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Youth Wellness Hubs Ontario: A Primer

November 2017

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About Youth Wellness Hubs Ontario.

The right services to youth and their families—at the right time and in the right place.

ON FEBRUARY 8, 2017, Ontario's Minister of Health and Long-Term Care, Dr. Eric Hoskins, announced the plan to implement up to nine integrated service hubs for youth across the province. This announcement reinforced a recommendation of Ontario's Mental Health and Addictions Leadership Advisory Council.

Youth Wellness Hubs Ontario will offer integrated services—including mental health and addiction services, primary care, and community and social services—for youth between the ages of 12 and 25. Through collaboration among many different providers and sectors, integrated services hubs provide easy and rapid access to services that address the needs of youth across multiple domains of their lives. The initiative reflects a partnership between the Ministry of Health and Long-Term Care and the Ministry of Child and Youth Services, with support from the Graham Boeckh Foundation.

There are many barriers that impact the ability of young people to get the care they need. Early intervention through stepped care and integrated service models like youth wellness hubs are emerging as a potentially effective (and cost-effective) method for addressing youth mental health and addiction concerns, while also improving treatment and access to care outcomes.

Ultimately, Youth Wellness Hubs Ontario will serve as a critical step toward improving Ontario's mental health and addiction services for youth and young adults.

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Purpose.

Youth Wellness Hubs Ontario aims to improve access and service standards for young people through integrated youth mental health and substance use services. These hubs will be places where young people aged 12-25 years can receive walk-in access to high-quality, integrated, "one-stop-shop" mental health and substance use services, as well as other health, social, and employment supports.

Values.

The following values and commitments are central to YWHO. We will:

- Take a service approach that's youth-centred, developmentally-informed, and holistic.
- Strive for meaningful engagement and co-creation.
- Aim to ensure access, equity, and inclusion for diverse youth.
- Increase visibility and address stigma.
- Collaborate across sectors and stakeholders.
- Evaluate our work and commit to quality improvement.

We have a challenge.

RESEARCH SHOWS THAT mental health and substance use disorders impact one in five Canadian youth (Boyle & Georgiades, 2010). In fact, about 90% of all adolescent health problems are due to mental disorders (Tylee, Haller, Graham, et al., 2007). But many youth still aren't receiving the care they need. Several studies have found that youth face many access barriers to mental health services (Tylee, Haller, Graham, et al., 2007; Wang, Berglund, Olfson, et al., 2005). As a result, only 25-30% of youth with mental health and substance use challenges access specialized treatment, most of which is not accessed at the time of highest need (Boyle & Georgiades, 2010; Merikangas et al, 2011; Ratnasingham, Cairney, Manson, et al., 2013; Henderson, Cheung, Cleverley, et al., 2017). In 2016, average wait times for some youth mental health services in Ontario typically exceeded six months, putting youth at significant risk while they wait for treatment (Office of the Auditor General of Ontario, 2016).

Compared to the general population, youth also face elevated rates of depression and anxiety (Begg et al., 2007). Suicide remains the second leading cause of death among young people (Public Health Agency of Canada, 2016). Nine out of ten deaths are associated with a diagnosable mental illness (Mann et al., 2005).

In terms of the social cost, the lifetime burden of mental disorders starting in childhood translates into $200 billion of lost productivity across Canada. Mental health problems among adolescents can translate into a premature loss of life, the onset of chronic illness and a variety of other social and behavioural health issues. For instance, poor mental health in adolescence has links to substance use, poor sexual and reproductive health, low educational achievement, unemployment, crime, risk-taking behaviours, self-harm, and inadequate self-care (UNICEF, 2011). Further, when left untreated, early-onset mental health disorders are associated with teenage pregnancy (Kessler et al., 1997), unstable employment (Kessler, Foster, Saunders, & Stang, 1995) , school failure (Kessler et al., 1995), early marriage, and marital instability (Forthofer, Kessler, Story, & Gotlib, 1996)and domestic violence (Kessler, Walters, & Forthofer, 1998)

There are barriers.

