth Engagement Working Group

In order to facilitate the development of a Youth Charter of Rights, a Youth Engagement Working Group was formed as part of the Coalition. This working group implemented a series of workshops with youth from across Wellington, Dufferin, and Guelph, which are described in greater detail below under *Wellington-Dufferin-Guelph Youth Engagement Workshops*. A primary activity of the workshops was to increase youth's understanding of the importance of a Charter of Rights and the valuable role they have in developing the Charter. The youth were empowered to write Charter statements that build on the Children's Charter of Rights. They were asked to capture what they felt were important aspects of their personal well-being, as well as that of their peers and community. The underlying meaning, or "spirit", of the Children's Charter is reflected in the revised statements; however, the language and wording was changed for many of them. The participating youth felt that each statement would make all youth in our community proud. The Working Group compiled all of the suggested revisions from the youth for analysis, leading to a draft Youth Charter of Rights. The draft was then taken back to two of the youth groups for member checking, to ensure that the statements in fact reflected their intended meaning, priorities, and language. This feedback resulted in the final WDG Youth Charter of Rights.

While the WDG Youth Charter of Rights provides the framework for this Report Card, the value of the Charter extends well beyond the Report Card. The hope is that the community, including municipal governments, community agencies, and local business, will adopt and endorse the Charter. The endorsement of the Charter will reflect the intent to support and advocate for the rights of youth, and a recognition that we have a duty to support families and youth by putting their health and well-being first. The community can use the Charter to guide and direct their commitment to youth health and development. Furthermore, youth may feel empowered to exercise their rights and protect the rights of their peers and other youth in the community.

What are determinants of health?

Determinants of health are factors or conditions that determine the health of groups of people. They are the circumstances, behaviours, and the biological, genetic, and environmental factors that make people healthy or unhealthy. Biological and genetic determinants of health are the characteristics that are inherited from our parents which play a role in determining our lifespan. Behavioural determinants of health include habits and behaviours that affect our health status, such as levels of physical activity. Social and environmental determinants of health are a list of social, economic, and contextual circumstances, which research has shown are the "best predictors" of individual and population health.[1]

In this Report Card, we refer to a range of determinants of health which have particular impact on youth and family health and well-being, with a strong emphasis on social and economic determinants of health. The determinants of health used for this Report Card are very similar to those used in the first two Report Cards, which focused on children ages birth to six and 7 to 13.

The determinants of health included in this Report Card are:

- Income and social status
- Food security and housing
- Healthy child development
- Education
- Physical environment
- Personal health, practices, and coping skills
- Social exclusion
- Social support and services
- Culture
- Access to health care
- Employment and working conditions
- Parenting support

Why use a determinants of health framework?

There is a great deal of research on the determinants of health framework. Each determinant of health has undergone extensive analysis and peer review in order to be considered a "predictor" of health. The determinants-of-health framework has been adopted into the policies and programs of many organizations that focus on health, education, the environment, transportation, social services, and general well-being, encouraging a more holistic view of health.

In the past several years, more interest has been placed on our improved understanding of the lives of groups of people and the conditions in which they live. Several well known organizations, such as the United Nations Children's Fund (UNICEF) and the Organization for Economic Cooperation

Determinants of Health

Canadians are largely unaware that *our health is shaped by how income and wealth is distributed*, whether or not we are employed, and if we are employed, the working conditions we experience. Furthermore, our well-being is also determined by the health and social services we receive, and our ability to obtain quality education, food, and housing, among other factors.

Contrary to the assumption that Canadians have personal control over these factors, in most cases, these living conditions are – for better or worse – imposed upon us by the quality of the communities, housing situations, our work settings, health and social service agencies, and educational institutions with which we interact.[2]

and Development (OECD), publish international report cards describing the health and well-being of youth and their families around the world using a determinants-of-health framework. These reports help to raise the profile of youth in all countries and are used to determine where progress is being made in supporting youth health and well-being. They are also used to identify areas where there is great need for aid and supports around the world.

How were the geographic reporting areas for the Report Cards selected?

Wherever possible, data in this Report Card are reported based on geographic area, such as municipalities and neighbourhoods. The goal is to describe differences in youth healthy development and well-being based on where they live.

In 2005, with the first implementation of the Early Development Instrument and the Kindergarten Parent Survey in our communities, and the flurry of local planning activities of the provincial Best Start initiative, we were becoming increasingly aware of the need to describe demographic and healthy development characteristics of our populations in a whole new way – through mapping.

For rural communities, we were able to use the municipal geographic boundaries already established by both Wellington and Dufferin Counties' political structures. For the City of Guelph, establishing the neighbourhood boundaries was more complex.

Guelph neighbourhoods were developed using print maps of the City of Guelph Community Neighbourhood Project (circa 2005). Neighbourhood boundaries were reconciled against Statistics Canada 2001 Dissemination Area (DA) Boundary Files. The boundaries of Guelph neighborhoods that are used in all Report Card publications are therefore collinear with 2001 DA boundaries. Semi-custom census profiles, by 2001 DA boundaries, have been produced by Statistics Canada for the 1996, 2001, and 2006 census periods. The census DA information can be aggregated (summed) within each neighborhood in the City of Guelph to produce indicators that are stable over time and place. This facilitates appropriate comparisons. In certain cases, where address or six digit postal codes (PC) are available, it is also possible to convert/translate the PC into a specific neighbourhood. Computer software, available from Statistics Canada (PCCF+), is used to do the "geocoding."

Report Card data sources

In this Report Card, we examine local data sources, including those collected directly from youth (e.g., the Wellington-Dufferin-Guelph (WDG) Youth Survey and the WDG Youth Workshops) and secondary data sources, such as provincial, local, and service provider agencies' databases. The range of data sources used is an indication of the extent to which we are supporting youth in their development and transition to adulthood. Furthermore, these data sources provide us with information related to many of the indicators necessary to understand the extent to which youth rights, as outlined by the WDG Youth Charter of Rights, are being realized in our communities.

Wellington-Dufferin-Guelph Youth Survey

In response to the significant gaps identified in local data available for youth, the WDG Coalition for Report Cards on the Well-Being of Children collected primary data for the first time, rather than relying solely on secondary data sources. To

collect data about youth health and well-being, the Coalition initiated the WDG Youth Survey. The Coalition chose a validated survey tool that has been successfully used to measure youth well-being in Halton Region. The survey tool was developed by the Halton Our Kids Network. A rigorous methodological process was used to develop the survey, including consultation with key informants (e.g., researchers and school board representatives), and pilot testing of the survey prior to its broader release. The survey is also aligned with the developmental assets from the Search Institute.

Throughout the 2011/2012 school year, students in grades 7 and 10 with the Upper Grand District School Board (UGDSB), Wellington Catholic District School Board (WCDSB), and Dufferin-Peel Catholic District School Board (DPCDSB) had the opportunity to complete the WDG Youth Survey, responding to questions about their physical activity, mental health, substance use, eating habits, time spent with family and friends, sense of safety, and school involvement. The overall response rate for students in Wellington, Dufferin, and Guelph was 55%. The response rates in Wellington and Guelph were comparable, at 58% and 57%, respectively. Dufferin County had a response rate of 48%.

Eight schools declined participation in the survey (four in Dufferin, two in Guelph, and two in Wellington). These were all elementary schools. Of those schools that did participate, the student response rate ranged from 1% to 100%, with an overall response rate of 58% (61% in Wellington, 56% in Dufferin, and 57% in Guelph). Schools that did not participate or that had a response rate of 30% or less were identified to their school boards. The school boards were confident that there were no important differences between the student populations of the schools that participated with response rates greater than 30%, and the student populations of schools that did not participate or participated with response rates of 30% or less. As a result, the Coalition is reasonably confident that the students in our survey are representative of all Wellington, Dufferin, and Guelph students. We are also satisfied that the overall survey sample size will provide an appropriate level of statistical power to detect important differences.

For the purposes of this Report Card, only grade 10 students' responses were examined and reported, as grade 7 students are not within the target age range and will be reported in the Report Card for the appropriate age group. In total, 1,235 grade 10 students completed the survey. Throughout this Report Card, when survey question results are shown, the number of students who did not respond is noted under the graph. In cases where a significant number of students did not respond, results may not be generalizable to the rest of the youth population in Wellington, Dufferin, and Guelph. It is important to note that there are no Catholic high schools located in Dufferin County. Catholic students living in Dufferin County are bused to Peel Region to attend a Catholic high school with the Dufferin Peel Catholic District School Board. It is also important to note that French, private, and parochial schools were excluded from the survey. For more information about the WDG Youth Survey and to access a copy of the survey, please visit **www.wdgreportcard.com**.

Data collected during the WDG Youth Survey have been analyzed according to gender and geographical location and are presented in this Report Card when the results are statistically

Statistically significant

Whenever the Report Card states that there is a statistically significant relationship between the indicator being examined and geographic area or gender, it means that this relationship is not due to chance or random variations in the sample. Furthermore, this means that the difference observed can be attributed to the geographic area or gender.

significant. This allows us to identify patterns in the data that may be influenced by gender and location as a means of better informing future programming. The geographic location is based on the location of the school that the student attends, rather than where they live. While these instances are limited, there may be students who live in a different geographic area (i.e., Wellington, Dufferin, and Guelph) than where they attend school. For example, a student may live in a Wellington County municipality, but attend school in the City of Guelph.

Other factors may also influence the patterns identified in the WDG Youth Survey indicators, such as family income and parental education level; however, these factors were beyond the scope of the current Report Card. This is an important limitation in the Report Card, and the data must be interpreted accordingly.

Individual student responses were aggregated according to the geographic location of schools to provide city- and county-level results for Wellington, Dufferin, and Guelph. For the purposes of the Report Card, data were not interpreted or presented at a level that could identify individual schools or school boards. Participating schools received individual School Profiles that summarize school-level results, which can be compared to board- and WDG-level results. These profiles are intended to support students, staff, and parents in school improvement planning, and provide a foundation for action.

Wellington-Dufferin-Guelph Youth Engagement Workshops

The WDG Coalition for Report Cards on the Well-Being of Children made youth engagement a priority for the development of a Report Card for youth ages 14 to 18. The Youth Engagement Working Group of the Coalition developed and implemented a series of workshops with youth from across Wellington, Dufferin, and Guelph. The goal of these workshops was to capture the voice of youth in our community and inform the development of the Report Card. The workshops empowered youth by promoting youth rights, gathering their input on a Youth Charter of Rights, consulting them about issues related to their health and well-being, and identifying other opportunities to participate in the development of this Report Card. The activities used in the workshops provided a safe environment for youth to interact and develop relationships with their peers, while working together with service providers to share their ideas.

The workshops were hosted throughout May and June 2012. Youth were brought together throughout the community by building on existing relationships and youth groups. The Coalition wanted to ensure that youth from varying backgrounds and geographic areas had the opportunity to participate. The following provides a breakdown of basic demographics of the youth that participated in the various workshops.

- 11 workshops in Wellington, Dufferin, and Guelph:
  - Wellington – 2 workshops
  - Dufferin – 3 workshops
  - Guelph – 6 workshops
- 112 youth participated in the workshops:
  - Wellington – 13 youth
  - Dufferin – 42 youth
  - Guelph – 57 youth
- Average age of participants: 15 years of age
- Gender of participants: 73 females and 39 males

The data collected from each workshop were compiled and analyzed. The themes that emerged from the analysis not only informed the work of the Coalition, but they have also been summarized in *Chapter 1: A Right to a voice in the issues that affect our lives* of the Report Card. The overall findings from these workshops have value to service providers working in all aspects of youth health and development. There are also findings that are specific to certain content areas, such as mental health. The youth perspective complements the local data presented in the Report Card, provides rich context, and supports a deeper understanding to inform youth service planning and delivery.

The Canadian Community Healthy Survey

For the first time, the Coalition is able to use the Canadian Community Health Survey (CCHS) as a data source for the Report Cards. Respondents of the CCHS are Canadians age 12 and over. The

CCHS gathers self-reported, health-related data that are available by geographic area: Wellington, Dufferin, and Guelph. The CCHS provides the community with valuable information on health indicators for this specific age group, including mental health, alcohol use, tobacco use, drug use, physical activity, and injuries. In order to make the CCHS data useable for the purposes of the Report Cards, a great deal of work has been devoted to extracting and preparing the data for analysis. With each CCHS indicator (e.g., alcohol use) there can be 50 to 100 specific sub-indicators that can be examined (e.g., *ever had an alcoholic drink, number of alcoholic drinks in the past 7 days*, etc.). The process necessary to include CCHS data in the Report Card required exploring the literature to determine which sub-indicators are most meaningful, analysis of the sub-indicators to examine trends across years, geography, age and genders, and finally, statistical analysis of these trends to determine if there are statistically significant differences. It is important to note, that all reported percentages from the CCHS are subject to varying degrees of sampling variation and should be interpreted with caution.

Statistics Canada Census Data

Whenever possible, the Data Analysis Working Group (DAWG) used 2009 intercensal estimates, which Statistics Canada releases to provide estimates of the population between official census dates. Intercensal data are available for all levels of geography used in the Report Card, including Dufferin and Wellington Municipalities, with the exception of the Guelph Neighbourhoods. During the writing process of the Youth Report Card, 2011 census data were released; however, due to the timing and availability of these data, the majority of population level data presented throughout the Report Card comes from the 2006 census. In some cases, data from the 2001 census were used for comparisons and trend analyses in the Report Card. Please take note of the source, as it is specified whether 2011, 2009 intercensal, 2006, or 2001 census data were used. In addition to publicly available data from Statistics Canada, the Report Card also benefited from "semi-custom run" datasets that allowed us to explore more specific demographic characteristics of our unique communities.

Provincial Health Planning Database (PHPDB) - Hospitalization Separation Data

Hospital separation records are historically the most comprehensive and accessible source of morbidity information. "Morbidity" is the relative incidence of a particular disease. Other components, or measures, of morbidity include visits to emergency rooms and physicians. A "separation" generally refers to the death, discharge home, or transfer to another facility of a patient. "External cause of injury" codes are used to classify the events, circumstances, and conditions that cause an injury, such as a motor vehicle traffic injury. Since a person may not be hospitalized, or may be hospitalized several times for the same disease or injury event, or may be released from more than one hospital (when transferred) for the same injury event, hospitalization data provide only a crude measure of the incidence of a cause. These data can also be influenced by factors that are unrelated to health status, such as availability and accessibility of care and administrative policies and procedures. This may have an impact on comparisons of statistics between geographic areas and over time. These data have been compiled by calendar year and residence of the patient. Ontario residents treated outside of the province are excluded from the datasets. Although less than 0.5% of all procedures performed for Ontario residents are out-of-province, areas bordering other provinces may be more affected.

Provincial Health Planning Database (PHPDB) - Emergency Room Visit Data

Emergency Room (ER) visit data can provide a crude measure of the prevalence of a cause of injury and disease. The Ontario-wide data have been compiled based on the residence of the patient and data are analyzed by calendar year. While this data is valuable, an important limitation to consider is that a person may visit the ER several times for the same disease or injury event, or may visit more than one hospital for the same disease or injury event.

Child Welfare Information System

The Child Welfare Information System (CWIS) is a database program that is used by a number of Children's Aid Societies across Ontario. The program was first implemented in 1997 and is used to record information pertaining to cases served by Children's Aid Societies under the mandate of the Child and Family Services Act (CFSA) (R.S.O. 1990, Chapter C.11). Children's Aid Societies are responsible for collecting and managing CWIS data, and routinely provide the Ministry of Child and Youth Services with information from this system and other systems. The information is also used internally by Children's Aid Societies to assist with planning and implementation of services.

Endnotes

1 Canadian Mental Health Association. (2002). A summary of research papers presented at York University: *The social determinants of health: An overview of the implications for policy and the role of the health sector*, Toronto, ON. Retrieved February 11, 2008: **http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/overview_implications/01_overview_e.pdf**

2 Mikkomen, J & Raphael, D. (2010). Social determinants of health: The Canadian facts. Toronto: *York University School of Public Health Policy and Management*

A portrait of children and families in Wellington, Dufferin, and Guelph

The portrait provides a brief demographic overview of the populations in Wellington County, Dufferin County, and the City of Guelph according to census data from 2001[1], 2006[2], 2009 intercensal[3], and 2011[4]. Given the ongoing release of 2011 census data at the time of writing, this portrait only highlights population information from 2011 when available. When 2011 data were not available, data from previous censuses are reported.

It is important to note that this Report Card as well as *The Well-Being of Children Ages 7 to 13: A Report Card for Wellington-Dufferin-Guelph*, uses 2009 intercensal data. Intercensal data are population estimates that are based on formulas developed by Statistics Canada. Given that these data are estimates, the estimated populations for 2009 may be higher than actual counts released in the 2011 census. This will be particularly important when comparing the 2009 intercensal data presented in the Report Cards to 2011 census data as it becomes available. Intercensal population information is used in the Report Cards as it is the best available information at the time of publication.

The information included in this section provides a snapshot of each of the three communities, and includes summary statistics on population demographics, culture and ethnicity, and work and family characteristics. Whenever possible, statistics specific to youth ages 14 to 18 are reported. This information is available to service providers to tailor their activities, promotion efforts and interventions to address the unique needs of specific populations and geographic areas. For example, understanding the rate of population growth is valuable for strategic planning, service and program planning, and policy development. Of equal importance is the need to understand the changing nature of the population. For example, census information can tell us where there may be higher concentrations of new immigrants, which helps organizations develop programming that is more accessible to this population.

City of Guelph

Population Snapshot

- Overall, the City of Guelph's population grew by 8.3% from 2001 to 2006, while Ontario's growth rate was 6.6%. This is a somewhat slower growth rate than from 1996 to 2001, when Guelph grew by 11%.
  - The population growth rate from 2006 to 2011 is 5.9% for the City of Guelph, which is slower than its growth rate from 2001 to 2006. The population growth rate in the City of Guelph is comparable to the growth in Ontario, which increased by 5.7% from 2006 to 2011.
- Between 2005 and 2009, there was a 1% increase in the number of youth ages 14 to 18 years in Guelph.
- As of 2009, there were an estimated 7,848 youth ages 14 to 18 years living in Guelph; in a total estimated population of 123,099, this represents 6% of the total population (see Map 1.1 and Map 1.2).

Culture and Ethnicity

- Guelph has 1,290 people who identify themselves as Aboriginal; this is 1.1% of the Guelph population (2006).[5]
- Twenty-one percent (21%) of Guelph's population is made up of people who have immigrated to Canada (2006). This is a slight rise from 20% in 2001. In Ontario, 28% of the population consists of immigrants to Canada (2006).
- Guelph has 1,630 people who report French as their mother tongue. This is 1.4% of the population (2006).
  - The number of people in Guelph who report speaking French as their mother tongue has remained fairly stable since 2006; it has declined slightly to 1,605 people in 2011. This represents 1.3% of the population.
- In 2006, ten percent (10%) of the Guelph population spoke languages other than English or French at home. The most prominent non-official languages were Chinese and Italian.
  - In 2011, the percent of the population that spoke languages other than English or French remained fairly stable at 9.7% of Guelph's population (n=11,460). The most prominent non-official languages were Vietnamese, Chinese and Panjabi.

Work and Family

- Twenty-four percent (24%) of Guelph's working population commutes to a municipality outside of Guelph (2006).[6]
- Sixteen percent (16%) of families are led by lone parents. This percentage is comparable to the rate in Ontario (2006).
  - The percent of lone-parent families reported in 2011 has remained approximately stable at 16.2%.

Wellington County

Population Snapshot

- Overall, Wellington County's population grew by 5.3% from 2001 to 2006, compared to 6.6% for Ontario. This is a somewhat slower growth rate than that from 1996 to 2001, when the County grew by 7%. Growth is mainly due to in-migration from other parts of the province and country.
  - The population increased between 2006 and 2011 by 1.4% for Wellington County, which is slower than the growth rate from 2001 to 2006. It is also slower than the growth rate in Ontario, which increased by 5.7% between 2006 and 2011.
- Between 2005 and 2009, the number of youth ages 14 to 18 has remained stable in Wellington County, with less than a 1% increase.
- As of 2009, there were an estimated 6,989 youth ages 14 to 18 living in Wellington County; in a total estimated population of 91,290, this represents 8% of the total population (see Map 1.1 and Map 1.2).

Culture and Ethnicity

- Wellington County has 525 people who identify themselves as Aboriginal – which is less than 1% of the County's population (2006).[7]
- Eleven percent (11%) of Wellington County's population is made up of people who have immigrated to Canada (2006). This is the same percentage as in 2001.[8] In Ontario, 28% of the population consists of immigrants to Canada (2006).
- In 2006 Wellington County had 705 people who report French as their mother tongue. This is just under 1% of the population.
  - The number of people in Wellington County who report speaking French as their mother tongue has remained stable since 2006, at 0.96% of the population (n=815) in 2011.
- Six percent (6%) of the County's population speaks languages other than English or French at home (2006). The most prominent non-official languages were German and Dutch.
  - In 2011, the percent of the population that spoke languages other than English or French decreased slightly to 5% of Wellington

County's population (n=4,280). The most prominent non-official languages were German and Dutch.

Work and Family

- Fifty-one percent (51%) of the County's working population commutes to a municipality outside their municipality of residence (2006).[9]
- Nine percent (9%) of families are led by lone parents (2006). This percentage is much lower than the rate in Ontario, which is 16%.
  - Families that are led by lone parents increased to 9.8% in 2011.

Dufferin County

Population Snapshot

- Overall, Dufferin County's population grew by 6.7% from 2001 to 2006. This is very comparable to Ontario's growth rate of 6.6%. However, population growth in Dufferin has slowed; between 1996 and 2001, Dufferin grew by 11.7%. The Town of Shelburne showed dramatic growth from 2001 to 2006 when it grew by 22%. Most of Dufferin's growth is due to in-migration from other parts of the province and country.
  - The population increased between 2006 and 2011 by 4.5% for Dufferin County, which is slower than the growth rate from 2001 to 2006. It is also slower than the growth rate in Ontario, which increased by 5.7% between 2006 and 2011.
- Between 2005 and 2009, there has been a 2% increase in the number of youth age 14 to 18.
- As of 2009, there were an estimated 4,691 youth ages 14 to 18 years living in Dufferin County; in a total estimated population of 58,014, this represents 8% of the total population (see Map 1.1 and Map 1.2).

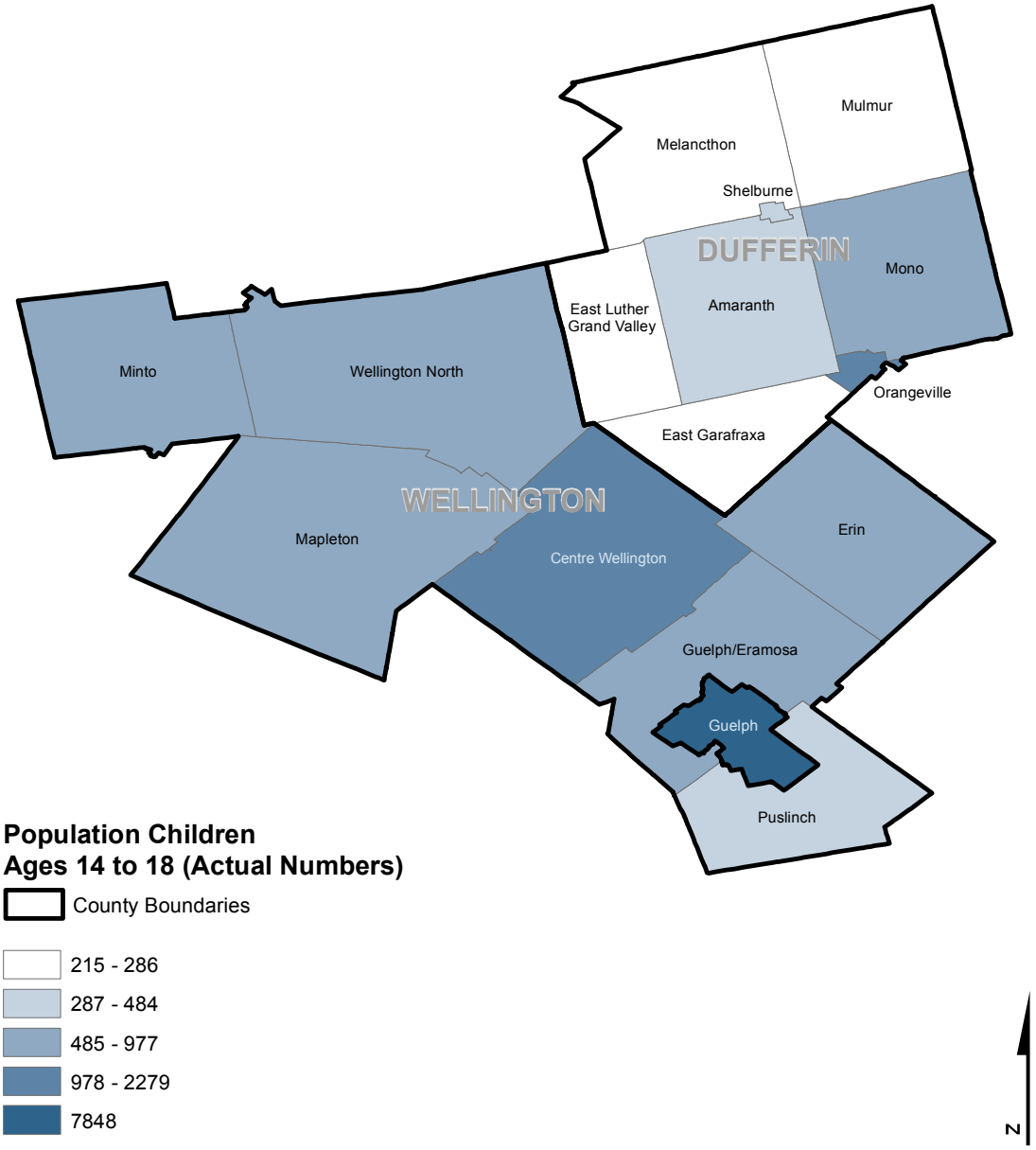
Culture and Ethnicity

- Dufferin County has 525 people who identify themselves as Aboriginal; this is 1% of the County's population (2006).
- Thirteen percent (13%) of Dufferin's population is made up of people who have immigrated to Canada (2006). This represents a slight increase since 2001 when immigrants accounted for 12.2% of the population. In Ontario, 28% of the population consists of immigrants to Canada (2006).
- Dufferin has 595 people who report French as their mother tongue (2006). This is about 1% of the population.
  - The number of people in Dufferin County who report speaking French as their mother tongue has remained stable since 2006, at 1.1% of the population (n=605) in 2011.
- Two percent (2%) of Dufferin's population speaks languages other than English or French at home (2006). The most prominent non-official languages were German and Portuguese.
  - In 2011, the percent of the population that spoke languages other than English or French decreased slightly to 1.8% of Dufferin County's population (n=1,025). The most prominent non-official languages are German and Polish.

Work and Family

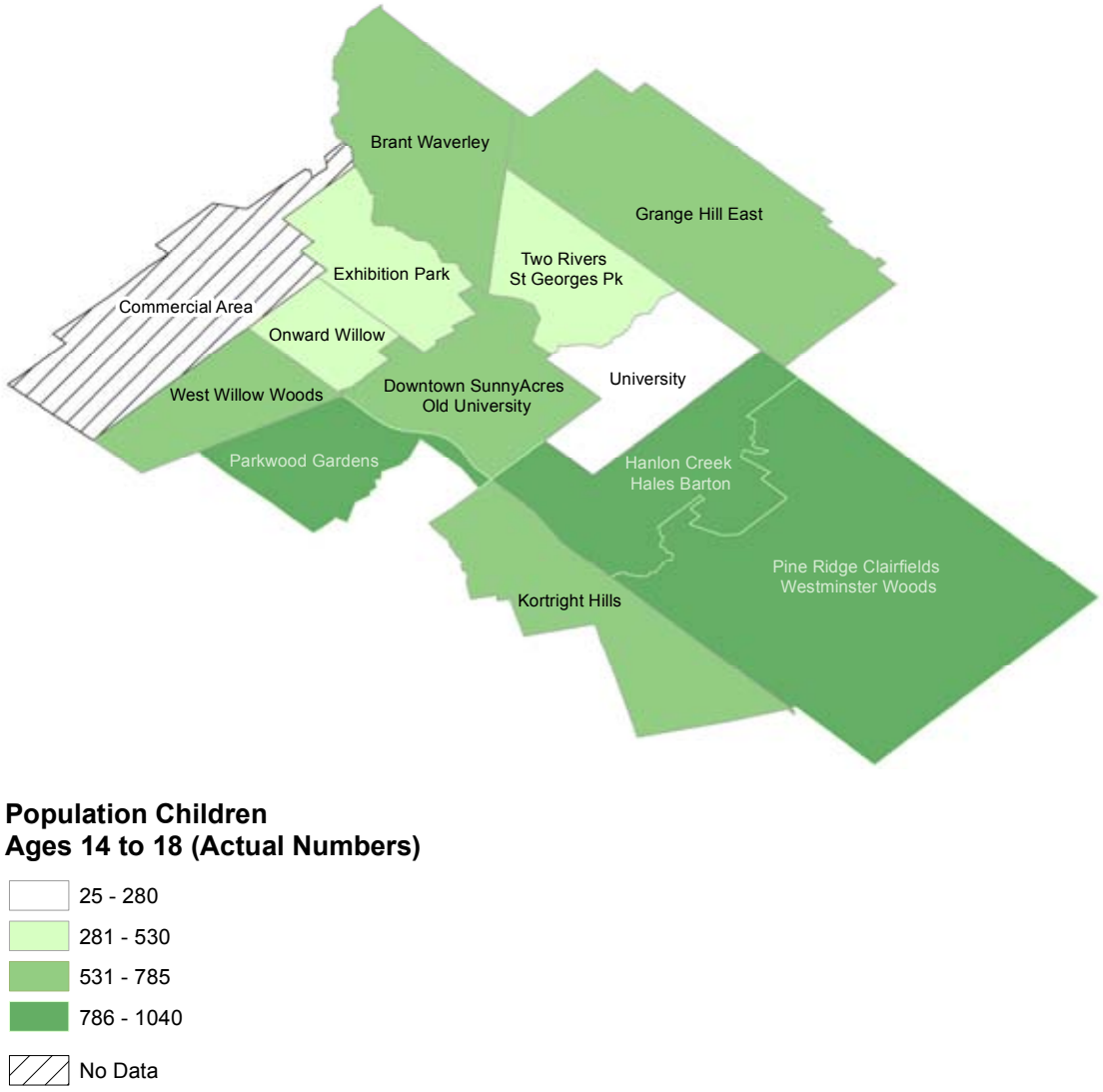
- Fifty-three percent (53%) of Dufferin's working population commutes to a municipality outside their municipality of residence (2006).[10]
- About 14% of families in Dufferin County are led by lone parents (2006). This percentage is slightly lower than the rate in Ontario, which is 16%.
  - Families that are led by lone parents have increased slightly to 15% in 2011.

Map 1.1 **2009 population distribution of youth, ages 14 to 18, Wellington, Dufferin, and Guelph**



Source: *Population of Youth Ages 14 to 18: Statistics Canada Intercensal Estimates, 2009*

Map 1.2 **2006 population distribution of youth, ages 14 to 18, Guelph Neighbourhoods**



Source: *Population of Youth Ages 14 to 18: Statistics Canada, 2006*

Endnotes

1 Statistics Canada. *2001 Community Profiles*. 2001 Census. Statistics Canada Catalogue. Ottawa. **http://www12.statcan.ca/english/profil01/CP01/Index.cfm?Lang=E** (accessed January 23, 2013).

2 Statistics Canada. (2007). *2006 Community Profiles*. 2006 Census. Ottawa. Released March 13, 2007. **http://www12.statcan.gc.ca/census-recensement/index-eng.cfm** (accessed January 23, 2013).

3 Statistics Canada. Intercensal Estimates, 2009. Statistics Canada. Ottawa.

4 Statistics Canada. (2012). *Census Profile*. 2011 Census. Ottawa. Released October 24, 2012. **http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E** (accessed January 23, 2013).

5 Statistics Canada (2001). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD).* Statistics Canada Catalogue no. 95F0300XCB2001001. & Statistics Canada (2006). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 97-551-X2006006.

6 Statistics Canada (2006). *Census Profile Subscription for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 94-581-XCB2006002. Subscription Catalogue no. 97C0017.

7 Statistics Canada (2001). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD).* Statistics Canada Catalogue no. 95F0300XCB2001001. & Statistics Canada (2006). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 97-551-X2006006.

8 Statistics Canada (2001). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD).* Statistics Canada Catalogue no. 95F0300XCB2001001. & Statistics Canada (2006). *Single Year of Age and Sex TBT for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 97-551-X2006006.

9 Statistics Canada (2006). *Census Profile Subscription for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 94-581-XCB2006002. Subscription Catalogue no. 97C0017.

10 Statistics Canada (2006). *Census Profile Subscription for Wellington and Dufferin (CDs by DA/CSD)*. Statistics Canada Catalogue no. 94-581-XCB2006002. Subscription Catalogue no. 97C0017.

1. A right to a voice in the issues that affect our lives

Introduction

The link to youth's well-being

The opportunity for youth to have a voice in the issues that affect their lives represents an important vehicle in promoting positive youth development.

Youth engagement is having young people actively involved in addressing issues that are important to them or that affect them personally.[1] Participation should not only be meaningful, but also sustained, in order to achieve the best results.[2] Youth engagement provides a unique and safe environment in which young people can raise concerns about issues that affect their lives, and collectively come up with creative solutions on how to take action.[3] Researchers have found links between youth engagement and several positive health outcomes, including decreased alcohol, marijuana and hard drug use, lower rates of school failure and drop-out, lower rates of sexual activity and pregnancy in girls, lower rates of anti-social and criminal behaviours, and lower rates of depression.[4] Youth that have more opportunities to become involved in their communities also have a better sense of control, empowerment, and other social and emotional capacities that enhance their health and well-being and reduce the likelihood of risk-taking behaviours.[5] Other benefits, ranging from moral-political awareness and civic identity to prosocial development and self-efficacy, have also been reported as a benefit of community involvement among youth.[6] In a study of the impacts of voice and resonance on youth development, youth often described opportunities to contribute to a school or organization as experiences in which they felt a greater sense of community.[7] They emphasized the importance of contributing their voice in a variety of settings, and indicated that they enjoyed feeling like a valued member of their community. Youth participation also contributed to a sense of identity and belonging in the community and developed the expectation for future active participation.[8] As youth became more aware of the issues in their communities, they spoke of a desire to change oppressive conditions, demonstrating how youth engagement can foster a sense of social responsibility and agency.[9]

Youth have the ability to act as important resources during the decision-making processes within their families, schools, and communities. In the context of the family, youth that have opportunities to express their opinions and beliefs in an environment of warmth and understanding have higher levels of intrinsic motivation and self-esteem.[10] Positive youth development is also facilitated when teachers engage students in the construction of knowledge and the enactment and enforcement of school rules.[11] Youth that have opportunities to contribute their voice to the school environment report lower levels of in-school delinquency and a greater sense of community.[12] At the societal level, the most consistent predictor of effective youth programming is the involvement of youth in the decision-making process.[13] Youth that have been treated as "community resources" have higher levels of resiliency and other protective health behaviours.[14] It is important to note, however, that youth voices must be met with resonance; youth cannot fulfill their potential to positively impact their environment without the cooperation of adults within their communities.

Indicators of youth's health and well-being in this chapter

The indicators that are included in this chapter will help us to understand the opportunities available for youth to become involved in their community and the extent to which they feel that they can make a difference. This chapter also provides an overview of local youth engagement opportunities, which were an important part of the process to develop this Report Card. The indicators included in this chapter are:

- Service to others
- Youth as resources
- Caring
- Equality and social justice
- Health priorities for youth

The value of this information to service providers

Having a voice in the issues that affect their lives is not only beneficial to youth themselves and to the community, but it also has value that extends to service planning, advocacy, and policy development. Service providers and other adults in the community have a critical role to play in helping to create opportunities for youth engagement. These opportunities can include participation in almost any type of activity that is felt to be meaningful, structured, and performed with a specific purpose in mind, including school, the arts, music, politics, or community work.[15,16] Youth are often the recipients of the influence of adults, however, the opportunity to return the influence is often unavailable. Adults have the ability to support youth development and empowerment by creating social structures in which youth can develop leadership skills and positively impact their environments. Youth engagement is an extremely powerful tool for service providers to use to amplify the youth voice.

Often youth feel like their voices are not heard, or are perhaps not taken as seriously when compared to adults. Youth engagement provides an opportunity for youth to voice their opinions and experiences, but also to enhance their leadership skills and engage in meaningful conversations with professionals in the community.[17]

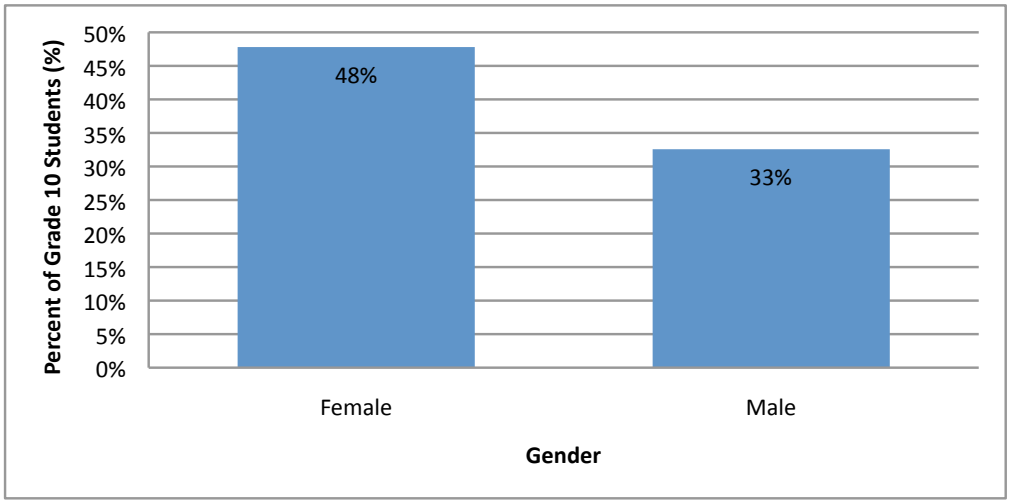
Youth engagement can also have several community benefits. For example, involving youth in the design, implementation, and evaluation of community programs and services not only makes them more accessible to target populations, but also makes these programs responsive to young people's needs and priorities.[18] Incorporating input from youth before making community investments can therefore allow funding to be directed at programs that are youth-centered, and avoid unnecessary expenditures that do not reflect the needs of the youth.[19] As such, the selection of information and statistics included in this Report Card was guided by each of the rights identified by youth in the Wellington-Dufferin-Guelph Youth Charter of Rights. These data can be useful to all of us in examining whether the current health and well-being of youth in our communities reflect a realization of their rights. Furthermore, by sharing key findings from the Wellington-Dufferin-Guelph Youth Engagement Workshops, service providers will be able to get a first-hand perspective on what youth feel is most important to their well-being and the well-being of their peers and community.

Service to others

The opportunity to engage in service to others is critical to youth development. Research has found an association between higher levels of service to other and health-related outcomes among youth, including a decreased likelihood of engaging in sexual intercourse, tobacco and cannabis use, and higher levels of self-worth and self-rated health.[20, 21] The Wellington-Dufferin-Guelph (WDG) Youth Survey asked youth whether they volunteer or help without pay in their community as a measure of *Service to Others*. The WDG Youth Survey found that in Wellington, Dufferin, and Guelph, 41% of students in grade 10 reported *Service to Others* in their community. There was no significant relationship between geographic area and *Service to Others*, although there was a significant relationship

between gender and *Service to Others*. As illustrated in Figure 1.1, more female (48%) grade 10 students reported volunteering without pay in their community compared to males (33%).

Figure 1.1 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported volunteering without pay in their community, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

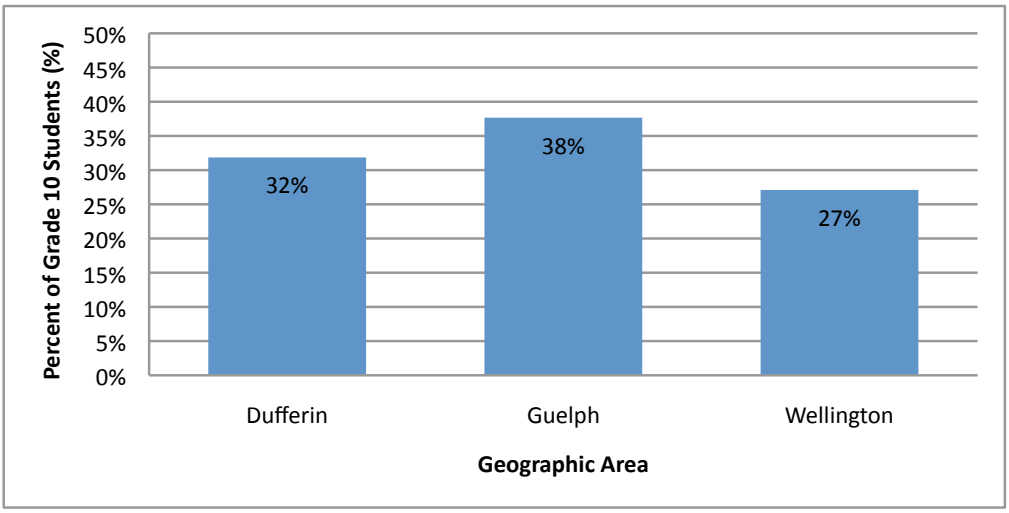
Note: 24 students (2%) did not complete the survey question for Service to Others.

Youth experience the positive outcomes associated with community service, regardless of whether it is voluntary or required.[22] Research has also found that rates of participation in volunteer activities and community service are higher among females than males.[23, 24] It is important to note, however, that all high school students in Ontario must complete a mandatory 40 hours of community service in addition to their regular classes in order to receive their secondary school diploma. Consequently, students who reported no community service during this survey may have already completed their mandatory community service hours during their grade 9 year, or may be planning to complete their hours during their grade 11 or 12 years. Some students may also choose to complete more than the mandatory hours of service, participating in regular volunteer activities throughout their high school years. While these data provide an interesting snapshot of current volunteer participation according to gender; they must be interpreted with the abovementioned limitations in mind.

Youth as resources

The WDG Youth Survey asked grade 10 students about the extent to which they feel they can make a difference in their community, as a measure of *Youth as Resources*. Results indicated that there was a significant relationship between geography and *Youth as Resources*. There were more grade 10 students in Guelph (38%) who feel they can make a difference in their community, compared to Dufferin (32%) and Wellington (27%)(Figure 1.2). There was no significant association between gender and *Youth as Resources*.

Figure 1.2 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who feel they can make a difference in their community, by geography, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

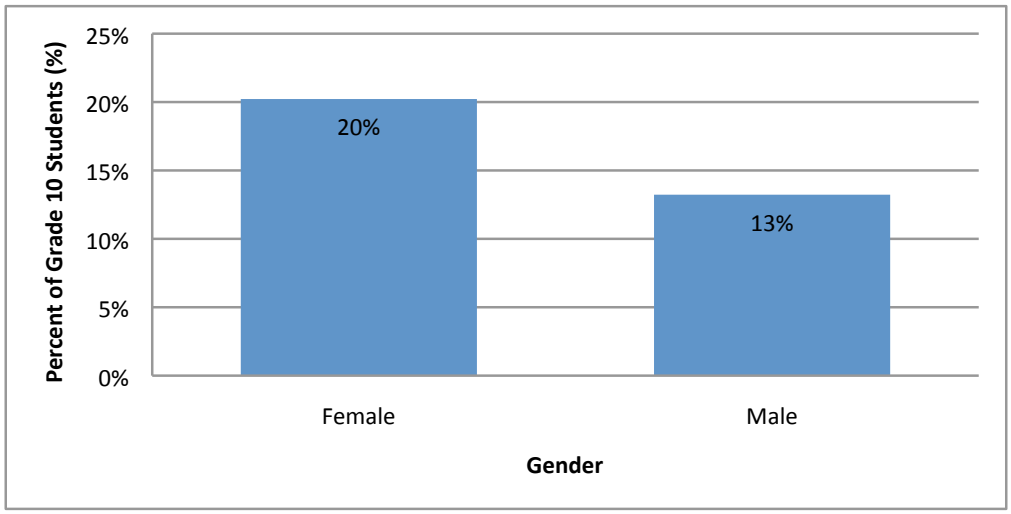
Note: 27 students (2%) did not complete the survey question for Youth as Resources.

Interestingly, a comparison between the percentage of youth who volunteer and the percentage of youth who feel that they can make a difference in their community highlights discrepancies between these two indicators. While 41% of youth volunteer within Wellington, Dufferin and Guelph, fewer youth (35%) feel that they can actually make a difference in their community, speaking to the importance of both voice and resonance previously discussed. This highlights the importance of creating meaningful opportunities for youth to volunteer in their community, where youth can address issues in order to have a positive impact, while providing relevant experience for their future lives.

Caring

The WDG Youth Survey asked students about the extent to which they care about others in their community, as a measure of *Caring*. The analysis revealed that there was no significant association between geography and *Caring* among grade 10 students. In Wellington, Dufferin, and Guelph, 17% of grade 10 students reported high levels of caring about others in their community. There was, however, a significant association between gender and *Caring*. More female grade 10 students (20%) reported high levels of caring about others in their community compared to males (13%)(Figure 1.3).

Figure 1.3 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of caring about others in their community, by gender, 2012**



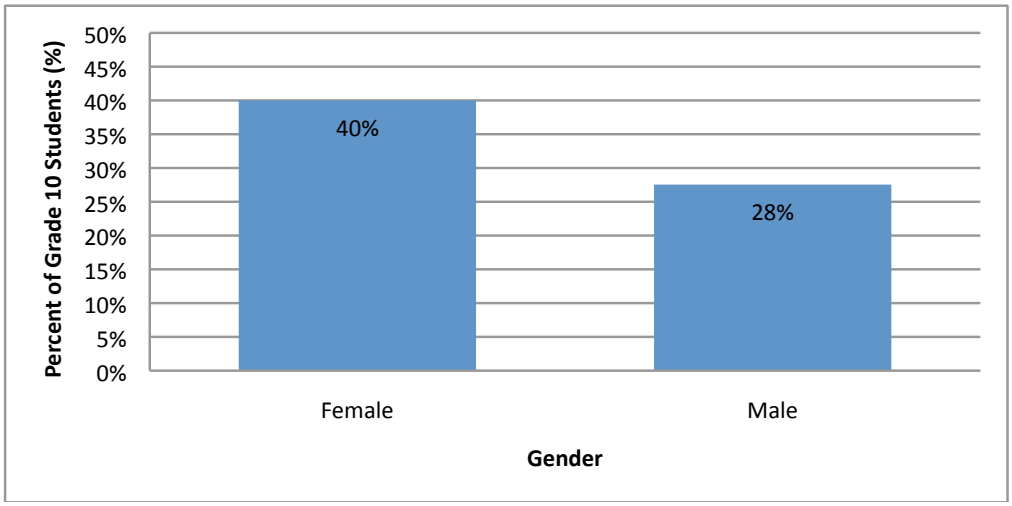
Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 30 students (2%) did not complete the survey questions for Caring.

Equality and social justice

The WDG Youth Survey asked youth about the extent to which they try to help solve social problems, as a measure of *Equality and Social Justice*. No significant associations emerged between geography and *Equality and Social Justice*. In Wellington, Dufferin, and Guelph, 34% of students in grade 10 reported high levels of promoting *Equality and Social Justice*. Similar to volunteer activities, there was a significant relationship between gender and *Equality and Social Justice*. Figure 1.4 illustrates that more female (40%) grade 10 students reported promoting *Equality and Social Justice* when compared to males (28%). The motivating factors that encourage more females to participate in volunteer activities may be similar to those that motivate more females to become involved in social issues. Regardless of gender, youth are more likely to regard public interests as a priority when their families stress an ethic of social responsibility.[25]

Figure 1.4 Percentage of grade 10 students in Wellington, Dufferin, and Guelph promoting *Equality and Social Justice*, by gender, 2012



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 25 students (2%) did not complete the survey question for Equality and Social Justice.

Health priorities for youth

Given the value of youth engagement discussed in this chapter, the WDG Coalition for Report Cards on the Well-Being of Children developed and implemented a series of workshops with youth from across Wellington, Dufferin, and Guelph. These workshops are described in greater detail in the *Overview* section of the Report Card. One of the workshop activities asked youth to prioritize issues related to their health and well-being and the health and well-being of their peers. Using a "dotmocracy" approach, youth were asked to identify the number one topic that was most important to them, as well as their next top four, from a list of 38 health-related topics. They were then asked to do the same again, but considering the perspective of their peers.

Given the large number of health-related topics, the topics were grouped into broad categories for purposes of analysis. The categories included: Acceptance, Community Engagement, Education, Injury Prevention, Mental Health, Physical Health, Poverty, Safety, Sexual Health, Substance Use, and Voice. The analysis ranked the health categories according to the number of dots associated with each of the topics within that category. Personal priorities identified by youth were similar to

Dotmocracy

The "dotmocracy" approach is an established facilitation method for collecting and recognizing levels of agreement among a large number of people. In the youth engagement workshops, participants used dot stickers to vote on their health priorities for the 38 health-related topics. Participants voted on their most important health priorities using a limited number of stickers. This priority setting approach can also be described as cumulative voting.

those they identified as priorities among their peers. As a result, Figure 1.5 only provides a visual representation of health categories ranked "most important" by youth. The size of the font corresponds to the ranking of the category, with larger words representing a higher number of dots and smaller words representing a lower number of dots.

Figure 1.5 **Ranking of health-related categories that were most important to youth, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

Source: Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012

The three categories with the highest number of dots were Mental Health, Physical Health and Substance Use (Figure 1.5). While Figure 1.5 provides a valuable snapshot about the health-related categories that are most important to youth, it does not capture the specific topics within these categories. In order to provide a greater level of detail, Table 1.1 summarizes the health-related topics that were given the highest number of dots, by "most important" and "other important", from both their personal perspective and the perspective of their peers.

Table 1.1 **Top five most important health-related topics, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

Most important health issue to me	Other important health issues to me	Most important health issue to my peers	Other important health issues to my peers
Depression	Having a voice	Suicide	Healthy weight/body image
Healthy weight/body image	Physical activity	Healthy weight/body image	Drug use
Healthy relationships	Alcohol use	Stress	Bullying
Alcohol use	Feeling safe at school	Bullying	Alcohol use
Physical activity	Drug use	Depression	Feeling safe at school

Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Overall, 50% of the topics that emerged in the top five were related to mental health (e.g., depression, suicide, body image, healthy relationships, stress, and bullying), many of which appear within the two *most important* categories. The other topics that emerged were feeling safe at school, substance use (e.g., alcohol and drugs), and physical activity.

Another workshop activity asked youth the following questions about their health and the health of their peers:

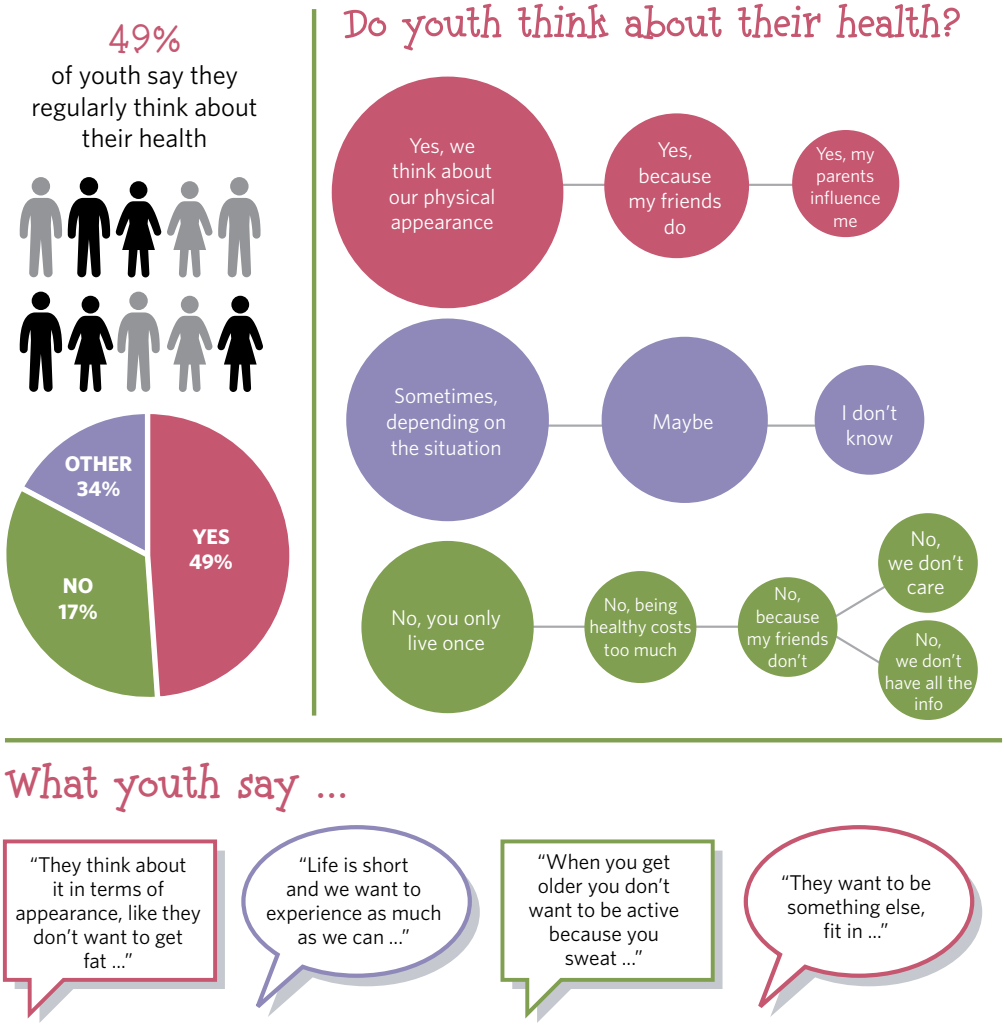
1. Do youth think about their health (being healthy)?
2. How can we make health more important to youth?
3. What does being healthy mean to youth?
4. What do you feel youth need to be healthy?
5. What do you think matters most to youth when it comes to their community/neighbourhood/ where they live and go to school?

Participants were asked to write down their response to each question on chart paper. Their responses were then reviewed through a facilitated discussion, where youth had the opportunity to describe the reasoning behind their response or provide additional information. The responses to each question and key points from the discussion were recorded. Qualitative analysis of these data revealed key themes related to each question. Figures 1.6 to 1.10 summarize these themes and quotes from the youth.

Figure 1.6 **Key themes related to whether youth think about their health, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

Do youth think about their health? Why or why not?

Youth were asked whether their peers thought about their health and then asked to explain why they answered "yes", "no" or "other".



What youth say ...

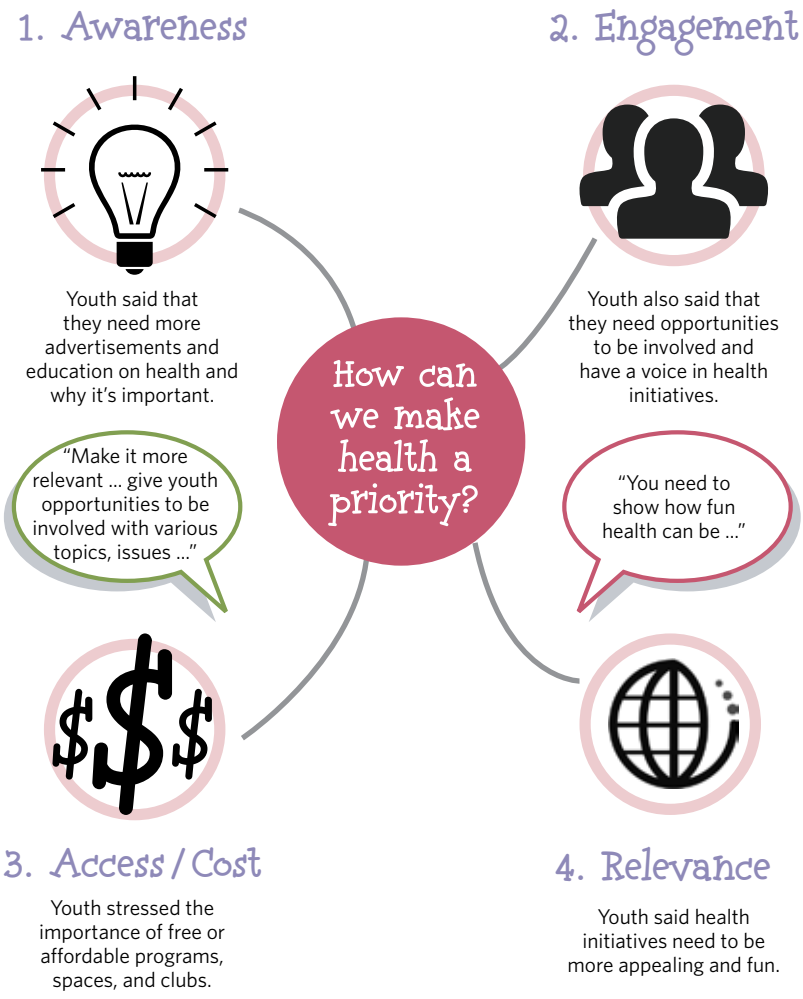
Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Note: The size of the bubbles under the heading, "Do youth think about their health" corresponds with the number of times that theme was mentioned by youth during the workshops.

Figure 1.7 **Key themes related to how we can make health more important to youth, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

How can we make health more important to youth?

This question asked youth what could be done to make health a priority for more youth. Responses were categorized into four main themes.



Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Note: The themes identified in this activity are numbered one through four based on the number of times the theme was mentioned by youth. Awareness was identified as the number one way to make health a priority for youth.

Figure 1.8 **Key themes related to what being healthy means to youth, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

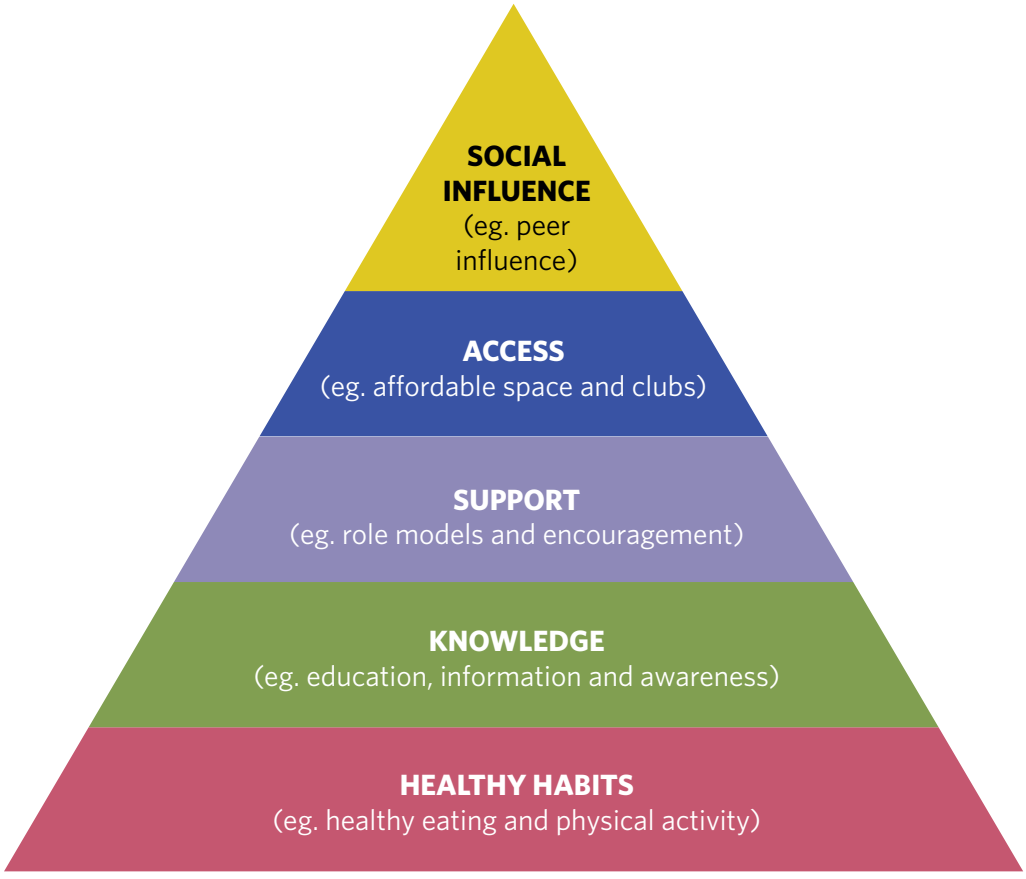
Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Note: The themes identified in this activity are numbered one through six based on the number of times the theme was mentioned by youth.

Figure 1.9 **Key themes related to what youth feel they need to be healthy, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

What do youth need to be healthy?

Youth were asked what they needed in order to live healthier lifestyles. Their responses are show below and are illustrated by using a model similar to Maslow's Hirarchy of Needs.



YOUTH HIERARCH OF HEALTH NEEDS

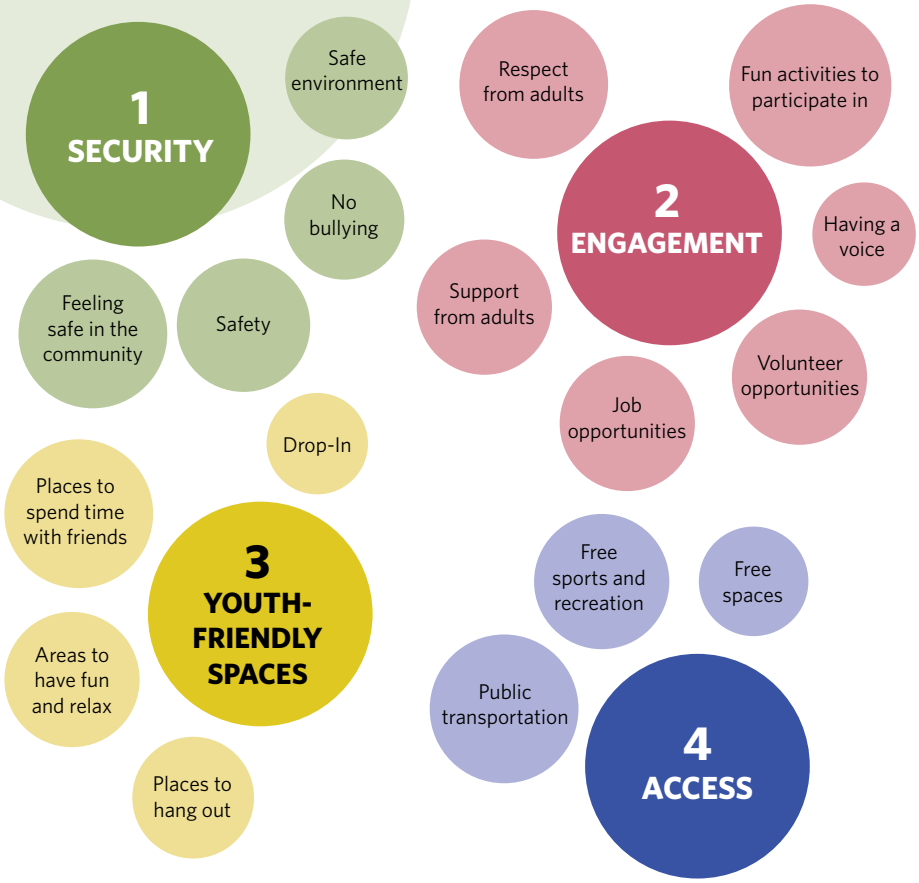
Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Note: Youth identified "Healthy Habits" as the foundational principle necessary to live healthy lives. They recognized that in addition to this foundation, they needed more knowledge, support, access to resources and positive social influences to live healthy lives.

Figure 1.10 **Key themes related to what matters most to youth about their community, youth engagement workshops, Wellington, Dufferin, and Guelph, 2012**

What matters most in the community?

Youth were asked to think about the most important aspects of their community and what mattered most to them. Overall, four major themes came out of the youth engagement workshops: **security, engagement, youth-friendly spaces, and access.** Below, we elaborate on each theme:



Source: *Wellington-Dufferin-Guelph Youth Engagement Workshops, 2012*

Note: The number next to each theme represents the ranking in terms of the most important aspects of the community identified by youth. The size of the coloured bubbles around each sub-theme corresponds with the number of times that it was mentioned by youth during the workshops.

The data summarized from the youth engagement workshops provides an understanding of priority areas for service planning targeted to youth. Specifically, the results identify the extent to which youth actually think about their health, how we can make health more important to them, what supports or resources they need to be healthy, and what matters most to them regarding their health and community. Youth involved in the workshops were interested in working towards improvements in the priority areas they identified related to their health and community, and were eager to receive education, services, and resources to support them in achieving this. It is important for service providers at all levels to understand the health- and community-related priorities among youth in order to ensure that opportunities, services, and resources reflect these priorities.

Endnotes

1 Ontario Public Health Association. (2011). Youth engagement toolkit –working with middle school students to enhance protective factors and resiliency: A resource for health professionals working with young people. Toronto, ON: OPHA.

2 Centres of Excellence for Children's Well-Being. (n.d). What is youth engagement? Retrieved from **http://www.engagementcentre.ca/files/Whatis_WEB_e.pdf**

3 Ontario Public Health Association. (2011). Youth engagement toolkit –working with middle school students to enhance protective factors and resiliency: A resource for health professionals working with young people. Toronto, ON: OPHA.

4 Centres of Excellence for Children's Well-Being. (n.d). What is youth engagement? Retrieved from **http://www.engagementcentre.ca/files/Whatis_WEB_e.pdf**

5 Ontario Public Health Association. (2011). Youth engagement toolkit –working with middle school students to enhance protective factors and resiliency: A resource for health professionals working with young people. Toronto, ON: OPHA.

6 Youniss, J., & Yates, M. (1997). Community service and social responsibility in youth. Chicago: University of Chicago Press.

7 Evans, S. D. (2007). Youth sense of community: Voice and power in community contexts. Journal of Community Psychology, 35(6), 693-709.

8 Ibid.

9 Ibid.

10 Steinberg, L. (2001). We know some things: Parent–adolescent relationships in retrospect and prospect. Journal of Research on Adolescence, 11(1), 1–19.

11 Zeldin, S. (2004). Preventing youth violence through the promotion of community engagement and membership. Journal of Community Psychology, 32(5), 623-641.

12 Ibid.

13 American Youth Policy Forum. (1999). Some things do make a difference for youth: A compendium of evaluations of youth programs and practices (Vol. 2). Washington, DC.

14 Ibid.

15 Pancer, M.S., Rose-Krasnor, L., & Loiselle, L.D. (2002). Youth conferences as a context for engagement. New Directions for Youth Development, 96, 47-64.

16 Centre of Excellence for Youth Engagement. (2003). Youth engagement and health outcomes: Is there a link? Retrieved from **http://www.engagementcentre.ca/files/litreview1_web_e.pdf**

17 Ontario Public Health Association. (2011). Youth Engagement Toolkit –Working with Middle School Students to Enhance Protective Factors and Resiliency: A Resource for Health Professionals working with Young People. OPHA: Toronto.
18 Center for the Study of Social Policy. (2011). Results-based public policy strategies for promoting youth civic engagement.
19 Ibid.
20 Canadian Institute for Health Information. (2005). Improving the Health of Young Canadians. Ottawa: Canadian Institute for Health Information.
21 Vesely, S.K., Wyatt, V.H., Oman, R.F., Aspy, C.B., Kegler, M.C., Rodine, S., Marshall, L, & McLeroy, K.R. (2004). The potential protective effect of youth assets from adolescent sexual risk behaviors. The Journal of Adolescent Health, 34(5), 356-365.
22 Schmidt, J.A., Shumow, L, & Kackar, H. (2007). Adolescents' participation in service activities and its impact on academic, behavioral, and civic outcomes. Journal of Youth and Adolescence, 36(2), 127-140.
23 Canadian Institute for Health Information. (2005). Improving the Health of Young Canadians. Ottawa: Canadian Institute for Health Information.
24 Schmidt, J.A., Shumow, L, & Kackar, H. (2007). Adolescents' participation in service activities and its impact on academic, behavioral, and civic outcomes. Journal of Youth and Adolescence, 36(2), 127-140.
25 Flanagan, C.A., Bowes, J.M., Jonsson, B., Csapo, B., & Sheblanova, E. (1998). Ties that bind: Correlates of adolescents' civic commitments in seven countries. Journal of Social Issues, 54(3), 457-475.

2. A right to good health by having our social, emotional, mental, physical, and spiritual needs met

Introduction

The link to youth's well-being

The social, emotional, mental, physical, and spiritual needs of youth are influenced by several complex and inter-related factors. For example, youth that are overweight may face social isolation or teasing, which reduces the likelihood that their social needs will be met. Additionally, youth who are experiencing a mental illness may be less able or less willing to participate in physical activity initiatives, decreasing the likelihood that their physical health needs will be met. Recognizing the interconnectedness of all areas of health, it is important to keep in mind how declines in one area of health may result in associated declines in other areas.

Mental health is an important aspect of overall health and development of youth. Most mental illnesses manifest in adolescence and early adulthood, and affect the health of individuals throughout their lifespan.[1] Positive mental health decreases the likelihood that youth will leave school early, which then leads to better income potential and higher levels of resilience.[2] Conversely, mental illness increases the likelihood of poverty and unemployment later on in life.[3] Mental illnesses also contribute to certain physical health problems, such as heart disease and chronic respiratory conditions.[4] Mental illnesses affect physical health through their impact on hormonal balances, sleep cycles, immune system functioning and the potential side effects (e.g., weight gain and irregular heart rhythms) of medications used to treat mental illnesses.[5] It is important to note, however, that the absence of mental illness does not necessarily imply positive mental health status. As such, factors that incorporate aspects of social and emotional health, such as sense of satisfaction, personal power, self-esteem, and sense of belonging, are often used as measures of an individual's mental health status, with higher levels of these indicators associated with a higher level of positive mental health.[6] Adolescence is an important time of development for social and emotional well-being. Among youth, suicide, depression, stress, anxiety, self-harm, and eating disorders are of particular concern.[7] Recognizing these problems during these years of development is especially important as early interventions and support are critical to improving and maintaining mental health.[8]

Physical health encompasses several important areas of health including healthy weights, active transport, healthy eating, physical activity, substance use, and sexual health, all of which can also be influenced by other areas of health. Levels of physical activity and access to nutritious foods impact the risk of obesity by shaping an individual's behaviours, perceptions, and knowledge regarding healthy weights and healthy lifestyles.[9] Across Canada, rates of obesity are increasing among all age groups, with obesity rates more than tripling, from 3% to 11%, between 1978/79 and 2007/09 among youth.[10, 11] Youth who are overweight or obese have a greater risk of developing certain chronic diseases, including cancer, cardiovascular disease, and type 2 diabetes.[12] Physical activity plays a critical role in maintaining healthy weights; increased levels of sedentary activity such as screen time greatly heighten the likelihood of obesity.[13] Among Canadian youth, the percentage of those who spend an average of 15 hours or more per week participating in sedentary

activities increased from 65% to 76% between 2000/01 to 2009.[14, 15] Active transport (e.g., walking, cycling, and using other non-motorized vehicles), particularly to and from school, is an important source of physical activity among youth. Considering that physical activity levels decrease through adolescence and that physical activity patterns developed in childhood are strong predictors of adult activity levels, encouraging youth to participate in active school transport can have a lifelong impact on physical activity levels.[16] Currently, over half of children in Canada, ages 5 to 17, rely on inactive modes of school transportation.[17] Eating habits also contribute to an individual's weight. In many cases, Canadian youth make poor nutritional choices, which leads to both dietary excesses and inadequacies.[18] Throughout adolescence, dietary quality declines with age, while the likelihood of skipping meals increases.[19] Some evidence suggests that Canadian youth are increasing their fruit and vegetable consumption, but at the same time the consumption of high-fat and high-sugar snack foods remains high.[20]

Adolescence is a time where exposure to substance use begins and occurs at high rates compared to other stages of development. One of the strongest correlates of drug use is age; with progressively increasing rates of drug use occurring as youth progress through this stage of development, typically peaking at age 16 and 17.[21] While experimenting with certain substances may be perceived as part of the transition to adulthood for many youth, it can lead to substance use problems and negatively impact physical, social, emotional, spiritual, and mental health.[22] Alcohol is the most common substance used by Canadian youth.[23] According to the 2009 Canadian Community Health Survey (CCHS), 70% of youth, ages 15 to 19, had consumed alcohol in the last year, with 48% consuming it regularly (at least two to three times each month).[24] In a 2009 survey, 18% of individuals age 15 to 29 reported at least one adverse outcome of alcohol consumption in the last year, with 29% of those being female youth, ages 15 to 19.[25] These outcomes included negative effects on physical health, learning abilities, social life, finances, home life, work, study, and/or employment opportunities. Violence, unprotected sexual intercourse, and self-harm were also associated with alcohol consumption.

In addition to the negative health impacts of alcohol use, the health implications of tobacco use are widely known; however, rates of tobacco use remain substantial among youth.[26] Approximately 87% of smokers begin smoking before the end of their teens, with 13% of youth currently smoking. While there has been a gradual decline in rates of tobacco use among youth, it remains a serious public health concern. Youth who do not smoke are also at risk for the negative health outcomes associated with second-hand exposure as they are less able to control their exposure both at home and among peers.

