Building and Scaling-up Effective School Mental Health Programming and Initiatives: The Importance of Global Collaboration and Leadership

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Executive Summary

The School Mental Health (SMH) Match hosted as part of the International Initiative for Mental Health Leadership (IIMHL) in October 2022 provided a platform for global leaders in SMH from over 10 countries (e.g., Australia, Canada, Germany, Ireland, Israel, Jamacia, New Zealand, Norway, Poland, UK, and USA) to come together to discuss current pressing practice, policy, and research issues. The Match included seven brief, interactive sessions delivered by experts in the field, on topics informed by participant interests and loosely structured across the Multi-Tiered System of Support (MTSS), including promotion/prevention (Tier 1), early intervention (Tier 2), and more intensive intervention (Tier 3). Replicating the public health framework and approach, MTSS in schools represents a broad strategy for mental health promotion, early intervention and intervention, with a burgeoning literature discussing aspects of exemplary SMH practice integrated into schools' MTSS (Eber et al., 2020; Hoover et al., 2019; Weist et al., 2018). Speakers focused on issues of leadership in developing, implementing, refining, and scaling evidence-based school mental health practices across the tiers. Participants included leaders in school mental health connected to the School Mental Health International Leadership Exchange (see www.smhile.com) and other IIMHL members who brought particular research, practice or policy expertise to the conversation.

Day 1 of the Match focused on school mental health promotion, prevention, and early intervention. Speakers presented examples of class-wide strength-based programming delivered in different structures and modalities (e.g., programmatic, modular, curriculum-linked, on-line). Discussion focused on ways to advance educator buy-in and uptake, the delivery of identity-affirming, culturally responsive programming, and ways of demonstrating impact. This session also included closer inspection of research and practice related to the use of digital technology for prevention and early intervention services. Across all the Tier 1 and 2 examples shared, close

attention was given to matters of uptake and sustainability, with strong recognition that it is easier to introduce programming than to reliably implement, scale and maintain impact.

Day 2 of the Match focused on more intensive intervention related to effective response to significant challenges such as natural disasters, school shootings, and war. In discussions, a parallel was drawn between models of disaster recovery and the path for post-pandemic recovery. Lessons learned from experiences shared by speakers were applied more generally to the current state of SMH practice. For example, several speakers noted the importance of triaging to ensure that those most disproportionately impacted by the disaster/tragic event, and/or in closest proximity, receive the most intensive supports. Similarly, the critical step of equipping all who serve and support young people; parents/caregivers, educators, faith and cultural leaders, sports leaders, and policy makers (among many others) with emphasis on the critical role of mental health literacy to equip all stakeholders with basic knowledge of mental health promotion (National Center for School Mental Health, 2020). Participants also described the importance of self-care and wellness for school and system leaders, who often carry the greatest burden in times of crisis (see Yanek et al., 2022). Finally, the enormous potential of collaboration, and global connection, was underscored with the powerful example of international mobilization to help with the refugee crisis in Poland following the conflict in Ukraine.

The SMH Match closed with a focus on parent/caregiver and youth engagement and leadership. Match hosts from New Zealand shared ways in which the school has become a gathering place and platform for wellbeing for students and families. In addition to guidance and resources for teachers, the *Mana Ake* ("stronger for tomorrow") approach seeks to provide a range of avenues for meaningful engagement of parents/caregivers to inform planning and

decision-making at the local level. Youth leaders drew the meeting to a close with a call to action related to creating space to elevate youth voice.

Overarching themes from the Match were brought forward to the IIMHL 2022 Leadership Exchange hub meetings held in New Zealand, Ireland, and the United States. These themes are discussed in detail within this report, with a particular focus on priorities related to: *effective leadership in times of complexity, change, and crisis; strategies to advance uptake and sustained implementation; meaningful engagement with diverse stakeholders (emphasizing family and student voice and leadership); collaboration across sectors and disciplines; workforce development; and interconnected measurement with a focus on research, practice, and policy impacts.*

In alignment with NASMHPD's vision that mental health is universally perceived as essential to overall health and well-being with services that are available, accessible, and of high quality, this report highlights, from a global perspective, how the education and mental health systems can collaborate to support the mental health of young people. The report begins with a brief background on Systems of Care, Multi-Tiered Systems of Support (MTSS), and School Mental Health (SMH). The next section provides an overview of the IIMHL SMH Match. This section is followed by a summary of all virtual SMH sessions, including descriptions of ideas that emerged in discussion, overarching themes and recommendations. Next, the presentations are placed into the framework of MTSS, including promotion/prevention (Tier 1), early intervention (Tier 2), and more intensive intervention (Tier 3). The report concludes with ideas to advance interconnected research, practice, and policy agendas. An Appendix is included with links to resources based on the presentations, resulting themes (Table 1), a visual graphic of the

typical phases of disaster (Figure 1), and a description of the successful School Mental Health Ontario program in Canada.

