School Health Situational Assessment Final Report

HASTINGS PRINCE EDWARD Public Health

Algonquin & Lakeshore Catholic District School Board

Hastings and Prince Edward District School Board

May 2019

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Acknowledgements

Hastings Prince Edward Public Health (HPEPH) would like to acknowledge the following groups and individuals who contributed to this project:

Educators, support staff, administrators and others employed by Algonquin and Lakeshore Catholic District School Board (ALCDSB) and Hastings and Prince Edward District School Board (HPEDSB) who provided input through surveys, focus groups and interviews.

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Executive Summary

As an Ontario Public Health Unit, Hastings Prince Edward Public Health (HPEPH) is mandated through the Ontario Public Health Standards (OPHS) to address school health "to achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools."[1] One of the requirements identified in these standards is to support school boards and schools with the implementation of health-related curriculum and school health needs based on the fourteen identified health promotion topics[1] .
HPEPH decided to conduct a situational assessment (SA) to identify how public health could best support the abovementioned needs with two local school boards: the Algonquin and Lakeshore Catholic District School Board (ALCDSB) and the Hastings and Prince Edward District School Board (HPEDSB).

A SA is an early step in a program planning process that provides information to support decision-making by identifying priority populations, goals, objectives, evidence-informed strategies and activities. The six steps of a SA, as per Public Health Ontario[2], are: 1) identify key questions to be answered or objectives; 2) develop a data gathering plan; 3) gather the data; 4) organize, synthesize and summarize the data; 5) communicate the information; and 6) consider how to proceed with planning.

The six objectives established for the project are outlined below with corresponding recommendations. These recommendations were informed through a mixed-methods approach to data collection: a survey of school board staff, a survey of school-related HPEPH staff, eight focus groups (seven with educators and administrators from both school boards and one with HPEPH staff), six interviews with senior leaders in the three organizations, and five interviews with selected school health personnel in other public health units. Over the 10-month duration of the project (June 2018 to April 2019), this work was supported by an Advisory Committee consisting of a representative from each of the two school boards, supporting staff from HPEPH (Healthy Communities Program Manager, School Health Coordinator, Health Promoter and the Social Determinants of Health Public Health Nurse) and a contracted consultant. Prior to the commencement of data gathering, the required ethics review process was undertaken within HPEPH and both school boards.

Through the analysis of collected data, congruent foundational concepts were identified to provide a foundation for future collaboration between HPEPH and the two school boards. The concepts of equity and well-being were shared by both school boards and public health even though terminology differed. It is evident that congruence at such fundamental levels of the organizations provides a solid basis on which to build partnerships and action.

It is encouraging that executive teams within all three organizations endorsed these recommendations, which will allow local school boards and public health to collaboratively implement new structures and processes leading to a school health approach that aims to achieve optimal health and well-being of school-aged children and youth in Hastings and Prince Edward Counties.

Recommendations

Objective 1: Identify priority health needs of two school boards, based on the input of all schools individually from within the 14 topic areas.

A: Recommendations for HPEPH

1.1 It is recommended that HPEPH focus initially on the topics determined to be of greatest need. These include the cluster of mental health topics as highest priority (mental health promotion, violence and bullying, life promotion and suicide prevention, and substance use and harm reduction), followed by healthy eating behaviours and food safety, physical activity and sedentary behaviour, and healthy sexuality. Although these have been identified as priority topics, it is recommended that, over time, supports be available for all 14 topics.

1.2 It is recommended that the degree of public health support provided for a topic should vary depending on its' level of priority.

1.3 It is recommended that efforts be made to access evidence reviews and resources related to the priority topics that are already available in other health unit jurisdictions.

1.4 It is recommended that the needs of identified priority populations be considered when providing public health support.

Objective 2: Identify the related supports required by schools across each of the two school boards for implementation of health-related curricula.

A: Recommendations for HPEPH

2.1 It is recommended that parents be supported through a range of comprehensive interventions in a variety of settings (e.g. community, workplace and schools). Building the capacity of parents to develop awareness and skills and creating supportive community environments was identified to be one of the most valuable supports to promote school health.

2.2 It is recommended to provide resources for educators in partnership with appropriate school board personnel, on sensitive and critical issues that can be used "in the moment" when situations arise or before action can be taken to refer the student elsewhere.

2.3 It is recommended that any professional development sessions provided to educators include as many of the following characteristics as possible:

- Interactive and include small group work
- Held during school hours, taking advantage of staff and committee meetings. This would be especially important when new resources become available. Teachers identify that they prefer to be "walked through" a resource
- Supported with take-away materials
- Follow up to debrief experiences within a few weeks

- Consistent with and build on curriculum expectation
- Offer practical, classroom-based strategies and activities that can be implemented with limited space, equipment, and expertise in the subject matter

2.4 It is recommended that electronic-based, engaging and curriculum-based resources, organized by topic and grade, be made available on the HPEPH website for schools, parents and students.

2.5 It is recommended that material tailored to parents and/or students appearing on the HPEPH web site be structured in a way that is conducive to mobile viewing. Additionally, information should be organized into very short "sound bites" with links to additional information, if desired.

2.6 It is recommended that HPEPH use language consistent with that in the School Mental Health Ontario resource.

2.7 It is recommended to promote mental health literacy to educators, including the continuum of mental health, to illustrate the difference between promoting mental health and addressing mental illness.

Objective 3: Identify how to make best use of a comprehensive health promotion approach/ framework to use for working with schools and School Boards.

A: Recommendations for HPEPH

3.1 It is recommended that the Ontario Ministry of Education's Well-Being Strategy, be adopted as the organizing framework for school health work between HPEPH and HPEDSB, and HPEPH and ALCDSB.

3.2 It is recommended that HPEPH consider existing strategies and adopt approaches that support the work in schools such as: early years, middle years and youth engagement strategies, parent engagement strategy, and a strengths-based approach.

3.3 It is recommended that the 'Foundations for a Healthy School' framework be used at the school level to implement the healthy schools process.

3.4 It is recommended that a school health service delivery model and protocol be developed that includes explanation regarding how health equity and evaluation will be approached within schools.

Objective 4: Increase understanding of the current partnerships between HPEPH and local school boards and schools.

No recommendations were developed for this objective as it was focused on understanding the current partnerships. The current partnership was identified as being in the initial stages of establishing connections and engagement. There is keen interest from both public health and school boards to

achieve a high level of engagement where collaborative planning takes place. Recommendations in Objective 5.0 have been developed to achieve this goal.

Objective 5: Determine strategies for effective collaboration and partnership between HPEPH and local school boards and schools.

A: Recommendations for HPEPH

General

5.1 It is recommended that clear and consistent single points of contact be established for HPEPH and both school boards (at both the board and school levels). Confirm HPEPH key points of contact for each school board at the beginning of the school year. Separate contacts for clinical programs, i.e., immunization, oral health, sexual health, and vision, and one for health promotion services should be established.

5.2 It is recommended that collaboration with KFL&A Public Health be considered regarding service delivery for the ALCDSB.