Drug use among youth is also of concern. While cannabis is the most widely used illicit drug among Canadian youth (27% of youth, ages 15 to 19, in 2009), abuse of cocaine, hallucinogens, and ecstasy also usually begins during adolescence. Cannabis can result in many short- and long-term health outcomes including increases in heart rate, respiratory distress, and risk of lung cancer, and decreases in blood pressure, concentration, reaction time, depth perception, information processing, and memory capacity. The 2011 Ontario Student Drug Use and Health Survey (OSDUHS) found that the non-medical use of prescription opioid pain relievers (e.g., Tylenol #3, codeine, Percocet, Percodan, and Demerol) ranked just after cannabis use. Not only is this concerning due to the addictive properties of opioids, but when used with other depressant drugs (e.g., alcohol), it can slow breathing and possibly result in death.[27] Other illicit drugs can also result in severe negative health outcomes, such as panic attacks, paranoia, violent behaviour, convulsions, and increased blood pressure. Long-term use of drugs, such as cocaine, hallucinogens, and ecstasy, can result in psychosis, impaired brain function, and lung or nasal tissue damage. The addictive properties of these drugs can also interfere with school/work performance, lead to social isolation, and, in extreme cases, result in death. An important public health consideration is the overlap between alcohol/drug use and mental health problems among youth. The 2011 OSDUHS found that approximately 9% of students who reported hazardous/harmful drinking

also reported elevated symptoms related to anxiety and depression, with up to 16% reporting both outcomes by grade 12.[28]

Sexual health is another important health issue emerging during the adolescent years. In 2009, the average age of engaging in sexual intercourse for the first time was 16 years of age among youth and young adults. Sexually active youth may engage in sexual behaviours that increase their risk for negative health outcomes, such as sexually transmitted infections (STIs) or unplanned pregnancies. Youth may lack the maturity or knowledge of the consequences of their behaviours and may not have access to resources to prevent STIs and unplanned pregnancies. STIs can have long-lasting health impacts including cervical, anal, and penile cancers. For women in particular, STIs can result in pelvic inflammatory disease, miscarriages, ectopic pregnancies, and low birth weight babies. Of youth, ages 15 to 19, who reported having sexual intercourse in the last year, 37% reported having more than one partner and 25% reported not using a condom during their last sexual experience.[29]

In addition to the mental and physical aspects of health among youth, spiritual health plays an important role in youth development. Spirituality encompasses an individual's beliefs, practices, and experiences, which are distinct from, albeit related to, religious doctrine or ritual. Religion is socially constructed; whereas spirituality is individually determined.[30] Spirituality has been associated with positive emotions, such as happiness, as well as positive physical and mental well-being.[31] Academic literature suggests that spirituality may influence positive youth development through four processes: (1) developing life goals, purpose, and compassion; (2) connecting an individual's life goals with ideals and narratives; (3) increasing an individual's awareness of his/her potential and possibility; and (4) understanding the interconnectedness of oneself, others, and the environment.[32]

Indicators of youth's health and well-being in this chapter

Local data presented in this chapter are reflective of the physical, emotional, mental, social, and spiritual well-being of youth in Wellington, Dufferin, and Guelph. Data regarding more specific aspects of each of these areas of health are also presented throughout other chapters of this report. For example, *Chapter 6: A right to quality time with our friends, family, and/or other positive mentors in our community* discusses *Positive Peer Influences* and *Family Support*, which relates to both social and emotional health. This chapter contains local data specific to indicators that have been organized according to the following aspects of adolescent physical, emotional, mental, social, and spiritual well-being:

- Mental health
- Physical health
- Healthy eating
- Physical activity
- Healthy weights
- Alcohol, drug, and tobacco use
- Hospitalizations
- Dental health
- Immunizations
- Communicable diseases

The value of this information to service providers

In order to create conditions that facilitate a healthy transition for youth into adulthood, service providers must continue to address the complex and interconnected areas of health and well-being. The health issues examined in this chapter will give service providers a broad understanding of the issues affecting youth in our community today. Through this understanding, programs can be tailored to improve health disparities and focus on the most critical aspects of health and well-being.

According to the Chief Public Health Officer's 2011 *Report on the State of Public Health in Canada*, Canadian service providers must focus on the following key areas to improve health outcomes for youth and young adults:

- Improving and making better use of population and program evidence
- Increasing education and awareness
- Building and maintaining supportive and caring environments
- Approaching problems from all sides with co-ordinated, multi-pronged, inter-sectoral action

This chapter includes local data specific to youth, ages 14 to 18, from many different sources. The data summarized along with relevant information from the literature aims to give service providers the information necessary to understand potential health disparities within this population and understand priority areas for data required to address the social, emotional, mental, physical and spiritual needs of youth in our community.

Mental health

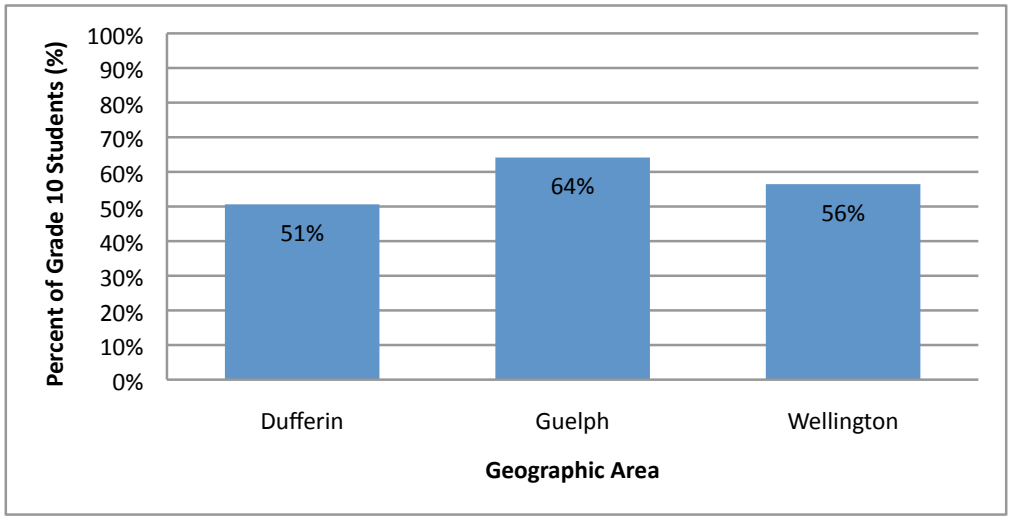
As discussed in the introduction, many mental health illnesses manifest during the adolescent years and may impact an individual's quality of life and overall health and well-being throughout their entire lifespan.[33] There are many demands and potential stressors placed on youth during this time of development, such as school expectations, employment opportunities, preparing for post-secondary education or careers, family, peer and partner relationships, and increasing independence. Early interventions and supports are critical to improving and maintaining mental health to reduce negative impacts.[34] As a result, it is critical that mental health illnesses be identified, diagnosed, and treated as early as possible. It is important that service providers have access to up-to-date information to better inform their services.

The Wellington-Dufferin-Guelph (WDG) Youth Survey asked several question related to mental health that provide us with a better understanding of the prevalence of youth who may be at-risk or experiencing mental health illnesses in our community. The WDG Youth Survey also provides information on youth who may be experiencing positive mental health, through measures of self-esteem, personal power, and positive mental health. There are also other social and emotional health indicators explored in other chapters in the Report Card that may have a role to play in overall mental health.

The first mental health indicator from the WDG Youth Survey that will be examined is *Self-Esteem*. The survey asked youth three questions about how often they feel good about themselves, how often they feel proud of themselves, and how often they are happy, which together provides a measure of *Self-Esteem*. Research has found that high levels of self-esteem are important for supporting the development of positive health-related behaviours and resilience.[35] Furthermore, low self-esteem has been associated with risky health behaviours (e.g., illicit drug use), poor physical health, and poor school and personal achievement.[36]

Analysis of the results found that there was a statistically significant relationship between geographic area and *Self-Esteem* among grade 10 students in Wellington, Dufferin, and Guelph. Figure 2.1 illustrates that there were more grade 10 students in Guelph (64%) who reported high levels of *Self-Esteem* compared to grade 10 students in Wellington (56%) and Dufferin (51%).

Figure 2.1 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting high levels of *Self-Esteem*, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

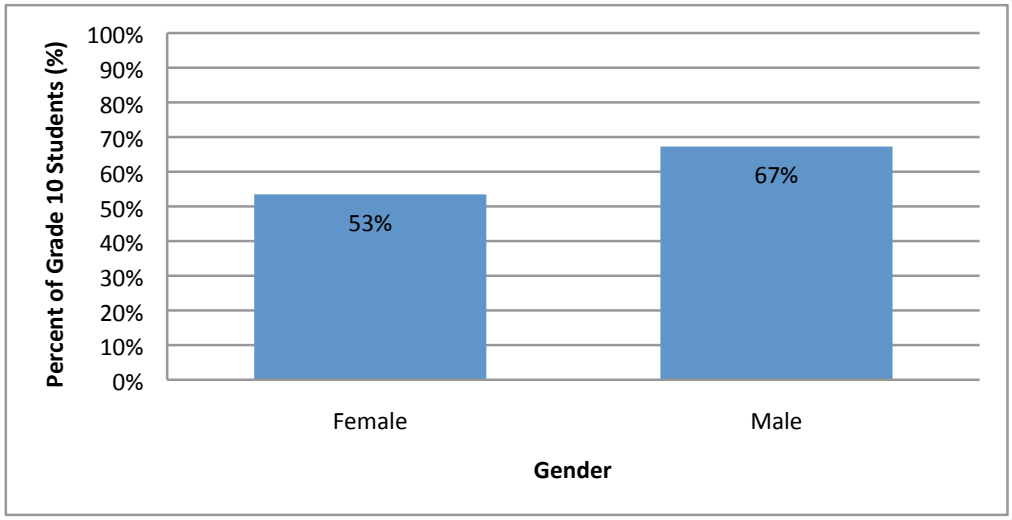
Note: 59 students (5%) did not complete the survey questions for Self-Esteem.

In Wellington, Dufferin, and Guelph, there appears to be an urban versus rural effect for *Self-Esteem*. There is limited research that specifically explores the relationship between adolescent self-esteem and place of residence. One study did find a significant interaction between self-esteem and both gender and urbanicity, with rural males reporting the highest levels of self-esteem.[37] This study found the opposite association between self-esteem and geographic location when compared to our local results. There are many important social variables related to self-esteem, such as race and socioeconomic status, that may help to explain these geographic differences; however, these variables go beyond the scope of the current analysis.

The 2009 Ontario Student Drug Use Survey (OSDUS) found that 9 out of 10 students in grade 7 to 12 reported high self-esteem. This is much higher than the percentages found for grade 10 students within our community. These differences should be interpreted with caution, as the 2009 OSDUS sample includes grades 7 to 12, instead of just grade 10 students, so it is not a completely comparable sample. Furthermore, the survey questions used to measure self-esteem on the 2009 OSDUS differ from the WDG Youth Survey.

The analysis also found a statistically significant relationship between gender and *Self-Esteem*. As illustrated in Figure 2.2, more male (67%) grade 10 students in Wellington, Dufferin, and Guelph reported high levels of *Self-Esteem* compared to females (53%). This is consistent with other research that has examined self-esteem among youth, with males reporting higher self-esteem than females.[38] The 2011 OSDUS found similar findings, where significantly more female youth reported low self-esteem compared to males.[39]

Figure 2.2 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting high levels of *Self-Esteem*, by gender, 2012**



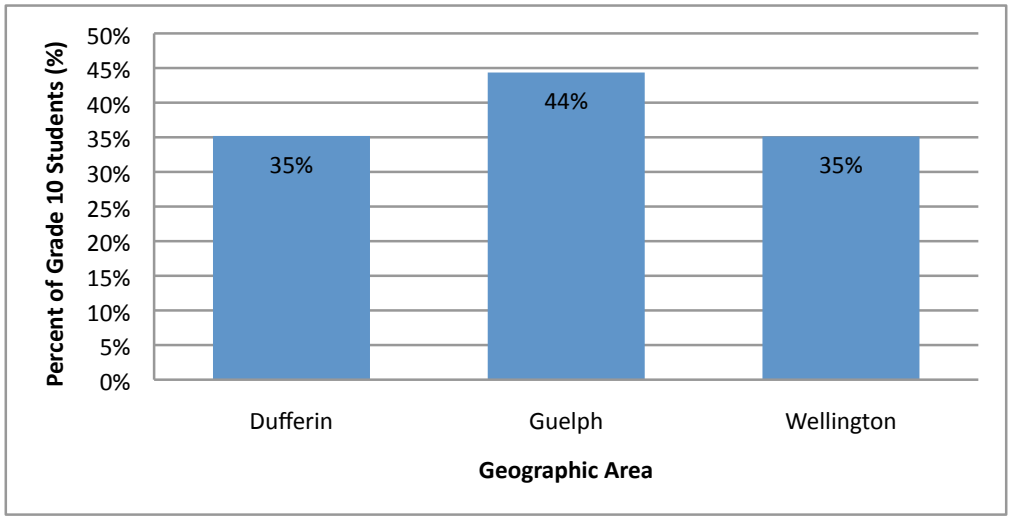
Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 59 students (5%) did not complete the survey questions for Self-Esteem.

The WDG Youth Survey asked youth two questions that provided a measure of *Positive View of their Personal Future*: 1) how often they feel good about their future, and 2) how strongly they feel that school will help them get where they want to be in the future. This is an important construct of mental health. Having a positive and realistic view of their future is necessary for youth to make a successful transition into adulthood.[40] The analysis found that there was no statistically significant relationship between geographic area and *Positive View of their Personal Future* or gender and *Positive View of their Personal Future* among grade 10 students. In Wellington, Dufferin, and Guelph, 71% of students in grade 10 reported having a *Positive View of their Personal Future*.

The WDG Youth Survey included questions that provided a measure of *Personal Power*. This indicator included the responses from three questions about how often youth deal with frustrations in positive ways, overcome challenges/problems in positive ways, and feel in control of their life. The construct of *Personal Power*, or personal control, has been found to be highly correlated to self-esteem.[41] Therefore, it is not surprising that the analysis of *Personal Power* similarly showed a statistically significant effect of geographic area and prevalence as *Self-Esteem*. As illustrated in Figure 2.3, more grade 10 students in Guelph reported high levels of *Personal Power* (44%) compared to grade 10 students in Dufferin (35%) and Wellington (35%).

Figure 2.3 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting high levels of *Personal Power*, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

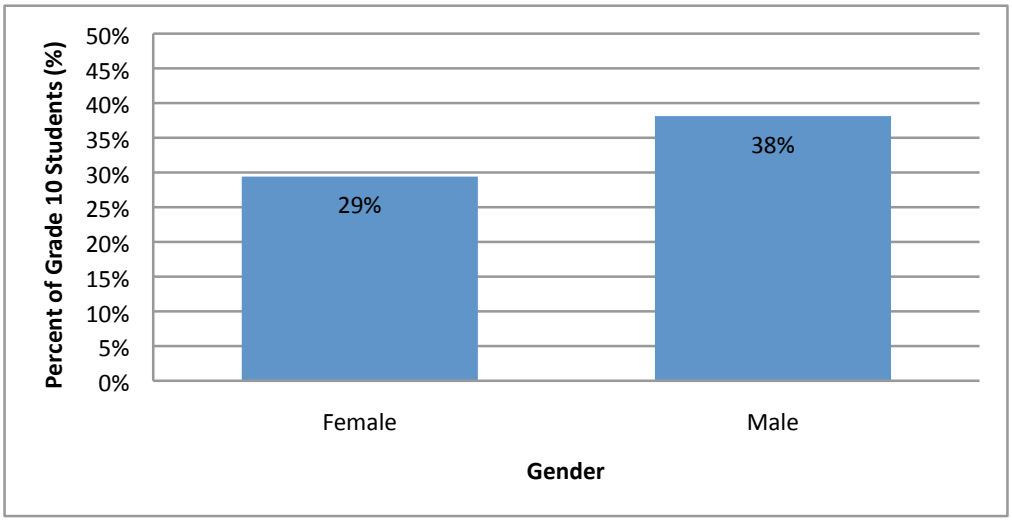
Note: 71 students (6%) did not complete the survey questions for Personal Power.

Unlike the *Self-Esteem* indicator, there was no statistically significant relationship between gender and *Personal Power*.

The WDG Youth Survey also provides a measure of *Positive Mental Health*. This indicator takes into consideration many aspects of how youth feel about themselves and their future and how they cope with potential stressors. The responses to seven questions from the survey contribute to the *Positive Mental Health* indicator, asking youth if they: 1) deal with frustrations in positive ways, 2) overcome challenges/problems in positive ways, 3) feel good about themselves, 4) feel proud of themselves, 5) feel in control of their life, 6) feel good about their future, and 7) feel happy. Positive mental health is a critical and complex aspect of youth development. Positive mental health among youth can be influenced by the views of adolescents and others (e.g., peers, parents, teachers, etc.), their developmental status, and sociocultural factors. The development of skills that protect youth from stressors as well as skills that allow them to engage in meaningful activities are key dimensions of positive mental health for youth. These skills allow youth to feel in control and to feel good about themselves and their future.[42]

The analysis found that there was no statistically significant relationship between geographic area and *Positive Mental Health* among grade 10 students. In Wellington, Dufferin, and Guelph, 34% of students in grade 10 reported high levels of *Positive Mental Health*. However, as seen in many of the other mental health indicators presented in this chapter, there was a statistically significant relationship between gender and *Positive Mental Health*. More male grade 10 students (38%) in Wellington, Dufferin, and Guelph reported high levels of *Positive Mental Health* compared to female students (29%), as illustrated in Figure 2.4. This gender difference related to positive mental health is well established throughout the literature. As early as adolescence, females experience higher levels of internalizing disorders, such as self-blame, sense of hopelessness, and sense of helplessness to improve their situation, all of which contribute to negative feelings towards oneself and one's overall mental health.[43]

Figure 2.4 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting high levels of *Positive Mental Health*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

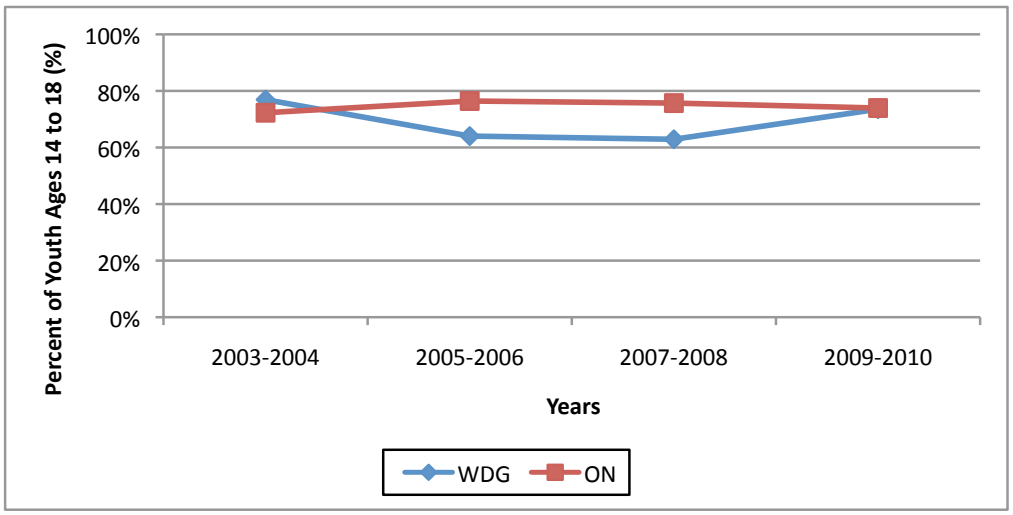
Note: 76 students (6%) did not complete the survey questions for Positive Mental Health.

The Canadian Community Health Survey (CCHS) also asks questions that provide a measure of mental health. An individual's self-assessment of their mental health is a commonly used measure of mental health. Figure 2.5 examines the percentage of youth, ages 14 to 18, who reported *Very Good* or *Excellent* on the *Self-Rated Mental Health* indicator of the CCHS. These data contribute to our understanding of mental health among our local youth, while providing a provincial comparator. Contrary to findings from the WDG Youth Survey and other research [44], the analysis revealed that there was no statistically significant difference between male and female youth, ages 14 to 18, for *Very Good* or *Excellent Self-Rated Mental Health*. There is also no trend over time for youth, ages 14 to 18, in Wellington, Dufferin, and Guelph and Ontario. As illustrated in Figure 2.5, in 2005-2006 and 2007-2008, the percentage of youth in Wellington, Dufferin, and Guelph, ages 14 to 18, with *Very Good* to *Excellent Self-Rate Mental Health* is lower compared to the Ontario-wide percentage; however, the Wellington, Dufferin, and Guelph and Ontario percentages are comparable in 2009-2010.

Canadian Community Health Survey

The Canadian Community Health Survey (CCHS) is a valuable source of population-level data for youth ages 12 and over. Several health-related indicators from the CCHS were examined and analysed using complex statistical methods. Only those indicators that meet Statistics Canada release requirements and demonstrate meaningful trends or differences are included in this Report Card. CCHS indicators are summarized throughout this chapter and Chapter 7.

Figure 2.5 **Percentage of youth, ages 14 to 18, with *Very Good* or *Excellent Self-Rated Mental Health*, Wellington, Dufferin, and Guelph and Ontario, by geographic area, 2003-2004 to 2009-2010**

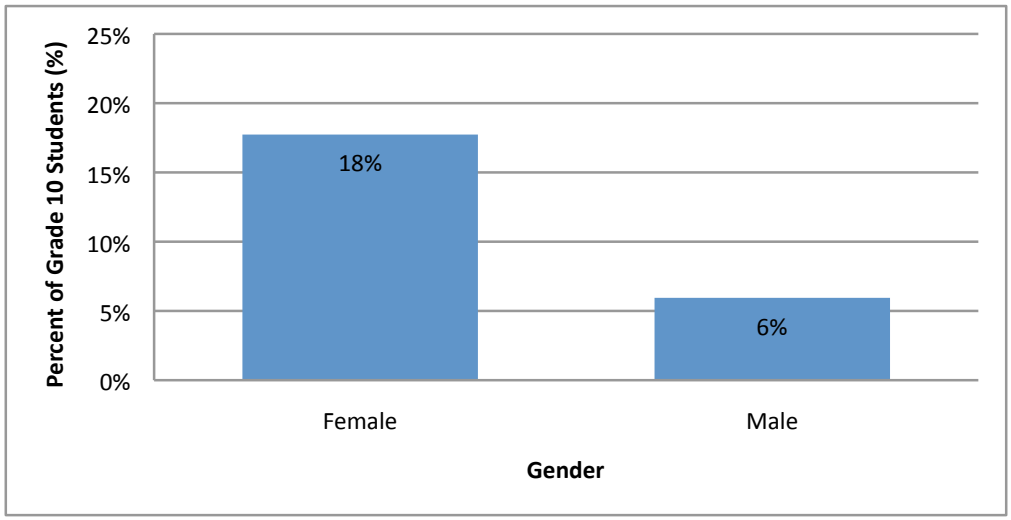


Source: *Canadian Community Health Survey Very Good to Excellent Self-Rated Mental Health, GEN-14.*

Another way of examining youth mental health is to look at youth who may be at-risk for mental health problems. In order to provide a measure of youth's risk for depression, the WDG Youth Survey included four questions that asked youth about how often in the last seven days they felt: 1) sad, 2) lonely, 3) depressed, and 4) like crying. Analysis of the WDG Youth Survey results revealed that there was no statistically significant relationship between geographic area and risk for depression among grade 10 students. In Wellington, Dufferin, and Guelph, responses from 12% of students in grade 10 indicated that they were at risk for depression.

There was, however, a statistically significant relationship between gender and *At Risk For Depression* among grade 10 students in Wellington, Dufferin, and Guelph. As depicted in Figure 2.6, there were more female (18%) grade 10 students at risk for depression compared to male (6%) grade 10 students. This gender difference for depression is well established in the literature. A study that examined national longitudinal panel data from three countries, Canada (e.g., Canadian National Population Health Survey), Great Britain, and the United States found that females have significantly higher rates of depression. Across each of the national samples, the gender gap for depression consistently emerges at age 14.[45]

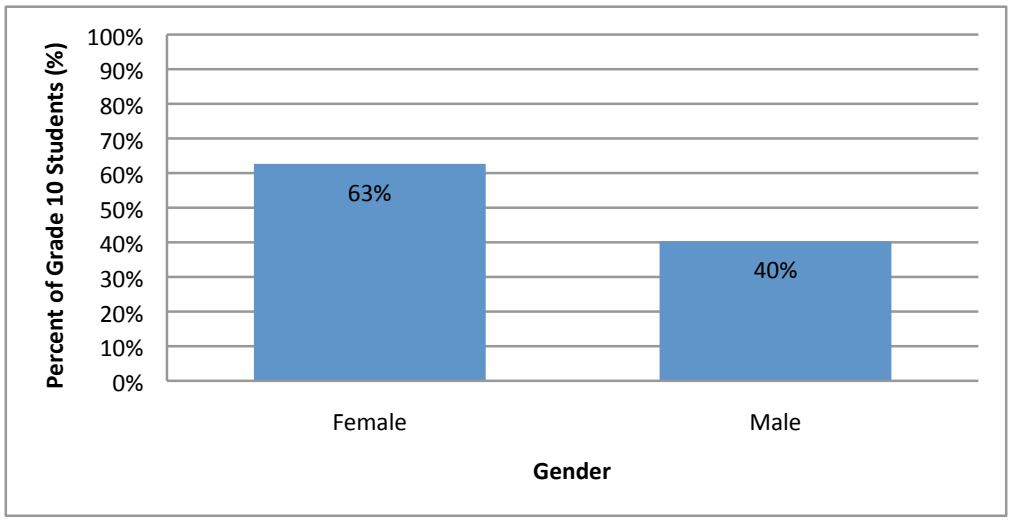
Figure 2.6 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph *At Risk for Depression*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 67 students (5%) did not complete the survey questions for At Risk for Depression.

Figure 2.7 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting they have *Too Many Problems* in their life, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 59 students (5%) did not complete the survey questions for Too Many Problems.

The WDG Youth Survey also asked youth about how often they felt they had too many problems in their life, thought about harming themselves, and seriously thought about suicide in the last 12 months. Only responses of "sometimes", "often" or "always" were amalgamated and analysed.

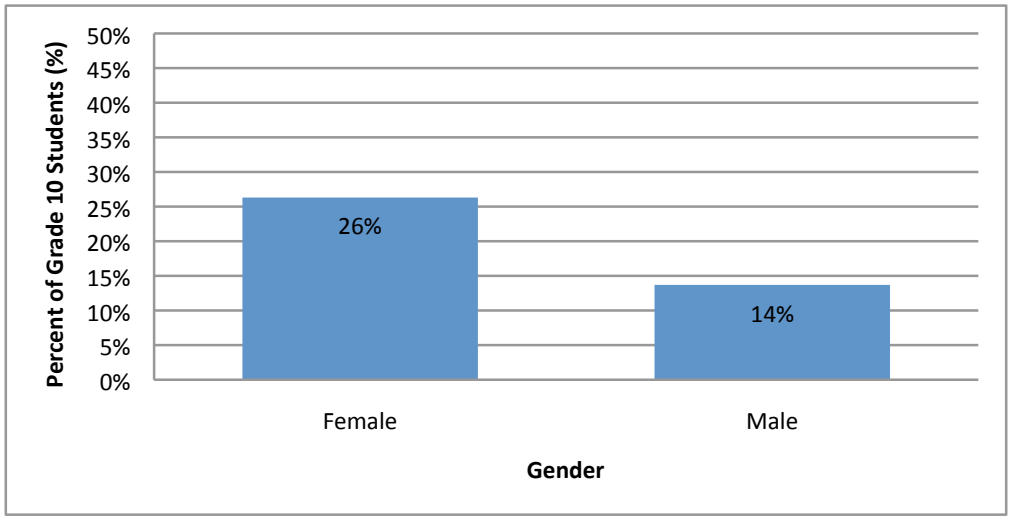
There was no statistically significant relationship between geographic area and *Too Many Problems*. In Wellington, Dufferin, and Guelph, 52% of grade 10 students reported that they felt they had too many problems in their life in the last 12 months.

There was a statistically significant relationship between gender and *Too Many Problems*. Figure 2.7 illustrates that more female (63%) grade 10 students felt like they had too many problems in their life in the last 12 months compared to the proportion of males (40%). This indicator follows the same gender trend as the other mental health indicators examined in this chapter. The higher rate of female students reporting too many problems may be explained by the finding that female adolescents experience a greater sense of helplessness and negative feelings towards themselves compared to males.[46]

Self-harm is an important measure of mental health among youth, as the initiation of self-harm usually occurs during the adolescent years, specifically ages 12 to 15.[47, 48] Often, self-harm is used by youth to cope with overwhelming negative emotions, or to induce emotions when they are lacking or absent.[49, 50, 51] There was no statistically significant relationship between geographic area and grade 10 students who reported thoughts of *Self-Harm* in the last 12 months. In Wellington, Dufferin, and Guelph, 20% of grade 10 students reported thoughts of *Self-Harm* in the last 12 months. This percentage seems alarming, given the severe nature of this coping strategy and the risk of these behaviours leading to suicide attempts. Our local percentage of *Self-Harm* is comparable to reports in other communities, with 17% of youth, ages 14 to 21, in British Columbia reporting that they had intentionally harmed themselves. In this report, the average age of initiation of self-harm was 15 years.[52]

Results of the WDG Youth Survey found that there was a statistically significant relationship between gender and *Self-Harm*, with more female (26%) grade 10 students who reported thoughts of *Self-Harm* in the last 12 months compared to males (14%) (Figure 2.8). This is consistent with trends in hospitalizations due to self-injury among Canadian youth. The rate of hospitalization due to self-injury was highest among female youth, ages 15 to 19, with 140 hospitalizations per 100,000 population, compared to 60 per 100,000 population among males.[53, 54]

Figure 2.8 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting thoughts of *Self-Harm*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 64 students (5%) did not complete the survey questions for thoughts of harming themselves.

Youth who engage in self-harm behaviours are at a greater risk for attempting and/or committing suicide later in life.[55] The WDG Youth Survey analysis revealed that there was no statistically significant relationship between *Serious Thoughts of Suicide* in the last 12 months and geographic area or gender. Overall, in Wellington, Dufferin, and Guelph, 13% of grade 10 students reported *Serious Thoughts of Suicide* in the last 12 months. This local percentage is slightly higher compared to the 7% of Canadian youth, ages 15 to 19, that reported thoughts of suicide in the past 12 months in the CCHS.[56, 57]

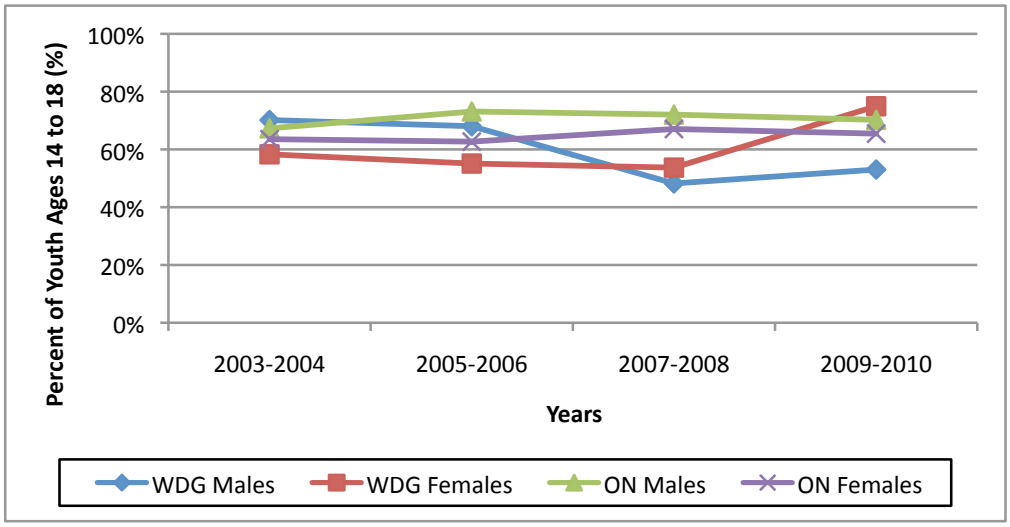
Overall, the hope is that these local data related to mental health will help to inform services and programs targeting youth to address the most important mental health concerns. As a result, local efforts may more effectively prevent mental health issues, respond to youth experiencing mental health illnesses and crises, and promote overall mental health and well-being. Schools can also play a critical role in the mental health of youth by increasing awareness of mental health issues, preventing stigma, and engaging in early identification. Programs that address these aspects of mental health should target multiple components of health, be sustainable over time, start early and focus on cognition and relationship-building, and be age-appropriate as well as culturally and gender-sensitive.[58]

Physical health

The CCHS also provides a measure of overall physical health. Figure 2.9 summarizes data specific to youth, ages 14 to 18, who rate their health as *Very Good* or *Excellent*. Findings from the 2007-2008 CCHS indicate that 68% of Canadian youth ages 12 to 19 perceive their health as *Very Good* or *Excellent*. While youth may have lower rates of mortality and fewer chronic conditions, compared to adults, youth ages 12 to 19, experience higher rates of injuries, increasing rates of obesity, and the highest rates of sexually transmitted infections. These issues are particularly concerning when experienced by youth, given the negative impact on their future health.[59]

Similar to the *Self-Rated Mental Health* indicator (Figure 2.5), there is no consistent trend with regards to *Very Good* or *Excellent Self-Rated Health* among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph, or in Ontario. There is, however, a statistically significant difference in the percentages of males and females that reported *Very Good* or *Excellent Self-Rated Health*. As a result, data is differentiated by gender in Figure 2.9. Among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph, the percentage of males reporting *Very Good* or *Excellent Self-Rated Health* was higher than females during 2003-2004 and 2005-2006, but then decreased to be lower than females in 2007-2008 and 2009-2010 (Figure 2.9). The difference in the percentages of males and females, ages 14 to 18, in Wellington, Dufferin, and Guelph reporting *Very Good* or *Excellent Self-Rated Health* was quite small during 2007-2008 (approx. 6%), but grew to over 20% in 2009-2010.

Figure 2.9 **Percentage of youth, ages 14 to 18, with *Very Good* or *Excellent Self-Rated Health*, Wellington, Dufferin, and Guelph, and Ontario, by gender, 2003-2004 to 2009-2010**



Source: *Canadian Community Health Survey, Very Good to Excellent Self-Rated Health, GEN-13*

In Ontario, the percentage of male youth, ages 14 to 18, who reported *Very Good* or *Excellent Self-Rated Health* remains slightly higher than females from 2003-2004 to 2009-2010 (Figure 2.9). It is also interesting to compare the differences in *Self-Rated Health* between youth, ages 14 to 18, in Wellington, Dufferin, and Guelph and Ontario (Figure 2.9). In 2009-2010, the percentage of male youth, ages 14 to 18, in Wellington, Dufferin, and Guelph who reported *Very Good* or *Excellent Self-Rated Health* was approximately 15% lower than males in Ontario. During this same time, the percentage of female youth, ages 14 to 18, in Wellington, Dufferin, and Guelph reporting *Very Good* or *Excellent Self-Rated Health* was 10% higher than that of Ontario females.

Healthy eating

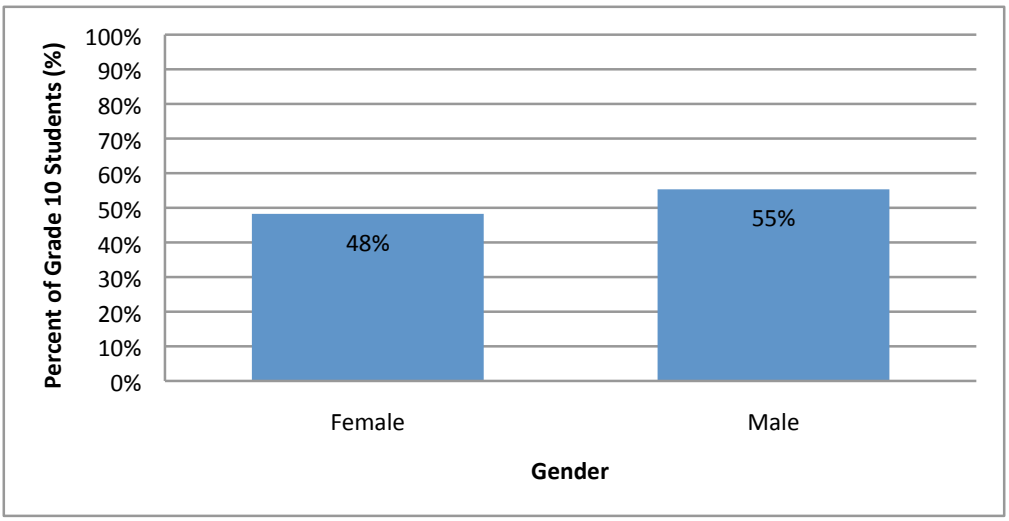
Another important component of adolescents' physical health and development is healthy eating. Throughout adolescence, dietary quality declines with age, while the likelihood of skipping meals increases.[60] Many studies have examined the impact of breakfast consumption on adolescent health and development. Students who eat breakfast have been found to be more likely to maintain a healthy body weight and are able to perform better in school.[61] Skipping breakfast has been linked to other health-compromising outcomes, such as poor energy levels and cognitive performance.[62] It has also been associated with risk-taking behaviours among adolescents, including tobacco, alcohol and substance use, increased snacking, and sedentary lifestyle.[63] Research has found that an effective way to increase access to breakfast is through school breakfast programs. These programs have been found to improve school attendance and improve cognitive functioning and academic performance for those who are undernourished.[64]

The WDG Youth Survey asked youth how often they eat breakfast in a usual school week (Monday to Friday). Youth who responded with "all five days" were considered to eat breakfast daily. Analysis of the WDG Youth Survey results revealed that there was no statistically significant relationship

between geographic area and eating breakfast daily among grade 10 students. In Wellington, Dufferin, and Guelph, 52% of students in grade 10 reported eating breakfast daily. This rate is comparable to findings from other studies. A study that examined the secondary school student response to the Centres for Disease Control and Prevention Youth Risk Behaviour Survey found that approximately 42% of students reported not eating breakfast within the past five days.[65]

The analysis of the WDG Youth Survey found that there was a statistically significant difference between gender and *Eating Breakfast Daily* among grade 10 students. Figure 2.10 illustrates that more male (55%) grade 10 students reported *Eating Breakfast Daily* compared to female (48%) grade 10 students. This finding is consistent with other research findings, where adolescent females are more likely to skip breakfast compared to males.[66]

Figure 2.10 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported *Eating Breakfast Daily*, by gender, 2012**

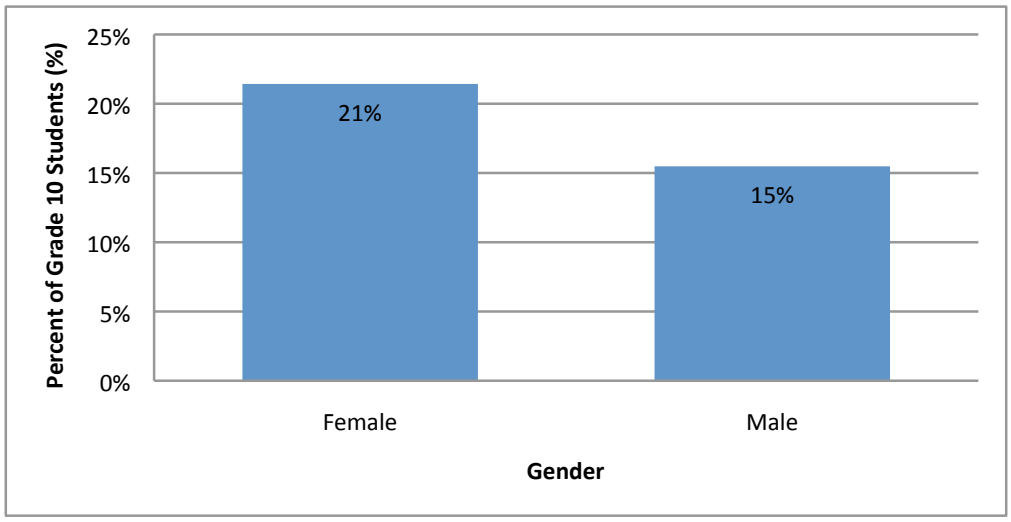


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 39 students (3%) did not complete the survey questions for how often they eat breakfast in a usual school week (Monday to Friday).

Another valuable way of interpreting this data is to examine the number of grade 10 students who reported *Never or Rarely Eating Breakfast* during a usual school week. Similar to the previous analysis of breakfast consumption, there was no statistically significant relationship between geographic area and *Never or Rarely Eating Breakfast* among grade 10 students. In Wellington, Dufferin, and Guelph, 19% of grade 10 students reported *Never or Rarely Eating Breakfast*. There was a statistically significant difference between gender and skipping breakfast among grade 10 students. Figure 2.11 illustrates that more female (21%) grade 10 students reported *Never or Rarely Eating Breakfast* compared to males (15%).

Figure 2.11 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported *Never* or *Rarely Eating Breakfast*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 39 students (3%) did not complete the survey question for how often they eat breakfast in a usual school week (Monday to Friday).

Physical activity

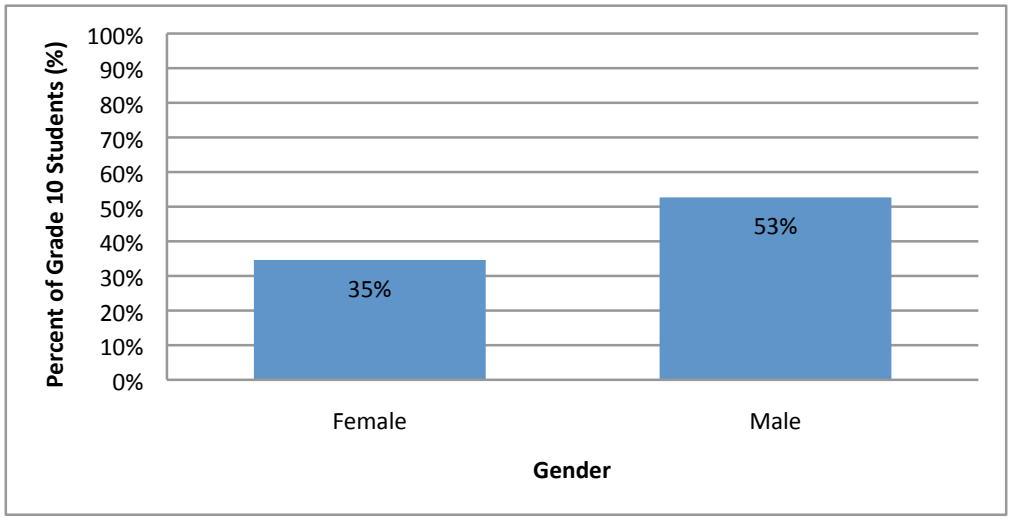
Physical activity plays a critical role in maintaining healthy weights, ensuring healthy development, supporting good mental health, and contributing to more positive health outcomes throughout the lifespan, including reduced risk for many chronic diseases.[67, 68] Studies have found that physical activity levels decline during the adolescent years.[69] Furthermore, physical activity behaviours that are established during adolescence often continue to endure throughout the adult years.[70] Many factors can impact youth involvement in physical activity such as the school environment, the built environment, access to recreational and organized sports, peer and parental influences, physical limitations (e.g., asthma, disability, etc.) and access to sedentary activities and screen time.[71, 72] Understanding these factors is necessary for informing effective intervention strategies.

At the time the WDG Youth Survey was adapted, the Canadian Physical Activity Guidelines recommended that youth engage in 90 minutes of physical activity per day, five days per week. Recently these guidelines have been revised. The revised guidelines recommend that youth ages 12 to 17 engage in 60 minutes of moderate-to-vigorous physical activity daily, which should include vigorous activity at least three days per week and strength building activity at least three days per week. The WDG Youth Survey asked youth how many days they are physically active for a total of at least 90 minutes per day over a typical week. As a result, analyses of the results are aligned with the previous guidelines. Youth were considered *Physically Active* if they responded that they were active for a total of at least 90 minutes per day, five to seven days per week.

The analysis revealed that there was no statistically significant relationship between geographic area and grade 10 students who reported being *Physically Active*. In Wellington, Dufferin, and Guelph, 43% of grade 10 students reported being *Physically Active*. There was a statistically significant relationship between gender and grade 10 students who reported being *Physically Active*. As seen in Figure 2.12, more

male (53%) grade 10 students reported being *Physically Active* compared to female (35%) grade 10 students. This is consistent with other findings in the literature. One of the most consistently supported findings related to demographic associations in adolescent physical activity levels is that adolescent males are more active than females.[73]

Figure 2.12 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported being *Physically Active*, by gender, 2012**

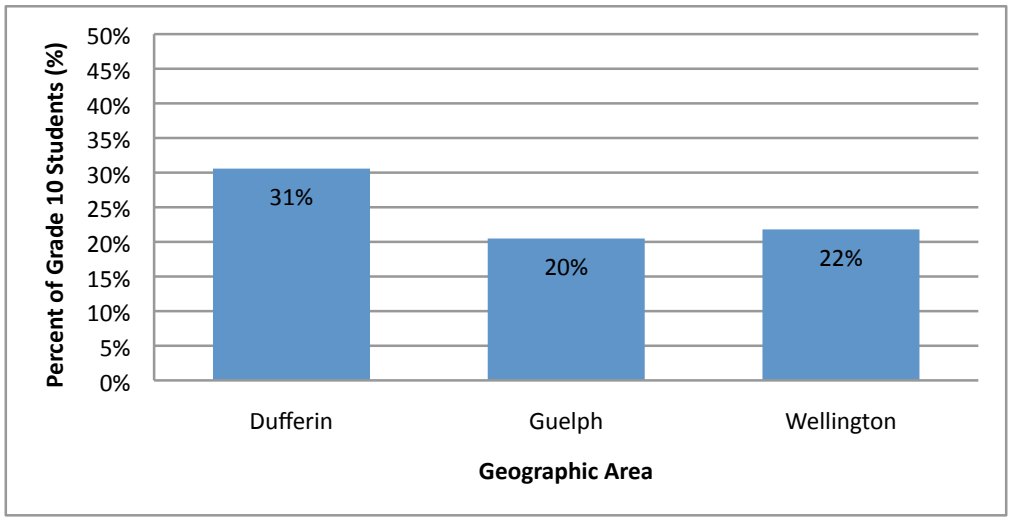


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 44 students (4%) did not complete the survey question for how many days they are physically active for a total of at least 90 minutes per day over a typical week.

Active transportation is an important form of physical activity for youth, especially to and from school. The WDG Youth Survey asked youth how often they walked (or biked or rollerbladed) to or from school in a usual school week (Monday to Friday). The analysis examined youth who reported walking, biking or rollerblading to or from school all five days. There was a statistically significant relationship between geographic area and grade 10 students who reported *Active Transportation*. Figure 2.13 illustrates that more grade 10 students in Dufferin (31%) used *Active Transportation* to or from school all five days compared to Guelph (20%) or Wellington (22%).

Figure 2.13 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who walk, bike or rollerblade to or from school every day, by geographic area, 2012**



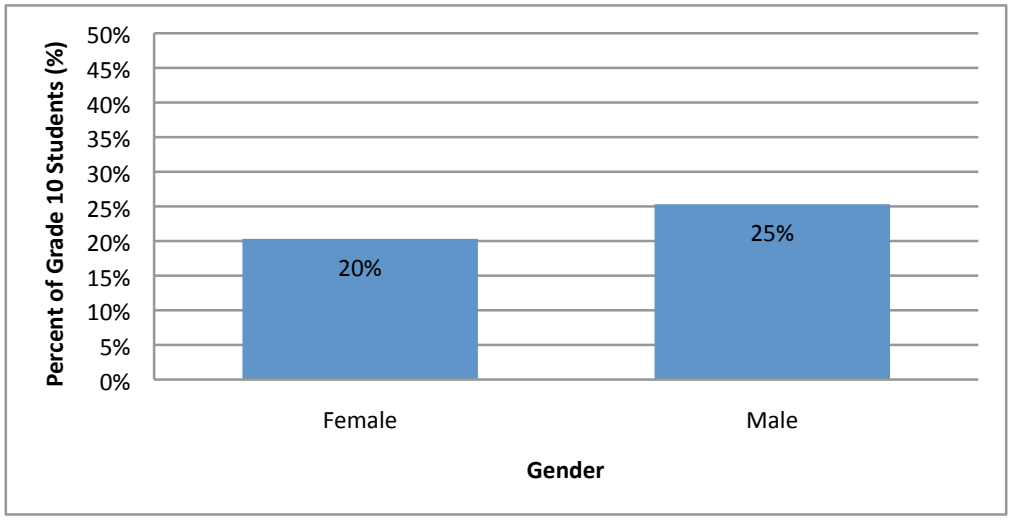
Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 40 students (3%) did not complete the survey question for how often they walk (or bike or rollerblade) to or from school in a usual school week (Monday to Friday).

This is an interesting finding, given that research has found that rural-dwelling youth are less likely to use an active form of transportation to school.[74] This has been largely attributed to the fact that rural communities have unique environmental and physical features (i.e., lack of sidewalks and bike lanes found in urbanized areas and greater distances to travel, making active transportation impractical) and social realities.[75] There are also many other factors influencing active transportation that may explain these geographic differences, including sociodemographic variables, community sociocultural characteristics, access to recreational space, and environmental, policy, and programmatic elements.[76, 77] Dufferin's rates may be largely influenced by the fact that all three secondary schools in Dufferin County are located within a town (Orangeville and Shelburne), making it possible for students who live in those towns to walk to school. The lower percentage of *Active Transportation* in the City of Guelph may be related to the fact that there are alternative transportation options available (i.e., public transit). Also, unlike rural areas, more parents may work within the City of Guelph, and are therefore able to drive their children to school on their way to work.

There was also a statistically significant relationship between gender and grade 10 students who reported *Active Transportation* to or from school all five days of a usual school week. Figure 2.14 indicates that more male (25%) grade 10 students used *Active Transportation* to or from school every day compared to females (20%). This is consistent with other research that has found that female children and youth are less likely to walk to or from school.[78]

Figure 2.14 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who walk, bike or rollerblade to or from school every day, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 40 students (3%) did not complete the survey question for how often they walk (or bike or rollerblade) to or from school in a usual school week (Monday to Friday).

The percentage of grade 10 students who *Never or Rarely use Active Transportation* to or from school in a usual school week was also examined. There was a statistically significant relationship between geographic area and the percentage of grade 10 students who *Never or Rarely use Active Transportation*. More grade 10 students in Wellington (64%) and Guelph (62%) reported *Never or Rarely use Active Transportation* compared to grade 10 students in Dufferin (46%). This is consistent with national rates, with over half of Canadian children and youth ages 5 to 17 relying on inactive modes of transportation to and from school.[79]

Healthy weights

As discussed in the previous sections, healthy eating and physical activity are necessary for maintaining healthy weights and preventing obesity. Other factors can influence healthy weights, including income and education level.[80] Ensuring healthy weights during the adolescent years is important given the negative health impacts associated with being overweight that can have lasting impact throughout the lifespan, such as chronic diseases.[81]

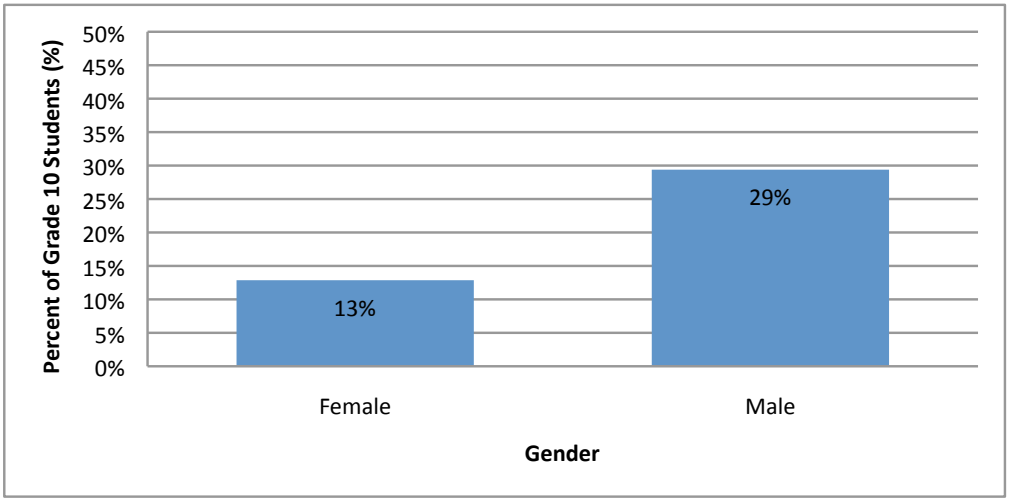
The WDG Youth Survey provides a measure of obesity by calculating the Body Mass Index (BMI) of students. The survey asked youth how tall they were without their shoes on (feet/inches or meter/centimeters) and how much they weighed without their shoes on (pounds or kilograms). As with any self-reported measure of height and weight, there are some limitations and biases. Research has found that adolescent respondents tend to underestimate their weight, which underestimates the prevalence of overweight and obesity.[82] It is also important to note that there were some data quality issues with the responses to these questions (e.g., reported weights and heights that were unrealistic) and, as a result, some of the responses were recorded as missing. Another relevant caution is the fact that this question had

the lowest response rate of any of the WDG Youth Survey questions.

The responses to the questions regarding height and weight were used to calculate each student's BMI. This calculation is comparable to how the Center for Disease Control and Prevention calculates BMI for children and youth, which takes into account age and gender. The results of the calculation classified youth as either *Normal Weight*, *Overweight*, or *Obese*. Analysis revealed that there was no statistically significant relationship between geographic area and grade 10 students considered to be overweight or obese. Overall, in Wellington, Dufferin, and Guelph, 21% of grade 10 students were considered to be *Overweight* or *Obese*. In Canada, according to the 2009 to 2011 Canadian Health Measures Survey, 30.1% of youth ages 12 to 17 were classified as overweight (19.9%) or obese (10.2%).[83]

There was a statistically significant relationship between gender and grade 10 students considered to be *Overweight* or *Obese*. As illustrated in Figure 2.15, there were more male (29%) grade 10 students considered to be *Overweight* or *Obese* compared to females (13%). The Canadian Health Measure Survey also found gender differences in the prevalence of obesity, with higher rates of overweight and obesity among male (29.6%) youth ages 12 to 17 compared to females (24.5%).[84] The percentage of grade 10 females in Wellington, Dufferin, and Guelph participating in the WDG Youth Survey who were considered *Overweight* or *Obese* (13%) was much lower than the Canadian percentage (24.5%).It is not anticipated that there are gender differences related to biases in self-reported height and weight information.[85] Comparable rates of overweight and obesity were found when examining the CCHS results related to BMI among youth, ages 14 to 18, in Wellington, Dufferin and Guelph.

Figure 2.15 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who were considered to be *Overweight* or *Obese*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 297 students (24%) did not complete the survey question for how tall they are without their shoes on and how much they weigh without their shoes.

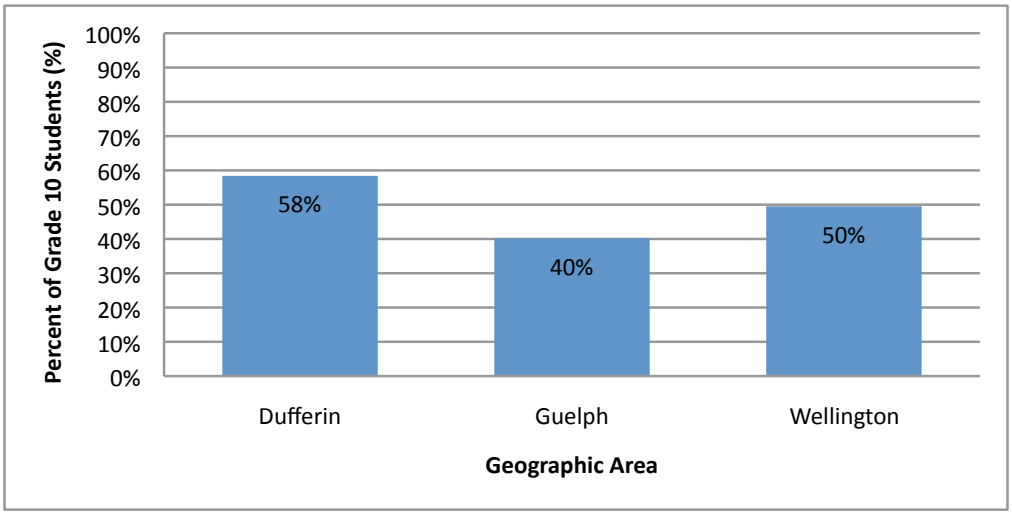
Alcohol, drug, and tobacco use

Alcohol, drug, and tobacco related indicators are important to examine among adolescents, given that this period of development typically marks the beginning of substance use.[86] Involvement in risk-taking behaviours, such as substance use, can have many negative impacts on overall health and well-being and may lead to future substance use problems.[87] Tobacco, alcohol, and cannabis have been found to be the most frequently used substances among Canadian youth.[88]

The WDG Youth Survey asked youth questions about their use of alcohol, tobacco, and cannabis. Alcohol is the most common substance used by Canadian youth.[89] On average, age 16 is the first time youth use alcohol.[90] Regular exposure to alcohol has been found to interfere with brain development, resulting in memory loss and other cognitive problems.[91] Alcohol exposure may also increase the likelihood of certain chronic diseases, including hypertension, stroke, and some cancers.[92] Additionally, binge drinking during youth is associated with anxiety, depression, and other mood disorders in adulthood.[93]

One of the WDG Youth Survey questions asked youth how often they had five or more alcoholic drinks on one occasion in the last 12 months. Analysis examined all youth who reported *At Least One Episode of Heavy Drinking in the Past 12 Months*. There was a statistically significant relationship between geographic area and *At Least One Episode of Heavy Drinking in the Past 12 Months*. Fewer grade 10 students in Guelph (40%) reported *At Least One Episode of Heavy Drinking in the Past 12 Months* compared to students in Wellington (50%) and Dufferin (58%) (Figure 2.16). There appears to be a higher prevalence of heavy drinking among youth living in rural communities compared to those living in urban areas. Other research has found a similar trend, with a greater proportion of rural youth binge drinking and using alcohol in the past month compared to their urban counterparts.[94, 95] Furthermore, rural youth reported more problems related to their alcohol use, such as drinking and driving, increasing the risks associated with alcohol use.[96]

Figure 2.16 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported At *Least One Episode of Heavy Drinking in the Past 12 Months*, by geographic area, 2012**

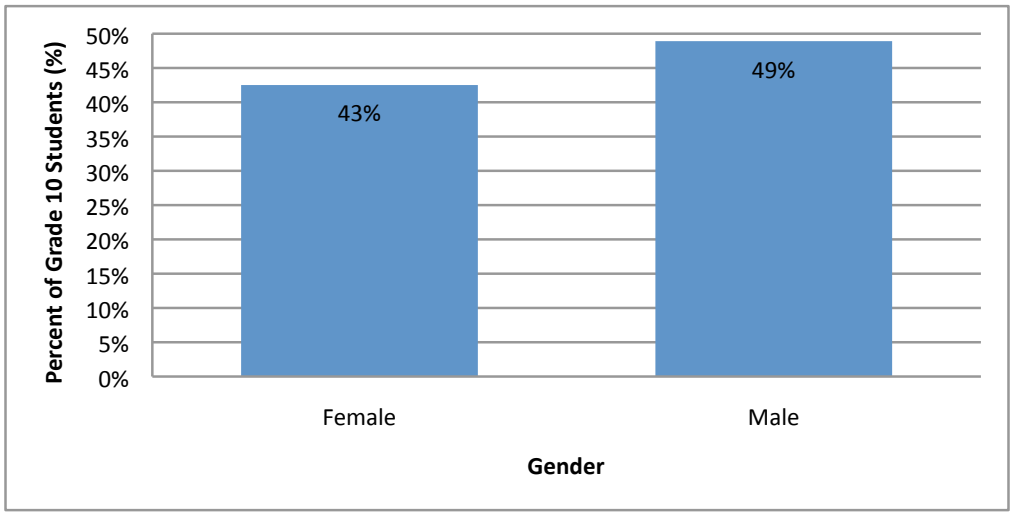


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 58 students (5%) did not complete the survey question for how often they had 5 or more alcoholic drinks on one occasion in the last 12 months.

There was also a statistically significant relationship between gender and at least one episode of heavy drinking the past 12 months. Figure 2.17 illustrates that more male (49%) grade 10 students reported *At Least One Episode of Heavy Drinking in the Past 12 Months* compared to females (43%). This is consistent with the trend in alcohol consumption among youth, with more adolescent males, ages 15 to 19, consuming five or more drinks at least once per week compared to adolescent females.[97]

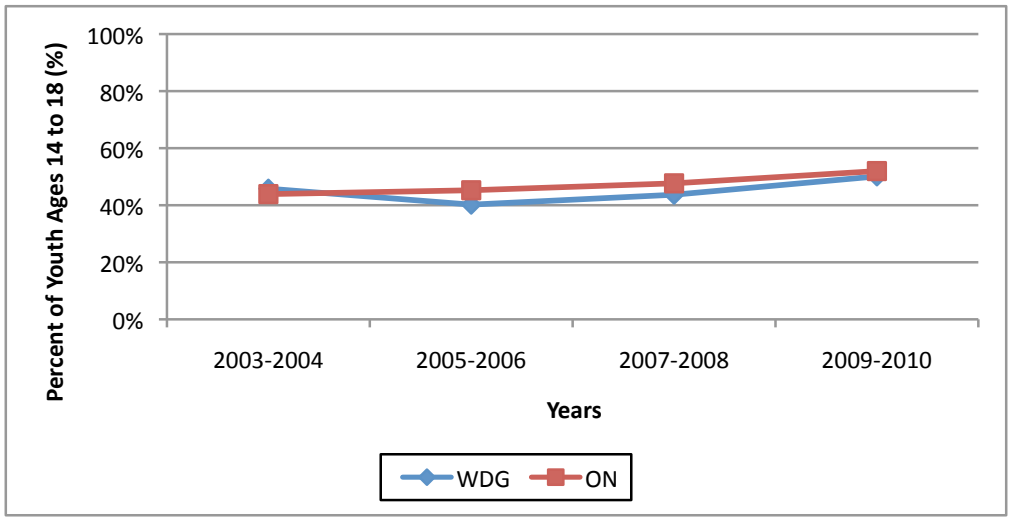
Figure 2.17 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported *At Least One Episode of Heavy Drinking in the Past 12 Months*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*
Note: 58 students (5%) did not complete the survey questions for how often they had 5 or more alcoholic drinks on one occasion in the last 12 months.

Alcohol use data from the CCHS adds to our understanding of alcohol consumption behaviours among youth in Wellington, Dufferin, and Guelph by collecting data on the percentage of youth, ages 14 to 18, who reported not drinking alcohol in the past 12 months.

Figure 2.18 **Percentage of youth, ages 14 to 18, who reported not drinking alcohol in the last 12 months, Wellington, Dufferin, and Guelph and Ontario, by geographic area, 2003-2004 to 2009-2010**



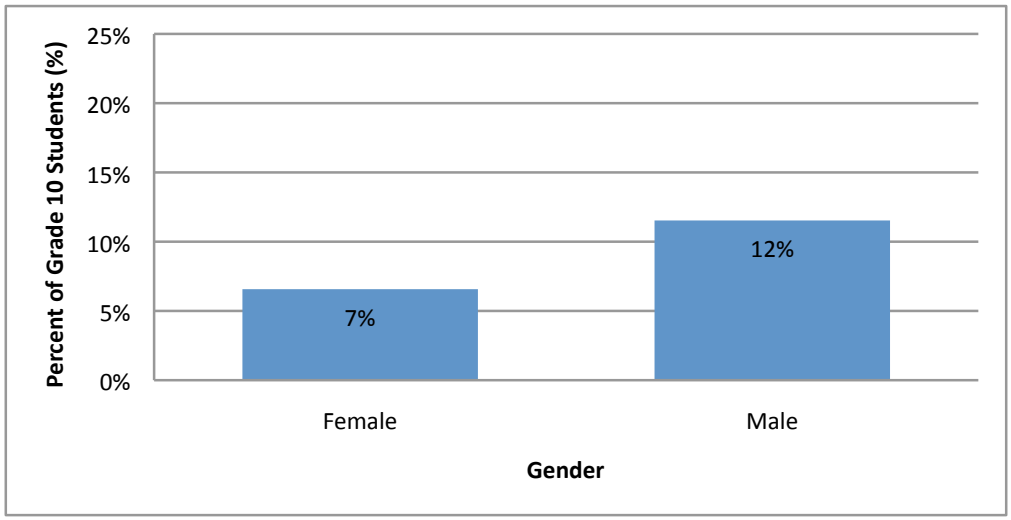
Source: *Canadian Community Health Survey, Did Not Drink Alcohol in Last 12 Months, ALC-1*

Analysis of the CCHS data revealed that there was no statistically significant difference between male and female youth, ages 14 to 18, for not drinking alcohol in the past 12 months. Examining Figure 2.18, there appears to be similar percentages and trends over time when comparing the percentage of youth, ages 14 to 18, who reported not drinking alcohol in the past 12 months in Wellington, Dufferin, and Guelph and Ontario. The trends for Wellington, Dufferin, and Guelph and Ontario converged during 2009-2010.

Smoking cigarettes is another important behaviour that is more likely to begin during adolescence. Research has found that there has been a decline in cigarette smoking among youth, ages 15 to 19, but given the negative health consequences, this is still an important public health priority.[98] The WDG Youth Survey asked youth how often they currently smoke cigarettes (response categories to this question included: every day; at least once a week, but not every day; less than once a week; do not smoke). There was no statistically significant relationship between geographic area and grade 10 students who reported that they *Currently Smoke Cigarettes*. Overall, in Wellington, Dufferin, and Guelph, 9% of grade 10 students reported that they *Currently Smoke Cigarettes*. This rate is comparable with the findings from the 2009 Canadian Tobacco Use Monitoring Survey, where 13% of youth, ages 15 to 19, were found to be smokers.[99]

There was a statistically significant relationship between gender and grade 10 students who reported that they *Currently Smoke Cigarettes*. As seen in Figure 2.19, there were more male (12%) grade 10 students who reported that they *Currently Smoke Cigarettes* compared to females (7%). Results from the 2009 Canadian Tobacco Use Monitoring Survey found a similar trend in gender among youth, ages 15 to 19, with more males (15%) reported being smokers compared to females (11%).[100]

Figure 2.19 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported that they *Currently Smoke Cigarettes*, by gender, 2012**

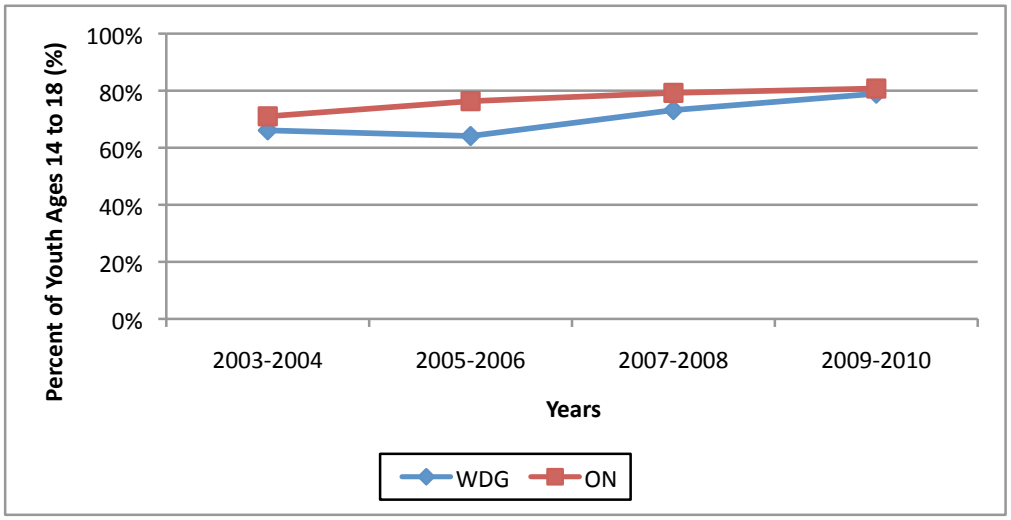


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 52 students (4%) did not complete the survey questions for how often they currently smoke cigarettes.

The CCHS also provides a measure of the prevalence of smoking. The percentage of youth, ages 14 to 18, who reported that they have never smoked was examined. Similar to the findings related to alcohol use among this population, there was no statistically significant difference between male and female youth, ages 14 to 18, who have never smoked. Figure 2.20 illustrates that while the percentage of youth who have never smoked is slightly higher in Ontario over time. The Ontario and Wellington, Dufferin, and Guelph percentages have progressively increased since 2003-2004. The difference between the Ontario and Wellington, Dufferin, and Guelph percentages converged during 2009-2010.

Figure 2.20 **Percentage of youth, ages 14 to 18, who reported that they have never smoked, Wellington, Dufferin, and Guelph and Ontario, by geographic area, 2003-2004 to 2009-2010**



Source: *Canadian Community Health Survey, Never Smoked, SMK-22*

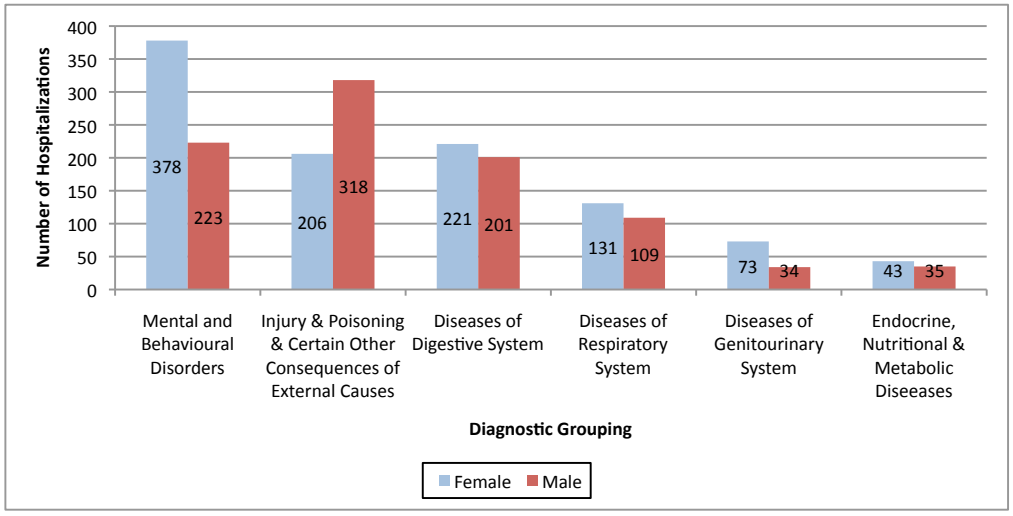
Cannabis is the most widely used illicit drug among Canadian youth. Youth who are smokers have much higher rates of cannabis use (75%) compared to youth who are non-smokers (24%).[101] As with other types of substance use examined in this section, cannabis can result in many negative short- and long-term health outcomes, including increases in heart rate, respiratory distress, risk of lung cancer, and decreases in blood pressure, concentration, reaction time, depth perception, information processing, and memory capacity.[102] Protective factors for cannabis use include living with both parents, higher levels of trust and effective communication with parents, and high academic achievement.[103]

The WDG Youth Survey asked youth how often they have used cannabis in the last 12 months. Students who reported *Using Cannabis in the Last 12 Months* were examined. The analysis revealed that there was no statistically significant relationship between cannabis use among grade 10 students and geographic area or gender. In Wellington, Dufferin, and Guelph, 22% of grade 10 students reported *Using Cannabis in the Last 12 Months*. The 2009 Canadian Alcohol and Drug Use Monitoring Survey found similar results with 27% of youth, ages 15 to 19, reporting cannabis use in the previous 12 months.[104]

Hospitalizations

Another source of data that provides insight into the overall physical health and well-being of youth is hospitalization data. Wellington-Dufferin-Guelph (WDG) Public Health has access to Hospitalization Separation data through the Provincial Health Planning Database. This database reports reasons for hospitalization according to Diagnostic Groupings and Diagnostic Criteria. Hospitalization data for Wellington, Dufferin, and Guelph were examined for youth, ages 14 to 18, by gender from 2005 to 2009. Figure 2.21 summarizes this data, which reveals the top six most prevalent Diagnostic Groupings related to hospitalization for both males and females.

Figure 2.21 **Number of hospitalizations among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph by top six Diagnostic Groupings and gender, 2005 to 2009**



Source: *Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 2009, 14 to 18, Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.*

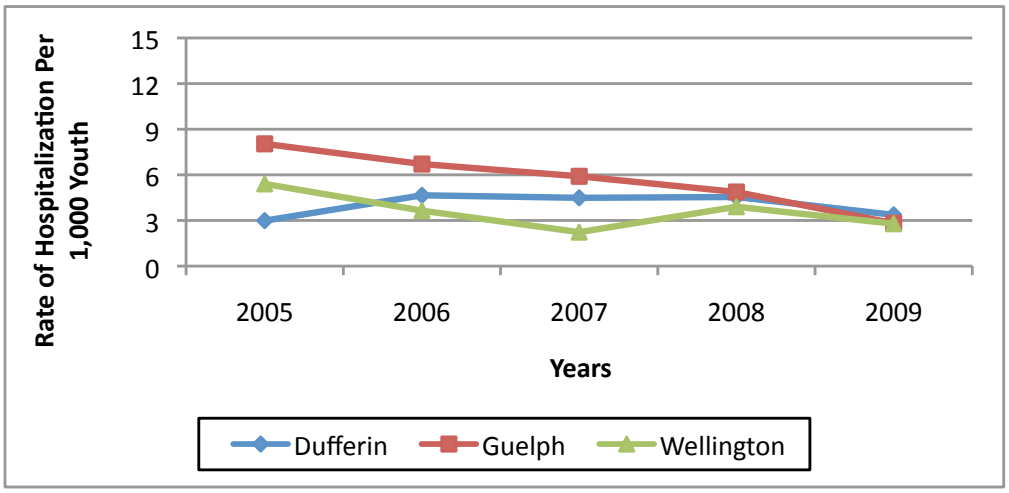
Note: The top six most prevalent Diagnostic Groups were determined by the largest number of cases of hospitalization based on counts. There may be situations of repeat hospitalization of an individual for the same cause. Also individuals may be diagnosed according to multiple Diagnostic Groupings, but the information in Figure 2.21 represents the Diagnostic Groupings most responsible for hospitalization.

