

**SCHOOL HEALTH PROGRAMMING  
TO MEET THE NEEDS OF  
AT RISK STUDENTS**

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*"I would like to dedicate this project to my family, friends, and colleagues who so patiently supported this work."*

## *Abstract*

*"Most health problems in North America today result from health compromising environments, as well as from personal behaviors established during the school years. Many people believe and expect adolescents to be healthy, yet they are the only group to experience an increase in mortality and morbidity since 1960 (Curtis, 1992). Although prevention is a difficult concept to sell, children who are at risk for school failure are also at risk for poor health. Schools are already serving as centers for delivering varied services and are establishing links between students, families and community resources (Graham & Uphold, 1993). Although there are literally thousands of "canned" health programs available to schools and teachers, there is little available for at risk students. Government and administrators have set the standard for mainstream youth and many teachers are not trained in adolescent development and health promotion. Public health nurses and community agencies are not being utilized for promoting healthy lifestyles. The most successful health programs have been those involving youth themselves. To reach these young people most in need, we need to find ways, in the services and information we offer, to fit into their frame of reference and their way of doing things. A health needs assessment was conducted by means of focus groups with at risk students at an alternate school. The data was analyzed for themes. A special health activity will be planned using this data."*

### *Acknowledgments*

*"I would like to thank 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services, staff, and students for enabling me to undertake this creative activity. A special thank you to Dr. Doug Scotney, executive director, and my two University of Lethbridge advisors, Dr. Rick Mrazek and Dr. Lance Grigg for their support, guidance, and patience. I would also like to thank the Wellness Services staff of the Chinook Health Region for their dedication to the health and well-being of all children."*

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## **BACKGROUND TO THE PROBLEM**

### **Adolescent Development**

In some cultures adolescence is marked by rituals and ceremonies, while in Western culture the transition from childhood to adulthood requires passage through several years of adolescence; a period of life frequently acknowledged as the most troubled, the most stressful, and the most unpleasant of all stages of development (Lefrancois, 1980). Western culture does not tell its children when they have become men and women; they must discover this for themselves.

Adolescence is the only time in the life cycle involving physical changes as rapid as those of infancy. Pubertal maturation affects youths not only physically but socially and psychologically. Their physical changes often overshadow developments in the cognitive or affective domains.

According to Piaget, it is during early adolescence that the cognitive processes approach the level of formal operations. At some point an adolescent is able to reason hypothetically and deduce consequences (Piaget, 1972). Elkind (1983) also proposes that before formal, operational, thought, and "to think about thinking", the adolescent has the emergence of two cognitive structures:

1. "everyone is thinking about what they are thinking about - themselves (The Imaginary Audience)"

2. "he or she believes that they are the object of everyone's attention (The Personal Fable)". As a result he or she logically concludes he or she is unique, important and invulnerable.

Erickson (1968), in contrast to Piaget's cognitive development theory, focuses on the fifth stage, out of a series of eight, of psychosocial development in the human lifespan. An adolescent is forming an identity and yet at the same time suffering identity diffusion. There is less reliance on parent's for emotional support and increasing reliance on peers. Whaley and Wong (1987) support Erickson's views. They believe that frustration exists for adolescents as they attempt to define their roles in achieving a sense of identity and their sense of the depressing distance between the utopia they envision and the actual world. While adolescents are seeking an identity, they are completing the separation process from the family and focusing on career-directed activities. This process often begins in early adolescence and can continue until the middle or late twenties.

### **Adolescent Health Behaviors**

Most health problems in North America result from health compromising environments, as well as personal behaviors established during the school years and transferred into adulthood. Few health care providers are trained in adolescent health care (Lear, Foster, & Wylie, 1985). Furthermore, society in general is not concerned with the health of adolescents, as many people believe

that adolescents

are and should be healthy, yet they are the only group to experience an increase in mortality and morbidity since 1960 (Curtis, 1992).

The adolescent years are a developmental period when risk taking behaviors and hazardous environments are particularly consequential. The risks that teens often take cause great frustration to their parents, as well as being a source of genuine concern. Parents, teachers, and the media attempt to teach adolescents about harmful consequences of some risks. However, why do teens continue to take risks?

Some risk taking is normal and even desirable in the adolescent years. When adolescents take risks, they are often attempting to demonstrate independence to their parents or to those they have emotional attachments to. Risks often assist them to make better choices in the future. The risks which are the most worrisome are those that place adolescents in potentially harmful situations. Wittacker (1997) has identified three areas of unhealthy, risk taking behaviors:

1. early or promiscuous sexual activity
2. smoking and drug use
3. problem drinking



Often the same teen will engage in all three types of risks. The results of these risks may be:

- a. unintended injury
- b. health problems
- c. trouble with the law
- d. conflicts with family
- e. failure in school

Scales (1995) believes that all problems, whether health based or not, are interrelated. This is especially true for those youths who are disadvantaged socioeconomically and belong to a diverse group (Dougherty et. al., 1992).