School Level

5.3 It is recommended that HPEPH facilitate an annual knowledge exchange process among the designated school champions at the end of the school year.

5.4 It is recommended that the starting points for building relationships within schools be the administrators and the designated healthy school champions. These could be either the same or different individuals.

5.5 It is recommended that when HPEPH staff are in a school they should be visible to the school community to increase the awareness of the role and presence of public health.

School Board Level

5.6 It is recommended that HPEPH investigate the possibility of being included in the process of establishing the Board Improvement Plan for Student Achievement and Well-Being (BIPSAW).

5.7 It is recommended that a map of relevant school board and public health committees be established to determine which opportunities are strategically and/or operationally useful for mutual representation.

5.8 It is recommended that HPEPH examine potential ways to work with the respective online data managements tools of the two school boards (HPEDSB - Google Classroom; ALCDSB – Microsoft OneNote).

Recommendations for HPEPH & Schools/School Boards

5.9 It is recommended to develop an evaluation plan for the new school health program.

5.10 It is recommended that school boards and public health jointly examine the internal information-sharing processes and structures for reviewing, disseminating and promoting resources, considering social media as well as formal memos.

Objective 6: Identify internal HPEPH structures and processes required to implement the identified comprehensive health promotion approach/framework within local schools.

A: Recommendations for HPEPH

In addition to the recommendations listed below, recommendations from objective 1.0 through 5.0 that pertain to structure and processes should be applied to this objective.

6.1 It is recommended that HPEPH shift resources to support school health program and service delivery by implementing the following:

- Develop an internal school health team or working group.
- Assign staff to a group of schools to act as the single point of contact for those schools.
- Assign a content lead for each of the 14 school health topics to keep appraised of the evidence, respond to internal or external questions, and be responsible for the quality of the public health resources available.
- Empower clinical staff to act as ambassadors of public health when working in schools, and ensure they are appraised of health promotion key messages and resources. An internal capacity building plan should be developed to provide an orientation for clinical staff about the 14 school health topics, key messages, and resources.
- Public Health Nurses working in secondary school Sexual Health Clinics, should be referred to as Well-Being Nurses and provide information and services for all priority school health topics using a proportionate universalism approach. Consider allocating such PHNs as part of the proportionate universalism approach to address health equity and have this role assigned to priority schools.
- Assign 1.0 FTE School Health Coordinator and/or School Health Manager. This role will oversee activities related to school health and liaise primarily with central school board staff.

6.2 It is recommended that HPEPH work with school boards using the proportionate universalism approach to ensure all schools receive a base level of service while others receive more in-depth service related to level of need, as jointly determined by public health and school boards.

6.3 It is recommended that HPEPH work with community partners including municipalities and other internal public health programs using a comprehensive health promotion approach to address key topic areas in the community and jointly improve the health and well-being of school-aged children and youth.

Recommendations for both Public Health and School Boards

6.4 It is recommended that annual meetings be held between the Medical Officer of Health and the Directors of Education.

6.5 It is recommended that a joint-planning process be implemented between public health and the school boards by developing an operational planning working group and annual operational plan. This method should be evaluated for effectiveness versus a more formal Memorandum of Understanding.

Introduction

Goals & Objectives

The goal of the situational assessment (SA) was to gain an understanding of how Hastings Prince Edward Public Health (HPEPH) should operationalize the new Ministry of Health and Long-Term Care's School Health Standard to meet the overall goal of achieving optimal health of school-aged children and youth (elementary and secondary) through partnership and collaboration with local school boards and schools.[1] See Appendix A for the School Health Guideline. Results of this assessment were used to make evidence-informed recommendations about health and well-being priorities in schools and guide future collaboration between HPEPH and two local school boards and schools in Hastings and Prince Edward (HPE) Counties.

A SA is an early step in a program planning process that provides evidence on which to base decisions. The six steps of a situational assessment, as provided by Public Health Ontario[2], are:

1. Identify key questions or objectives to be answered
2. Develop a data gathering plan
3. Gather the data
4. Organize, synthesize and summarize the data
5. Communicate the information
6. Consider how to proceed with planning

The two school boards of focus for this SA were the Hastings and Prince Edward District School Board (HPEDSB) and the Algonquin and Lakeshore Catholic District School Board (ALCDSB). It is recognized that there are other schools and school boards within the jurisdiction of HPEPH; however, the decision to focus on these two school boards was based on the number of schools and overall percentage of student population within the HPEPH boundaries. See Appendix B for the list of included schools.

Six key objectives were identified:

1. Identify the priority health needs of two school boards, based on the input of all schools, individually, from within the 14 topic areas.
2. Identify the related supports required by schools across each of the two school boards for implementation of health-related curricula.
3. Identify how to make the best use of a comprehensive health promotion approach/framework when working with schools and school boards.
4. Increase understanding of the current partnership between HPEPH and local school boards and schools.
5. Determine strategies for effective collaboration and partnership between HPEPH and local school boards and schools.
6. Identify internal HPEPH structures and processes required to implement the identified comprehensive health promotion approach/framework within local schools.

Methodology

In preparation for the situational assessment (SA), approval was received from the HPEPH Executive Committee and a meeting was held with each school board's Director of Education to gain support to proceed. A Request for Proposals (RFP) was developed to select a project consultant. DU B FIT Consulting was selected, and communication methods were established with the HPEPH Project Management Team, which consisted of the Manager of Healthy Communities, the School Health Coordinator, a Health Promoter and a Health Equity Specialist Nurse. An Advisory Committee was established that included the HPEPH Project Management Team, as well as a representative from each of the two school boards; a Secondary School Principal; and a School Effectiveness System Principal. Terms of Reference were developed for this committee (Appendix C).

Data Gathering Plan

A Data Gathering Plan was developed to outline questions to be answered throughout the SA; data sources; allocation of responsibility for the work; specific methodologies for the surveys, focus groups and key informant interviews; and a glossary (Appendix D).

The overall timeline for the SA project is depicted below. In general, a convergent design was used such that the larger data sets were collected first (surveys), the results of which helped to inform the subsequent methods (i.e., focus groups and key informant interviews). Email correspondence between Advisory Committee members occurred throughout the project.

Table 1: Situational Assessment Timeline

<table>
<tr><th colspan="9">2018</th><th colspan="3">2019</th></tr>
<tr><th>Jan-March</th><th>June</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>March</th></tr>
<tr><td>HPEPH internal approval process</td><td colspan="2">Confirm Data Gathering Plan</td><td colspan="2">Ethics Review</td><td>School and public health surveys</td><td>8 Focus Groups</td><td>8 Key Informant Interviews</td><td>Interviews with 5 External Health Units</td><td>Recommendations confirmed</td><td>Final Report Written</td></tr>
<tr><td>Meetings with Directors of Education</td><td colspan="2" rowspan="2">Advisory Committee Meeting</td><td colspan="2" rowspan="2">Advisory Committee Meeting</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2">Advisory Committee Meeting</td><td rowspan="2"></td></tr>
<tr><td>RFP Process & Selection of Consultant</td></tr>
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Ethics Review

The ethics review process was completed through internal processes by all three organizations. The two school board representatives on the Advisory Committee were instrumental in the completion of this process.