THE GOOD NEWS: there are potentially effective treatments for youth experiencing mental health and addiction problems. But the lack of early, affordable, access to these services remains a barrier to youth well-being, and recently there has been a significant rise in emergency hospital visits. Delivery of youth mental health services through emergency departments is costly and does not provide an appropriate setting for care for most youth. In Ontario alone, there was a 32% increase in the number of young people who visited emergency departments (EDs) between 2006 and 2011 (MHASEF Research Team, 2015). In British Columbia, ED visits for youth increased by 85% between 2009 and 2013 (BC-YSCI, 2015). This percentage continues to climb (MHASEF Research Team, 2015; CIHI, 2015).

Youth and families have identified Ontario's youth mental health system as fragmented, under-resourced, unresponsive, and inefficient (Kozloff et al., 2013). There's an urgent need for improvement in the following areas:

- Reduced wait times and removal of barriers to accessing care
- Improved clarity about where to go for help
- Improved communication and coordination between services and between ministries responsible for services
- Comprehensive and meaningful engagement of youth and their families
- Elimination of mandated service transitions for youth to the adult care system at age 18 and provision of supported and seamless transitions when transitions are required
- Improved information about quality and outcomes of services

- Appropriate care given at the right time by the right provider

While there *are* effective evidence-based mental health interventions for youth, which come with clinical guidelines that ensure a level of standardization and adherence to treatment protocols, there's still a lot to learn about how these interventions work across various settings and contexts (Henderson, Cheung, Cleverley, et al., 2017; Hetrick, Simmons, Thompson, et al., 2011).

We need to intervene early, integrate our efforts, and step up.

BECAUSE ROUGHLY 75% of all adult mental disorders begin before the age of 18 (Tylee, Haller, Graham, et al., 2007), the adolescent years mark a critical period. In fact, preventive interventions aimed at youth between the ages of 12 and 25 provide greater personal, economic, and social impacts than interventions or preventive efforts carried out at any other time (World Health Organization and Calouste Gulbenkian Foundation, 2014)

Integrated approaches to care can help identify problems early—and improve outcomes. For instance, Access Economist, a health economics consulting group from Australia, estimated that for every dollar invested in mental health treatment, $3.26 is saved (2009). Early intervention and prevention efforts on conduct disorders through social-emotional learning programs have shown a return of investment as high as $9.42 (Ashton, 2017). Helping young people get access to comprehensive, integrated care is a key way to reduce both individual suffering and larger social and economic impacts (Henderson, Cheung, Cleverley, et al., 2017).

By "integrated care," we mean services that address the needs of youth through multidisciplinary collaboration across care providers, services, and sectors (McGorry, Tanti, Stokes, et al., 2007). Integrated care models also address youth needs across multiple domains of their lives, such as mental health, substance use, physical health, education, employment, and housing. Integrated care is usually combined with a model called "stepped care," which tailors service intensity to youth need. The goal: providing the 'right service' at the 'right time' by the 'right provider.' In addition, equitable partnerships with youth and other sectors can promote innovative and equitable new ways of providing services. They can also create lasting changes in perceptions, behaviours, and policies that have negatively impacted youth in the past (Blanchet-Cohen, Mack, & Cook, 2011).

A "stepped" care model is organized according to an individual's type (and intensity) of treatment needs. Intensity can be stepped up or down depending on a youth's level of need. Here, more intensive and expensive interventions are only implemented after less intrusive, less costly interventions have proven to be unsuccessful (Davison, 2000). Integrated stepped care models have been shown to positively influence clinical treatment outcomes, namely by decreasing symptoms and increasing the psychological and adaptive functioning of youth (van der Leeden et al., 2011; Zatzick et al., 2014). Such models have also demonstrated positive impacts on health system outcomes, including increased access to care, reduced wait times, and improved perceptions of care (Rickwood et al, 2015).

Youth Wellness Hubs Ontario will address current problems in the health care system—without replacing existing services—by building an integrated and collaborative model of care. By providing services in youth-friendly, non-traditional "mental health treatment" settings, YWHO aims to decrease stigma toward mental health and substance use treatment and to improve how diverse youth access care.

We have momentum.