## **THE PRESENT PROBLEM**

### **School Health Programming to Meet the Needs of At Risk Students**

Schools are already serving as centers for delivering varied services and are establishing links between schools, students and families, and a network of community resources (Graham and Uphold, 1993). Since children's knowledge and beliefs are influenced and largely shaped by the educational system, the school is an important site for instilling health promotion concepts and programs to reduce risky health behaviors. In addition, schools can help shape the behaviors of parents who have enrolled children.

Dunkle (1990) believes that prevention is a difficult concept to sell to adults, let alone to adolescents. Most of us preach it, but few of us practice it. Anyone involved with education and health knows that the same children who are at risk for school failure are also at risk for poor health. Health Canada links low income with poor health. It is the number one determinant for poor health (Health Canada, 1996). At risk young people are more likely to have untreated health problems while living in a dangerous environment. This is especially true of many aboriginal youths. Adolescents at risk are also less likely to have accurate information about good health. Not surprisingly, they are least likely to have a strong sense of self esteem to translate health knowledge into healthy, everyday behaviors.

There are literally thousands of "canned" health programs available to schools and teachers. Although some programs have been highly successful with mainstream youth, there have been few programs available for at risk youths. What is available has failed to consider literacy levels of students, diversity issues, and the emotional and social development of adolescents. Many teachers, not trained in adolescent development and health promotion, are placed in charge of the health curriculum. Little or no input is received from students on important health issues which concern them. The most successful student health programs are those developed and run by students (Gillis, 1996). Some junior high schools

in Lethbridge have set aside twenty minutes for health/advisor period. The majority of this time is spent taking attendance and doing classroom business according to teachers (Wolkowycki, 1997). Little effort is made for health needs.

In the past, health curricula has been set by government with little or no flexibility for each school community. The Alberta Education health curriculum has had no revisions since 1988 (ATA,1988). The expert model driven approach, "we'll tell you what you need", has been the norm. Many educators even desire "canned" health curricula. Community agencies and public health nurses are not being utilized for health promotion in schools, particularly those involving at risk youth.

Public health nurses are the single most important group of health care providers who can play a key role in the movement toward proactive partnerships between schools, families, and the greater community (Graham and Uphold, 1993). Historically nurses have been involved in keeping school children healthy so that they could reach their full learning potential. The traditional knowledge base of nurses is an integration of biophysiologic, psychosocial, and cultural concepts, which contrasts sharply with the current biomedical model that focuses on technology and disease cures.

To reach these young people most in need, it is we, not they who must change. We need to stop blaming them for failing to fit into the structures, forms,

and delivery systems we have created (Dunkle, 1990). Rather, we need to find ways, in the services and information we offer, to fit into their frame of reference and their way of doing things. Anything less is not enough.

## **METHODOLOGY**

One of the major flaws of school health programming is that decisions about health curricula are made at the top by governments and administrators. Often a "canned" health program directed at mainstream youth is delivered. There has been no input from the at risk students.

In the initial planning stages of this project, a tobacco health promotion activity was contemplated as approximately 95% of the students at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services are tobacco users. This idea was set aside, since it was a top down decision. Using the community development perspective, a health needs assessment would be conducted with at risk students who would be able to express their health needs and priorities (Edmonton Social Planning Council, 1988). For its obvious advantages, a school health questionnaire was designed with ideas from school personnel and public health nurses (see Appendix A). However, in view of low literacy levels of at risk students, four questions were adapted from this questionnaire to be used with a focus group approach (see Appendix B).

Other

projects at 5<sup>TH</sup> on 5<sup>TH</sup> had used focus groups successfully. The students would also gain added experience in the participation of a focus group.

### **Population Sample**

The sample of students for the focus groups would be those attending one or more of the programs at 5<sup>TH</sup> on 5<sup>TH</sup> (see Appendix C). Three programs were used for groups. Group A members were from the "Quest For Success" program which focuses on self-esteem building. Group B participants were from an academic program and a job skills club. These particular programs were chosen by school staff as they were already functioning. Some of the other programs were just beginning to admit students for September enrollments.

The ages of the students varied between seventeen and twenty four years. Some live with their families, but most live independently on social assistance. Some of the female students are single mothers or are pregnant. Many students, face a daily struggle for food, clothing, shelter, and other basic necessities. Poverty exists. The majority have no support systems and are struggling to obtain meaningful work. Self-esteem is low. Most have had challenges in the traditional school system.

### **Focus Groups**

Carey (1994) believes that focus groups provide insight into beliefs and attitudes that underlie behavior. Data regarding perceptions and opinions are

enriched through group interaction because individual participation can be enhanced in a group setting. The focus group technique is especially suited for problems in health research, where complex issues are often best explored through a qualitative approach. The focus group approach is particularly useful for a needs assessment, exploring a new concern, or studying a new population. This method has been useful for development or refinement of instruments and for the enrichment and exploration of research results, particularly if results appear contradictory.