Hospitalization Separation data captures individuals hospitalized based on residence versus the hospital they were treated in. Therefore, if someone living in Orangeville was treated at McMaster Hospital, they would be captured in hospitalization counts for Wellington, Dufferin, and Guelph.

Figure 2.21 illustrates the differences between male and female youth, ages 14 to 18, in Wellington, Dufferin, and Guelph by the most common causes of hospitalization. Although their ranking varies by gender, the top three causes of hospitalization within this age group for both genders are mental health, injuries, and digestive conditions. In order to investigate patterns of hospitalization within Wellington, Dufferin, and Guelph over time, rates were calculated per thousand youth, ages 14 to 18, for the top three reasons for hospitalization. This analysis is presented in *Chapter 7: Be and feel safe in our homes, schools and communities* (Figures 7.20 and 7.21).

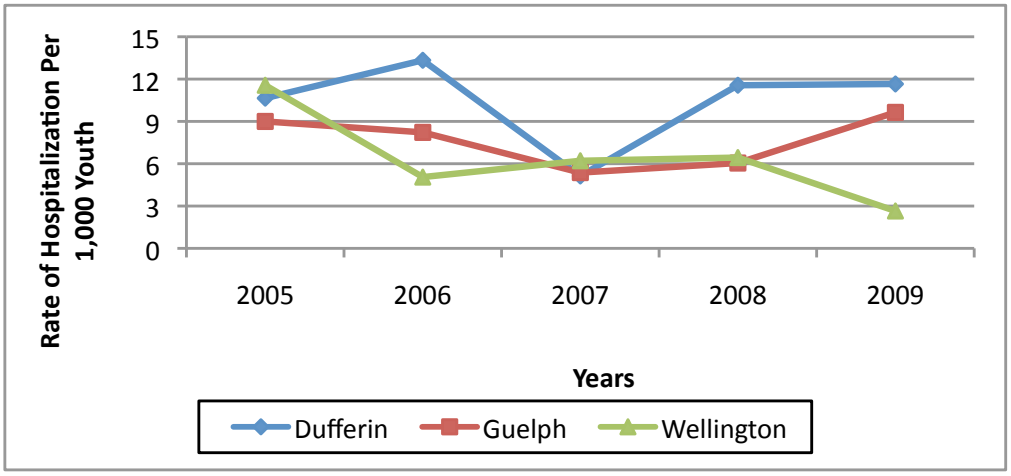
Figures 2.22 and 2.23 illustrate different trends across time in Wellington, Dufferin, and Guelph for mental health hospitalizations. While the rates of hospitalization due to mental health among male youth, ages 14 to 18, appeared similar in Wellington and Dufferin over time, especially in recent years, the trend over time for Guelph was different (Figure 2.22). In 2005, the rate of mental health hospitalization in Guelph was approximately eight per one thousand male youths; this rate has progressively declined over time. In 2009, the rate of mental health hospitalization among male youth in Guelph was comparable to the rates among Wellington and Dufferin male youth. Analysis of the rates among female youth, ages 14 to 18, in Wellington, Dufferin, and Guelph found no consistent trends across time (Figure 2.23).

Figure 2.22 **Rate of hospitalization due to Mental and Behavioural Disorders, male youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**



Source: Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 2009, 14 to 18, Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.

Figure 2.23 **Rate of hospitalization due to Mental and Behavioural Disorders, female youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**

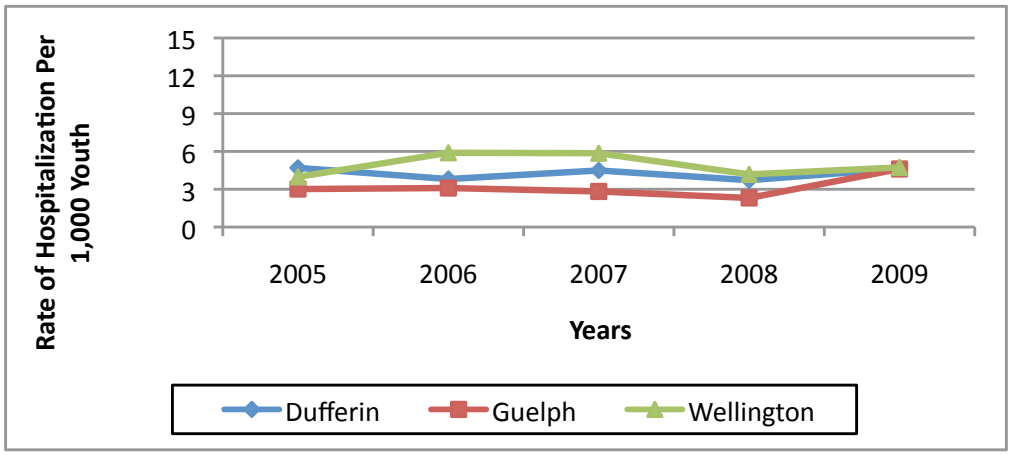


Source: Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 2009, 14 to 18, Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.

Hospitalization data can be further analyzed to understand the sub-type categories that make up each Diagnostic Grouping. For both male and female youth, mood/affective disorders were the most common reason for mental health hospitalizations in Wellington, Dufferin, and Guelph.

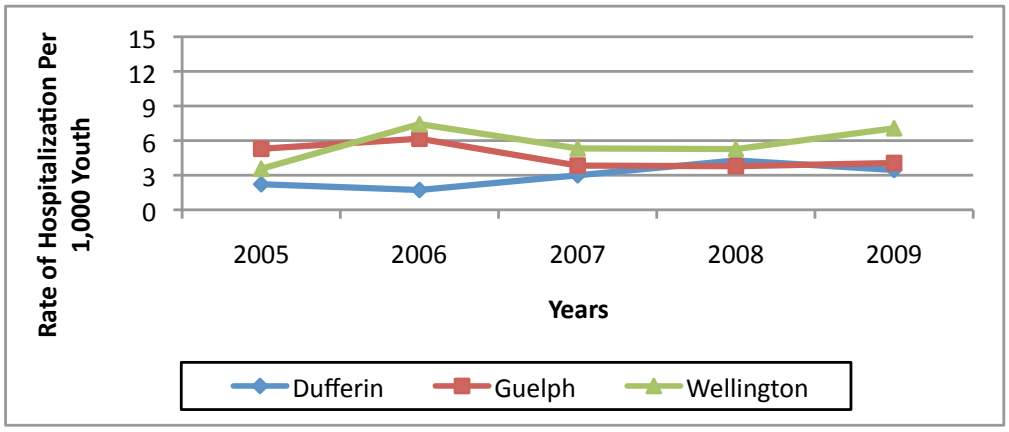
Figures 2.24 and 2.25 summarize the analysis of trends of hospitalizations due to digestive conditions over time in Wellington, Dufferin, and Guelph. Hospitalization rates among youth, ages 14 to 18, for Diseases of the Digestive System did not display consistent trends over time for either males or females. Among males (Figure 2.25), the rates in Guelph appear to be lower from 2005 to 2008 compared to Wellington and Dufferin, but are similar to Wellington and Dufferin in 2009.

Figure 2.24 **Rate of hospitalization due to Diseases of the Digestive System, male youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**



Source: Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 2009, 14 to 18, Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.

Figure 2.25 **Rate of hospitalization due to Diseases of the Digestive System, female youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**



Source: Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 2009, 14 to 18, Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.

Further analysis of Diseases of the Digestive System revealed that the most common causes of hospitalizations for this Diagnostic Grouping among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph were for diseases of the appendix and disorders of the teeth and their supporting structures.

Dental health

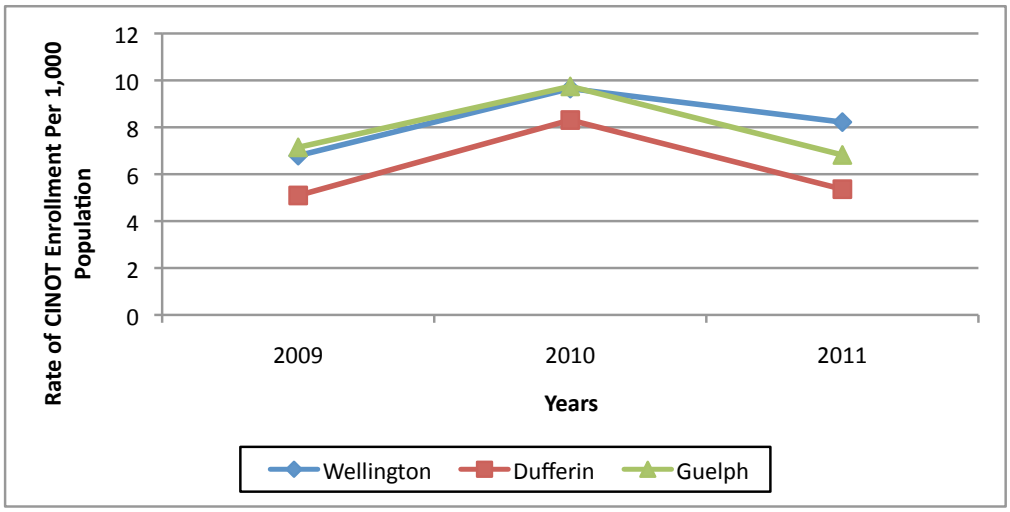
Oral health is an important part of overall health and well-being. Research has demonstrated a link between gum disease and other health conditions, including diabetes, pneumonia, and other respiratory disease, heart disease, and stroke.[105] Dental caries (i.e., tooth decay or cavities) is one of the most common chronic diseases.[106] Youth who have poor dental health are likely to experience pain, difficulties eating, and gastrointestinal disorders, as well as poor nutritional status. Furthermore, dental caries can impact an adolescent's concentration and ability to learn, school performance, sleep patterns, and self-esteem.[107] Findings from the oral health component of the 2007-2009 Canadian Health Measures Survey indicate that 59% of adolescents have been affected by tooth decay.[108]

Dental health is closely tied to many determinants of health, such as socioeconomic status, and nutrition. Income level and socio-economic status have been found to be the major determinants associated with children who suffer from early childhood caries.[109] Families with low income that do not have access to dental insurance are much less likely to bring their children to the dentist on a regular basis to receive ongoing, preventive care. Food insecurity is also closely related to this issue, as low-income families often do not have the resources to meet the requirements for a healthy diet necessary for good oral health.[110]

WDG Public Health offers free dental care for children and youth, up to and including 17 years of age, who do not have dental insurance and experience financial hardship. Through public health community-based and elementary school-based screening clinics, dental hygienists screen children's and adolescents' teeth to assess their dental health. If urgent dental needs are identified, such as pain, infection, cavities, bleeding gums, or mouth injuries, they are referred to the Children in Need of Treatment (CINOT) program. Recently, there has been an expansion of the public health dental programs available to youth, ages 14 to 17, with the implementation of Healthy Smiles Ontario (HSO) in 2010 and the expansion of the Children in Need of Treatment (CINOT) program to include youth ages 14 to 17 in 2009. Dental screening clinics are not offered in our local secondary schools, and as a result, gaining a comprehensive picture of dental health among local youth ages 14 to 17 is more challenging.

The data presented in Figure 2.26 represents the rate of CINOT enrollment for youth, ages 14 to 17, per 1,000 youth. It is important to note that, unlike elementary school children who are referred to CINOT through the school screening program, youth accessing these programs are self-selected or referred from other community partners or local dentists.

Figure 2.26 **Rate of CINOT enrollment among youth, ages 14 to 17, Wellington, Dufferin, and Guelph, 2009 to 2011**

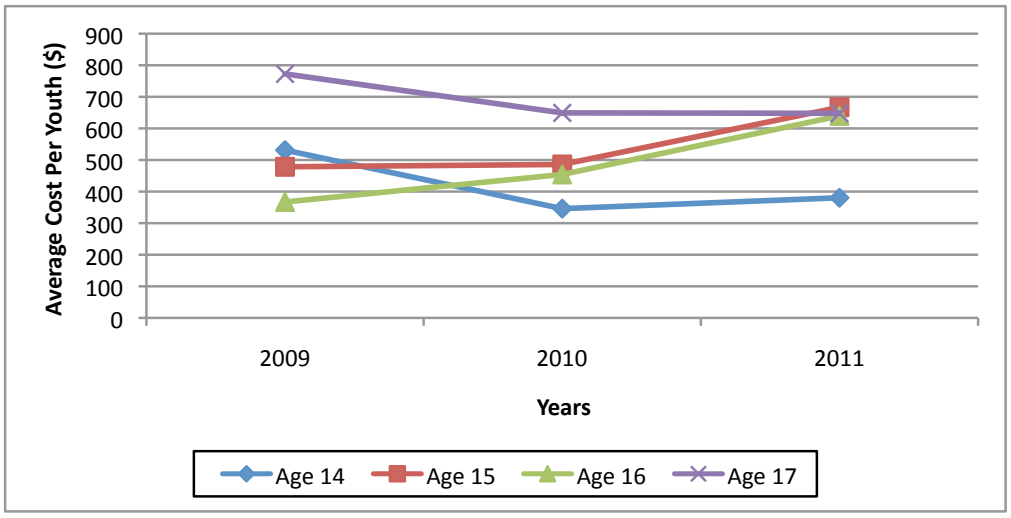


Source: Oral Health Information Support System (OHISS), Wellington-Dufferin-Guelph Public Health, March 2012.

In all geographic areas, there appears to be a spike in CINOT enrollment among youth, ages 14 to 17, in 2010. This may be partially related to the fact that the CINOT expansion to include youth ages 14 to 17 began in 2009. While uptake was slower at first, there was province-wide promotion of this expansion in early 2010, potentially increasing enrollment rates. In 2011, there is a higher rate of enrollment in Wellington County compared to Guelph or Dufferin. This may be explained by strong partnerships with local dental providers, as well as community clinics that are targeted to the Low-German speaking Mennonite community in Wellington County.

Another way of understanding the oral health needs of youth, ages 14 to 17, in Wellington, Dufferin, and Guelph is to examine CINOT expenditures for this population. Figure 2.27 presents the average CINOT expenditure per youth, ages 14 to 17, by age group. Overall, the average CINOT expenditure increases with age. There are several reasons that may explain this trend. Firstly, youth that are 14 years of age may have new adult teeth that have not yet had the chance for decay. For youth that do experience tooth decay, if it is not treated during the early stages, it can worsen and become more expensive to repair the longer it remains untreated. Finally, youth ages 17 or older have all of their permanent teeth and may even have their wisdom teeth. Extracting wisdom teeth can be very costly due to the need for general anaesthesia (i.e., cost could range from $1,000-1,400 depending on the difficulty). These findings related to the increase in CINOT expenditures with age further support the need for preventive dental care to ensure that fewer youth require emergency dental treatment or have dental needs that remain untreated.

Figure 2.27 **Average CINOT expenditure among youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2009 to 2011**



Source: *Oral Health Information Support System (OHISS), Wellington-Dufferin-Guelph Public Health, March 2012.*

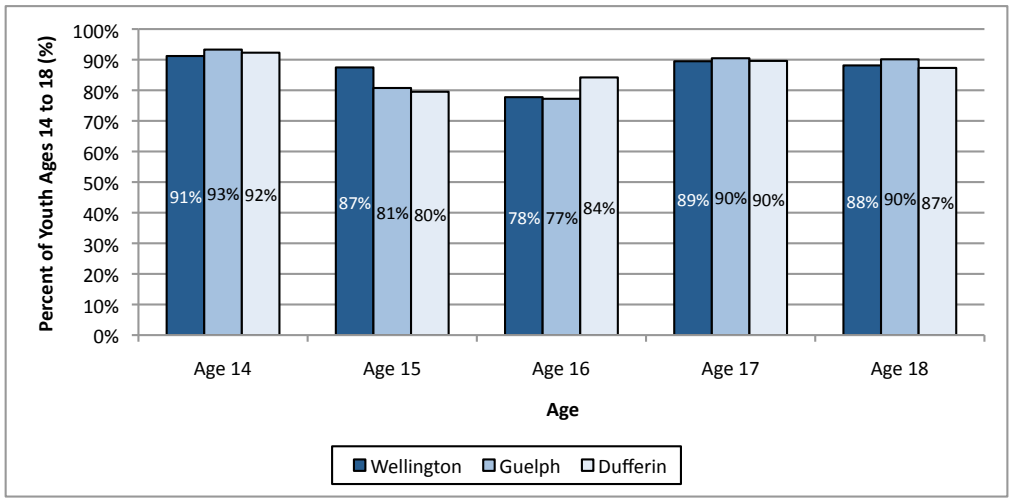
Immunizations

Immunizations are a safe and effective way to prevent illness and death caused by vaccine-preventable diseases. Some of these diseases can have very serious outcomes. Polio, diphtheria, measles, and whooping cough can result in pneumonia, heart problems, brain damage, paralysis and even death in children who are not protected.[111]

In order to uphold the Immunization of School Pupils Act (ISPA), WDG Public Health must assess and maintain immunization records for all children and youth attending school in our service area. Up-to-date immunization records allow WDG Public Health to identify students who may be at risk of contracting vaccine-preventable diseases if there is an outbreak at the school. Parents provide their child's complete immunization records when they register their child for school. Immunization is not mandatory in Ontario, but if a parent chooses not to immunize their child they must obtain legal exemption according to the ISPA. The ISPA does require that parents or guardians provide information about their child's immunization records. Incomplete immunization records result in school suspension.

The information presented in Figure 2.28 shows the percentages of children born between 1994 and 1998 (i.e., youth, ages 14 to 18, as of June 2012) that have up-to-date immunizations.

Figure 2.28 **Percentage of youth, ages 14 to 18, with up-to-date immunizations in Wellington, Dufferin, and Guelph, 2012**



Source: *Immunization Registry Information System (IRIS), Wellington-Dufferin-Guelph Public Health, June 2012.*
Note: Immunization data is collected at each secondary school in Wellington, Dufferin, and Guelph. The school-level data was aggregated across all schools within their respective geographic area to provide Wellington, Dufferin, and Guelph percentages.

This data is based on where the youth attends school, rather than place of residence.

The immunizations included in Figure 2.28 include DPT-Polio & MMR. Youth are eligible for a booster for these immunizations from age 14 to 15. WDG Public Health offers clinics at all of our secondary schools to provide easy access for immunizations. If youth have not received their booster for these immunizations at age 16, they are considered overdue and at-risk.

"Herd immunity" is a concept borrowed from veterinary sciences, implying that individuals in a population are protected from vaccine-preventable diseases when a certain proportion of a population has received the necessary vaccination.[112] The Center for Disease Control and the World Health Organization have estimated herd immunity thresholds for vaccine-preventable diseases. For most of these diseases, 75% to 94% of the population must be immunized in order to achieve herd immunity.[113] As demonstrated in Figure 2.28, the percent of youth, ages 14 to 18, who have up-to-date immunization records ranges from approximately 77% to 93% across all secondary schools in Wellington, Dufferin, and Guelph. This would imply that although there is some vulnerability, we are achieving successful protection in our area for each age group. There does not appear to be any geographic trends across the age groups. Youth ages 15 and 16 have the lowest rates of immunization (Figure 2.28). This may be largely explained by the fact that immunizations for these youth are not yet considered overdue, and therefore cannot be enforced by school suspension until they reach age 16.

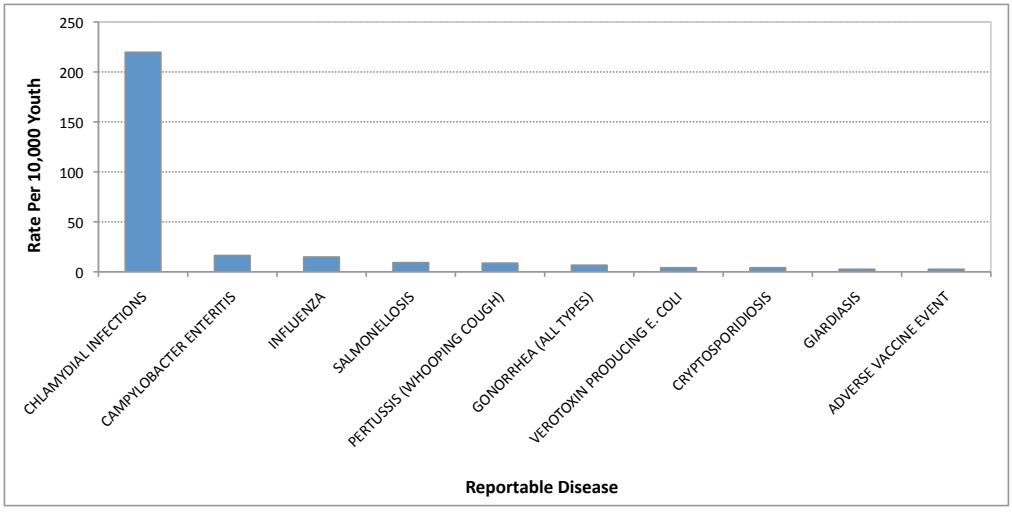
Communicable diseases

Children and youth are highly susceptible to communicable diseases, simply because they spend most of their days in large groups where there is increased contact and exposure to the pathogenic agents of infectious diseases. Immunizations are an important way of protecting youth from communicable diseases, such as influenza, hepatitis B, and meningitis. With the emergence of a new Influenza A virus (pandemic H1N1) in 2009, there was increased public awareness about the importance of public health interventions to prevent the spread of communicable disease.

WDG Public Health provides a variety of services to control communicable diseases, including education, investigation of outbreaks and reportable communicable diseases, and vaccination programs and clinics. WDG Public Health maintains a list of Reportable Diseases. Medical laboratories, health professionals and school principals are required, under the Health Protection and Promotion Act (Section 28), to report suspected or confirmed cases of these Reportable Diseases to the Medical Officer of Health. There are over 70 Reportable Diseases, including influenza, measles, food poisoning, meningitis, and tuberculosis.

Figure 2.29 displays the rates of lab-confirmed cases of reportable disease among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph from 2007 to 2011. According to the WDG Public Health reportable diseases, Chlamydia infections (a sexually transmitted infection or STI) represent the highest rates of all reportable disease among this population, followed by campylobacter enteritis (the most common cause of food poisoning, due to consumption of contaminated food or water), influenza, and salmonellosis (another common type of food poisoning).

Figure 2.29 **Rates of lab-confirmed cases for the ten most prevalent reportable diseases among youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2007 to 2011**



Source: Integrated Public Health Information System (iPHIS), Wellington-Dufferin-Guelph Public Health February 2012

Note: WDG Public Health provides information about common communicable diseases, including the descriptions below.

Chlamydia Infections: Chlamydia infection is the most common sexually transmitted infection (STI). It is caused by the bacterium Chlamydia trachomatis and can be transmitted during vaginal, anal, or oral

sex or passed from a mother to her infant during vaginal childbirth. Common symptoms include discharge from the penis, pain while urinating, and epididymitis among men, and pelvic inflammatory disease among women. It is common for both males and females to experience no symptoms. If left untreated, it can lead to severe reproductive problems and both short-term and long-term health consequences, such as ectopic pregnancy and infertility among females.

Campylobacter Enteritis: Campylobacter bacteria are common bacteria that cause diarrhea, abdominal pain, malaise and fever. Campylobacter are found most frequently in poultry and pets. The most common cause of infection is through consumption of contaminated food or water.

Influenza: More commonly known as the flu. The most common symptoms are fever, cough, plus one or more of the following: sore throat, muscle pain, joint pain, or weakness (includes extreme tiredness).

Salmonellosis: Salmonella is a food-borne bacteria and one of the main causes of food-borne illness. Any raw meats, especially raw or undercooked poultry, may carry Salmonella. Reptiles and pets are also common sources of Salmonella, especially turtles and lizards. Symptoms include sudden onset of cramps, diarrhea, nausea, fever, chills, headache, and vomiting.

Pertussis: More commonly known as Whooping Cough. It is caused by bacteria in the lungs or throat and can be prevented through vaccination. The bacteria are spread through aerosolized droplets, which, when inhaled, may result in Pertussis, making it a very contagious disease. When an infected individual talks, coughs, or sneezes, droplets are released into the air that carry the bacteria.

Gonorrhea (All Types): Gonorrhea is a common STI, which can be spread by contact with the mouth, vagina, penis, or anus. It is caused by the bacteria Neisseria gonorrhoeae. Symptoms may appear as early as two to five days after infection or up to a month. Some individuals may never experience symptoms and therefore may not know that they are infected. If left untreated, it can be spread to other individuals and the risks of complications related may increase. Common symptoms include burning/pain while urinating, increased urination, discharge from the vagina or penis, and severe pain in lower abdomen and fever among females.

Verotoxin Producing E. Coli: Type of E. Coli that causes gastroenteritis. Verotoxin Producing E. coli (VTEC) is found in the gut of cattle. The most common symptom is diarrhea (bloody), which may be accompanied by stomach cramps and vomiting. Symptoms can be severe in children.

Cryptosporidiosis: A parasitic infection that causes diarrhea (often watery). Diarrhea can last one to two weeks, which can be accompanied by abdominal cramps, fatigue, nausea, vomiting, and low-grade fever. The Cryptosporidium parasite can be found in food, water, soil, or surfaces that have been contaminated with the feces from infected humans or animals.

Giardiasis: A parasitic infection that causes diarrhea. Children are infected more often than adults. Symptoms include stomach cramps, bloating, severe gas, weight loss, dehydration, and fatigue. The Giardia lamblia parasite can be found in food, water, soil, or surfaces that have been contaminated with the feces from infected humans or animals.

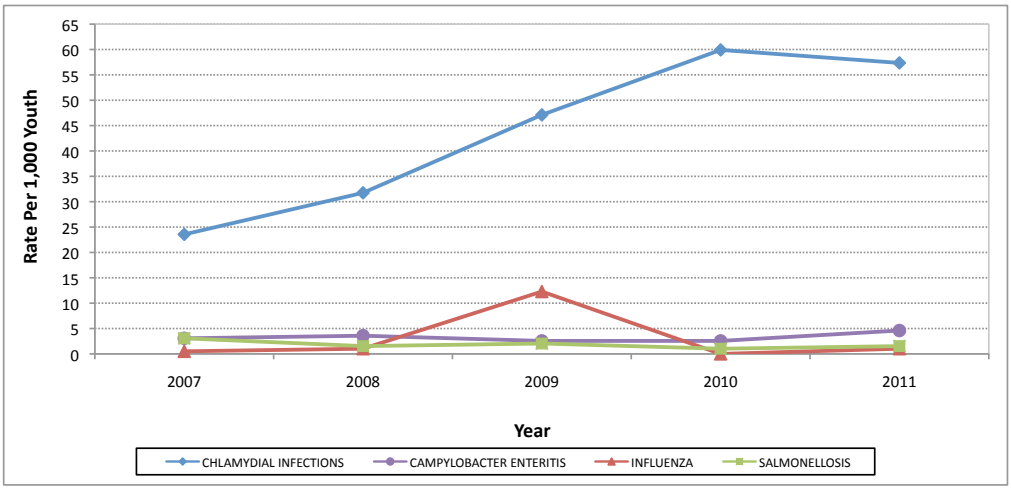
Adverse Vaccine Event: A severe reaction after receiving a vaccine. The reaction may not have a causal relationship with the administration of the vaccine. Most symptoms are mild, such as swelling or pain at the site of the injection, fever, drowsiness, or nausea. Most reactions occur within minutes of receiving the vaccine, and up to a couple of days following vaccination.

According the Public Health Agency of Canada (PHAC), Chlamydia infections are the most commonly reported bacterial sexually transmitted infection (STI) in Canada. The prevalence of Chlamydia infections is highest among younger populations, particularly women.[114] PHAC reported that in 2008, 82.6% of reported Chlamydia infections were among those 30 years of age and younger, with the largest prevalence among youth, ages 20 to 24. Given this, and the potentially severe health consequences related to Chlamydia infection (e.g., including pelvic inflammatory disease, ectopic pregnancy and infertility among females, and increased susceptibility of contracting

HIV), the prevention of a Chlamydia infection among adolescents is an important public health priority. It is common for both males and females to experience no symptoms. If left untreated, it can lead to severe reproductive problems and both short-term and long-term health consequences.[115]

Figure 2.30 displays the rates of the most prevalent lab-confirmed cases of Reportable Diseases among youth, ages 14 to 18, living in Wellington, Dufferin, and Guelph over time. From 2007 to 2010, there was an increasing trend in the rates of Chlamydia infection among this population in Wellington, Dufferin, and Guelph. During this same time period, reported rates of Chlamydia infection increased in Canada among both males and females. From 1998 to 2008, there was a 6.8% increase per year on average, with the largest percent increase occurring in 2007 to 2008.[116]

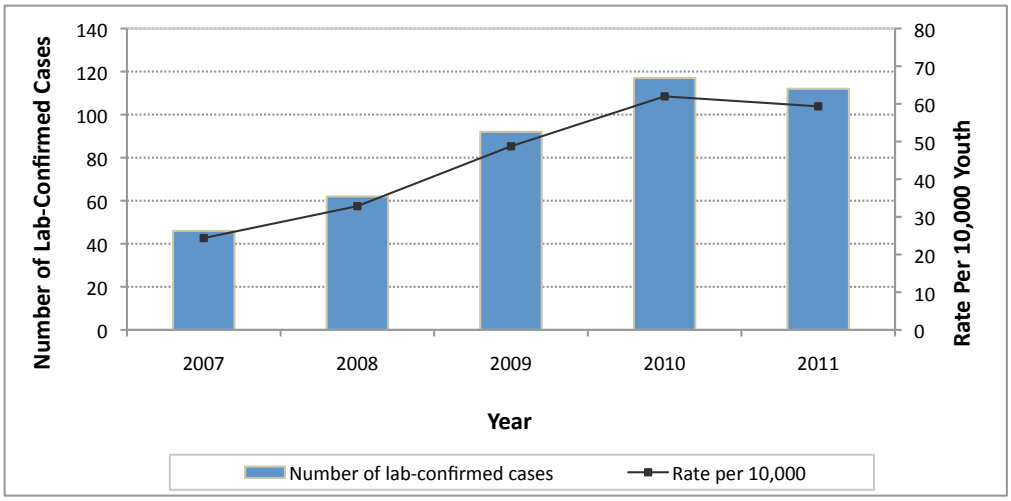
Figure 2.30 **Rates of most prevalent lab-confirmed cases of reportable diseases among youth, ages 14 to 18, Wellington, Dufferin, Guelph, over time, 2007 to 2011**



Source: *Integrated Public Health Information System (iPHIS), Wellington-Dufferin-Guelph Public Health February, 2012*

Figure 2.31 further examines Chlamydia infections among youth, ages 14 to 18, in Wellington, Dufferin, and Guelph by presenting the actual counts of lab-confirmed cases. This is valuable to service providers, as it demonstrates the actual number of cases underlying the rates presented in Figure 2.30.

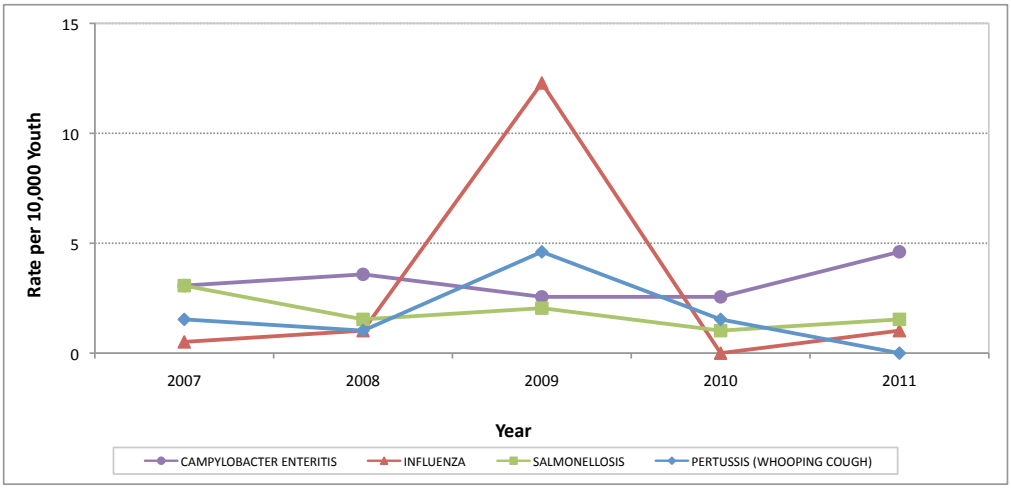
Figure 2.31 **Chlamydia infections diagnosed among youth, ages 14 to 18, Wellington, Dufferin, and Guelph 2007 to 2011**



Source: Integrated Public Health Information System (iPHIS), Wellington-Dufferin-Guelph Public Health February, 2012

Finally, Figure 2.32 includes only non-STI reportable diseases in order to better examine the rates of other prevalent reportable diseases among this population and potential trends over time. Influenza rates are actually lower compared to the other non-STI reportable diseases with the exception of 2009. The 2009 spike in influenza rates can be attributed to the presence of H1N1.

Figure 2.32 **Most prevalent lab-confirmed cases of reportable diseases (non-STI) among youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2007 to 2011**



Source: Integrated Public Health Information System (iPHIS), Wellington-Dufferin-Guelph Public Health February, 2012

Endnotes

1 Government of Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada 2006* (Cat. No. HP5-19/2006E), Ottawa, ON: Canada Minister of Public Works and Government Services Canada Retrieved from **http://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf**

2 European Communities. (2008). *Mental Health in Youth and Education-Consensus paper*. Luxembourg: Jane-Llopis, E. & Braddick, F. (Eds). Retrieved from **http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/docs/consensus_youth_en.pdf**

3 Canadian Mental Health Association. (2009). *The Connection between Mental and Physical Health*. Toronto, ON. Retrieved from **http://www.ontario.cmha.ca/fact_sheets.asp?cID=3963**

4 ibid

5 ibid

6 Keyes, C. L. M. (2007). Promoting and Protecting Mental Health as Flourishing: A Complementary Strategy for Improving National Mental Health. *American Psychologist,* 62(2), 95-108.

7 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.

8 ibid

9 Canadian Institute for Health Information. (2006). *Improving the Health of Canadians: Promoting Healthy Weights.* Ottawa, ON: Canadian Institute for Health Information.

10 Statistics Canada. *Canada Health Survey, 1978* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.

11 Statistics Canada. *Canadian Health Measures Survey, 2007: Cycle 1* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.

12 Health Canada. (2003). *Canadian Guidelines for Body Weight Classification in Adults.* Ottawa, ON: Health Canada.

13 Shields, M. & Tremblay, M. (2008). Screen time among Canadian adults: A profile. *Health Reports,* 19(2), 31-43.

14 Statistics Canada. *Canadian Community Health Survey, 2000: Cycle 1.1* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.

15 Statistics Canada. *Canadian Community Health Survey, 2009: Annual* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.

16 Faulkner, G. E. J., Buliung, R. N., Flora, P. K., & Fusco, C. (2009). Active school transport, physical activity levels and body weight of children and youth: A systematic review. *Preventive Medicine, 48*(1), 3-8.

17 C.L. Craig, C. L., Cameron, C., Russell, S. J., & Beaulieu, A. (2001). *Increasing physical activity: Supporting children's participation*. Ottawa, Canada: Canadian Fitness and Lifestyle Research Institute.

18 Taylor, J. P., Evers, S., & McKenna, M. (2005).Determinants of health eating in children and youth. *Canadian Journal of Public Health, 96*(3), 520-527.

19 ibid

20 ibid

21 Paglia-Boak, A., Adlaf, E.M., & Mann, R.E. (2001). Detailed OSDUHS findings: Drug use among Ontario students 1977-2011. *CAMH Research Document Series No. 32*.

22 Public Health Agency of Canada. (2007). *Canadian Street Youth and Substance Use. Findings from Enhanced Surveillance of Canadian Street Youth, 1999-2003.* Ottawa, ON: Public Health Agency of Canada.

23 Canadian Centre on Substance Abuse. (2007). *Substance Abuse in Canada: Youth in Focus.* Ottawa: Canadian Centre on Substance Abuse.
24 Statistics Canada. *Canadian Community Health Survey, 2009: Annual* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.
25 Health Canada. *Canadian Alcohol and Drug Use Monitoring Survey, 2009* [Public-Use Microdata File]. Ottawa, Ontario: Health Canada.
26 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
27 Paglia-Boak, A., Adlaf, E.M., & Mann, R.E. (2001). Detailed OSDUHS findings: Drug use among Ontario students 1977-2011. *CAMH Research Document Series No. 32*.
28 ibid
29 Statistics Canada. Canadian Community Health Survey, 2009: Annual [Share Microdata File]. Ottawa, Ontario: Statistics Canada. All computations on these microdata were prepared by Public Health Agency of Canada and the responsibility for the use and interpretation of these data is entirely that of the author(s).
30 Kapuscinski, A. N. & Masters, K. S. (2010). The current status of measures of spirituality: A critical review of scale development. *Psychology of Religion and Spirituality*, *2*, 191–205.
31 Johnson, C. (2008). The spirit of spiritual development. In R. M. Lerner, R. W. Roeser, & E. Phelps (Eds.), *Positive youth development and spirituality: From theory to research* (pp. 25–41). West Conshohocken, PA: Templeton Foundation Press.
32 Roehlkepartain, E. C., Benson, P. L., Scales, P. C., Kimball, L. & King, P. E. (2008). *With their own voices: A global exploration of how today's young people experience and think about spiritual development*. Minneapolis, MN: Search Institute.
33 Government of Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada 2006* (Cat. No. HP5-19/2006E), Ottawa, ON: Canada Minister of Public Works and Government Services Canada Retrieved from **http://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf**
34 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
35 Vickerman Galliher, R., Scales Rostosky, S., & Hughes, H.K. (2004). School belonging, self-esteem, and depressive symptoms in adolescents: An examination of sex, sexual attraction status, and urbanicity. *Journal of Youth and Adolescence, 33*(3), 235-245.
36 Paglia-Boak, A., Adlaf, E.M., Hamilton, H.A., Beitchman, J.H., Wolfe, D. & Mann, R.E., (2012). The mental health and well-being of Ontario students, 1991-2011: Detailed OSDUHS findings (CAMH Research Document Series No. 34). Toronto, ON: Centre for Addiction and Mental Health.
37 Vickerman Galliher, R., Scales Rostosky, S., & Hughes, H.K. (2004). School belonging, self-esteem, and depressive symptoms in adolescents: An examination of sex, sexual attraction status, and urbanicity. *Journal of Youth and Adolescence, 33*(3), 235-245.
38 ibid
39 Paglia-Boak, A., Adlaf, E.M., Hamilton, H.A., Beitchman, J.H., Wolfe, D. & Mann, R.E., (2012). The mental health and well-being of Ontario students, 1991-2011: Detailed OSDUHS findings (CAMH Research Document Series No. 34). Toronto, ON: Centre for Addiction and Mental Health.
40 Catalano, R.F., Berglund, M.L., Ryan, J.A.M., Lonczak, H.S., & Hawkins, J.D. (2004). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. The *Annals of the American Academy of Political and Social Science, 591,*98-124.
41 Ross, C.E. & Beckett, A.B. (2000). The roles of self-esteem and the sense of personal control in the academic achievement process. *Sociology of Education, 73,* 270-284.

42 Compas, B.E. (1993). Promoting positive mental health during adolescence. In Millstein, S.G., Petersen, A.C., & Nightingale, E.O. (Eds.),*Promoting the health of adolescents: New directions for the twenty-first century* (pg 159-176). New York: Oxford University Press.
43 ibid
44 ibid
45 Wade, T.J., Cairney, J., & Pevalin, D.J. (2002). Emergence of gender differences in depression during adolescence: National panel results from three countries. *Journal of American Academy of Child & Adolescent Psychiatry, 41*(2), 190-198.
46 Rosenfield, S. & Mouzon, D. (2013). Gender and mental health. In Aneshensel, C.S., Phelan, J.C., Bierman, A. (Eds.), *Handbook of Sociology of Mental Health, Second Edition,* (pg 277-296).
47 Correctional Service Canada. (2010). *Self-injurious behaviour: A review of the literature and implications for corrections*. Power, J. & Brown, S. L.
48 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
49 Polk, E. & Liss, M. (2007). Psychological characteristics of self-injurious behavior. *Personality and Individual Differences, 43*(3), 567-577.
50 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
51 White Kress, V. E., Gibson, D. M., & Reynolds, C. A. (2004). Adolescents who self-injure: Implications and strategies for school counselors. *Professional School Counseling, 7*(3), 195-201.
52 Nixon, M. K., Cloutier, P., & Jansson, S. M. (2008). Nonsuicidal self-harm in youth: a population-based survey. *Canadian Medical Association Journal, 178*(3), 306-312.
53 Canadian Institute for Health Information. (2011). Health Indicators 2011. (Ottawa: Canadian Institute for Health Information).
54 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
55 Fliege, H., Lee, J. R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of Psychosomatic Research, 66*(6), 477-493.
56 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
57 Statistics Canada. Canadian Community Health Survey, 2002: Cycle 1.2 [Share Microdata File]. Ottawa, Ontario: Statistics Canada. All computations on these microdata were prepared by Public Health Agency of Canada and the responsibility for the use and interpretation of these data is entirely that of the author(s).
58 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
59 ibid
60 Taylor, J. P., Evers, S., & McKenna, M. (2005).Determinants of health eating in children and youth. *Canadian Journal of Public Health, 96*(3), 520-527.
61 Halton Our Kids Network. (2011). Report Card 2011: A vision for children in Halton. Retrieved online **http://www.halton.ca/cms/one.aspx?portalId=8310&pageId=27533**
62 Zullig, K., Ubbes, V.A., Pyle, J., & Valois, R.F. (2006). Self-reported weight perceptions, dieting behavior, and breakfast eating among high school adolescents. *Journal of School Health, 76*(3), 87-92.
63 Keski-Rahkonen, A., Kaprio, J., Rissanen, A., Virkkunen, M, & Rose, R.J., (2003). Breakfast skipping and health-compromising behaviours in adolescents and adults. *European Journal of Clinical Nutrition, 57*, 842-853.
64 Taras, H. (2005). Nutrition and student performance at school. *Journal of School Health, 75*(6), 199-213.

65 Zullig, K., Ubbes, V.A., Pyle, J., & Valois, R.F. (2006). Self-reported weight perceptions, dieting behavior, and breakfast eating among high school adolescents. *Journal of School Health, 76*(3), 87-92.
66 Keski-Rahkonen, A., Kaprio, J., Rissanen, A., Virkkunen, M, & Rose, R.J., (2003). Breakfast skipping and health-compromising behaviours in adolescents and adults. *European Journal of Clinical Nutrition, 57*, 842-853.
67 Ferreria, I., Van Der horst, K., Wendel-Vos, W., Kremers, S., Van Lenthe, F.J., & Brug, J. (2007). Environmental correlated of physical activity in youth: A review and update. *Obesity Reviews, 8*(2), 129-154.
68 Erlichman, J., Kerbey, A.L., James, W.P. (2002). Physical activity and its impact on health outcomes. Paper 1: the impact of physical activity on cardiovascular disease and all-cause mortality: an historical perspective. *Obesity Reviews : An Official Journal of the International Association for the Study of Obesity, 3,* 257–271.
69 Aaron, D.J., Storti, K.L., Robertson, R.J., Kriska, A.M., & LaPorte, R.E. (2002). Longitudinal study of the number and choice of leisure time physical activities from mid to late adolescence: implications for school curricula and community recreation programs. *Archives of Pediatrics & Adolescent Medicine, 156*, 1075–1080.
70 Gordon-Larsen, P., Nelson, M.C., & Popkin, B.M. (2004). Longitudinal physical activity and sedentary behavior trends: adolescence to adulthood. *American Journal of Preventive Medicine, 27*, 277–283.
71 Trost, S.G., Sallis, J.F., Pate, R.R., Freedson, P.S., Taylor, W.C., & Dowda, M., Evaluating a model of parental influence on youth physical activity. *American Journal of Preventive Medicine, 25*(4), 277-282.
72 Ferrieria, I., Van Der horst, K., Wendel-Vos, W., Kremers, S., Van Lenthe, F.J., & Brug, J. (2007). Environmental correlated of physical activity in youth: A review and update. *Obesity Reviews, 8*(2), 129-154.
73 Sallis, J.F., Prochaska, J.J., & Taylor, W.C. (2000). A review of correlates of physical activity of children and adolescents. *Medicine & Science in Sports & Exercise,* 963-975.
74 Pabayo, R. & Gauvin, L. (2008). Proportions of students who use various models of transportation to and from school in a representative population-based sample of children and adolescents, 1999. *Preventive Medicine, 46*(1), 63-66.
75 Yousefian, A. Ziller, E., Swartz, J., Hartley, D. (2009). Active living for rural youth: Addressing physical inactivity in rural communities. *Journal of Public Health Management & Practice, 15*(3), 223-231.
76 Kerr, J., Frank, L., Sallis, J.F., & Chapman, J. (2007). Urban form correlates of pedestrian travel in youth: Differences by gender, race-ethnicity and household attributes. *Transportation Research Part D: Transport and Environment, 12*(3), 177-182.
77 Yousefian, A. Ziller, E., Swartz, J., Hartley, D. (2009). Active living for rural youth: Addressing physical inactivity in rural communities. *Journal of Public Health Management & Practice, 15*(3), 223-231.
78 Pabayo, R. & Gauvin, L. (2008). Proportions of students who use various models of transportation to and from school in a representative population-based sample of children and adolescents, 1999. *Preventive Medicine, 46*(1), 63-66.
79 Craig, C. L., Cameron, C., Russell, S. J., & Beaulieu, A. (2001). *Increasing physical activity: Supporting children's participation.* Ottawa, Canada: Canadian Fitness and Lifestyle Research Institute.
80 Canadian Institute for Health Information. (2006). *Improving the Health of Canadians: Promoting Healthy Weights.* Ottawa, ON: Canadian Institute for Health Information.
81 Health Canada. (2003). *Canadian Guidelines for Body Weight Classification in Adults.* (Ottawa: Health Canada).
82 Elgar, F.J., Roberts, C., Tudor-Smith, C. & Moore, L. (2005). Validity of self-reported height and weight and predictors of bias in adolescents. *Journal of Adolescent Health, 37*(5), 371-375.

83 Statistics Canada. (2012). *Overweight and obesity in children and adolescents: Results from the 2009 to 2011 Canadian Health Measures Survey*. Roberts, K.C., Shields, M. de Groh, M., Aziz, A., & Gilbert, J. 82-003-X. Health Reports, 23 (3). Retrieved from **http://www.statcan.gc.ca/pub/82-003-x/2012003/article/11706-eng.htm**
84 ibid
85 Wang, Z., Patterson, C.M., & Hills, A.P. (2002). A comparison of self-reported and measured height, weight and BMI in Australian adolescents. *Australian and New Zealand Journal of Public Health, 26*(5), 473-478.
86 Paglia-Boak, A., Adlaf, E.M., & Mann, R.E. (2001). Detailed OSDUHS findings: Drug use among Ontario students 1977-2011. *CAMH Research Document Series No. 32*.
87 Public Health Agency of Canada. (2007). *Canadian Street Youth and Substance Use. Findings from Enhanced Surveillance of Canadian Street Youth, 1999-2003.* Ottawa: Public Health Agency of Canada.
88 Paglia-Boak, A., Mann, R. E., Adlaf, E. M., & Rehm, J. (2009). Drug Use Among Ontario Students, 1977-2009. (Toronto: Centre for Addiction and Mental Health).
89 Canadian Centre on Substance Abuse. (2007). *Substance Abuse in Canada: Youth in Focus.* Ottawa: Canadian Centre on Substance Abuse.
90 Health Canada. (2010-06-30*). Health Concerns. Canadian Alcohol and Drug Use Monitoring Survey*. Retrieved on November 16, 2010, from **http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2009/summary-sommaire-eng.php**
91 Canadian Centre on Substance Abuse. (2007). *Substance Abuse in Canada: Youth in Focus.* Ottawa: Canadian Centre on Substance Abuse.
92 Rehm, J., Patra, J., & Popova, S. (2006). Alcohol-attributable mortality and potential years of life lost in Canada 2001: implications for prevention and policy. *Addiction,* 101(3), 373-384.
93 Pak, T. (2010). Teen binge-drinking linked to adult depression: Study. *Proceedings of the 2010 Neuroscience Meeting Planner.* Society for Neuroscience: San Diego.
94 Park, J., Kosterman, R., Hawkins, J.D., Haggerty, K.P., Duncan, T.E., Duncan, S.C., & Spoth, R. (2000). Effective of the "preparing for the drug free years" curriculum on growth in alcohol use and risk for alcohol use in early adolescence. *Prevention Science, 1*(3).
95 Gfroerer, J.C. Larson, S.L., & Colliver, J.D. (2007). Drug use patterns and trends in rural communities. *The Journal of Rural Health, 23*(s1), 10-15.
96 Edwards, R.W. , Blasser, S.M., Blaser, J., Pantoja, K. (1995). Alcohol, tobacco and other drug use by youth in rural communities. Su
97 Statistics Canada. Canadian Community Health Survey, 2009: Annual [Share Microdata File]. Ottawa, Ontario: Statistics Canada. All computations on these microdata were prepared by Public Health Agency of Canada and the responsibility for the use and interpretation of these data is entirely that of the author(s).
98 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.
99 ibid
100 ibid
101 ibid
102 ibid
103 Public Health Agency of Canada. (2008). Healthy Settings for Young People in Canada. (Ottawa: Public Health Agency of Canada).
104 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.

105 Seymour, R.A., Preshaw, P.M. & Steele, J.G. (2002). Oral health and heart disease. Primary Dental Care, 9(4), 125-130.
106 Ontario Ministry of Health and Long-Term Care. (2012). *Oral health-more than just cavities: A report by Ontario's Chief Medical officer of Health*. Catalogue No. 016978. Toronto, ON: Queen's printer for Ontario.
107 ibid
108 Health Canada. (2010). *Report on the findings of the oral health component of the Canadian Health Measures Survey 2007-2009*. Ottawa, ON: Her Majesty the Queen in Right of Canada. Retrieve from: **http://www.fptdwg.ca/assets/PDF/CHMS/CHMS-E-tech.pdf**
109 Harrison, R. (2003). Oral health promotion for high-risk children: Case studies from British Columbia. *Journal of the Canadian Dental Association*, 69(5), 292-296.
110 Snow, P. & McNally, M. (2010). Examining the implications of dental treatment costs for low-income families. *Journal of the Canadian Dental Association, 76*(2).
111 Health Canada. (2009). *It's Your Health: Childhood Immunization*. Retrieved March 10, 2011 from: **http://www.hc-sc.gc.ca/hl-vs/alt_formats/pacrb-dgapcr/pdf/iyh-vsv/med/childhood-immunization-eng.pdf**
112 John, T.J. & Samuel, R. (2000). Herd immunity and herd effect: New insights and definitions. European *Journal of Epidemiology, 16*(7), 601-606.
113 Centre for Disease Control & the World Health Organization. (No date). History of epidemiology of global smallpox eradication. From the training course titled: Smallpox: Disease, Prevention, and Intervention, Slide 16-17.
114 Public Health Agency of Canada. (2008). Report on sexually transmitted infections in Canada: 2008. Retrieved from **http://www.phac-aspc.gc.ca/std-mts/report/sti-its2008/03-eng.php**
115 ibid
116 ibid


OLDNAVY
Lipton

3. A right to a place to sleep, clothes to wear, food to eat, and supportive friends and/or family

Introduction

The link to youth's well-being

When families have fewer economic and environmental resources, such as nutritious foods and safe and affordable housing, it can impact youth health and development, setting a trajectory that is difficult to alter. If youth do not have adequate access to basic needs, it can negatively impact their school performance, health, and sense of well-being.

Housing and health are related in several ways. Housing provides youth with facilities for proper food and water storage, protection from environmental elements, and a place to interact with their families. According to the World Health Organization's *Health Principles of Housing*, the relationship between adequate housing and health includes a reduction in psychological and social stress, prevention against communicable diseases, and protection from poisonings, injuries, and chronic diseases.[1] The affordability of adequate housing also interacts with health. A lack of affordable housing in a community can result in familial instability, living in overcrowded dwellings, or experiencing periods of homelessness.[2] To avoid homelessness or overcrowding, lower income families may be forced to limit spending on nutritious foods, medical expenses, or other necessities in order to afford rent.[3] Youth from low income families emphasize the high social costs of poverty, such as a limited ability to participate in clubs and sports, embarrassment over not being able to fit in, low self-confidence, and decreased mental health outcomes.[4, 5]

Economic and social circumstances also influence the dietary intake of youth. Food security, defined as, "access by all people at all times to enough food for an active, healthy life," influences both the health and development of all individuals.[6] Without readily available nutritious and safe foods, optimal physical, cognitive, and emotional development cannot be achieved.[7] Compared with higher income individuals, families and youth living in low income households are significantly less likely to consume the required nutrients to maintain adequate health and well-being.[8]

Finally, youth stressed the importance of support from family and friends. The more connected youth feel to their peers, and the more positive the relationships that youth have with their families, the less likely they are to engage in risky behaviours.[9] Youth with adequate support from family and friends are more likely to complete secondary school and report good overall health.[10] They also exhibit less anti-social behaviour, delinquency, and stress.[11] Collectively, these basic needs provide the foundation for positive health and development among youth.

Indicators of youth's health and well-being in this chapter

In order to understand how effectively the basic needs of youth, ages 14 to 18, in Wellington, Dufferin, and Guelph are being met, this chapter reports on the following indicators:

- Economic security
- Government financial assistance
- Food security
- Housing and shelters
- Supportive family and friends

The value of this information to service providers

The information in this chapter is incredibly valuable for service providers as they attempt to decrease disparities in health and resources across the community. When available, both local and provincial data are presented to give service providers a better understanding of how youth in our community fare in comparison to the rest of Ontario. Additionally, some of the information is presented at the neighbourhood level, which allows service providers to consider targeted approaches for areas where the population experiences greater challenges in acquiring basic needs, especially when funding is insufficient for universal service delivery. There are many other valuable uses of this information, such as the collaborative work of service partners and agencies that can emerge from discussions about these data to better address some of the basic unmet needs of youth and their families in our community.

Economic security

Economic security is influenced by factors including employment, income rates, and education level. Economic security impacts an individual's well-being, not only in terms of their ability to provide basic needs, such as clothing, food, and shelter, but it also has an impact on an individual's sense of self-worth, and feelings of inclusion. As previously mentioned, youth also highlight the social costs of poverty and its effects on friendships and social inclusion.[12] Without adequate economic resources, lower income youth report feeling embarrassed about their limited ability to participate in social activities, such as clubs, sports, and informal social gatherings.[13] A lack of participation can lead to bullying, social exclusion, and teasing.[14] Youth also report experiencing social exclusion when they are not able to purchase fashionable clothing. Low income youth who cannot afford brand-name clothing feel that they are not able to "fit in" with others in their peer group, resulting in low levels of social participation, self-confidence, and mental health outcomes.[15]

Table 3.1 highlights the percentage of families living below the LICO before and after tax within each of our communities. The percentage of families living below the LICO before tax in Guelph (7.5%) is higher than the percentage of families in Wellington (4.4%) and Dufferin (5.5%). However, overall, the percentage of families in all three communities is lower than Ontario (11.7%). A similar trend is seen when looking at the percentage of families living below the LICO after tax with a larger proportion of families in Guelph (5.5%) living below the LICO than those in Wellington (3.1%) and Dufferin (3.9%). However, the percentage of families living below the LICO after tax in Wellington, Dufferin, and Guelph as a whole (4.3%) is exactly half of that in Ontario (8.6%). This means that families in Wellington, Dufferin, and Guelph have greater economic security than the average family in Ontario.

Defining poverty

Canada does not have an official poverty line, so defining poverty is not straight forward. Statistics Canada provides measures of low income, which are used in this chapter report, including the Low Income Cut-off (LICO). LICO is a statistical calculation that is based on where a family lives, family size and income. It is connected to how much income an average family would spend on the essentials of food, shelter and clothing.[16]

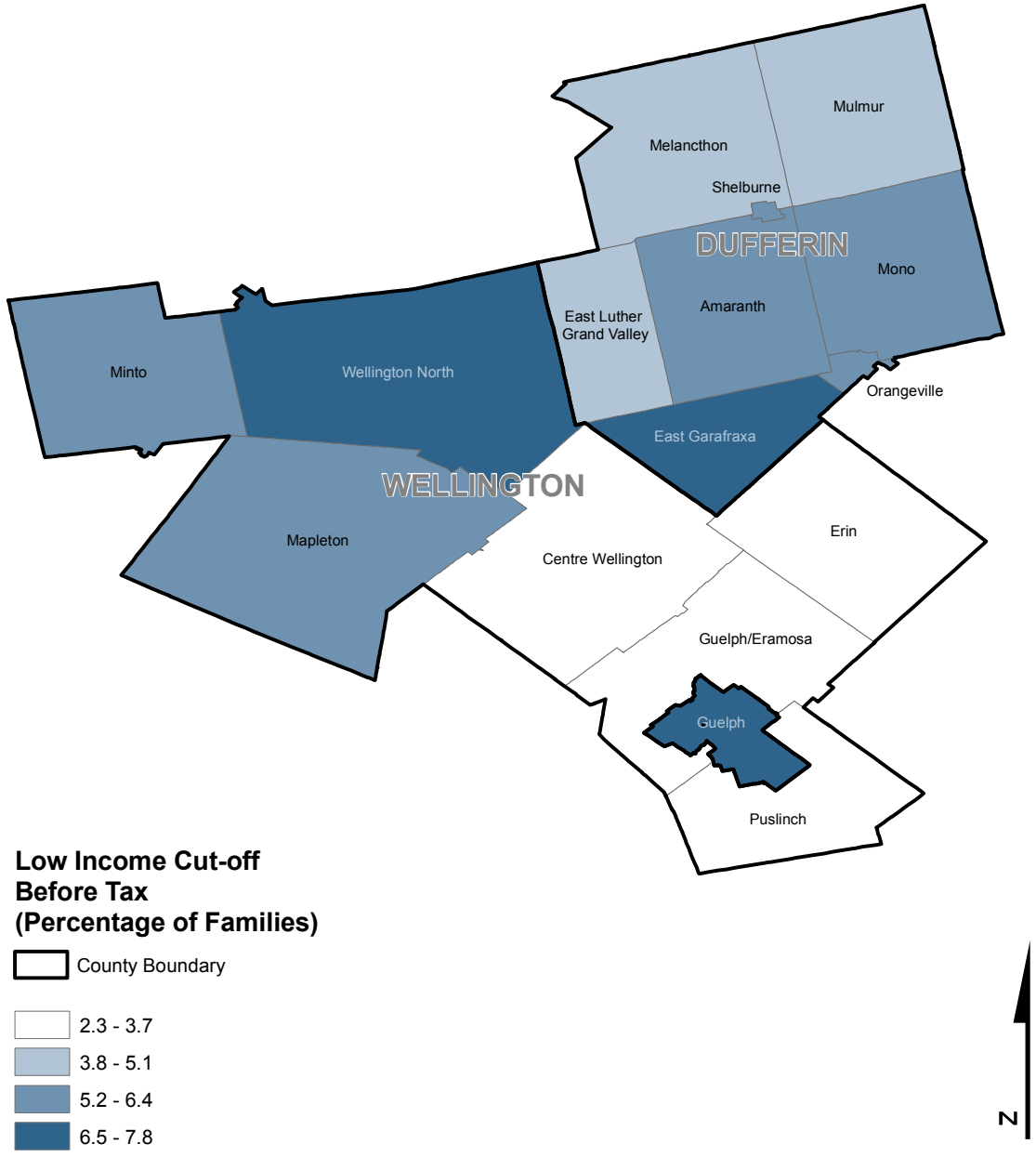
Table 3.1 **Percentage of families living below the Low Income Cut-Off (LICO) before and after tax in Wellington, Dufferin, and Guelph, 2006**

	Wellington	Dufferin	Guelph	WDG	Ontario
% of families below the LICO (before tax)	4.4	5.5	7.5	6.0	11.7
% of families below the LICO (after tax)	3.1	3.9	5.5	4.3	8.6

Source: *Statistics Canada, 2006 Census*

The following maps illustrate the distribution of the percentage of families living below the LICO before tax, first by municipality (Map 3.1) and then by City of Guelph neighbourhoods (Map 3.2).

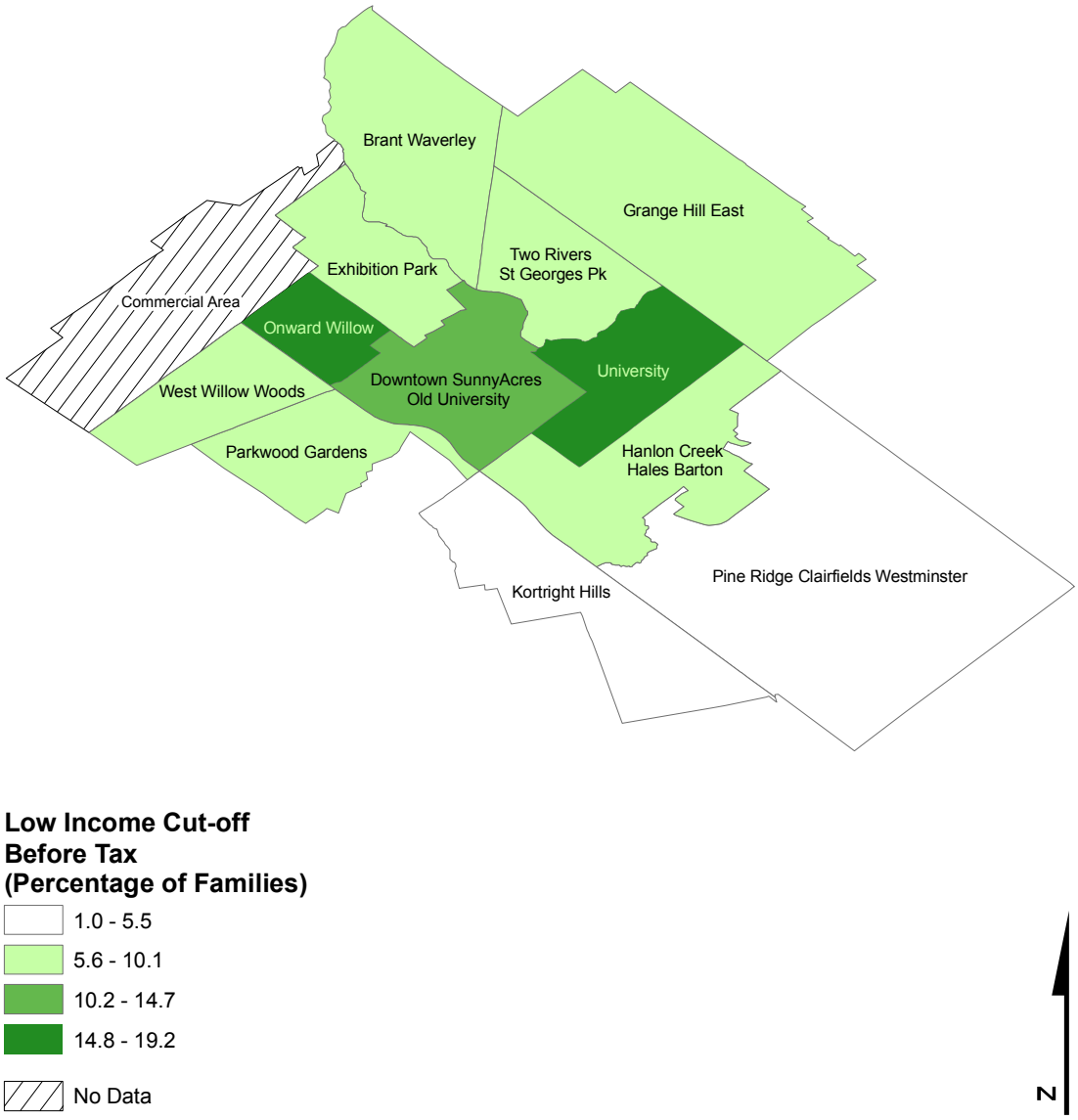
Map 3.1 **Percentage of families living below the Low Income Cut-Off (LICO) before tax for Wellington, Dufferin, and Guelph, by municipality, 2006**



Source: *Statistics Canada, 2006 Census*

As indicated in Map 3.1, the municipalities with the lowest percentage of families living below the LICO before tax are Centre Wellington, Erin, Guelph/Eramosa, and Puslinch. The municipalities with the highest percentage of families living below the LICO before tax are Wellington North and East Garafraxa.

Map 3.2 **Percentage of families living below the Low Income Cut-Off (LICO) before tax in Guelph, by neighbourhoods, 2006**



Source: *Statistics Canada, 2006 Census*

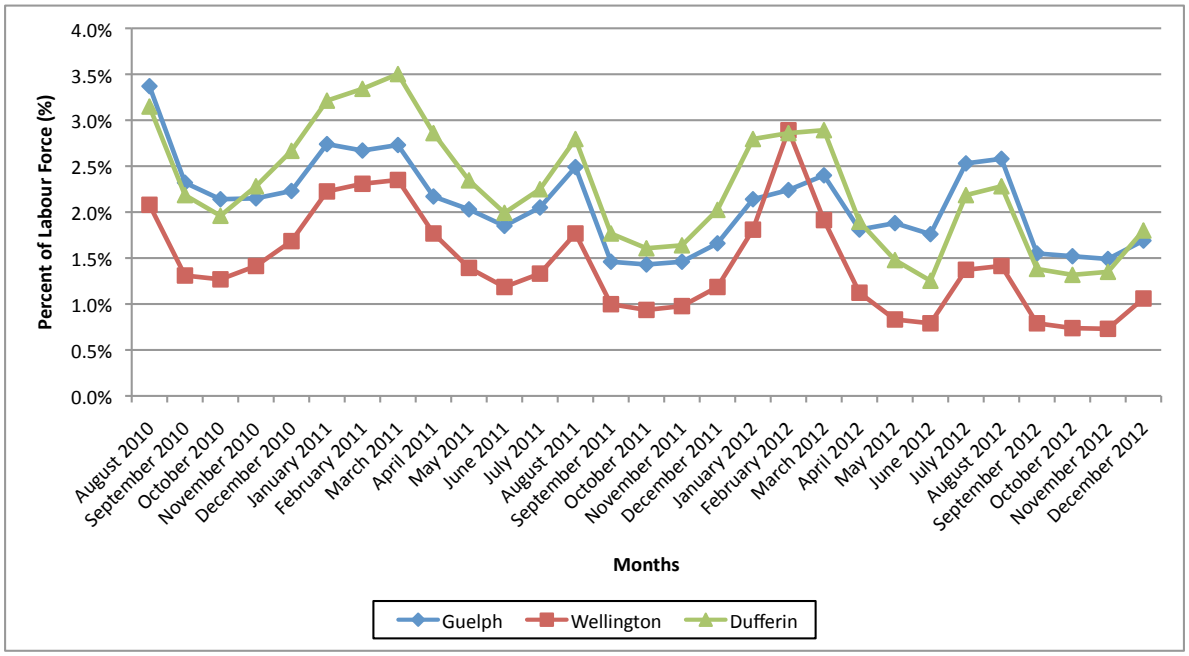
Note: University neighbourhood has the lowest percentage of youth, ages 14 to 18, in Guelph and the highest percentage of families living below the low income cut-off before tax. This is partially explained by the high percentage of university students living in this neighbourhood.

As indicated in Map 3.2, the neighbourhoods with the lowest percentage of families living below the LICO before tax are Kortright Hills and Pine Ridge Clairfields Westminster. The neighbourhoods with the highest percentage of families living below the LICO before tax are Onward Willow and University.

Government financial assistance

Economic security is an important determinant of the health and social inclusion of youth and their families. One means of supporting the economic security of individuals and families is through social assistance programs. In the aftermath of the global recession that plagued most of 2008 and 2009, there was a steady increase in the number of people accessing both Employment Insurance (EI) and Ontario Works (OW). Since 2010, the numbers have begun to decline. Between August 2010 and December 2012, the number of EI beneficiaries declined across Wellington, Dufferin and Guelph (Figure 3.1).

Figure 3.1 **Wellington, Dufferin, and Guelph Employment Insurance beneficiaries, August 2010 to December 2012**



Source: *Statistics Canada CANSIM using CHASS.*

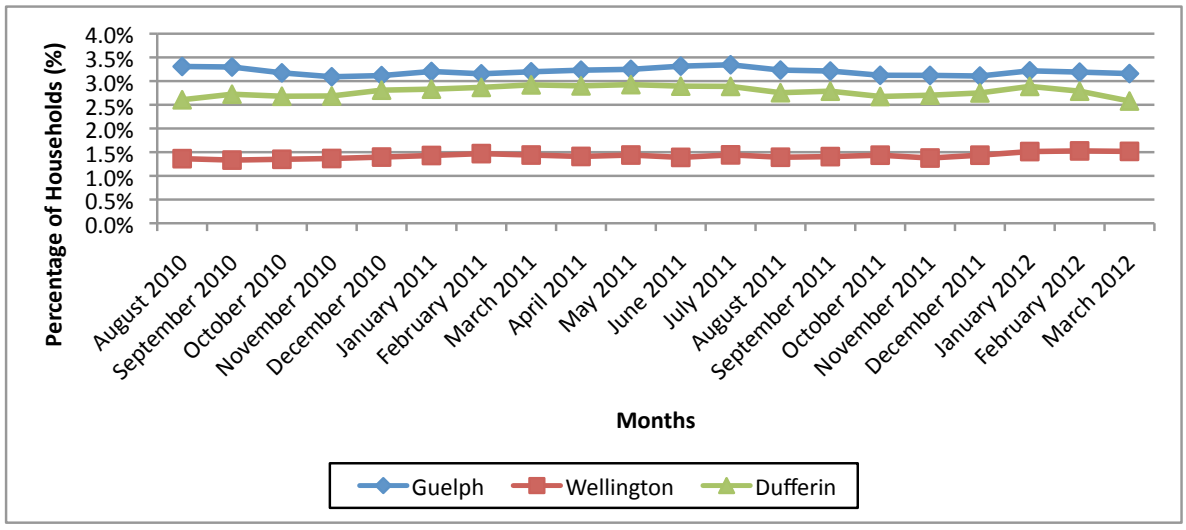
Note: "Beneficiaries" are individuals receiving employment insurance. In order to calculate EI numbers for Wellington, Dufferin, and Guelph as a percentage of the workforce, Statistics Canada (2006) "In the labour force" information was used. Statistics Canada defines the "Labour Force" as the group of people who are employed or unemployed during the week (Sunday to Saturday) prior to Census Day (May 16, 2006). Although this chart shows EI beneficiaries for the period August 2010 to December 2012, the 2006 labour force numbers were used as the denominator for all of the years, as there is no other more current measure of labour force activity available for Wellington, Dufferin, and Guelph.

There are some important differences in the way EI beneficiaries were presented in this Report Card compared to the EI beneficiaries presented in the previous Report Card, The Well-Being of Children Ages 7 to 13. The data in the previous Report Card included all government financial assistance beneficiaries (including Ontario Disability Support Program(ODSP), etc.) and not just EI beneficiaries. Furthermore, the beneficiary numbers from Statistics Canada for Wellington County included the City of Guelph beneficiaries. This resulted in Wellington County's beneficiary numbers being artificially inflated, as the denominator had the City of Guelph's labour force removed. A revised and more appropriate figure that is comparable to the data presented in Figure 3.1 has been replaced in The Well-Being of Children Ages 7 to 13: A Report Card for Wellington-Dufferin-Guelph. This can be accessed at **www.wdgreportcard.com**.

Examining Figure 3.1, we see that while the overall percentage of the labour force accessing EI benefits between August 2010 and December 2012 has declined, there are several spikes in the percentages. These spikes occurred during the winter and summer months and are likely due to the number of seasonal workers within Wellington, Dufferin, and Guelph. Seasonal work is often, but not always, dictated by weather patterns. Seasonal industries are those that are forced to close or lay off workers due to inclement weather or scarce resources. Individuals who work in industries such as construction or landscaping tend to be repeat EI beneficiaries. Additionally, individuals who work in elementary and secondary schools that are employed during the winter months may be temporarily laid off during July and August, and, therefore, would be eligible for EI during this time.

The percentage of households receiving OW is another important indicator when examining the economic security of our communities. Figure 3.2 highlights the percentage of households receiving OW in Wellington, Dufferin, and Guelph between August 2010 and March 2012.

Figure 3.2 **Wellington, Dufferin, and Guelph Ontario Works caseload, August 2010 to March 2012**



Source: 1. County of Dufferin, Community Services (June 2012); 2. County of Wellington, Social Services (June 2012); 3. Number of Households, Statistics Canada 2006 Census Profiles

Note: The Ontario Works Caseload is presented as a percentage of households in Wellington, Dufferin, and Guelph. The "total private households" from the 2006 Statistics Canada Census Profiles were used to calculate the percentage for each month. As defined by Statistics Canada, households can be a single person, married or common-law couples, families (couples with children, single parents with children, or grandparent(s) with grandchildren), other related individuals, or other unrelated individuals.