THE WORK OF the Youth Wellness Hubs Ontario initiative aligns closely with many other provincial strategies and local initiatives. This collection of work is an indication that momentum is growing for integrated care models within the youth mental health and substance use sector, and that the time is right for Ontario to dedicate itself to enhancing and expanding integrated youth service hubs in the province. Some examples of these influential strategic documents include:

- ***Open Minds, Healthy Minds:*** Ontario's ten-year Comprehensive Mental Health and Addiction Strategy is built on foundational pillars such as a) ensuring early identification and intervention, b) providing the right care, at the right time and in the right place, and c) developing integrated service coordination.

- ***Patients First: Action Plan for Health Care***: This blueprint for creating a health care system that is "patient-centred" focuses on the need to a) improve patients' access to the right care, and b) deliver better coordinated and integrated care in the community, while c) providing these services closer to home.

Youth Wellness Hubs Ontario builds on similar initiatives already underway in Canada, such as ACCESS Open Minds (Pan-Canadian) and Foundry (British Columbia), as well as previous international initiatives in Ireland (Jigsaw) and Australia (Headspace).

There are also four existing research-funded hubs in Scarborough, Toronto East, Central Toronto (YouthCan IMPACT), and Chatham-Kent (ACCESS Open Minds), and many communities across the province are also delivering hub-like services. To build upon this existing work in local communities across the province, YWHO will:

- Support communities to understand their assets;
- Bring them together into a collaborative process to better understand the needs and strengths of their youth; and
- Customize implementation of YWHO values, standards, and services to optimize youth outcomes.

We have a solution.

YOUTH WELLNESS HUBS Ontario will serve as a critical step toward improving Ontario's mental health and addiction services for youth and young adults by:

- Providing rapid access to easily identifiable mental health and substance use services with walk in, low-barrier services and clear service pathways
- Providing evidence-based interventions matched to individuals' level of need, and supported transitions to specialized care services when the severity of need is evident
- Integrating mental health, substance use, primary care, vocational, housing, and other support services into a one-stop shop model of care offered in a youth-friendly space
- Reducing transitions between services through an expanded age range for youth services (12 to 25 years), co-location and shared services in a single place
- Establishing common evaluation across sites
- Co-creating services with youth and families

This process will be led by Dr. Joanna Henderson, and will be facilitated by a team from the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre) and the Centre for Addiction and Mental Health's Provincial System Support Program (PSSP). The team from this "backbone" organization will collaborate with communities across the province to support the planning and implementation of up to nine youth wellness hubs. The work of PSSP and the

Centre will include: implementation and site support; knowledge exchange and communications; equity and Indigenous approaches; youth and family engagement; and evaluation support.

A call for proposals will go out in fall 2017 for those that would like to have a Youth Wellness Hub implemented in their community. Site decisions will emphasize the importance of youth and family engagement and equity principles. While only a limited number of sites will be selected for direct funding, implementation support and opportunities for engagement will be available for additional communities in the future.

We have to engage.

HISTORICALLY, YOUTH HAVE been systematically excluded from decision-making opportunities, which has been shown to worsen pre-existing inequalities in health among this population (Christens & Dolan, 2011). Consequently, youth engagement must take a "whole community" approach; it must be an active and ongoing process that embeds youth at all levels of planning, implementation, and evaluation.

Youth engagement in the mental health sector has multiple benefits, including:

- Improving program effectiveness and the ability of an agency to connect with and provide better tailored services for youth (Zeldin et al., 2000), as well as enhanced access to mental health services (Schauer et al., 2007)
- Better promotion of a culture of inclusion and diversity (Zeldin et al., 2000)
- Increased visibility of mental health services in the community (Schauer et al., 2007)
- Promoting positive health, behavioural, and developmental outcomes through opportunities that increase young people's sense of control, self-efficacy, and social responsibility as well as social and political awareness (Carlson, 2006)
- Contributing to the development of a positive self-identity, improved self-esteem, and enhanced critical thinking abilities (Carlson, 2006); as well as a sense of belonging, and feelings of safety and closeness (Shaw et al., 2014); leading to:
- Enhanced academic outcomes, improved physical health, and reduction of anti-social behaviours, alcohol, drug consumption, and rates of addiction (Carlson, 2006).