Systems of Care, Multi-Tiered Systems of Support, and School Mental Health

Many communities, especially those located in urban or rural settings, lack accessible, high quality, comprehensive treatment for children and adolescents (see Young et al., 2015). Navigating complex systems to seek mental health care for youth often presents challenges for families and caregivers, such as long wait times, inadequate specialized mental health care services, shortage of providers in the community, high costs of treatment, and lack of insurance coverage. In response to these challenges, an organized framework was developed that focuses on a specific service delivery model known as the systems of care model. This model seeks to coordinate and integrate services for children, youth, and their families by strengthening the collaboration of local and broader systems to provide responsive and high-quality mental health supports and services (School and Community System of Care Collaborative, 2022; Struol et al., 2010; 2021). Schools are particularly critical settings for mental health service delivery within the broader system of care, with a specific focus on mental health promotion, early identification, prevention and early intervention, some ongoing support, and in rarer instances acute crisis response (see Weist et al., 2014). Schools provide low barrier access to care, and often are the first point of contact for a young person struggling with a mental health disorder (Duong et al, 2021; Georgiades et al., 2019).

Within the school system, the multi-tiered system of support (MTSS) framework is responsive to the systems of care model and values by offering a comprehensive system of social, emotional, and behavioral supports to promote student wellness and improve engagement in learning (see Eber et al., 2020). One of the strengths of the MTSS approach is the focus on an

effective, organized, and data-driven approach to mental health services in schools. To provide some brief background, MTSS follows a public health model (Eber et al., 2020; Hoover et al., 2019; Weist et al., 2018) for school mental health service delivery that focuses on establishing priorities, clarifying roles, and ensuring service coordination and quality. The MTSS approach seeks to provide a continuum of services that includes mental health promotion, early identification, prevention and early intervention, and targeted intervention or service strategies for more intensive mental health needs. MTSS uses data and applies evidence-based approaches to support the wellbeing of all students, the emerging or continuing mental health needs of some students, and to provide intensive strategies for a few students with the most significant mental health needs. Programming is organized across "tiers" of Tier 1 – promotion/prevention for all students, Tier 2 – early intervention for students presenting early signs of problems or contending with conditions of risk, and Tier 3 involving more intensive intervention for students with established mental health challenges. Ideally, programming is aligned across tiers; for example, a community experiencing a high level of trauma would integrate mental health literacy strategies at Tier 1, more intensive classroom focused support at Tier 2, and evidence-based trauma focused therapy at Tier 3 (Kern et al., 2022).

MTSS follow a "stepped care" (Von Korff et al., 1997) approach whereby the least intensive interventions are provided to individuals (in this case students) with less acute needs but can quickly pivot to advanced treatment intensity for students who are not improving or whose problems are escalating. Stepped care models represent a guiding framework for intervention that relies on tracking outcomes for evaluation of student response to lower intensity treatment, pragmatic clinical decision making, and more effective and efficient services (Lyon et al., 2016)

Overview of the IIMHL SMH Match

The International Initiative for Mental Health Leadership (IIMHL; https://www.iimhl.com/) brings together and connects mental health leaders to help spread innovation and best practices to improve mental health and addiction services around the globe. IIMHL is a global collaboration with participant leaders from Australia, England, Northern Ireland, Canada, the Netherlands, New Zealand, Republic of Ireland, Scotland, USA, and Sweden.

IIMHL sponsors and organizes a Leadership Exchange, which is a learning event held every two years, hosted within one participating country on each occasion. The Leadership Exchange provides an opportunity for leaders and emerging leaders at all levels to share knowledge about what works in leading systems for mental health, substance use and disability. Participants include persons with lived experience, family members, youth leaders, caregivers, community workers, executives, policy analysts, researchers, clinicians, and board members. Each Leadership Exchange includes a series of small Matches on specific topics in mental health leadership (i.e., typically 15-25 participants per Match), followed by a large Network Meeting for participants of all the Matches held in the host country for that year (i.e., 400-500 participants). Participants engage in one in-person Match within the host country, before traveling to the Network meeting. Leaders involved in the Leadership Exchange are encouraged to continue connections and discussions in the months between the Exchanges. The intent is that the benefits of such a collaborative effort will cascade to all staff and service users. Potential avenues for collaboration include joint programs and service development, staff exchanges and sabbaticals, collaborative service evaluation, managerial, operational, and clinical knowledge sharing, research, and peer consultation.

Due to the pandemic, there were changes to the meeting format for the 2022 Leadership Exchange, which was hosted by New Zealand. In this instance, participants joined a two-day virtual Match followed by three in-person meeting hubs in Christchurch, New Zealand, Washington, DC, and Dublin, Ireland, occurring in late October 2022. The theme for this year was *Valuing inclusion, resilience, and growth*. The Matches focused on a specific subject or topic such as Peer Leadership, Emerging Leaders, Suicide Prevention, Child and Youth Mental Health, Wellbeing in Cities, Indigenous Leadership, Addictions, and Leadership, among others. This year, rather than convening separately, an Infant, Child, and Youth Mental Health "Super-Match" was created. In this way, those who were leading Matches related to infant mental health, family and caregiver support, child and youth intervention, and school mental health could share across individual topic areas for broader and deeper discussion of important themes and to purposefully help expand professional networks. Leaders of the Super-Match met over an 18-month period to plan this aspect of the 2022 Leadership Exchange, and to participate in joint learning sessions.