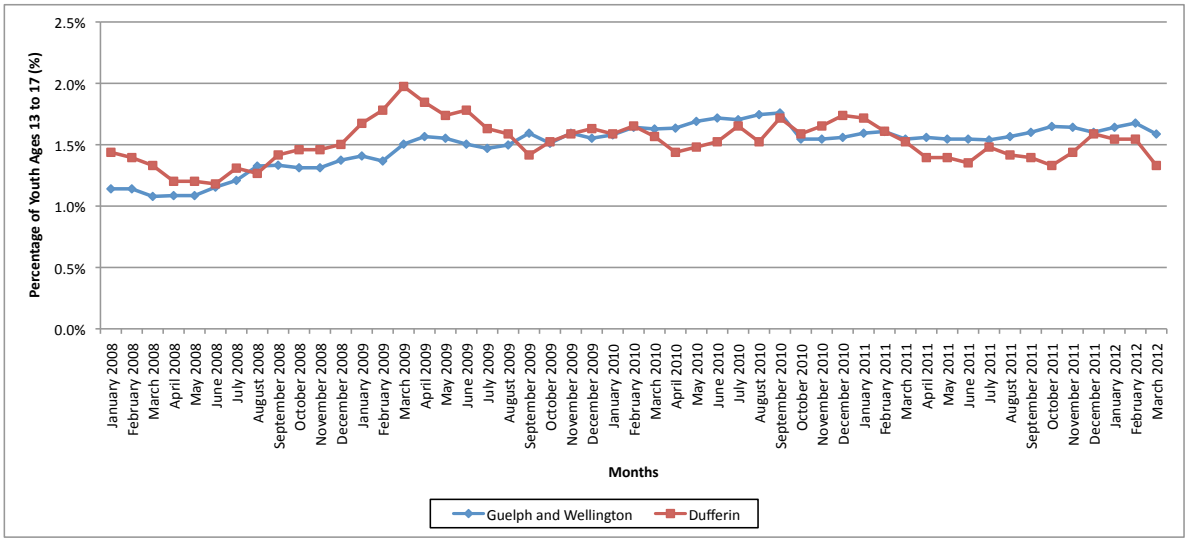
Presenting the Ontario Works Caseload as a percentage of households allows for comparison between Wellington, Dufferin, and Guelph, within the context of their respective private household counts. Households were used because, in the majority of cases, only one person can receive OW assistance in a given household when the other residents of the household are financial dependents of this person (e.g., spouse, child, or other dependents). It is important to note that there is a small margin of error in this calculation due to cases where there are other people in the household who are financially independent (e.g., adult child who is not dependent on the parent, or where roommates share a household). In these

situations, more than one person can receive OW assistance in a given household.

Figure 3.2 illustrates that the Ontario Works caseload has remained stable between August 2010 and March 2012, after experiencing an increase from early 2008 to 2010. The City of Guelph and Dufferin County continue to experience higher rates of OW assistance compared to Wellington County.

The municipalities track the number of youth, ages 13 to 17, who are dependents and independents on Ontario Works. These numbers are presented in Figure 3.3 as a percentage of youth, ages 13 to 17, in Wellington, Dufferin, and Guelph. The percentage increased slightly in the beginning of 2008, but has remained relatively stable for the duration of 2010, 2011, and 2012. Youth are only eligible to apply for OW as an independent at the age of 16 to 17. In Wellington County and Guelph, the percentage of youth independently receiving OW as a percentage of the total number of youth on OW ranged from 6.5% to 13.4% between January 2008 and March 2012, while this percentage ranged from 2.7% to 12.9% in Dufferin County. Therefore, the majority of youth, ages 13 to 17, on OW are dependent (i.e., living with a parent or caregiver), rather than independent (i.e., living on their own).

Figure 3.3 **Total number of youth, ages 13 to 17, (dependents and independents) on Ontario Works as a percentage of total population of youth, ages 13 to 17, in Guelph and Wellington County and Dufferin County, January 2008 to March 2012**



Source: *1. County of Dufferin, Community Services (June 2012); 2. County of Wellington, Social Services (October June 2012); 3. Number of Youth, Ages 13 to 17, Statistics Canada Intercensal Estimates, 2009*

Note: Figure 3.3 includes both dependent and independent youth. Dependent youth are those that are living with a parent or caregiver while independent youth are those that live on their own. A household with multiple youth (whether or not a caregiver is present) would be counted multiple times on this graph; consequently, these percentages do not represent household percentages across the region. It is also important to note the total number of youth, ages 13 to 17, receiving OW in Guelph and Wellington are presented together.

A recent community research project by the Institute for Community Engaged Scholarship (the Research Shop) at the University of Guelph explored the lived experience of people facing economic hardships in Guelph and Wellington through focus groups with community members who have lived in poverty. Those participants who were receiving assistance through OW, EI, and/or the Ontario Disability Support Program had difficulties meeting their basic needs. Participants also stated that accessing information about assistance programs was difficult and the information was sometimes hard to understand. The amount of paperwork required and difficulties finding employment were also found to be significant stressors for the participants in this study. This research project provides an important perspective with respect to how people experience economic insecurity in our own communities.[17]

It is also important to be aware of families who may not be eligible for social assistance programs, but still struggle to meet their basic needs. The majority of those living in poverty are "working poor", not social assistance recipients.[18] The "working poor" are individuals and families who are able to maintain regular employment but still experience relative poverty due to low levels of pay and dependent expenses. These individuals receive low salaries, and despite their employment, may be working in jobs that are part time, temporary, contract, or self-employed.[19]

In 2008, across Canada, approximately one in three (33%) children living in a low income family had at least one parent who worked full time year round, but could not rise out of poverty[20]. Employment of this nature can begin to undermine health due to additional stress that results from these poor employment opportunities and often limited child care arrangements.[21] Furthermore, when families leave social assistance programs for employment, their publicly funded drug card and limited dental benefits are often terminated. In the case of OW recipients, when they exit the program due to employment, they are eligible for continued health benefits for a transitional period of up to six months or until the employer offers health benefits, whichever comes first. When employment is part time, contract, or temporary, these benefits are rarely replaced by the employer. This reality leads to inconsistent access to services necessary to support the health of youth and their families. Employment alone does not ensure that families are able to meet their basic needs.

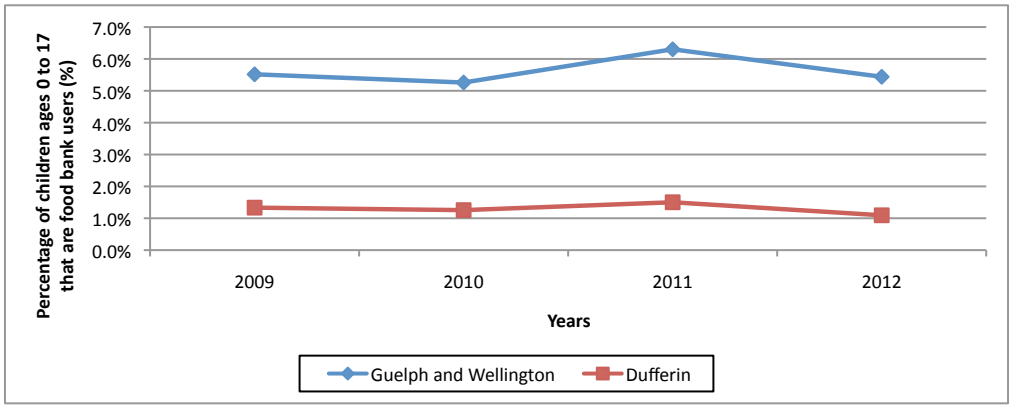
Food security

An important part of healthy development and well-being for youth is nutrition and food security. However, individuals and families receiving financial assistance or earning minimum wage do not have adequate income to purchase nutritious food on a consistent basis. Often, these individuals must choose between meeting their basic shelter needs and meeting their nutritional needs. Lower income families tend to purchase less expensive, but filling foods, that are energy dense and nutrient poor; consequently, low income individuals consume foods that are high in starches, sugars, salt and fats, which increase the risk of overweight and obesity, a leading cause of morbidity and mortality.[22] Food insecurity not only influences physical health, but also has important consequences for mental well-being. In a study of youth, ages 15 to 16, food insecurity was associated with depression, thoughts of death, and suicide attempts.[23] Food insecurity has also been associated with lower psychosocial functioning, and increased cognitive and behavioural problems in school.[24]

Food security continues to be a concern throughout Wellington, Dufferin, and Guelph. In 2011, nearly 6,000 people in Guelph and Wellington County, and nearly 500 people in Dufferin County accessed food banks in their communities.[25] While food bank use has remained fairly stable in Dufferin County, the number of users continues to increase in Guelph and Wellington, up from just over 5,200 in 2009.[26] Figure 3.4 demonstrates that the percentage of children, ages 0 to 17, who access food banks in Wellington,

Dufferin, and Guelph has remained fairly stable from 2009 to 2012 with no clear increasing or decreasing trend. It is important to note that the information presented in Figure 3.4 includes only those food banks that are members of the Ontario Association for Food Banks (OAFB). There are other resources available that are not captured in these numbers, such as local food pantries, soup kitchens, the Central Student Association (CSA) Food Bank at the University of Guelph, and food vouchers available through social service agencies, which would provide a clearer picture of food security needs of families in our communities.

Figure 3.4 **Percentage of children, ages 0 to 17, who are food bank users in Guelph and Wellington County and Dufferin County, 2009 to 2012**



Source: *1) Food Banks Canada Hunger Count Survey, 2009 to 2012, Adult and Children Breakdown for Wellington and Dufferin Counties. Personal correspondence with Food Banks Canada, May 2012. 2) Population Ages, 0 to 17, 2009 Intercensal Estimates.*

Note: Since the previous Report Card, The Well-Being of Children Ages, 7 to 13, data collection on food bank usage moved from the Ontario Association of Food Banks to Food Banks Canada. As a result, it was no longer possible to separate Guelph from the rest of Wellington County. The data presented in Figure 3.4 represents the number of individuals served during a one-month period each year. Individuals that access the food bank more than once during that month are only counted once.

Food banks included in Figure 3.4: Arthur Ministerial Food Bank, East Wellington Advisory Group Food Share Pantry, Centre Wellington Food Bank, Guelph Food Bank, Harriston Food Bank, Mount Forest Community Food Bank, Palmerston Food Bank, Orangeville Food Bank, Shepherds Cupboard (Shelburne).

One Canadian study found that only 35.4% of household experiencing food insecurity reported receiving food from a food bank, soup kitchen, or other charitable agency in the past year.[27] This indicates that the number of households with food insecurity is likely much greater than the number of those actually accessing food banks. It is important to keep this in mind when reviewing the data presented in Figure 3.4 for our communities.

"A Nutritious Food Basket (NFB) is a survey tool that measures the cost of basic healthy eating according to current nutrition recommendations and average food purchasing patterns. Food costing is used to monitor both affordability and accessibility of foods by relating the cost of the food basket to individual/family incomes."[28] Foods included in the NFB are based on *Eating Well with Canada's Food Guide* and the *Dietary Reference Intakes*. They are the lowest-priced and healthiest food items and include grains (e.g., breads and cereals), vegetables and fruit, dairy products (e.g., milk and cheese), and meats and alternatives (e.g., beans and fish). They do not include food chosen for religious/cultural reasons (e.g., kosher or halal),

Nutritious Food Basket
Often the cost of a Nutritious Food Basket (NFB) is reported as a weekly figure for a reference family of four. A reference family of four includes a man and a woman, ages 31 to 50 years, a boy, ages 14 to 18 years, and a girl, ages 4 to 8 years.

non-food items (e.g., soap or toothpaste), infant or baby foods, food for company or special occasions, special diets, or food consumed at restaurants. In 2012, an average family of four (i.e., a man and a woman, ages 31 to 50; a boy, ages 14 to 18; and a girl, ages 4 to 8) living in Wellington, Dufferin, and Guelph needed $191.29 per week to purchase a NFB.[29] The cost of a NFB for our area has increased by 5.7% since 2011 and by 14.5% since 2009.[30] This may partially explain the rise in food bank use in Guelph and Wellington County during this time period.

Breakfast, lunch, and snack programs for secondary school youth are quite common in Wellington, Dufferin, and Guelph. The majority of both public and Catholic secondary schools are supported by Food and Friends, a program run by the Children's Foundation of Guelph and Wellington. Food and Friends operates in 91% of secondary schools in the Upper Grand District School Board and 75% of high schools in the Wellington Catholic District School Board. Food and Friends expects to support more than 13,000 school-aged children and youth in the 2012/2013 school year. As of 2011, Food and Friends ran 83 nutrition programs for students across Wellington, Dufferin and Guelph.

Housing and shelters

The availability of affordable housing also impacts the healthy development of youth and children. When safe and affordable housing is accessible to families, it reduces the risk for injury, illness and communicable diseases, such as influenza, and a variety of other negative health outcomes. A lack of affordable housing can also negatively impact parent-youth relationships, result in sleep deprivation, cause difficulties at school, and increase the likelihood for behavioural problems.[31, 32]

Unstable housing can result in a very transient lifestyle for youth, as families need to move multiple times in order to find adequate housing. This transient lifestyle can have a negative impact on development, diminishing the social and emotional well-being of youth and children. Research has demonstrated that youth who move more than three times during their childhood are at an increased risk for experiencing behavioural problems and poor school performance.[33] Moving also disrupts youth's social supports, causing them to lose valuable ties with family, friends, and community.[34] Stable, affordable housing is also considered to be essential for securing employment and for providing a supportive home for raising youth. In addition, stable housing allows families easier access to essential services such as education, and health care. Housing is considered affordable if it costs less than 30% of the household income.[35]

- In Ontario, one out of every five rental households pays more than 50% of their household income on rent.[36] With the money that is left over, it is often a financial struggle to provide other basic needs.
- Based on 2006 Census data, 41.2% of tenant households in Guelph spent 30% or more of their income on rent, and 18.0% spent 50% or more of their income on rent.[37]

Tables 3.2 and 3.3 provide information on the availability of subsidized housing in our community, and subsequent wait times for people to obtain this housing. Subsidized housing is administered

by the County of Wellington and the County of Dufferin, and includes county-owned buildings, non-profit housing, co-operative housing, and some private housing providers. The rent for subsidized housing is geared to the income level of the tenant (rent-geared-to-income). Availability of subsidized housing can change from month to month. Caution must be taken when comparing numbers between these tables, as they include raw numbers rather than proportional references. It is important to consider the difference in population size in the areas shown. Also, the time frame of the reported data varies between Table 3.2 and 3.3. Data from Dufferin County (Table 3.2) comes from July 2011 to July 2012; while data from Guelph and Wellington County (Table 3.3) comes from January 2011.

Table 3.2 **Dufferin County subsidized housing units for families with wait times**

Unit size	Number of subsidized units	Average wait time	Range of wait time
2 bedrooms	317 (all filled)	1 year 11 months	1 year 6 months – 2 years 6 months
3 bedrooms		2 years 4 months	n/a
4 bedrooms		3 years 8 months	n/a
5 bedrooms		n/a	n/a

Source: *Housing Access Dufferin. Yardi Software Database. Accessed August 2012. General Waitlist Report, Unit Directory Report by Unit Size, and Average Wait for Housing.*

Note: "Average wait time" and "range of wait time" are based on wait times that were experienced by tenants in housing August 2012 who moved in between July 2011 and July 2012.

Wait times for subsidized housing in Dufferin County (Table 3.2) range from just under two years to more than three years, depending on the size of the unit, the number of bedrooms, and where it is located. In Dufferin, wait times increase as the number of bedrooms per unit increases. As of July 2012, there were 135 families (with dependents from birth up to age 18) on the wait list for a unit with two or more bedrooms. Youth, aged 16 and older, can be eligible for subsidized housing as head of the household (i.e., living independently), but there were no youth in subsidized housing as head of the household as of July 2012 for Dufferin County. There were, however, three youth, ages 16 to 18, on the wait list.

Table 3.3 **Guelph and Wellington County subsidized housing units for families with wait times**

	Number of subsidized units		Average wait time	
Unit size	**Guelph**	**Wellington County**	**Guelph**	**Wellington County**
1 bedroom	2,238	516	3 to 9 years	3 to 5 years
2 bedrooms			3 years 6 months	2 years
3 bedrooms			4 years	2 years
4-5 bedrooms			6 years	2 years 6 months

Source: *County of Wellington Housing Services. Personal correspondence, October 2012.*
Note: Average wait times are based on wait times as of January 2011.

As shown in Table 3.3, the average wait time in Guelph varies depending on the size of the unit, from three years to nine years. In Wellington County, the average wait time varies between two and five years. In both cases, one bedroom units have the longest wait times. As of December 2011, there were 1,320 active households on the social housing wait list in Wellington County. Of those active households on the waitlist, 502 were families.

Families who do not have adequate supports to maintain housing and who do not have access to subsidized units may need to access emergency shelters. Family breakdown or safety concerns may also necessitate accessing emergency shelters. Emergency shelters are available throughout Wellington, Dufferin, and Guelph and some are accessible to families with children and youth. Youth, ages of 16 and older, can also access shelter independently.

Table 3.4 outlines the total number of youth, ages 16 to 18, who independently accessed emergency shelters in Wellington, Dufferin, and Guelph between 2007 and 2011. The numbers in the table represent unique individuals who accessed the services in a year. Again, caution must be taken when comparing numbers between Wellington, Dufferin, and Guelph, as this table includes raw numbers, rather than proportional references. It is important to consider the difference in population size in the areas shown. Additionally, it is important to note that due to the transient nature of many of the youth who access emergency shelters, some of the youth captured in the figures below may be from a community outside of Wellington, Dufferin, and Guelph and may not have always been residents of the area. Also, other than Ramoth House, which serves pregnant and parenting young women, there are no emergency youth shelters in Wellington County. This means that youth, who are not pregnant or parenting, from Wellington County must go to Guelph, Dufferin, or other surrounding communities to access emergency shelters.

Table 3.4 **Emergency shelter and long-term transitional housing use among youth, ages 16 to 18, in Wellington, Dufferin, and Guelph, 2007 to 2011**

Number of youth, ages 16 to 18, accessing emergency shelters		
Year	**Guelph & Wellington**	**Dufferin**
2007	74	47
2008	85	40
2009	90	48
2010	88	35
2011	79	43

Source: *Homeless Individuals & Families Information System (HIFIS), 2007 to 2011; Personal Correspondence with Wyndham House, Women in Crisis, and Michael House, March 2012 to February 2013.*

Note: Wellington & Guelph Shelters include: Wyndham House Youth Shelter (Guelph), Michael House (for pregnant women)(Guelph), Ramoth House (Wellington), and Women in Crisis (Guelph). Michael House is not represented in 2007, as numbers were tracked in a different database prior to 2008 and have been archived. Dufferin Shelters include: Choices Youth Shelter.

Stepping Stones and Elizabeth Place are part of the Welcome In Drop-In Corporation and are for adults 21 years of age and over.

Local housing priorities have been identified to provide shelter to individuals living in poverty and to assist homeless individuals, families, and those at risk of homelessness to gain and maintain stable housing. The Wellington and Guelph Housing Committee, a committee of the Guelph & Wellington Task Force for Poverty Elimination (the Poverty Task Force), advocates for and encourages the development and retention of adequate housing to meet the needs of the homeless and to provide an adequate supply of stable and affordable rental housing for the residents of Guelph and Wellington County. The federal government also funds community agencies in Wellington and Guelph, under the Homelessness Partnering Strategy, to provide housing supports and homelessness prevention services. In Dufferin, there are also a number of agencies that provide emergency, transitional, or long-term housing and support, as well as homelessness prevention services. The County of Dufferin also has a Homelessness Prevention Program run by the Community Services department.

Hidden homelessness

The shelter statistics presented in this chapter do not provide the complete picture of homelessness experienced in Wellington, Dufferin, and Guelph. Many more youth experience "hidden homelessness", living transiently with family or friends, or even in a car.[38] At present, there is no consistent way of measuring hidden homelessness.

In addition to housing security, the Poverty Task Force also aims to address each of the abovementioned indicators, including economic and food security. This local initiative moves poverty reduction issues forward on many levels through active involvement of the members, which include residents, organizations, local businesses, government, and researchers. This initiative was developed in response to recommendations from the Poverty Symposium to develop a local strategy for addressing poverty.

Supportive family and friends

The abovementioned indicators in this chapter represent tangible and material resources related to basic needs. While youth in our community, through the Wellington-Dufferin-Guelph Youth Engagement Workshops, outlined nutritious food, shelter, and financial stability as essential needs, they also stressed the importance of family and friends as a fundamental requirement for adequate health and well-being. Findings from the Wellington-Dufferin-Guelph Youth Survey relating to the influence and support of friends and family are discussed in greater detail in *Chapter 6: A right to quality time with our friends, family, and/or other positive mentors in our community.*

Endnotes

1 World Health Organization. (1989). *Health principles of housing*. Geneva, Switzerland: World Health Organization.

2 Anderson, L. M., St. Charles, J., Fullilove, M. T., Scrimshaw, S. C., Fielding, J. F., et al. (2003). Providing affordable family housing and reducing residential segregation by income. *American Journal of Preventative Medicine, 24*(4S), 47-67.

3 Freeman, L. (2002). America's affordable housing crisis: a contract unfulfilled. *American Journal of Public Health, 92*, 709–12.

4 Roker D. (1998). *Worth more than this: Young people growing up in family poverty*. The Children's Society: London.

5 Attree, P. (2006). The social costs of child poverty: A systematic review of the literature. *Children & Society, 20*, 54-66

6 Anderson, S.A. (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition, 120*(11S), 1559–1600.

7 Cook, J. T., & Frank, D. A. (2008). Food security, poverty, and human development in the United States. *Annals of the New York Academy of Sciences, 1136*, 193-209.

8 Public Health Agency of Canada. (2011). *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*.

9 Canadian Institute for Health Information. (2005). *Improving the Health of Young Canadians.* Canadian Institute for Health Information: Ottawa.

10 Ibid.

11 Ibid.

12 Attree, P. (2006). The social costs of child poverty: A systematic review of the literature. *Children & Society, 20*, 54-66.

13 Roker D. (1998). *Worth more than this: Young people growing up in family poverty*. The Children's Society: London.

14 Daly, M. & Leonard, M. (2002). *Against all odds: Family life on a low income in Ireland*. Combat Poverty Agency: Dublin.

15 Attree, P. (2006). The social costs of child poverty: A systematic review of the literature. *Children & Society, 20*, 54-66.

16 Shillington, R. & Stapleton, J. (2010). Cutting through the fog: Why is it so hard to make sense of poverty measures? Metcalf Foundation. Retrieved from: **http://metcalffoundation.com/wp-content/uploads/2011/05/cutting-through-the-fog.pdf**

17 Institute for Community Engaged Scholarship, The Research Shop. (2010). The community researcher project: Exploring economic hardship in Guelph and Wellington. Retrieved from: **http://www.theresearchshop.ca/sites/default/files/The%20Community%20Researcher%20Project.pdf**.

18 Langille, D (2010). Poor no more: Facts about the working poor in Canada. Retrieved from: **http://www.poornomore.ca/files/workingpoor.pdf**.

19 Ibid.

20 2010 Report Card on Child and Family Poverty in Canada: 1989-2010. Retrieved from: **http://www.campaign2000.ca/reportCards/national/2010EnglishC2000NationalReportCard.pdf**.

21 Beaujot, R., Avison, W., Davies, L., Fernando, R., Kerr, D., Andersen, R. & Ravanera, Z.R. (2004). The Family, Community, and Health in the Context of Economic Change. Retrieved from: **http://sociology.uwo.ca/familyhealth/Health%20Impact%20of%20Economic%20Change%20Proposal4.pdf**.

22 Cook, J. T., & Frank, D. A. (2008). Food security, poverty, and human development in the United States. *Annals of the New York Academy of Sciences, 1136*, 193-209.

23 Alaimo, K., Olson, C. M., & Frongillo, E. A. (2002). Family food insufficiency, but not low family income, is positively associated with dysthymia and suicide symptoms in adolescents. *Journal of Nutrition, 132,* 719–725.
24 Cook, J. T., & Frank, D. A. (2008). Food security, poverty, and human development in the United States. *Annals of the New York Academy of Sciences, 1136*, 193-209.
25 Food Banks Canada Hunger Count Survey, 2009 to 2012, Adult and Children Breakdown for Wellington and Dufferin Counties. Personal correspondence with Food Banks Canada, May 2012.
26 Ibid.
27 Mercer, N. (October 3, 2012). Board of health report – BH.01.OCT0312.R22. Wellington-Dufferin-Guelph Public Health.
28 Ministry of Health Promotion. (2010). Nutritious food basket guidance document (Draft). Retrieved from: **http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/pdfs/nutritious_food_basket_guidance_document.pdf**.
29 Mercer, N. (October 3, 2012). Board of health report – BH.01.OCT0312.R22. Wellington-Dufferin-Guelph Public Health.
30 Ibid.
31 Children's Hospital of Eastern Ontario (2003). *Adequate and Affordable Housing: A Child Health Issue. An Overview of Research Linking Children's Health Status to Poor Housing*.
32 Goldstein, G., Novick, R., & Schaefer, M. (1990). Housing health and well-being: an international perspective. *Journal of Sociology and Social Welfare,* 17(1), 161-181.
33 Institute of Child Protection Services. (2006). *The experiences and effects of family homelessness for children.* Retrieved from: **http://www.dhcs.act.gov.au/__data/assets/pdf_file/0004/10300/Homeless_Children_LitReviewExperiences.pdf**
34 Beauvais, C. & Jenson, J. (March 2003). *The well-being of children: are there "neighbourhood effects"?* Retrieved from: **http://www.cprn.org/documents/18052_en.pdf**.
35 Canadian Mortgage and Housing Corporation (2010). *What is the common definition of affordability*? Retrieved from: **http://www.cmhc-schl.gc.ca/en/corp/faq/faq_002.cfm#5**
36 Watt, J., Dickey, M. & Grakist, D. (No date). Middle childhood matters: A framework to promote healthy development of children 6 to 12. Retrieved from: **http://www.child-youth-health.net/en/child-youth-health/Middle_Childhood_Matters_p275.html**.
37 Statistics Canada (2006). *Gross Rent as a Percentage of 2005 Household Income.* Retrieved from: **http://www40.statcan.ca/l01/cst01/famil129d-eng.htm**
38 Echenberg, H. & Jensen, H. (2008). Defining and enumerating homelessness in Canada. *Library of Parliament*, Retrieved from: **http://www.parl.gc.ca/Content/LOP/researchpublications/prb0830-e.pdf**


RACE FACE

4. A right to affordable activities and programs, and safe places to hang out

Introduction

The link to youth's well-being

Individual health is shaped by the social and physical environments of neighbourhoods. Youth are more likely to be physically active when they live in neighbourhoods that have affordable resources for exercise, such as parks and jogging trails, and have less litter and graffiti.[1] Youth are also more likely to be active when neighbourhoods have lower levels of crime, vandalism, and individuals exhibiting unhealthy behaviours such as smoking and alcohol use.[2] Throughout the literature youth regularly identify the need for activities and programs that are safe, affordable, and close in proximity.[3] The importance of adult supervision, adequate lighting, reduced fees, and low travel costs have been highlighted as important precursors to regular youth engagement. Without the abovementioned factors, youth are less willing to engage in community programs. Additionally, while youth cite the importance of having an adult present to act as moderator and remove any individuals who are causing problems, they also stress the importance of having their own space to interact with peers away from adult supervision.

Quality time with peers is an important component in the healthy development of youth. Youth who have difficulty developing and maintaining positive relationships with peers are more likely to engage in violent behaviour,[4] have high degrees of loneliness and depression,[5] report low academic achievement, and experience high levels of unemployment later in life.[6] Youth friendships can also buffer the negative impact of family problems,[7] improve self-esteem,[8] and enhance social competence and leadership qualities.[9] As a result, access to safe and affordable programs that foster peer relationships while engaging youth in physical activity or other programming is important in the healthy development of youth.

The hours between 3:00 pm and 6:00 pm on school days are typically unstructured time for youth, as they are not in school during these hours and their parents/caregivers may not be home from work. During this time, they are more likely to commit crimes, participate in sexual activity, smoke, drink, and use drugs.[10] Consequently, after-school programs that are close in proximity, safe, and affordable have the potential to drastically reduce unhealthy behaviours in youth. Youth that access after-school programs are also more likely to have more positive behaviours, higher academic standing, and better school attendance.[11]

The physical environment of a community is an important determinant of youths' participation in physical activity and recreation.[12] The built environment (e.g., community design, availability of open spaces, parks, etc.) is a critical consideration when assessing youths' access to safe spaces and has received increased attention in public health and social planning. The 2009 *Report on the State of Public Health in Canada* identified the built environment as a key area of action to counteract the increasing rates of overweight and obesity among children.[13] Research evidence has demonstrated that physical activity levels are significantly higher and obesity rates lower in more walkable environments and in communities where youth live close to parks and recreation facilities.[14, 15,16] More recently, there is evidence that

suggests that the built environment and natural environmental experiences can also impact mental health (e.g., depressive symptoms and stress levels), behavioural issues (e.g., attention-deficit hyperactivity disorder), learning and cognitive functioning, and overall health and well-being in young people.[17]

Indicators of youth's health and well-being in this chapter

The indicators for which there will be local data in this chapter include:

- Youth programs
- Supports for participation in recreational activities
- Access to community-based recreation and organized activities

The value of this information to service providers

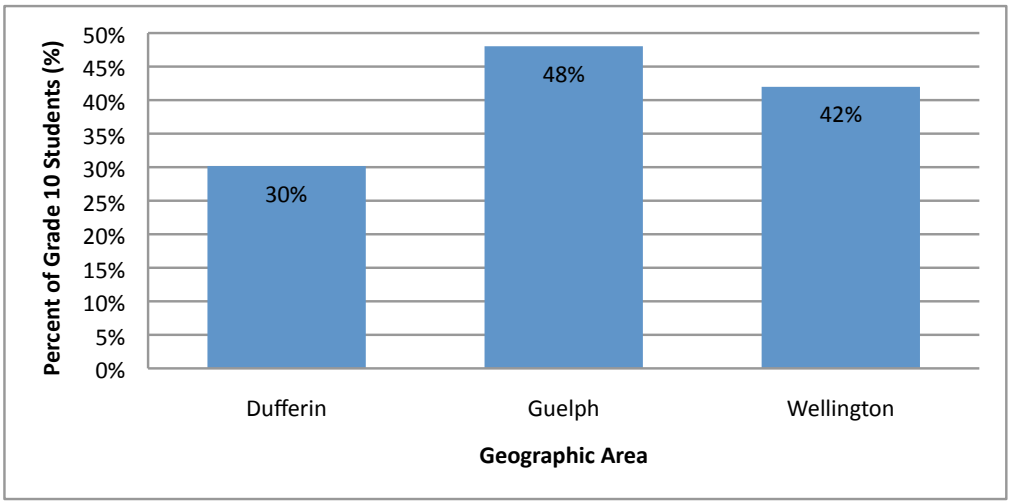
Compared with adults, youth are more limited in their ability to plan their daily routines and gain access to activities and programs without transportation or help from a parent or guardian.[18] Youths' access can be further limited or varied because of factors such as family resources and support.[19] As a result, the built environment is an even more important determinant of health and engagement among youth. Service providers must create programs that can encourage youth involvement regardless of socioeconomic status by providing free and/or low cost opportunities that are easily accessible by youth. Additionally, research has underscored the importance of creating safe places to hang out and affordable programming within neighbourhoods. By providing youth with activities and programs that are closer to home, it reduces associated travel costs and improves concerns regarding safety, potentially increasing enrolment.

Planning for safe and effective environments, programs, and activities that support youth development is complex. At the community level, planning for youth recreational activities tends to be less coordinated than planning for other services that are publicly funded. Developmental health research evidence has identified several elements needed within recreation activities for supporting youth's positive development. These elements include physical and psychological safety; emotional and moral support; supportive adult relationships; opportunities to form close human relationships; promotion of belonging and feeling valued; opportunities for skill building; support for personal efficacy; and opportunities to contribute to one's community.[20]

Youth programs

The Wellington-Dufferin-Guelph (WDG) Youth Survey included questions that provide a measure of involvement in various youth programs. The survey asked youth how often they have participated in the following activities in the past 12 months: (1) played on a sports team (e.g., basketball, hockey, soccer, volleyball); (2) visited their local library; (3) attended religious services; and (4) attended a youth program (e.g., drop-in program). The *Youth Programs* indicator takes into consideration the responses to all four questions. Analysis of this indicator revealed that there was a statistically significant relationship between *Youth Programs* and geographic area. Figure 4.1 illustrates that more grade 10 students in Guelph (48%) reported high levels of *Youth Programs* involvement when compared to students in Wellington (42%) and Dufferin (30%).

Figure 4.1 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Youth Programs* involvement, by geographic area, 2012**



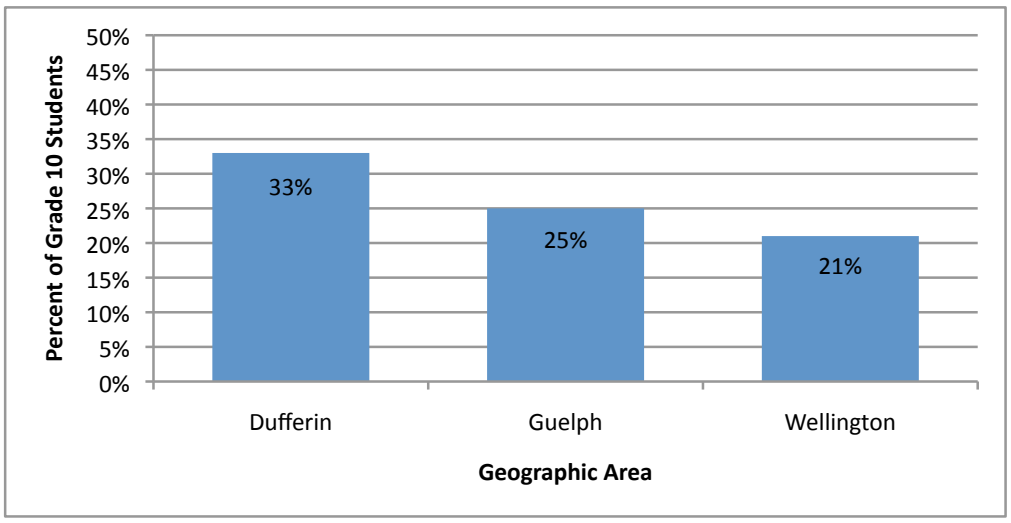
Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 44 students (4%) did not complete the survey questions for Youth Programs.

While the geographic differences illustrated in Figure 4.1 may be partially understood by considering urban versus rural differences in access, there is still a notable difference between the rates in Wellington and Dufferin. In order to further understand this indicator, the four questions included in *Youth Programs* were broken down by type of activity for analysis. This level of analysis is also valuable given that these activities are quite different in nature. The survey questions for each of these activities involved multiple response categories (e.g., never, less than once a month, once a month, 2-3 times a month, once a week, more than once a week). Given that there is no established level of participation necessary to experience the associated benefits of youth program involvement, examining the absence of these activities was the most appropriate approach for examining these data. Therefore, Figures 4.2 to 4.6 present the percentage of youth who have "never" participated in each of these activities in the past year.

The first question asked youth about their participation in sports teams. There is a vast body of research that demonstrates the positive outcomes associated with sport involvement among children and youth, including physical health, psychological well-being, self esteem, and lowered risk for substance use.[21] Figures 4.2 and 4.3 illustrate the percentage of grade 10 students who reported never playing on a sports team in the past 12 months. As indicated in Figure 4.2, there was a statistically significant relationship between not playing on a sports team in the past 12 months and geographic area. More students in Dufferin (33%) have not played on a sports team in the past 12 months, compared to Guelph (25%) and Wellington (21%). In Wellington, Dufferin, and Guelph, there does not appear to be an urban versus rural difference when looking at youth who have not played on a sports team in the past 12 months, despite what previous research suggests. Studies have indicated that youth living in rural communities may face more challenges to participation in organized sports and physical activity opportunities compared to their urban peers.[22] There may be several explanations for these differences in local participation rates, such as the economic, community and cultural environment, which are beyond the scope of the WDG Youth Survey analysis.

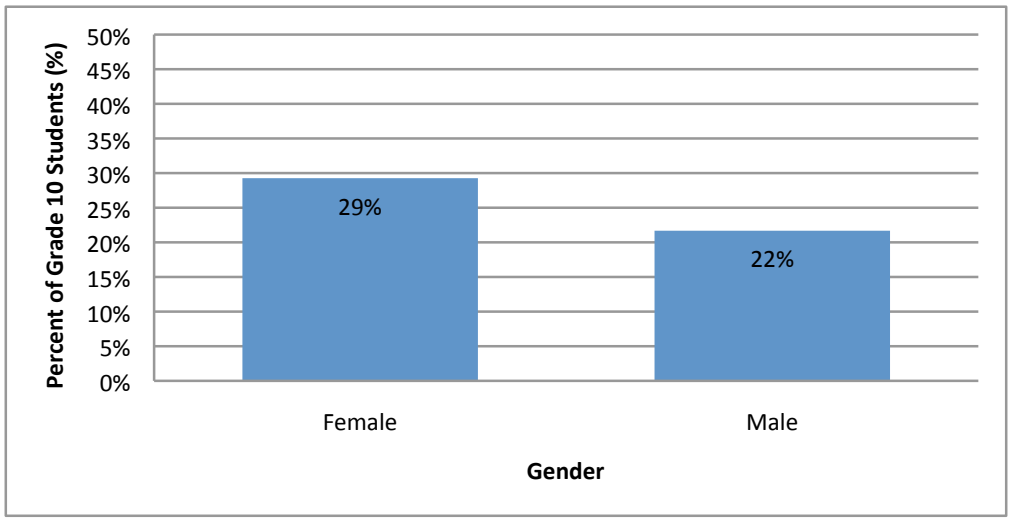
Figure 4.2 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph, who reported *never* playing on a sports team in the past 12 months, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 19 students (2%) did not complete the survey question for playing on a sports team.

Figure 4.3 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph, who reported *never* playing on a sports team in the past 12 months, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 19 students (2%) did not complete the survey question for playing on a sports team.

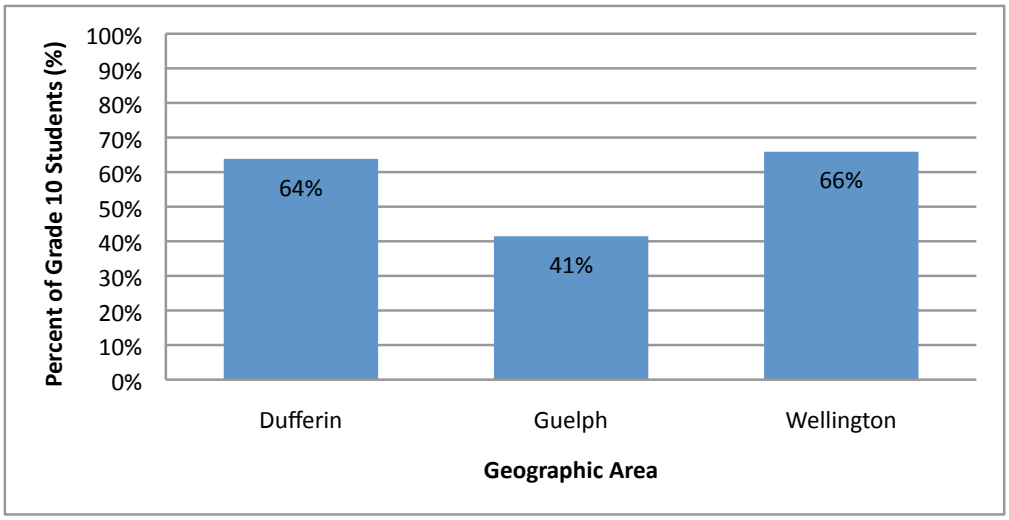
There was also a statistically significant relationship between youth who reported never playing on a sports team in the past 12 months and gender. Figure 4.3 demonstrates that more grade 10 females (29%) reported never playing on a sports team in the past 12 months compared

to males (22%). This gender difference is consistent with the findings from a larger body of sociological and psychological research that has concluded that females, especially in late childhood and adolescence, have much lower activity levels in many organized sport and other forms of physical activity involvement compared to males.[23,24,25,26] Sociological research has found that these gender differences are quite strong and emerge at an early age. The gender differences can be partially explained by attitudes toward sport, which are largely a consequence of gender-socialization, rather than actual gender-related aptitude differences in sport.[27] A more recent study on adolescents, ages 12 to 16, concluded that body image concerns and teasing may explain why female participation rates in sport and other physical activities are lower compared to males.[28]

Attending religious services was another activity examined in the *Youth Programs* indicator. Compared to other recreational activities, involvement in religious or faith-based services has not been as widely researched. There is a growing body of empirical evidence that demonstrates an association between greater religious involvement among parents and youth and several protective factors for youth.[29] Religious involvement has also been found to support positive developmental outcomes and prosocial behaviour among youth.[30] A study examined the benefits associated with religious involvement among youth through the mediating effects of developmental resources proven to be important during adolescence. The study found that religious involvement was associated with increases in developmental assets among youth. The researchers suggest that these positive outcomes can be explained by the increased access to a variety of social and personal resources as a result of their religious affiliate, rather than simply religious involvement.[31]

Overall, there is a limited understanding of youth involvement in religious services. To address this gap, a study mapped religious participation among American youth and found that there is a great deal of variance in the frequency of religious service attendance.[32] Analysis of the WDG Youth Survey found that there was a statistically significant relationship between never attending a religious service in the past 12 months and geographic area. Figure 4.4 illustrates that more grade 10 students in Dufferin (64%) and Wellington (66%) reported never attending a religious service in the past 12 months compared to grade 10 students in Guelph (41%).

Figure 4.4 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph, who reported *never* attending a religious service in the past 12 months, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 27 students (2%) did not complete the survey question for attending religious services.

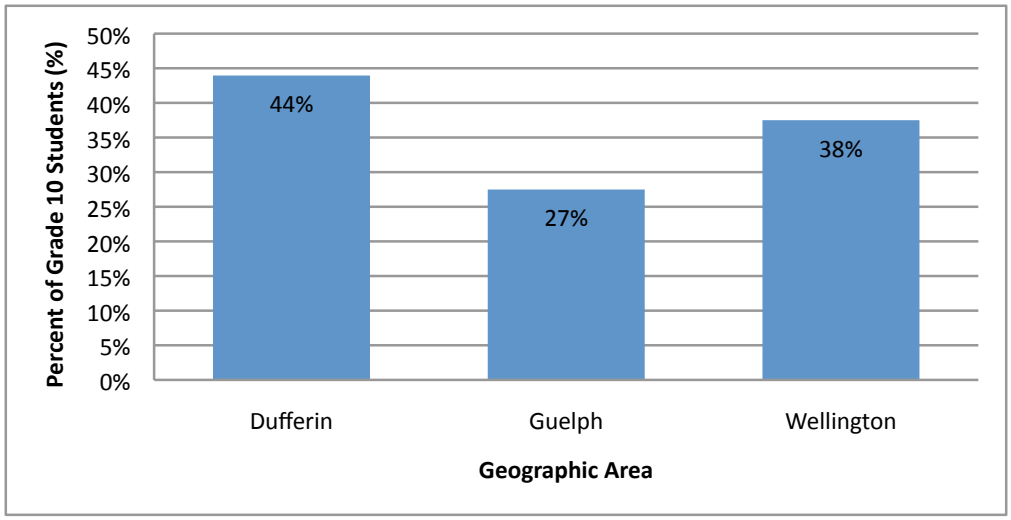
There is very little research that explores urban and rural differences in religious service involvement, especially specific to youth. One study found that there was greater religious involvement among rural families, which was explained by the central importance of a church in rural community life.[33] In Wellington, Dufferin, and Guelph, more youth report never attending a religious service in the past 12 months in our more rural areas. A potential explanation may be that, in urban areas, there are more options, and a greater diversity of options in terms of religious affiliations. Urban areas often have a more ethnically diverse population than rural areas. Also, among different ethnic, racial, and cultural communities, there are varying degrees of expectations related to religious involvement and traditions.[34] Furthermore, these geographic patterns of religious service involvement may also be explained by the fact that, within our geographic area, Catholic Secondary Schools are located only in the City of Guelph.

In Wellington, Dufferin, and Guelph, there was no relationship between never attending a religious service in the past 12 months and gender.

Another construct of the *Youth Programs* indicator is visiting the local library in the past 12 months. In recent years, community libraries are increasingly viewed as an integral part of community collaboration to support positive youth development. Collaborative planning systems, community organizations, and citizens alike view libraries as an important partner for supporting youth development.[35] Libraries provide ideal spaces for youth in the community, as they possess many of the key characteristics of what youth desire in spaces (e.g., an area where they can convene with other youth and be alone, accessible, unsupervised (but within reach of an adult), safe).[36] Even if a library does not have the capacity to create spaces dedicated to youth, it is still important that they create a youth-friendly environment.[37] In the past decade, there has been a dramatic increase in the amount of space dedicated to youth in libraries. [38] Youth spaces in libraries are essential for encouraging the positive use of libraries for recreational activities and education.[39] Libraries can be one of the most valuable community resources to support youths' education (both informal and formal learning) and development. Libraries can contribute to youth development through specific programs and services targeted at youth, and also by providing an intentionally safe and supportive environment, facilitating opportunities to connect with peers and adults in a positive way, build skills, and have a sense of belonging. [40]

An analysis of the WDG Youth Survey found that there was a statistically significant relationship between youth who never visited their local library in the past 12 months and geographic area. Figure 4.5 illustrates that there were fewer grade 10 students who have not been to the library in the past 12 months in Guelph (27%), compared to Dufferin (44%) and Wellington (38%).

Figure 4.5 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph, who reported *never* going to their local library in the past 12 months, by geographic area, 2012**



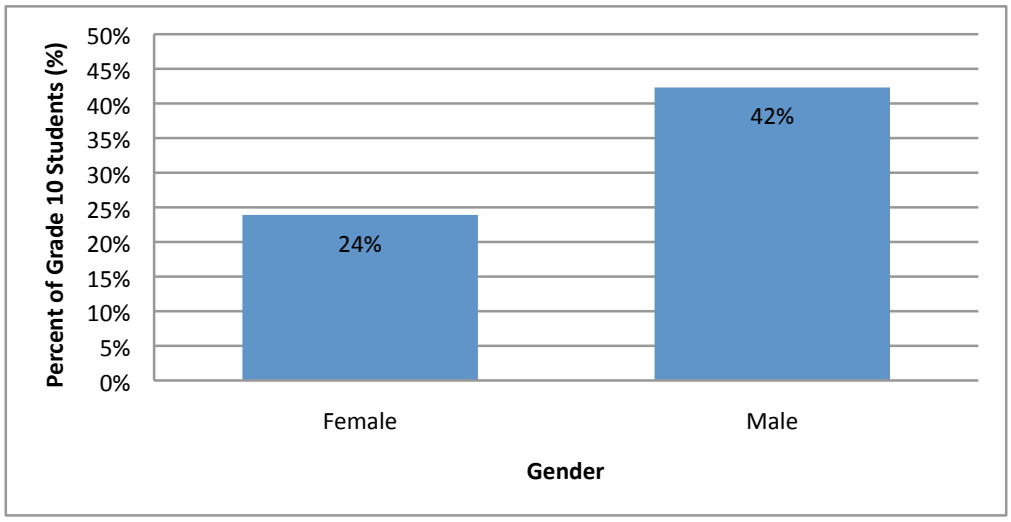
Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 18 students (1%) did not complete the survey question for visiting a local library.

These differences may be partially attributed to geographic distribution of libraries and potentially inequitable access when comparing urban and rural areas. It is also important to consider that there are likely differences in education, culture, and relationships that tie individuals to community organizations such as libraries, and other socio-economic conditions that influence whether or not youth access libraries within the smaller communities of Wellington, Dufferin, and Guelph. [41]

The WDG Youth Survey analysis also revealed a statistically significant relationship between never visiting the local library in the past 12 months and gender among grade 10 students in Wellington, Dufferin, and Guelph. Figure 4.6 illustrates that more males (42%) reported never visiting their local library in the past 12 months compared to females (24%). This trend is consistent with the existing body of research literature on adolescent gender differences and public library use. Research has found that, in general, female youth express more positive attitudes toward libraries than males. Females are more likely to check out books, report that staff members are friendly to them, and attend youth activities at the library. [42, 43] There are, however, no identified gender differences in terms of what motivates youth to use the library. A study found that the top three reasons for utilizing a public library among both male and female youth were for informational needs, social interaction, and the beneficial physical environment of the library.[44] This indicates that libraries may provide an important space for youth, despite the increasingly cyber-oriented world in which libraries can operate.

Figure 4.6 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph, who reported *never* going to their local library in the past 12 months, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 18 students (1%) did not complete the survey question for visiting a local library.

The final construct of the *Youth Programs* indicators from the WDG Youth Survey was attending a youth program (e.g., drop-in program). There was no statistically significant relationship between youth attending a youth program and geographic area or gender. Overall, in Wellington, Dufferin, and Guelph, 70% of youth reported never attending a youth program in the past 12 months. In the past 30 years, there has been an increased focus on programming targeted to youth, and recently, research has focused on evaluating these programs to understand what elements contribute to successful programs.[45] A review of the literature on best practices of youth development programs identified three key components of youth programs, including: 1) an asset-based approach, which promotes the strengths and skills of youth and focuses on positive development; 2) caring and supportive adults that provide leadership in the programs and develop strong bonds with the youth; and 3) an ongoing evaluation and tracking system to monitor the effectiveness and quality of implementation that results in regular involvement of youth in positive activities. [46, 47]

An example of a youth drop-in program in our community is the Youth Resource Centre through Wyndham House in Guelph. The Resource Centre began in 2008 and is targeted to at-risk youth, ages 16 years of age and older. Youth accessing the Resource Centre may be seeking emergency shelter or assistance finding alternative housing, access to emergency food or clothing, bus tickets, ID replacement referrals, counselling referrals, or assistance with any basic needs. The Resource Centre also offers a variety of workshops to youth as a means of fostering life skills and improving quality of life. Since its inception, the Resource Centre has consistently experienced increases in the number of youth accessing the space, services, and programs. For example, the number of youth, ages 16 to 18, accessing the Resource Centre increased from 233 in 2009 to 462 in 2011. It is also worthwhile noting that the Resource Centre tends to attract older youth (i.e., ages 18 years and older) to their space. Within the 16 to 18 year old age group examined, approximately 80% of those youth are 18 years old.

Supports for participation in recreation activities

The understanding of the positive impact of participation in recreation activities on the health, development, and well-being of children and youth is recognized in health promotion, recreation studies, and development studies. At the same time, however, access to recreation activities is more dramatically polarized than other social services. Recreation activities, especially formal, organized activities, are considered to be optional and participation is largely influenced by individual or family interest toward specific reaction activities. This perception tends to distance the responsibility of planning recreational activities for all children and youth from the service delivery sector. Instead, the responsibility for planning recreational activities for youth tends to rest at the family- or personal-level. Consequently, the social and economic circumstances of families and youth impacts how they participate in organized recreational activities. Research demonstrates that children and youth in families with fewer social and economic resources not only have less access to formal recreational activities, but they also have less access to time and space for more informal activities and recreation within their local neighbourhoods.[48]

In an attempt to rectify some of the inconsistencies in access to recreation activities, subsidies are sometimes available. Subsidies for participation in recreation tend to be offered by independent organizations or by local foundations. They are most often delivered to families based on family income levels or an assessment of need. In some cases, recreation subsidies are made available to families of children and youth with special developmental needs. It is important to note that the numbers presented below do not fully capture the need in our community. Research has shown that information about recreational programming, available subsidies, and the process to apply for the subsidies can all be barriers to actually pursuing these resources.[49] Furthermore, these numbers do not capture those families with children and youth that applied, but did not receive the subsidy.

In Guelph and Wellington, the Children's Foundation provides subsidies for a wide variety of recreation activities for children and youth, ages birth to 18. These subsidies support a range of community-based activities, including organized sports, swimming, summer camps, and art and music lessons. In 2010, the Children's Foundation of Guelph and Wellington funded 699 children and youth for participation in these activities. This number increased to 731 in 2011. While there are no data to report on the number of applicants submitted each year, the Children's Foundation has reported an increase in the number of applicants over recent years. This further highlights the need to develop more accessible and barrier-free recreational activities in our community.

Subsidies provided by the YMCA-YWCA support access to YMCA-YWCA based programs for children and youth from birth to 18 years of age. The YMCA-YWCA of Guelph reports that, in 2010, they experienced a 30% increase in requests for recreation subsidies compared to the previous year. For a 12-month period (June 2009 to June 2010), 776 children and youth received support for a YMCA-YWCA membership, and 410 children and youth received support for participation in day and resident YMCA-YWCA camp programs, for a total of 1,186 children and youth supported. In 2011, this number increased for a total of 1,215 children and youth who received subsidies for participation in YMCA-YWCA memberships and recreation programs, including camps.

In Dufferin County, there are recreation subsidies available through the Jumpstart Program for children and youth, ages 4 to 18. Each fall and spring since 2008, Jumpstart has provided subsidies for activities such as soccer, hockey, dance, gymnastics, swimming, football, martial arts, Guides, and Scouts. Table 4.1 summarizes the number of children and youth, ages 4 to 18, who received subsidies during 2010 to 2012, as well as the average cost per child. The number of children

and youth that received subsidies had increased each year, as well as the average cost per child. This increase can be attributed mainly to additional funding, due to carryover from previous funding years, as well as an increase in program awareness, and an increase in community partners who can field requests for recreation subsidies.

Table 4.1 **Number of children and youth, ages 4 to 18, who received recreation subsidies (Jumpstart) and average cost, Dufferin County, 2010 to 2012**

Year	Number of children and youth, ages 4 to 18	Average cost per children and youth, ages 4 to 18
2010	69	$176.48
2011	147	$211.92
2012	205	$210.47

Source: *Jumpstart Charities (Orangeville Chapter), personal communication, March 2013*

Based on the proven benefit of recreation and leisure activities for at-risk youth, a group of community partners in Guelph and Wellington received support from the Healthy Communities Fund to develop a program that would remove some of the barriers to accessing recreation. The STEPS Program (Support Through Engagement, Programming and Sport) was launched in Guelph during March 2011. This program is run through Wyndham House in partnership with the City of Guelph and Wellington-Dufferin-Guelph Public Health. STEPS is targeted to at-risk youth, ages 15 to 24, or anyone that is youth-identified, providing them with free access to recreation and leisure activities in Guelph and Wellington. The program does not involve any fee and provides clothing, shoes, equipment and transportation when necessary. As of March 2013, the STEPS program has provided recreational programming to over 700 youth who would not normally have had access to such opportunities.

Access to community-based recreation and organized activities

As discussed throughout this chapter, it is critical to acknowledge the range of constraints that youth experience when attempting to access recreational and organized activities. In doing so, service providers will be better able to address these constraints so that our community can support youth in realizing their right to affordable activities, programs, and safe places to hang out. Many health and developmental outcomes for youth that are understood to be connected to coordinated systems of supports and services for youth are also being connected to their involvement in recreation and community-based activities.

In the previous *Report Card on The Well-Being of Children Ages 7 to 13*, local services, programs, agencies, and infrastructure (e.g., recreation centres, pools, arenas) that provided resources to children, ages 7 to 13, were mapped along with the distribution of that population age group. The purpose of these maps was to illustrate access to recreational and organized activities that are valuable to the health and development of children in middle childhood. There were several limitations

to presenting the information in this way. The programs and services captured on the maps may not have included all services available, but only those found in local community databases. Furthermore, it is difficult to assess the extent to which these sources are maintained and kept up-to-date. It is also difficult to identify clear inclusion and exclusion criteria for the services, programs, agencies, and infrastructure included on the maps. Finally, maps are limited in their ability to capture the diversity of the access barriers, beyond geographic location. While programs may appear to be accessible to children and youth due to their geographic proximity on a map, they may not be accessible with regards to the resources necessary to participate (e.g., finances, transportation and cost, social and family support, and other intrapersonal considerations).

New approaches to research in this area demonstrate that simple measures of frequency of involvement in activities, or lists of available programs and activities may not fully explain the relationships between child and youth involvement in recreational activities and how those relationships contribute to their thriving development and well-being.[50] As more sophisticated models of analysis are being developed around leisure research, it is possible to identify the many constraints that affect an individual's choice to participate and their actual participation in these activities.[51] Given all of these considerations, rather than including maps that illustrate a potentially incomplete service inventory for youth, ages 14 to 18, the remainder of this chapter addresses other important access constraints that must be considered when engaging in youth program planning and service delivery.

As addressed in the previous section, socioeconomic constraints are well understood and researched in terms of recreation and leisure activities. Beyond the socioeconomic capacities of individual families, it is important to recognize that many low income residents live in communities and neighbourhoods that are "resource poor." Research has demonstrated that communities characterized by low income and visible minority populations experience limited access to parks and recreation. Furthermore, these parks are not as well maintained, are less safe, and have fewer services and facilities. [52,53] As a result, this may require additional transportation costs to segments of the population that already face challenges related to cost, safety, and time.

Recreation and leisure research encourages service providers to move beyond socioeconomic and geographical barriers to recognize a more comprehensive set of constraints. Researchers have proposed various models for understanding the full picture of constraints for participation in recreation among children and youth. Key concepts of these models include intrapersonal (e.g., perceived self-skill, socialization), interpersonal (e.g., interactions with others in the activities, social support, family support leaders/facilitators, cultural exposures and potential prejudice), and structural constraints (e.g., opportunities, facilities, time, transportation, and costs). [54,55] These models still acknowledge that socioeconomic factors pose systematic barriers to participation and result in significant inequalities.[56]

Family support can act as an important barrier or a facilitator to youth participation. Parents serve as important role models for their children and youth. Parents that are involved in community and recreational activities may serve as important facilitators to participation. Parents and family members can also provide important support and encouragement for participation. A study that examined data from Statistics Canada's General Social Survey on Time Use found that parental participation in sports activities is actually a stronger predictor of children's participation than income.[57]

Finally, service providers and organizations must also consider that youth services, recreational programs, and facilities need to be inclusive of all youth from various cultural, ethnic, and socio-economic backgrounds.[58] Research has demonstrated that ethnic minority youth are less likely to participate in activities and programs,[59] suggesting that service providers should focus on these populations to improve participation. Furthermore, many organizations do not have policies or procedures that support working with youth to ensure that programming is relevant, appealing, and meets the needs of all youth.[60]

Given the value of youth engagement discussed throughout this Report Card, as agencies work towards making youth-friendly programs and services that overcome many of the constraints discussed, it is critical that they involve youth in the planning and development.

Despite the understanding that recreation and youth programming are vital for healthy youth development, many barriers still exist and continue to create a divide among the youth population between those who can participate in programs and activities and those who cannot. This divide will likely be diminished as service providers continue to explore and understand these barriers to youth involvement.

Endnotes

1 Heinrich, K., Lee, R., Suminski, R., et al. (2007). Associations between the built environment and physical activity in public housing residents. *International Journal of Behavioral Nutrition and Physical Activity, 4*(1), 56.

2 Sampson, R., Morenoff, J., & Gannon-Rowley, T. (2002). Assessing "neighborhood effects": Social processes and new directions in research. *Annual Review of Sociology, 28*, 443-478.

3 Humbert, M. L., Chad, K. E., Bruner, M. W., Spink, K.S., Muhajarine, et al. (2008). Using a naturalistic ecological approach to examine the factors influencing youth physical activity across grade 7 to 12. *Health Education & Behavior, 35*(2), 158-173.

4 Newcomb, A.F., Bukowski, W.M., & Pattee, L. (1993). Children's peer relations: A meta-analytic review of popular, rejected, neglected, controversial, and average sociometric status. *Psychological Bulletin, 113,* 99-128.

5 Parker, J., Rubin, K., Price, J., & de Rosier, M. (1995). *Peer relationships, child development, and adjustment.* In D. Cicchetti & D. Cohen (Eds.), Developmental psychopathology: Vol 2. Risk, disorder, and adaptation (pp. 96-161). New York: Wiley.

6 Woodward, L.J., & Fergusson, D.M. (2000). Childhood peer relationship problems and later risks of educational under-achievement and underemployment. *Journal of Child Psychology and Psychiatry, 41,* 191-200.

7 Bolger, K.E., Patterson, C.J., & Kupersmidt, J.B. (1998). Peer relationships and self-esteem among children who have been maltreated. *Child Development*, *69*, 1171-1197.

8 Azmitia, M. (2002). Self, self-esteem, conflicts, and best friendships in early adolescence. In T. M. Brinthaupt (Ed.), Understanding early adolescent self and identity: Applications and interventions (pp. 167-192). Albany: State University of New York Press.

9 Newcomb, A.F., & Bagwell, C.L. (1995). Children's friendship relations: A meta-analytic review. *Psychological Bulletin, 117*, 306-347.

10 Newman, S., J. A. Fox, E. A. Flynn, and W. Christeson. 2000. *America's afterschool choice: The prime time for juvenile crime, or youth enrichment and achievement.* Washington, D.C.: Fight Crime: Invest in Kids.

11 de Kanter, A. (2001). After-school programs for adolescents. *NASSP Bulletin*, *85*(626), 12-21.

12 Moore, J.B., Jilcott, S.B., Shores, K.A., Evenson, K.R., Brownson, R.C., & Novick, L.F. (2010). A qualitative examination of perceived barriers and facilitators of physical activity for urban and rural youth. Health Education Research, 25 (2): 335-367.

13 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.

14 Frank, L. D., Anderson, M. A., & Schmid, T. L. (2004). Obesity relationships with community design, physical activity, and time spent in cars. *American Journal of Preventive Medicine, 27*(2), 87-96.

15 Canadian Institute for Health Information. (2004). Improving the health of Canadians. Ottawa, ON: Canadian Institute for Health Information.

16 University of California, Berkeley. Parks and Recreational Programs Help to Reduce Childhood Obesity Policy Brief. July 2011. University of California Regents. Retrieved from **http://www.activelivingresearch.org/files/PolicyBrief_ParkProximity.pdf**

17 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from **http://publichealth.gc.ca/CPHOreport**.

18 Moore, J. B. (2008). The built environment and physical activity: Influencing physical activity through healthy design. *Journal of Public Health Management and Practice, 14*, 209–10.

19 The Canadian Parks and Recreation Association (CPRA). (2001). Recreation and children and youth living in poverty: Barriers, benefits and success stories (Section II-Literature review and analysis). Developed by The Canadian Council on Social Development. Retrieved from **http://www.cpra.ca/UserFiles/File/EN/sitePdfs/initiatives/EGTP/literature.pdf**
20 Henderson, K. A., Whitaker, L. S., Bialeschki, M. D., Scalin, M. M., & Thurber, C. (2007). Summer camp experiences: Parental perceptions of youth development outcomes. *Journal of Family Issues, 28*: 987-1007.
21 Vilhjalmsson, R. & Kristjandsdottir, G. (2003). Gender differences in physical activity in older children and adolescents: The central role of organized sport. *Social Science & Medicine, 56,* 363-374.
22 Moore, J.B., Jilcott, S.B., Shores, K.A., Evenson, K.R., Brownson, R.C., & Novick, L.F. (2010). A qualitative examination of perceived barriers and facilitators of physical activity for urban and rural youth. *Health Education Research, 25*(2): 335-367.
23 Armstrong, N., Balding, J., Gentle, P., & Kirby, B. (1990). Patterns of physical activity among 11 to 16 year old British children. *British Medical Journal, 301,*203-205.
24 Guinn, B., Vincent, V., Semper, T., & Jorgensen, L. (2000). Activity involvement, goal perspective, and self-esteem among Mexican American adolescents. *Research Quarterly for Exercise and Sport, 71,* 308-311.
25 Sallis, J.F., Zakarian, J.M., Hovell, M.F., & Hofstetter, C.R. (1996). Ethnic, socioeconomic, and sex differences in physical activity among adolescents. *Journal of Clinical Epidemiology, 49,* 125-134.
26 Dunton, G.F., Berrigan, D., Ballard-Barbash, R., Perna, F., Graubard, B.I., Atienza, A.A. (2012). Differences in the intensity and duration of adolescents' sports and exercise across physical and social environments. *Research Quarterly for Exercise and Sport, 83* (3), 376-382.
27 Eccles, J.S. & Harold, R.D. (1991). Gender difference in sport involvement: Applying Eccles' expectancy-value model. *Journal of Applied Sport Psychology, 3,* 7-35.
28 Slater, A. & Tiggemann, M. (2011). Gender difference in adolescent sport participation, teasing, self-objectification and body image concerns. *Journal of Adolescence, 34*(3), 455-63.
29 Sutherland Institute. (2005). *How family religious involvement benefits adults, youth, and dhildren and strengthen families.* Salt Lake City, UT: Dollahite, D.C. & Thatcher, J.Y. Retrieved from **http://www.faithformationlearningexchange.net/uploads/5/2/4/6/5246709/how_family_religious_involvement_benefits_-_dollahite__thatcher.pdf**
30 Mans Wagener, L., Furrow, J., Ebstyne King, P., Leffert, N., & Benson, P. (2003). Religious involvement and developmental resources in youth. *Review of Religious Research, 44*(3), 271-284.
31 ibid
32 Smith, C., Lundquist Denton, M., Faris, R., & Regnerus, M. (2002). Mapping American adolescent religious participation. *Journal for the Scientific Study of Religion, 41*(4), 597-612.
33 Hunt, L. L. (2001). Race, region, and religious involvement: A comparative study of whites and African Americans. *Social Forces, 80*(20), 605-631.
34 Smith, C., Lundquist Denton, M., Faris, R., & Regnerus, M. (2002). Mapping American adolescent religious participation. *Journal for the Scientific Study of Religion, 41*(4), 597-612.
35 Yohalem, N. & Pittman, K. (2003) *Public libraries as partners in youth development: Lessons and voices from the field*. Washington, DC: The Forum for Youth Investment. Retrieved from **www.froumforyouthinvestment.org**.
36 Curry, A. & Schwaiger, U. (1999). The balance between anarchy and control. *School Libraries in Canada, 19*(1), 9-12.
37 Bourke, C. (2010) Library youth spaces vs youth friendly libraries: How to make the most of what you have. *Australasian Public Libraries and Information Services 23*(3), 98-102.
38 ibid

39 Young Adult Library Services Association. (2008). *The need for teen spaces in public libraries*. Chicago, IL: Bolan, K. Retrieved from **http://www.ala.org/yalsa/guidelines/whitepapers/teenspaces**
40 Yohalem, N. & Pittman, K. (2003) *Public libraries as partners in youth development: Lessons and voices from the field*. Washington, DC: The Forum for Youth Investment. Retrieved from **www.froumforyouthinvestment.org**.
41 Hartley, D. (2004). Rural health disparities, population health, and rural culture. American Journal of Public Health, 94(10), 1675-1678
42 Cook, S.J., Parker, R.S., & Pettijohn, C.D. (2005). The public library: An early teen's perspective. *Public Libraries, 44*, 157-161.
43 Agosto, D.E., Paone, K.L., & Ipock, G.S. (2007). The female-friendly public library: Gender differences in adolescents uses and perceptions of U.S. public libraries. *Library Trends, 56*(2), 387-401.
44 ibid
45 Catalano, R.F., Berglund, L.M., Ryan, J.A.M., Lonczak, H.S., & Hawkins, D.J. (2002). Positive youth development in the United States: Research finding on evaluations of positive youth development programs. *Prevention & Treatment, 5*(1).
46 United Way of Greater Toronto. (2005). *Best practice for youth programs.* Toronto, ON: Bonnell, J. & Zizys, T. Retrieved from **http://www.unitedwaytoronto.com/downloads/whatWeDo/reports/YouthBestPractices-FinalPublicReport.pdf**
47 Catalano, R.F., Berglund, L.M., Ryan, J.A.M., Lonczak, H.S., & Hawkins, D.J. (2002). Positive youth development in the United States: Research finding on evaluations of positive youth development programs. *Prevention & Treatment, 5*(1).
48 Lester, S. & Russell, W. (2010). Children's right to play: An examination of the importance of play in the lives of children worldwide. Working Paper No.57. The Hague, The Netherlands: Bernard van Leer Foundation. Page 34.
49 The Canadian Parks and Recreation Association (CPRA). (2001). Recreation and children and youth living in poverty: Barriers, benefits and success stories (Section II-Literature review and analysis). Developed by The Canadian Council on Social Development. Retrieved from **http://www.cpra.ca/UserFiles/File/EN/sitePdfs/initiatives/EGTP/literature.pdf**
50 Metzger, A., Crean, H.F., Forbes-Jones, E.L. (2009). Patterns of organized activity participation in urban, early adolescents: Associations with academic achievement, problem behaviors, and perceived adult support. Journal of Early Adolescence, 29 (3): 426-442.
51 The Canadian Parks and Recreation Association (CPRA). (2001). Recreation and children and youth living in poverty: Barriers, benefits and success stories (Section II-Literature review and analysis). Developed by The Canadian Council on Social Development. Retrieved from **http://www.cpra.ca/UserFiles/File/EN/sitePdfs/initiatives/EGTP/literature.pdf**
52 University of California, Berkeley (2011). *Disparities in park space by race and income. A policy brief.* University of California Regents.
53 Taylor, W. & Lous, D. (2011). *Do all children have places to be active? Disparities in access to phsycial activity environments in racial and ethnic minority and lower-income communities. A research synthesis*. Princeton, NJ: Active Living Research, a National Program of the Robert Wood Johnson Foundation. Retrieved from **http://www.activelivingresearch.org/files/Synthesis_Taylor-Lou_Disparities_Nov2011_0.pdf**
54 Crawford, D., E. Jackson, & Godbey, G. (1991). A hierarchical model of leisure constraints. *Leisure Sciences, 13*, 309-320.
55 Donnelly, P. & Harvey J. (1999). *Class and gender: Intersections in sport and physical activity*. Sport and Gender in Canada. Oxford University Press, Don Mills, ON: Eds. White, P. & Young, K.M.

56 The Canadian Parks and Recreation Association (CPRA). (2001). Recreation and children and youth living in poverty: Barriers, benefits and success stories (Section II-Literature review and analysis). Developed by The Canadian Council on Social Development. Retrieved from **http://www.cpra.ca/UserFiles/File/EN/sitePdfs/initiatives/EGTP/literature.pdf**

57 Kremarik, F. (2000). A family affair: Children's participation in sports. *Canadian Social Trends, Autumn*, 20-24.

58 Canadian Council on Social Development. (2001). The progress of Canada's children 2001. Ottawa, ON.

59 Brown, R., & Evans, W. P. (2002). Extracurricular activity and ethnicity: Creating greater school connection among diverse student populations. *Urban Education*, *37*(1), 41-58.

60 National Recreation and Park Association. (2010). *Measuring the economic impact of park and recreation services. Research series*. Crompton, J.


01-14

5. A right to education, training and opportunities that prepare us for our future lives

Introduction

The link to youth's well-being

The school environment is a prominent part of youths' lives and, thus, the experiences they gather in a school setting strongly influence their social and emotional health and development.[1, 2] It is in this environment that youth build relationships with peers, foster life skills, learn new things, and enhance their abilities to develop and express opinions. For some youth, the school environment provides a space in which they can thrive, providing a sense of stability and a caring climate.

The economic future of the province depends on the academic success and achievement of optimal health and well-being of its youth. Experts from around the globe have presented compelling evidence that demonstrates the inextricable link between health and education.[3] Education not only impacts the health of our youth, but also influences their financial potential, their opportunities for employment, and their likelihood of becoming active and contributing members of our society.[4] In short, while the bulk of an individual's formal education occurs before their transition into adulthood, it affects the health and well-being of that individual throughout their lifespan.

A positive school environment can make a significant impact in lives of youth, by helping them to develop strong emotional bonds, self-esteem, and self-confidence. This is supported by findings from the *Health Behaviour in School-aged Children (HBSC) Survey*, which found that "students with higher academic achievement and a positive attitude towards school are more likely to engage in healthy behaviours and have better emotional health and well-being."[5] The survey also found that the school environment has important influences on alcohol and drug use, participation in physical activity, nutrition, dental hygiene, and mental and physical health.[6]

For students that do not thrive within the academic environment, it is especially important to create additional opportunities for training and development that will improve their health and well-being throughout their lives by providing them with the tools they need to succeed. Students enter secondary school with different home and neighbourhood experiences, as well as a wide range of commitment to education, academic preparation, and post-secondary education aspirations. Career and technical training programs offer students alternatives to the traditional academic focus of schooling. These training opportunities may occur within the classroom, such as family studies classes, or in the form of extra-curricular activities, such as design and technology clubs. Research demonstrates that these programs decrease dropout rates and enhance college enrollment, while also improving grades and attendance records.[7]

Indicators of youth's health and well-being in this chapter

Given the importance of the school environment in positive youth development and well-being, this chapter presents data that illustrate the experiences of local youth within the secondary school system. This chapter reports information and local data on the following indicators:

- Education Quality and Accountability Office (EQAO) standardized testing
- Youth with special health support needs
- Comprehensive School Health (CSH) approach

- School engagement
- Grades
- School bonding
- School climate and caring

The value of this information to service providers

Schools and service providers have the unique opportunity of equipping our youth with the skills and the confidence they need to succeed in adulthood. Considering that education is such an important determinant of health, it is important to examine the school environment and its capacity to encourage engagement, promote academic success, and provide a caring and positive setting. Data from this chapter can provide a foundational understanding of what may enhance the school environment to ensure that all schools foster academic, social, and life skills among youth. Standardized test results, provided by the EQAO, offer a glimpse into the academic performance levels of children in grades 9 and 10. These data, along with other developmental and social indicators, can be useful in supporting the development of programs and activities for youth.

Youths' universal access to education means that school is more than just academically relevant. School is also a place where youth can gain access to broad social and service networks. There are a wide range of supports delivered by the education system, such as developmental and academic screening and assessments, and school-based extra-curricular activities. Additionally, there are collaborative and community-based programs delivered through schools, such as public health services, school safety, and crime prevention programs. While interpreting the data presented in this chapter, it is necessary to acknowledge the impact of the school environment on youth. The more caring the school environment, and the greater the sense of belonging that youth experience within the school setting, the more likely youth are to make use of these social and service networks. Also, the more positive the school environment, the more likely youth are able to develop their own opinions and find their voice.

Education Quality and Accountability Office (EQAO) standardized testing

In Canada, the delivery of education is a provincial responsibility. Ontario's *Education Act* is the legislation which defines the responsibility of local school boards for operating publicly funded schools in their area. At the same time, school boards are sometimes described as "creatures of the provincial government," given that all the governing and service delivery organizations and personnel (e.g., Ministry of Education, school board trustees, and teachers) have legally defined and expected roles set out in provincial legislation.[8] As members of the corporate board, school board trustees are elected to be legally accountable to the public for the decisions of the school board and for the delivery and quality of educational services.

In Wellington, Dufferin, and Guelph, there are two publicly funded Ontario school boards that have secondary schools located in our geographic area:

- Upper Grand District School Board (English Public)
- Wellington Catholic District School Board (English Catholic)

There are three other publicly funded Ontario school boards that service families in Wellington, Dufferin, and Guelph, but do not have any secondary schools within our geographic area, including Dufferin-Peel Catholic District School Board (English Catholic), Conseil scolaire de district catholique Centre-Sud (French Catholic), and Conseil scolaire public de district Centre Sud-Ouest (French Public).