The logistics of the focus groups were planned. After several consultations with the executive director at 5<sup>TH</sup> on 5<sup>TH</sup> and a presentation at a staff meeting, it was decided that the principal investigator would be the groups's facilitator. The teacher of the particular group would serve as recorder. The recorder was expected to be familiar with the project proposal and was instructed to collect the data verbatim. The recorder would also observe non-verbal behaviors in the groups. A private classroom with chairs and tables would be arranged in a circle format. The time best suited for a focus group at 5<sup>TH</sup> on 5<sup>TH</sup> was 10:30 a.m., as many students began their classes. A snack of juice and muffins would be served. According to Carey (1994), food facilitates conversation. It also fills a nutritional need for those students who did not have breakfast. A "toilet paper" ice breaker activity would be

optional. One teacher felt that the ice breaker activity was not suitable for all the groups. There would be no recording equipment.

Being the group facilitator, my preparation involved keeping an alert and calm mental state. I was to encourage responses with caution exercised towards disagreeing or endorsing. It would be necessary to remain neutral to the context and at the same time encourage candid responses. I needed to be careful that my background in adolescent health did not interfere with the focus group process. Additionally, alertness to the non-verbal behaviors of the students was necessary.

Before the focus groups began, a letter of consent would be read to the students (see Appendix D). A written copy would also be distributed. Any student would be free not to participate.

The participant rules would be reviewed with the students (see Appendix E). Students would be able to add any other rules beneficial to their group. Students would be reminded that there are no right or wrong answers to the questions. A brief plan of the session would be outlined (see Appendix F). Prior to the consideration of the questions, the definitions of "health", "need", and "needs assessment" would be reviewed for the purpose of the focus groups (see Appendix G). Highly technical and verbose definitions would be simplified. Easel pages of the four questions, definitions, and the plan for the group session would be placed on a nearby wall. At the conclusion of the sessions, students would be

encouraged to fill out a mini-evaluation of the focus group (see Appendix H).

Door prizes

would be drawn at the end of the session. After dismissal, the recorder would document the non-verbal behaviors of the students (see Appendix I).

### **Predictions**

Since hypotheses are generally not stated in qualitative research, predictions can be made (Polit & Hungler, 1993). My predictions were as follows:

1. Students at 5<sup>TH</sup> on 5<sup>TH</sup> would identify psychosocial health issues as opposed to physical ones.
2. Literacy skills involving speaking and writing was expected to be poor, as these students had already failed both academically and socially in mainstream schools.
3. Since many at risk students have come from very negative environments with personal and social challenges, it was expected they would exhibit difficulties in finding strengths at 5<sup>TH</sup> on 5<sup>TH</sup>.
4. It was predicted that the public health nurse would be viewed as another authority figure who "gives needles and gives information on baby care".

### **RESULTS**

Students were greeted upon their arrival into the classroom and encouraged



to participate in refreshments of muffins and juice. No student refused. (This step was placed at the beginning of the group session plan, as not all students arrived at the same time. It was an excellent way to establish rapport and have the students get settled.) There had been three groups scheduled for consultation, but Group B was a combination of an academic program and a job skills program. Group A was from a "Quest for Success" program and had been together for a week. A male student from Group A was absent which made the group extremely small. The students in the combined Group B had been several weeks together, with the exception of one student. The House Rules of 5<sup>TH</sup> on 5<sup>TH</sup> were reviewed. To complement the house rules, these statements were added: "all responses are valuable", "there were no right or wrong answers to the upcoming four questions", and "the responses to the questions were confidential". The students were in agreement with the complementary statements.

In Group A, conversation began immediately, as the students partook of refreshments. In Group B, the students helped themselves to snacks, but did so with little chatter and enthusiasm. The students in Group A expressed appreciation for the snacks, but the students in Group B were very reserved and quiet at this time. After my brief introduction which included my interest in young adults' health issues, the letter of consent was administered. There were no further concerns or questions from the students. No students declined participation at the

start or during the groups.

Prior to the consideration of the four focus group questions, a brief lecturette on the definitions was presented. The definitions which were taken from academic papers were simplified. "Health" was defined as "a process or a state or a condition which one strives for. It has physical, social, emotional, and spiritual aspects". It has now been recognized that the spiritual component of an individual's health has much to do with his or her overall well-being. This is especially true with aboriginal culture. A "need" was defined as "something that is required or wanted or a combination of something that is both essential and desirable". Several examples of life sustaining needs were used (rest and comfort, food, clean air, etc.) The "wanted" aspect of a need was self-explanatory. The "combination" aspect of a need was demonstrated by way of an example. Perhaps a teen recreation centre is required, but at the same time it is desired by many students. The "needs assessment" was explained as "a process for finding out who has the need, how important the need be filled, and the number experiencing the need". The students appeared comfortable with the definitions. Students were reminded to use these definitions when answering the questions.