The School Mental Health Match element of the Infant, Child, and Youth Super-Match was jointly chaired by New Zealand hosts from Werry Workforce Wharaurau and the School Mental Health International Leadership Exchange (SMHILE). Since 2018, SMHILE (see www.smhile.com; Weist et al., 2016) has been working with IIMHL to advance global collaboration on SMH including recent conferences in Sweden (2018) and Washington, DC (2019). SMHILE is focused on leadership in SMH, the exchange of innovative programming ideas/strategies within and across countries, and is guided by a Leadership Team, including leaders from many countries participating in this match. Working alongside Wharourou partners, and in consultation with those who expressed an interest in the Match, an agenda was

created to highlight key issues in global SMH. Invited speakers assisted with preparation and delivery of the session. During the 2022 Leadership Exchange, chairs from other Super-Match areas attended the SMH Match to support continuity across Matches. The following section provides brief summaries and highlights from the virtual sessions delivered during Day One and Day Two of the SMH Match.

SMH Match Day One Highlights

1. Ciaran Fox, New Zealand, Mental Health Promoter, Mental Health Foundation of New Zealand (*Sparklers*)

2. Grant Rix, New Zealand, Director of Mindfulness, Pause Breathe Smile Trust, New Zealand (*Pause Breathe Smile*)

The first two presentations on Day One of the Match focused on school mental health and wellness promotion. Two speakers from New Zealand (Ciaran Fox and Grant Rix) presented examples of unique strength-based programming that utilize different approaches to class-wide implementation. The presentation by Ciaran Fox highlighted the *Sparklers* program which was initially developed in response to the impacts of the Canterbury earthquakes on children and young people. *Sparklers* is an example of a population-level program that is modular and contains wellbeing activities aligned with the New Zealand education curriculum for year 1-8 students. The presentation by Grant Rix described *Pause Breathe Smile*, a mind health program designed to provide children aged five to 12 with the necessary tools to manage the ups and downs of life and set them up for a healthy future. *Pause Breathe Smile* is delivered in schools, by teachers, and is aligned with the New Zealand education curriculum.

Both presenters and participants noted the value of a whole class approach as a crucial component of multicultural practice. For example, when the programs are delivered to the whole class as opposed to select students with heightened mental health or behavioral challenges, the

advantages include: 1) treating class as a collective; 2) enhancing the emphasis on prevention; 3) creating culture change in a classroom by overtly using models to depict wellbeing/health as a wholistic construct; and 4) taking a strengths-based approach (Te Whare Tapa Wha; https://mentalhealth.org.nz/te-whare-tapa-wha).

The discussion also focused on problem-solving for various challenges that include: 1) how best to advance educator buy-in and active use of innovative programming; 2) the delivery of identity-affirming, culturally responsive programming, and 3) effective ways of demonstrating program impact.

3. Brian P. Daly, Drexel University, USA, Shannon Litke, Drexel University, USA, Annie Resnikoff, Drexel University, USA, and Ashley Anil, Drexel University, USA (*Mobile Health Technologies for Supporting Youth Mental Health: Gaps and Opportunities*)

4. John Weisz, Harvard University, USA, and Kathy Short, Executive Director, School Mental Health Ontario, Canada (*Scalable, Available Youth Mental Health Care: Little Interventions with Big Reach*)

The second part of the Day One session included presentations focused on the use of digital technology for prevention and early intervention programming. Brian Daly (USA) reviewed the research on mobile health (mHealth) technologies to improve the availability and effectiveness of mental health assessments and interventions including those delivered in school-based settings. Findings from the review revealed that although several mHealth apps were associated with significant improvements in youth mental health outcomes (e.g., decreased depression and anxiety), there remain too few well-controlled studies to draw firm conclusions. The review also found that almost no mHealth apps were designed with culturally sensitive adaptations and likewise there was scarce representation of racial/ethnic minority youth in research samples.

John Weisz (USA) and Kathy Short (Canada) presented on an innovation created during the pandemic in response to a rise in subclinical feelings of worry, loneliness, and sadness expressed by students. This innovation, called Brief Digital Interventions (BDI), was inspired by emerging evidence on the power of single session interventions. It was developed in consultation with school mental health professionals and students and was piloted in Ontario schools beginning in summer 2020 (Cwinn et al., 2022). BDIs include four Coping Kits, each derived from common elements of effective interventions: **Project Solve** (problem solving), **Project Calm** (relaxation techniques), **Project Think** (cognitive restructuring) and **Trying the Opposite** (exposure, behavioral activation). These single session interventions were made available digitally so that students could access them between meetings with a SMH professional but could also be used during in-person therapeutic sessions. A progress monitoring tool was included as part of the intervention to assist clinicians in tracking student progress. The Match ignite session introduced the BDI innovation and focused on implementation enablers and barriers to uptake.