In 1998, the *Education Quality Improvement Act (Bill 160)* and the *Education Accountability Act (Bill 74)* were passed in Ontario. These Acts hold school trustees, as a group, accountable to demonstrate that the resources allocated to their local school systems directly contribute to improved learning

environments and student achievement.[9] For Ontario, the mechanism for measuring education quality for youth is the EQAO standardized testing that takes place in grades 9 and 10. In grade 9, students complete EQAO standardized testing focused on mathematics; in grade 10, students complete the Ontario Secondary School Literacy Test (OSSLT), administered by the EQAO, which focuses on reading and writing. The EQAO describes the following as rationale for conducting province-wide tests:[10]

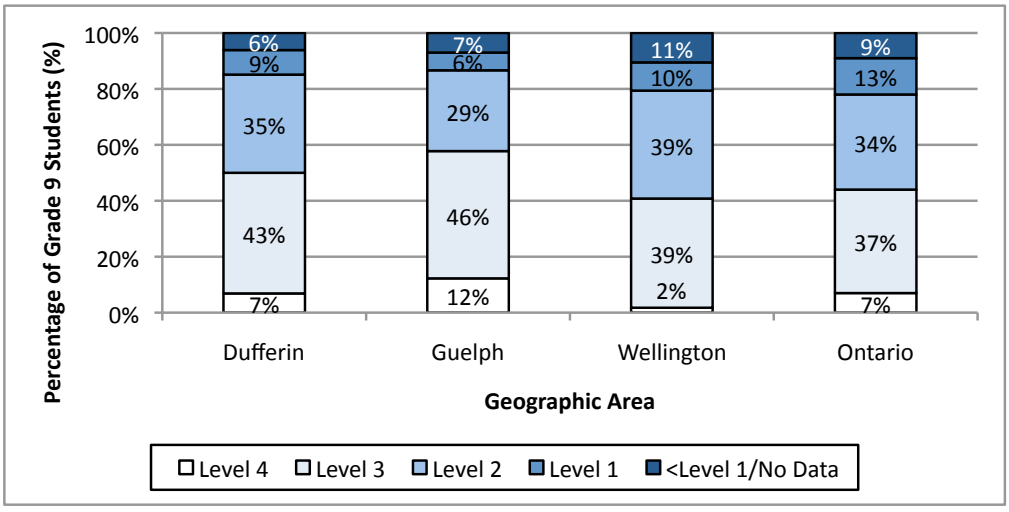
- To Identify trends in student learning
- To identify curriculum areas that need more attention
- To target resources where they are needed
- To give an indication of how each child is learning
- To strengthen accountability

The EQAO tests are based on the Ontario Curriculum, which sets out expectations for youths' learning outcomes in each grade.[11] Student performance is also evaluated by teachers on an individual basis, according to the Ontario Curriculum.

Grade 9 EQAO math scoring is based on a scale ranging from level 1 to level 4. Figures 5.1 and 5.2 show the percentage of youth who have received a score of level 1 to level 4 in Wellington, Dufferin, and Guelph, in both grade 9 Applied level math classes and Academic level math classes. The Ontario percentage is included in each of the figures, as a comparator. Each level of the EQAO scale is defined as the following:

- *Level 1*: The student has demonstrated some of the required knowledge and skills in limited ways. Achievement falls much below the provincial standard.
- *Level 2*: The student has demonstrated some of the required knowledge and skills. Achievement approaches the provincial standard.
- *Level 3*: The student has demonstrated most of the required knowledge and skills. Achievement meets the provincial standard.
- *Level 4*: The student has demonstrated the required knowledge and skills. Achievement exceeds the provincial standard.

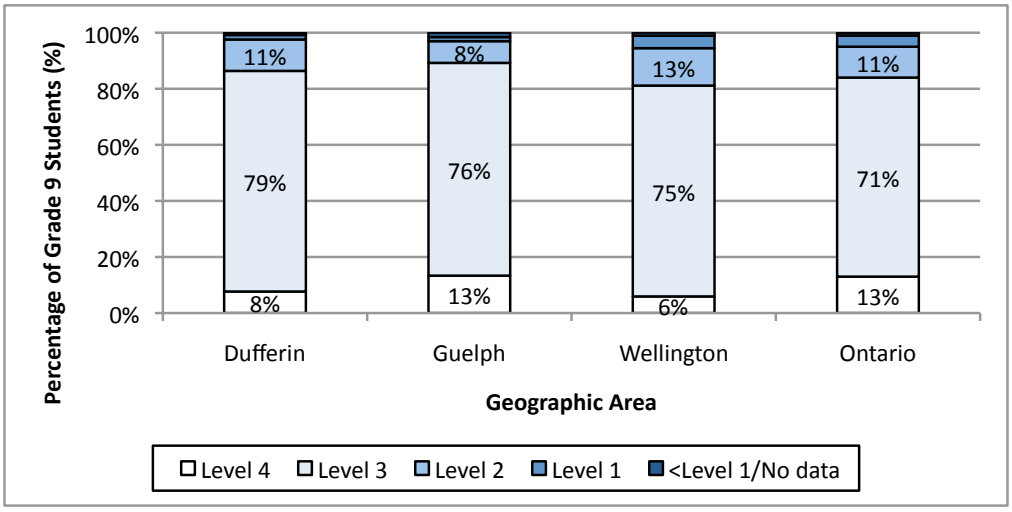
Figure 5.1 **Grade 9 Applied math scores for Wellington, Dufferin, and Guelph, 2011/2012 school year**



Source: EQAO School Reports, Grade 9 Assessments of Mathematics, 2011-2012, retrieved June 2012 from: www.eqao.com

In Figure 5.1 we can see that more students in Guelph received a Level 3 or 4 score on the Applied math EQAO assessment compared to students in Wellington, Dufferin, and all of Ontario. Overall, students in Wellington County scored lower than students in Guelph and Dufferin, with a lower percentage of students achieving a Level 3 or 4 and a greater percentage of students achieving a Level 1 or less.

Figure 5.2 **Grade 9 Academic math scores for Wellington, Dufferin, and Guelph, 2011/2012 school year**

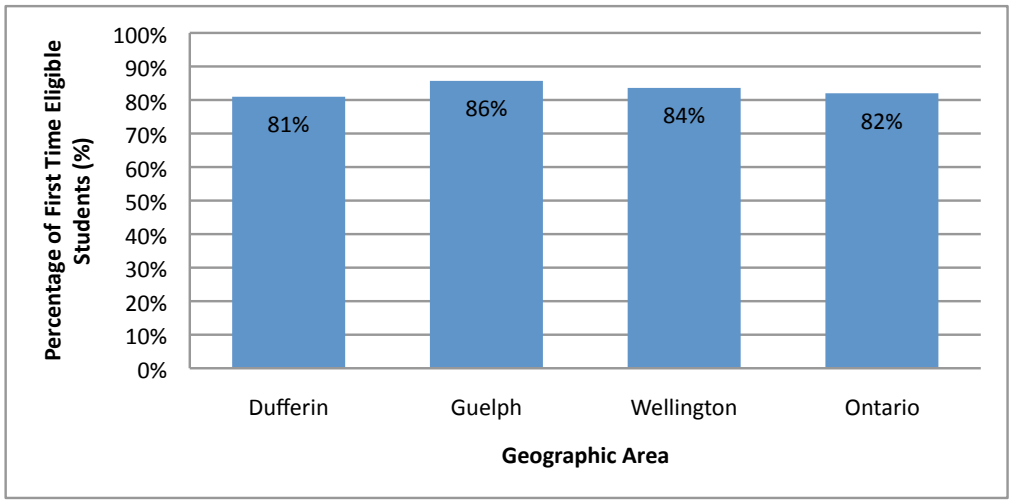


Source: EQAO School Reports, grade 9 Assessments of Mathematics, 2011-2012, retrieved June 2012 from: www.eqao.com

Students writing the Academic EQAO math assessment achieved comparable results across Wellington, Dufferin, Guelph and Ontario (Figure 5.2). Similar to the Applied math results, a greater percentage of students in Wellington County scored on Level 2 or less, and a smaller percentage of students in Wellington County achieved Level 4, when compared to Dufferin and Guelph.

The OSSLT, unlike the EQAO testing for math, is not scored by levels; instead, students are graded as either successful or unsuccessful. The OSSLT success benchmark is comparable to a Level 3 or above on the EQAO mathematics testing previously discussed. Unlike the EQAO mathematics testing, however, students must successfully complete the OSSLT; students cannot receive their Ontario Secondary School Diploma without OSSLT completion. If students are not successful, they are required to take the test during future administrations until they are successful. Figure 5.3 shows the percentage of students in Wellington, Dufferin, and Guelph who attained the success benchmark on the OSSLT. The percentages of first-time eligible students who were successful on the OSSLT are comparable across Wellington, Dufferin, Guelph, and Ontario.

Figure 5.3 **Percentage of first-time eligible students who were successful on the Ontario Secondary School Literacy Test Scores for Wellington, Dufferin, and Guelph, 2011/2012 school year**



Source: *EQAO School Reports, Ontario Secondary School Literacy Test, March 2012, retrieved June 2012 from: www.eqao.com*

Note: First-Time Eligible Students typically entered Grade 9 during the 2010–2011 school year. These students (and any others who were placed in this cohort) were required to write the Ontario Secondary School Literacy Test (OSSLT) for the first time in March 2012. First-time eligible includes all students in the first-time eligible cohort who are working toward an Ontario Secondary School Diploma (OSSD).

Youth with special health support needs in secondary school

In Ontario, the percentage of children and youth requiring special health support needs continues to grow. In 2011/2012, 24% of secondary students were receiving some form of special education assistance, a 10% increase from 2000/2001 (14%).[12]

The Ontario Regulation 181/98 sets out the process of identifying exceptional students and determining a placement for them. As well, every school board must establish a special education advisory committee and maintain a special education plan in accordance with the Ontario Regulation 464/97 and 306, respectively.[13]

In the final report released by Deloitte on the Review of School Health Support Services (SHSS), July 2010, a number of challenges were identified within the program. Some examples include varied interpretations of the SHSS program mandate, lack of standardized provincial guidelines and tools, lack of effective processes in place to ensure effective transitions from one school to another, wait list management, and reduced focus on secondary school transitions.[14]

The transfer of cases from one school to another is known to be a challenging process. This is due to the variability in referral processes among different Community Care Access Centres (CCACs), and the associated administrative work involved.[15] This often leads to incremental delays in service provision for children and youth. Although wait times to access SHSS vary across the province, stakeholders are generally dissatisfied with the wait for service, particularly for children and youth who are considered low priority.[16]

Transfers between elementary school and secondary school can also be a confusing process, especially when the secondary school falls under a different CCAC.[17] At this developmental stage in a youth's life, service levels are commonly reported to drop.[18] Regardless of the fact that adolescents require less SHSS compared to younger children, parents and service providers across the province feel that youth who still require school support services in secondary school are underserved.[19]

In the 2012 Annual Report on Ontario's Publicly Funded Schools, many of the over 1,000 principals surveyed from elementary and secondary schools reported concerns about serving students with special needs.[20] Many schools have a cap on the number of students that can be assessed each academic year.[21] This has resulted in tremendous pressure on parents and families to pay as much as $2,500 to have their child assessed by a psychologist in a private practice. However, pursuing private assessments allows parents who can afford to access this service to get ahead in the Identification Placement and Review Committee (IPRC) process.[22] The IPRC determines the type of educational placement that is appropriate for students who are identified through this process. The IPRC can recommend special education programs and/or services necessary to meet the needs of the student including integration into regular classes or placement in special education classes.

This report also highlights the dramatic increase in the ratio of special education students to special education teachers in secondary schools, with the average ratio being 69:1 in 2011/2012, up from 48:1 in 2000/2001.[23] Schools are also coping with fewer Educational Assistants (EAs) to provide crucial support to individual students with significant special needs, or to those having substantial behavioural or medical issues. On average, there are 51 special education students assigned to each EA, up from 42 students five years ago.[24]

It is important to note that the school boards in our community partner with many agencies to offer support for students with special health needs. These partnerships facilitate early identification and referral to a wide range of developmental and health services. For example, each secondary school has a public health nurse that delivers clinical services onsite. Recently, new positions through Trellis Mental Health and Developmental Services allow for case workers to work directly in secondary schools. Given the universal function of schools, there is a need for ongoing partnerships between community agencies and school boards to support the growth and development of our students.

Comprehensive School Health approach

In 1995, The World Health Organization (WHO) spearheaded a Global School Health Initiative 'designed to improve the health of students, school personnel, families and other members of the community through schools'.[25] Since then, this model has been well received and adopted all over the world, including in Canada.[26]

The Comprehensive School Health (CSH) approach (also known as Healthy Schools, Comprehensive Health Promotion approach in school settings, or Health Promoting Schools) has been gaining momentum in Canada, especially since the creation of the pan-Canadian Joint Consortium for School Health (JCSH) in 2004.[27]

In December 2006, the Ministries of Education and Health Promotion introduced the *Foundations for a Healthy School* framework, which many Ontario public health units adopted.[28] This framework highlights four components to address health-related topics using a comprehensive approach:[29]

- High-quality instruction and programs
- A healthy physical environment
- A supportive social environment
- Community partnerships

The diverse, multifaceted approach of the JCSH strategy combines not only teaching skills in the classroom, but also addresses healthy social and physical environments, and emphasizes both individual and community empowerment and engagement.[30, 31] This includes the whole school community in identifying its strengths, weaknesses,

and concerns and implementing strategies to create a healthy, supportive environment for students, their parents, and the entire school staff.[32]

The local school boards in Wellington, Dufferin, and Guelph are beginning to implement the model with the support of public health. As of January 2011, Comprehensive School Health is being implemented in elementary schools that expressed interest and readiness for implementation. It will eventually expand to high schools throughout Wellington, Dufferin, and Guelph.

Access and financial support through broad population-based programs have also contributed to an increasing number of young Canadians seeking and completing post-secondary education.[33] Additionally, youth and young adult programs have helped many individuals build experience and skills necessary for attaining full-time employment.[34]Recent studies on comprehensive school health promotion initiatives have reported a link between the successful implementation of this approach and the academic performance of students, as measured by EQAO test scores.[35]

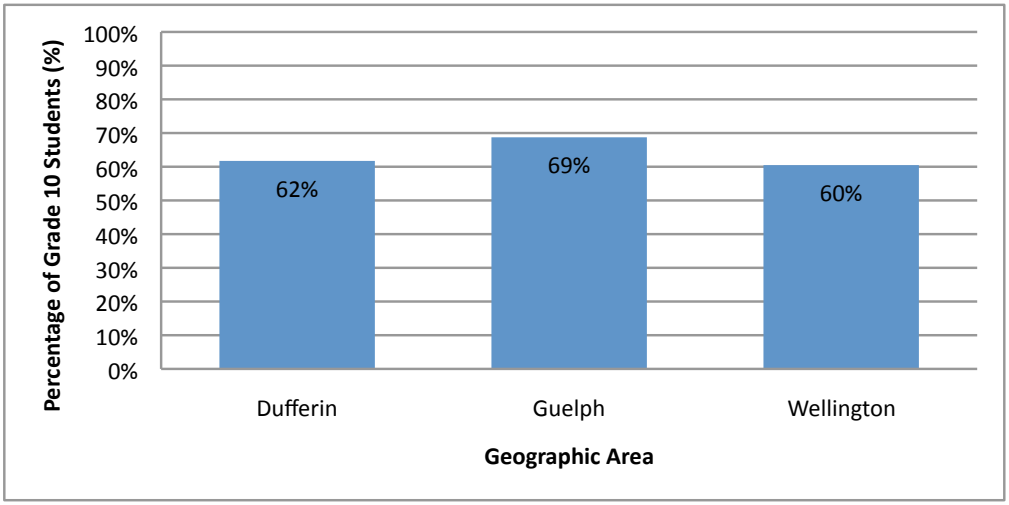
School engagement

The concept of engagement is typically described as having three components: behavioural (e.g., effort, participation); emotional (e.g., interest, positive attitude about learning); and cognitive (e.g., self-regulation, learning goals).[36] A variety of variables can enhance or impede school engagement. External variables such as family support, peer relationships, neighbourhood characteristics,[37] and school environment can have an important effect on a youth's desire to become engaged.[38] Additionally, internal variables such as self-efficacy and autonomy impact school engagement.[39]

Research consistently demonstrates the link between increased levels of engagement and academic success in high school students. School engagement has been shown to enhance cognitive abilities and improve the acquisition of critical thinking skills, which, in turn, enables students to earn better grades. [40, 41] Engaged students often exhibit increased practical competence and are better able to transfer skills to new situations.[42] School engagement is also positively correlated with psychosocial development and identity formation,[43] such as moral and ethical development and increased openness to diversity and challenges.[44] Students who are engaged also report lower levels of substance use, depression, suicidal ideation, fighting, and sexual activity.[45] They also report higher levels of physical activity, better nutrition, increased bicycle helmet use, and safer sex.[46]

The Wellington-Dufferin-Guelph (WDG) Youth Survey asked students about the importance of good grades, extra-curricular involvement, making friends, showing up for class, expressing opinions, and taking part in student council or other similar groups. The data collected from these questions was combined to create one *School Engagement* measure. As shown in Figure 5.4, more grade 10 students in Guelph (69%) reported high levels of *School Engagement* when compared to students in Dufferin (62%) and Wellington (60%). This finding contradicts previous academic research on this topic. Studies comparing rural and urban high school student engagement consistently demonstrated that students in larger, more urban schools participate less, most likely due to the availability of opportunities per student.[47] Students in smaller, more rural schools may face less competition when competing for placement in school activities, increasing their potential to participate.[48] Rural students may also participate more due to a lack of alternative activities available outside of school.[49] While previous research appears to contradict our local findings, it is important to note that students participating in the WDG Youth Survey from Wellington and Dufferin Counties largely attend schools in semi-urban settings (e.g., Orangeville). As a result, these students may be given similar opportunities to engage in school activities when compared to students in Guelph.

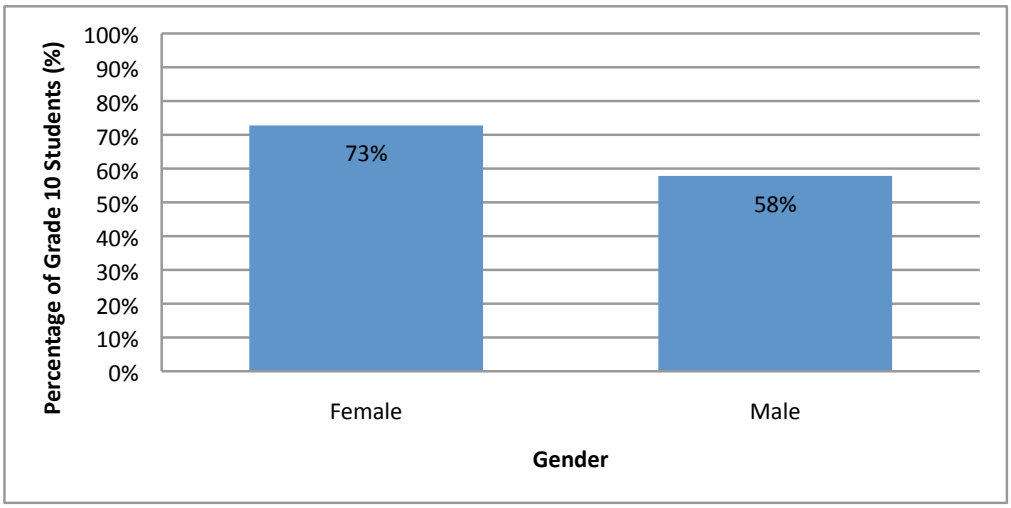
Figure 5.4 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *School Engagement*, by geography, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (<1%) did not complete the survey questions for School Engagement

Figure 5.5 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *School Engagement*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (<1%) did not complete the survey questions for School Engagement

The analysis also revealed a statistically significant relationship between gender and School Engagement (Figure 5.5). More female grade 10 students (73%) reported high levels of School Engagement when compared to males (58%). This is consistent with previous studies on gender differences in school engagement. While male students more regularly participate in

sports compared to females, females consistently participate in academic, artistic, and other school activities (e.g., student council) more readily than males.[50] Additionally, females typically participate in multiple activities more frequently than males.[51]

According to previous research, females are also more likely to report high levels of friend connectedness and lower dropout rates, important tenets of school engagement. [52, 53]

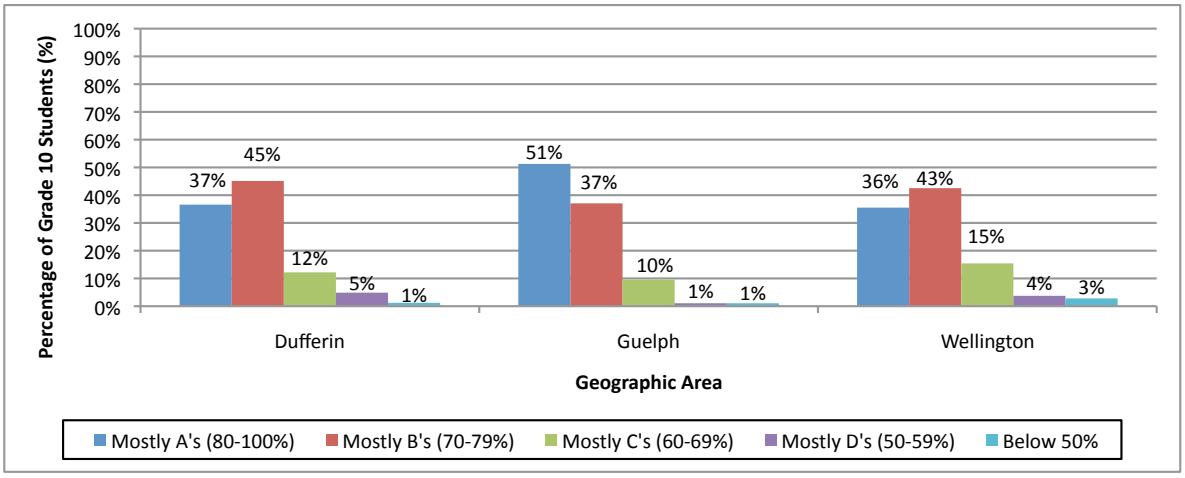
Grades

Academic grade achievement can be influenced by a variety of factors, including family socioeconomic status, personal ability, community, neighbourhood and school characteristics, access to information, and friends' habits.[54, 55] While academic grade achievement cannot, on its own, demonstrate student success and dedication to learning, it is an important measure of student achievement.

The link between education and health has been explained through several different pathways. First, education may help individuals improve or maintain their health through an increased understanding of health issues, access to information, and enhanced cognitive abilities.[56] Educational achievement is also correlated with higher earnings, increased access to better job opportunities and larger social networks, which translate into a greater expenditure on healthy foods and activities.[57] Finally, healthier individuals may be able to focus more time and energy on their academic studies and have better cognitive abilities as a result.[58]

The WDG Youth Survey asked youth what grades they usually get in school. Figures 5.6 and 5.7 illustrate the distribution of responses by grade in Wellington, Dufferin, and Guelph. More grade 10 students in Guelph reported usually getting A's (51%) in school when compared to Dufferin (37%) and Wellington (36%)(Figure 5.6). Additionally, female grade 10 students throughout Wellington, Dufferin, and Guelph reported higher levels of academic achievement than males, with 52% of female grade 10 students and 39% of male grade 10 students reported that they usually get A's (Figure 5.7).

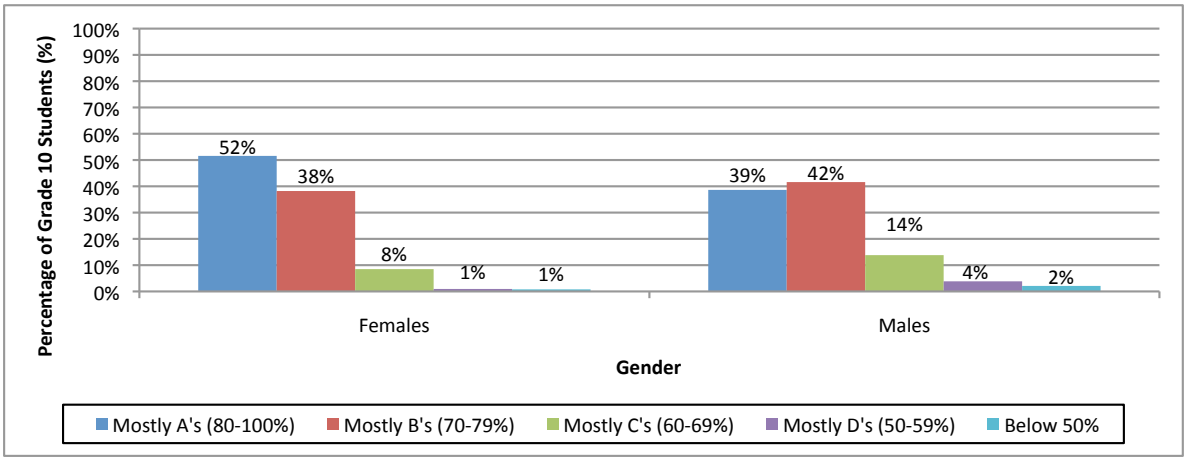
Figure 5.6 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported achieving each grade letter, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (<1%) did not complete the survey question for grade achievement

Figure 5.7 **Percentage grade 10 students in Wellington, Dufferin, and Guelph who reported achieving each grade letter, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

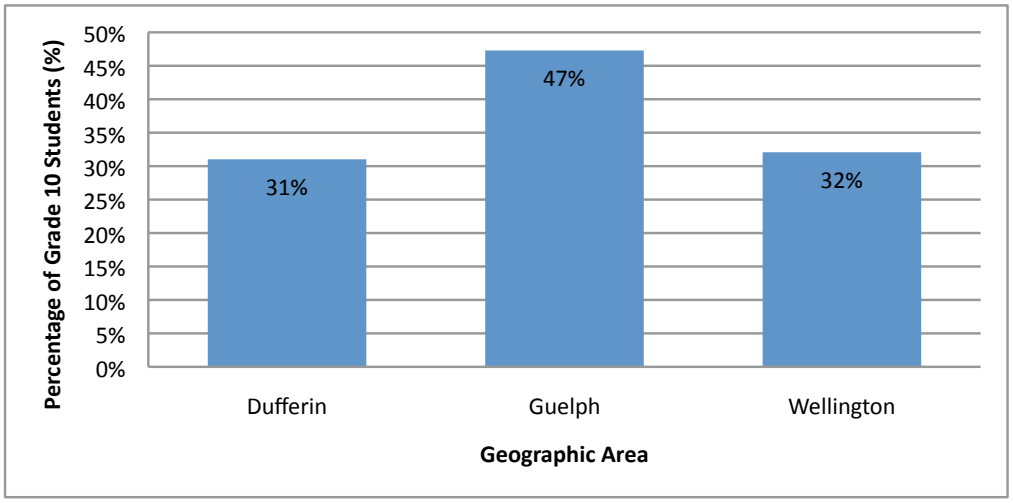
Note: 5 students (<1%) did not complete the survey question for grade achievement

School bonding

School bonding is an umbrella term that encompasses several aspects of a student's relationship with school. According to the Social Development Research Group, school bonding can be defined as the presence of attachment and commitment.[59] Here, attachment represents an emotional link to the school; whereas commitment reflects an investment in the school. Several studies have demonstrated the association between school bonding and increases in positive developmental experiences and positive health behaviours.[60] Moreover, increases in school bonding have been shown to result in decreases in risky and problem behaviours among youth.[61] The Seattle Social Development Project, for example, found that school bonding during middle and high school years is significantly and inversely associated with substance use, delinquency, gang membership, violence, academic problems, and sexual activity.[62] In short, school bonding is a critical component in the positive developmental experience of youth.

The WDG Youth Survey asked students two questions relating to school bonding: (1) how do you feel about school; and (2) are you proud of your school? These questions aimed to represent commitment and attachment measures among youth. Responses to these questions were analysed together to determine *School Bonding* levels. Figure 5.8 illustrates that more grade 10 students reported high levels of *School Bonding* in Guelph (47%) when compared to Wellington (32%) and Dufferin (31%). As illustrated by Figure 5.9, more female grade 10 students (47%) reported high levels of *School Bonding* when compared to males (35%).

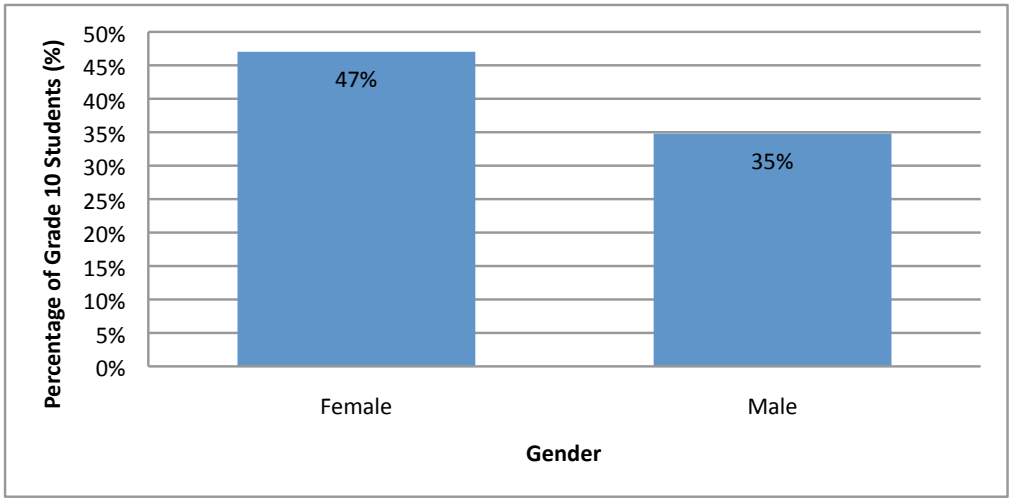
Figure 5.8 **Percentage of grade 10 students in Wellington, Dufferin and Guelph reporting high levels of *School Bonding*, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (<1%) did not complete the survey questions for "School Bonding".

Figure 5.9 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph reporting high levels of *School Bonding*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (<1%) did not complete the survey questions for "School Bonding".

School climate and caring

Many of the indicators explored in this chapter can be linked to the overall safety of the environments in which youth live. An important component of perceived safety of the neighbourhood and sense of belonging are relationships with neighbours. "Sense of community belonging embodies the social attachment of individuals and reflects social engagement and participation within communities."[63] Sense of belonging, and how youth relate to their wider social networks and communities, has an important effect on their health and well-being. Specifically, research has found that sense of community belonging is highly correlated with physical and mental health.[64, 65] This sense of community is important in all environments in which youth interact with others, however, as youth spend many of their waking hours in the school setting, a positive and caring school environment has an important impact on youth health and development.

Caring School Climate is one of the indicators from the WDG Youth Survey, which provides a measure of the extent to which youth experience a caring school climate. This indicator is measured by questions that ask youth about their interactions with their teachers. These questions asked youth the extent to which they believe their teachers have high expectations of them, are interested in them as people, and notice when they do a good job. There was no statistically significant relationship between *Caring School Climate* and geographic area. In Wellington, Dufferin, and Guelph, 66% of grade 10 students reported experiencing a caring climate at school. There was also no statistically significant difference between gender and *Caring School Climate*.

Endnotes

1 Weare, K. (2000). *Promoting mental, emotional, and social health: A whole school approach*. London: Routledge.

2 Public Health Agency of Canada. (2008). *Healthy settings for young people in Canada.* Retrieved from: **http://publications.gc.ca/collections/collection_2008/phac-aspc/HP35-6-2007E.pdf**

3 Ministry of Health Promotion (2010). *School Health: Guidance Document.* Retrieved from: **http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf**

4 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from: **http://publichealth.gc.ca/CPHOreport**.

5 Ministry of Health Promotion (2010). *School Health: Guidance Document.* Retrieved from: **http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf**

6 Ibid.

7 Hughes, K., Bailey, T., & Mechur, M. (2001). *School-to-Work: Making a differencein education*. New York: New York Institute on Education and the Economy.

8 Watson, N. (2003). Educational governance: A look at the landscape. Background notes for the summit on educational governance. The Learning Partnership. Pg 2. Retrieved from: **http://www.tlpresources.ca/policy_research/EducationalGovernance_LookattheLandscape.pdf**

9 Ibid.

10 Education Quality and Accountability Office (EQAO). (2010). What parents need to know about province-wide testing; EQAO assessments of reading, writing and mathematics, primary division (grades 1-3) and junior division (grades 4-6). Retrieved January 18, 2011: **http://www.eqao.com/pdf_E/10/WhatParentsNeedtoKnow.pdf**.

11 Ontario, Ministry of Education (2004). The Ontario Curriculum Grades 1-12, Achievement Charts (Draft). Retrieved January 18, 2011: **http://www.edu.gov.on.ca/eng/document/policy/achievement/charts1to12.pdf**

12 People for Education. (2012). *Annual report on Ontario's publicly funded schools*. Retrieved from: **http://www.peopleforeducation.ca/wp-content/uploads/2012/05/Annual-Report-2012-web.pdf**

13 Ministry of Education. (2011). Ontario schools: Kindergarten to grade 12 – Policy and program requirements. Retrieved from: **http://www.edu.gov.on.ca/eng/document/policy/os/onschools.pdf**

14 Deloitte & Touche LLP. (2010). Review of school health support services: Final report. Retrieved from: **http://www.health.gov.on.ca/en/public/contact/ccac/docs/deloitte_shss_review_report.pdf**

15 Ibid.

16 Ibid.

17 Ibid.

18 Ibid.

19 Ibid.

20 People for Education. (2012). *Annual report on Ontario's publicly funded schools*. Retrieved from: **http://www.peopleforeducation.ca/wp-content/uploads/2012/05/Annual-Report-2012-web.pdf**

21 Ibid.

22 Ibid.

23 Ibid.

24 Ibid.

25 School and youth health: Global school health initiative **http://www.who.int/school_youth_health/gshi/en/**

26 Comprehensive School Health Handout The Ontario Healthy Schools Coalition

27 Ministry of Health Promotion (2010). *School Health: Guidance Document.* Retrieved from: **http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf**

28 Ibid.

29 Ibid.

30 Ibid.
31 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from: **http://publichealth.gc.ca/CPHOreport**.
32 Ministry of Health Promotion (2010). *School Health: Guidance Document.* Retrieved from: **http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf**
33 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from: **http://publichealth.gc.ca/CPHOreport**.e Chief Public Health Officer's Report on the state of Public health in Canada 2011: *Youth and Young Adults — Life in Transition*
34 Ibid.
35 Ministry of Health Promotion (2010). *School Health: Guidance Document.* Retrieved from: **http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf**
36 Fredericks, J. A., Blumenfeld, P. C., & Paris, A. H. (2004). School engagement: Potential of the concept, state of the evidence. *Review of Educational Research, 74,* 59-109.
37 Foley, K. (2012). Can neighbourhoods change the decisions of youth on the margins of university participation? *Canadian Economics Association, 45* (1): 167-188.
38 Caraway, K., Tucker, C. M., Reinke, W. M., & Hall, C. (2003). Self-efficacy, goal orientation, and fear of failure as predictors of school engagement in high school students. *Psychology in the Schools, 40*(4), 417-427.
39 Ibid.
40 Pascarella, E. T., Palmer, B., Moye, M., & Pierson, C. T. (2001). Do diversity experiences influence the development of critical thinking? *Journal of College Student Development, 42,* 257-271.
41 Tross, S. A., Harper, J. P., Osherr, L. W., & Kneidinger, L. M. (2000). Not just the usual cast of characteristics: Using personality to predict college performance and retention. *Journal of College Student Development, 41,* 325-336.
42 Kuh, G. (1995). The other curriculum: Out-of-class experiences associated with student learning and personal development. *Journal of Higher Education, 66,* 123-155.
43 Torres, V., Howard-Hamilton, M. F., & Cooper, D. L. (2003). Identity development of diverse populations: Implications for teaching and administration in higher education. *ASHE-ERIC Higher Education Report, 29*(6). San Francisco: Jossey-Bass.
44 Pascarella, E., et al. (2006)/ Institutional selectivity and good practices in undergraduate education: How strong is the link. *The Journal of Higher Education, 77,* 251-285.
45 Carter, M., McGee, R., Taylor, B., & Williams, S. (2007). Health outcomes in adolescence: Associations with family, friends and school engagement. *Journal of Adolescence, 30,* 51-62.
46 Ibid.
47 McNeal, R. B., Jr. (1998). High school extracurricular activities: Closed structures and stratifying patterns of participation. *The Journal of Education Research, 91,*183-191.
48 Feldman, A. F., & Matjasko, J. L. (2007). Profiles and portfolios of adolescent school-based extra-curricular activity participation. *Journal of Adolescence, 30,* 313-332.
49 McNeal, R. B., Jr. (1998). High school extracurricular activities: Closed structures and stratifying patterns of participation. *The Journal of Education Research, 91,*183-191.
50 Feldman, A. F., & Matjasko, J. L. (2007). Profiles and portfolios of adolescent school-based extra-curricular activity participation. *Journal of Adolescence, 30,* 313-332.
51 Ibid.
52 Carter, M., McGee, R., Taylor, B., & Williams, S. (2007). Health outcomes in adolescence: Associations with family, friends and school engagement. *Journal of Adolescence, 30,*51-62.
53 Statistics Canada. (2006). Labour Force Survey: HRSDC Indicators of Well-Being in Canada.
54 Cutler, D. & Lleras-Muney, A. (2006). *Education and health: Evaluating theories and evidence.* Cambridge, MA: NBER (Working Paper No. 13217).

55 Foley, K. (2012). Can neighbourhoods change the decisions of youth on the margins of university participation? *Canadian Economics Association, 45* (1): 167-188.
56 Cutler, D. & Lleras-Muney, A. (2006). *Education and health: Evaluating theories and evidence.* Cambridge, MA: NBER (Working Paper No. 13217).
57 Gan, L. & Gong, G. (2007). *Estimating interdependence between health and education in a dynamic model.* Cambridge, MA: NBER (Working Paper No. 12830).
58 Ibid.
59 Hawkins, J.D., Guo, J., Hill, K.G., Battin-Pearson, S., & Abbott, R.D. (1996) Long-term effects of the Seattle Social Development intervention on school bonding trajectories. *Applied Developmental Science,* 5(4), 225-236.
60 Catalano, R. F., Haggerty, K. P., Oesterle, S., Fleming, C. B., & Hawkins, J. D. (2004). The importance of bonding to school for healthy development: Findings from the Social Development Research Group. *Journal of School Health, 74*(7), 252-261.
61 Ibid.
62 Ibid.
63 Berkman, L.F., Glass, T., Brissette, I., & Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science and Medicine, 51*, 843-857.
64 Statistics Canada. (2002). *Community belonging and health*. Health Reports (Catalogue 82-003), 13(3), 33-39, Ross, N.
65 Statistics Canada. (2008). *Community belonging and self-perceived health*. Health Reports (Catalogue 82-003), 19(2), 51-60, Shields M.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6. A right to quality time with our friends, family, and/or other positive role models in our community

Introduction

The link to youth's well-being

Healthy youth development is influenced by a myriad of factors, including the social relationships built with family, friends, and other mentors. Youth who feel nurtured by family members or adult mentors, and who are engaged with their friends and community report better overall health, decreased participation in unsafe behaviours, and a greater sense of self-worth.[1] Healthy relationships with others also help to build resilience and competence, reducing the risk for a variety of negative health outcomes and providing youth with the skills they need to overcome adversity and other challenges.[2] These healthy relationships promote positive bonding, which is critical to healthy youth development. Positive bonding increases a youth's trust in self and others; however, inadequate bonding creates patterns of insecurity and self-doubt, leading to an emotional emptiness that youth may try to fill with negative behaviours.[3]

The importance of quality time with family has been regularly demonstrated in the literature. While living in low income households can reduce the ability of families to acquire the necessary supports for positive youth development, these social and economic struggles can be mitigated through a positive home environment and quality time with family.[4] Shared family experiences, such as meal times, offer important opportunities for socialization and relationship building, which can create a sense of unity and connectedness. Youth that have connected and positive relationships with parents and family are less likely to engage in delinquency, anti-social behaviours, and risk-taking activities, or to report feelings of emotional distress. Specifically, quality time with family is associated with a decreased risk for cigarette smoking, alcohol drinking, and marijuana use.[5] These youth are also more likely to engage in positive social relationships, report good overall health, complete secondary school, and pursue post-secondary education.[6] Youth that enjoy fewer opportunities to participate in quality time with their parents are at greater risk for substance use, low academic achievement, and depressive symptoms.[7]

As youth transition into young adulthood, they gradually reduce connections with family members and increase their connections with peers. Spending quality time with peers in the absence of parental supervision is also an important component in the healthy development of youth. Youth who have difficulty developing and maintaining positive relationships with peers are more likely to engage in violent behaviour,[8] experience high degrees of loneliness and depression,[9] report low academic achievement, and experience high levels of unemployment later in life.[10] Youth friendships can also buffer the negative impact of family problems,[11] improve self-esteem,[12] and enhance social competence and leadership qualities.[13] Dating relationships are also particularly important during the transition into adulthood. These relationships offer youth important opportunities to learn about communication, compromise, trust, and respect. While many positive outcomes can arise from dating relationships, there is also the potential for negative outcomes to occur. Dating violence

can occur at any age; however, it is more likely to begin during the adolescent years as individuals experiment with new dating behaviours.[14] Programs that help youth to develop the skills to foster and maintain healthy intimate relationships in a climate of equality are necessary to support youth in the transition to young adulthood.

Positive relationships with non-family adults have also been shown to contribute to healthy youth development. These relationships can serve as an opportunity to have fun and to provide an escape from daily stressors, contributing to improvements in emotional well-being.[15] The impact of mentoring relationships on emotional well-being is particularly critical for youth who have experienced inconsistent or negative relationships with caregivers.[16] When mentors are sensitive and consistently show youth that they are worthy of care, youth may in turn be more likely to ask for emotional support to help them cope with stressful events. Moreover, when youth know that their mentors are dependable and provide a source of protection in times of need, they are more likely to explore their environment, enhancing the development of knowledge and skills that would otherwise not have been attainable.[17] By demonstrating care and compassion, mentors can transform negative views that youth may have of themselves or of their relationships with adults, effectively serving as a sort of "corrective experience".[18] Youth with positive mentors are more likely to graduate from high school and attend a post-secondary institution,[19] and less likely to engage in risky behaviours.

Developmentally, the adolescent years are a time of significant emotional and social growth, which is greatly influenced by home, school, and community environments. Consequently, it is particularly important that youth are surrounded by mentors, peers, and family members that can provide models for positive social interactions. Healthy relationships experienced during this time of development provide the foundation for future interaction with family, peers, and society. As a result, it is critical that all youth are able to experience quality time with friends, family, and other positive role models in the community.

Indicators of youth's health and well-being in this chapter

To provide an understanding of the extent to which youth, ages 14 to 18, experience quality time with friends, family, and/or positive role models in our community, this chapter presents local data on the following indicators:

- Positive peer influence
- Peer connectedness
- Family support
- Positive family communication
- Time at home

The value of this information to service providers

Several factors can affect a youth's opportunity for quality time with family, mentors, and peers. Providing love, support, and nurturing relationships can be challenging for families. All parents and caregivers, regardless of their education level or socioeconomic status, require support from local community members, including family, friends, or formal services. Consequently, local service providers have a crucial role in providing parents with knowledge, skills, tools, and opportunities that support quality time with families, friends, and other role models.

A meta-analysis of youth development programs (e.g., leadership programs, neighbourhood groups, youth groups, teen parenting programs, employment or training programs, etc.) found that effective youth programs typically maintained five key characteristics.[20] First, these programs focus on at least five of the following youth development constructs, many of which relate directly or indirectly to positive social relationships:

- Bonding
- Behavioural competence
- Clear and positive identity
- Resilience
- Moral competence
- Belief in the future
- Social competence
- Self-determination
- Recognition for positive behaviour
- Emotional competence
- Spirituality
- Opportunities for prosocial involvement

- Cognitive competence
- Self-efficacy
- Prosocial norms

Second, effective youth programs regularly measure positive and problem outcomes to enhance their understanding of the effects of their programs on youth. Third, these programs abide by a structured curriculum as a means of attaining consistency. Fourth, the vast majority of programs are delivered over a nine-month period or longer to allow time for the youth constructs to develop. Finally, programs are routinely monitored for quality assurance during implementation.

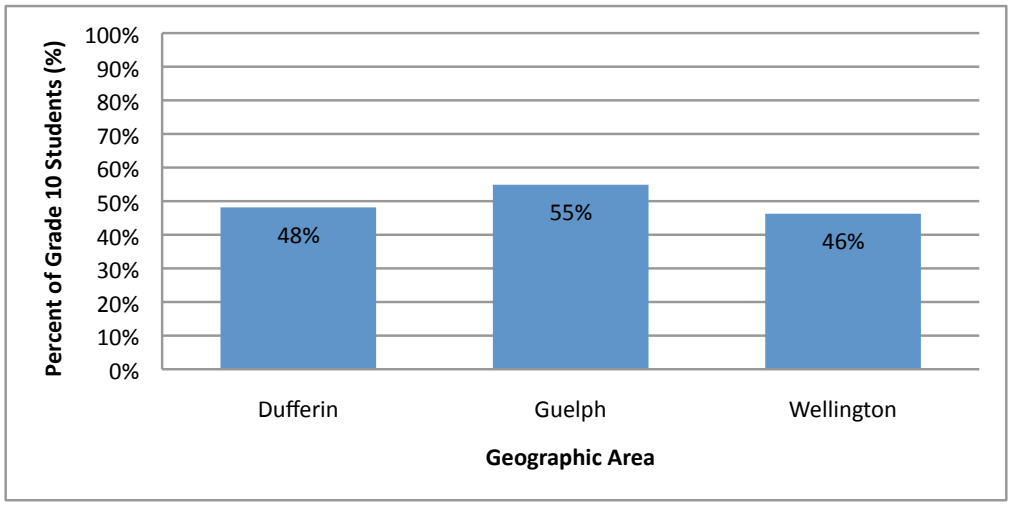
In terms of mentoring relationships, research supports the idea that the longevity of the relationship, in addition to the quality of previous relationships, plays important roles in determining the efficacy of mentoring. Youth who have experienced emotional, sexual, or physical abuse, or who have been previously referred to psychological or educational programs, typically end their mentoring relationships prematurely when compared to youth without similar histories.[21] This finding is critical, given that mentoring relationships that last less than a year produce relatively modest effects on developmental outcomes. Youth that participate in short-term mentoring relationships may even suffer relative declines in self-worth and academic achievement.[22] Conversely, youth that experience mentoring relationships that last one year or more experience relative gains in self-worth, parental relationship quality, academic achievement, and perceived social acceptance. This trend is particularly pronounced for youth between the ages of 13 to 16 years.

Positive peer influence

Quality time with friends can be very influential on youth, as they begin to spend increasing amounts of time with friends while they begin their transition into adulthood. Friendships contribute to the development of social and emotional skills among youth.[23] Peers can have both a positive and negative impact on adolescent health behaviours.[24] Relationships with peers who model prosocial behaviours (e.g., assisting troubled teens or involvement in school activities) can have positive influences on youth.[25] For example, research has found that youth whose friends engage in few health risk behaviours and have good grades are less likely to become pregnant in their teenage years, and are more likely to abstain from using tobacco, drugs, or alcohol.[26,27] It can also serve as a protective factor against violent behaviour.[28] In turn, relationships with friends who engage in risk behaviours are strong predictors of adolescents' own health risk behaviours, particularly with regards to violent behaviours and substance use.[29]

The Wellington-Dufferin-Guelph (WDG) Youth Survey included questions that provide a measure of *Positive Peer Influence.* This indicator included the responses from four questions about how many of their close friends like school, get along with their parents, smoke cigarettes, and use drugs. In Wellington, Dufferin, and Guelph there was a significant relationship between geographic area and *Positive Peer Influence.* More students in Guelph (55%) reported high levels of *Positive Peer Influence* compared to Wellington (46%) and Dufferin (48%)(Figure 6.1). This finding is consistent with previous research, which has reported that urban youth are more likely to experience positive peer influences than youth living in rural communities.[30] Urban youth may have access to a larger and more diversified network of peers, increasing their likelihood of positive interaction.

Figure 6.1 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Positive Peer Influence*, by geographic area, 2012**

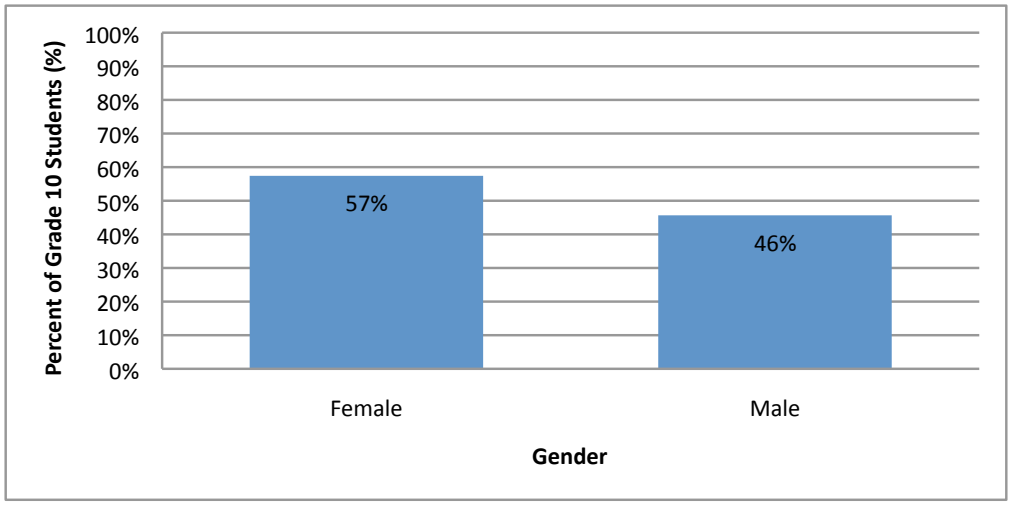


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 31 students (3%) did not complete the survey questions for Positive Peer Influence.

There was also a significant relationship between gender and Positive Peer Influence. More female grade 10 students (57%) in Wellington, Dufferin, and Guelph reported high levels of Positive Peer Influence compared to male students (46%)(Figure 6.2). Related research has found that in general, girls report higher quantities of, and greater satisfaction with, peer support when compared to boys.[31]

Figure 6.2 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Positive Peer Influence*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 31 students (3%) did not complete the survey questions for Positive Peer Influence.

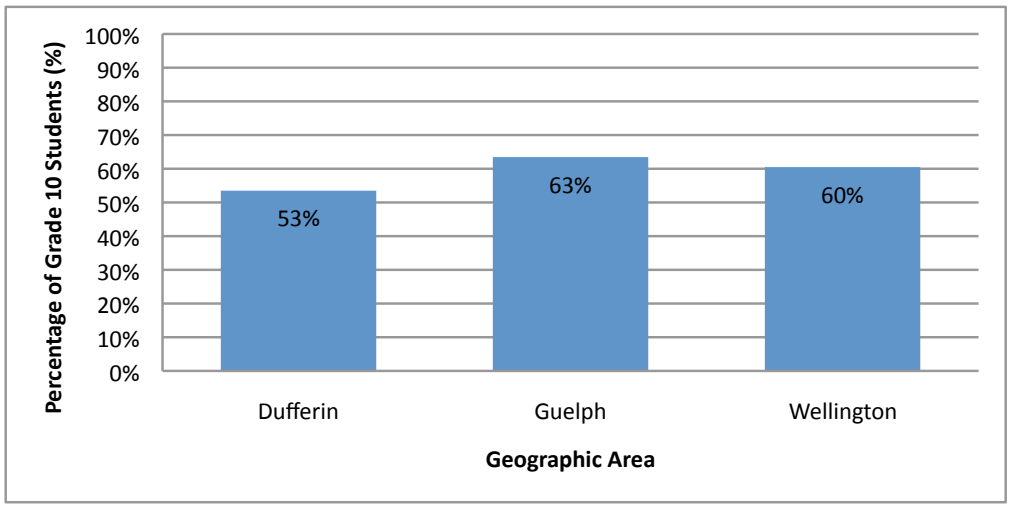
Adolescents typically choose friends who engage in similar behaviours and socialization effects, where they implicitly or explicitly influence each other.[32] This is important to note, as changes in adolescent behaviour often have social consequences. This also supports the idea of peer-led interventions as an effective strategy for reducing health risk behaviours.[33]

Peer connectedness

Peer Connectedness is the level of intimacy, closeness, and warmth shared in relationships with individual peers and peer groups. The quality of interactions within friendships influences the degree of peer connectedness. Previous research has found that youth who report having high quality relationships with their peers were more likely to have more friends, experience lower levels of depression and drug use, and have higher grades in school.[34] These friends can serve as an effective buffer against social pressures, problems, and health risk behaviours. The Canadian Population Health Initiative (CPHI) examined the impact of *Peer Connectedness* and found that youth who reported high levels were more likely to report high self-worth, low levels of anxiety, and "very good" to "excellent" health status.[35]

In order to provide a measure of *Peer Connectedness*, the WDG Youth Survey asked youth the extent to which they agreed with the following statements related to their friends: I have many friends; I get along easily with others my age; others my age want to be my friend; most others my age like me. There was a statistically significant relationship between *Peer Connectedness* and geographic area. As illustrated in Figure 6.3, more grade 10 students in Guelph (63%) and Wellington (60%) reported high levels of *Peer Connectedness* compared to students Dufferin (53%).

Figure 6.3 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Peer Connectedness*, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 32 students (3%) did not complete the survey questions for Peer Connectedness.

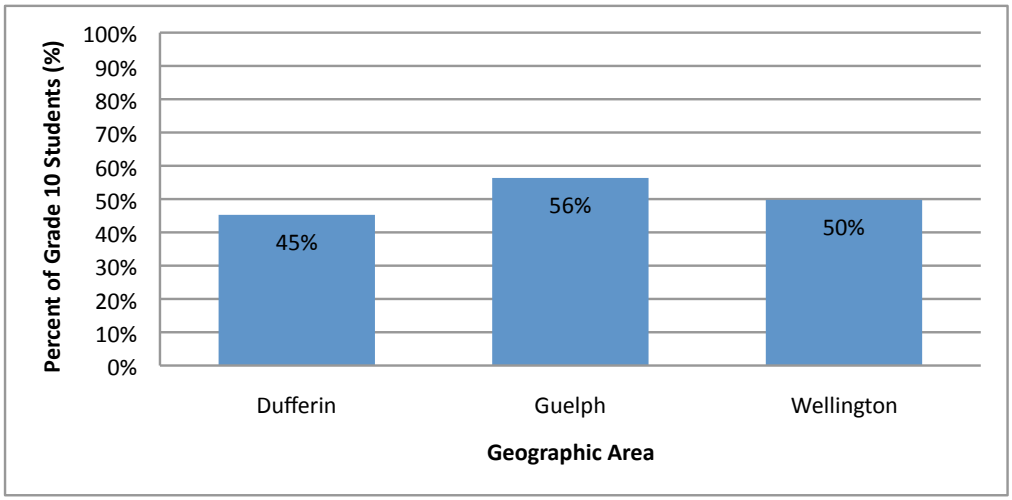
There was no statistically significant relationship between *Peer Connectedness* and gender in Wellington, Dufferin, and Guelph. However, the CPHI analysis identified gender differences in *Peer Connectedness* levels, where fewer male youth (76%) reported high levels of *Peer Connectedness* compared to females (84%).[36]

Family support

Supportive family relationships that involve love, encouragement, and comfort foster positive affects in youth and serve as an important protective factor for substance use. The many stresses and changes that occur during adolescence can be buffered by family support. Family support is crucial for developing adaptive and persistent coping skills among adolescents. This support influences adolescents' attitudes, beliefs, and values, which in turn influences how they will respond to social pressures and opportunities to engage in deviant behaviors.[37] Adolescents who do not experience supportive family relationships may also experience more negative outcomes. For example, youth who have symptoms of depression are more likely to report unsupportive relationships with their family members.[38]

The *Family Support* indicator includes questions from the WDG Youth Survey that asked youth about their interactions with their parents/guardians in the past six months. Specifically, it asked whether their parents talk about the good things they do, if they seem proud of them, smile at them, praise them, and let them know they are appreciated. In Wellington, Dufferin, and Guelph there was a significant relationship between geographic area and *Family Support*. More students in Guelph (56%) reported high levels of *Family Support* compared to Dufferin (45%) and Wellington (50%)(Figure 6.4). The literature on rural and urban differences in family support largely finds the opposite pattern: rural families, particularly those living on farms, appear to have closer family connections and supports.[39] Isolation, less accessible rural public services, and a lack of public transportation increase the need for intra-family cooperation.[40] At the present time, the reason for the opposite trend occurring within Wellington, Dufferin and Guelph is unknown.

Figure 6.4 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Family Support*, by geographic area, 2012**

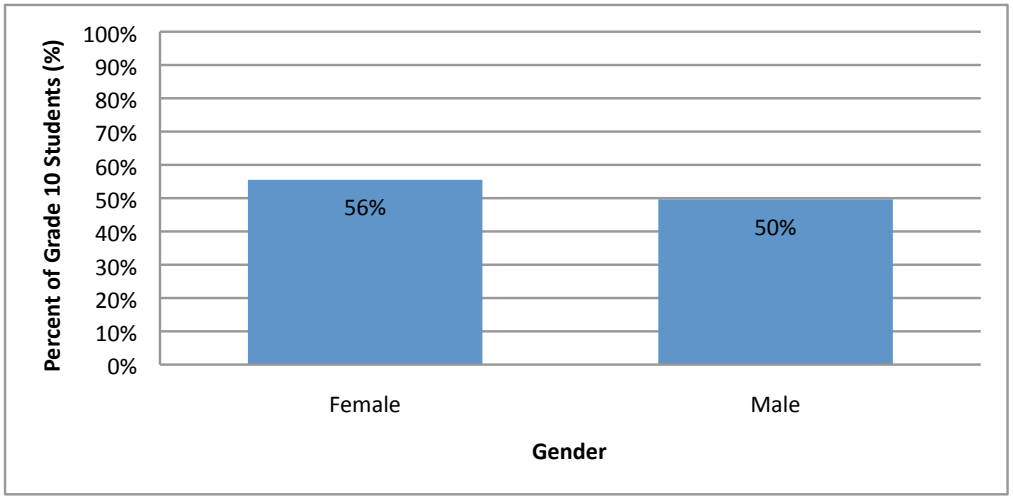


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 67 students (5%) did not complete the survey questions for Family Support.

There was also a significant relationship between gender and *Family Support*. More female students (56%) reported high levels of *Family Support* compared to male students (50%)(Figure 6.5).

Figure 6.5 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Family Support*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

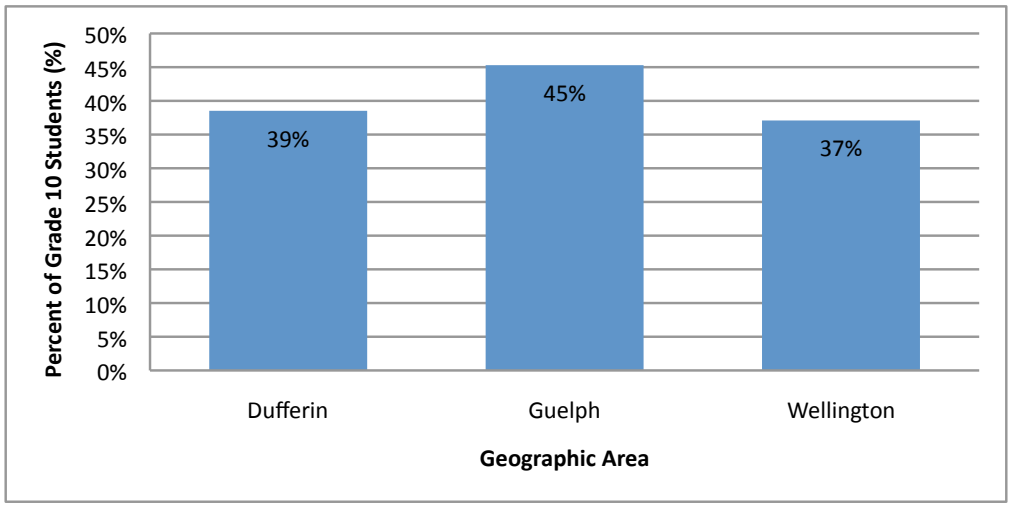
Note: 41 students (3%) did not complete the survey questions for Family Support.

Positive family communication

Effective family communication between adolescents and parents has been associated with a lack of disagreement and greater satisfaction with the family. It is also associated with higher self-esteem among adolescents, more effective coping strategies, and positive impacts on many aspects of their well-being.[41]

The WDG Youth Survey provided a measure of *Positive Family Communication* by asking youth whether their parents/guardians listen to their ideas and opinions and if they solve problems together whenever there is disagreement. Similar to *Family Support*, there was a significant relationship between geographic area and *Positive Family Communication*. A larger percentage of students in Guelph (45%) reported high levels of *Positive Family Communication* compared to students in Dufferin (39%) and Wellington (37%)(Figure 6.6). Again, this trend contradicts the bulk of academic literature on this topic that suggests rural families are more interdependent, requiring higher levels of positive family communication.[42]

Figure 6.6 **Percentage of grade 10 Students in Wellington, Dufferin, and Guelph who reported high levels of *Positive Family Communication*, by geographic area, 2012**

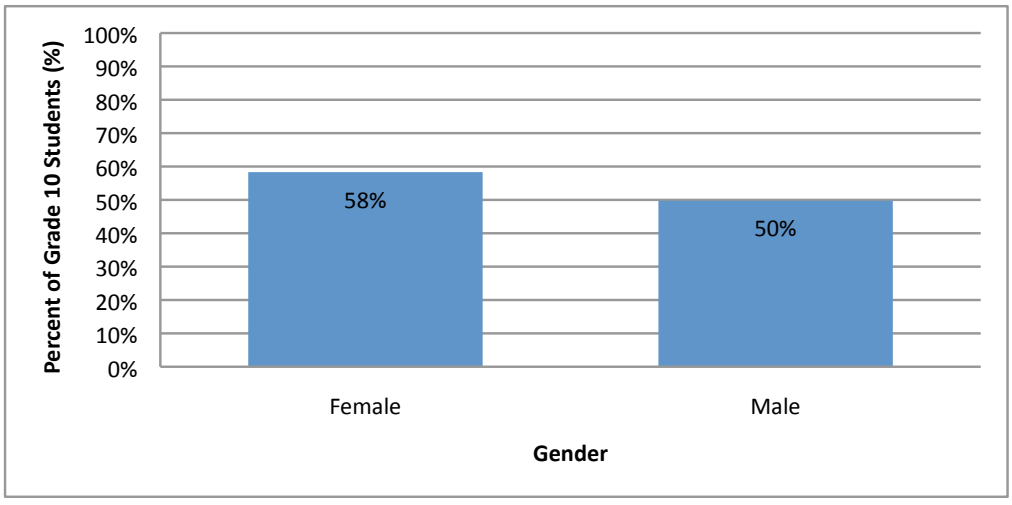


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 34 students (3%) did not complete the survey questions for Positive Family Communication.

There was no significant relationship between gender and *Positive Family Communication* in Wellington, Dufferin, and Guelph, with both males and females reporting equal levels of this indicator.

Figure 6.7 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported spending high amounts of quality time with their families, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 32 students (3%) did not complete the survey questions for Time at Home.

Time at home

A common measure of quality time at home that is examined in the literature is the frequency of family dinners. This body of research has found that time with family can serve as a protective factor to prevent high-risk behaviors, such as substance use, sexual activity, depression, suicide, antisocial behaviors, violence, and school problems. It has also been found to have a positive relationship with many developmental assets, including support, social competencies, and positive identity. This type of quality time with family may also alleviate daily life stressors.[43]

The WDG Youth Survey asked youth the extent to which they have spent quality time at home with their parents/guardians. No significant differences emerged between geography and levels of *Time at Home* with family. In Wellington, Dufferin, and Guelph 54% of grade 10 students reported spending high amounts of *Time at Home* with family. Similar to Family Support, there was a significant relationship between gender and *Time at Home*. As illustrated in Figure 6.7 more female students (58%) reported high levels of *Time at Home* when compared to male students (50%).

Endnotes

1 Canadian Institute for Health Information. (2005). *Improving the Health of Young Canadians.* Ottawa: Canadian Institute for Health Information.

2 The International Resilience Project. (2006). *International Resilience Project: Project Report.* Halifax: The International Resilience Project, School of Social Work.

3 Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, M. & Cohen, P. (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. *Genetic, Social, and General Psychology Monographs,* 116, 111-267.

4 Canadian Institute for Health Information. (2005). *Improving the Health of Young Canadians.* Ottawa: Canadian Institute for Health Information.

5 The National Center on Addiction and Substance Abuse at Columbia University. (2011). *The importance of family dinners*.

6 Canadian Institute for Health Information. (2005). *Improving the Health of Young Canadians.* Ottawa: Canadian Institute for Health Information.

7 Eisenberg, M, E., Olsen, R. E., Neumark-Sztainer, D., Story, M., & Bearinger, L. H. (2004). Correlations between family meals and psychosocial well-being among adolescents. *Archives of Pediatrics & Adolescent Medicine, 158*(8), 792-796.

8 Newcomb, A.F., Bukowski, W.M., & Pattee, L. (1993). Children's peer relations: A meta-analytic review of popular, rejected, neglected, controversial, and average sociometric status. *Psychological Bulletin, 113,* 99-128.

9 Parker, J., Rubin, K., Price, J., & de Rosier, M. (1995). *Peer relationships, child development, and adjustment.* In D. Cicchetti & D. Cohen (Eds.), Developmental psychopathology: Vol 2. Risk, disorder, and adaptation (pp. 96-161). New York: Wiley.

10 Woodward, L.J., & Fergusson, D.M. (2000). Childhood peer relationship problems and later risks of educational under-achievement and underemployment. *Journal of Child Psychology and Psychiatry, 41,* 191-200.

11 Bolger, K.E., Patterson, C.J., & Kupersmidt, J.B. (1998). Peer relationships and self-esteem among children who have been maltreated. *Child Development*, *69*, 1171-1197.

12 Azmitia, M. (2002). Self, self-esteem, conflicts, and best friendships in early adolescence. In T. M. Brinthaupt (Ed.), Understanding early adolescent self and identity: Applications and interventions (pp. 167-192). Albany: State University of New York Press.

13 Newcomb, A.F., & Bagwell, C.L. (1995). Children's friendship relations: A meta-analytic review. *Psychological Bulletin, 117*, 306-347.

14 Mahony, T. H. (2010). Police-reported dating violence in Canada, 2008. *Juristat,* 30(2).

15 Rhodes, J.E. (2005). A model for youth mentoring. In D.L. DuBois & M.J. Karcher (Eds.), Handbook of youth mentoring (pp. 30-43). Thousand Oaks, CA: Sage.

16 ibid

17 ibid

18 ibid

19 DuBois, D. L., & Silverthorn, N. (2005). Natural mentoring relationships and adolescent health: Evidence from a national study. *American Journal of Public Health.*

20 Catalano, R. F., Berglund, M. L., Ryan, J. A. M., Lonczak, H. S., & Hawkins, J. D. (2004). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *The Annals of the American Academy of Political and Social Science, 591*, 98-126.

21 Grossman, J. B., & Rhodes, J. E. (2002). The test of time: Predictors and effects of duration in youth mentoring programs. *American Journal of Community Psychology, 30,* 199-219.
22 ibid
23 Canadian Institute for Health Information. (2005). *Improving health of young Canadians.* Ottawa, ON.
24 Prinstein, M.J., Boergers, J. & Spirito, A. (2001). Adolescents' and their friends' health-risk behavior: Factors that alter or add to peer influence. *Journal of Pediatric Psychology, 26*(5), 287-298.
25 Group for Advancement of Psychiatry. (1999). Violent behavior in children and youth: preventive intervention from a psychiatric perspective. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 235-241.
26 Kirby, D. (2002). Antecedents of adolescent initiation of sex, contraceptive use, and pregnancy. *American Journal of Health Behaviour, 26*(6), 472-485.
27 Oman, R.F., Vesely, S., Aspy, C.B., McLeroy, K.R., Rodine, S., & Marshall, L. (2004). The potential protective effect of youth assets on adolescent alcohol and drug use. *American Journal of Public Health, 94*(8), 1425-1430.
28 Group for Advancement of Psychiatry. (1999). Violent behavior in children and youth: preventive intervention from a psychiatric perspective. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 235-241.
29 Prinstein, M.J., Boergers, J. & Spirito, A. (2001). Adolescents' and their friends' health-risk behavior: Factors that alter or add to peer influence. *Journal of Pediatric Psychology, 26*(5), 287-298.
30 Ide, J.K., Parkerson, J., Haertel, G.D., & Walberg, H.J. (1981). Peer group influence on educational outcomes: A quantitative synthesis. *Journal of Educational Psychology, 73*(4), 472-484.
31 Colarossi, L.G., & Eccles, J. (2000). A prospective study of adolescents' peer support: Gender differences and the influence of parental relationships. *Journal of Youth and Adolescence, 29*(6), 661-678.
32 Bandura, A. (1973). Aggression: A social learning analysis. *Englewood Cliffs,* NJ: Prentice Hall.
33 Prinstein, M.J., Boergers, J. & Spirito, A. (2001). Adolescents' and their friends' health-risk behavior: Factors that alter or add to peer influence. *Journal of Pediatric Psychology, 26*(5), 287-298.
34 Field, T., Diego, M., & Sanders, C. (2002). Adolescents' parent and peer relationships. *Adolescence, 37*(145). 121-30.
35 Canadian Institute for Health Information. (2005). *Improving health of young Canadians.* Ottawa, ON.
36 ibid
37 Ashby, T., Donato, V. & McNamara, G. (1992). The role of life events, family support, and competence in adolescent substance use: A test of vulnerability and protective factors. *American Journal of Community Psychology, 20*(3), 349-374
38 Schulenberg, J., Maggs, J.L., & Hurrelnamm, K. (1997). Health risks and developmental transitions during adolescence. *Cambridge University Press.*
39 Crockett, L. J., Shanahan, M. J., & Jackson-Newsom, J. (2000). Rural Youth: Ecological and Life Course Perspectives. *Faculty Publications, Department of Psychology.* Paper 246.
40 Hofferth, S. L., & Iceland, J. (2011). Social capital in rural and urban communities. *Rural Sociology, 63*(4), 574-598.
41 Jackson, S., Bijstra, J., Oostra, L., & Bosma, H. (1998). Adolescents' perceptions of communication with parents relative to specific aspects of relationships with parents and personal development. *Journal of Adolescence, 21*(3), 305-322.
42 Hofferth, S. L., & Iceland, J. (2011). Social capital in rural and urban communities. *Rural Sociology, 63*(4), 574-598.
43 Fulkerson, J.A., Story, M., Mellin, Al., Leffert, N., Neumark-Sztainer, D., & French, S.A. (2006). Family dinner meal frequency and adolescent development: Relationships with developmental assets and high-risk behaviours. *Journal of Adolescent Health, 39*(3), 337-345.


It'll never be the same as it is here, it can never be the same but we can have a good crack at it
- Jacqueline Fawn
Believe the impossible
- Dominique Oliveira
We all begin as strangers
- Robin Kelly
SOMEBODY TOLD ME that this IS THE PLACE where EVERYTHING is better and everything is Safe
The only thing we will regret are The Things we never did -Mike Ziemerink
life is the art of drawing without an eraser
We walk the path of learning faith and respect together
inside we're all a little weird
- Graham Nasbett
6 billion people in the world, 6 billion souls and sometimes all you need is one

7. A right to be and feel safe in our homes, schools and communities

Introduction

The link to youth's well-being

Issues of safety, positive environments, and feeling safe have been discussed throughout the Report Card, highlighting the importance of the environment in positive youth development and well-being. Chapter 3 discussed issues of safe housing and safe places to sleep. Chapter 4 investigated the association between safe neighbourhoods and physical activity participation, while also discussing the importance of after-school programs in reducing crime rates and unhealthy behaviours. Chapter 5 emphasized the impact of the school environment on youth engagement and academic achievement. Chapter 6 examined the role of nurturing home environments, as well as peer and family support in positive youth development. Next, Chapter 8 will present data on discrimination and bullying in the school environment. In addition to the above-mentioned safety indicators, this chapter will focus on additional indicators, including involvement in the child welfare system, youth crime, injuries, and perceptions of safety are also important correlates of youth development and well-being.

Children and youth who have been involved in the child welfare system have often experienced negative conditions including neglect, abandonment, physical, emotional or sexual abuse, family violence, parental substance abuse, and extreme poverty.[1] These experiences can negatively impact healthy development and the transition into adulthood.[2] For example, youth who have experienced physical or sexual abuse are more likely to report poor health and consider suicide.[3] They are also more likely to skip school and carry a weapon, and less likely to believe that they are able to graduate from college or university.[4] Youth involved in the child welfare system are at a greater risk for depression, poor mental health, maladaptive behaviours, impaired relationships, lower educational achievement, and overall poor health.[5,6,7] Research has also found that youth in care are at greater risk for financial hardship, interaction with the criminal system (e.g., arrests), and teen pregnancy.[8]

The transition into adulthood has changed over recent decades. It is more common for youth today to live with their parents/caregivers and depend on them for a longer period of time in order to pursue education and employment opportunities. Youth involved in the child welfare system, especially those living in care, may face additional challenges during this transition, as they may lack the necessary social and family supports.[9] Despite these adversities, research has found that youth in care possess many of the developmental assets that are necessary for resilience.[10,11]

Crimes committed during adolescence can also negatively impact the trajectory of development. Approximately 5-15% of youth who enter the justice system will become serious offenders with lengthy criminal careers.[12] In a study of 955 adult inmates in Ontario, 43.6% reported that they were arrested for the first time prior to the age of 16, suggesting that adult offenders often begin their criminal activity at an early age.[13] Consequently, early identification of youth who are at a high risk for criminal activity is critical to decreasing the rates of adult criminal activity in Canada. Research suggests that there are two risk factor domains

that can predict serious and chronic offending among youth.[14] First, individual risk factors, such as antisocial behaviour, hyperactivity, impulsion, and attention problems can increase the likelihood for criminal activity.[15] Second, family risk factors, such as poor child-rearing methods, relationship difficulties, and criminal family members can also impact a youth's likelihood of offending.[16] Persistent or even one-time criminal charges can reduce the educational and employment opportunities for individuals, decreasing the likelihood that they will maintain sufficient income levels, and negatively impacting their health and well-being.[17] There is a large body of evidence that explores the complex nature of youth criminal activity, including individual risk factors, as well as the social, political, and economic context in which youth live in order to understand the mechanisms of successful prevention strategies. The evidence supports the idea that various youth programs (including sports, recreational activities, arts and crafts, etc) provide the context for unique and valuable social interactions that are otherwise missing from the lives of at-risk youth. These relationships have been found to not only prevent youth from engaging in violent behaviours, thus contributing to crime prevention, but they also have a positive impact on overall youth development and resilience[18]. Approaches for ensuring that youth have access to these programs and other important relationships are discussed in further detail in Chapters 4 and 6, respectively.