Surveys

Two surveys were undertaken – one with staff from the two school boards and the other with HPEPH staff who had worked with schools in the previous two years.

School Board Staff

An online survey was developed for school staff. This included administrators; educators; auxiliary workers, such as secretaries; Early Childhood Educators (ECEs); Child & Youth Workers; school nutrition coordinators; and others. The Advisory Committee reviewed the questions in advance and the survey was piloted by four representatives of the target population. Approximately one week prior to the circulation of the survey, an email was sent to all intended respondents with a link to a short invitational video from the HPEPH Medical Officer of Health (MOH) introducing the survey and explaining the situational assessment.

The initial email message, with the link to the survey, was sent via the "system-wide memo" mechanism within each school board on October 11, 2018. The survey was open until October 26, 2018, providing respondents a two-week window in which to complete the survey. Reminders were sent via Twitter on two occasions prior to the final survey deadline, as well as a final email reminder.

Public Health Staff

An online survey was developed for HPEPH staff who had worked with schools within the past two years. The survey was piloted by one staff and one manager. Invitations to participate were made through a combination of email and face-to-face approaches, and the process was completed in two waves ending November 2, 2018.

Survey results from both sources were compiled in Word, Excel and PDF formats and forwarded to the consultant for analysis. In some cases, the tables and summaries provided through the survey platform could be used directly however, some manual data manipulations were required for cross-tabulation to answer select questions. Data from the surveys helped to inform the development of questions for focus groups and interviews.

Focus Groups

Focus groups were the second wave of data collection and were held in November 2018. The questions were developed by the Advisory Committee based on the questions in the Data Gathering Plan and were derived from themes that arose from the survey results. Questions were then prioritized for the two-hour timeslots and, to some degree, tailored to the groups.

Eight groups were planned, each with a homogeneous make-up based primarily on school roles. The school board representatives on the Advisory Committee

recruited the participants for Focus Groups using a combination of targeted recruitment and open call. HPEPH covered the cost of teacher-release time and the Boards of Education covered participants' travel costs. The questions, along with the background information, were circulated to participants in advance. A Focus Group Discussion Guide was developed for the Facilitator and participants that included guidelines for the discussion, as well as a disclaimer that information collected would be aggregated and any direct quotes shared in the report would not be attributed to any identifiable individual.

With permission, each session was digitally recorded and transcribed by group and then across all groups by question. Transcriptions were augmented with written notes taken by HPEPH staff. Data was analyzed using a mixed-methods approach consisting of descriptive statistics for quantitative questions and summarization for open-ended questions.

Key Informant Interviews

Key informant interviews were conducted in December 2018. The Advisory Committee selected representatives for the telephone interviews based on their role and key topic areas.

The consultant sent an email to schedule the half-hour telephone interview and forward the list of questions. Questions were developed from the Data Gathering Plan and differed slightly due to the role of the key informant (KI). Each interview was digitally recorded, with the permission of the KI and notes were taken by HPEPH staff as back-up. In most cases, comments were separated by organization (each school board and public health). Where may add insight to a comment, the role or name of the respondent was included.

Review of the 2018 Ontario School Health Managers Network Survey

An environmental scan of school health programs was conducted in Spring 2018 through a provincial group of school health managers in public health. Based on the results of this survey; school health team structure and processes; and similarity to HPEPH in terms of population served, structure and budget; the HPEPH Project Management Team identified six Ontario health units (HUs) to be approached for interviews. Personnel from the six HU were interviewed by phone for approximately 45 minutes.

Recommendation Review Process

Project recommendations were generated using a three-step process. The first draft came from the consultant and underwent review and discussion by the Advisory Committee and the HPEPH Director of Public Health Programs. Revised recommendations were subsequently reviewed by the HPEPH Project Management Team before being included in this report.

Limitations

While this SA provides evidence regarding community preferences and actions from the local education sector to support evidence informed decision-making, it was not intended to be rigorous in nature, but rather provides a baseline understanding. Efforts were made to reduce the limitations for each method of data collection. The limitations identified for each method are listed below.

Table 2: Data Collection Methods Limitations

DATA COLLECTION METHOD	LIMITATIONS
Surveys	• When calculating the response rate, it was not possible to be exact due to the unknown number in the pool under the category of "Other" (e.g., custodians, parents, trustee, chaplain, etc.).
Focus Groups	• Participation from teachers was limited to those who could access substitute teachers for a half or full day.
Key Informant Interviews	• One superintendent spoke on behalf of a Director of Education; the HPEPH School Health Coordinator was not available for an interview.
External Public Health Units	• A limited number of organizations were selected; therefore, there may be others with models and processes of value to consider.

Results

Participation Rates by Data Collection Method

The number of individuals participating in each data collection method of the SA is presented below as both an absolute value and as a percentage.

Table 3: Data Collection Methods Participation Rates

METHOD	TOTAL PLANNED	NUMBER PARTICIPATING	RESPONSE RATE
School Survey	2105	295	14%*
Public Health Survey	16	11	69%
Focus Groups	80	60	75%
Key Informant Interviews	10	8	80 %
External Health Units	6	5	83 %

*Although the school survey response rate appears to be low, this was identified by the school board representatives on the Advisory Committee to be typical for a wide-spread survey. It was reinforced in the Focus Groups that educators are fielding large amounts of information through various channels and need to be selective about responses. It was felt that those who wanted to participate were able to provide input. This reinforces the approach taken during this SA for a mixed-methods data collection strategy.

Congruent Concepts – Well-Being and Equity

Key documents identified by the Project Management Team (Appendix E), representing both public health and education at the provincial and local levels, were reviewed at the beginning of the SA. Key concepts from both sectors were found to overlap and complement one another. This congruence at such fundamental levels of the organizations provides a solid basis on which to build partnerships and action.

Table 4: Aligning Driving Documents

Components	Ministry of Education	Ministry of Health and Long-Term Care
Equity and Inclusive Education	Equity Strategy	Health Equity Guideline
Healthy Schools	Foundations for a Healthy School Ophea Healthy Schools	School Health Standard and Guideline (Foundations for a Healthy School)
Positive Mental Health	Open Minds, Healthy Minds School Mental Health Ontario	Mental Health Promotion Guideline (School Mental Health Ontario)

A. Well-Being

Although the specific terms varied, the concept of well-being was central to both public health and school boards. With respect to school boards, well-being is a key component of their Board Improvement Plan for Student Achievement and Well-Being (BIPSAW) and related School Improvement Plan for Student Achievement and Well-Being (SIPSAW). For public health, well-being is the essence of health promotion initiatives and included in several public health standards and guidelines.

B. Equity

While there is a common commitment in both the public health and education sectors to address the social determinants of health (SDOH), differing language is used. The term "equity" resonated with both sectors. Public health uses the term health equity to describe the ability of all individuals to reach their full health potential regardless of socially-determined circumstances.[3] In education, the concept of equity applies to access to opportunities for education, including other supports within the school system. There was interest expressed by the Advisory Committee members in applying an equity approach to the completion of the SA. While the broader term "equity" would be used in the completion of the SA, the term "health equity" would be used in the context of the specific work conducted by public health within schools.