As part of YWHO's equity and engagement strategy, youth, family members and service providers will identify and articulate community needs and priorities to ensure that wellness hubs are youth-friendly and responsive to the ever-changing needs of young people. In addition to youth, family members and caregivers have first-hand experience of how services operate, how they help (or fail to help), and how they may be improved (Chovil, 2009; Funchess et al., 2014; MacKean et al., 2012). This approach to family engagement aligns with the Centre and the

Ministry of Children and Youth Services' (MCYS, 2013) definition, which defines "family engagement" as "an active partnership between families and services providers, which involves listening to what families have to say, engaging in two-way communication, and seeing the families as partners and allies in youth mental health."

In short, the voices of youth and families will be embedded throughout all aspects of this work. Youth Wellness Hubs Ontario's commitment to young people and families is additionally reflected by family member and youth involvement in YWHO's various advisory groups and site selection process. Individuals and families who are not part of these advisory groups will be given the opportunity to take part in engagement sessions, in-person or virtual, at the provincial and/or local level.

The Youth Wellness Hub at its core.

WHILE THE SPECIFIC services provided at each hub site will be determined through consultation and co-development with local youth and community members, the YWHO model involves a core set of services that is consistent across sites, while remaining adaptable to local needs and context. Core services will include:

- Mental health
- Substance use
- Care navigation
- Peer support
- Family support
- Outreach
- Primary care
- Education, employment & training
- Housing and other community & social services

A core feature of youth wellness hubs will be that these services will be seamlessly integrated with one another.

We will evaluate what we do.

THE EVALUATION strategy for YWHO aims to be as comprehensive as possible in order to demonstrate the overall appropriateness and effectiveness of the integrated stepped care model for youth in Ontario. Therefore, it will include measurements of youth and family member perceptions of services, functional outcomes for youth, as well as service and health system impacts and population health outcomes. Evaluation will also be done throughout the planning and implementation process, to assess youth and family engagement with YWHO, and to monitor the fidelity of the care model and interventions being implemented at each site.

To ensure comparability, and as per the collective impact approach, the youth hub sites will develop and use common or shared measurement system/evaluation approaches while still reflecting the needs of the local community. Standardized assessment tools will be used at each site, with types of data and data definitions consistent across sites.

At the health system level, indicators will include wait times for services and cost-effectiveness. We will also evaluate the potential usefulness of digital tools for providing alternative access to services, health literacy, and self-management.

Together we will intervene, integrate, and step up.

Youth Wellness Hubs Ontario is poised to respond to longstanding and persistent calls to improve how youth and their families access and move among services as well as the quality of those services. These hubs are designed to provide youth and their families with rapid access to high quality mental health and substance use services through easily identifiable, low-barrier, youth-friendly locations. These hubs will deliver evidence-based mental health and substance use interventions and are the next step in continuous efforts to improve services and supports for young people across the province of Ontario

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Glossary

Backbone organization: A group dedicated to coordinating the various dimensions and collaborators involved in an initiative. In the case of YWHO this backbone is comprised of the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre) and the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health.

Co-creation: Co-creation means working collaboratively on a shared purpose, joint decision-making, a commitment to action, and collective accountability among all stakeholders.

Collective impact approach: An approach involving a group of actors from different sectors who come together over a common agenda to solve a specific social problem using a structured form of collaboration.

Developmental stages: Developmental stages are stages through the lifespan that correspond with physical and psychological changes and that can be characterized by differences in thought, emotions and/or behaviour. YWHO recognizes that "youth" is a developmental stage that starts at ends at different ages for different people.

Integrated care: Integrated care for youth refers to services that address the needs of youth through multidisciplinary collaboration across care providers, services, and sectors. Furthermore, it aims to address youth needs across multiple domains of their lives, such as mental health, physical health, education, employment, and housing.

Meaningful engagement: Meaningful engagement means ensuring that those affected by a given program, intervention or initiative are involved throughout the entire program or initiative cycle, including agenda setting, planning, designing, implementation, storytelling, and monitoring and evaluating. It is not enough to have people present, or be consulted; they must be actively involved in shared decision-making.

Proof of concept: A proof of concept is a demonstration, the purpose of which is to verify that certain concepts or models are feasible and have the potential for real-world application.