Both presenters highlighted that digital mental health interventions alone may be sufficiently helpful to some students while others would benefit from these interventions as supplementary to individual or family-based psychosocial interventions. However, it was noted that research in this area still struggles to identify what works for whom, when, and at what level of "dosage." Challenges also were cited around implementation buy-in from professionals such as teachers and SMH professionals given their many competing demands. At the same time, some positive enablers to uptake were noted, including explicit implementation support (e.g., community of practice offerings, flexible training avenues, hands-on coaching), and the use of influential ambassadors who highlight benefits of the intervention and demonstrate techniques

for overcoming barriers. In general, participants were interested in learning more about how technology interventions might support their work but there also was a sense of caution given the necessary use of telehealth during the ongoing pandemic – suggesting some technology "fatigue."

SMH Match Day Two Highlights

1. Vanessa Cobham, University of Queensland, Australia (*Responding to Natural Disasters*)

2. Eric Bruns, University of Washington, School of Medicine, USA, Lenka Felcmanova, Charles University, Czech Republic, Robert Porzak, University of Economics and Innovation in Lublin, Poland, and Sharon Hoover, University of Maryland School of Medicine, USA (*Behavioral Health Support for Ukrainian Refugees: Training School Staff in Poland and the Czech Republic to be Effective First Responders*)

Day two of the Match focused on more intensive intervention efforts (Tier 2 and Tier 3) that were in response to significant challenges such as natural disasters, school shootings, and war. Vanessa Cobham (Australia) presented on a universal parenting intervention, *Disaster Recovery Triple P*, based on the *Triple P – Positive Parenting Program* (https://www.triplep-parenting.com) which helps parents to be better informed about what to expect when children have been exposed to a community-wide potentially traumatic event (e.g., natural disaster). The two-hour universal seminar is offered to all parents in a disaster-impacted area such that there is no entry threshold to participate. The program represents a multi-tiered (stepped care) approach to disaster management that utilizes a screen and treat approach for students who likely have post-traumatic stress disorder (PTSD). The presenter noted that preparation work with parents can be reassuring even when the child does not meet any criteria for PTSD.

Eric Bruns (USA), Lenka Felcmanova (Czech Republic), Robert Porzak (Poland), and Sharon Hoover (USA) described the process of training school staff in Poland and the Czech Republic to be effective first responders for children and families displaced and impacted by the war in Ukraine. Initial first responder activities were grounded in efforts to train local volunteers

to build local capacity to sustain this important work. The presenters discussed the importance of translation efforts to get resources to schools to support refugees. They also noted the importance of integrating these responses into multi-tiered systems of support, using strategies from trauma informed schools, and the "Asking is Caring" suicide prevention program.

3. Karaitiana Tickell and Clare Shepherd, Mana Ake initiative, Canterbury District Health Board, New Zealand (*Family Engagement*)

In their presentation, Karaitiana Tickell and Clare Shepherd (New Zealand) described *Mana Ake – Stronger for Tomorrow*, a program that provides mental health and wellbeing support for children in primary school years 1-8 across Canterbury, New Zealand. The initial impetus for developing *Mana Ake* was due to the ongoing impact of the Canterbury earthquakes. The presenters highlighted the importance of parents, extended family, and caregivers as being key to promoting and supporting wellbeing and mental health of children and young people. The presenters emphasized how ensuring genuine engagement can occur when delivering interventions through school settings, not only to provide wrap-around support but also to enhance understanding of how best to support wellbeing for all and reduce stigma. The presenters noted that through the implementation of *Mana Ake* it is evident that having multiple avenues for families to access information and support is critical to building trust and ensuring information is accessible in a way that provides equitable access. The following strategies were highlighted to support engagement: 1) regular times to connect with staff informally in school settings – especially at drop off and pick up times; 2) virtual advice and guidance sessions; 3) using school newsletters to share key messages; 4) face to face information sessions both in schools and in local communities; 5) more formal parenting workshops – both face to face and virtual; and 6) having a trusted website with access to a web portal so that families can seek personalized support.

Presenters and participants engaged in thoughtful discussion about how to effectively address chronic/ongoing trauma vs. discrete traumatic events. Likewise, the question was raised about how to strike the right balance of identifying and addressing trauma while also identifying and leveraging assets/strengths? The participants grappled with how we can share resources and interventions in a coordinated, responsive manner when the inevitable natural disasters, school shootings, and crises occur such that we avoid further fragmentation, piecemeal approaches, and "savior" responses. Finally, the participants considered the nuances of the tiered system of support "balancing act" such that we guard against downstream interventions further pathologizing impacted communities.