Proportionate Universalism

Several different approaches to program planning can be taken to promote health equity. Proportionate universalism is "an approach that balances targeted and universal population health perspectives. This approach makes health actions or interventions available to the whole population, but with a scale, intensity and delivery that is proportionate to the level of need and disadvantage in particular populations."[3] Proportionate universalism is recognized by public health as the method to reduce health inequities among groups, while promoting the overall health of the population (see Appendix A: School Health Guideline). This information was shared with the school board representatives of the Advisory Committee and accepted as the method for ensuring equitable public health program and service delivery to schools.

Determining Priority Schools

To effectively apply a proportionate universalism approach, priority populations must be identified. The term priority population is used in public health to describe "those experiencing and/or at increased risk of poor health outcomes due to the burden of disease and/or risk factors for disease; the determinants of health, including the social determinants of health; and/or the intersection between them".[3] It was determined by the Advisory Committee that for purposes of public health working within schools, the term priority populations would be used and that priority schools would be identified.

It was acknowledged that each organization determines priority schools using different data and processes. HPEDSB uses Education Quality and Accountability Office (EQAO) testing results (in grades 3, 6, 9, 10). ALCDSB identified that they use EQAO testing results and the Community Early Development Instrument (EDI) data; rural and isolated information; socioeconomic status (SES); and the prevalence of mental health, addictions or learning disabilities. HPEPH uses the Ministry of Education Opportunities

Index (EOI) and program-level data to identify priority schools. During the February 2019 Advisory Committee meeting, the different methods were acknowledged, and it was decided the three organizations would collectively determine how to identify priority schools and allocate resources and supports appropriately.

Results by Objective

Objective 1: Identify priority health needs of two school boards, based on the input of all schools individually from within the 14 topic areas.

Key Findings and Rationale

Based on the overall results of the situational assessment, the topics perceived to be of highest priority overall are:

1. Mental health promotion
2. Violence and bullying
3. Healthy eating behaviours and food safety
4. Life promotion and suicide prevention
5. Physical activity and sedentary behaviour
6. Substance use and harm reduction
7. Healthy sexuality

When the results were examined for the elementary and secondary panels and for each school board individually, the rankings differed slightly:

Table 5: Topic Prioritization by Elementary and Secondary Schools

Elementary Panel	**Secondary Panel**
1. Mental health promotion	1. Mental health promotion
2. Violence and bullying	2. Violence and bullying
3. Healthy eating behaviours and food safety	3. Life promotion and suicide prevention
4. Physical activity and sedentary behaviour	4. Substance use and harm reduction
5. Life promotion and suicide prevention	5. Healthy eating behaviours and food safety
6. Substance use and harm reduction	6. Healthy sexuality
7. Healthy sexuality (considered healthy growth and development)	7. Physical activity and sedentary behaviour

Table 6: Topic Prioritization by School Board

ALCDSB	**HPEDSB**
1. Mental health promotion	1. Mental health promotion
2. Violence and bullying	2. Violence and bullying
3. Healthy eating behaviours and food safety	3. Healthy eating behaviours and food safety
4. Substance use and harm reduction	4. Physical activity and sedentary behaviour
5. Life promotion and suicide preventions	5. Life promotion and suicide prevention
6. Physical activity and sedentary behaviour	6. Healthy sexuality
7. Healthy sexuality	7. Substance use and harm reduction

The survey provided the first and most detailed insight into the prioritization of the 14 topics. Priority topics were determined by the frequency with which topics were mentioned and their perceived

urgency. For instance, school staff, especially during the focus groups, repeatedly mentioned the "crisis" occurring in their school communities. School staff reliance on public health for accurate and sensitively-worded messaging (e.g., healthy eating and healthy sexuality) also played a role in establishing priority.

It was identified that several topics should be grouped and addressed together due to their interconnectedness. These topics include mental health promotion, violence and bullying; life promotion and suicide prevention; and substance use and harm reduction.

Mental health promotion was repeatedly mentioned as the most pressing issue for both elementary and secondary schools. It was identified that in many cases it encompasses students, their families and staff. Of note is that school staff did not typically differentiate between the prevention of mental illness and promotion of mental health, and the challenges of diagnosis and treatment of mental disorders. Mental Health Leads in both boards reinforced the need to address prevention rather than diagnostics and treatment of mental illness. School staff repeatedly shared that they did not feel equipped to manage the issues when they arose and were not clear about which community resources to approach for help for themselves or their students. The most commonly mentioned mental health resource available to support school staff was School Mental Health ASSIST (now called School Mental Health Ontario).

For several of these topics, potential subtopics were identified. These included self-regulation, anxiety, stress, stigma, body image and addiction to pornography as subtopics for mental health promotion; food insecurity, body image and healthy lunches as subtopics for healthy eating behaviours and food safety; sleep and digital dependency/digital citizenship as subtopics for physical activity and sedentary behaviours; vaping and self-medication as subtopics for substance use and harm reduction; and healthy relationships for healthy sexuality.

Another theme that was identified through the survey and focus groups was the health of school staff. Those at the school level felt that employee well-being was important, and that healthy school staff can serve as strong role models. Both school boards validated this in the key informant interviews and discussed the various components of their individual workplace wellness programs. Very few of the key informants offered specific suggestions regarding how public health could support staff wellness.

It was noted that when working with specific schools, the priority topics would need to be customized from within the broader list based on their need and context.

Identifying Priority Populations

School respondents in the surveys, focus groups and interviews were provided with a list of possible priority populations identified in the OPHS Health Equity Impact Assessment and asked if any should be considered at greater need for public health support for any of the health promotion topics. It was generally acknowledged that all priority populations included in the list were present in local schools and that, similar to the topics, several were frequently clustered together (e.g., those with a disability are often living in low income households and therefore are food insecure and sometimes homeless). This demonstrates the importance of considering the intersectionality of the social determinants of health when planning for priority populations.

Priority populations were identified as age-related groups (children, youth), those living in low income households, students who identify as LGBTQ2+, students who identify as Indigenous, those living in rural and remote areas, students living with disabilities, and transient families (i.e. military families). The only population that was suggested to be added to the list were new Canadians, specifically Syrian refugees. Certain priority populations may experience a greater need for public health interventions, however the identification of priority populations is best achieved at the topic-level. It is noted that gender and sexual orientation needs to be handled sensitively within the context of the school board system.

It was reinforced by respondents that mental health is an area of high priority for all populations listed and this priority extended to parents who were described as often being disengaged.

A: Recommendations for HPEPH

1.1 It is recommended that HPEPH focus initially on the topics determined to be of greatest need. These include the cluster of mental health topics as highest priority (mental health promotion, violence and bullying, life promotion and suicide prevention, and substance use and harm reduction), followed by healthy eating behaviours and food safety, physical activity and sedentary behaviour, and healthy sexuality. Although these have been identified as priority topics, it is recommended that, over time, supports be available for all 14 topics.