Stepped care: Stepped care is a model of healthcare delivery in which the most effective, yet least resource intensive, treatment is delivered to patients first, only 'stepping up' to more intensive services as needed.

References

Access Economics (2009). The economic impact of youth mental illness and the cost effectiveness of early intervention. Retrieved from https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Economic-Impact-of-Youth-Mental-Illness/CostYMH_Dec2009?ext=.

Ashton, J.R. (2017). Better mental health for all: A public health approach to mental health improvement. Faculty of Public Health. Retrieved from: http://www.fph.org.uk/uploads/Better%20Mental%20Health%20For%20All%20FINAL%20low%20res.pdf

Blanchet-Cohen, N., Mack, E.& Cook, M.(2011). Changing the landscape: Involving youth in social change: A guidebook for youth engagement. *Global Journal for Community Psychology & Practice,* 2(1), 27-31. Retrieved from: http://www.gjcpp.org.

Begg , S. Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A. D. (2007). The burden of disease and injury in Australia (2003). PHE 82. Canberra: Australian Institute of Health and Welfare (AIHW). Retrieved from: https://www.aihw.gov.au/getmedia/f81b92b3-18a2-4669-aad3-653aa3a9f0f2/bodaiia03.pdf.aspx?inline=true

Boak, A., Hamilton, H.A., Adlaf, E.M., Henderson, J.L., & Mann, R.E. (2016). The mental health and well-being of Ontario students, 1991-2015: Detailed OSDUHS findings (CAMH Research Document Series, No. 43). Toronto, ON: Centre for Addiction and Mental Health.

Boyle, M. H., & Georgiades, K. (2010). Disorders of childhood and adolescence. In: Cairney, J., & Streiner, D. L. (Eds.). (2010). *Mental disorder in Canada: an epidemiological perspective*. Toronto, ON: University of Toronto Press, 205-26.

BC-IYSI Working Group. (2015). British Columbia integrated Youth Services Initiative: Rationale and Overview. Retrieved from: http://bciysi.ca/assets/downloads/bc-iysi-background-document.pdf

Canadian Institute for Health Information. (2015). Care for Children and Youth with Mental Disorders. Ottawa, ON: CIHI.

Carlson, C.(2006). The Hampton experience as a new model for youth civic engagement. *Journal of Community Practice,* 14(1), 89-106.

Chovil, N. (2009). Engaging Families in Child and Youth Metal Health: A Review of Best, Emerging, and

Promising Practices. The F.O.R.C.E. Society for Kids' Mental Health. Retrieved from http://www.forcesociety.com/sites/default/files/Engaging%20Families%20in%20Child%20%26%20Youth%20Mental%20Health.pdf

Christens, B.D. & Dolan, T.(2011). Interweaving youth development, community development and social change through youth organizing. *Youth & Society, 43*(2), 528-548.

Davison, G. C. (2000). Stepped-care: Doing more with less? *Journal of Consulting and Clinical Psychology, 68*(4), 580-585.

Forthofer, M.S., Kessler, R.C.,Story, A.L., & Gotlib I.H. (1996). The effects of psychiatric disorders on the probability and timing of first marriage. *Journal of Health and Social Behav*ior, 37,121- 132.

Kania, K. & Kramer, M. (2010). Collective impact. *Stanford Social Innovation Review,* December. Retrieved from: http://www.ssireview.org/articles/entry/collective_impact/.

Kessler, R.C., Foster, C.L., Saunders, W.B., Stang, P.E. (1995). Social consequences of psychiatric disorders, I: educational attainment. *American Journal of Psychiatry*,152, 1026-1032.

Kessler R.C., Berglund, P.A., Foster, C.L., Saunders., W.B., Stang, P.E., & Walters, E.E. (1997). Social consequences of psychiatric disorders, II: teenage parenthood. *American Journal of Psychiatry*,154,1405-1411.

Kessler, R.C., Walters, E.E., Forthofer, M.S.(1998). The social consequences of psychiatric disorders, III: probability of marital stability. *American Journal of Psychiatry,* 155, 1092-1096.