### **Student Responses to the Four Questions (Verbatim)**

1. "What are the five most important health issues at 5<sup>TH</sup> on 5<sup>TH</sup>?" (There was no distinction made as to whether these health issues would be personal or ones

affecting other students.)

#### Group A

- depression,
- unprotected sex,
- fighting addictions,
- violence with family, other students, and in relationships,
- smoking (cued by recorder),
- self-esteem,
- peer pressure with drugs,
- sexual harassment,
- acceptance of alcohol misuse and abuse and that getting drunk is cool,
- media pressures for looks, skinny girls and buffed guys,
- eating disorders.

#### Group B

- stress,
- pregnancy,
- depression,
- drugs,
- sexually transmitted diseases,
- AIDS,

- abuse - physical,
- harassment - sexual, verbal.

2. "How could we learn about these health issues?"

Group A

- discussion groups,
- books or movies on certain subjects,
- speakers coming in that have gone through the experiences

Group B

- having a counselor on site,
- health unit,
- family doctor,
- pamphlets,
- seminars/workshops/group discussions,
- health classes,
- friends and family,
- teachers,
- pastor,
- Sexual Health Centre.

3. "How does 5<sup>TH</sup> on 5<sup>TH</sup> now help students to have good health?"

Group A

- giving an alternative to regular school so you can get through at your own pace,
- Quest for Success for self-esteem,
- helping students find jobs so they can have better futures,
- puts your feet on the ground so you don't have to depend on others,
- teachers and staff are friendly, cool teachers,
- condom posters,
- native literacy and the Blackfoot culture (cued response),
- combination of all of their programs when you have no where to go,
- help bring your self-esteem up.

Group B

- youth care workers/counselors,
- Life Management Class, a guest speaker on AIDS,
- job search, working you feel better about yourself.

4. "How can the Public Health Nurse better assist students at 5<sup>TH</sup> on 5<sup>TH</sup> to deal with health concerns?"

**Group A**

- let them know that you understand them and you are not going to judge them,
- being young, easier to identify with us,
- telling them where you can get certain products you need,
- make condoms readily available,
- be there if anybody has a problem, either in person or a phone number (cell phone),
- Help Hotline for various health concerns,
- letting them know the risks of the problems.

**Group B**

- personal concerns, work with them one to one,
- having pamphlets/information on site,
- more posters (cued),
- make it easily accessible.

**Student Evaluation of Group Sessions A and B (Verbatim)**

(There may appear to be errors in this section, but these notes were copied directly from the data sheets. Please also note that not all sections were responded to.)

1. "What did you like about the group session?"

- free and open discussion,
- we had the chance to give our opinions to make the health program better,
- it gave some very informative information on where to get information, concerns that you never thought about, along with other stuff I never knew,
- that the group was able to understand and hopefully develop all the needs and understanding that has and will go on,
- it was relaxed,
- discussing the types of physical health issues and how we can deal with them,
- that I'll be helping people with figuring out stuff,
- it was okay, I like how there was more than me talking,
- it brought up some concerns I know lots of people share and need to be addressed.

2. "What did you not like about the group session?"

- lack of people, only two students,
- there isn't anything,
- everything was just great, nothing was wrong,

- I think there should be smaller groups,
- not enough chairs to sit in but it wasn't a big deal,
- it was a little boring, not too bad,
- people didn't talk very much.

3. "What could be done to improve the group session?"

- nothing,
- nothing,
- smaller groups,
- make it a little more interesting,
- people could be more open,
- have men as well as women.

4. "Would you be willing to help with the development of a special health project?"

- yes,
- yes,
- yes,
- undecided,
- too busy with school and my son,
- I would just like to know more about it,



- yes I would as long as it didn't take very long,
- yes.

### **Recorder's Evaluation of Non-verbal Behaviors**

(Responses were copied from data sheets; semi-colon denotes separation of Group A and Group B.)

- arms folded across chest: no; yes,
- leaning back in chair: no, sitting upright and forward, listening,
- eye contact: interested, direct when talking; many people looked away, looked down, looked up, searching for answers,
- nods of agreement: yes, could tell they felt important; yes,
- body language: comfortable and open after initial nervousness was over,
- affect: excited, happy to be heard.
- overall comments: The students were interested, and were made to feel comfortable. They appeared to feel that their opinions and ideas were valued and of importance. A well done focus group!; most participants were quiet, hesitant to speak out.