1.2 It is recommended that the degree of public health support provided for a topic should vary depending on its' level of priority.

1.3 It is recommended that efforts be made to access evidence reviews and resources related to the priority topics that are already available in other health unit jurisdictions.

1.4 It is recommended that the needs of identified priority populations be considered when providing public health support.

Objective 2: Identify the related supports required by schools across each of the two school boards for implementation of health-related curricula.

Key Findings and Rationale

Participants in the survey, focus groups and interviews were asked about the supports needed in the delivery of health-related curricula. Suggested supports were prioritized based on frequency of mention and the associated rationale for the supports. They have been organized by three levels:

a) School-Board Level

- Single point of contact at public health
- Work with public health to jointly determine how to provide support and distribute resources based on school need

b) School Level

- Designate a well-being champion in each school
- Improve HPEPH web site accessibility
- Resources and supports in building skills for parents and guardians that reinforce the same messages students are receiving at school
- Public health attendance at school events (e.g., curriculum nights) to reach parents
- Well-being support during educational transitioning times (i.e., kindergarten, grade 1, grade 9, out of secondary school)
- Engage existing student leaders in broader health promotion initiatives such as those undertaken as part of Smoke Free Ontario

c) Classroom Level

- Team teaching with public health and teachers
- Public health training teachers to deliver programs [e.g., through Professional Development (PD) days or staff "lunch and learns"]
- Public health providing resources to teachers that are current and applicable

The top two preferences for potential support to educators that were identified in the HPEPH staff survey included **"**team teaching with public health staff and the classroom teacher" followed by "teachers being trained by public health." Public health key informants supported a team approach with teachers being the experts on classroom delivery, and public health focused on evidence-informed content development and training for teachers, where necessary.

Nearly all participants in data collection from schools identified the desire for a single point of contact at public health. However, they stated that it needn't be the same person for both school boards or across all schools. It was understood that the contact person might not be the one to deliver a requested service, but the contact person could act as an intake and referral source to find the service needed.

When focus group participants talked about supports and contacts, the idea of having designated champions or a well-being lead was raised many times. This was felt to be a viable approach in their school community. The respondents agreed that the champion would not need to be part of the physical education staff but could be anyone with an interest in well-being.

It was noted in all forms of data collection that the HPEPH web site needs to be simplified for educators and other school staff to find desired material. It was noted that navigation was challenging. One suggestion for change was to have three separate sections for parents, students, and educators/administrators. The section for each topic should include links to available resources from other credible sources. It was also suggested that Twitter (coordinated through the Curriculum Services Coordinator) could be used to promote resources. Social media, including Snapchat and Instagram, were two social media platforms that could foster student engagement. Focus group participants also identified the need for staff, parents and students to be able to view resources on mobile devices.

Specific to the topic of mental health promotion, the supports identified by school board representatives included consistent messaging to students and their families (e.g., positive messages for life promotion), and clarity on community resources available for specific ages related to diagnosis, treatment and support of mental health challenges. A clear distinction should be made between mental health promotion and the diagnosis and treatment of mental illness. The 3-tiered model in School Mental Health Ontario (formerly known as School Mental Health ASSIST) will help to describe this. As well, in order to make effective change, messages delivered in the community must align with those of the school. A strategy for the effective creation and dissemination of resources should be prepared, in conjunction with the appropriate school board personnel. Educators also identified that, in general, supports were needed when teaching about sensitive topics where incorrect information had the possibility of doing harm. This included topics such as suicide prevention, substance misuse, and aspects of healthy relationships.

School personnel repeatedly identified how important it is for families to hear about, understand and practise the health promotion topics that their children are learning at school such as healthy eating, regulating screen time, and sleep regimens that are within primary control of the family. Participants repeatedly identified how important parents are to the health of their children. School staff stated that they could focus more on the academic achievements of students if the basic needs of the students were met. However, effectively reaching and engaging with parents is a pervasive problem. A frequently mentioned strategy that public health could employ was to attend school events that typically attract a larger number of parents (e.g., curriculum nights, kindergarten orientations, etc.) and use these opportunities as a means of sharing information and offering workshops.

Starting with the school staff survey results and reinforced with focus group data, it became apparent that school personnel were generally unaware of the programs and services offered by public health. Secondary school personnel were largely aware of the clinical public health nurses in their schools but were not aware of other available health promotion services. After hearing more about the topics and resources available through public health, there was a great deal of interest in finding out more and utilizing their services.

As much as educators were interested in professional development from public health, the challenges of finding time and money to support this were identified by many. Educators require consistent, age-appropriate messaging and curriculum-based materials for use in the classroom (e.g. lists of curriculum connections for resources and topics), as well as resources to address these issues in a more systematic way within schools to ensure supportive environments are in place.

A: Recommendations for HPEPH

2.1 It is recommended that parents be supported through a range of comprehensive interventions in a variety of settings (e.g. community, workplace and schools). Building the capacity of parents to develop awareness and skills and creating supportive community environments was identified to be one of the most valuable supports to promote school health.

2.2 It is recommended to provide resources for educators in partnership with appropriate school board personnel, on sensitive and critical issues that can be used "in the moment" when situations arise or before action can be taken to refer the student elsewhere.

2.3 It is recommended that any professional development sessions provided to educators include as many of the following characteristics as possible:

- Interactive and include small group work
- Held during school hours, taking advantage of staff and committee meetings. This would be especially important when new resources become available. Teachers identify that they prefer to be "walked through" a resource
- Supported with take-away materials
- Follow up to debrief experiences within a few weeks
- Consistent with and build on curriculum expectations
- Offer practical, classroom-based strategies and activities that can be implemented with limited space, equipment, and expertise in the subject matter

2.4 It is recommended that electronic-based, engaging and curriculum-based resources, organized by topic and grade, be made available on the HPEPH website for schools, parents and students.

2.5 It is recommended that material tailored to parents and/or students appearing on the HPEPH web site be structured in a way that is conducive to mobile viewing. Additionally, information should be organized into very short "sound bites" with links to additional information, if desired.

2.6 It is recommended that HPEPH use language consistent with that in the School Mental Health Ontario resource.

2.7 It is recommended to promote mental health literacy to educators, including the continuum of mental health, to illustrate the difference between promoting mental health and addressing mental illness.

Objective 3: Identify how to make best use of a comprehensive health promotion approach/ framework to use for working with schools and School Boards.

Key Findings and Rationale

It was determined by the Advisory Committee that the use of the Ontario Ministry of Education's Well-Being Strategy (Figure, 1, Appendix F) would be acceptable for both the school boards and public health. The Well-Being Strategy can be a foundational document for the School Health Standard from the Ontario Public Health Standards and encompasses the Foundations for a Healthy Schools, Equity Strategy, Safe and Accepting Schools and Open Minds, Healthy Minds. Foundations for a Healthy School outlines how schools and school boards can develop healthier schools in partnership with parents and community. A separate strategy for youth engagement was identified as being important.