Injuries are the leading cause of death for youth and young adults in Canada.[19] Every year, hundreds of thousands of youth also experience non-fatal injuries, which can have long-term impacts on their quality of life.[20] According to the 2009 Canadian Community Health Survey (CCHS) data, 27% of youth reported that they had experienced an injury in the last 12 months; however, only 55% of those sought medical care for their injuries.[21] Youth living in low income neighbourhoods were more likely to seek medical care for cuts and poisonings, while youth from high income neighbourhoods more readily sought care for falls.[22] Across all income quintiles, workplace injuries are becoming more and more of a concern among youth. In 2008, youth ages 15 to 19, experienced nearly 80,000 workplace injuries in Canada, accounting for 25% of all workplace injuries that year.[23] This is of particular concern given that youth, ages 15 to 24, represent only 15% of Canada's labour force.[24] Overall, 15% of injured young workers report permanent physical impairments and a further 26% report ongoing medical issues.[25] Thus, injuries sustained during adolescence can have long-lasting negative effects on health and development.

Youth perceptions of safety within their schools, homes, and neighbourhoods also have important consequences for health. As mentioned in Chapter 4, youth who perceive their neighbourhoods to be safe are more likely to participate in after-school programs and recreational activities. Because schools are typically situated within neighbourhoods, the crime and poverty rates of a particular neighbourhood often predict school violence and impact perceptions of school safety.[26] School safety perceptions are of critical importance, as they have been shown to impact school attendance, grades, attitude towards school, school engagement, and behaviour.[27] However, parental involvement in a youth's life can moderate the perceptions of school and neighbourhood safety. Youth with strong attachments to their parents learn to trust others and feel less threatened in both school and neighbourhood environments.[28]

Indicators of youth's health and well-being in this chapter

In light of the above research, this chapter will add to the safety indicators discussed in other chapters by presenting data on the following indicators:

- Protection investigations
- Children and youth in care
- Foster care and kinship
- Partner violence
- Parent-teen conflict
- Criminal activity
- Injuries
- Caring neighbourhood
- Safety
- Family boundaries

The value of this information to service providers

The child welfare information presented in this chapter will help service providers understand the extent to which children and youth in our community are involved in this system of care. Keeping in mind the adversities that can be experienced, as well as the many assets that youth possess, service providers can offer important support to youth through relationship building, nurturing support, and access to community resources. Ensuring that youth develop positive relationships with caring, competent adults, and experience nurturing consistent care are the strongest protective factors for youth who may feel displaced or have disruptions in family or caregiver attachments.[29,30] Interventions that build on the strengths of youth and focus on the "acquisition of developmental assets", while reducing risks, will result in more positive outcomes in terms of physical and mental health and academic/professional performance, and will support a resilient transition into adulthood.[31] The local data, along with the additional contextual research, will increase our understanding of both the developmental and institutional transitions that youth experience when "aging out" of child welfare services. [32]

The crime rates that are highlighted in this chapter are valuable for service providers across the region. Crime rates by location give service providers an important understanding of which geographic areas may benefit from additional after-school programming to reduce the rates of youth criminal activity. The hours between 3:00 pm and 6:00 pm on school days are typically unstructured time for youth, as they are not in school during these hours and their parents/caregivers may not be home from work. During this time, they are more likely to commit crimes, participate in sexual activity, smoke, drink, and use drugs.[33] As a result, the creation of after-school programs could create positive alternatives for at-risk youth.[34] This data also serves as a concise overview of why youth deserve access to safe places that offer important respite from negative environmental impacts.

The injury data presented in this chapter will also help inform programming. This data provides a better understanding of the risk factors in youth development. There are connections evident in the literature that link neighbourhood environments and youth health outcomes. Service providers can use the information regarding the types of injuries experienced by youth to develop strategies for reducing risks to youth health and development.

Finally, data regarding youth perceptions of safety will allow service providers to better understand the youth population in the region. Data showing particularly low levels of perceived safety within an environment may create the impetus for the creation of programs/initiatives that improve safety.

Protection investigations

The Ontario Association of Children's Aid Societies (OACAS) promotes the welfare of children, youth and families in the province through advocacy, services and leadership.[35] In Ontario, Children's Aid Societies (CASs) are the only community agencies responsible for investigating child abuse and neglect. CASs are funded and mandated by the Ministry of Children and Youth Services (MCYS) to protect children from harm by investigating any reported cases of abuse and/or neglect. CASs operate under the Child and Family Services Act (CFSA). Guelph and Wellington County are served by Family & Children's Services of Guelph and Wellington County (FCSGW), while Dufferin Child and Family Services (DCAFS) serves Dufferin County.

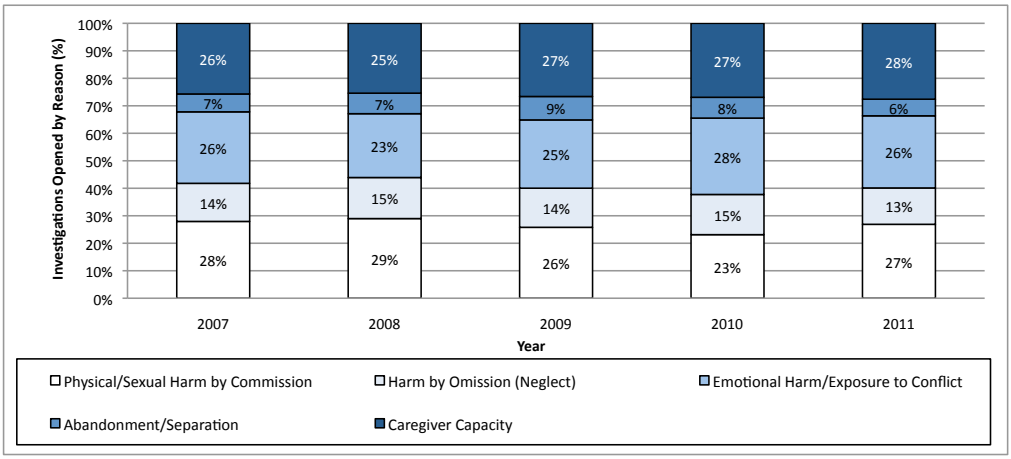
Throughout the history of CASs in Ontario, there have been several significant changes, including the shift in staffing from volunteers to professionals, and the shift from institutional care to family- and community-based services. CASs have become increasingly standardized across the province, with each agency guided by a volunteer Board of Directors. Currently, the role of CASs is clearly defined in legislation. There are various options to meet complex needs of children and families

to ensure that more children can be helped while still living with their families. There are also more supports available for families where an increased risk has been identified, as well as time to find, screen, and train extended family as an alternative to foster care.

When a CAS receives a referral from the community (e.g., a phone call, in person, or police report), the referral is evaluated using the Ontario Child Welfare Eligibility Spectrum (see detailed description below) to determine if a protection investigation is required. This evaluation considers factors such as the severity of the situation and the age of the children involved. According to the CFSA, CASs in Ontario only become involved in investigations with families that have children and youth under the age of 16 years. Currently, the OACAS is advocating to raise the age of protection from 16 to 18 years of age, as Ontario is the only province in Canada where youth are not protected until age 18. Once it is determined that an investigation is necessary, the safety of the child is assessed within a prescribed timeframe. When risk has been identified, a CAS child protection worker develops a customized investigation plan, working to keep children safe in the home whenever possible. During the course of service, CASs collaborate closely with other community service agencies to ensure that clients receive all of the supports they need to achieve successful outcomes. These partnerships include schools, police, mental health and addiction services, shelters, Ontario Works, health professionals and many others.

The following figures include local data from FCSGW and DCAFS. Figure 7.1 and Figure 7.2 illustrate protection investigations opened by reason (based on the Eligibility Spectrum) as a percentage of total protection investigations opened in a given year. A protection investigation can be opened for multiple reasons; however, these data represent the most severe or "primary" reason for opening an investigation. These data represent investigations opened, rather than families investigated, as one family may have more than one investigation opened in a year.

Figure 7.1 **Protection investigations opened by reason as a percentage of total investigations opened, children under 16 years of age, Family & Children's Services of Guelph and Wellington County, 2007 to 2011**



Source: *Family & Children Services of Guelph and Wellington, December 2012*

Note: Descriptions of Eligibility Spectrum Codes for Ontario Child Welfare (from Ontario Child Welfare Eligibility Spectrum Revised October 2006, © OACAS)

The Eligibility Spectrum (Spectrum) is a tool designed to assist CAS staff in making consistent and accurate decisions about eligibility for service at the time of referral. Figure 7.1 and 7.2 include spectrum codes for which protection investigations are opened (when deemed necessary). Referrals can be coded

with multiple codes; one primary code (most severe) and two to three secondary codes, if necessary. The information submitted for FCSGW and DCAFS for protection investigations opened are for the primary codes. The description of the eligibility spectrum codes are as follows.

Section 1 — Physical/Sexual Harm By Commission: The child has suffered physical or sexual harm or there is a risk that the child is likely to suffer physical or sexual harm as a result of an act or action by a caregiver.

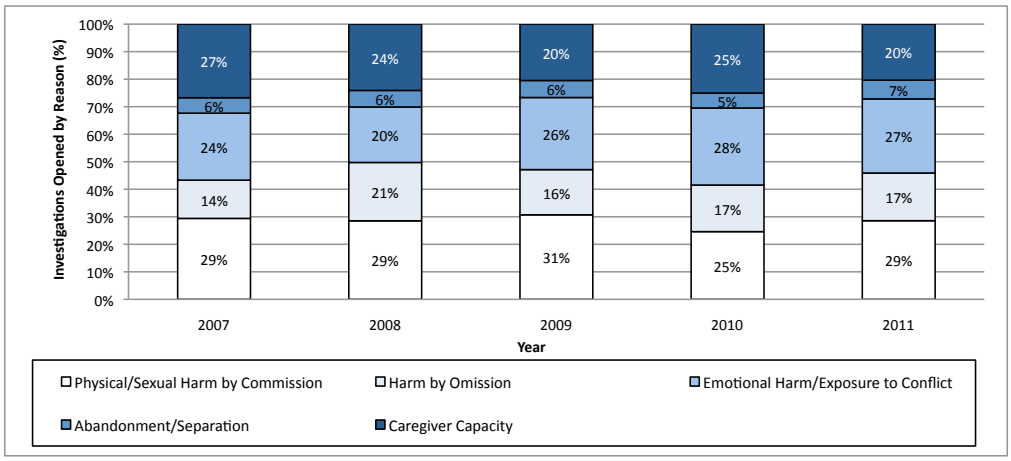
Section 2 — Harm By Omission: The child has been harmed or there is a risk that the child is likely to be harmed as a result of the caregiver's failure to adequately care for, provide for, supervise, or protect the child.

Section 3 — Emotional Harm/Exposure to Conflict: The child has been emotionally harmed or is at risk of emotional harm as a result of specific behaviours or patterns of neglect of the caregiver towards the child or resulting from the caregiver failing to adequately address the emotional condition.

Section 4 — Abandonment/Separation: The child has been abandoned or is at risk of being separated from the caregiver as a result of intentional or unintentional actions of the caregiver.

Section 5 — Caregiver Capacity: No harm has yet come to the child and no evidence is apparent that the child may be in need of intervention for a reason indicated in Sections 1 through 4. The caregiver, however, demonstrates characteristics that indicate that without intervention, the child would be at risk in one of the previous sections.

Figure 7.2 **Protection investigations opened by reason as a percentage of total investigations opened, children under 16 years of age, Dufferin Child and Family Services, 2007 to 2011**



Source: Dufferin Child and Family Services, December 2012

Overall, in Wellington, Dufferin, and Guelph , the total number of investigations opened increased between 2007 and 2011. This is consistent with the trends in Ontario, with a 1.6% increase in the number of referrals requiring an investigation and 2.2% increase in the number of new child protection cases opened.[36] In Guelph/Wellington (Figure 7.1) and Dufferin (Figure 7.2), there was a slight decreasing trend in investigations opened for Physical/Sexual Harm by Commission and a slight increasing trend in investigations opened for Emotional Harm/Exposure to Conflict as a percentage of total investigations. Investigations opened for Caregiver Capacity increased slightly

as a percentage of total investigations in Guelph/Wellington, and decreased slightly in Dufferin from 2007 to 2011.

Once the investigation is completed, a decision is made regarding whether the children are in need of further protection services. If no further services are required, the file is closed or transferred for non-protection services (e.g., for the family to participate in a group, or to connect the family to another service, agency, or program). If the children require further protection services, the case is transferred for ongoing child welfare services. During this time, children are left in the family home whenever possible. The family often requires other support services and resources in the community, further illustrating the need for collaborative planning and service integration. However, if risk cannot be managed by keeping the child at home, other options must be explored, including placing the children with extended family members out of care or admitting children into care.

Children and youth in care

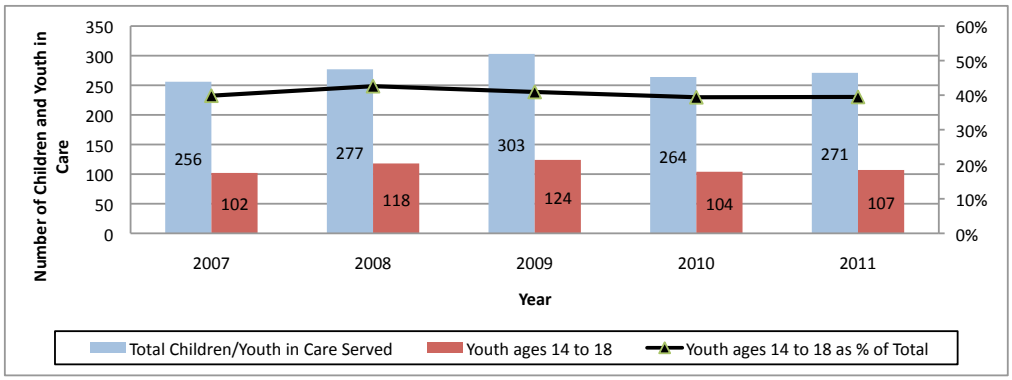
There are many reasons why children and youth are placed into alternative care. Parents may require support to identify abusive patterns and develop parenting skills that can keep their children safe at home. Parents may voluntarily request assistance from a CAS if they are not able to care for their children.[37] A common concern about youth in care is that they may experience social isolation, as they often become detached from their peers and social networks. They often rely more heavily on formal services rather than informal social supports, have smaller social networks compared to their peers, and have fewer positive role models.[38] Placement into a stable alternative home may help to ensure that youth experience a "sense of belonging".[39] The hope is that youth will develop long-term caring relationships and connections with adults that will continue throughout their lives.[40] Meaningful relationships with adults from the school or care setting can enhance youths' self-esteem and self-efficacy, sense of identity, and belonging.[41]

Figures 7.3 and 7.4 illustrate the total number of children and youth served in care in Guelph/Wellington and Dufferin between 2007 and 2011. Specifically, these figures include the total number of children and youth served in care, the number of youth, ages 14 to 18, served in care, and the percentage of youth, ages 14 to 18, served in care as a percentage of the total number of children in the care. Children and youth served in care represents the number of children and youth in care at the start of year (i.e., January 1st), plus the number of admissions to care during that year. These numbers represent unique children and youth served; and therefore, do not capture multiple admissions for an individual in a single year. Also, these data do not include other society wards (i.e., the child or youth is a ward of an agency in another jurisdiction, but is residing in a placement in Guelph/Wellington or Dufferin, where FCSGW or DCAFS are responsible for supervising the placement).

CAS Placements

The types of care placements available include kinship service (placement with extended family out of care), kinship care (placement with extended family in care), family-based foster care, adoption, group homes, institutions, independent living, extended care and maintenance (ECM), or other specific arrangements. At 18 years of age, youth can enter into an ECM agreement with their CAS to continue receiving support during the transition to independence at age 21. In January 2013, the Ontario government announced increased supports for youth, ages 21 to 25, who are enrolled in post-secondary education.

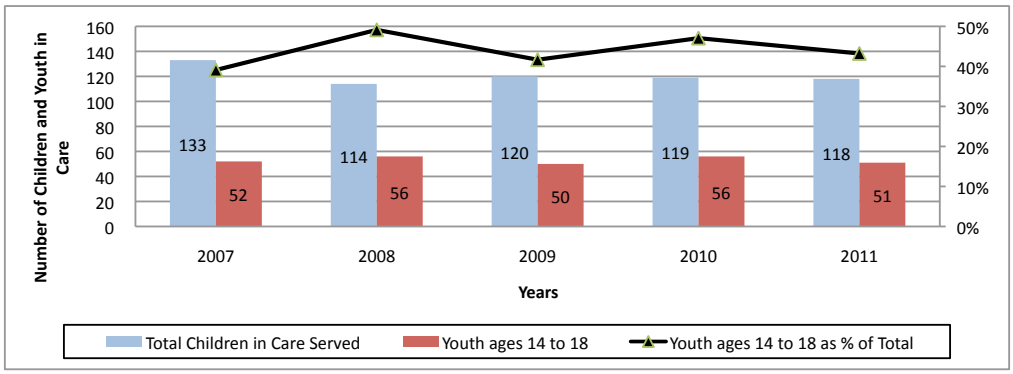
Figure 7.3 **Number of children and youth in care served by Family & Children's Services of Guelph and Wellington County, 2007 to 2011**



Source: *Family & Children Services of Guelph and Wellington, December 2012*

Note: Caution must be taken when comparing between FCSGW and DCAFS data, as some of the data presented include raw numbers or counts. It is important to consider the difference in population size that is served by each agency. FCSGW services a much larger population than DCAFS.

Figure 7.4 **Number of children and youth in care served by Dufferin Child and Family Services, 2007 to 2011**



Source: *Dufferin Child and Family Services, December 2012*

Note: Caution must be taken when comparing between FCSGW and DCAFS data, as some of the data presented include raw numbers or counts. It is important to consider the difference in population size that is served by each agency. FCSGW services a much larger population than DCAFS.

Figures 7.3 and 7.4 demonstrate fairly stable trends over the five year span from 2007 to 2011 in Guelph/Wellington and Dufferin. In Guelph/Wellington (Figure 7.3), there was an increase in the total number of children and youth served in care between 2007 and 2009. However, the percentage of youth, ages 14 to 18, as the total number of children in care remained fairly stable across each year, with an average of 40% over the five years. In Dufferin (Figure 7.4), the average percentage across 2007 to 2011 is slightly higher at 44%.

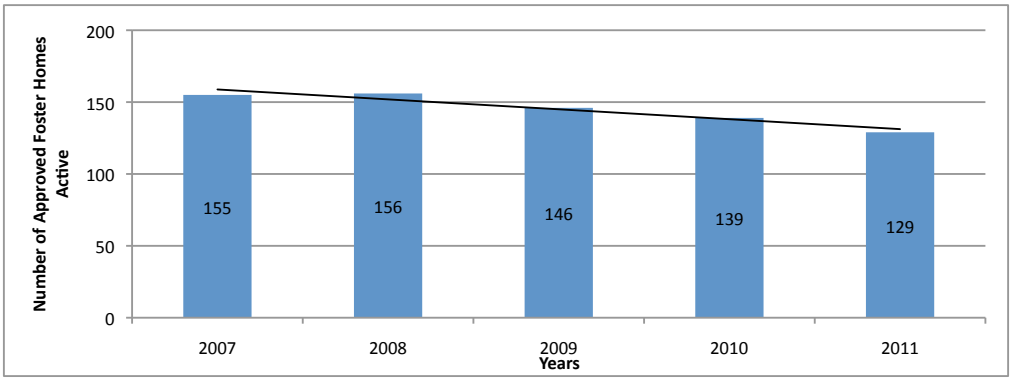
In Ontario, the total number of children in care declined 7% between 2007/08 and 2011/12.[42] This is attributed to the efforts being made by CASs to increase the range of options available for placing children in permanent homes, such as care by relatives (kinship service) and legal custody. As well, CASs have also been focused on efforts to enhance parenting skills and increase referrals to other community services and resources whenever possible to safely keep children in their homes.[43]

Foster care and kinship

When children and youth are not able to remain in their family home, the CAS first explores extended family or other people that are well-known to the child (e.g., kinship service). If these alternative options are not safe, available, or financially possible, then the CAS are responsible for finding an appropriate foster family that will provide a safe, caring, nurturing, and stable environment for the child. Standardized screening tools from the Ministry of Children and Youth Services are used to approve potential kinship and foster parents. Foster placements are intended to be a temporary option, with many children returning home within weeks or months. If the family situation remains unsafe for a child to return home to their parents, a long-term permanency plan is required, which includes options such as legal guardianship or adoption.[44] Foster families are encouraged to consider providing a permanent home for children in their care if they are unable to return to parents or kin.

Figures 7.5 and 7.6 provide local information on the number of approved foster homes that were active through FCSGW and DCAFS from 2007 to 2011. These data represent the number of open and approved foster homes as of the first day of year (i.e., January 1st), plus any new foster homes that were approved during the year. It is important to note that some open and approved foster homes may not have had children or youth staying with them consistently or at all throughout the year.

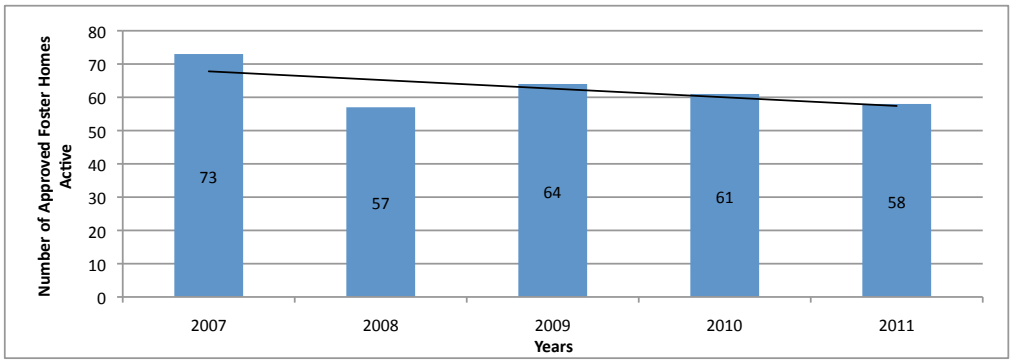
Figure 7.5 **Approved foster homes active, Family and Children's Services of Guelph and Wellington County, 2007 to 2011**



Source: *Family & Children Services of Guelph and Wellington, December 2012*

Note: Caution must be taken when comparing between FCSGW and DCAFS data, as some of the data presented include raw numbers or counts. It is important to consider the difference in population size that is served by each agency. FCSGW services a much larger population than DCAFS.

Figure 7.6 **Approved foster homes active, Dufferin Child and Family Services, 2007 to 2011**



Source: *Dufferin Child and Family Services, December 2012*

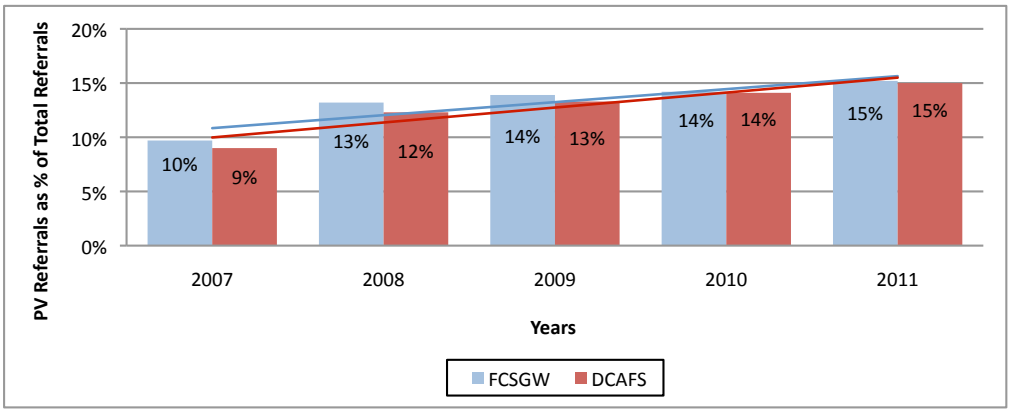
Note: Caution must be taken when comparing between FCSGW and DCAFS data, as some of the data presented include raw numbers or counts. It is important to consider the difference in population size that is served by each agency. FCSGW services a much larger population than DCAFS.

In Guelph/Wellington (Figure 7.5) and Dufferin (Figure 7.6), the number of approved foster homes decreased between 2007 and 2011. It can be more difficult to recruit foster homes for youth, compared to younger children. Given that 40-44% of children in care are between the ages of 14 and 18, finding alternative care options for these youth, such as foster homes, can be challenging. Furthermore, many foster homes that want to adopt often want younger children. By the age of 16 or 17, some youth are trying to find their own living accommodations and take care of the responsibilities that accompany this (e.g., part-time job, rent, bills, cleaning, cooking, laundry, etc.), while still attending school. As a result, many of these youth struggle with managing school and drop-out to cope with the other demands. Research by the OACAS found that CAS youth are less likely to graduate from high school (44%)[45] compared to their peers (81%)[46], and are also less likely to enroll in post-secondary education. This underscores the importance of recruiting and retaining permanent homes for youth in order to provide them with a stable, supportive family environment and relationships to help them through the transition to adulthood.

Partner violence

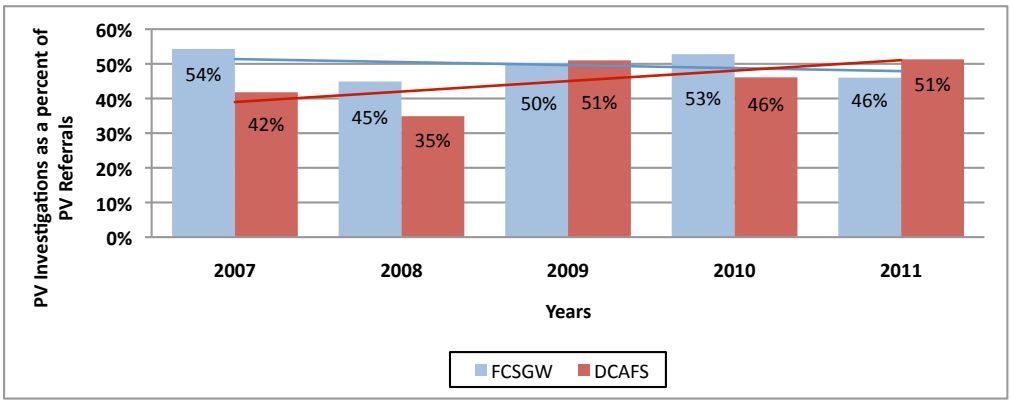
Children affected by parental partner violence (PV) in their homes are more likely to experience guilt, anxiety, anger, grief, confusion, and other negative emotions.[47] Research suggests that lowered self-esteem and depression are some of the long-term effects of exposure to parental partner violence.[48] It has also been found that youth are at a higher risk of crime victimization if they live or have lived in households with adult partner violence.[49] FCSGW and DCAFS respond to PV through referrals and investigations as reported in the figures below. Figure 7.7 reports PV referrals as a percentage of total referrals and Figure 7.8 illustrates PV investigations as a percentage of PV referrals.

Figure 7.7 **Partner violence referrals as a percentage of total referrals, Family & Children's Services of Guelph and Wellington County (FCSGW) and Dufferin Child and Family Services (DCAFS), 2007 to 2011**



Source: Family & Children Services of Guelph and Wellington and Dufferin Child and Family Services, December 2012

Figure 7.8 **Partner violence investigations opened as a percentage of partner violence referrals, Family & Children's Services of Guelph and Wellington County (FCSGW) and Dufferin Child and Family Services (DCAFS), 2007 to 2011**



Source: Family & Children Services of Guelph and Wellington and Dufferin Child and Family Services, December 2012

Figure 7.7 shows that the percentage of referrals for PV increased over the five year period from 2007 to 2011 for both FCSGW and DCAFS. Figure 7.8 illustrates that the investigations opened for partner violence as a percentage of referrals for partner violence increased for DCAFS, and decreased slightly for FCSGW during this time.

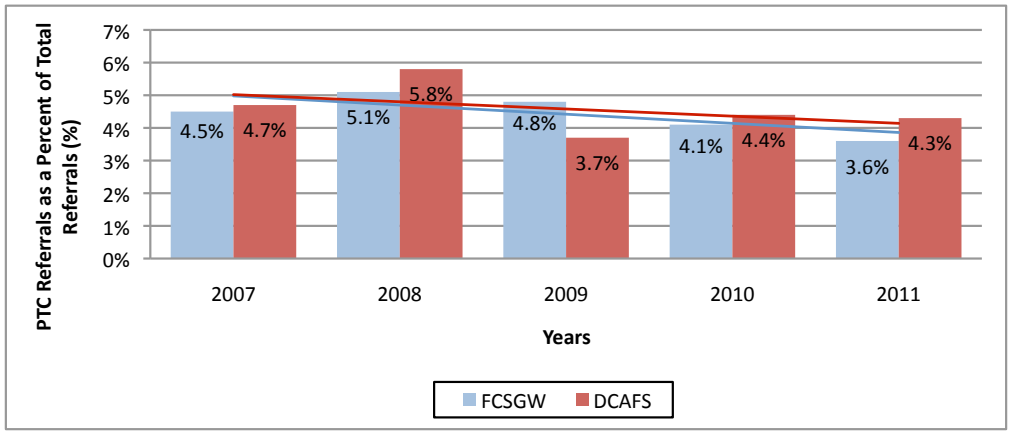
The data presented in this section is specific to partner violence between parents of children and youth, but it is important to acknowledge violence between intimate partners in adolescent relationships, or dating violence.[50] Dating violence can be emotional, physical, or sexual behaviour that negatively impacts the development and integrity of an individual in an intimate relationship.[51] As youth develop these relationships, it is just as important that they have the same sense of safety in these relationships as they do with their parents, caregivers, or other important role models. Dating violence among youth, its impact on their health, and important considerations for youth programming are discussed in Chapter 6.

Parent-teen conflict

Much of the research on parent-teen conflict (PTC) focuses on family-based models of coping strategies and conflict management. Often, reports of PTC involve the parent calling to request support about how to manage conflict with their teen. FCSGW has a Family Support Program to help parents manage and cope with their children's behaviour, improve overall family communication, and build healthy relationships between parents and children. Survive and Thrive in the Adolescent Years (STAY) is a group specifically for parents of youth, ages 12 to 16, which focuses on the challenges of the adolescent years, such as communication and problem-solving with teens.

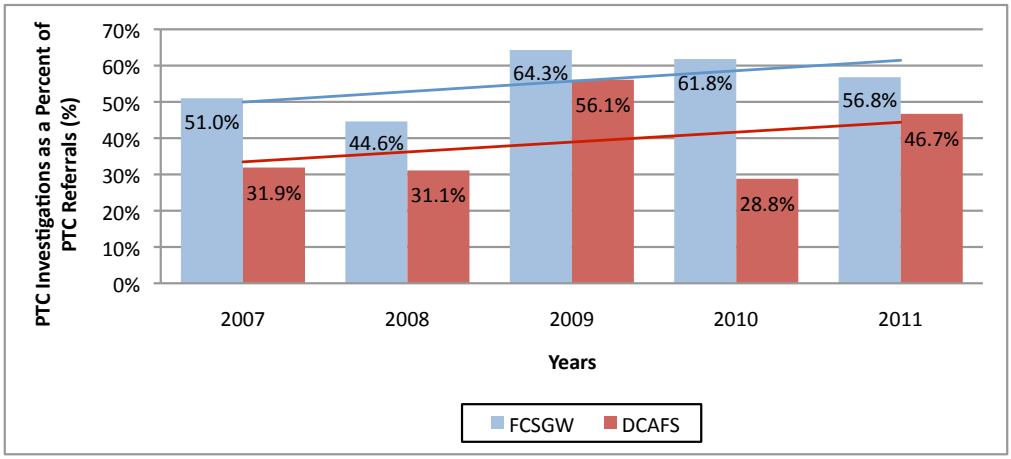
Figure 7.9 reports the PTC referrals as a percentage of the total referrals and Figure 7.10 reports the PTC investigations as a percentage of PTC referrals from 2007 to 2011. PTC is a subset of the abandonment and separation spectrum code reported in Figures 7.1 and 7.2 and largely involves youth, ages 13 to 15.

Figure 7.9 **Parent-teen conflict referrals as a percentage of total referrals, Family & Children's Services of Guelph and Wellington County (FCSGW) and Dufferin Child and Family Services (DCAFS), 2007 to 2011**



Source: Family & Children Services of Guelph and Wellington and Dufferin Child and Family Services, December 2012

Figure 7.10 **Parent-teen conflict investigations opened as a percentage of parent-teen conflict referrals, Family & Children's Services of Guelph and Wellington County (FCSGW) and Dufferin Child and Family Services (DCAFS), 2007 to 2011**



Source: Family & Children Services of Guelph and Wellington and Dufferin Child and Family Services, December 2012

Figures 7.9 and 7.10 illustrate that the referrals for parent-teen conflict are on the decline for both FCSGW and DCAFS, while the investigations are increasing for both during 2007 to 2011.

Criminal activity

Given the negative impact of criminal activity on youth health and developmental outcomes in addition to the broader societal implications (e.g., costs related to health care services, law enforcement, and judicial services), it is important to understand the extent to which youth are involved in various types of criminal activity in our community.[53] Involvement in various illegal activities places youth at greater risk for receiving a criminal charge and increases the likelihood of general involvement with law enforcement. The Wellington-Dufferin-Guelph (WDG) Youth Survey asked youth questions about their involvement in different types of criminal activity in the past year. Given that the different types of criminal activity vary in terms of the severity and potential

Parent-Teen Conflict

"Arguments with parents can often be understood in this context. While those common teenager/parent quarrels, which explode every few days, are, at a superficial level, about curfews, homework, housework, and respect, a teenager's real focus is on a parent's acknowledgement of his maturity and capability and human value. Teens get so heated in arguments with parents because so much is at stake: they are fighting to change their relationship with a parent, to make a parent see that they are not the child the parent thinks she knows."

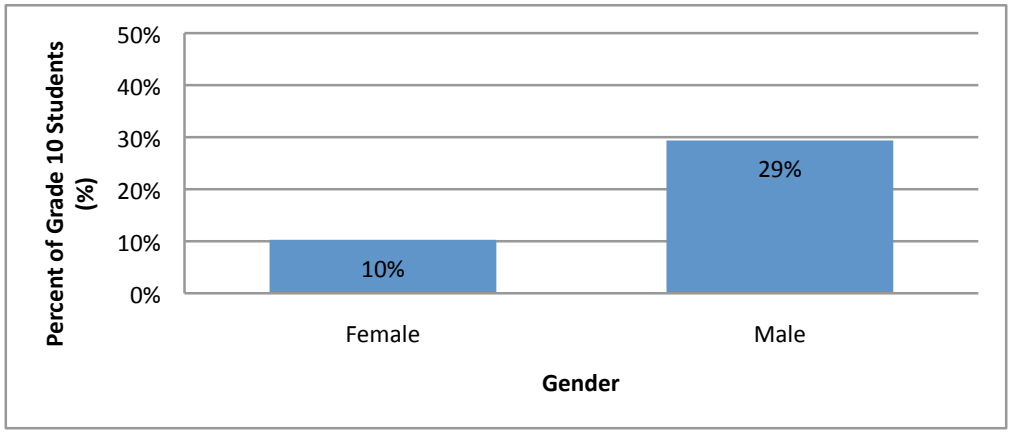
– Dr. Terri Apter, University of Cambridge, Domestic Intelligence[52]

consequences, they have been presented individually in the figures below.

The WDG Youth Survey asked youth whether they have damaged or destroyed something that did not belong to them in the last 12 months (e.g., damaged a bicycle, car, school furniture, broken windows, or written graffiti). Analysis of the results found that there was no significant relationship between geographic area and this type of criminal activity. In Wellington, Dufferin, and Guelph, 19% of grade 10 students reported damaging or destroying something that did not belong to them.

There was, however, a significant relationship between gender and damaging or destroying something that did not belong to them. As illustrated in Figure 7.11, more males (29%) reported damaging or destroying something that did not belong to them when compared to females (10%). This is a consistent trend across all of the criminal activity indicators measured by the WDG Youth Survey. This trend is consistent with a wider understanding of gender differences in criminal activity. Historically, females are less likely to commit criminal offenses than males. Females also tend to commit criminal offenses later on in life, they are less likely to reoffend, and commit less serious offences than males.[54]

Figure 7.11 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph that have damaged or destroyed something that did not belong to them, by gender, 2012**

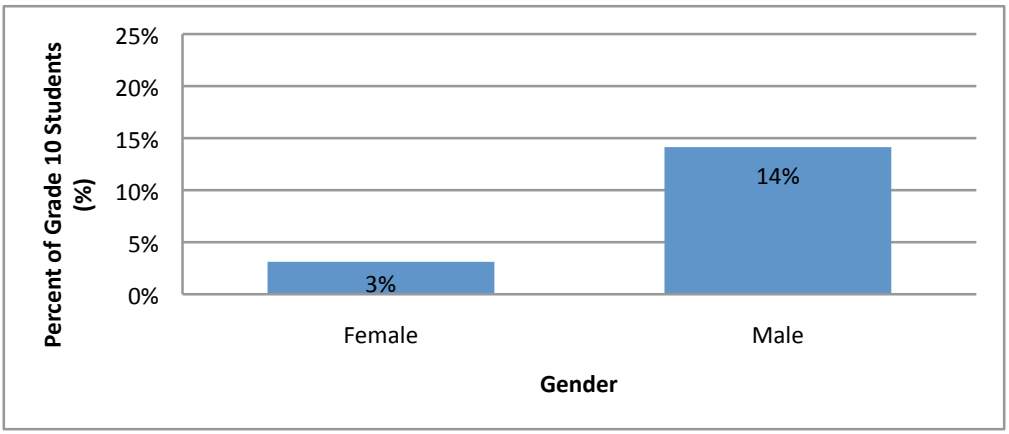


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 21 students (2%) did not complete the survey question for "damaged or destroyed something that did not belong to them".

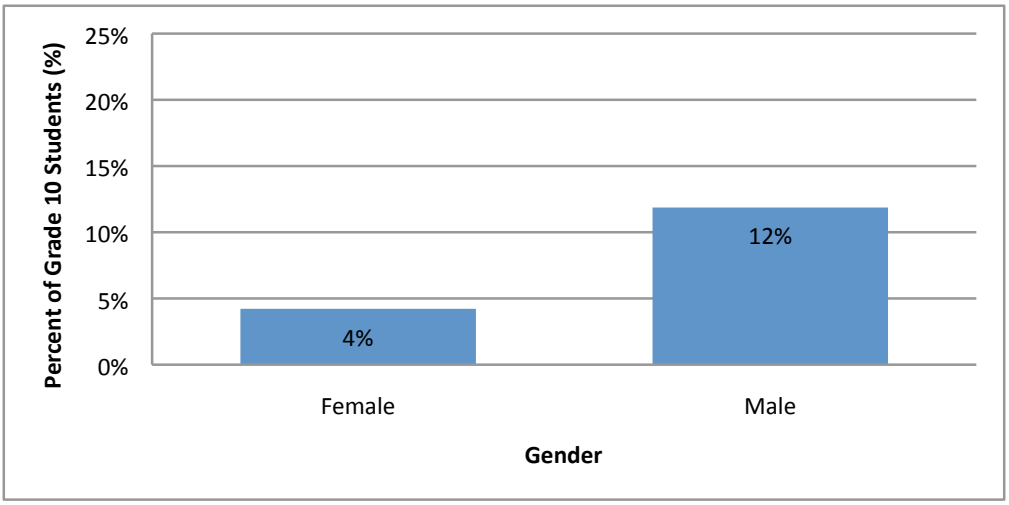
The WDG Youth Survey also asked youth about whether they had carried a weapon for the purpose of defending themselves or using it in a fight in the past 12 months. This is a valuable indicator to investigate as carrying a weapon is an important risk factor for violence among youth.[55] There was no significant relationship between geographic area and carrying a weapon. In Wellington, Dufferin, and Guelph, 8% of grade 10 students reported carrying a weapon for the purpose of defending themselves or using it in a fight. There was a statistically significant relationship between gender and carrying a weapon. Figure 7.12 demonstrates that males (14%) were more likely to carry a weapon for the purposes of defending themselves or using it in a fight compared to females (3%). Again, this trend is consistent with a wider understanding of gender differences in criminal activity.

Figure 7.12 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph that carried a weapon for the purpose of defense or use in a fight, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*
Note: 20 students (2%) did not complete the survey question for "carried a weapon for the purpose of defense or use in a fight".

Figure 7.13 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph that sold any drugs, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*
Note: 22 students (2%) did not complete the survey question for "sold any drugs".

Results from the British Columbia Adolescent Health Survey asked a similar question about carrying a weapon to school. The analysis found that students who carried a weapon to school felt less safe at school. Students who had been physically attacked, verbally harassed, or excluded from social groups at school were more likely to carry a weapon to school. Among those students who reported carrying a weapon, the most

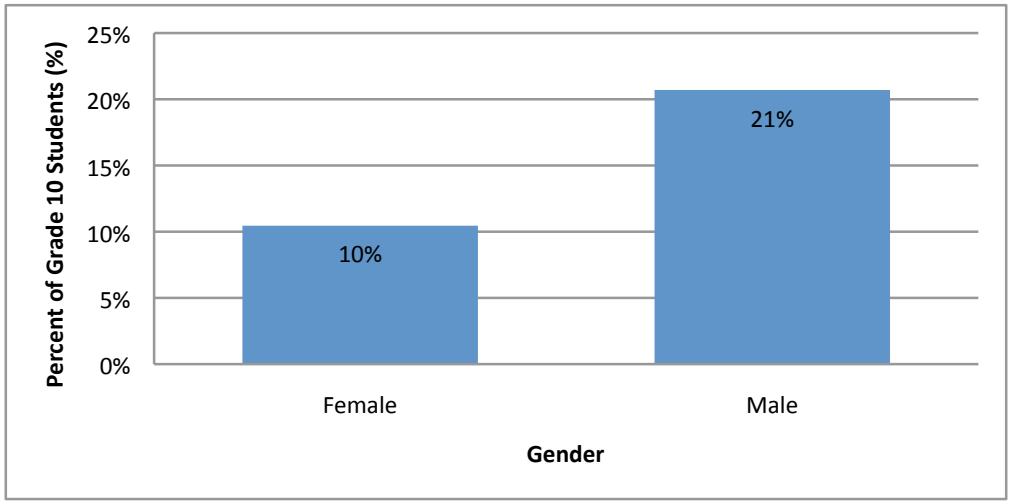
common type of weapon was a knife or razor (73%), followed by a club, stick, bat or pipe (9%).[56]

Another indicator of criminal activity measured by the WDG Youth Survey was involvement with selling drugs in the past 12 months. There was no statistically significant relationship between geographic area and selling drugs. In Wellington, Dufferin, and Guelph, 8% of grade 10 students reported selling drugs. Again, there was a statistically significant relationship between gender and selling drugs. Grade 10 males (12%) were more likely to sell drugs than females (4%), as indicated in Figure 7.13.

Research indicates that youth involvement in selling drugs has increased in recent decades.[57] There is a large body of evidence that has found a correlation among youth between selling illicit drugs and several delinquent behaviours, including substance use,[58,59] violence,[60] gang participation,[61] and carrying a weapon.[62] Much of this research focuses on youth involved in the justice system and those living in high-risk or disadvantaged urban neighbourhoods, rather than the general population of youth. Research that examined the general population of youth found that youth who sold drugs were more likely to engage in delinquent behaviours and use a wider variety of drugs.[63]

Finally, the survey asked youth about whether they had "been part of a group that broke the law by stealing, hurting someone, damaging property, etc." in the past 12 months. There was no statistically significant relationship between this indicator of criminal activity and geographic area. In Wellington, Dufferin, and Guelph, 15% of grade 10 students reported being a part of a group that broke the law. There was a statistically significant relationship between being a part of a group that broke the law and gender. Figure 7.14 illustrates that grade 10 males (21%) were more likely to report being a part of a group that broke the law than females (10%).

Figure 7.14 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph that have been part of a group that broke the law by stealing, hurting someone, damaging property, etc, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

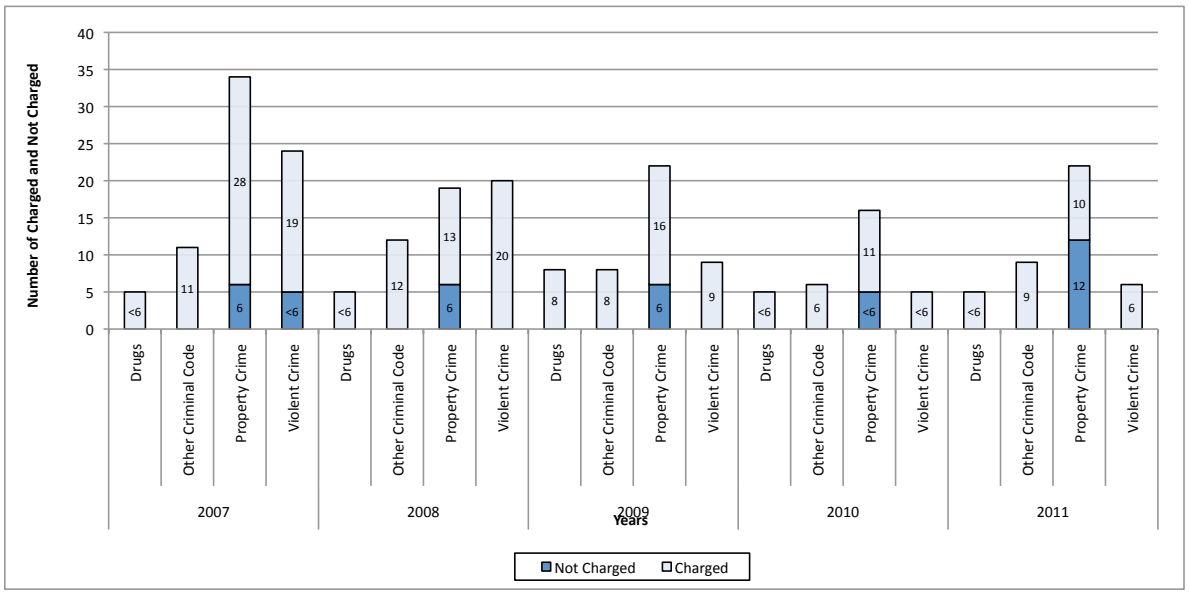
Note: 24 students (2%) did not complete the survey question for "been part of a group that broke the law by stealing, hurting someone, damaging property, etc".

Research has found that involvement in "gangs" is largely a male phenomenon and that gang involvement typically occurs during the adolescent years or early twenties. Similar to the other criminal

activities explored in this chapter, involvement in groups that break the law, or gangs, is associated with other delinquent or illegal activities and violence.[64]

In addition to the self-reported information collected through the WDG Youth Survey, local law enforcement detachments provided data on crimes committed by youth in our community. Wellington, Dufferin, and Guelph are served by the following detachments for law enforcement: Guelph Police Service, County of Wellington Ontario Provincial Police (OPP), Dufferin OPP, Shelburne Police Services, and Orangeville Police Services. A current gap in the information is the number of crimes committed against youth, due to difficulties in obtaining and interpreting these data. The following figures (7.15 to 7.19) present the number of "charged" and "not charged" among youth, ages 12 to 17, by type of crime. It is important to note that these data represent the number of criminal events among youth, ages 12 to 17, and not the number of youth committing criminal events. In other words, a crime committed by one individual can be "charged" or "not charged" under multiple crime categories (e.g., violent crime and property crime). The crimes are organized into the following categories: drugs, property crime, violent crime, and other criminal codes. These categories are further defined below.

Figure 7.15 **Number of youth, ages 12 to 17, charged and not charged, by type of crime, Ontario Provincial Police, Dufferin Detachment, 2007 to 2011**



Source: *Personal communication, Dufferin County OPP Detachment, October 2012*

Note: "Charged" means the youth is given a court date for either criminal or federal court charges.

"Not Charged" means the youth is not charged but is given a consequence such as a warning, formal caution (e.g., a letter goes on the individual's file), diversion (e.g., in lieu of going to court, the matter has been referred to another agency, like John Howard Society), extra-judicial program (similar to diversion), referral to community program, or no action.

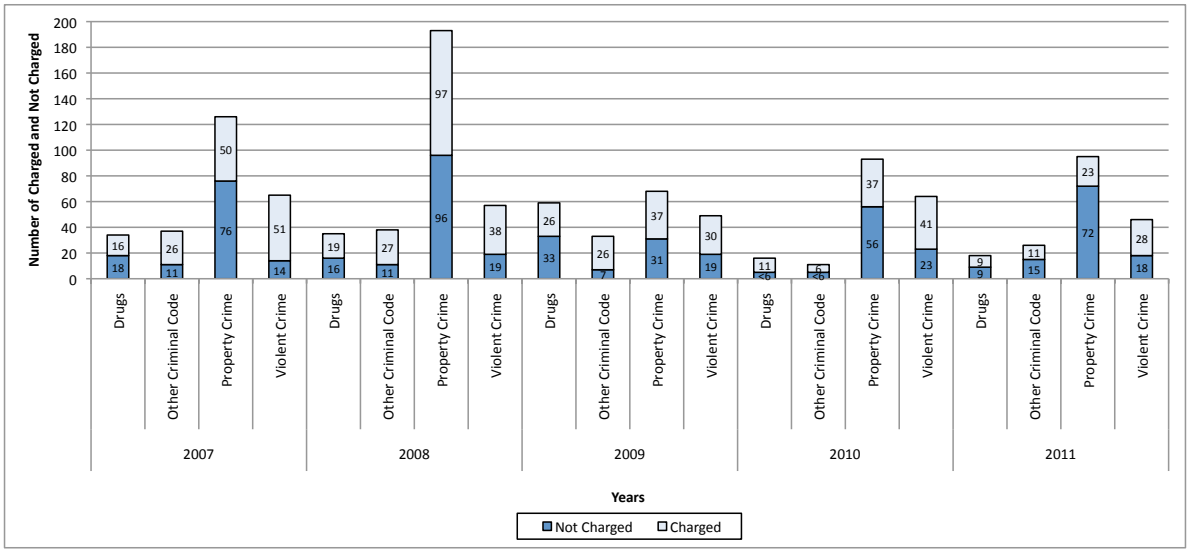
Property crime includes arson, break and enter, theft, fraud, and mischief to property.

Drug crime includes possession of drugs, trafficking, and production of drugs.

Violent crime includes sexual assault, assault with weapons, common assault, criminal harassment, robbery, and threats.

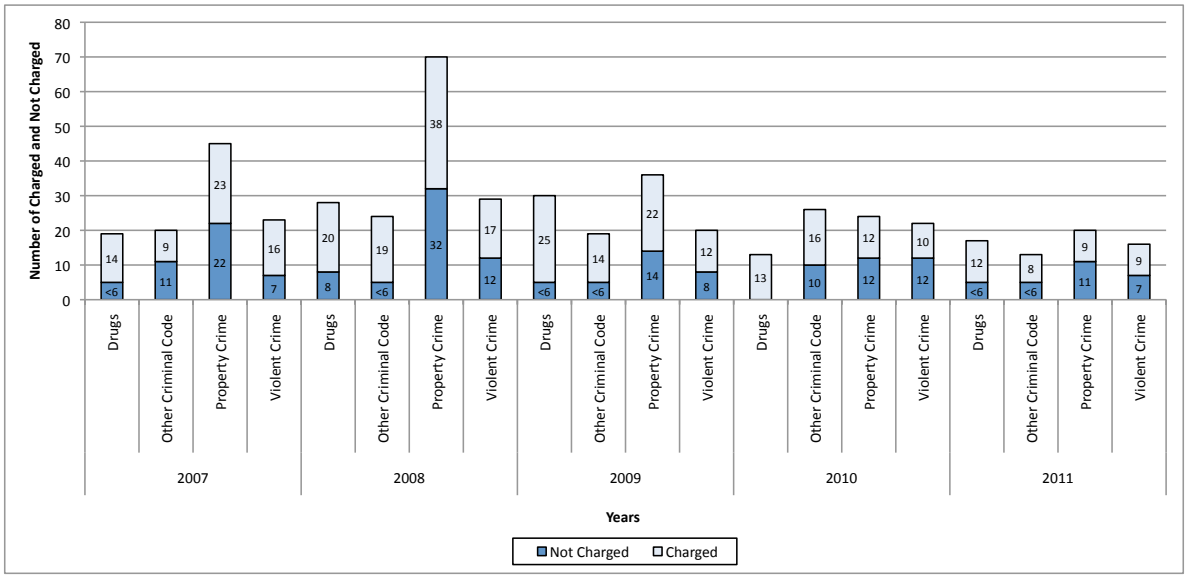
Other criminal code is all other types of crimes lumped together such as bail violations, impaired driving, obstruction, etc.

Figure 7.16 **Number of youth, ages 12 to 17, charged and not charged, by type of crime, Orangeville Police Services, 2007 to 2011**



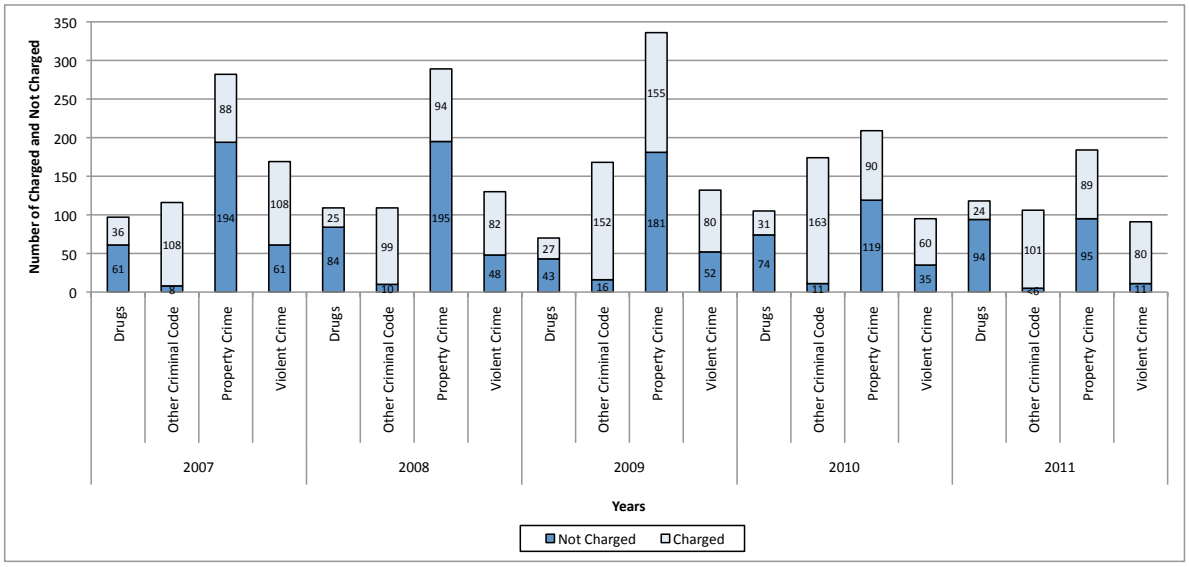
Source: *Personal communication, Orangeville Police Services, October 2012*

Figure 7.17 **Number of youth, ages 12 to 17, charged and not charged, by type of crime, Shelburne Police Services, 2007 to 2011**



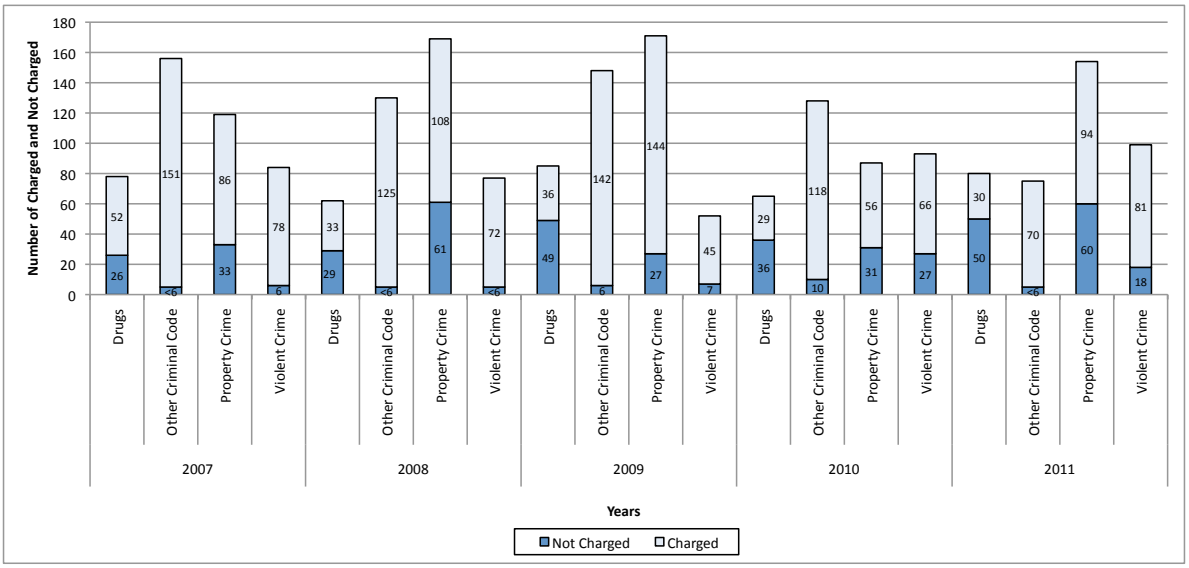
Source: *Personal communication, Shelburne Police Services, October 2012*

Figure 7.18 **Number of youth, ages 12 to 17, charged and not charged, by type of crime, Guelph Police Services, 2007 to 2011**



Source: *Personal communication, Guelph Police Services, August 23, and Nov. 20, 2012*

Figure 7.19 **Number of youth, ages 12 to 17, charged and not charged, by type of crime, Ontario Provincial Police, Wellington Detachment, 2007 to 2011**



Source: *Personal communication, Wellington County OPP Detachment, July 3, 2012*

Across all five law enforcement detachments, Property Crimes often represent the largest number of "charged" and "not charged" youth for each year. In Wellington County (Figure 7.19), Other Criminal Codes represented the largest number of charges with the exception of 2009 and

2011. There are no clear trends over time for any of the law enforcement detachments. However, in Canada, youth (ages 12 to 17) crime rates and the youth Crime Severity Index (measures the seriousness of a crime) have been declining in the past 10 years.[65] The Crime Severity Index for youth decreased by 10% from 2001 to 2011. It is also interesting to note that the Youth Criminal Justice Act was implemented in 2003. During this same year, the rate of youth "not charged", or diverted from the formal justice system, began to exceed the rate of youth "charged" in Canada and continued to exceed the rate of youth "charged" up until the most recent Census 2011.[66] Historically, the rationale behind the use of diversion programs is that they provide youth with structured activities that keep them occupied and out of trouble and to deter others from committing crimes in the areas where they operate. As more youth are diverted from the formal justice system, it is important to acknowledge more recent research that suggests the need for diversion programs to focus on the pro-social development of youth, or a "social opportunity" approach, versus the more traditional approach of "social control". Diversion programs that focus on affecting the lives of youth by creating positive social opportunities, rather than simply diverting violence, may be extremely valuable for positive youth development and are more likely to address the root causes of youth violence.[67]

One local initiative with a focus on reducing crime is the Wellington Guelph Drug Strategy Committee. This committee has adopted a wide-ranging strategy that works with community partners to reduce drug and drug-related activity through evidence-based programs that target youth and their families.[69]

Another important community resource for addressing youth criminal activity is the John Howard Society, which uses a community approach to prevent crime, by way of services, social and educational programs, advocacy, and reform. Locally, our community is served by the John Howard Societies of Waterloo-Wellington and Peel-Halton-Dufferin. The John Howard Society has several programs targeted to youth, ages 12 to 17, who may be at risk of offending, or who have recently offended, to prevent future delinquent behaviours. It was not possible to present local data from the John Howard Society given the geographic coverage of these agencies. Furthermore, the John Howard Society only becomes involved with a subset of youth involved in the criminal system and therefore these data are limited and would not be able to provide a population-level picture. There have been recent cuts to their Diversion Programs, which is important to note, given that one of the actions taken by our local law enforcement detachments is to refer to these programs in lieu of being charged and appearing in court. This is especially noteworthy given that we have seen an increase in the number of youth being "diverted" from the criminal system. Ensuring that youth in our community have access to diversion programs that promote positive social opportunities, as previously discussed, is very important for addressing youth crime.

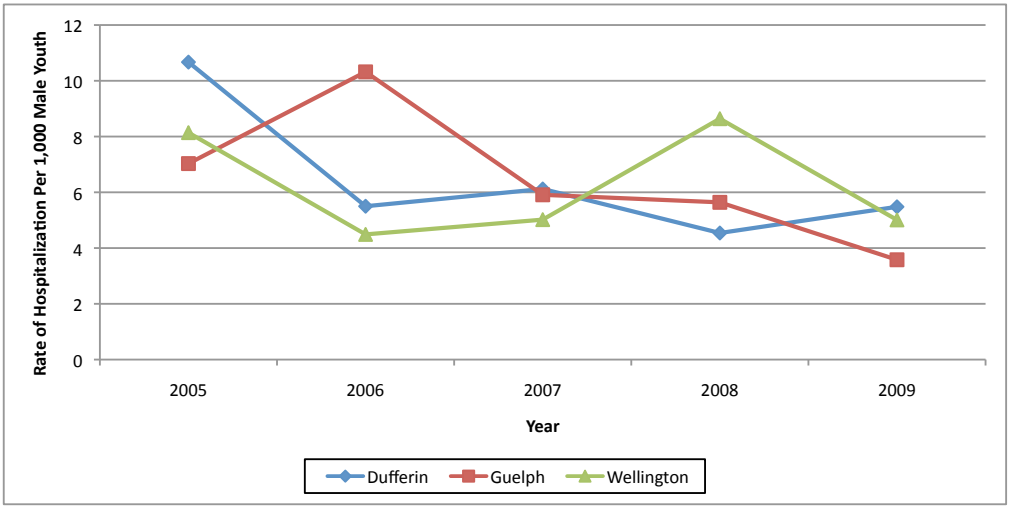
Police Reported Crime Severity Index

In the most recent census (2011), Guelph had the lowest Police Reported Crime Severity Index (PRCSI) in Canada, with a 7% decrease from 2010. "The Police Reported Crime Severity Index (PRCSI) measures changes in the level of severity of crime in Canada from year to year. In the index, all crimes are assigned a weight based on their seriousness. The level of seriousness is based on actual sentences handed down by the courts in all provinces and territories. More serious crimes are assigned higher weights, less serious offences lower weights. As a result, more serious offences have a greater impact on changes in the index."[68]

Injuries

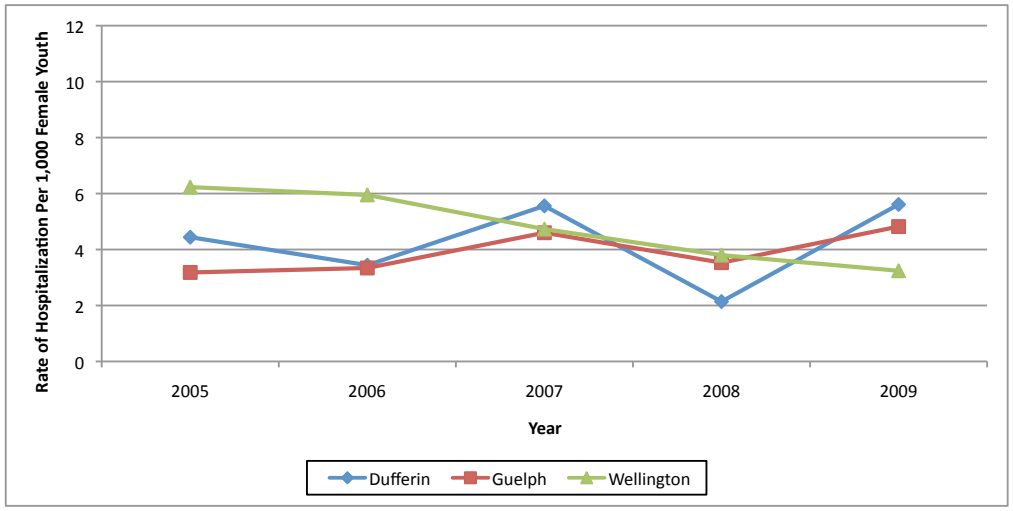
Another source of data that provides insight into the overall safety of youth in our community is data related to injuries. As previously discussed, injuries are the leading cause of death for youth and young adults in Canada. Hundreds of thousands of youth experience non-fatal injuries each year, many of which are not severe enough to require medical attention or hospitalization.[70] In order to investigate patterns of injuries within Wellington, Dufferin, and Guelph, hospitalization data were analyzed. These represent the most severe injuries as they required being admitted to the hospital. Rates were calculated per one thousand youth, ages 14 to 18, to examine trends across Wellington, Dufferin, and Guelph over time, by reasons for hospitalization. A detailed analysis, which is reported in *Chapter 2: A right to good health by having our social, emotional, mental, physical, and spiritual needs met*, revealed that injuries and poisonings were the primary leading cause of hospitalization for males and the third leading cause of hospitalization for females in Wellington, Dufferin, and Guelph between 2005 and 2009. The hospitalization data were separated by gender to demonstrate how the rates differ between males and females. Figure 7.20 illustrates the rate of hospitalization due to injuries and poisoning among male youth, ages 14 to 18, in Wellington, Dufferin and Guelph. Similarly, Figure 7.21 shows these rates for females.

Figure 7.20 **Rate of hospitalization due to injuries and poisoning, male youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**



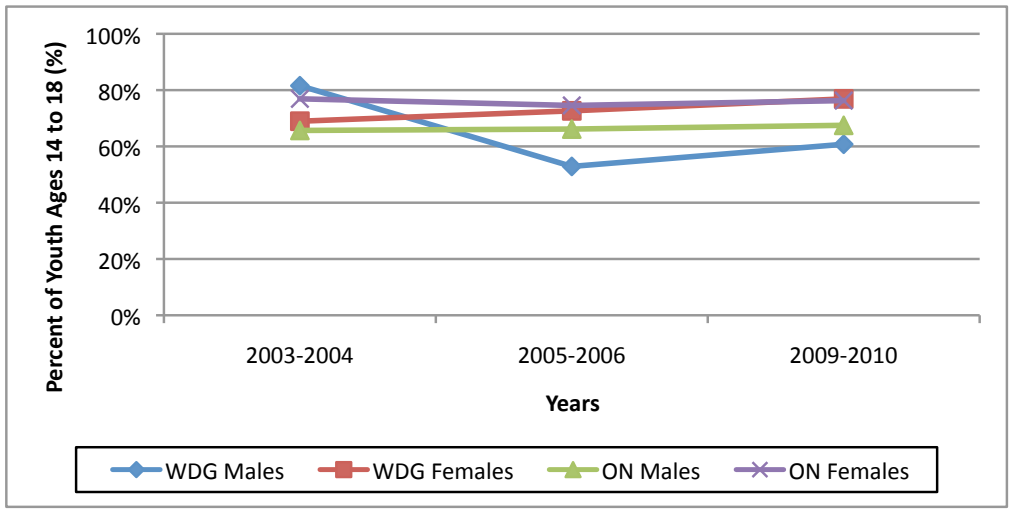
Source: *Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 1009, 14 to 18 Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.*

Figure 7.21 **Rate of hospitalization due to injuries and poisoning, female youth, ages 14 to 18, Wellington, Dufferin, and Guelph, 2005 to 2009**



Source: Wellington-Dufferin-Guelph Hospitalization Diagnosis, 2005 to 1009, 14 to 18 Age at Discharge Counts, Provincial Health Planning Database, extracted May 2012.

Figure 7.22 **Percentage of youth, ages 14 to 18, who reported no injuries in the past 12 months, Wellington, Dufferin, and Guelph, and Ontario, by gender, 2003-2004, 2005-2006 and 2009-2010**



Source: Canadian Community Health Survey Very Good to Excellent Self-Rated Mental Health, INJ-22.
Note: The 2007-2008 cycle of the CCHS did not collect injury-related data, and as a result, this year is not included in Figure 7.22.

There appears to be a decreasing trend over time in rates for males in Dufferin and in Guelph (Figure 7.20). On the other hand, for females (Figure 7.21), Wellington County is the only area

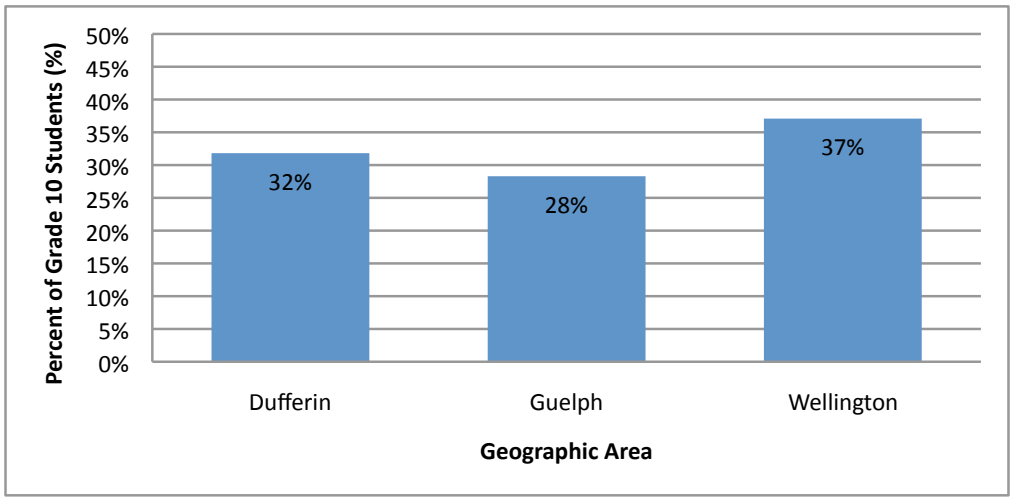
where rates seem to be decreasing over time. These data can be further analyzed to understand the sub-type of injuries and poisoning. For females, poisonings by illicit drugs, prescription medications, and biological and toxic effects of substances (N=92) is the largest cause of hospitalizations for injuries and poisoning, while a variety of other injuries is the highest for males (N=42).

The Canadian Community Health Survey (CCHS) also provides a measure of the rates of injuries within our communities. As discussed in *Chapter 2: A right to good health by having our social, emotional, mental, physical, and spiritual needs met,* the CCHS is a valuable source of population-level health indicators data for youth ages, 12 and over. Figure 7.22 summarizes data specific to youth, ages 14 to 18, who reported no injuries in the past 12 months in Wellington, Dufferin, and Guelph and Ontario.

Analysis of the data presented in Figure 7.22 revealed a statistically significant gender difference and a complex pattern of differences between youth in Wellington, Dufferin, and Guelph, and Ontario as a whole. Among youth, ages 14 to 18, the percentage of males in Wellington, Dufferin, and Guelph who reported no injuries in the past 12 months during 2003-2004 was higher than males in Ontario as well as females in Wellington, Dufferin, and Guelph, and Ontario. In 2005-2006, the percentage of males in Wellington, Dufferin, and Guelph who reported no injuries in the past 12 months decreased to be lower than males in Ontario as well as females in Wellington, Dufferin, and Guelph, and Ontario (Figure 7.22), and remained the lowest in 2009-2010. During the 2009-2010 time period, while the gender-specific differences between Wellington, Dufferin, and Guelph and Ontario are not large, there was a larger difference (approximately 15%) between males and females in Wellington, Dufferin, and Guelph, compared to males and females in Ontario (approximately 10%) who reported no injuries in the past 12 months.

The WDG Youth Survey also provides a measure of injuries among youth in Wellington, Dufferin, and Guelph. The survey asked youth whether they had been injured seriously enough to require medical attention (e.g., a broken bone, bad cut or burn, head injury, etc.) by a doctor, nurse, or dentist in the past 12 months. Analysis of the results found that there was a statistically significant relationship between serious injuries and geographic location, but not for gender. Figure 7.23 illustrates that more grade 10 students in Wellington County (37%) reported being seriously injured in the past 12 months compared to grade 10 students in Dufferin County (32%) and Guelph (28%).

Figure 7.23 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph seriously injured in the past 12 months, by geographic area, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 52 students (4%) did not complete the survey questions for Serious Injuries.

Caring neighbourhood

Many of the indicators explored in this chapter can be linked to the overall safety of the neighbourhoods in which youth live. An important component of perceived neighbourhood safety and sense of belonging is relationships with neighbours. "Sense of community belonging embodies the social attachment of individuals and reflects social engagement and participation within communities."[71] Sense of belonging, and how youth relate to their wider social networks and communities, has an important effect on their health and well-being. Specifically, research has found that sense of community belonging is highly correlated with physical and mental health.[72,73] A study of youth, ages 12 to 15, found that while youth largely depend on interpersonal networks of friends and family members, neighbours can act as very important enablers of social interaction, contributing to their overall sense of belonging.[74]

Caring Neighbourhood is one of the indicators from the WDG Youth Survey, which provides a measure of the extent to which youth experience caring neighbours. This indicator is measured by a question that asks youth if they feel their neighbours care about them. There was no statistically significant relationship between *Caring Neighbourhood* and geographic area. In Wellington, Dufferin, and Guelph, 53% of youth reported high levels of *Caring Neighbourhood*. There was also no statistically significant relationship between gender and *Caring Neighbourhood*.