### **ANALYSIS AND INTERPRETATION OF DATA**

Analysis of focus group data is similar, in general, to other qualitative data with the added dimension of the group context. Group A, the smaller one,

consisted of female students who were enthusiastic to participate and had been in sessions for over a week. Group B consisted of eight female students. They had been in classes for several weeks, yet were hesitant to participate. Group B was twenty minutes late and the reason why was not known. Carey (1994) points out that each group has a chemistry and a dynamic that are greater than the sum of its members. This was certainly evident with both groups.

The analysis and interpretation of focus group data can be very complex. Analysis is similar, in general, to other qualitative data analysis. According to Carey (1994), the researcher can draw meaning from the data by applying appropriate qualitative approaches and incorporating the relevant psychosocial concepts.

The concern of generalization for focus group data analysis has been suggested to be appropriate for people in settings similar to the focus group member. Because each group has a dynamic and a chemistry that is greater than the sum of its members, it can be difficult to readily compare data across groups. This was especially true with Group A and Group B. It is therefore more appropriate to examine broad themes across sessions. Carey sites Messick's work and believes that data from a focus group session can be thought of as being potentially incompletely collected. What is collected, though possibly subject to some constraints, represents the reality of experiences of the group members.

A group member's contribution will often elicit another member's contribution on the same topic, and this interaction is a major advantage of the focus group technique. Group A appeared to have this direction. The two members often added to each other's responses. In Group B this was beginning to happen at the close of the session. A probing technique was used with Group B, with little success. Perhaps there may have been more responses, if individuals were asked for their views.

Both groups showed some evidence of censoring and conforming. Group A displayed a more conforming atmosphere, as both participants engaged in similar contributions. However, it is impossible to say that conformity did occur. It was possible both students had comparable histories and experiences. Since these students were in a self esteem program, this may have influenced their responses. Group B may have displayed censoring, particularly at the start of the session. Potential contributions may have been withheld due to a lack of trust in the facilitator, other members, or the future use of the data. It is difficult to explain their lack of participation without delving further into the context and background of the group. Although there were incentives of refreshments and door prizes, this did not encourage Group B to participate freely. The plan for the session was explained before consideration of the questions and students were allowed to make

any adjustments. The time frame was strictly adhered to. Perhaps age, ethnicity, and social class of the teacher and the facilitator had been a likely influence.

### **Themes**

Several themes emerged from the data collected, although the groups differed greatly in dynamics and numerics. Psychological and social health needs were identified by both groups. These included depression, violence and abuse, sexual and verbal harassment, and the use of drugs for recreation and resulting addiction problems. Human sexuality issues such as pregnancy, STDS and AIDS, and unprotected sex were identified by both groups. Group A also identified media pressures and eating disorders. Although 95% of students use tobacco at 5<sup>TH</sup> on 5<sup>TH</sup>, it was not identified by the students.

The verbal Group A, not surprisingly, identified group discussions as one of the major ways to learn about health issues. They also suggested that books or movies were avenues, but specifically stated that a guest speaker should have had similar experiences to themselves. Group B's comments centered on one to one learning through a health professional or a counsellor, yet they also suggested learning about health issues through workshops or seminars.

Both groups identified that 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services boosted self esteem and assisted with meaningful job searches for students. The groups also identified specific programs which did this: Quest For Success and Life Management Skills.

Group A identified that 5<sup>TH</sup> on 5<sup>TH</sup> was an alternate for education and a place that increased independence for students.

Students had past experiences with public health nurses and requested that the nurses have personal concern, understanding, and a non-judgmental attitude. They preferred a "younger" individual who could be a role model. Two students related negative experiences with an "older nurse" who did not understand their concerns. The students felt that a nurse on-site would be ideal, but if this was not possible, she should be available by cellular phone or have access to a Help Hotline for any health concerns. Group B felt that the nurse should have written information and pamphlets on site for health concerns.

The students' evaluations of the group sessions were overall very positive. Students appeared to have "ownership" attitudes of 5<sup>TH</sup> on 5<sup>TH</sup>. Several expressed that they were glad that their opinions would be used for "making health programs better at 5<sup>TH</sup> on 5<sup>TH</sup>". One student stated that "it brought up concerns many people share and need to be addressed".

Although one student mentioned she was "a bit bored", there were two comments in reference to group size: Group A was too small, while Group B was too large. One student mentioned the lack of male input. The students from both groups were overwhelmingly positive about helping out with a special health activity at 5<sup>TH</sup> on 5<sup>TH</sup>. One stated that she was "undecided"; another felt she

"could not spare any time as she was busy with her young son". One student felt that she would "like to know more about what would be involved". The two recorders, who were also observing non-verbal behaviors, had recorded vast differences between the groups. Group A was "totally participating and involved", while Group B was "distant and hesitant" and engaged very minimally. It was the last ten minutes of the session that Group B became more involved with responses. No student monopolized group discussions.