Figure 1: Ontario Ministry of Education's Well-Being Strategy, 2016.

It was noted through data collection that school personnel do not typically differentiate between public health supports such as clinical services (e.g., immunizations, oral health or sexual health) and health promotion interventions (e.g., tobacco prevention, healthy eating or physical activity programs). It is suggested that when public health staff are in the schools, they should not be "compartmentalized" by service.

When school personnel were asked to identify any frameworks they currently use, the four resources mentioned were "Five Domains of Self-Reg" with Stuart Shanker, Eco Schools, Ophea's Healthy Schools, and School Mental Health ASSIST (now School Mental Health Ontario). This list demonstrates that school staff are more interested in and aware of practical tools, techniques and programs and services to support the delivery of curriculum expectations and build a more positive school environment, than of specific frameworks.

External health units identified approaches used when working with schools such as the Foundations for a Healthy School, youth engagement strategies, strength-based approach, and a model to address equity and evaluation, such as Simcoe Muskoka District Health Unit's conceptual model for integration of SDOH

and health equity. These approaches are in congruence with the key concepts listed in the School Health Guideline.

To equitably allocate public health resources (e.g., staff time and financial resources) to schools, it was identified that HPEPH should use a proportionate universalism approach. This approach ensures all schools will receive a base level of service, while others will receive more in-depth service, based on level of need. Public health focus groups and surveys identified that need may be assessed collaboratively with school boards using public health program-level data, and the Education Opportunities Index (EOI) from the Ministry of Education. Schools could be organized into categories of priority based on criteria established in partnership with the respective school boards. It was noted that HPEPH could develop an internal procedure to outline this process.

A: Recommendations for HPEPH

3.1 It is recommended that the Ontario Ministry of Education's Well-Being Strategy, be adopted as the organizing framework for school health work between HPEPH and HPEDSB, and HPEPH and ALCDSB.

3.2 It is recommended that HPEPH consider existing strategies and adopt approaches that support the work in schools such as: early years, middle years and youth engagement strategies, parent engagement strategy, and a strengths-based approach.

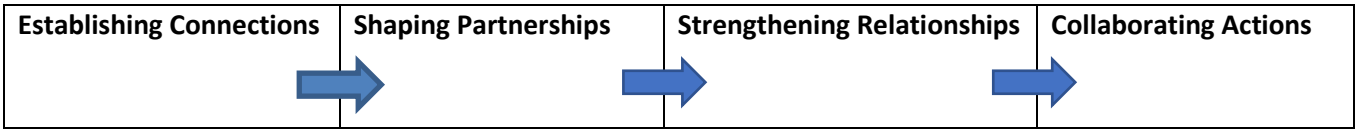
3.3 It is recommended that the 'Foundations for a Healthy School' framework be used at the school level to implement the healthy schools process.

3.4 It is recommended that a school health service delivery model and protocol be developed that includes explanation regarding how health equity and evaluation will be approached within schools.

Objective 4: Increase understanding of the current partnerships between HPEPH and local school boards and schools.

Key Findings and Rationale

The Cross-Sector Engagement Framework from Healthy Schools, BC (Appendix G) was shared with key informants and focus group participants to identify where they felt the current partnership stood on the continuum. The four stages of the framework include establishing connections, shaping partnerships, strengthening relationships, and collaborating actions.



For the relationship between HPEPH and HPEDSB:

1. HPEDSB identified the current partnership as shaping partnerships.
2. HPEPH identified the current partnership as shaping partnerships.

For the relationship between HPEPH and ALCDSB:

1. ALCDSB identified the partnership was tied between shaping partnerships and strengthening relationships.
2. HPEPH identified the current partnership as establishing connections.

Respondents at the school board level were more likely to rate the partnership between their board and HPEPH higher on the continuum if they had worked more closely with the HPEPH School Health Coordinator. Secondary school staff were more likely to describe the current partnership beyond the establishing connections stage due to their awareness of clinical public health nurses in their schools. Public health nurses working with secondary schools in both clinical and health promotion capacities, and staff who worked on a specific time-limited project with school boards, were more likely to rank the current level of partnership higher.

Overwhelmingly, the greatest challenge to an effective partnership at the school level was not knowing enough about public health including the resources available, how to access resources, and, most importantly whom to contact. Few school personnel who provided input though the survey and focus groups were aware of or accessed the support/services of the HPEPH School Health Coordinator. This is likely due to the mandate of the School Health Coordinator to connect at a board level and the lack of public health staff connecting directly with schools to provide support.

No recommendations were developed for this objective as it was focused on understanding the current partnerships. There is keen interest from both public health and school boards to achieve a high level of engagement, where collaborative planning takes place. Recommendations in Objective 5.0 have been developed to achieve this goal.

Objective 5: Determine strategies for effective collaboration and partnership between HPEPH and local school boards and schools.

Key Findings and Rationale

Although the general relationship between public health and the school boards was described as positive by both parties, suggestions for improvement were received. These suggestions specifically fall under the categories of communication, shared planning and collaboration/information sharing. Participants in surveys and focus groups felt the implementation of these suggestions would lead to, not only better operational processes, but also the development of improved trust and a commitment to work together strategically and innovatively in the longer term.

Communication

Focus group participants from both public health and school boards overwhelmingly identified the need for clear points of contact and understanding of lines and processes for communication. It may be necessary to establish different points of contact within the organizations for different purposes (e.g. clinical vs. health promotion programs). These contacts should be used for proactive and reactive communication in both directions, as well as emergency situations (e.g. outbreaks). Another key

communication support identified by both public health and school boards was that HPEPH has had historical difficulty in accessing online platforms such as Google Classroom, which is used by HPEDSB. Improved access for communication and collaboration is necessary to make efficient use of internal systems of school boards to implement resources and services. It was identified that communication should also include an annual event for well-being champions, preferably face-to -face, and could be considered in "families of schools" groupings. At the school level, it was identified that the starting points for building relationships within schools are the administrators and the designated "well-being champion"; this could be either the same or different individuals.

Shared Planning

Both public health and school boards undertake rigorous planning annually. Through consultation, it became evident that neither party was aware of the timelines and processes for the other's planning cycles and responsible parties, leading to missed opportunities for public health to support the well-being work of school boards. Involving HPEPH in strategic and board improvement planning for well-being would assist in identifying shared goals and would help to establish understanding and connections between parties. This would result in purposeful resource allocation by HPEPH, resulting in the development of relevant impactful programs and services for school communities. Developing shared goals and agreeing to feasible joint projects was indicated as a way to maintain the connection between public health and school boards to maximize impact on school communities. An example provided by public health was the evaluation of the implementation of the new school health approach. Both school boards should be consulted and ideally involved in the evaluation planning process to ensure the needs of all stakeholders are being met, and the final plan should be agreed upon by both public health and school boards.