Safety

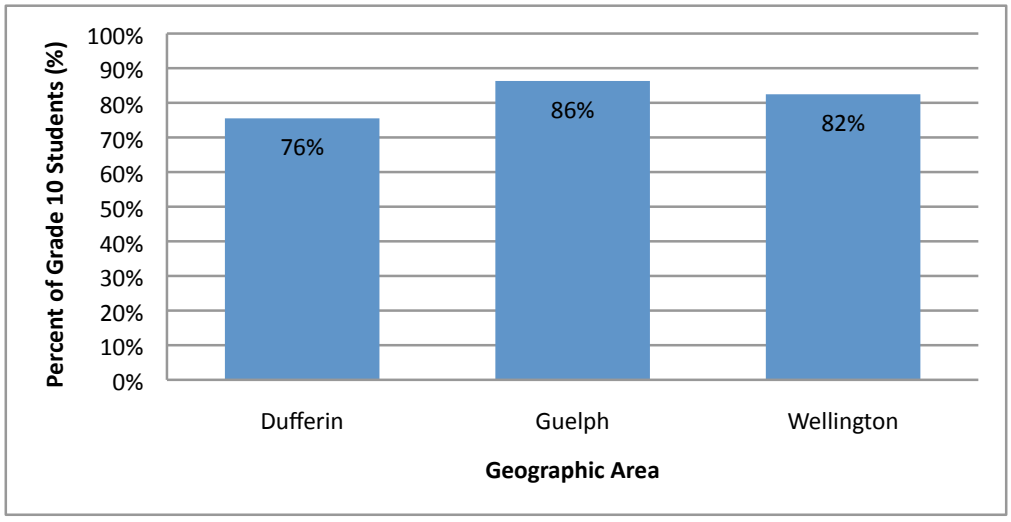
The WDG Youth Survey also provides a measure of *Safety*, which is specific to how safe youth feel at home, school, and in their neighbourhoods. This indicator is measured by two questions that ask youth about how safe they feel at school and where they live (i.e., their home and neighbourhood). Feelings of safety in each of these environments are an important component of youth health and

well-being. For example, youth who experienced victimization (i.e., teasing, exclusion, or physical assault) at school or on their way to/from school were more likely to report poor or fair health, and were more likely to have reported considering and/or attempting suicide in the past year.[75] More encouragingly, youth who feel safe in their neighbourhoods are more likely to enjoy quality time at home and participate in positive social behaviours.[76]

Research indicates that overall sense of safety in each of these three environments (i.e., home, school, and neighbourhood) is very much interrelated. In order to understand sense of school safety, it is necessary to understand family and neighbourhood conditions. What makes a school feel safe is based on a complex interaction between parents, teachers, social influences (e.g., friendships and bullying) and the surrounding community/neighbourhood.[77] For example, research has found that relationships with parents and sense of safety at home can impact how safe youth feel within their school and neighbourhood.[78] A common underlying component of perceived safety in each of these settings, or in any environment, is a sense of belonging or attachment.[79] For example, a critical element of a safe school is feeling "valued and respected".[80]

Analysis of WDG Youth Survey data found that there was a statistically significant relationship between geographic area and *Safety*. More grade 10 students in Guelph (86%) reported feeling safe at home, school, and in their neighbourhood when compared to Wellington (82%) and Dufferin (76%), as demonstrated in Figure 7.24. When interpreting these figures, it is important to consider the effects of other indicators discussed in the Report Card on the overall sense of safety among youth, such as bullying, positive role models, and other aspects of health and well-being. These influences can provide additional context for safety data, where we can see similar geographical and gender trends for *Positive Peer Influence*, *Family Support*, and *Positive Family Communication* (Chapter 6).

Figure 7.24 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported feeling safe at school, at home, and in their neighbourhood, by geographic area, 2012**

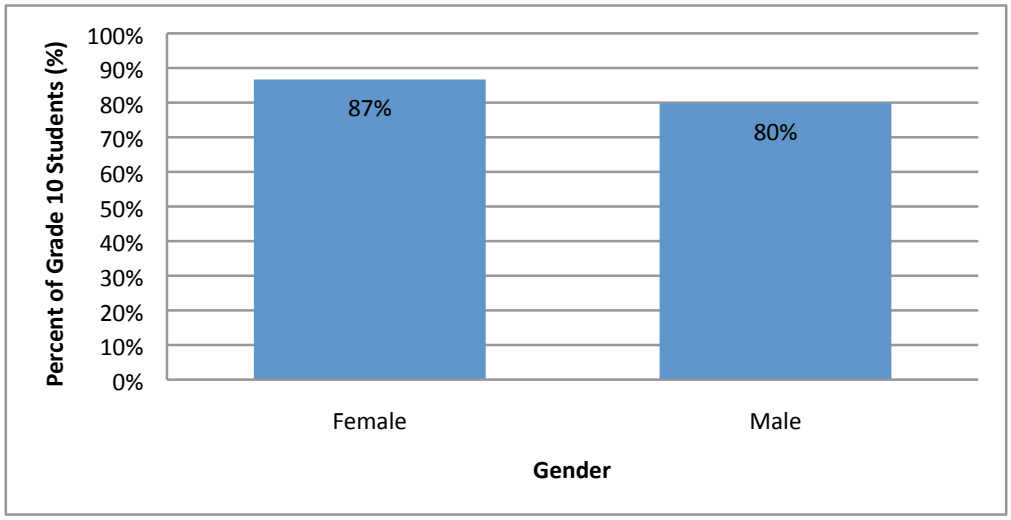


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 34 students (3%) did not complete the survey questions for Safety.

There was also a statistically significant relationship between gender and *Safety*. Figure 7.25 illustrates that more females (87%) reported feeling safe at home, school, and in their neighbourhoods when compared to males (80%). Analysis of the CCHS (2007) data found that females were more likely to report high levels of sense of belonging than males, which influences overall sense of safety.[81]

Figure 7.25 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported feeling safe at school, at home, and in their neighbourhood, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 34 students (3%) did not complete the survey questions for Safety.

Safe Schools Act

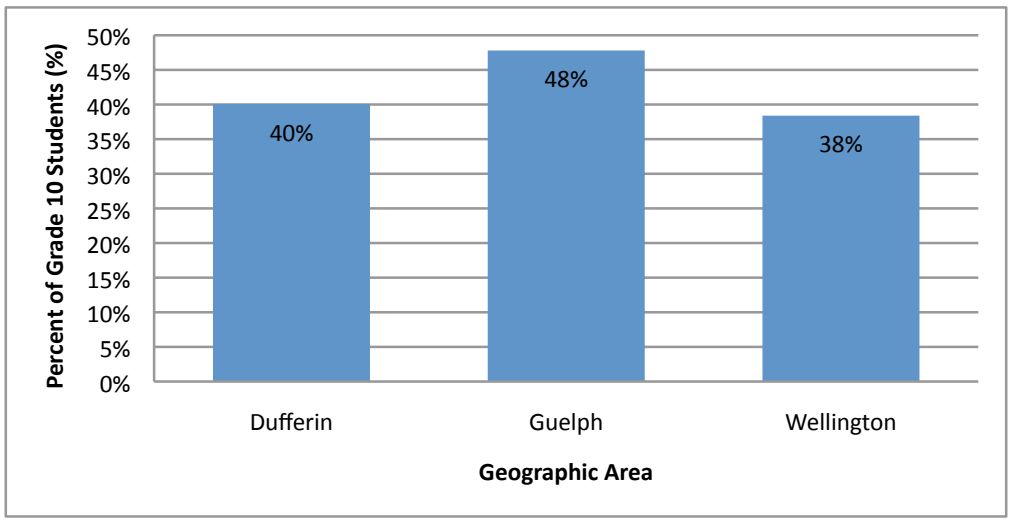
In 2000, the provincial government announced Bill 81, Safe Schools Act. This Act was put in place to "increase respect and responsibility, to set standards for safe learning and safe teaching in schools". Recently, schools and boards of education are increasingly being held accountable to demonstrate school-level activities, programs, and supports to prevent and respond to serious incidents, especially with increased attention on bullying.

Family boundaries

Another measure of youth perceptions of safety from the WDG Youth Survey is *Family Boundaries*. *Family Boundaries* is the extent to which parents/guardians/caregivers are aware of their children's whereabouts and set/enforce clear rules and consequences. To measure this indicator, the WDG Youth Survey asked youth if they can go out anytime they want, if they are told what time to be home, and if their parents know where they are going and who they are with. Research has found that youth who are exposed to approaches to parenting that "set limits on behaviour, models constructive conflict resolution and encourages independence with a democratic approach" are more likely to develop pro-social behaviours, complete high school, and pursue post-secondary education.[82] Furthermore, youth who are more highly monitored by their parents (e.g., their parents take interest in where they are going, set limits on how often they go out, set curfews etc.) are less likely to report engaging in risky behaviours, such as using alcohol, tobacco and marijuana.[83] Attachments between parents and youth are critical for a healthy transition into adulthood and increased autonomy.[84,85] Youth that have strong attachments to their parents learn to trust others and feel less threatened in both school and neighbourhood environments.[86]

Analysis of the WDG Youth Survey results found that there was a statistically significant relationship between *Family Boundaries* and geographic area. Figure 7.26 demonstrates that more grade 10 students reported high levels of *Family Boundaries* in Guelph (48%) when compared to Dufferin (40%) and Wellington (38%).

Figure 7.26 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Family Boundaries*, by geographic area, 2012**

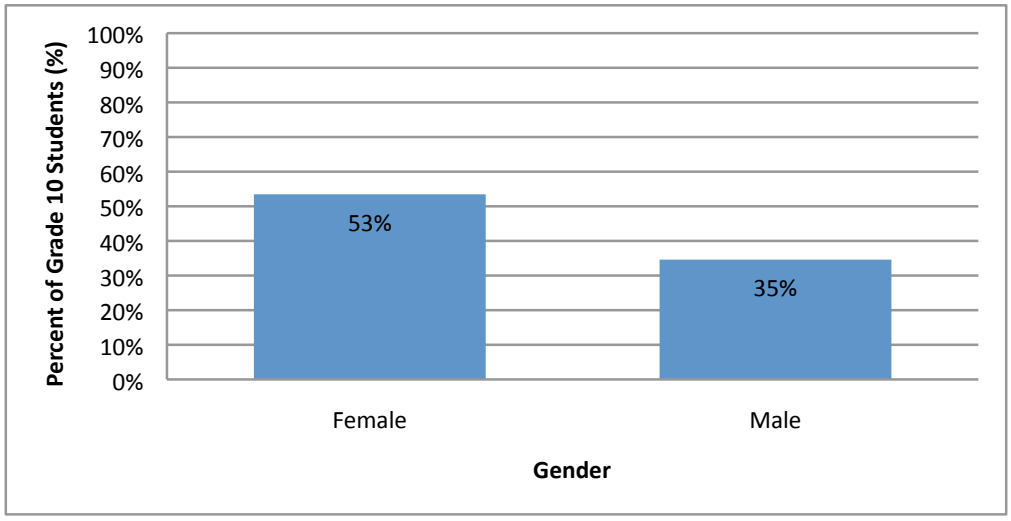


Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 54 students (4%) did not complete the survey questions for Family Boundaries.

There was also a statistically significant relationship between *Family Boundaries* and gender. More grade 10 females (53%) reported high levels of *Family Boundaries* when compared to males (35%), as shown in Figure 7.27. Previous research has also found that females report more perceived parental monitoring compared to males.[87]

Figure 7.27 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported high levels of *Family Boundaries*, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 54 students (4%) did not complete the survey questions for Family Boundaries.

Endnotes

1 Vincent, C., Moffat, S., Paquet, M., Flynn, R., & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. *Ontario Association of children's Aid Society Journal 52*(2), 2-5.

2 Langlois, K.A. & Garner, R. (2013). Trajectories of psychological stress among Canadian adults who experience parental addiction in childhood. *Statistics Canada Health Reports, 24 (3): 14-21.*

3 McCreary Centre Society. (2009). A picture of health: Highlights from the 2008 BC Adolescent Health Survey. *Gibson Library Connections, Inc.*

4 ibid

5 Vincent, C., Moffat, S., Paquet, M., Flynn, R., & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. *Ontario Association of children's Aid Society Journal 52*(2), 2-5.

6 Federal/Provincial/Territorial Advisory on Population Health. (1999). Toward a healthy future: Second Report on the Health of Canadians. Ottawa: Health Canada.

7 Durrant, J.E., Ensom, R. & the Coalition on Physical Punishment of Children and Youth. (n.d.). Joint statement on physical punishment of children and youth. Ottawa: Coalition of Physical Punishment of Children and Youth

8 Southerland, D., Casanueva, C.E., & Ringeisen, H. (2009). Young adult outcomes and mental health problems among transition age youth investigated for maltreatment during adolescence. *Children and Youth Services Review, 31, 947-956.*

9 ibid

10 Ungar, M. (2005). Resilience among children in child welfare, corrections, mental health and educational setting: Recommendations for services. *Child & Youth Care Forum, 34(6), 445-464.*

11 Vincent, C., Moffat, S., Paquet, M., Flynn, R., & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. *Ontario Association of children's Aid Society Journal 52*(2), 2-5.

12 Day, D., Nielsen, J. D., Ward, A. K., Rosenthal, J. S., Sun, Y., Bevc, I., & Duchesne, T. (2011*). Criminal Trajectories of Two Subsamples of Adjudicated Ontario Youths. Research Report. Ottawa: Public Safety Canada*

13 Andrews, D. A., Bonta, J., & Wormith, S. J. (2004). *The Level of Service Inventory/Case Management Inventory. Toronto: Multi-Health Systems.*

14 Day, D., Nielsen, J. D., Ward, A. K., Rosenthal, J. S., Sun, Y., Bevc, I., & Duchesne, T. (2011*). Criminal Trajectories of Two Subsamples of Adjudicated Ontario Youths. Research Report. Ottawa: Public Safety Canada*

15 ibid

16 ibid

17 ibid

18 Ministry of Children and Youth Services. (2010). *Review of the roots of youth violence: Literature review. Toronto, ON: Queen's Printer for Ontario.*

19 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from* **http://publichealth.gc.ca/CPHOreport**.

20 ibid

21 Statistics Canada. *Canadian Community Health Survey, 2009: Annual* [Share Microdata File]. Ottawa, Ontario: Statistics Canada.

22 Oliver, L. N. & Kohen, D. E. (2010). Neighbourhood variation in hospitalization for unintentional injury among children and teenagers. *Health Reports,* 21(4), 9-18.

23 Association of Workers' Compensation Boards of Canada. (2009). *National Work Injury, Disease and Fatality Statistics, 2006-2008.* (Association of Workers' Compensation Boards of Canada).
24 Statistics Canada. (2009). Industry employment by age groups, 2006 counts - employed, for Canada, provinces and territories. Ottawa. Updated April 5, 2009. Retrieved from **http://www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-559/T602-eng.cfm?Lang=E&T=602&GH=4&SC=1&SO=99&O=A**
25 Koehoorn, M., Breslin, F. C., & Xu, F. (2008). Investigating the longer-term health consequences of work-related injuries among youth. *Journal of Adolescent Health, 43*(5), 466-473.
26 Laub, J.,&Lauritsen, J. (1998). The interdependence of school violence with neighborhood and family conditions. In D. Elliott, B. Hamburg, & K. Williams (Eds.), Violence in American schools (pp. 55–93). New York, NY: Cambridge University Press.
27 Hilarski, C. (2004). How school environments contribute to violent behavior in youth. *Journal of Human Behavior in the Social Environment, 9,* 165–178.
28 Twemlow, S. W., Fonagy, P., & Sacco, F. C. (2002). Feeling safe in school. *Smith College Studies in Social Work, 72*, 303–326.
29 Vincent, C., Moffat, S., Paquet, M., Flynn, R., & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. *Ontario Association of children's Aid Society Journal 52*(2), 2-5.
30 Hawkins-Rodgers, Y. (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behavior and building resiliency. *Children and Youth Services Review, 29(9), 1131-1141.*
31 Vincent, C., Moffat, S., Paquet, M., Flynn, R., & Marquis, R. (2008). Developmental assets and resilient outcomes: Findings from the Ontario Looking After Children (OnLAC) Project. *Ontario Association of children's Aid Society Journal 52*(2), 2-5.
32 Southerland, D., Casanueva, C.E., & Ringeisen, H. (2009). Young adult outcomes and mental health problems among transition age youth investigated for maltreatment during adolescence. *Children and Youth Services Review, 31, 947-956.*
33 Newman, S., J. A. Fox, E. A. Flynn, and W. Christeson. 2000. *America's afterschool choice: The prime time for juvenile crime, or youth enrichment and achievement.* Washington, D.C.: Fight Crime: Invest in Kids.
34 Newman, S., J. A. Fox, E. A. Flynn, and W. Christeson. (2000). *America's afterschool choice: The prime time for juvenile crime, or youth enrichment and achievement.* Washington, D.C.: Fight Crime: Invest in Kids.
35 Ontario Association of Children's Aid Societies. (2012). *Child Welfare Report.* Toronto, ON. Retrieved from **http://www.oacas.org/newsroom/releases/12childwelfarereport.pdf**
36 ibid
37 Canadian Council on Social Development. (2000). The progress of Canada's children in the millennium. Ottawa. p.28
38 Flynn, R.J., Duddling, P.M, & Barber, J.G. (2006). Promoting resilience in child welfare. *University of Ottawa Press*
39 ibid
40 ibid
41 ibid
42 Ontario Association of Children's Aid Societies. (2012). *Child Welfare Report.* Toronto, ON. Retrieved from **http://www.oacas.org/newsroom/releases/12childwelfarereport.pdf**
43 ibid
44 ibid

45 Ontario Association of Children's Aid Societies. (2010). *Gateway to Success, Cycle Two.* As referenced in Ontario Association of Children's Aid Societies (2010). *Your Children's Aid: Child welfare report 2009/10.* Toronto, ON, Retrieved from **http://www.oacas.org/pubs/oacas/papers/oacaschildwelfarereport2010.pdf**
46 Ministry of Education (**http://news.ontario.ca/opo/en/2011/03/81-per-cent-of-high-school-students-graduating.html**). As referenced in Ontario Association of Children's Aid Societies (2010). *Your Children's Aid: Child welfare report 2009/10.* Toronto, ON, Retrieved from **http://www.oacas.org/pubs/oacas/papers/oacaschildwelfarereport2010.pdf**
47 Cunningham, A. & Baker, L. (2007). Little eyes, little ears: How violence against a mother shapes children as they grow. The Centre for Children and Families in the Justice System. Retrieved Spring 2009: **http://www.lfcc.on.ca/little_eyes_little_ears.html**.
48 Carlson, B.E. (2000). Children exposed to intimate partner violence. *Trauma, Violence, and Abuse, 1*(4).
49 Mitchell, K.J. (2001). Risk of crime victimization among youth exposed to domestic violence. *Journal of Interpersonal Violence, 16*(9), 944-964.
50 Centre for Children & Families in the Justice System. (2003). *Youth exposed to domestic violence: A handbook for the Juvenile Justice System to enhance assessment and intervention strategies for youth from violent homes.* Baker, L.L. & Jaffe, P.G. Retrieved from **http://www.lfcc.on.ca/Youth_Justice_Handbook.pdf**
51 Flores, J., Hamel, C., Lavoie, F., & Rondeau, L. (2005). Promoting Informed Action. Subject: Youth dating relationships. (Centre québécois de ressources en promotion de la sécurité et en prévention de la criminalité).
52 Apter, T. (2009). Teens and parents in conflict. *Psychology Today. Retrieved from* **http://www.psychologytoday.com/blog/domestic-intelligence/200901/teens-and-parents-in-conflict**
53 World Health Organization. (2002). *World Report on Violence and Health. Geneva. Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R.*
54 Gelsthorpe, L. & Sharpe, G. (2006). Gender, Youth Crime and Justice. In Goldson, B. & Muncie, J. (Eds.), *Youth Crime and Justice* (47-61). London, U.K.: Sage Publications Ltd.
55 World Health Organization. (2002). *World Report on Violence and Health. Geneva. Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R.*
56 McCreary Centre Society. (2009). A picture of health: Highlights from the 2008 BC Adolescent Health Survey. *Gibson Library Connections, Inc.*
57 Little, M., Steinberg, L. (2006). Psychosocial correlates of adolescent drug dealing in the inner city. *The Journal of Research in Crime and Delinquency, 43, 357–386.*
58 Li X., Stanton, B., Feigelman, S., Black, M.M., & Romer, D. (1994). Drug trafficking and drug use among urban African American early adolescents. *Journal of Early Adolescence, 14(4), 491–508.*
59 McCurley, C., Snyder, H.N. (2008). Co-occurrence of substance use behaviors in youth. *Juvenile Justice Bulletin. Washington, DC: US Department of Justice, Office of Juvenile Justice and Delinquency Prevention.*
60 Li, X., Stanton, B., Feigelman, S. (1999). Exposure to drug trafficking among urban low-income African American children and adolescents. *Archives of Pediatrics & Adolescent Medicine, 153, 161–168.*
61 Moore, J. (1990). Gangs, drugs, and violence. In: Drugs and Violence: Causes, Correlates, and Consequences. Rockville, MD: National Institute of Drug Abuse Research, US Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration.
62 van Kammen W.B., Loeber R. (1994). Are fluctuations in delinquent activities related to the onset and offset in juvenile illegal drug use and drug dealing? *Journal of Drug Issues, 24, 9–24.*
63 Vaughn, M.G., Shook, J.J., Perron, B.E., Abdon, A., & Ahmedani, B. (2011). Patterns and correlates of illicit drug selling among youth in the USA. *Substance Abuse and Rehabilitation, 2,* 103-111.
64 World Health Organization. (2002). *World Report on Violence and Health. Geneva. Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R.*

65 Statistics Canada. (2012). *Youth Crime, 2011*. Retrieved from **http://www.statcan.gc.ca/pub/85-005-x/2012001/article/11749-eng.htm**
66 ibid
67 Ministry of Children and Youth Services. (2010). *Review of the roots of youth violence: Literature review. Toronto, ON: Queen's Printer for Ontario.*
68 Statistics Canada. (2012). *Crime Severity Index.* Retrieved from **http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/legal51a-eng.htm**
69 Guelph Police Services. (2010). Annual Report 2010.
70 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from* **http://publichealth.gc.ca/CPHOreport**.
71 Berkman, L.F., Glass, T., Brissette, I., & Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science and Medicine, 51*, 843-857.
72 Statistics Canada. (2002). *Community belonging and health. Health Reports (Catalogue 82-003), 13(3), 33-39, Ross, N.*
73 Statistics Canada. (2008). *Community belonging and self-perceived health*. Health Reports (Catalogue 82-003), 19(2), 51-60, Shields M.
74 Health Development Agency. (2001) *Networks and neighbourhoods: children's and young people's perspectives.* London, UK: London School of Economics. Morrow, V.
75 McCreary Centre Society. (2009). A picture of health: Highlights from the 2008 BC Adolescent Health Survey. *Gibson Library Connections, Inc.*
76 Canadian Institute for Health Information. (2005).Improving the health of young Canadians. Ottawa, ON.
77 Twemlow, S. W., Fonagy, P., & Sacco, F. C. (2002). Feeling safe in school. *Smith College Studies in Social Work, 72*, 303–326.
78 Laub, J.,&Lauritsen, J. (1998). The interdependence of school violence with neighborhood and family conditions. In D. Elliott, B. Hamburg, & K. Williams (Eds.), Violence in American schools (pp. 55–93). New York, NY: Cambridge University Press.
79 Haigh, R. (1996). The matrix in milieu: The ghost in the machine. In J. Georgas & M. Manthouli, et al. (Eds.), Contemporary psychology in Europe: Theory, research, and applications (pp. 288-302). Kirkland, WA: Hogrefe & Huber Publishers.
80 Flaherty, L. (2001). School violence and the school environment. In M. Shafii & S. Shafii (Eds.), School violence: Assessment, management, prevention (pp. 25-51). Washington, DC: American Psychiatric Publishing, Inc.
81 Statistics Canada. (2008). *Community belonging and self-perceived health*. Health Reports (Catalogue 82-003), 19(2), 51-60, Shields M.
82 Canadian Institute for Health Information. (2005). *Improving the Health of Young Canadians.* Ottawa: Canadian Institute for Health Information.
83 ibid
84 Moretti, M. M. & Peled, M. (2004). Adolescent-parent attachment: Bonds that support healthy development. *Paediatrics & Child Health 9*(8), 551-555.
85 Public Health Agency of Canada. (2000). *Attachment to parents and adjustment in adolescence: Literature review and policy implications. Ottawa, ON, Doyle, A.B. & Moretti, M.M.*
86 Twemlow, S. W., Fonagy, P., & Sacco, F. C. (2002). Feeling safe in school. *Smith College Studies in Social Work, 72*, 303–326.
87 Webb, J.A., Bray, J.H., & Adams, G. (2002). Gender, perceived parental monitoring, and behavioral adjustment: Influences on adolescent alcohol use. *American Journal of Orthopsychiatry, 72*(3), 392-400.


Be different. Be unique. Be you.

8. A right to be accepted for who we are and what we believe without being discriminated against

Introduction

The link to youth's well-being

Discrimination can have severe and long-lasting effects on youth health and development. Research demonstrates that the harmful effects of discrimination can range from negative mental health outcomes,[1] such as depression and anxiety, to poor physical health outcomes,[2] including hypertension and poor self-perceived health. Additionally, persistent discrimination can increase risk factors for disease such as obesity, substance use, and nonparticipation in behaviours that promote health, including cancer screenings and condom use.[3] Youth who do not experience a sense of belonging are also more likely to have behavioural problems, such as aggression or withdrawal, higher school dropout rates, and emotional distress that results in violence, loneliness, or suicide.[4] A sense of belonging has been categorized as a basic human need, regardless of age, that is particularly critical during the adolescent years as it influences behaviours later in life.[5]

Through the Wellington-Dufferin-Guelph Youth Engagement Workshops, youth in our communities have stressed the importance of this charter right, emphasizing that all individuals deserve to not only be tolerated, but accepted. They deserve to not be treated differently on the basis of race, class, gender, sexual orientation, ethnicity, disability, language, faith/religion, or any other physical, mental, social, emotional, or cultural representation.

One way to understand the mechanisms through which discrimination and a lack of belonging can impact youth development and health is to view it as a stressor.[6] While most stressful experiences do not broadly influence health, those that are uncontrollable, persistent, and unpredictable can be particularly harmful. These characteristics are common to discrimination experiences.[7] Discrimination can also affect health by reducing the energy and resources that individuals have for making healthy behaviour choices, resulting in poor long-term health outcomes.[8]

Indicators of youth's health and well-being in this chapter

The indicators in this chapter are intended to provide a brief picture of the diversity of our youth and family populations in Wellington, Dufferin, and Guelph. There are also indicators related to organizational responses to meeting the needs of diverse families and youth.

- Newcomer and immigration demographics
- Anti-bullying and anti-discrimination policies of school boards
- Incidence of bullying at school
- Youth with special needs and developmental disabilities

The value of this information to service providers

The data presented in this chapter provides a rationale for service providers to support their work in developing multidimensional approaches that are better able to reflect the needs of youth and their families, moving away from a "one size fits all" approach. All youth, regardless of their background,

should have access to critical resources now and in the future.

Multi-leveled and many-pronged supports that emphasize outreach to all youth are much more likely to improve overall health and development of this age group, reducing accessibility barriers because of race, ability, family status, class, sexual orientation, and culture.[9] Methods of measuring community and individual developmental health that provide an accurate reflection of culture, race, ethnicity, and variations within these groups, are essential to gaining a full picture of the need for supports and services for the health, development, and well-being of youth.

An understanding of our collective inclination for bias is of the utmost importance for service providers as our communities become more diverse. Dominant cultural views can translate into practice without the much needed analysis of potential, yet unintended, risks to youth development. Service providers must incorporate a multi-faceted approach to reach a wider youth population and improve the overall health and development of youth in our communities.

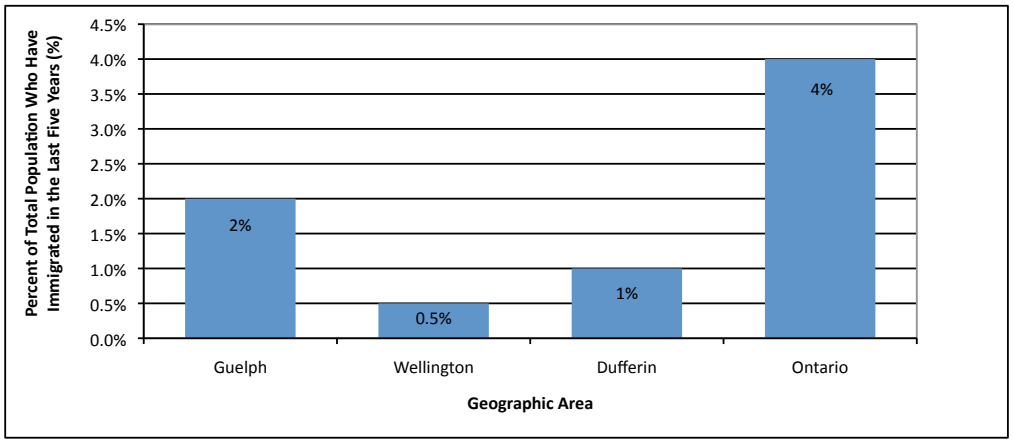
Newcomer and immigration demographics

The vision of the Local Immigration Partnership (LIP) for Guelph and Wellington County - "a caring, equitable community where everyone thrives" [10] - is based on the premise that attraction and retention of new immigrants to smaller urban and rural areas can be achieved when a range of economic opportunities are available to newcomers, and when the communities are welcoming and have the appropriate social supports.[11] *A welcoming community* has been defined in a report prepared for Citizenship and Immigration Canada as a physical location (such as a town, city, or region) in which newcomers feel welcome, and as a place in which there is intentional and strategic involvement in activities that facilitate the integration of newcomers.[12]

Newcomers tend to settle first in larger urban centres such as the Greater Toronto Area, Vancouver, Montreal, and other large cities across the country.[13] However, there is evidence to suggest that, in recent years, smaller urban areas that are still close to the large urban centres may also be attracting more new immigrants.[14] This is partly because, in theory, a higher economic standard of living can be obtained in areas like Guelph, and Wellington and Dufferin Counties.

- Guelph's population alone included 3,030 new immigrants (or 2% of the total population) between 2006 and 2011.[15] This represents a 21% decrease in the number of new immigrants coming to Guelph compared to the number of people who immigrated between 2001 and 2006.
- In 2010, approximately 685 immigrants moved directly to Guelph or Wellington County upon arrival to Canada. Another 70 moved directly to Dufferin County.[16]
- The 2011 populations for Wellington and Dufferin Counties do not include as many new immigrants as the City of Guelph's population. One percent (1%) of Dufferin County's population and 0.50% of Wellington County's population represents new immigrants between 2006 and 2011 (Figure 8.1).[17] This translates to 510 new immigrants in Wellington County and 315 new immigrants in the County of Dufferin.
- The majority of new immigrants coming to our communities over the last 30 years have come from Asia and the Middle East.

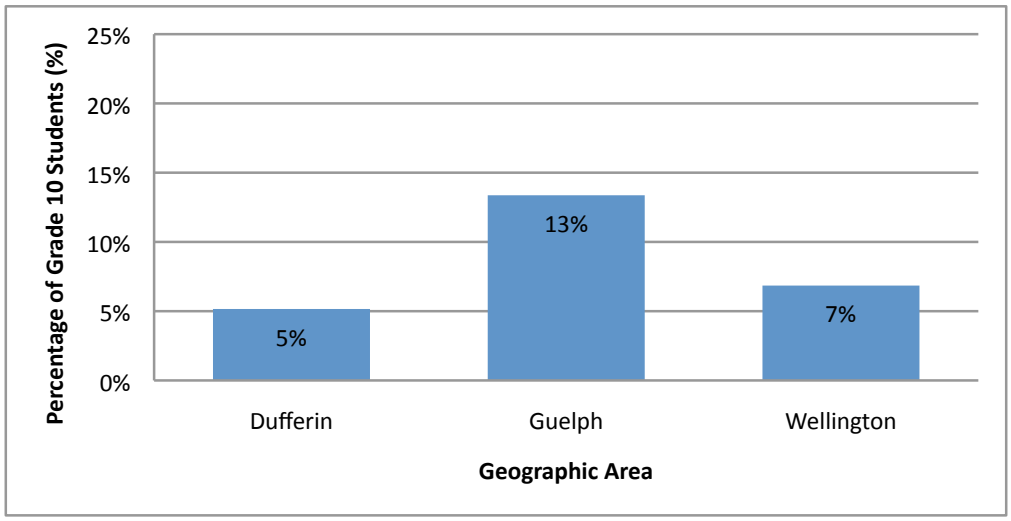
Figure 8.1 **Percentage of total population in Wellington, Dufferin, Guelph, and Ontario who immigrated between 2006 and 2011**



Source: Statistics Canada (2011). Census Profile Subscription for Wellington and Dufferin (CDs by DA/CSD). Statistics Canada Catalogue no. 94-581-XCB2006002. Subscription Catalogue no. 97C0017.

This trend can also be seen among youth in our community. The WDG Youth Survey found a statistically significant relationship between geographic area and grade 10 students who were not born in Canada. As seen in Figure 8.2, more grade 10 students in Guelph (13%) were born outside of Canada compared to Wellington (7%) and Dufferin (5%).

Figure 8.2 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who were not born in Canada, by geographic area, 2012**

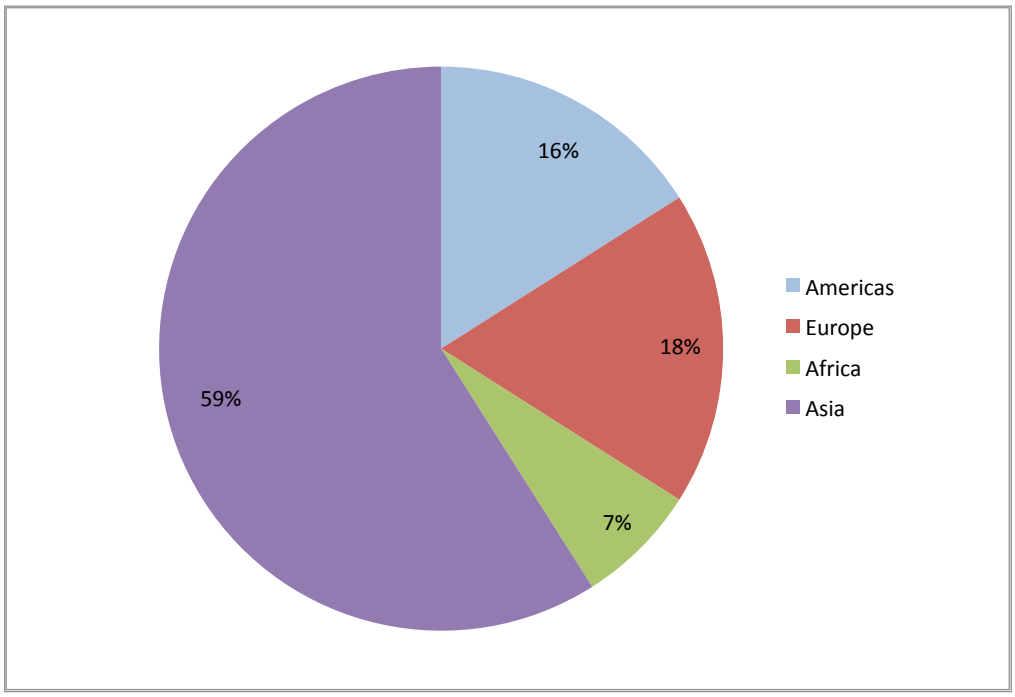


Source: Wellington-Dufferin-Guelph Youth Survey, 2012

Note: 4 students (<1%) did not complete the survey question for being born in Canada.

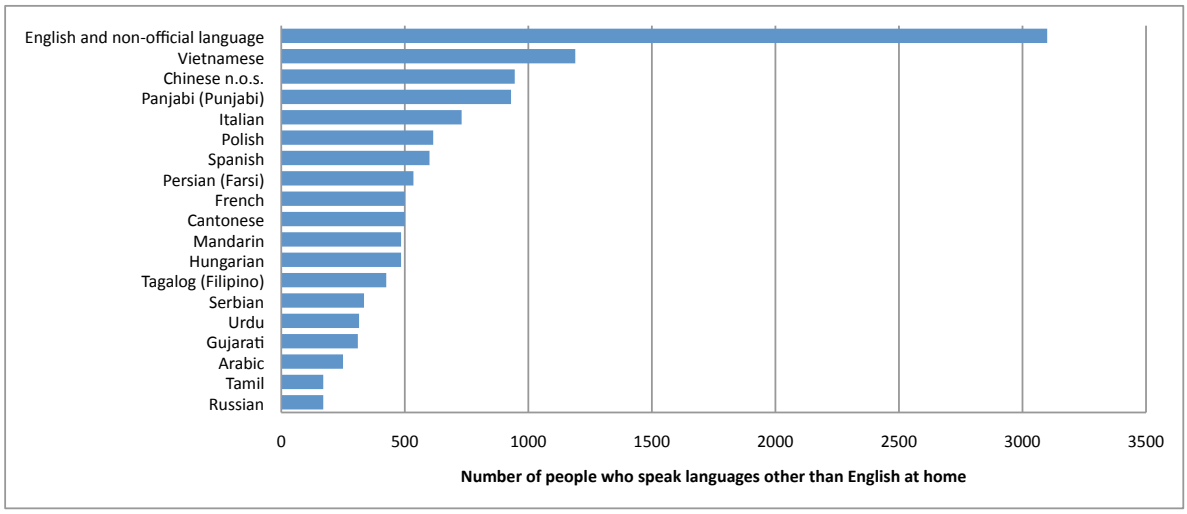
Figure 8.3 shows the regions of origin for the greatest percentages of recent newcomers to Guelph. Most immigrants moving to this area are coming from countries where a language other than English is spoken. As a result, many experience language barriers when they come to our communities. As indicated in Figure 8.4, according to the 2011 Census, the most common non-English languages spoken in the City of Guelph include Vietnamese, Chinese, Panjabi (Punjabi), and Italian, which reflects the diversity of immigrant origin.

Figure 8.3 **Percentage of total new immigrants in the City of Guelph by their region of origin, from 2006 to 2011**



Source: *Statistics Canada (2011). Census Profile Subscription for Wellington and Dufferin (CDs by DA/CSD). Statistics Canada Catalogue no. 94-581-XCB2006002. Subscription Catalogue no. 97C0017.*

Figure 8.4 **Languages other than English spoken, City of Guelph, 2011**

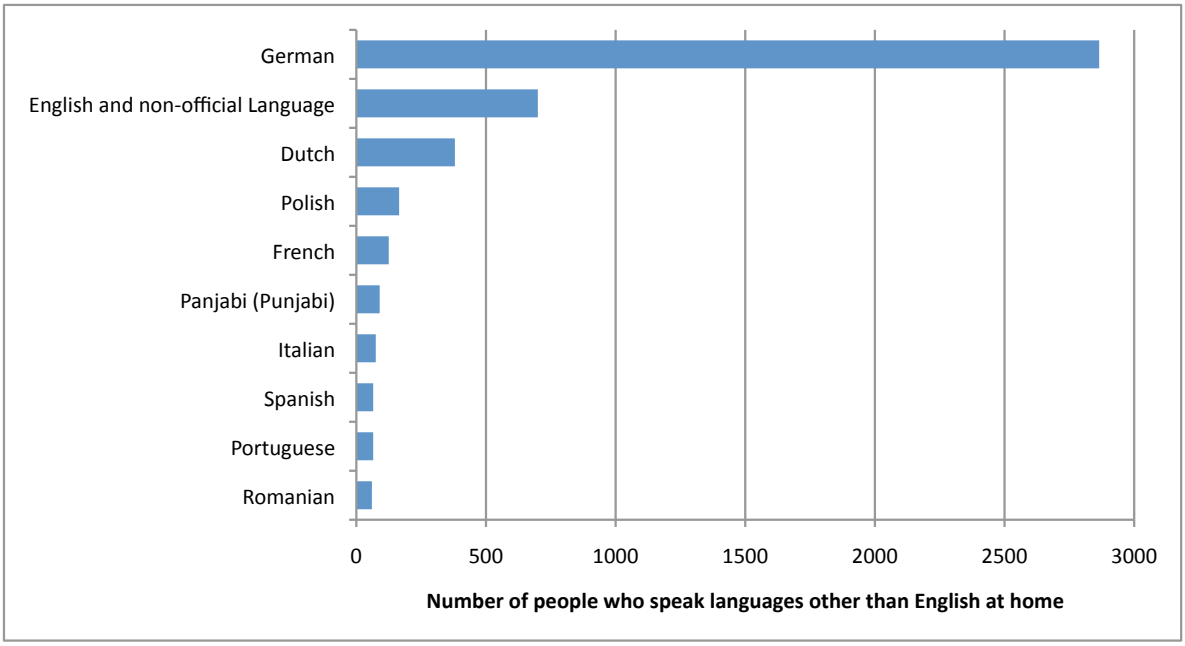


Source: *Statistics Canada. 2012. Guelph, Ontario (Code 3523008) and Wellington, Ontario (Code 3523) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012.* http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E.

Note: The term "non-official language" refers to a language other than English and French. The category "English and non-official language" is a count of individuals who are bilingual in Guelph, speaking both English and another language that is not French.

Figures 8.5 and 8.6 demonstrate the most common non-English languages spoken in the County of Wellington and County of Dufferin, respectively. Both German and Polish emerge in the top five for both counties.

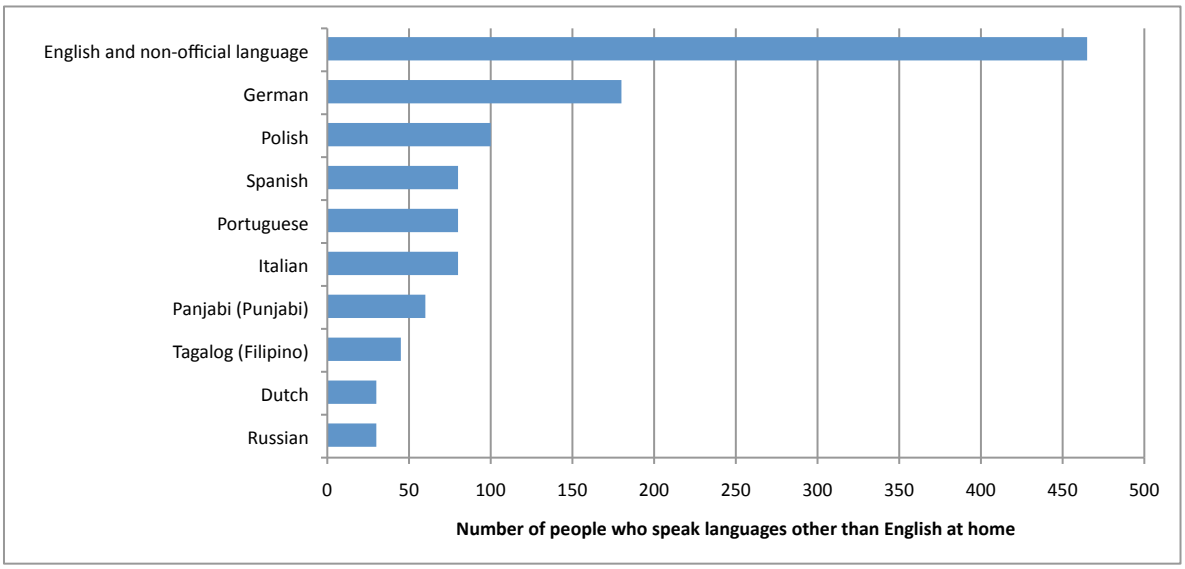
Figure 8.5 **Languages other than English spoken, Wellington County, 2011**



Source: *Statistics Canada. 2012. Wellington, Ontario (Code 3523) and Ontario (Code 35) (table) and Guelph, Ontario (Code 3523008) and Wellington, Ontario (Code 3523) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012. http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E*

Note: The term "non-official language" refers to a language other than English and French. The category "English and non-official language" is a count of individuals who are bilingual in Guelph, speaking both English and another language that is not French.

Figure 8.6 **Languages other than English spoken, Dufferin County, 2011**

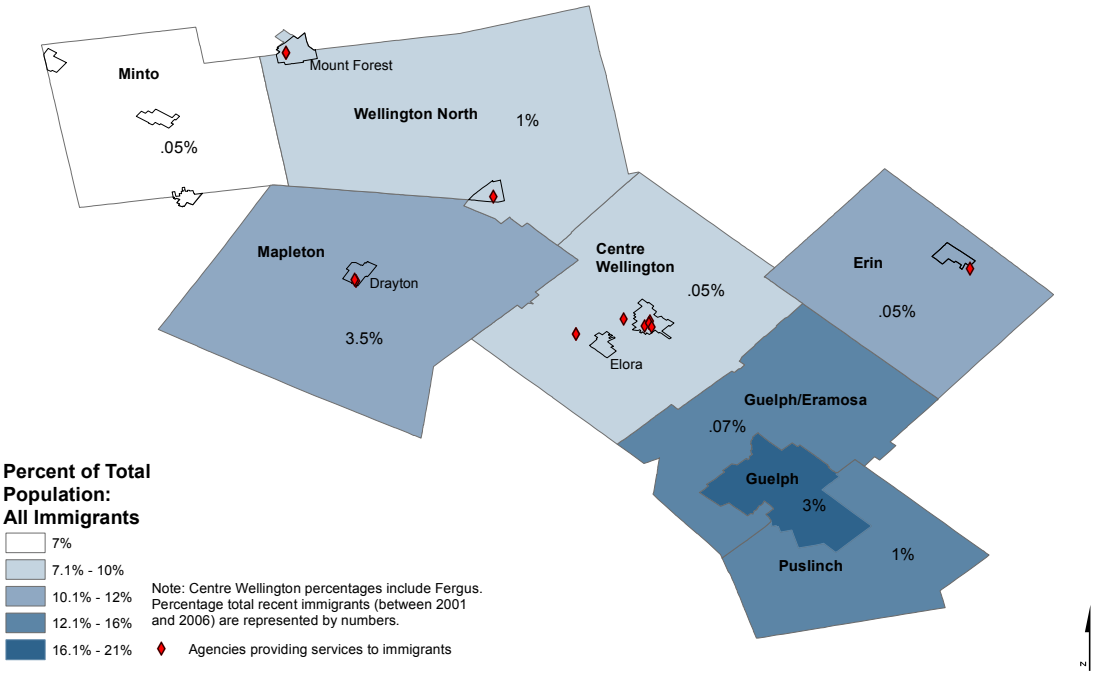


Source: *Statistics Canada. 2012. Dufferin, Ontario (Code 3522) and Ontario (Code 35) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012. http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E*

Note: The term "non-official language" refers to a language other than English and French. The category "English and non-official language" is a count of individuals who are bilingual in Guelph, speaking both English and another language that is not French.

As part of the Research Component of the LIP, an environmental scan of services specific to the immigrant population was conducted to identify assets, capacities and opportunities that can help in the development of a local immigration strategy for Guelph and Wellington. The service inventory that resulted as part of this environmental scan has been mapped below with the percentage of new immigrants that came between 2001 and 2006, according to the 2006 Census. The County of Dufferin conducted a comparable service inventory for Dufferin County for the purposes of *The Well-Being of Children Ages 7 to 13: A Report Card for Wellington-Dufferin-Guelph*, which has also been used in this Report Card. Maps 8.1 to 8.3 indicate the location of agencies providing services to immigrants, compared to where immigrants have settled in Wellington, Dufferin, and Guelph. The programs and services captured on the maps may not include all services available, just those identified through the LIP environmental scan and the County of Dufferin listing. Furthermore, agencies in Guelph and Wellington that were asked to participate in the environmental scan may have interpreted what it means to provide services to immigrants differently. While the maps may not be comprehensive, they provide an overall picture of service location distribution.

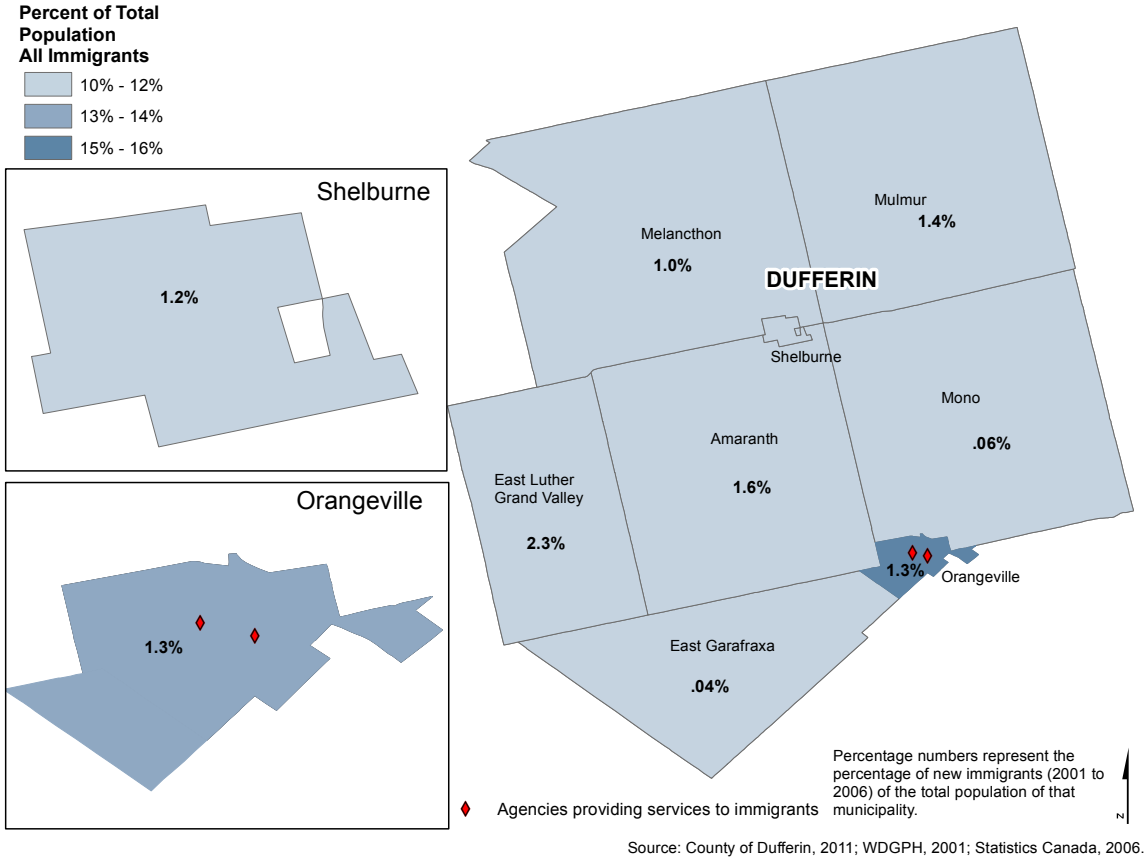
Map 8.1 **Availability of services for immigrants, percentage total immigrants and percentage total recent immigrants, Wellington County**



Source: *Statistics Canada 2006 Census, Catalogue # 94-581-XCB2006002; List of Services: City of Guelph, Immigration Partnership Strategy, 2010*

Note: The placement of symbols on the map is not guaranteed to be the exact location due to technical limitations of postal code data and software limitations.

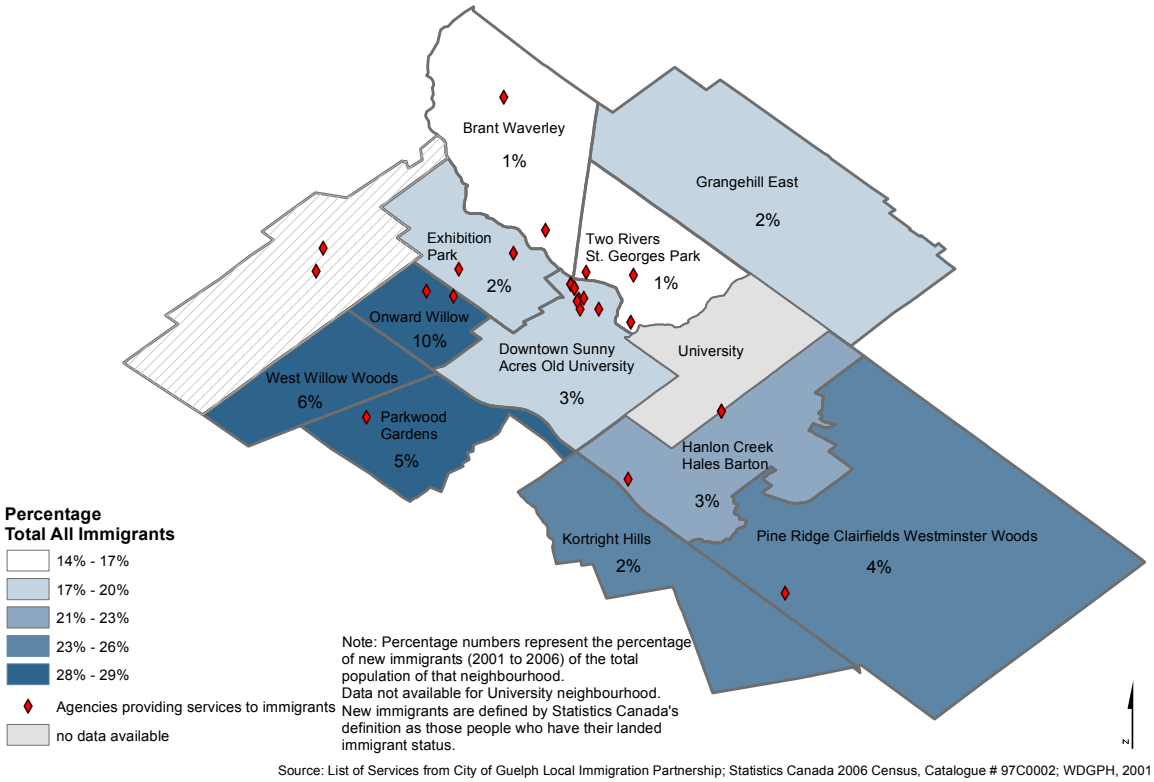
Map 8.2 **Availability of services for immigrants, percentage total immigrants and percentage total recent immigrants, Dufferin County**



Source: *Statistics Canada 2006 Census, Catalogue # 94-581-XCB2006002; List of Services: County of Dufferin, 2011*

Note: The placement of symbols on the map is not guaranteed to be the exact location due to technical limitations of postal code data and software limitations.

Map 8.3 **Availability of services for immigrants, percentage total immigrants and percentage total recent immigrants, City of Guelph**



Source: *Statistics Canada 2006 Census, Catalogue # 97C0002; List of Services: City of Guelph, Immigration Partnership Strategy, 2010*

Note: The placement of symbols on the map is not guaranteed to be the exact location due to technical limitations of postal code data and software limitations.

A study of the experiences of newcomers in the Wellington County and Guelph communities found that they tend to have more difficulty gaining sufficient employment that matches their qualifications, more difficulty finding affordable and stable housing, and more difficulty accessing child care.[18] In 2010, a formal community dialogue process in Guelph and Wellington identified a number of possible activities that would enhance social inclusion.[19]

In 2011 and 2012, the LIP began work on a number of initiatives to improve the social and economic inclusion of immigrants. On the issue of social inclusion, work is being done to improve the coordination of local services, improve access to information about local immigration services and systems, develop a friendship program, improve access to interpretation, ensure immigrant voices are heard on local housing issues, and raise awareness of mental and physical health issues as they relate to immigration. Specific to the issue of economic inclusion, work is being done to promote the benefits of hiring immigrants in the workforce, provide supports to employers to transition their workforce, develop supports for immigrants to obtain jobs that match their skills and qualifications, improve access and awareness of English language training, and workshops to build professional networks in targeted sectors.

The environmental scan revealed that one of the gaps in services in Guelph and Wellington County is the lack of data regarding the percentage

of immigrants and recent immigrants who are children and youth.[20] The service and community-based priorities that are most frequently identified through consultation with adult newcomers, immigrants, and employment and social service providers, are supports for employment and financial stability; access to education and training; and available and accessible supports to help the integration process, such as English as a second language (ESL) programs. Schools provide ESL programs for children and youth. Other priorities include access to primary health care practitioners; information on essentials such as legal rights and housing; availability of multicultural centres or community centres where ethnic associations can meet and cultural events can take place; longer term social integration and inclusion supports; and supports for specific populations, such as refugees, who may have experienced trauma prior to their arrival in Canada.[21]

Anti-bullying and anti-discrimination policies of school boards

Each of the public school boards with secondary schools located in Wellington, Dufferin, and Guelph have bullying prevention and anti-discrimination policies mandated in the Accepting Schools Act amendment to the Education Act.[22] The Accepting Schools Act requires all school boards to instate preventative measures against bullying, amplify consequences for bullying, and support students who want to promote mutual respect for all.[23] The legislation contains a comprehensive action plan for new mental health workers in schools, a public awareness campaign, an Accepting Schools Expert Panel to provide evidence-informed resources, and direction to Ontario's Curriculum Council to provide bullying prevention strategies and strengthen equity and inclusive education.

The Upper Grand District School Board has a Safe, Equitable and Inclusive Schools Steering Committee that is responsible for reviewing student discipline and bullying policies. The Steering Committee also provides support to individual schools in the establishment of school-based Safe and Inclusive Schools Committees. The Wellington Catholic District School Board's bullying and antidiscrimination policies integrate the Ontario Human Rights Code over all policies and administration documents, while stating the School Board's goal of promoting Catholic values in all of its activities.

The Ontario Ministry of Education houses an on-line registry of bullying programs available for schools and other organizations to access. The registry includes a checklist which outlines the various attributes of each program, including information such as who the program is designed for (e.g., young children, teens, parents, teachers,

Cyber-bullying

Cyberspace is opening up the world in ways we could not have predicted. For many children (and adults) it means another frontier where they might be vulnerable to bullying. The problem of cyber-bullying is complex – it can be instantaneous, and the perpetrator is often anonymous. The following actions are recommended for taking a proactive in approach against cyber-bullying: work with community groups who have expertise, such as the police; involve young people in developing rules and codes of conduct; and develop policies and practices that support freedom of expression, while reinforcing responsibility and respect for others (Beatrice Schriever, Ontario College of Teachers, 2007).

etc.); the type of resources that make up the program (e.g., DVD, workshops, etc.); and evaluation materials related to the effectiveness of the program.[24]

Bullying policies are often connected with discrimination policies, as the act of bullying can be harassment based on assumptions regarding sex, gender identity, sexual orientation, race, colour, ethnicity, culture, citizenship, ancestry, origin, religion, creed, family status, socio-economic status, or disability, which are all areas of protection under the Ontario Human Rights Code.[25]

Incidence of bullying at school

Over the past few years, the tragic cases of Canadian youth that have committed suicide or been seriously impaired by bullying has raised awareness on the importance of this issue. Bullying can occur in any social setting including school, the home, and online. Bullying involves the repeated, persistent and harmful behaviour directed at an individual or group of individuals that is intended to cause physical or emotional distress, fear, or harm. Bullying typically occurs when there is a real or perceived imbalance of power. It can be physical, verbal, social, emotional, or communicated through the use of technology.

Recent amendments to the Education Act, arising from the Accepting Schools Act, 2012, changed the way principals, teachers, and students approach bullying and cyber-bullying and recognize that a positive school environment can only be achieved when all members of the school community feel safe, included, and accepted.[26] The principles of equity and inclusive education, and fostering a culture of mutual respect, are identified as key components to bullying prevention.[27] The extent to which youth feel safe at school is explored in further detail in *Chapter 7: A right to be and feel safe in our homes, schools and communities*.

According to the most recent Ontario Student Drug Use and Health Survey (OSDUHS), male students have reported a decline in bully victimization, bully perpetration, and fighting in schools across all grades.[28] Female students reported being twice as likely to be victims of cyber-bullying when compared to males (28% versus 15%) and a greater percentage of females also reported being victimized at school (31% versus 26%).[29] The most common forms of bullying reported by females include teasing and indirect bullying (e.g., exclusion or spreading lies about the victim).[30] Incidents of direct bullying (e.g., physical aggression) are more commonly reported among males across all grades.[31]

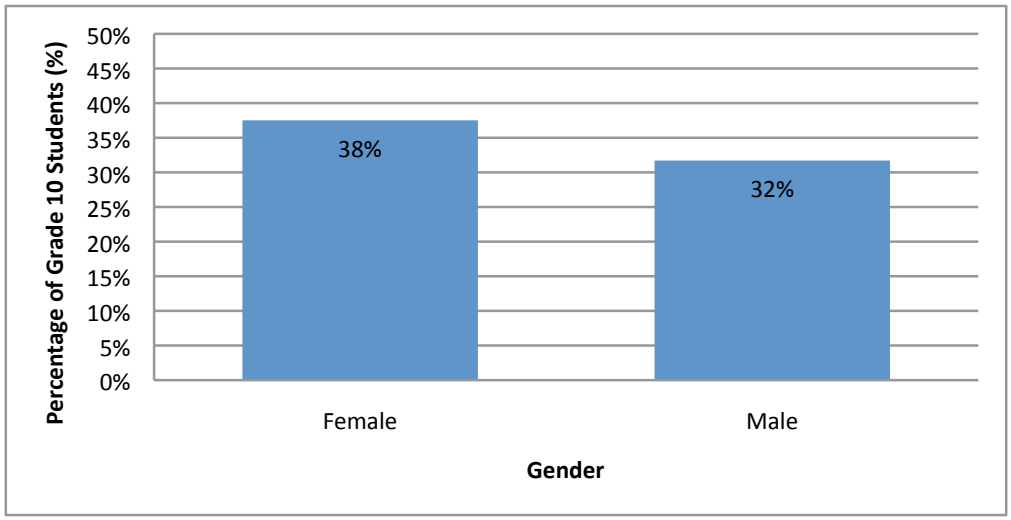
Immigrant status as a mediator of bullying victimization has only recently received attention in research studies. Existing literature shows that bullying victimization among immigrant children and youth is often a function of their cultural differences, and not their proficiency in speaking the dominant language of the country.[32] According to the 2006 Health Behaviour in School-aged Children (HBSC) survey, racial bullying occurred less frequently than all other forms of bullying examined (e.g., physical bullying, sexual harassment, teasing, indirect bullying, electronic bullying, etc.) among victimized students in grade 6 to 10. Among grade 10 victimized students, 20% of males and 9% of females reported being a victim of racial bullying. Reports of racial bullying slightly increased from 2002 to 2006.[33]

Sexual minority youth are at a much higher risk for being victims of physical and sexual abuse, harassment, and victimization at school, regardless of gender.[34] A recent study conducted by the Toronto District School Board of students in grade 7 to 12 indicated that 8% of students identified as lesbian, gay, bisexual, trans-identified, two-spirited, queer, or questioning (LGBTQ); a positive school climate must also include a climate of understanding and acceptance for these youth.[35] In an online survey of both current and former Canadian high school students, approximately 59% of LGBTQ youth reported verbal harassment about their sexual orientation at school, compared to 7% of heterosexual youth.[36] LGBTQ youth also reported higher levels of physical harassment (25%), indirect bullying at school (55%), and bullying through text-messaging or the internet

(31%).[37] Bullying is of particular concern among the LGBTQ population given that LGBTQ youth often indicate a lack of family support needed to counteract the negative effects of bullying by peers, which results in an increased risk for suicide and self-harm.[38] A study of gay and bisexual male youth in Alberta found that these youth were 13.9 times more at risk for a serious suicide attempt than their heterosexual peers.[39] A similar trend was found among lesbian and bisexual teen girls in British Columbia who were 5 times more likely to attempt suicide than heterosexual girls.[40] Other studies have consistently demonstrated that LGBTQ youth who experience bullying are also more likely to disengage from school[41], try drugs and alcohol, and participate less frequently in physical activity.[42]

The Wellington-Dufferin-Guelph Youth Survey asked students whether or not they had experienced any form of bullying while at school. The question did not ask students to differentiate between the different forms of bullying that they experienced at school. There was no statistically significant relationship between geographic area and grade 10 students who reported being bullied at school. Overall, 35% of grade 10 students reported being bullied at school in Wellington, Dufferin, and Guelph. As indicated in Figure 8.7, more female (38%) grade 10 students reported being bullied at school than males (32%). This trend is similar to the one found in the OSDUHS; however, more males and females in Wellington, Dufferin, and Guelph reported being bullied at school when compared to the OSDHUS provincial average (38% versus 31% for females; 32% versus 26% for males).

Figure 8.7 **Percentage of grade 10 students in Wellington, Dufferin, and Guelph who reported bullying at school, by gender, 2012**



Source: *Wellington-Dufferin-Guelph Youth Survey, 2012*

Note: 5 students (0.41%) did not complete the survey question for bullying at school.

Youth with special needs and developmental disabilities

Reports and summaries of "current issues" affecting youth in Canada tend to focus on higher profile categories annotating youth's vulnerabilities related to broader Canadian and provincial public policies such as poverty, justice, and immigration.[43] As such, public policy development related specifically to inclusion and the needs of youth with special needs and developmental disabilities is sometimes left behind. Obtaining reliable data regarding youth with special needs and developmental disabilities for local service planning is complicated by the fact that the information is service delivery and agency-based data. There is no single, reliable source of data, nor is there an established single-system approach. As such, the data are likely to be less clear due to duplications in counts of families and youth accessing services. Missing information is also a concern, since not all families and youth with special needs and developmental disabilities may be accessing those services. A single-system approach is taken in Ontario for coordination of services for school-age youth in need of occupational and physical therapy, personal care, medical equipment and supports in order to attend school (i.e., Community Care Access Centre (CCAC) coordinates School Health Support Services in this province). Some of these challenges may be connected to weakly developed public policy that could, if strengthened, help to ensure that all youth are receiving the supports they need in order to fully participate in all aspects of school, social activities, and recreation programs with their same-aged peers.

The Laidlaw Foundation identified the concept of social inclusion as a useful tool that "turns public policy upside down." They recommend viewing public policy through this lens of social inclusion, wherein society is charged with the task of providing a meaningful place for everyone; rather than making it incumbent on individuals to "fit the program."[44] Using such a lens for viewing the policies, activities and services for youth, it becomes clear that we have many opportunities still ahead of us. Through it, we can see that there is much work to be done to ensure that youth with special needs and developmental disabilities are supported in their well-being, so that they can experience the feeling that they belong, are cared for, and are accepted for who they are.

Endnotes

1 Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology,35*(4), 888–901.

2 Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32,* 20–47.

3 Pascoe, E. A., & Richman, L. S. (2009). Perceived discrimination and health: A meta-analytic review. *Pyschological Bulletin, 135*(4), 531-554.

4 Osterman, K. F. (2000). Students' need for belonging in the school community. *Review of Educational Research, 70*(3), 323-367.

5 Hagerty, B. M., Williams, R. A., & Oe, H. (2002). Childhood antecedents of adult sense of belonging. *Journal of Clinical Psychology, 58*(7), 793-801.

6 Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32,* 20–47.

7 Ibid.

8 Inzlicht, M., McKay, L., & Aronson, J. (2006). Stigma as ego depletion: How being the target of prejudice affects self-control. *Psychological Science, 17*(3), 262–269.

9 Yonezawa, S., Jones, M., & Joselowsky, F. (2009). Youth engagement in high schools: Developing a multidimensional, critical approach to improving engagement for all students. *Journal of Educational Change, 10*(2-3), 191-209.

10 Local Immigration Partnership Council. (2011). *Guelph Wellington settlement strategy vision: Terms of reference.* p.3.

11 Wayland, S.V. (2010). *Guelph Wellington Local Immigration Partnership Environmental Scan: Final Report.* Cited in Local Immigration Partnership Council (2011). *Guelph Wellington settlement strategy vision: Terms of reference.* p.3.

12 Esses, V.M., Hamilton, L.K., Bennett-AbuAyyash, & Burstein, M. (2010). *Characteristics of a welcoming community*. Welcoming Communities Initiative Report, prepared for the Integration Branch of Citizenship and Immigration Canada.

13 Immigration News Service (2007). Most Canadian immigrants settle in Toronto, Vancouver, Montreal. Retrieved from: **www.migratenow.ca/articles/104.asp**.

14 Di Biase, S. & Bauder, H. (2004). Immigrants in Ontario: Linking spatial settlement patterns and labour force characteristics. Guelph, ON: Department of Geography, University of Guelph. Retrieved from: **www.geography.ryerson.ca/hbauder/Immigrant%20Labour/Settlement%20in%20Ontario_report.pdf**.

15 Statistics Canada. (2011 Census). Community profiles.

16 Citizenship and Immigration Canada. (2011). Datacube.

17 Statistics Canada. (2011 Census). Community profiles.

18 Guelph Inclusiveness Alliance (June, 2008). *New Canadians in Guelph and Wellington: What local service providers and new Canadians are saying about immigration and settlement: A Guelph inclusiveness alliance initiative*. Presentation to County of Wellington, Child Care Services.

19 Sousa-Batista, I. & Lusis, T. (2010). *Building practices of inclusion: Dialogue summary*. Guelph Wellington Local Immigration Partnership. Retrieved from: **http://guelphwellingtonlip.ca/files/BPI_Summary_Document_Final.pdf**.

20 Wayland, S.V. (April 2010). *Guelph Wellington Local Immigration Partnership Environmental Scan: Final Report.* Section 6.4, p. 40.

21 Ibid.

22 For the policies, see: Conseil scolaire de district catholique Centre-Sud: **http://www.csdccs.edu.on.ca/politiques.php**; Conseil scolaire public de district du Centre-Sud-Ouest: **http://www.csviamonde.ca/csviamonde/index.php?q=politiques**; Dufferin-Peel Catholic District School Board: **http://www.dpcdsb.org/CEC/About+Us/PoliciesRegulations/Index+of+PoliciesRegulations.htm**; Upper Grand District School Board: **http://www.ugdsb.on.ca/About_policy.htm**; Wellington Catholic District School Board: **http://www.wellingtoncssb.edu.on.ca/policy.html**.

23 Ministry of Education, Ontario. (2012). *Safe and accepting schools.* Retrieved from: **http://www.edu.gov.on.ca/eng/teachers/safeschools.html**

24 Ministry of Education, Ontario. (2012). *Registry of bullying prevention programs.* Retrieved from: **http://www.edu.gov.on.ca/eng/teachers/bullyprevention/registry.html**.

25 For the Ontario Human Rights Code, go to: **http://www.ohrc.on.ca/en/resources/code**.

26 Ministry of Education, Ontario (2012). *Safe and accepting schools.* Retrieved from: **http://www.edu.gov.on.ca/eng/teachers/safeschools.html**

27 Ibid.

28 Centre for Addiction and Mental Health. (2011). *The mental health and well-being on Ontario students 1991-2011.* Retrieved from: **http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2011%20OSDUHS%20Docs/2011OSDUHS_Detailed_MentalHealthReport.pdf**

29 Ibid.

30 Ibid.

31 Ibid.

32 Jimerson, S.R., Swearer, S.M. & Espelage, D.L. (Eds.). (2010). *Handbook of bullying in schools: An international perspective*. New York, NY: Taylor & Francis.

33 Public Health Agency of Canada. (2008). *Healthy settings for young people in Canada.* Ottawa, ON: Public Health Agency of Canada.

34 Butler-Jones, D. (2011). *The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition.* Retrieved from: **http://publichealth.gc.ca/CPHOreport**.

35 Yau, M., & O'Reilly, J. (2007). *2006 Student census: System overview.* Toronto, ON: Toronto District School Board.

36 Taylor, C., Peter, T., Schachter, K., Paquin, S. et al. (2008). *Youth speak up about homophobia and transphobia: The first national climate survey on homophobia in Canadian schools. Phase one report.* Toronto: Egale Canada Human Rights Trust.

37 Ibid.

38 Friedman, M. S., Koeske, G. F., Silverstre, A. J., Korr, W. S., & Sites, E. W. (2006). The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth. *Journal of Adolescent Health, 38*, 621-623.

39 Bagley, C., & Tremblay, P. (1997). Suicidal behaviors in homosexual and bisexual males. *Crisis, 18,* 24-34.

40 Saewyc, E. M., Poon, C., Wang, N., Homma, Y., Smith, A. & The McCreary Centre Society. (2007). *Not yet equal: The health of lesbian, gay, & bisexual youth in BC.* Vancouver, BC: The McCreary Centre Society.

41 Espelage, D. L., Aragon, S. R., Birkett, M., & Koenig, B. W. (2008). Homophobic teasing, psychological outcomes, and sexual orientation among high school students: What influence do parents and schools have? *School Psychology Review, 37*, 202-216.

42 Saewyc, E. M., Poon, C., Wang, N., Homma, Y., Smith, A. & The McCreary Centre Society. (2007). *Not yet equal: The health of lesbian, gay, & bisexual youth in BC.* Vancouver, BC: The McCreary Centre Society.

43 See National Alliance for Children and Youth (April 2011). 7 *Key Issues Affecting Children and Youth in Canada*. Retrieved May 11, 2011: **www.nacy.ca**.

44 Hanvey, L. (2003). *Social inclusion research in Canada: Children and youth: What do we know and where do we go?* Retrieved from: **www.ccsd.ca/events/inclusion/papers/hanvey.pdf**.