4. Romy Lee, Youth Advisory/Peer Workforce Development Lead, Wharaurau, New Zealand, and Joyce Erogun, Student Engagement Lead, School Mental Health Ontario, Canada (*Student Voice*)

The SMH Match closed with a powerful call to action related to youth engagement, leadership, and voice within school mental health. Presenters noted the importance of finding ways to elevate and amplify student perspectives in decisions about programming, supports and services. They also called on researchers and practitioners to collaborate with young people when planning interventions and initiatives and to also use student input to think through potential impacts including both intended and unintended consequences. The presenters invited participants to think about the role they might play in shifting narratives to inspire hope – acknowledging adversity and challenge but situating the focus towards resilience and well-being.

To translate the virtual presentations into "real-world" applicability, the next section of this report highlights how programs, technology strategies, stakeholder engagement efforts, and crisis responses can be situated in an MTSS framework of mental health promotion, early

identification, prevention and early intervention, and acute and intensive response. Several examples are noted that cut across various levels of the tiers.

Promotion/prevention (Tier 1)

Tier 1 focuses on widespread screening, promoting mental health, and preventing occurrences of problems for all students within a school system. Because schools play a key role in supporting and promoting everyday wellbeing, mental health promotion and wellness programming should be integrated into schools MTSS. Examples of Tier 1 programming from the virtual match presentations include *Sparklers* (https://sparklers.org.nz/) and *Pause, Breathe, Smile* (https://pausebreathesmile.nz/). These programs are delivered at the Tier 1 population-level, support and promote wellbeing and skill development, enhance coping strategies, and share a commonality in being linked to the New Zealand education curriculum. Both programs utilize teachers to deliver the content class-wide, whereas *Sparklers* also offers activities that can be completed in the home setting. Independent evaluations of these programs reveal positive impacts on students' social and emotional learning. Overall, there is strong evidence that Tier 1 prevention and intervention programs designed to promote mental health and wellbeing in schools are effective in improving wellbeing and in reducing symptoms of mental health problems for young people (Cefai et al, 2022; Durlak et al., 2011), highlighting the importance of integrated these supports into schools.

Mana Ake – Stronger for Tomorrow (https://manaake.health.nz/) is an example of how parent and caregiver engagement is meaningful and cross-cutting across the tiers of intervention. Programs and support services can be delivered at various tiers (i.e., tiers 1 and 2) and also effectively integrated into schools to assist children, teachers, and other school personnel with the goal of promoting wellbeing among students. For instance, at the tier 1 level, *Mana Ake* kaimahi (workers) provide information and resources to parents and teachers that help children

develop skills for coping, managing difficult emotions, and building positive relationships. The kaimahi support parents and teachers, work directly with students at home or school, and facilitate connections with community resources. At the tier 2 level, *Mana Ake* kaimahi can provide targeted group and individual interventions when children are experiencing new or escalating mental health challenges such as distress, anxiety, phobias, or trauma. At this level, kaimahi also work with schools and parents to provide advice, guidance and support that is targeted to identified needs, allowing parents to come together in workshop presentations and share their experiences as well as learn strategies to help address the concerns their child(ren) are experiencing.

Early intervention (Tier 2)

Tier 2 services focus on preventing risk factors or early-onset or escalating mental health problems from progressing. These services often utilize brief, evidence-informed targeted screening and early interventions, and more direct support. Supports in this tier are organized in a stepped care fashion, with a focus on assessment and ongoing progress monitoring, or measurement-based care, to assist with clinical decision-making related to the intensity level and type of intervention needed (School Mental Health Ontario, 2022).

Examples of innovative Tier 2 programming from the virtual match presentations include digital interventions such as mobile mental health (mHealth) technologies and apps that represent a promising pathway toward facilitating effective mental health intervention in and outside of school-based settings. Given the ubiquity of smartphones, the interaction with mHealth apps has the potential to help reduce logistical-and systems-level barriers as well as stigma for children and families seeking mental health support services. The use of mHealth apps can also improve treatment engagement and quality of care by providing more continuous access to self-guided tools. Another presentation examined the effectiveness of supplementing general mental health

support with brief digital interventions. There were some very promising findings from this pilot study, and a related randomized trial conducted in the USA, but engagement with the digital intervention by school counselors was challenging during the pandemic, despite the use of several implementation support vehicles. Overall, the research base is small, but growing, around innovations in mental health service delivery, like apps and packaged digital interventions, and their potential additive value to early intervention work in schools.

More intensive intervention (Tier 3)

Tier 3 focuses on individual and family-based interventions that address more serious student mental health concerns and prevent the worsening of symptoms that can impact daily functioning. As such, these services are generally reserved for students identified as experiencing the most concerning mental health challenges. There is compelling data to support that in the aftermath of natural disasters, some children need ongoing support to help protect them from developing serious mental health issues such as post-traumatic stress disorder, depression, and/or anxiety. Several presentations at the virtual match described interventions and responses to crisis and community trauma including a presentation that detailed the implementation of *Disaster Recovery Triple P* (Cobham et al., 2018) following a major natural disaster (e.g., flooding) or traumatic incident (e.g., school shootings) and how this program can be utilized in a stepped care fashion in a MTSS as an approach to potential and actual disaster management. At the tier 1 level, *Universal Triple P* is a parenting communication strategy designed to educate and support parents to be better informed as to what to expect when children have been exposed to a community-wide PTE (e.g., natural disaster). At the Tier 3 level, following a major disaster or incident, the *Disaster Recovery Triple P* parenting seminar can be delivered as a 2-hour seminar to provide emotional support, information, and reassurance to

parents in communities impacted by the disaster or traumatic incident. These presentations spurred discussions among the participants about the importance of building crisis services that serve under-resourced minority communities, but also making sure these services are culturally relevant.