### **ASSUMPTIONS AND LIMITATIONS**

Although it was assumed that most students at 5<sup>TH</sup> on 5<sup>TH</sup> had limited literacy skills, this did not appear to be case with the students sampled. The conclusion was made after considering the verbal and written responses. However, it cannot be assumed that all students at 5<sup>TH</sup> on 5<sup>TH</sup> have adequate literacy skills. Reading abilities of students were not explored.

The original written questionnaire would have gathered data with reference to numbers. School health programming would have been implemented by statistics and "majority rules" However the focus group was a superior method because it provided some insight into beliefs and attitudes of the students. Data regarding perceptions and opinions was enriched through group interactions. This made the data more informative. Therefore, the focus group health needs assessment was the method of choice.

Another assumption of the focus group is that dialogue creates a climate for further responses. This was not entirely true for Group B. Some students may have preferred a written questionnaire, but this was not an option. A "talking circle" may have increased dialogue for Group B, particularly for aboriginal students.

A serious limitation of the focus group technique is that some members may interpret their role as consensus building. Although the facilitator at the outset reminded students that there were no right or wrong answers, this could have easily been overlooked. There may have been a slight "bandwagon effect" with Group A, as both students had comparable experiences. Exaggeration in either of the groups was not evident.

The data generated from this project probably has a high degree of generalizability to another, at risk, female group in the same setting. Although this gender biased data could not be generalizable to male, at risk students, the male students probably share many similar health concerns. The data became accidentally gender biased due to absenteeism and the timing of the school year.

The prediction of students identifying psychosocial health needs was correct. Nearly all of the responses could be related to psychosocial health concerns. Although other research studies mention significance with literacy rates, the prediction of low literacy levels is debatable as the sample was extremely

small. The prediction of students viewing the public health nurse as “another authority figure who gives needles and information on baby care” was incorrect. The students appeared to know the roles of public health nurses. Several mentioned contact with her in the past year. Students could easily identify how 5<sup>TH</sup> on 5<sup>TH</sup> presently assists with health issues. This prediction was incorrect.

The small, select sample constitutes a major limitation. As many of the programs were inoperable at this time of year, it was impossible to obtain a random selection of the programs. However, the sample included students from three different programs. For convenience, the groups were selected by the executive director and the school staff. It is not known if the groups were representative of the general population at 5<sup>TH</sup> on 5<sup>TH</sup>. However, they were representative of female students.

The recorders for both groups cued for responses on at least one occasion, but this was documented in the results. One recorder was familiar with the proposal. The second recorder was a substitute. As the substitute recorder was more interactive with the group, she could have contributed to some consensus building. As there was no recording equipment and to ensure credibility of responses, the responses were recorded verbatim. The facilitator verified each response with the students. It may have been advantageous to hire a recorder, but the downside would be that two unfamiliar adults in the room could make students



uncomfortable.

I believe most students were comfortable with me as the group facilitator. I succeeded in remaining neutral, while at the same time, I encouraged responses. I became off schedule once, when a student exhibited a serious concern for AIDS. I let her know of an upcoming event in the community. Although this may not have followed protocol, I believe it encouraged further responses from this group. My response showed that I really did care and it filled an immediate need.

As the refreshments were served prior to the start of the group sessions to relax and stimulate comraderie, some of the students may have felt an obligation to participate. The door prizes, to be awarded at the end of the sessions, were kept out of view and were not referred to until the letter of consent was administered and the group session plan outlined. Although students were told they could leave the group at anytime, some may have felt pressure to stay for the prizes.

The groups' surroundings were pleasant. The well-lighted room was familiar to students. Comfortable furniture was arranged in a circle. However, space was at a premium for Group B, as one student did not have a chair. Although she was offered one, she chose to half-sit and lean onto a desk.

## CONCLUSION AND RECOMMENDATIONS

This project is an example of how most at risk youth prefer to be involved in their own school health programming. This involvement can range from the assessment phase to the development and implementation of activities. Although the data is generalizable to similar settings, its primary function was to assist 5<sup>TH</sup> on 5<sup>TH</sup> with school health programming. Students were able to identify strengths of their facility readily. This was surprising as many students have lived in very negative environments. They were able to state how the public health nurse could assist with health concerns, as opposed to how the nurse would decide to help them. While many preferred the nurse one-to-one, others requested that she be a resource.

Health needs specific to the aboriginal population were not addressed. As aboriginals have higher morbidity and mortality rates than the general population, this is an area local health regions are now exploring (Chinook Health Region, 1996). Since 5<sup>TH</sup> on 5<sup>TH</sup> has a significant aboriginal student population, aboriginal health could be a priority.

Students had the opportunity to experience a focus group, although this may not be their method of choice for expressing their opinions. As group size and gender were criticisms by students, it would appear that groups of four or five would be most advantageous.