9. A right to access to quality and affordable child care, early education programs and/or parenting supports

Introduction

The link to youth's well-being

For all mothers, pregnancy is a time of life-altering physical, social, and emotional changes. These changes can be particularly impactful for adolescent mothers. Compared to adults, youth are limited in their economic resources, life experiences, employment opportunities, and educational background, making the transition to parenthood more difficult.[1] Youth, as parents, are expected to be responsible for the well-being and care of their children; however, youth, as minors, are also subject to social controls that can interfere with their ability to act as parents. Compared to older mothers, teen mothers are at an increased risk for many health problems ranging from anemia and hypertension[2] to pre-eclampsia and depressive disorders.[3] Teen mothers are also less likely to complete high school,[4] and more likely to be dependent on social assistance programs for financial support.[5] Young mothers report less autonomy, more difficulties with trust, and lower self-esteem than their childless peers.[6] Their children are also at a higher risk for perinatal mortality, preterm birth, and low birth weight.[7] Despite a shortage of research examining young fathers, there is longitudinal evidence showing that adolescent fathers experience higher levels of depression that last longer into adulthood than their peers without children and older fathers.[8] Throughout early childhood, children of teen parents are more likely to experience cognitive and behavioural problems, achieve poor school performance, and have troubled peer relationships.[9] This may be a result of fewer intellectually stimulating resources,[10] increased family instability,[11] lower levels of healthy parent-child interaction,[12] and a higher likelihood of experiencing child abuse.[13] Children of adolescent parents are also at an increased risk of becoming adolescent parents themselves.[14]

Access to high quality and affordable child care, early childhood education programs, and parenting supports can moderate the effects of early pregnancy on both the parents and children. Organized, high quality licensed child care support is particularly critical for teen parents.[15, 16] Young parents who have adequate child care access are more likely to complete their education, have meaningful employment, and report lower stress levels.[17] This results in an improved standard of living for both young parents and their children. Research has shown that children of young parents who are enrolled in early educational programs have improved health and nutrition, lower levels of abuse and neglect, higher intellectual and academic achievement as young adults, and reductions in teen pregnancy rates.[18] Finally, even though additional research is needed to understand the complexities underlying these findings; informal and formal parenting supports have been shown to ameliorate the potential negative effects of early parenting.[19] Young women who have access to parenting supports report a greater sense of competency in the maternal role.[20] These young mothers are more likely to engage in higher quality interactions with their children, provide more nurturing home environments, and have a greater understanding of developmental milestones and child development.[21] Mothers who have larger support networks also exhibit less maternal stress and have lower levels of depression.[22] Collectively, the research demonstrates that high quality,

accessible and affordable supports for young parents improve the health and developmental outcomes for both children and parents.

Indicators of youth's health and well-being in this chapter

Given the importance of formal child care and parenting supports for young parents and their children, it is important for local service providers to have an understanding of programs available to young parents, especially mothers, in Wellington, Dufferin, and Guelph. In order to provide a local picture of the accessibility of quality and affordable child care, early education, and parenting supports, this chapter highlights local data regarding:

- Young parents in Wellington, Dufferin, and Guelph
- Parenting supports for young parents

The value of this information to service providers

Service providers are in a unique position to positively impact the lives of young parents and their children, influencing their parenting skills, self-esteem, academic achievement, and their ability to obtain and maintain gainful employment. These programs must be both long-term and comprehensive, while also tailored to each family's needs and situation. As with many communities in Ontario, the availability of licensed child care spaces in Wellington, Dufferin, and Guelph is limited and inconsistent. Given this, service planning regarding our communities' child and family health needs should consider organized and collaborative programs that incorporate opportunities for quality child care and parenting support for young mothers that are inclusive of all families and children.

Data included in this chapter that address the availability of parenting and family supports in Wellington, Dufferin, and Guelph can also help inform collaborative efforts. Research has demonstrated that in addition to postnatal supports, identifying and encouraging teens to participate in parenting programs before pregnancy has a greater impact on several health outcomes.[23] Following pregnancy, rather than reducing the level of intervention for young mothers, service providers should maintain the level of intervention to assure a smooth transition into parenthood.[24] At each transition point, from pregnancy to postpartum, and from postpartum to on-going parenting, service providers should reassess the needs of the parents to promote comprehensive and individualized care.[25] It is also important to note that because teen mothers and fathers[26] are at an increased risk for depressive disorders, service providers can address this trend by actively promoting mental health evaluations among new and expectant parents.[27] Teen mothers often have less knowledge about services provided and often underutilize important services.[28] Service providers can improve youth awareness of the existence and importance of services that can improve health and developmental outcomes of their families.

Accessibility of child care

In Wellington and Guelph, there is a full time licensed infant space (serving children birth to 18 months) for less than 2% of the infant population. There are even fewer licensed infant spaces accessible for families who qualify for child care subsidy in Wellington and Guelph (County of Wellington, Child Care Services, March 26, 2013). Given the nature of teen parent demographics, the impact of the lack of available, accessible licensed child care spaces to meet parents' needs for affordable and reliable non-parental care arrangements (so they can attend school and/or work) and to meet their children's needs for access to high quality early childhood education and care, is especially concerning.

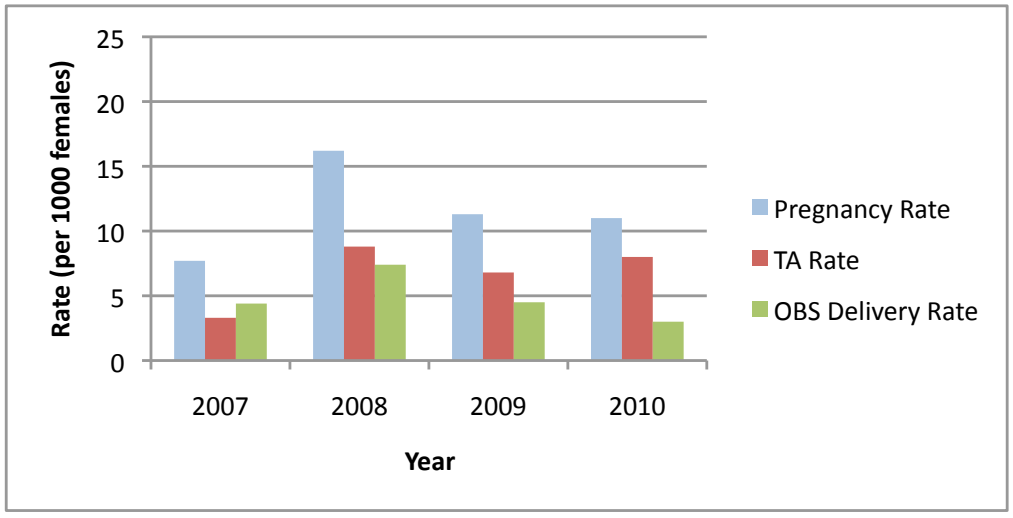
Young parents in Wellington, Dufferin and Guelph

As discussed in *Chapter 2: A right to good health by having our social, emotional, mental, physical, and spiritual needs met*, sexual health is an important health issue emerging during the adolescent years. In 2009, 46% of youth, ages 15 to 19, years reported being sexually active, with 16 as the average age of engaging in sexual intercourse for the first time among youth and young adults.[29] One of the potential outcomes for youth who engage in risky sexual behaviours, such as unprotected sex, is an unplanned pregnancy. Among youth, ages 15 to 19, who were pregnant, more than 90% reported that the pregnancy was unplanned and more than half of unplanned adolescent pregnancies end in induced or spontaneous abortion.[30]

In order to provide a local picture on the rate of pregnancies among female youth, ages 14 to 18, data from the Association of Public Health Epidemiologists of Ontario (APHEO) was analyzed. APHEO collects data on pregnancies, therapeutic abortions, and obstetric deliveries across Ontario. APHEO defines teen pregnancy as either a therapeutic abortion (TA) or an obstetric (OBS) delivery to a female teen under the age of 20. The following three figures (9.1, 9.2 and 9.3) summarize the rates of pregnancy, TA, and OBS delivery in Wellington County (excluding Guelph), Dufferin County, and Guelph. Rates are given per 1,000 females, ages 14 to 18, in each year.

As depicted in Figure 9.1, the TA rate in Wellington County has gradually increased as a proportion of pregnancies since 2007. In 2007, more young mothers were having an OBS delivery; by 2010, the TA rate was over two and a half times greater than the OBS delivery rate.

Figure 9.1 **Rates of pregnancy, therapeutic abortion (TA), and obstetric (OBS) delivery among female youth, ages 14 to 18, Wellington County, 2007 to 2010**



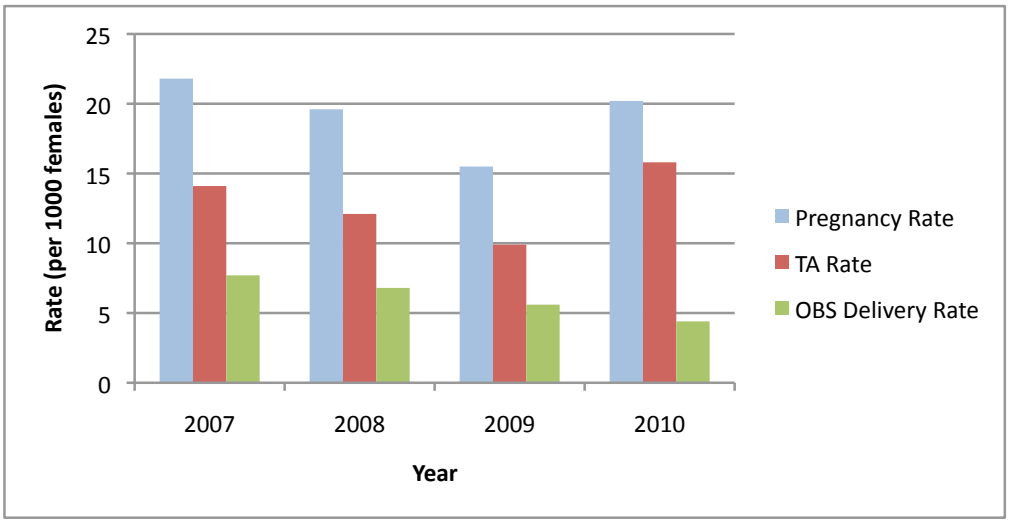
Source: *Inpatient Discharges (DAD), Ambulatory Visits (NACRS), Therapeutic Abortion Summary (DAD, NACRS, CHDB), OHIP Approved Claims File [2007-2010], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracte: [Mar 19, 2013]*

Note: Therapeutic abortions (TAs) include those performed in hospitals, clinics and private physicians' offices. These counts are adjusted to exclude second procedures that were performed within 40 days of the first procedure because it is more likely due to complications from the first procedure.

Obstetric (OBS) deliveries are those occurring in Ontario hospitals and exclude home births and those occurring in non-Ontario hospitals. Counts are for deliveries, not the number of babies born (i.e., a delivery of multiples is counted as one pregnancy).

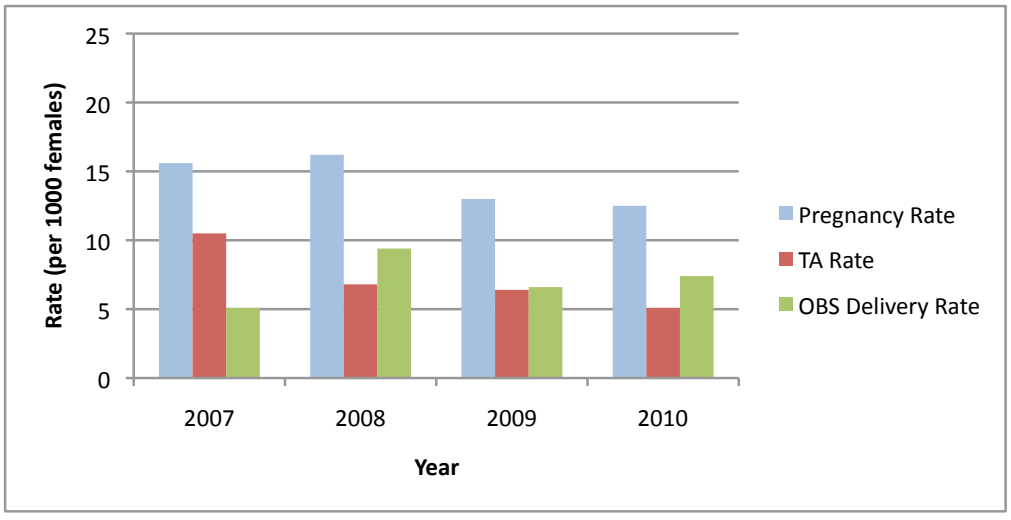
In Dufferin County (Figure 9.2), the OBS delivery rate has also declined as a proportion of the pregnancy rate since 2007. By 2010, the TA rate was more than three and a half times that of the OBS delivery rate.

Figure 9.2 **Rates of pregnancy, therapeutic abortion (TA), and obstetric (OBS) delivery among female youth, ages 14 to 18, Dufferin County, 2007 to 2010**



Source: Inpatient Discharges (DAD), Ambulatory Visits (NACRS), Therapeutic Abortion Summary (DAD, NACRS, CHDB), OHIP Approved Claims File [2007-2010], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracte: [Mar 19, 2013]

Figure 9.3 **Rates of pregnancy, therapeutic abortion (TA), and obstetric (OBS) delivery among female youth, ages 14 to 18, Guelph, 2007 to 2010**



Source: Inpatient Discharges (DAD), Ambulatory Visits (NACRS), Therapeutic Abortion Summary (DAD, NACRS, CHDB), OHIP Approved Claims File [2007-2010], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracte: [Mar 19, 2013]

In contrast to the trend noticed in the counties, in the City of Guelph (Figure 9.3), the TA rate has progressively declined between 2007 and 2010. In 2007, the TA rate was more than double the OBS delivery rate; however, by 2010, the OBS delivery rate was nearly one and a half times greater than the TA rate.

Overall, between 2007 and 2010, the pregnancy rate among young women, ages 14 to 18, was highest in Dufferin County, peaking in 2007 with a rate of 21.8 pregnancies per 1,000 females. Wellington County consistently maintained the lowest pregnancy rate; however, in 2008, both Wellington County and Guelph had a rate of 16.2 pregnancies per 1,000 females. Of all years, the lowest pregnancy rate occurred in Wellington County in 2007 with a rate of 7.7 pregnancies per 1,000 females. In Canada, there has been a steady decrease in adolescent pregnancies and births during the period from 1975 to 2005. As of 2005, the rate of pregnancies was 29 per 1,000 female youth, ages 15 to 19, and 13 per 1,000 for births.[31] While these rates are higher compared to those for Wellington, Dufferin, and Guelph, it is important to note that the national numbers include female youth age 19 and the rate of pregnancies increases with age.[32]

No distinct trend occurred for OBS delivery rates. The highest rate occurred in Guelph in 2008 at 9.4 OBS deliveries per 1,000 females; the lowest rate occurred in Wellington County in 2010 at 3.0 per 1,000 females.

Overall, Dufferin County experienced the highest rate of TAs with the rate peaking in 2010 at 15.8 per 1,000 females. While the City of Guelph had the second highest TA rate in 2007, the rates progressively declined between 2008 and 2010 to reach the lowest rate of 5.1 per 1,000 females in 2010.

Unintended pregnancies and births have been recognized as a stressful life event regardless of age.[33] Given that therapeutic abortion rates exceed obstetric delivery rates among female youth, ages 14 to 18, in Wellington County from 2008 to 2010 and in Dufferin County from 2007 to 2010, it is also worthwhile to acknowledge the potential consequences associated with abortions. A recent study found that adolescents who aborted unwanted pregnancies were more likely to seek psychological counselling, reported more frequent sleeping problems, and were more likely to use marijuana compared to adolescents who delivered unwanted pregnancies. Many factors influence the post-abortion transition for adolescent females, including their feelings toward becoming pregnant, the decision-making process to abort the pregnancy, and support (or absence of support) from family, friends, and other important people.[34,35]

Parenting supports for young parents

There are various programs available in Wellington, Dufferin, and Guelph to support young parents. Given that each program offered is very specific, it is necessary to present each program individually, rather than amalgamating relevant information from each program into an overall picture for Wellington, Dufferin, and Guelph as a whole. Each program varies in terms of the services provided and the data collected about client involvement in the programs.

A plethora of positive parenting programs are offered throughout Wellington, Dufferin, and Guelph that, while open to young parents, are not specifically designed to meet their unique needs. Currently, a positive parenting survey is being circulated to all agencies that provide parenting supports. Once completed, there will be a comprehensive list of all parenting programs available in the area. For the purposes of the Report Card, only those programs targeted to young parents will be discussed in the following section. The programs are organized according to the geographic location where they are offered.

Learning, Earning, and Parenting

The Learning, Earning, and Parenting (LEAP) program is available to young parents, between the ages of 16 and 25, who are receiving Ontario Works across Wellington, Dufferin, and Guelph. LEAP is mandatory for parents who are 16 or 17

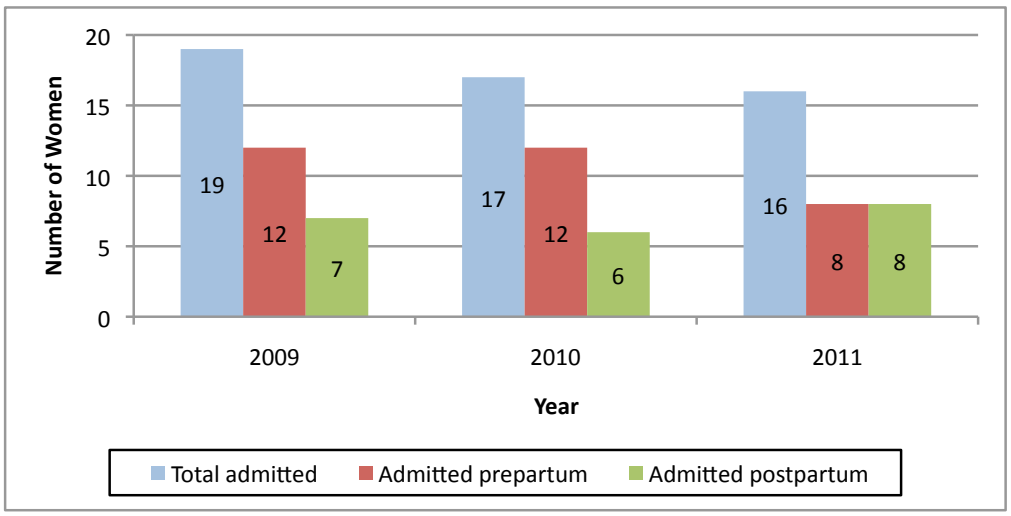
years of age, who are receiving Ontario Works and who have not graduated from high school. Young parents who are between the ages of 18 and 25 who are receiving Ontario Works, but who have not received their high school diploma can also participate voluntarily. LEAP can help young parents to graduate from secondary school, enhance their parenting skills, and find employment. Individuals who successfully complete LEAP requirements earn a $500 bursary to use towards post-secondary education or to invest in an education fund for their children.

Michael House

Michael House has a facility in Guelph with six bedrooms and offers support to pregnant women and/or women with children up to age two. The length of stay ranges depending on the needs of each client, with the average stay being approximately six months. Supports include, but are not limited to pre- and post-natal care, parenting skills, assistance in finding safe and stable housing, and ongoing support once a client has left Michael House. As demonstrated in Figure 9.4, the number of women admitted to Michael House has decreased slightly between 2009 and 2011.

Michael House admits women 16 years of age and older. The data presented below does not separate women by their age; however, youth, ages 16 to 18, represented between 30% and 42% of the total number of women admitted each year.

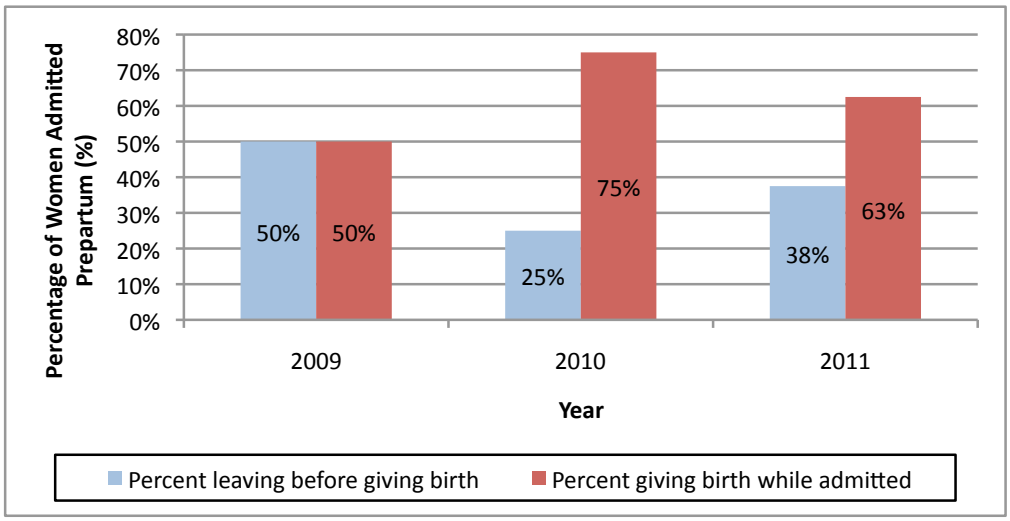
Figure 9.4 **Total number of women admitted to Michael House, Guelph, 2009 to 2011**



Source: *Personal communication, Michael House, June 2012*

Michael House also tracks information on the outcomes of women who are admitted before giving birth to their baby. Figure 9.5 demonstrates the proportion of women who leave Michael House before giving birth and the proportion that give birth while admitted to Michael house as a percentage of women admitted prepartum.

Figure 9.5 **Outcomes for women admitted to Michael House prepartum, Guelph, 2009 to 2011**



Source: *Personal communication, Michael House, June 2012*

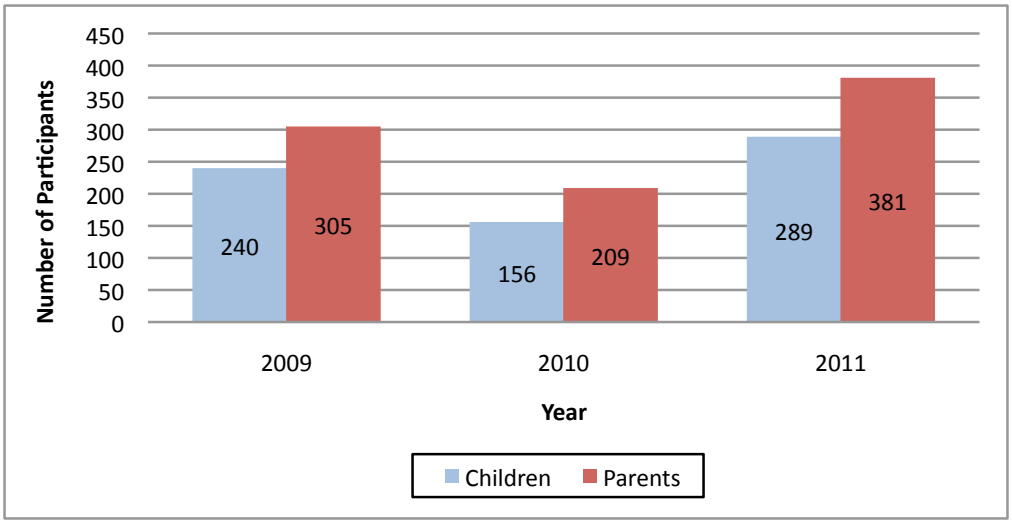
Note: According to Michael House staff, when women leave Michael House before giving birth, this is considered a good outcome. Women leave mostly because they have found a more suitable and stable environment where they are comfortable to have their baby. Often this means "their family has taken them back in or they found suitable housing". Others, however, leave because they feel the program is not suitable for them.

Teen Age Parent Program (TAPPS)

The Guelph YMCA/YWCA Teen Age Parent Program (TAPPS) provides support, resources, and information to pregnant and parenting teens. Programs are offered for women up to age 21 and men up to age 24. The goal of TAPPS is to support the personal growth of pregnant and parenting teens, as well as their children, while also assisting young parents in improving their parenting skills, education, and well-being.

TAPPS offers parenting, life skills, and educational/homework supports, as well as recreational services to pregnant or parenting adolescents, both male and female. The number of young mothers who attended TAPPS far surpasses the number of young fathers; however, several fathers do regularly attend the program. Figure 9.6 demonstrates the sum of attendance counts for children and young parents per year.

Figure 9.6 **Total number of youth, ages 14 to 18, and their children involved in YMCA-YWCA TAPPS, 2009 to 2011**



Source: *Personal communication, YMCA-YWCA of Guelph, June 2012*

Note: These records do not capture the number of unique clients in the program each year. The data above represent a sum of attendance counts from each session. Therefore, youth who access the program several times throughout the year are counted multiple times. The data also do not distinguish whether youth are accessing the services with their partners or by themselves.

In general, the number of youth who accessed TAPPS increased with age, and more females participated in the program than males. Between April 2011 and March 2012, for example, the total number of females, ages 14 to 18, involved in TAPPS was 111, while the total number of females ages 19 and above was 221. In comparison, the total number of males, ages 14 to 18, involved in TAPPS during this time period was 32, while the total number of males ages 19 and above was 128. On average, the total number of youth who accessed TAPPS per month from April 2011 to March 2012 was 41.

Early Years Outreach Program

The Early Years Outreach Program is targeted to young and at-risk parents of children ages birth to six. The program includes offsite early years programs (e.g., infant massage, Baby Basics, and Mother Goose) and services. The location of these programs rotates between identified Guelph neighbourhoods. The program also includes regular parent support and education sessions, which are offered at Stonehenge Therapeutic Community and Michael House. In addition, a Community Outreach Worker offers one-to-one parent support and education session to clients who are referred from the Guelph Community Health Centre (GCHC) clinical roster. These clients can be either self-referred or referred by GCHC staff. All programs and services incorporate the importance of, and strategies for, building parent-child attachment and adopting a child-centered, positive guidance approach to parenting (i.e., strategies for setting clear and consistent expectations or boundaries, using praise for reinforcement of positive behaviours, and non-punitive consequences for negative behaviours). Each program encourages parents to support and network with one another for capacity building within the neighbourhoods.

Teen Canada Prenatal Nutrition Program

The Teen Canada Prenatal Nutrition Program (CPNP) is offered at the Guelph Community

Health Centre to pregnant women, ages 21 and under. Expectant mothers can speak with a nurse or dietitian about labour, delivery, baby care, and nutrition. Expectant mothers can also receive free bus tickets, prenatal vitamins, and gift certificates for food. The program runs Monday afternoons and is available by registration or drop in.

Guelph Young Parent Education Program

The Guelph Young Parent Education Program is a collaborative program with College Heights Secondary School in Guelph and various community partners .It is offered at the Shelldale Community Centre. This program is targeted to young parents, ages 14 to 19, who have not yet completed their Ontario Secondary School Diploma. The program is open to any student attending a Guelph secondary school. Teens can earn credits towards their Ontario Secondary School Diploma, while meeting other young parents, developing parenting skills, and exploring future career options. The program is offered throughout the school year during the afternoons.

Orangeville Young Parent Education Program

The Orangeville Young Parent Education Program (YPEP) operates in a similar fashion to that of the Guelph Young Parent Education Program. It is a collaborative program offered by Orangeville District Secondary School (ODSS) in partnership with various community agencies. This program aims to enhance the quality of life for teen parents and pregnant teens, ages 14 to 19, who have not yet completed their Ontario Secondary School Diploma, by improving access to education and building life-long learning skills. During YPEP, teens work towards their Ontario Secondary School Diploma, explore career and work opportunities, and enhance their parenting and life skills, within a caring and supportive environment. Young parents have access to both regular and modified secondary school courses in nutrition, lifestyle, and parenting. In addition to educational courses, the program aims to build self-reliance and self-esteem among young parents. The program runs in the afternoons during the school year.

Come Understand Parenting

The Come Understand Parenting (CUP) program is offered in Orangeville at the Ontario Early Years Centre once a week. The program is specifically designed for parents, ages 16 to 24. Each week, CUP begins with a nutritious lunch and is followed by a workshop that assists young parents with various life skills, such as money management, self-esteem, and education. In 2012, 237 young parents and 181 infants, toddlers, and preschool-aged children attended this program. These numbers do not represent unique individuals, but rather the sum of attendance counts each week.

Young Parent Program

The Young Parent Program (YPP) is offered in Shelburne at the Ontario Early Years Centre once a week. This program is available to young mothers and fathers. YPP consists of three components: (1) a nutritious meal; (2) a young mother's group; (3) a young father's group. However, currently, the program does not have any fathers enrolled. Young parents are offered support and resources through access to public health nurses, Child and Family Services, and weekly guest speakers, who address topics related to healthy relationships, nutrition, financial management, emergency preparedness, and more. Once a month, parents participate in a "Coffee and Conversation day", where they are given the afternoon to discuss a wide range of topics. In 2012, 189 young parents and 244 infants, toddlers, and preschool-aged children attended this program. These numbers do not represent unique individuals, but rather the sum of attendance counts each week.

Young and Parenting Program

The Young and Parenting (YAP) Program is offered at the Ontario Early Years Centre in Fergus and Mount Forest on alternating weeks. The program provides an opportunity for young parents to hear from guest speakers and share experiences with their peers. YAP is available to youth, ages 14 to 24, who are parenting or preparing to parent. Each week, dinner is provided for young parents and their children. Child care is provided during guest speaker presentations.

Endnotes

1 Benson, M. J. (2004). After the adolescent pregnancy: Parents, teens, and families. *Child and Adolescent Social Work Journal, 21*(5), 435-456

2 Blum, R. W., Beuhring, T., & Rinehart, P. M. (2000). *Protecting teens: beyond race, income and family structure*. Minneapolis, MN: Center for Adolescent Health, University of Minnesota.

3 Dryburgh, H. (2000). Teenage Pregnancy. *Health Reports,* 12(1), 9-19.

4 Maynard, R. A. (1996). Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing. New York: The Robin Hood Foundation.

5 Maynard, R. A. (1997). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.

6 Osofsky, J., Hann, D., & Peebles, C. (1993). *Adolescent parenthood: Risks and opportunities for mothers and infants*. In: Zeanah, C. (ed). Handbook of Infant Mental Health. New York: Guilford Press.

7 Dryburgh, H. (2000). Teenage Pregnancy. *Health Reports,* 12(1), 9-19.

8 Lee, Y., Fagan, J., & Chen, W. (2012). Do late adolescent fathers have more depressive symptoms than older fathers? *Journal of Youth Adolescence, 41*: 1366-1381.

9 Maynard, R. A. (1997). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.

10 Maynard, R. A. (1996). Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing. New York: The Robin Hood Foundation.

11 Passino, A., Whitman, T., Borkowski, J., et al. (1993). Personal adjustment during pregnancy and adolescent parenting. *Adolescence, 28*, 97-122.

12 Maynard, R. A. (1996). *Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing*. New York: The Robin Hood Foundation.

13 Maynard, R. A. (1997). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.

14 Nord, C.W., Moore, K.A., Morrison, D.R., Brown, B., & Myers D.E. (1992). Consequences of teen-age parenting. *Journal of School Health, 62*, 310–318.

15 Levine-Coley, R., & Chase-Lansdale, P. (1998). Adolescent pregnancy and parenthood: recent evidence and future directions. *American Psychology, 53*, 152-66.

16 Mollborn, S., Blalock, C. (2012). Consequences of teen parents' child care arrangements for mothers and children. *Journal of Marriage and Family, 74*: 846-865.

17 Ramey, S. L. (2000). Persistent effects of early childhood education on high-risk children and their mothers. *Applied Developmental Science, 4*(1), 2-14.

18 Currie, J. (2001). Early childhood education. *The Journal of Economic Perspectives, 15*(2), 213-238.

19 Smith, M.L., Gilmer, M.H., Salge, L.E., Dickerson, J.B., Wilson, K.L. (2013). Who enrolls in teen parent education programs? An emphasis on personal and familial characteristics and services received. *Child and Adolescent Social Work Journal, 30*: 21-36.; Sadler, L.S., Swartz, M.K., Ryan-Krause, P., Seitz, V., et al (2007). Promising outcomes in teen mothers enrolled in a school-based parent support program and child care centre. *Journal of School Health, 77* (3): 121-130.; SmithBattle, L. & Leonard, V. (2012). Inequities compounded: explaining variations in the transition to adulthood for teen mothers' offspring. *Journal of Family Nursing, 18*(3): 409-431.

20 Mercer, R. T., Hackley, K. V., & Bostrom, A. (1984). Social support of teenage mothers. *Birth Defects: Original Article Series, 20*, 245-290.

21 Letourneau, N. L., Stewart, M. J., & Barnfather, A. K. (2004). Adolescent mothers: Support needs, resources, and support-education interventions. *Journal of Adolescent Health, 35,* 509-525.

22 ibid

23 Sangalang, B. B., & Rounds, K. (2006). Differences in health behaviors and parenting knowledge between pregnant adolescents and parenting adolescents. *Social Work in Health Care, 42*(2), 1-22.
24 ibid
25 ibid
26 Lee, Y., Fagan, J., & Chen, W. (2012). Do late adolescent fathers have more depressive symptoms than older fathers? *Journal of Youth Adolescence, 41*: 1366-1381.
27 Dryburgh, H. (2000). Teenage Pregnancy. *Health Reports,* 12(1), 9-19.
28 Logsdon, M. C., Hines-Martin, V., & Rakestraw, V. (2009). Barriers to depression treatment in low-income, unmarried, adolescent mothers in a southern, urban area of the United States. *Issues in Mental Health Nursing, 30,* 451-455.
29 Statistics Canada. Canadian Community Health Survey, 2009: Annual [Share Microdata File]. Ottawa, Ontario: Statistics Canada. All computations on these microdata were prepared by Public Health Agency of Canada and the responsibility for the use and interpretation of these data is entirely that of the author(s).
30 Klein, J.D. (2005). Adolescent Pregnancy: Current trends and issues. *Pediatrics, 116*(1), 281-286.
31 Statistics Canada. (2010-10-22). CANSIM Table 106-9002 Pregnancy outcomes, by age group, Canada, provinces and territories, annual [Data File]. Retrieved on February 21, 2011, from **http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&id=1069002&pattern=1069002&searchTypeByValue=1**
32 Butler-Jones, D. (2011). The chief public health officer's report on the state of public health in Canada, 2011: Youth and young adults – Life in transition. Retrieved from **http://publichealth.gc.ca/CPHOreport**.
33 Coleman, P.K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. *Journal of Youth and Adolescence,35,* 903-911.
34 Shoshanna Ehrlich, J. (2003). Grounded in reality of their lives: Listening to teens who made the abortion decision without involving their parents. *Berkeley Women's Law Journal, 18* 61-180.
35 Coleman, P.K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. *Journal of Youth and Adolescence,35,* 903-911.

Neighbourhood and Municipality Profiles

The neighbourhood profiles presented on the following pages provide a more in depth look at each of the 28 neighbourhoods and communities in Wellington, Dufferin, and Guelph to provide a greater understanding of the context in which youth are living. The indicators and population characteristics included in the profiles are grouped by geographic area, and then divided and reported on in the same sequence as the sections of the Report Card. Some data used for the Report Card could not be effectively reported at the neighbourhood- or municipality-level due to low numbers, or the data were simply not available at this geographic level. Other than population counts, there are a limited number of indicators that are specific to youth, ages 14 to 18.

Other communities that prepare reports similar to *The Well-Being of Youth Ages 14 to 18: A Report Card for Wellington-Dufferin-Guelph* have sometimes included ranking systems that categorize neighbourhoods in terms of their social or economic risk. For the Wellington, Dufferin, and Guelph Report Cards, it was decided not to rank the neighbourhoods, but to represent them with the data as they are. To support the reader in making comparisons using the data provided, we have included the corresponding statistics for all of Wellington, Dufferin, and Guelph, as well as Ontario.

Starting in 2005, a process began to establish Guelph neighbourhood and municipality boundaries through consultation with key informants familiar with local neighbourhood and community development and service delivery. Our geographic coding system was also informed by Statistics Canada's Census boundaries (such as, dissemination areas and census subdivisions), and by Wellington-Dufferin-Guelph Public Health's defined reporting areas for service delivery and data collection. For the City of Guelph, a few neighbourhoods have been combined (for example, Downtown Sunny Acres and Old University, as well as Hanlon Creek and Hales Barton). This was done to ensure that the sample sizes from key data sources are large enough for effective reporting. At the beginning of this section is a Profile Key, which provides visual representation of Wellington, Dufferin, and Guelph and a scale to understand the geographic distance. Within each profile, there is an additional map to identify the location of the specific township or neighbourhood within their corresponding County or the City of Guelph.

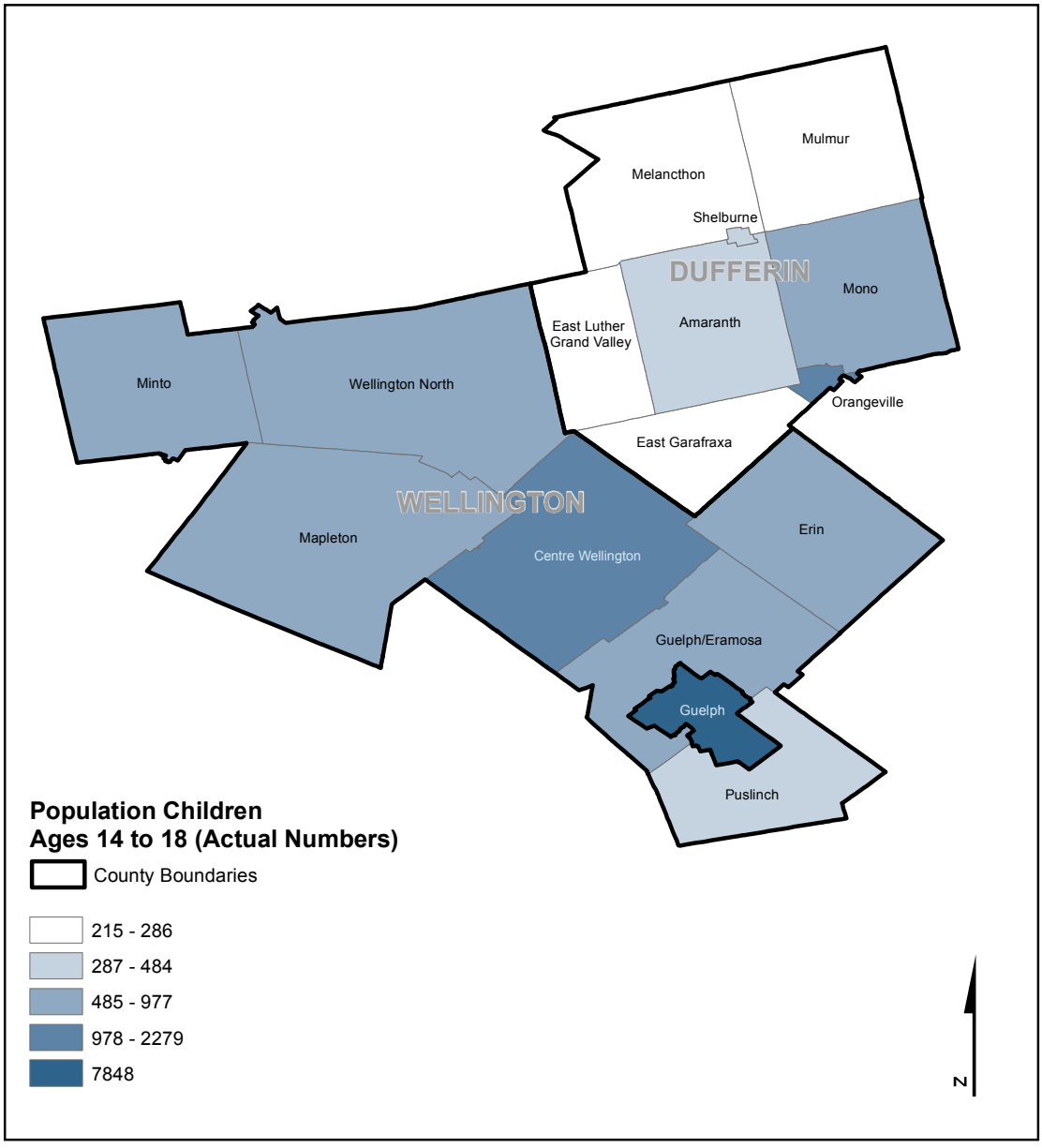
The Data Analysis Working Group of the Coalition has worked diligently to ensure that only the strongest and most useful data available are presented in these profiles. To determine neighbourhood-based need for services and supports, it is advisable to look for overall patterns in the data presented rather than to focus on specific findings. As is the case for any statistical output, caution should be used in interpreting and using these results. The sources for the data within each neighbourhood profile can vary from one line of data to the next, making information presented for a single neighbourhood not necessarily comparable or statistically compatible with other information in that particular profile. In addition, the sample sizes for some of the data are small. This means that while the information presented is still useful for identifying potential trends in populations across neighbourhoods, the small sample sizes can interfere with how confidently the information can be generalized to the overall population.

The key data sources for the neighbourhood profiles are the 2006 Census from Statistics

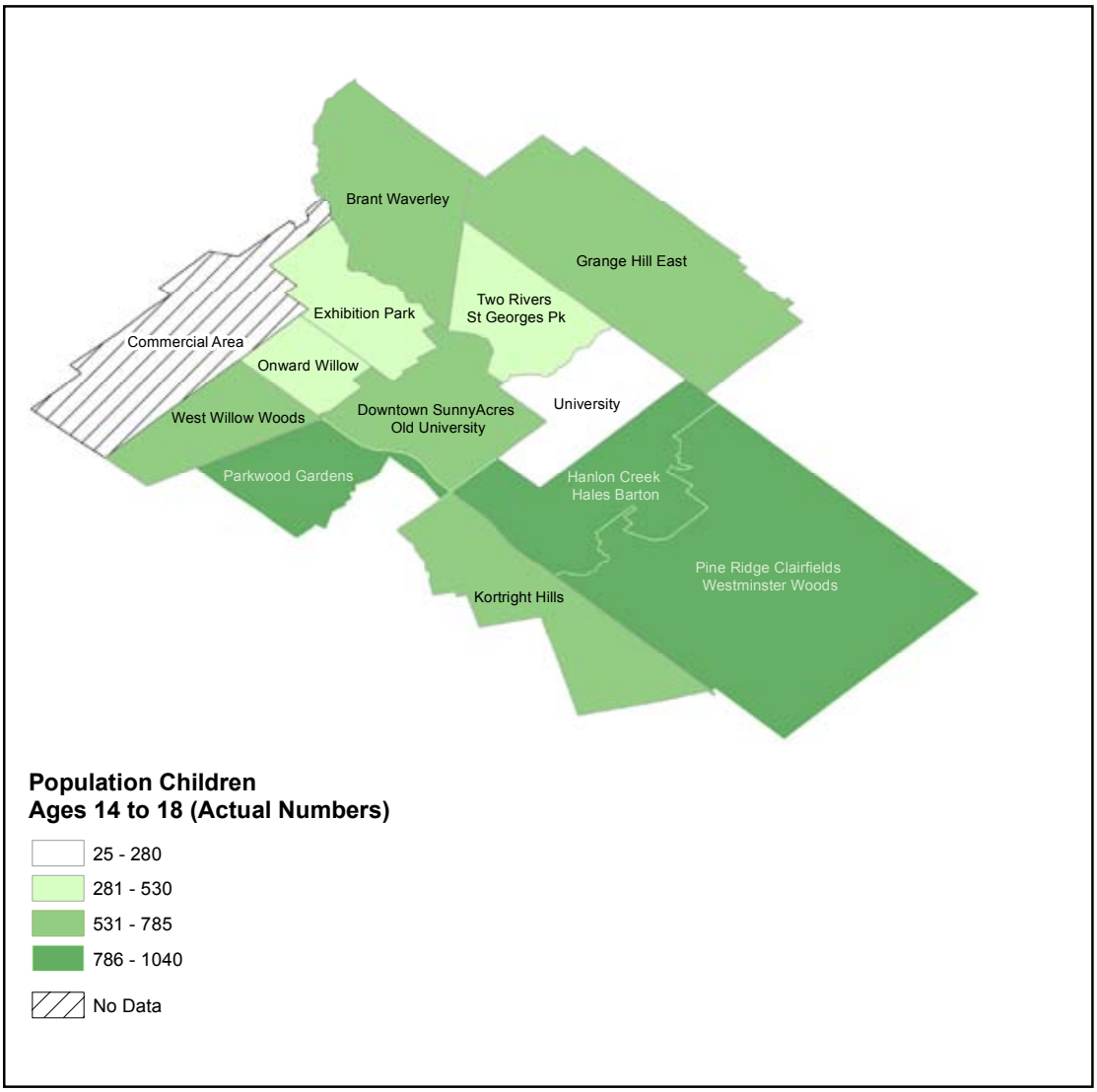
Canada and 2009 Statistics Canada Intercensal Estimates. Guelph neighbourhood population counts for youth, age 14 to 18, are based on 2006 Census data, while the Municipality population counts for youth, ages 14 to 18, are based on 2009 Intersensal Estimates. It is important to note that this Report Card, as well as *The Well-Being of Children Ages 7 to 13: A Report Card for Wellington-Dufferin-Guelph,* uses 2009 Intercensal Estimates.

Intercensal data are population estimates that are based on formulas developed by Statistics Canada. Given that these data are estimates, the estimated populations for 2009 may be higher than actual counts released in the 2011 Census. This will be particularly important when comparing the 2009 Intercensal Estimates presented in the Report Cards to 2011 census data as it becomes available.

Profile Key: **Wellington, Dufferin, and Guelph**



Profile Key: **City of Guelph Neighbourhoods**



Sources:

1. Census 2006 Single Year of Age and Sex TBT for Wellington and Dufferin CDs by DA/CSD-97-551-X2006006
2. Census 2006 Profile Subscription for Wellington and Dufferin CDs by DA/CSD Data Catalogue #-94-581-XCB2006002 Subscription Cat. # 97C0017
3. Population of Youth Ages 14 to 18: Statistics Canada, 2006
4. Statistics Canada Intercensal Estimates, 2009

Guelph Neighbourhoods

Brant Waverly

Demographics[1 2 3]	Brant Waverley	Guelph	WDG	Ontario
Total population	12,210	123,099	272,403	13,069,182
# of youth 14 to 18	730	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	6.0%	6.1%	7.2%	6.6%
% lone parent families	17.0%	16.0%	13.0%	16.0%
% total immigrant population	14.3%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	1.0%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	5.4%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	6.0%	10.0%	7.0%	15.0%
% total population visible minority	5.1%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	17.1%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.4%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	8.1%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	7.1%	5.5%	4.0%	8.6%
% families with family income less than $30,000	13.3%	11.1%	10.3%	14.2%
Government transfer payment % of total income	10.0%	7.6%	7.6%	8.8%
Median family income $ after tax	$61,487	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$33,369	$35,879	$37,885	$34,206
% of households owner occupied	70.4%	69.0%	78.0%	71.0%
% commuters to work	19.0%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	14.4%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph
Neighbourhoods

Downtown Sunny Acres / Old University

Demographics[1 2 3]	Downtown Sunny Acres / Old University	Guelph	WDG	Ontario
Total population	11,615	123,099	272,403	13,069,182
# of youth 14 to 18	570	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	4.9%	6.1%	7.2%	6.6%
% lone parent families	16.0%	16.0%	13.0%	16.0%
% total immigrant population	17.0%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	3.0%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	2.3%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	4.6%	10.0%	7.0%	15.0%
% total population visible minority	9.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	11.0%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	7.5%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	9.2%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	5.1%	5.5%	4.0%	8.6%
% families with family income less than $30,000	14.8%	11.1%	10.3%	14.2%
Government transfer payment % of total income	10.0%	7.6%	7.6%	8.8%
Median family income $ after tax	$71,126	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$38,479	$35,879	$37,885	$34,206
% of households owner occupied	47.0%	69.0%	78.0%	71.0%
% commuters to work	24.0%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	22.0%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Two Rivers – St. George's Park

Demographics[1 2 3]	Two Rivers – St. George's Park	Guelph	WDG	Ontario
Total population	8,800	123,099	272,403	13,069,182
# of youth 14 to 18	505	7,470	19,528	866,876
Population growth rate 2001 to 2006	610	8.3%	7.7%	959,401
% of youth 14 to 18	5.7%	6.1%	7.2%	6.6%
% lone parent families	20.0%	16.0%	13.0%	16.0%
% total immigrant population	13.6%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	0.008%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	0.0%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	5.0%	10.0%	7.0%	15.0%
% total population visible minority	4.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	18.0%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	4.9%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	9.0%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	5.9%	5.5%	4.0%	8.6%
% families with family income less than $30,000	14.7%	11.1%	10.3%	14.2%
Government transfer payment % of total income	11.8%	7.6%	7.6%	8.8%
Median family income $ after tax	$54,749	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$41,848	$35,879	$37,885	$34,206
% of households owner occupied	64.0%	69.0%	78.0%	71.0%
% commuters to work	21%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	16.0%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Onward Willow

Demographics[1 2 3]	Onward Willow	Guelph	WDG	Ontario
Total population	7285	123,099	272,403	13,069,182
# of youth 14 to 18	395	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	5.4%	6.1%	7.2%	6.6%
% lone parent families	24.0%	16.0%	13.0%	16.0%
% total immigrant population	27.5%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	10.3%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	11.5%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	22.0%	10.0%	7.0%	15.0%
% total population visible minority	23.5%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	23.1%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	6.0%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	16.0%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	10.7%	5.5%	4.0%	8.6%
% families with family income less than $30,000	23.1%	11.1%	10.3%	14.2%
Government transfer payment % of total income	14.3%	7.6%	7.6%	8.8%
Median family income $ after tax	$49,113	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$30,757	$35,879	$37,885	$34,206
% of households owner occupied	43.0%	69.0%	78.0%	71.0%
% commuters to work	16.7%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	20.4%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

West Willow Woods

Demographics[1 2 3]	West Willow Woods	Guelph	WDG	Ontario
Total population	9,730	123,099	272,403	13,069,182
# of youth 14 to 18	720	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	7.4%	6.1%	7.2%	6.6%
% lone parent families	19.4%	16.0%	13.0%	16.0%
% total immigrant population	28.4%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	5.5%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	7.7%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	16.0%	10.0%	7.0%	15.0%
% total population visible minority	26.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	11.0%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	0.0%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	8.1%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	6.6%	5.5%	4.0%	8.6%
% families with family income less than $30,000	11.0%	11.1%	10.3%	14.2%
Government transfer payment % of total income	7.7%	7.6%	7.6%	8.8%
Median family income $ after tax	$60,524	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$36,160	$35,879	$37,885	$34,206
% of households owner occupied	70.0%	69.0%	78.0%	71.0%
% commuters to work	24.7%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	17.3%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Parkwood Gardens

Demographics[1 2 3]	Parkwood Gardens	Guelph	WDG	Ontario
Total population	9,820	123,099	272,403	13,069,182
# of youth 14 to 18	900	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	9.2%	6.1%	7.2%	6.6%
% lone parent families	13.1%	16.0%	13.0%	16.0%
% total immigrant population	29.2%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	4.6%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	10.1%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	17.4%	10.0%	7.0%	15.0%
% total population visible minority	27.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	14.4%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	4.3%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	6.2%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	4.4%	5.5%	4.0%	8.6%
% families with family income less than $30,000	7.0%	11.1%	10.3%	14.2%
Government transfer payment % of total income	6.3%	7.6%	7.6%	8.8%
Median family income $ after tax	$67,252	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$47,661	$35,879	$37,885	$34,206
% of households owner occupied	85.2%	69.0%	78.0%	71.0%
% commuters to work	23.1%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	11.1%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Exhibition Park

Demographics[1 2 3]	Exhibition Park	Guelph	WDG	Ontario
Total population	10,645	123,099	272,403	13,069,182
# of youth 14 to 18	515	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	4.8%	6.1%	7.2%	6.6%
% lone parent families	15.3%	16.0%	13.0%	16.0%
% total immigrant population	17.2%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	2.2%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	2.2%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	3.6%	10.0%	7.0%	15.0%
% total population visible minority	5.6%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	10.4%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	5.5%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	7.0%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	3.8%	5.5%	4.0%	8.6%
% families with family income less than $30,000	11.2%	11.1%	10.3%	14.2%
Government transfer payment % of total income	11.5%	7.6%	7.6%	8.8%
Median family income $ after tax	$59,234	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$40,607	$35,879	$37,885	$34,206
% of households owner occupied	58.3%	69.0%	78.0%	71.0%
% commuters to work	22.0%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	10.4%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Grange Hill East

Demographics[1 2 3]	Grange Hill East	Guelph	WDG	Ontario
Total population	10,880	123,099	272,403	13,069,182
# of youth 14 to 18	690	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	6.3%	6.1%	7.2%	6.6%
% lone parent families	16.5%	16.0%	13.0%	16.0%
% total immigrant population	18.5%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	2.3%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	4.0%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	9.5%	10.0%	7.0%	15.0%
% total population visible minority	10.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	12.3%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	1.7%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	7.2%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	5.9%	5.5%	4.0%	8.6%
% families with family income less than $30,000	8.6%	11.1%	10.3%	14.2%
Government transfer payment % of total income	8.7%	7.6%	7.6%	8.8%
Median family income $ after tax	$65,389	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$41,372	$35,879	$37,885	$34,206
% of households owner occupied	88.3%	69.0%	78.0%	71.0%
% commuters to work	25.3%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	16.3%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Kortright Hills

Demographics[1 2 3]	Kortright Hills	Guelph	WDG	Ontario
Total population	7060	123,099	272,403	13,069,182
# of youth 14 to 18	580	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	8.2%	6.1%	7.2%	6.6%
% lone parent families	10.0%	16.0%	13.0%	16.0%
% total immigrant population	24.0%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	2.0%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	4.1%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	10.0%	10.0%	7.0%	15.0%
% total population visible minority	14.2%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	6.3%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	5.9%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	0.0%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	2.0%	5.5%	4.0%	8.6%
% families with family income less than $30,000	3.5%	11.1%	10.3%	14.2%
Government transfer payment % of total income	5.9%	7.6%	7.6%	8.8%
Median family income $ after tax	$79,636	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$61,768	$35,879	$37,885	$34,206
% of households owner occupied	88.3%	69.0%	78.0%	71.0%
% commuters to work	25.0%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	10.0%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Hanlon Creek Hales Barton

Demographics[1 2 3]	Hanlon Creek Hales Barton	Guelph	WDG	Ontario
Total population	14,015	123,099	272,403	13,069,182
# of youth 14 to 18	1,040	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	7.4%	6.1%	7.2%	6.6%
% lone parent families	15.1%	16.0%	13.0%	16.0%
% total immigrant population	21.4%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	3.2%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	3.5%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	9.0%	10.0%	7.0%	15.0%
% total population visible minority	15.0%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	7.0%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.8%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	7.7%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	8.2%	5.5%	4.0%	8.6%
% families with family income less than $30,000	10.5%	11.1%	10.3%	14.2%
Government transfer payment % of total income	7.6%	7.6%	7.6%	8.8%
Median family income $ after tax	$75,611	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$40,757	$35,879	$37,885	$34,206
% of households owner occupied	75.0%	69.0%	78.0%	71.0%
% commuters to work	26.3%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	15.0%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Guelph Neighbourhoods

Pine Ridge Clairfields Westminster Woods

Demographics[1 2 3]	Pine Ridge Clairfields Westminister Woods	Guelph	WDG	Ontario
Total population	11,860	123,099	272,403	13,069,182
# of youth 14 to 18	800	7,470	19,528	866,876
Population growth rate 2001 to 2006	n.d.	8.3%	7.7%	959,401
% of youth 14 to 18	6.7%	6.1%	7.2%	6.6%
% lone parent families	8.3%	16.0%	13.0%	16.0%
% total immigrant population	23.0%	21.0%	16.0%	28.0%
% of total population immigrated in the last five years	3.7%	3.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	3.0%	6.0%	5.0%	8.0%
% speaking other "non-official" languages at home	9.1%	10.0%	7.0%	15.0%
% total population visible minority	17.3%	14.0%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	5.6%	12.0%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.2%	5.2%	4.0%	5.2%
% of families falling below LICO before tax	2.8%	7.5%	6.0%	11.7%
% of families falling below LICO after tax	2.4%	5.5%	4.0%	8.6%
% families with family income less than $30,000	4.0%	11.1%	10.3%	14.2%
Government transfer payment % of total income	4.3%	7.6%	7.6%	8.8%
Median family income $ after tax	$83,869	$63,497	$66,148	$59,377
Median female lone parent family income $ after tax	$52,430	$35,879	$37,885	$34,206
% of households owner occupied	94.0%	69.0%	78.0%	71.0%
% commuters to work	36%	24.0%	39.0%	33.0%
% of total population who have moved in the last year	18.7%	16.0%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile

Note: n.d. — no data available

Wellington County

Puslinch

Demographics[1 2 3]	Puslinch	Wellington County	WDG	Ontario
Total population	7,190	91,290	272,403	13,069,182
# of youth 14 to 18	484	6,989	19,528	866,876
Population growth rate 2001 to 2006	13.7%	5.1%	7.7%	959,401
% of youth 14 to 18	6.7%	7.7%	7.2%	6.6%
% lone parent families	6.0%	8.8%	13.0%	16.0%
% total immigrant population	16.0%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	1.0%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	0.0%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	2.4%	5.5%	7.0%	15.0%
% total population visible minority	3.5%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	14.4%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	4.4%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	2.3%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	2.3%	3.0%	4.0%	8.6%
% families with family income less than $30,000	7.4%	9.2%	10.3%	14.2%
Government transfer payment % of total income	4.6%	7.9%	7.6%	8.8%
Median family income $ after tax	$81,721	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$38,245	$40,128	$37,885	$34,206
% of households owner occupied	91.2%	85.1%	78.0%	71.0%
% commuters to work	67.0%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	10.6%	10.4%	13.0%	13.0%

Source: *see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile*
Note: *n.d. — no data available*

Wellington County

Guelph/Eramosa

Demographics[1 2 3]	Guelph/ Eramosa	Wellington County	WDG	Ontario
Total population	12,867	91,290	272,403	13,069,182
# of youth 14 to 18	963	6,989	19,528	866,876
Population growth rate 2001 to 2006	8.0%	5.1%	7.7%	959,401
% of youth 14 to 18	7.5%	7.7%	7.2%	6.6%
% lone parent families	9.4%	8.8%	13.0%	16.0%
% total immigrant population	13.8%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	1.0%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	3.0%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	3.0%	5.5%	7.0%	15.0%
% total population visible minority	2.0%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	11.0%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	4.8%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	3.6%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	2.7%	3.0%	4.0%	8.6%
% families with family income less than $30,000	7.0%	9.2%	10.3%	14.2%
Government transfer payment % of total income	6.4%	7.9%	7.6%	8.8%
Median family income $ after tax	$76,134	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$48,266	$40,128	$37,885	$34,206
% of households owner occupied	91.0%	85.1%	78.0%	71.0%
% commuters to work	66.6%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	10.6%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

North Wellington

Demographics[1 2 3]	North Wellington	Wellington County	WDG	Ontario
Total population	11,974	91,290	272,403	13,069,182
# of youth 14 to 18	912	6,989	19,528	866,876
Population growth rate 2001 to 2006	920	5.1%	7.7%	959,401
% of youth 14 to 18	7.6%	7.7%	7.2%	6.6%
% lone parent families	10.3%	8.8%	13.0%	16.0%
% total immigrant population	9.4%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	1.3%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	14.6%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	7.3%	5.5%	7.0%	15.0%
% total population visible minority	2.6%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	26.1%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	5.0%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	7.8%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	4.8%	3.0%	4.0%	8.6%
% families with family income less than $30,000	13.4%	9.2%	10.3%	14.2%
Government transfer payment % of total income	11.9%	7.9%	7.6%	8.8%
Median family income $ after tax	$56,788	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$33,318	$40,128	$37,885	$34,206
% of households owner occupied	77.7%	85.1%	78.0%	71.0%
% commuters to work	34.4%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	11.8%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

Centre Wellington

Demographics[1 2 3]	Centre Wellington	Wellington County	WDG	Ontario
Total population	27,835	91,290	272,403	13,069,182
# of youth 14 to 18	2,116	6,989	19,528	866,876
Population growth rate 2001 to 2006	7.4%	5.1%	7.7%	959,401
% of youth 14 to 18	7.6%	7.7%	7.2%	6.6%
% lone parent families	10.1%	8.8%	13.0%	16.0%
% total immigrant population	10.3%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	0.05%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	2.4%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	2.1%	5.5%	7.0%	15.0%
% total population visible minority	1.0%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	15.4%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	2.0%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	3.5%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	3.2%	3.0%	4.0%	8.6%
% families with family income less than $30,000	7.8%	9.2%	10.3%	14.2%
Government transfer payment % of total income	7.4%	7.9%	7.6%	8.8%
Median family income $ after tax	$67,027	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$38,812	$40,128	$37,885	$34,206
% of households owner occupied	83.7%	85.1%	78.0%	71.0%
% commuters to work	44.5%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	10.0%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

Fergus

Demographics[1 2 3]	Fergus	Wellington County	WDG	Ontario
Total population	n.d.	91,290	272,403	13,069,182
# of youth 14 to 18	n.d.	6,989	19,528	866,876
Population growth rate 2001 to 2006	6.2%	5.1%	7.7%	959,401
% of youth 14 to 18	n.d.	7.7%	7.2%	6.6%
% lone parent families	14.2%	8.8%	13.0%	16.0%
% total immigrant population	8.9%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	0.03%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	2.1%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	1.2%	5.5%	7.0%	15.0%
% total population visible minority	1.0%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	17.0%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	1.5%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	3.1%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	2.7%	3.0%	4.0%	8.6%
% families with family income less than $30,000	9.3%	9.2%	10.3%	14.2%
Government transfer payment % of total income	8.6%	7.9%	7.6%	8.8%
Median family income $ after tax	$61,919	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$34,875	$40,128	$37,885	$34,206
% of households owner occupied	76.3%	85.1%	78.0%	71.0%
% commuters to work	44.3%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	13.4%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

Erin

Demographics[1 2 3]	Erin	Wellington County	WDG	Ontario
Total population	11,868	91,290	272,403	13,069,182
# of youth 14 to 18	977	6,989	19,528	866,876
Population growth rate 2001 to 2006	0.9%	5.1%	7.7%	959,401
% of youth 14 to 18	8.2%	7.7%	7.2%	6.6%
% lone parent families	9.3%	8.8%	13.0%	16.0%
% total immigrant population	12.3%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	0.05%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	0.0%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	2.0%	5.5%	7.0%	15.0%
% total population visible minority	2.0%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	13.0%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	1.0%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	2.8%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	1.7%	3.0%	4.0%	8.6%
% families with family income less than $30,000	6.2%	9.2%	10.3%	14.2%
Government transfer payment % of total income	5.4%	7.9%	7.6%	8.8%
Median family income $ after tax	$79,037	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$39,678	$40,128	$37,885	$34,206
% of households owner occupied	91.0%	85.1%	78.0%	71.0%
% commuters to work	61.0%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	10.5%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

Mapleton

Demographics[1 2 3]	Mapleton	Wellington County	WDG	Ontario
Total population	10,444	91,290	272,403	13,069,182
# of youth 14 to 18	875	6,989	19,528	866,876
Population growth rate 2001 to 2006	5.9%	5.1%	7.7%	959,401
% of youth 14 to 18	8.4%	7.7%	7.2%	6.6%
% lone parent families	4.0%	8.8%	13.0%	16.0%
% total immigrant population	12.5%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	3.4%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	16.2%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	21.0%	5.5%	7.0%	15.0%
% total population visible minority	1.6%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	38.1%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.3%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	6.1%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	4.0%	3.0%	4.0%	8.6%
% families with family income less than $30,000	10.3%	9.2%	10.3%	14.2%
Government transfer payment % of total income	8.0%	7.9%	7.6%	8.8%
Median family income $ after tax	$60,092	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$50,713	$40,128	$37,885	$34,206
% of households owner occupied	88.1%	85.1%	78.0%	71.0%
% commuters to work	48.1%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	8.5%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Wellington County

Minto

Demographics[1 2 3]	Minto	Wellington County	WDG	Ontario
Total population	9,112	91,290	272,403	13,069,182
# of youth 14 to 18	662	6,989	19,528	866,876
Population growth rate 2001 to 2006	4.2%	5.1%	7.7%	959,401
% of youth 14 to 18	7.3%	7.7%	7.2%	6.6%
% lone parent families	8.6%	8.8%	13.0%	16.0%
% total immigrant population	7.5%	11.4%	16.0%	28.0%
% of total population immigrated in the last five years	0.05%	1.0%	2.0%	5.0%
% of total immigrants with no knowledge of English	11.2%	5.6%	5.0%	8.0%
% speaking other "non-official" languages at home	6.0%	5.5%	7.0%	15.0%
% total population visible minority	1.0%	1.7%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	24.3%	18.8%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.5%	2.8%	4.0%	5.2%
% of families falling below LICO before tax	6.4%	4.6%	6.0%	11.7%
% of families falling below LICO after tax	2.3%	3.0%	4.0%	8.6%
% families with family income less than $30,000	15.5%	9.2%	10.3%	14.2%
Government transfer payment % of total income	11.8%	7.9%	7.6%	8.8%
Median family income $ after tax	$54,664	$67,923	$66,148	$59,377
Median female lone parent family income $ after tax	$34,420	$40,128	$37,885	$34,206
% of households owner occupied	77.4%	85.1%	78.0%	71.0%
% commuters to work	44.5%	51.1%	39.0%	33.0%
% of total population who have moved in the last year	10.8%	10.4%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Orangeville

Demographics[1 2 3]	Orangeville	County of Dufferin	WDG	Ontario
Total population	28,631	58,014	272,403	13,069,182
# of youth 14 to 18	2,279	4,691	19,528	866,876
Population growth rate 2001 to 2006	6.6%	6.7%	7.7%	959,401
% of youth 14 to 18	8.0%	8.1%	7.2%	6.6%
% lone parent families	17.4%	13.9%	13.0%	16.0%
% total immigrant population	12.9%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	1.30%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	1.3%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	1.4%	2.0%	7.0%	15.0%
% total population visible minority	5.2%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	14.3%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	5.4%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	5.8%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	4.0%	4.0%	4.0%	8.6%
% families with family income less than $30,000	10.5%	10.6%	10.3%	14.2%
Government transfer payment % of total income	7.9%	8.4%	7.6%	8.8%
Median family income $ after tax	$65,245	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$36,391	$36,838	$37,885	$34,206
% of households owner occupied	80.0%	84.9%	78.0%	71.0%
% commuters to work	42.7%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	11.7%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Shelburne

Demographics[1 2 3]	Shelburne	County of Dufferin	WDG	Ontario
Total population	5,449	58,014	272,403	13,069,182
# of youth 14 to 18	344	4,691	19,528	866,876
Population growth rate 2001 to 2006	22.2%	6.7%	7.7%	959,401
% of youth 14 to 18	6.3%	8.1%	7.2%	6.6%
% lone parent families	14.7%	13.9%	13.0%	16.0%
% total immigrant population	9.8%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	1.20%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	3.0%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	2.0%	2.0%	7.0%	15.0%
% total population visible minority	2.8%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	22.9%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	5.4%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	6.1%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	4.7%	4.0%	4.0%	8.6%
% families with family income less than $30,000	11.3%	10.6%	10.3%	14.2%
Government transfer payment % of total income	9.3%	8.4%	7.6%	8.8%
Median family income $ after tax	$62,297	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$39,409	$36,838	$37,885	$34,206
% of households owner occupied	78.9%	84.9%	78.0%	71.0%
% commuters to work	49.2%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	18.7%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

East Garafraxa

Demographics[1 2 3]	East Garafraxa	County of Dufferin	WDG	Ontario
Total population	2,552	58,014	272,403	13,069,182
# of youth 14 to 18	215	4,691	19,528	866,876
Population growth rate 2001 to 2006	7.9%	6.7%	7.7%	959,401
% of youth 14 to 18	8.4%	8.1%	7.2%	6.6%
% lone parent families	7.9%	13.9%	13.0%	16.0%
% total immigrant population	11.7%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	0.4%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	5.4%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	2.3%	2.0%	7.0%	15.0%
% total population visible minority	5.4%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	10.8%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	6.1%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	6.7%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	6.0%	4.0%	4.0%	8.6%
% families with family income less than $30,000	12.7%	10.6%	10.3%	14.2%
Government transfer payment % of total income	6.1%	8.4%	7.6%	8.8%
Median family income $ after tax	$70,823	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$37,582	$36,838	$37,885	$34,206
% of households owner occupied	94.8%	84.9%	78.0%	71.0%
% commuters to work	58.3%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	12.4%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Mono

Demographics[1 2 3]	Mono	County of Dufferin	WDG	Ontario
Total population	7,591	58,014	272,403	13,069,182
# of youth 14 to 18	665	4,691	19,528	866,876
Population growth rate 2001 to 2006	2.3%	6.7%	7.7%	959,401
% of youth 14 to 18	8.8%	8.1%	7.2%	6.6%
% lone parent families	9.6%	13.9%	13.0%	16.0%
% total immigrant population	15.7%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	0.6%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	0.0%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	1.3%	2.0%	7.0%	15.0%
% total population visible minority	3.2%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	9.9%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	0.0%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	5.1%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	3.7%	4.0%	4.0%	8.6%
% families with family income less than $30,000	8.1%	10.6%	10.3%	14.2%
Government transfer payment % of total income	6.3%	8.4%	7.6%	8.8%
Median family income $ after tax	$78,176	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$43,693	$36,838	$37,885	$34,206
% of households owner occupied	95.0%	84.9%	78.0%	71.0%
% commuters to work	67.9%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	10.0%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Mulmur

Demographics[1 2 3]	Mulmur	County of Dufferin	WDG	Ontario
Total population	3,552	58,014	272,403	13,069,182
# of youth 14 to 18	286	4,691	19,528	866,876
Population growth rate 2001 to 2006	7.1%	6.7%	7.7%	959,401
% of youth 14 to 18	8.1%	8.1%	7.2%	6.6%
% lone parent families	9.0%	13.9%	13.0%	16.0%
% total immigrant population	10.9%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	1.40%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	0.0%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	2.6%	2.0%	7.0%	15.0%
% total population visible minority	4.6%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	13.3%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	0.0%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	4.1%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	2.0%	4.0%	4.0%	8.6%
% families with family income less than $30,000	8.1%	10.6%	10.3%	14.2%
Government transfer payment % of total income	7.9%	8.4%	7.6%	8.8%
Median family income $ after tax	$65,773	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$46,121	$36,838	$37,885	$34,206
% of households owner occupied	94.1%	84.9%	78.0%	71.0%
% commuters to work	66.5%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	5.3%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Melancthon

Demographics[1 2 3]	Melancthon	County of Dufferin	WDG	Ontario
Total population	3,108	58,014	272,403	13,069,182
# of youth 14 to 18	279	4,691	19,528	866,876
Population growth rate 2001 to 2006	5.7%	6.7%	7.7%	959,401
% of youth 14 to 18	9.0%	8.1%	7.2%	6.6%
% lone parent families	9.8%	13.9%	13.0%	16.0%
% total immigrant population	11.7%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	0.9%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	2.9%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	4.0%	2.0%	7.0%	15.0%
% total population visible minority	2.2%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	23.6%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	3.7%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	4.1%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	2.9%	4.0%	4.0%	8.6%
% families with family income less than $30,000	12.9%	10.6%	10.3%	14.2%
Government transfer payment % of total income	7.9%	8.4%	7.6%	8.8%
Median family income $ after tax	$60,916	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$32,675	$36,838	$37,885	$34,206
% of households owner occupied	91.5%	84.9%	78.0%	71.0%
% commuters to work	70.2%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	11.1%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

Amaranth

Demographics[1 2 3]	Amaranth	County of Dufferin	WDG	Ontario
Total population	4,117	58,014	272,403	13,069,182
# of youth 14 to 18	354	4,691	19,528	866,876
Population growth rate 2001 to 2006	2.9%	6.7%	7.7%	959,401
% of youth 14 to 18	8.6%	8.1%	7.2%	6.6%
% lone parent families	10.1%	13.9%	13.0%	16.0%
% total immigrant population	15.2%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	1.6%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	1.7%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	4.3%	2.0%	7.0%	15.0%
% total population visible minority	2.0%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	10.4%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	0.0%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	5.5%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	4.5%	4.0%	4.0%	8.6%
% families with family income less than $30,000	12.3%	10.6%	10.3%	14.2%
Government transfer payment % of total income	9.0%	8.4%	7.6%	8.8%
Median family income $ after tax	$67,733	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$64,311	$36,838	$37,885	$34,206
% of households owner occupied	92.3%	84.9%	78.0%	71.0%
% commuters to work	73.5%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	10.8%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

Dufferin County

East Luther Grand Valley

Demographics[1 2 3]	East Luther Grand Valley	County of Dufferin	WDG	Ontario
Total population	3,014	58,014	272,403	13,069,182
# of youth 14 to 18	269	4,691	19,528	866,876
Population growth rate 2001 to 2006	0.1%	6.7%	7.7%	959,401
% of youth 14 to 18	8.9%	8.1%	7.2%	6.6%
% lone parent families	12.3%	13.9%	13.0%	16.0%
% total immigrant population	11.8%	13.0%	16.0%	28.0%
% of total population immigrated in the last five years	2.3%	1.2%	2.0%	5.0%
% of total immigrants with no knowledge of English	4.5%	1.5%	5.0%	8.0%
% speaking other "non-official" languages at home	2.5%	2.0%	7.0%	15.0%
% total population visible minority	1.1%	3.8%	8.0%	23.0%
Income and Employment				
% pop. 25-64 years without high school certificate	17.9%	14.7%	14.7%	13.5%
Unemployment rate for families with children at home under 6	4.8%	4.4%	4.0%	5.2%
% of families falling below LICO before tax	5.0%	5.5%	6.0%	11.7%
% of families falling below LICO after tax	3.1%	4.0%	4.0%	8.6%
% families with family income less than $30,000	13.1%	10.6%	10.3%	14.2%
Government transfer payment % of total income	7.4%	8.4%	7.6%	8.8%
Median family income $ after tax	$60,957	$65,883	$66,148	$59,377
Median female lone parent family income $ after tax	$25,056	$36,838	$37,885	$34,206
% of households owner occupied	83.6%	84.9%	78.0%	71.0%
% commuters to work	55.5%	53.3%	39.0%	33.0%
% of total population who have moved in the last year	10.6%	11.6%	13.0%	13.0%

Source: see page 217 of the Neighbourhood and Municipality Profiles for the complete list of sources of the data presented in each profile
Note: n.d. — no data available

more info at:
www.wdgreportcard.com

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