Themes from Match Dialogue with Global Leaders in SMH

Effective Leadership in times of complexity, change, and crisis

The SMH Match discussions on effective leadership focused on 1) the importance of maintaining and promoting staff and personal wellbeing to meet the complexities and inevitable changes associated with school and system leadership; 2) the benefits of well-designed and comprehensive systems of supports for students and school personnel that are rooted in foundational infrastructure (teams, protocols, agreements, data systems, etc.) and responsive to emerging mental health needs and pressures; and, 3) how a conceptual framework of disaster response and recovery can be applied to support leaders whose schools and local communities are impacted by a disaster, crisis, or traumatic event.

Many school leaders and district administrators, such as superintendents, directors, and principals, acknowledge the multitude of job-related stressors they encounter including excessive and overwhelming workload and demands, lack of control, increasingly complex and broader variety of roles and tasks, insufficient rewards, values conflict with shifting policies, and potential challenges collaborating with the local community (Pont et al., 2008). Despite these various stressors, school and system leaders are still expected to maintain a positive district and school environment. Perhaps not surprisingly, recent data highlight that burnout rates are especially high across all levels of leadership such as district administrators and school principals (Steiner et al., 2022). Senior decision makers in school districts such as superintendents and

directors are often the lead for mental health in school systems and therefore exert significant influence on policy and practice in school mental health, but also carry the greatest burden of responsibility. Encouragingly, there is some evidence to suggest that school leaders who actively address their own wellbeing are perceived as effective leaders because they adopt a positive, initiative-taking style and can meet the needs of students, teachers, and parents because they have the available resources to meet the challenges of their role (Hesbol, 2019; Wells & Klocko, 2018). Unfortunately, few professional development resources and trainings are provided to support the wellbeing of current school leaders and instead they are frequently evaluated on how busy they are instead of whether they provide high-quality leadership (Pont et al., 2008).

During the Match discussion, participants highlighted the importance of maintaining or enhancing wellbeing through self-care and professional development for leaders knowing that any leadership tenure will necessarily involve times of change and complexity inside and outside of the school building. Self-care is defined as proactively doing things that are good for physical, emotional, and psychological wellbeing, and is emerging as an essential behavioral strategy for effective school leaders. When district leaders explicitly model attention to their own wellness, this priority and practice connotes permission and encouragement for principals and vice-principals to follow (Yanek et al., 2022). In turn, when school leaders effectively practice self-care that supports their wellbeing, they are modeling for teachers the importance of these behaviors. This is important because teacher wellbeing is associated with more effective and quality teaching and lower levels of stress and burnout (for review, see Hascher & Waber, 2021). Links to resources and recommendations related to self-care activities and professional development opportunities focused on wellbeing for school leaders are found in Appendix A.

The role of leadership, and leadership support, is critical in building a comprehensive system of support for students in school that aligns and integrates with the broader system of care. To effectively co-create and sustain programming across the tiers of intervention, leaders should create the foundations for effective school mental health practice (e.g., good host environments and structures/processes at the district and school level), strong implementation practices (e.g., high quality role-specific training and ongoing coaching support), and the selection of scalable and sustainable evidence-informed practices that are amenable to busy school and classroom practice. In times of complexity and change, leaders can draw on these solid foundations to mobilize quickly in response to emerging pressures and needs.

Disasters or traumatic events can have individual impacts on students and collective impacts on schools and the surrounding community. Zunin and Myers (2000) developed a widely used conceptual framework of psychological responses to disaster and recovery (see Figure A). In this model, survivors' emotions, such as feelings of vulnerability and loss of control, generally become more difficult to manage around the time of disaster warning, and their negative feelings increase through disaster threat and impact. Their emotions, such as altruism, improve in a heroic phase, in which they are inclined to try to contribute to the disaster response. This stage is followed by a honeymoon phase when community cohesion and bonding peaks. At this stage, many are optimistic that all will return to normal. Following the honeymoon, however, is disillusionment, sometimes spurred by stress, fatigue, and disappointment in the slower-than-expected pace of disaster recovery. Disillusionment typically occurs in the second half of the year after the disaster, and after the disaster's first anniversary, it is generally followed by reconstruction, as survivors adjust to their "new normal" after the disaster. In the reconstruction stage, there can be a recognition of growth and opportunity.