Considering the data from this project, some practical special health activities could include an information package or a pamphlet display case for student mothers. The nurse could make arrangements with the community health office to have an easily accessible, phone-in service or make better use of existing services for health needs. An abuse or sexual harassment workshop could be developed using the local police force, women's shelter, and students. The "idea" of a tobacco free lifestyle could be subtly incorporated with psychosocial health issues. 5<sup>TH</sup> on 5<sup>TH</sup> students could develop a health promotion program to complement their already highly successful literacy, job finding, and self esteem programs.

The focus group technique is a useful research technique, and participants have reported they find the sessions enjoyable, supportive, informative, and provide a sense of commonality of experience. The opportunity to have a voice in the topic of study has made participants at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services feel important and empowered. These individuals are willing to take an active role in school health programming for at risk students.

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## Appendix A

### School Health Questionnaire

1. (a) Health can be emotional (e.g. feelings), physical (e.g. body functions), social (e.g. relationships) or environmental (e.g. school safety).

Please place a circle around the 5 most important health needs at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services:

alcohol use	drug abuse	tobacco use
depression	suicide-suicidal thoughts	body image or personal appearance
communication skills	relationships with family and others	
healthy eating	weight loss	self esteem
stress	growth and development	personal hygiene
injuries	family violence	school violence
verbal abuse	problem solving skills	health careers
parenting skills and baby care		other (please state _____)

- (b) What are some ways we could deal with these health concerns?  
(please circle those that would help you)

talk to someone on your own (nurse, doctor, etc.)	poster displays	
presentations	guest speakers	videos
handouts(printed materials)	workshops	
field trips	group or class discussions	health fairs
drop-in health centre	other (please state _____)	

- (c) How does 5<sup>TH</sup> on 5<sup>TH</sup> now help students to have good health?

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- (d) How can the Public Health Nurse better assist 5<sup>TH</sup> on 5<sup>TH</sup> students to deal with health concerns?

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2. Please respond to the following and circle those that apply:

I am:            male            female  
I live:            alone            with family            with friends  
The highest grade I have completed: \_\_\_\_\_  
My age in years is \_\_\_\_\_  
I consider myself:            a tobacco user            a non-tobacco user  
I am at 5<sup>TH</sup> on 5<sup>TH</sup> for:            schooling            job and life skills  
I work: full-time            part-time            full-time student  
I would be willing to assist with a special health project at 5<sup>TH</sup> on 5<sup>TH</sup>:  
   Yes            No

## Appendix B

### Consultation Record

Date: \_\_\_\_\_ Class (group): \_\_\_\_\_

Facilitator: \_\_\_\_\_ Recorder: \_\_\_\_\_

Number in Group: \_\_\_\_\_ Males: \_\_\_\_\_ Females: \_\_\_\_\_

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Highlights of discussion regarding students knowledge of what health/need/needs assessment is:

What are the (five) most important health issues at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services?

How could we learn about these issues?

How does 5<sup>TH</sup> on 5<sup>TH</sup> now help students to have good health?

How can the Public Health Nurse better assist students at 5<sup>TH</sup> on 5<sup>TH</sup> to deal with health concerns?

## **Appendix C**

### **5<sup>TH</sup> on 5<sup>TH</sup> Youth Services Programs**

5<sup>TH</sup> on 5<sup>TH</sup> Youth Services  
435 - 5<sup>th</sup> Street South  
Lethbridge, AB  
T1J 2B6  
(Tele) 329-3555  
(Fax) 380-4584

This Centre provides youth with a comprehensive range of programs and services intended to promote academic development, social development, career development, and employment. Among the programs and services offered are:

5<sup>TH</sup> on 5<sup>TH</sup> Alternate High School - for clients 16 to 20 years of age who work on individualized programs of study, often with the aid of computer-assisted learning modules.

Hire A Student - youth over the age of 14 years are the primary focus of this service, offered annually from May-August. Largely a job listing service, over 1,400 job vacancies were successfully filled in 1996. Staff also provide assistance in the areas of job search and occasionally organize workshops on related topics. An odd-job squad is organized to provide younger youth with supervised casual employment.

Native Connections - a literacy program for native youth focusing on the development of basic skills.

Work Experience - emphasis is on assessment and employment related skill development. Participation in this program may enable youth to obtain high school credits.

Quest for Success - a 5 week program for 16 - 24 years olds, with an intake every week. Programming focuses on teamwork and building trust by engaging youth in real-life activities to deal with conflict resolution, manage anger and develop social relationships.

Job Finding Club - this is a 3 week program for 16 - 24 years olds that runs continuously year round. Job search skills are developed in a support group setting.

Career and Employment Counseling - one on one assistance is provided to help 16 to 24 year olds deal with personal and employment issues, develop career plans and conduct successful job searches.

Young Parents - offered quarterly, this six to twelve week program addresses the needs and interests of youth who are thinking of becoming parents as well as the needs of pregnant and parenting teens.