Collaboration and Information Sharing

Collaboration was identified at all levels of data gathering. ALCDSB boundaries span two public health unit jurisdictions. It was identified by this school board that an ongoing relationship, similar to the strong partnership that exists between KFL&A Public Health and ALCDSB, should be pursued. Another key area for collaboration is to liaise with school staff, such as social or youth workers and guidance staff in the secondary schools, to support their work in mental health promotion. However, it should be noted that requests for school board staff participation on HPEPH projects and initiatives should be streamlined to increase efficiency. Roles could range from an active role (e.g. on-going membership on committees or leading a project or development/revision of resources), to a consulting role with more infrequent connections (e.g. providing feedback on strategic plans). Elements of success were identified through discussions with other public health units and included strategies to build relationships with school administrators. To form successful partnerships with schools, public health should assist schools with achieving their goals by supporting well-being initiatives. Data sharing agreements were common in situations where there was a formal agreement between public health and school boards.

A: Recommendations for HPEPH

General

5.1 It is recommended that clear and consistent single points of contact be established for HPEPH and both school boards (at both the board and school levels). Confirm HPEPH key points of contact for each school board at the beginning of the school year. Separate contacts for clinical programs, i.e., immunization, oral health, sexual health, and vision, and one for health promotion services should be established.

5.2 It is recommended that collaboration with KFL&A Public Health be considered regarding service delivery for the ALCDSB.

School Level

5.3 It is recommended that HPEPH facilitate an annual knowledge exchange process among the designated school champions at the end of the school year.

5.4 It is recommended that the starting points for building relationships within schools be the administrators and the designated healthy school champions. These could be either the same or different individuals.

5.5 It is recommended that when HPEPH staff are in a school they should be visible to the school community to increase the awareness of the role and presence of public health.

School Board Level

5.6 It is recommended that HPEPH investigate the possibility of being included in the process of establishing the Board Improvement Plan for Student Achievement and Well-Being (BIPSAW).

5.7 It is recommended that a map of relevant school board and public health committees be established to determine which opportunities are strategically and/or operationally useful for mutual representation.

5.8 It is recommended that HPEPH examine potential ways to work with the respective online data managements tools of the two school boards (HPEDSB - Google Classroom; ALCDSB – Microsoft OneNote).

Recommendations for HPEPH & Schools/School Boards

5.9 It is recommended to develop an evaluation plan for the new school health program.

5.10 It is recommended that school boards and public health jointly examine the internal information-sharing processes and structures for reviewing, disseminating and promoting resources, considering social media as well as formal memos.

Objective 6: Identify internal HPEPH structures and processes required to implement the identified comprehensive health promotion approach/framework within local schools.

Key Findings and Rationale

Key elements for structuring and working with schools were identified through the various data collection methods when exploring objectives one through five. Gaining an understanding of the needs of educators and the related supports for implementation of health-related curricula, of the various frameworks and approaches to use for working with schools, and of strategies for effective collaboration and partnership with schools and school boards, led to several possibilities for the development of a new HPEPH school health structure and related processes.

Public Health Structures

Participants in the public health focus group discussed how HPEPH could support health promotion efforts in schools. It was generally expressed that, if the school health topics are to be addressed, a different and enhanced allocation of HPEPH staff will be required. There was general support for the establishment of a school health team as a possible means to accomplish this goal.

It was also identified that relationships with schools need to be fostered through consistent and on-going connections with schools. The staff of the HPEPH School Health Team should be assigned to a group of schools as the single point of contact for those schools. It was suggested that connecting with identified 'well-being' contacts in the school would be beneficial. This was felt to be achievable from the education perspective. In addition to this, HPEPH content leads should be identified for each of the 14 topics to keep abreast of the related evidence and resources and to support the staff working with schools on specific topic areas.

The public health focus group discussed the role of clinical staff working in schools. It was felt that staff providing clinical services should also be able to convey the health promotion messages; however, they are busy with clinical work and the health promotion aspect would take lower priority. Staff should be supported to learn about the school board and school improvement plans as they relate to well-being; the school health approach; and health promotion key messages and related resources for priority topics. This will enable them to act as an ambassador for health promotion areas when working in schools, as the need arises, such as connecting educators/administrators to the correct HPEPH content lead for the health topic of interest.

Public Health Nurses working in the sexual health program in secondary schools should take a more generic role of 'Well-Being Nurses'. It was deemed that this broadened role would eliminate the stigma attached to going to see the 'Sexual Health Nurse' and expand the scope of their role to support priority health promotion topic areas.

To improve coordination at the school board level, it was identified that a full-time School Health Coordinator and/or School Health Manager is required. Staff secondment was an element of work with several of the health units interviewed. Two health units had staff working within school boards while

one health unit had a school employee working within their health unit. These approaches were found to be successful arrangements that primarily assisted with communication, planning and collaboration between health units and school boards. Exploring the specific school board committees on which it would be advantageous to participate was suggested.

Through external public health unit interviews, it was found that all, but one of the five health units interviewed have a team of staff working on the topic of school health; all health units address, to some degree, the 14 health promotion topics outlined in the Ontario Public Health Standards (2018); and all have a framework in place to guide their work. It was important that, internal to public health, there be coordination among those providing any service to schools. Extending beyond this, coordination of service to parents was also identified as essential to ensuring consistency of messages.

Public Health Processes

For HPEPH processes, it was identified that the proportionate universalism approach should be used as a consistent service delivery model. At the school level, under the jointly accepted 'Well-Being Strategy,' the 'Foundations for a Healthy School' process should be utilized but in a flexible way to meet needs of individual schools. Other approaches to consider adding include a broad youth engagement strategy that goes beyond the school setting, a strength-based (asset-based) approach, and parent engagement. Specific to curriculum support, it was deemed that building educator capacity would be more effective than providing direct service in classrooms.

At the Advisory Committee meeting in February 2019, it was validated that partnership at the senior level of the two systems was important and could be recognized with annual meetings of the Medical Officer of Health and Directors of Education. It was agreed that a joint-planning process would be beneficial for multiple areas of collaborative work. The opportunity for public health to participate in each of the school board BIPSAW processes was discussed as a possibility but would require additional exploration. Each school board is at a different stage of incorporating community partners into their planning process.

Planning and Evaluation

Key informant interviews with school boards indicated there was little need for a formal Memorandum of Understanding (MOU) between HPEPH and either board; however, an annual operational plan was seen to be helpful. The Operational Plan would include details of procedures related to the working relationship with each school board and HPEPH such as sharing data, the process used for the identification of priority schools, communication processes and channels, and the processes for the distribution of materials. Once the Operational Plan is established, only minor adjustments would be necessary in subsequent years. The creation of an Operational Planning Working Group, with representatives from the three organizations, would be required to develop the initial plan and update annually. Since HPEPH was interested in a more formal Memorandum of Understanding, this could be revisited as the Operational Plan method is evaluated.

The Operational Plan could contain a matrix to identify the various supports needed by educators as expressed in the survey and focus groups, and the resources that are available from public health to meet those needs, organized through the proportionate universalism approach and varying levels of service delivery. Joint decision-making is required for the selection of schools for the levels of service delivery under the proportionate universalism approach.