For school system leaders, although the phase of disillusionment is predictable, it also is especially challenging and requires adept leadership to navigate and support the emotional reactions of students and school personnel as optimism turns to discouragement and stress takes a continuing toll on the school community. In this phase, which can last months and even years, the gap between need and assistance can lead to feelings of abandonment, low morale, and disengagement. These complex challenges underscore the importance of self-care and wellbeing since the school community will look to and will depend on their leader for guidance throughout the entire event and the recovery from that event. Effective leaders are visible to their students, staff, parents, and the broader school community and present a calm, organized manner that offers hope, answers questions, and continually works to reduce anxiety. As mentioned earlier, schools that have a well-established comprehensive system of support that prioritizes social-emotional needs, and strong partnerships with communities and agencies, are better prepared to mitigate crises.

Strategies to advance uptake and sustained implementation

Leadership commitment is a critical pre-requisite for effective school mental health practice, as noted above. In addition, during the Match it was acknowledged that leaders who are championing mental health promotion, prevention, and early intervention services in schools need a wide range of tools to advance uptake and sustained implementation of evidence-informed resources and supports. As implementation science teaches us, having a strong host environment and robust evidence informed intervention is necessary but not sufficient for achieving scalable and sustainable SMH programming and positive student outcomes (Fixsen et al, 2005; Short, 2016). Interventions are only helpful if they are used! Explicit and intentional implementation supports can be used to enhance uptake, with broad fidelity, over time.

Several implementation vehicles were highlighted during presentations and related Match discussions. This begins with the process of **needs assessment and programming selection**. Decision-making related to mental health promotion, prevention and early intervention protocols in schools is informed by context: student needs, available resources (time, funding, staffing, materials), and alignment with school and board strategy and priorities. Speakers and participants spoke about the need to ensure that programming selected is supportive of the cultures, identities, strengths, and needs of student served. In addition, there was a recognition that buy-in is facilitated when programming is feasible, familiar, and fits with the busy practice of a school professional. That is, programming is most likely to be successful when it is both evidence-informed and implementation-sensitive (Crooks et al., 2022).

Several speakers noted the importance of **co-design and co-creation of interventions** with key stakeholder audiences. For example, *Sparklers* created a number of small classroom activities over two years, with iterative input from a community of practice for educators, to ensure that these resources would be deemed immediately useful (without need for lengthy training sessions), seen as curriculum linked, and peer informed. The team also grew alongside Maori partners who provided guidance to assist with cultural responsivity.

Other speakers and participants mentioned the importance of **role specific training that is fit for purpose**, rather than one size fits all. When introducing new school mental health programming into a school, like *Pause, Breathe, Smile*, there is a critical step in engaging and equipping school leaders so they can bring forward a whole school approach with knowledge and confidence. This type of preparation, on matters of staff engagement, school strategy alignment, and progress monitoring is different than the sort of training required for educator program implementation. Similarly, in describing the *Supporting Transition Resilience of Newcomer*

Groups (STRONG), an evidence-informed, school-based intervention for immigrant and refugee youth (K-12th grades), speakers highlighted the importance of offering expertise level training for SMH professionals that fits with the role of a busy practitioner, and includes hands-on case examples, role play, and identity-affirming techniques that can be easily absorbed into practice. Several participants noted that when training is flexible and practical, and specific to role, school and system personnel are more likely to try out, engage, and then recommend the programming.

Several presenters offered commentary related to the importance of **ongoing iterative learning and coaching support**. The presenters were clear that, in most cases, one-time training sessions are insufficient to garner uptake and sustainability. Having a range of implementation supports, like the learning collaboratives and office hours for front-line SMH professionals engaging with BDIs, weekly newsletter updates and communication related to *Sparklers*, and regular coaching consultation calls for clinical supervisors who oversee the work of school practitioners who provide STRONG or the *Brief Intervention for School Clinicians* (BRISC), are an essential part of sustainable school mental health implementation.

Meaningful stakeholder engagement

To deliver mental health and wellbeing services and supports in schools that are fit for purpose and to maximize the potential for stakeholder engagement requires a commitment to design what is offered with schools and their communities. A co-design approach acknowledges that every school and every community have different priorities, strengths and challenges, and seeks to understand from them how best to contribute the skills and knowledge and ensure that they are provided in a way that works best for their context. Speakers and participants in the SMH Match noted that to do this well requires leaders and practitioners to commit to an approach that is informed by relevant culture(s), inclusive of all interested parties and that it is

ongoing, leading to continuously evolving responses. The speakers underscored that this process also requires a fundamental belief in the adage that 'the whole is greater than the sum of its parts'.