Best Matches - an individualized program to support individuals living with a disability.

Job Board/Casual Labour - coordination of recruitment and placement of youth for employers



**Appendix D**  
**Letter of Consent**

**Dear student:**

**I am seeking input from you about student health at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services. This information will lead to development of a special school health activity at 5<sup>TH</sup> on 5<sup>TH</sup>. It is planned that this health activity will encourage healthy behaviors among students. I am working on this project through the University of Lethbridge.**

**I would appreciate your valuable input by attending and participating in the group session today which should take a maximum of forty five minutes. You will not be identified in any way by your responses. You are free to leave the classroom at this time if you are not interested in participating. You are also free to leave the session at any time.**

**If you, or your parents have any questions or concerns regarding this discussion group, please feel free to call me at 328 - 9446 (res.) and 382 - 6666 (business no. after Aug. 15, 1997).**

**A published paper will be available to 5<sup>TH</sup> on 5<sup>TH</sup> in October, 1997.**

**Thank you for your participation.**

**Yours truly,**

**Arlene Wolkowycki, BN., M.Ed.(c)**

## **Appendix E**

### **House Rules**

#### **Zero tolerance rule applies in all:**

- Situations of violence on or near the premises of 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services
- All drugs or alcohol related issues.
- All theft related issues.

#### **No loitering:**

- This facility is for the youth participating in the programs at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services.

#### **Respect and be courteous to your fellow youth, the staff and yourself by:**

- Keeping the noise level down.
- Not participating in malicious gossip.
- Avoiding put downs.
- Not using foul language on or near the premises.

#### **Conflict:**

- Resolve conflict in a manner that will create a win-win situation.

#### **Environment:**

- A clean, safe and nurturing environment for all youth in our programs is a priority at 5<sup>TH</sup> on 5<sup>TH</sup> Youth Services. If you know of something that makes your environment unsafe, report it to a staff member or the executive director.

**A Project of the Lethbridge Youth Foundation**

## Appendix F

### Group Session Plan

1. Introduce myself.
2. Distribute and read aloud Letter of Consent. Answer any questions.
3. Serve refreshments. Icebreaker "toilet paper" activity(optional).
4. Review house rules of 5th on 5th and group session plan from easel pad.  
(Remember there are no right or wrong answers.)
5. Discuss definitions: health, need, needs assessment. (lecturette for less than 10 minutes)
6. Refer students to the four questions. Have group recorder ready.
7. Review the responses with the group that the recorder has collected to ensure accuracy.
8. Students complete mini-evaluation.
9. Door prizes.
10. Recorder completes evaluation of non-verbal behaviors

#### Items to bring:

easel pad, stand, and markers  
written information for easel pad  
letters of consent for each student  
juice and muffins, napkins  
three wrapped door prizes per session  
toilet paper for optional icebreaker  
masking tape

## **Appendix G**

### **Definitions**

#### **Technical Definitions**

**Health:** "Health is a process in which one strives to achieve complete physical, mental and social well-being and furthermore, is a resource which gives people the ability to manage and even change their surroundings. Hence, it is a basic and dynamic force in our daily lives, influenced by the circumstances, beliefs and culture, as well as social, economic and physical environments" (ATA, 1988, p.1).

**Need:** "The term need means different things to different people. A needs assessment can be used to find out peoples' needs, wants, preferences, or some combination of these" (Edmonton Social Planning Council, 1988, p.6).

**Needs Assessment:** "Needs assessment is a systematic process for finding out who has the need, how important it is that the need be filled and how many people are experiencing the need. Needs assessment may also examine why a particular need exists and may point to some possible solutions for meeting the needs which have been identified" (Edmonton Social Planning Council, 1988, p.6).

#### **Student Definitions**

**Health:** A process, state or condition one strives for. It has physical, social, emotional, and spiritual parts. Physical refers to looks or how the body works; social refers to relationships with others; emotional refers to feelings, and spiritual refers to values and beliefs.

**Need:** A need is something required or wanted or a combination of the two. Needs range from life sustaining things such as food, air, and water to wants or desires for name brand clothing.

**Needs Assessment:** A process or method for finding out who has the need, how important the need be filled, and how many are experiencing the need. The focus group or consultation group is one of those methods.

## Appendix H

### Student Mini-evaluation of Group Session

1. What did you like about the group session?
2. What did you not like about the group session?
3. What could be done to improve the group session?
4. Would you be willing to help with the development of a special health project?
5. **THANK YOU VERY MUCH FOR YOUR TIME AND RESPONSES. HAVE A GREAT DAY!**

## **Appendix I**

### **Recorder's Evaluation of Non-verbal Behaviors**

**arms folded across chest**

**leaning back in chair**

**eye contact**

**nods of agreement**

**body language**

**affect**

**Overall comments:**