Based on information from the public health focus groups, external public health units and key informant interviews, it was highlighted that a specific partnership arrangement should be made with HPEPH and KFL&A to ensure consistent implementation of public health programs and services for the ALCDSB schools. In addition, it was discussed at the Advisory Committee to work more broadly in the community to meet the goals of supporting student health and well-being.

Finally, an evaluation plan to monitor the implementation of new school health programs and services, based on the data collected from the SA, would be welcomed by the three organizations.

Decision-making and implementation of the HPEPH structures and processes will need to be addressed in the next phase of planning by the HPEPH Executive Team and in collaboration with HPEDSB and ALCDSB Directors of Education and other school board key stakeholders.

A: Recommendations for HPEPH

In addition to the recommendations listed below, recommendations from objective 1.0 through 5.0 that pertain to structure and processes should be applied to this objective.

6.1 It is recommended that HPEPH shift resources to support school health program and service delivery by implementing the following:

- Develop an internal school health team or working group.
- Assign staff to a group of schools to act as the single point of contact for those schools.
- Assign a content lead for each of the 14 school health topics to keep appraised of the evidence, respond to internal or external questions, and be responsible for the quality of the public health resources available.
- Empower clinical staff to act as ambassadors of public health when working in schools, and ensure they are appraised of health promotion key messages and resources. An internal capacity building plan should be developed to provide an orientation for clinical staff about the 14 school health topics, key messages, and resources.
- Public Health Nurses working in secondary school Sexual Health Clinics, should be referred to as Well-Being Nurses and provide information and services for all priority school health topics using a proportionate universalism approach. Consider allocating such PHNs as part of the proportionate universalism approach to address health equity and have this role assigned to priority schools.

- Assign 1.0 FTE School Health Coordinator and/or School Health Manager. This role will oversee activities related to school health and liaise primarily with central school board staff.

6.2 It is recommended that HPEPH work with school boards using the proportionate universalism approach to ensure all schools receive a base level of service while others receive more in-depth service related to level of need, as jointly determined by public health and school boards.

6.3 It is recommended that HPEPH work with community partners including municipalities and other internal public health programs using a comprehensive health promotion approach to address key topic areas in the community and jointly improve the health and well-being of school-aged children and youth.

Recommendations for both Public Health and School Boards

6.4 It is recommended that annual meetings be held between the Medical Officer of Health and the Directors of Education.

6.5 It is recommended that a joint-planning process be implemented between public health and the school boards by developing an operational planning working group and annual operational plan. This method should be evaluated for effectiveness versus a more formal Memorandum of Understanding.

Lessons Learned

As conducting a situational assessment of this scope was a novel undertaking by HPEPH, capturing the lessons learned was viewed to be important to inform future internal projects of similar magnitude. As well, external health units interested in exploring how they work with their school boards, may benefit from learning about the process undertaken and these findings. The following list was generated by members of the Advisory Committee.

Overall Process

1. Initial meetings between Medical Officer of Health and Directors of Education to gain support for situational assessment before beginning the work was a key to success.
2. Knowing the schedules of the school boards is key. For example, timelines for data collection were set to avoid such things as report card writing times and take advantage of key administrator meetings and existing system communication opportunities.
3. Having a representative from each school board on the Advisory Committee was critical. The benefits of this included:
    a. Providing the unique education perspective to the advisory process
    b. Assistance with the ethics review/approval process, approval of and implementation of data collection tools, survey promotion/distribution, and recruitment for focus groups and key informant interviews
    c. Sending messages to education representatives on behalf of the Advisory Committee
    d. Arranging meetings with key informants and focus group participants, including the locations for face-to-face meetings
    e. Advice on wording and terminology to use or avoid
    f. Insight and advice on recommendations
4. A data gathering plan, approved first internally and then with the Advisory Committee, was essential as it kept the team on track, not only during the data collection phases, but also as a focus for summarizing the results and it was an important element of the ethics applications for both school boards.
5. It was important to establish an effective communication mechanism for the consultant to interface with the Project Management Team and the Advisory Committee.
6. A primary internal contact at HPEPH was very helpful for the consultant.
7. The planning phase requires more meetings than the data collection and report writing phases.
8. The process associated with the situational assessment served as an intervention in and of itself, as relationships between public health and the school boards were improved and the organizations became much more familiar with each others' operations.

Data Collection and Analysis

9. It is important to consistently highlight to participants that the questions are about health promotion, not clinical services for topics such as oral health, sexual health, and immunization.

10. In topic prioritization questions, it is important to identify that topics are prioritized by level of importance, regardless of whether they believe there are adequate supports currently in place.
11. The survey platform used allowed the project management team to choose the parameters for running reports (e.g., limiting the responses for certain questions). However, the user agreement required surveys to be deleted within 60 days of the survey closing, which unfortunately limited the ability to return to the surveys to run additional reports at a later date.

Conclusion

This school health situational assessment identified key priority topics, supports, structures and processes required to enhance the school health program in HPE Counties. It also provided additional benefits including increasing awareness of public health resources for local educators and strengthening the existing partnerships between HPEPH and the two school boards, HPEDSB and ALCDSB.

For next steps, it is recommended that this report be endorsed by the three organizations involved (Algonquin Lakeshore District School Board, Hastings Prince Edward District School Board and Hastings Prince Edward Public Health), be communicated broadly to participants and stakeholders, and that the implementation of the recommendations be initiated.

Overall, the recommendations, when implemented, will create a foundation for an effective school health program and demonstrate the benefits of collaboration between public health and school boards to support optimal health and well-being of school aged children and youth in HPE Counties.

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Appendices

A: MOHLTC School Health Guideline

MOHLTC School
Health Guideline 20

B: Schools within the Districts of the two School Boards

Schools Within
Health Unit Jurisdict

C: Terms of Reference for Core Working Group

Terms of Reference
August 24 2018.doc

D: Data Gathering Plan (and Glossary)

Data Gathering
Plan & Glossary FIN

E: Key Documents for Review

Key Documents for
Review.docx

F: Ontario Ministry of Education's Well-Being Strategy

Ontario's
Well-Being Strategy

G: The *Key Components of Cross-Sector Engagement Rubric,* Healthy Schools BC

Healthy Schools BC
Cross-Sector Engage

Abbreviations

Algonquin & Lakeshore Catholic District School Board - ALCDSB

Board Improvement Plan for Student Achievement and Well-Being – BIPSAW

Director of Education – DOE

Director of Health Promotion – DHP

Education Quality and Accountability Office – EQAO

Focus Group – FG

Hastings and Prince Edward Counties – HPE

Hastings and Prince Edward District School Board - HPEDSB

Hastings Prince Edward Public Health – HPEPH

Key Informant – KI

Key Informant Interviews – KII

Kingston, Frontenac and Lennox & Addington Public Health – KFL&A PH

Medical Officer of Health – MOH

Mental Health Lead – MHL

Mental Health Promotion – MHP

Ministry of Health and Long-Term Care – MOHLTC

Ontario Public Health Standards – OPHS

School Improvement Plan for Student Achievement and Well-Being – SIPSAW

Situational Assessment – SA

Student Success Lead – SSL

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