Kozloff, N., Cheung, A. H., Ross, L. E., Winer, H., Ierfino, D., Bullock, H., & Bennett, K. J. (2013). Factors influencing service use among homeless youths with co-occurring disorders. *Psychiatric Services*, *64*(9), 925-928.

MacKean, G., Spragins, W., L'Heureux, L., Popp, J., Wilkes, C., & Lipton, H. (2012). Advancing family-centered care in child and adolescent mental health: A critical review of the literature. *Healthcare Quarterly*, 15, 64-75.

Mann, J., Apter, A., Bertolote, J. et al. (2005). Suicide prevention strategies: A systematic review. *JAMA, 294*(16), 2064-2074.

McGorry, P. D., Tanti, C., Stokes, R., Hickie, I. B., Carnell, K., Littlefield, L. K., & Moran, J. (2007). Headspace: Australia's National Youth Mental Health Foundation-where young minds come first. *Medical Journal of Australia*, *187*(7), S68.

MHASEF Research Team. (2015). The Mental Health of Children and Youth in Ontario: Baseline Scorecard. Toronto, ON: Institute for Clinical Evaluative Sciences.

Office of the Auditor General of Ontario. (2016). Annual Report 2016, Chapter 3, Section 3.01 Retrieved from http://www.auditor.on.ca/en/content/annualreports/arreports/en16/v1_301en16.pdf

O'Keefe L, O'Reilly A, O'Brien G et al. (2015). Description and Outcome Evaluation of Jigsaw: An Emergent Irish Mental Health Early Intervention Programme for Young People. *Irish Journal of Psychological Medicine*, 32: 71-77.

Rainbow Health Centre. (2012). *Rainbow Health Centre Ontario.* Retrieved from: http://www.rainbowhealthOntario.ca

Ratnasingham, S., Cairney, J., Manson, H., Rehm, J., Lin, E., & Kurdyak, P. (2013). The burden of mental illness and addiction in Ontario. *The Canadian Journal of Psychiatry*, *58*(9), 529-537.

Rickwood, D.J., Telford, N.R., Parker, A.G., Tanti, C.J., & McGorry, P.D. (2014). Headspace – Australia's innovation in youth mental health: who are the clients and why are they presenting? *The Medical Journal of Australia, 200*(2), 108-111.

Rickwood, D. J., Mazzer, K. R., Telford, N. R., Parker, A. G., Tanti, C. J., & McGorry, P. D. (2015). Changes in psychological distress and psychosocial functioning in young people visiting headspace centres for mental health problems. *The Medical Journal of Australia*, *202*(10), 537-542.

Schauer, C., Everett, A., del Vecchio, P. & Anderson, L. (2007). Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal*, 31, 54-61.

Shaw, A., Brady, B., McGrath, B., Brennan, M. A., & Dolan, P. (2014). Understanding youth civic engagement: debates, discourses, and lessons from practice. *Community Development*, *45*(4), 300-316.

Tylee, A., Haller, D. M., Graham, T., Churchill, R., & Sanci, L. A. (2007). Youth-friendly primary-care services: how are we doing and what more needs to be done?. *The Lancet*, *369*(9572), 1565-1573.

UNICEF. (2011). The state of the world's children: Adolescence an age of opportunity. Retrieved from https://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf

van der Leeden, A. J., van Widenfelt, B. M., van der Leeden, R., Liber, J. M., Utens, E. M., & Treffers, P. D. (2011). Stepped care cognitive behavioural therapy for children with anxiety disorders: A new treatment approach. *Behavioural and Cognitive Psychotherapy*, *39*(1), 55-75.

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 603-613.

World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Retrieved from http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf?ua=1

Zatzick, D., Russo, J., Lord, S. P., Varley, C., Wang, J., Berliner, L., ... & Rivara, F. P. (2014). Collaborative care intervention targeting violence risk behaviors, substance use, and posttraumatic stress and depressive symptoms in injured adolescents: a randomized clinical trial. *JAMA pediatrics*, *168*(6), 532-539.

Zeldin, S. (2000). Integrating research and practice to understand and strengthen communities for adolescent development: An introduction to the special issue and current issues. *Applied Developmental Science*, 4(Suppl. 1), 2-10.