Co-design creates a culture of shared power where relationships are nurtured and strengthened within, between and across health, education and social sectors and the communities they support to achieve a shared vision. Speakers and participants discussed the importance of creating ongoing opportunities for participation in design which values the skills and knowledge of all participants and builds active partnership which, in turn, builds capability and empowers communities. Participants noted that, typically, health responses have been designed by health professionals and delivered to schools and families. Speakers describing the Mani Aka approach in New Zealand indicated that the education model and culture are strengths based and focused on skill development. This allows for an avoidance of pitfalls of a more deficit-based model, focused on diagnosis and treatment, which can result in a lack of confidence amongst teachers and parents, and a belief that specialist intervention is required to address the child's needs. The presenters noted that using a co-design approach to create supports in school settings has nudged the health sector in New Zealand to learn about the school curriculum, priorities for school leaders and teachers, and the culture of individual school settings to work collaboratively to develop successful muti tiered responses that promote wellbeing and positive mental health in a way that has the potential to become embedded within each context.

Participants suggested that rather than focusing on systems and processes that perpetuate a health service model (e.g., characterized by a focus on 'referral', 'wait list', 'discharge', and 'criteria'), it is important when seeking services to embed supports in an education context. Learning how schools recognize and respond to children's stress and distress and working with

them to consider how they might use the resources available for greatest impact creates a culture of partnership and shared responsibility. Building trusted relationships in school communities through regular presence and by providing support in a wide variety of contexts creates multiple pathways for children and families to seek advice, guidance and support and provide input and feedback. Participants emphasized that responding to feedback from families, teachers, school leaders and community partners about what works and seeking to revise what is offered or how it is offered builds a sense of ownership, empowerment, and engagement.

Collaboration across sectors and disciplines

The development and utilization of systems that promote cross-discipline and cross-sector collaboration is a critical component of establishing comprehensive and sustainable school mental health programming. The need for collaborative initiatives designed to address gaps in the health/education interface is particularly salient in some IIMHL regions, such as New Zealand, wherein schools are self-managing (i.e., schools are governed by appointed representatives and are not mandated to collaborate with the Ministry of Health or other government departments). Given that self-managing schools are not required to include mental health programming in their curricula, it is crucial for professionals and stakeholders across these sectors to foster collaborative relationships that promote the establishment of shared visions to meet the mental health needs of students.

One such example of a platform that aims to facilitate interdisciplinary collaboration is the Mental Health-Education Integration Consortium (MHEDIC; USA). Through biannual meetings, MHEDIC brings together educators, mental health professionals, families, and advocates to share perspectives and offer mutual support for a range of topics related to mental health and education (see https://cayci.osu.edu/initiatives/mental-health-education-integration-

consortium-mhedic/). This group also is an incubator for new ideas, and a hub for cross-jurisdictional collaboration. There is an explicit focus on teaching and mentorship, so that early career researchers are given an opportunity to learn alongside more seasoned professionals, sharing ideas and building bridges across disciplines and sectors. Several MHEDIC members attended the SMH Match and echoed the need for more forums of this nature to stimulate ideas and partnership.

To sustain the impact of interdisciplinary systems of care, members should work together to establish a unified, child-centered vision, and to develop specific operational definitions to clarify the roles and responsibilities of all members within the system. One example of an operational framework for coordinating systems of care to promote youth mental health is the *Right Time, Right Care* model, developed in Ontario, Canada (see https://smho-smso.ca/wp-content/uploads/2022/04/report-right-time-right-care.pdf). This initiative provides an aspirational vision for the child and youth mental health system of care, and tools to support actionable plans for how local schools and community mental health agencies can work together to provide comprehensive, effective mental health care that is responsive to students' needs. By establishing a framework that operationalizes the development and implementation of collaborative care partnerships, this model sets the stage for school and community mental health partners to navigate the path forward more effectively from shared vision to committed action.

Measurement-base care and progress monitoring

Measurement-based care (MBC) is defined as the continuous collection of client-report data used to support clinical decision-making as part of standard care. Best practices for MBC include routine progress monitoring. In school mental health, progress monitoring is used to quantify a student's rate of improvement or responsiveness to prevention or intervention, and to

evaluate the effectiveness of interventions using valid and reliable measures. Across all levels of the system sites monitor progress to provide feedback for improvement. With progress monitoring, teams use valid and reliable tools, and focus on fidelity of implementation for interventions, with consideration for cultural and linguistic responsiveness and recognition of student strengths.

At several points in the SMH Match, participants and speakers expressed a need for more robust and consistent data systems to measure progress in school mental health. It was noted that this approach serves individual student care, and can also help with case-making, at a policy level, for continued and additional investments. Several jurisdictions spoke about measurement systems in place but noted that these tend to be rather fragmented across service areas, sectors, and disciplines. At an individual student level, several of the protocols described at tier 2 include an embedded progress monitoring system, to optimize the use of MBC as part of regular clinical practice (e.g., BDI, BRISC, STRONG). The strong value of using data as a feedback tool for young people was emphasized. Data use was also highlighted as an important lever for school and system leaders, to inform their planning and decision-making. Several speakers noted that measurement in school mental health should move beyond tracking of illness indicators, to include measures of flourishing and wellness, given that so much of the focus in schools is on mental health promotion and strength-based programming.

Takeaway Points on Challenges and Opportunities in SMH

The takeaway points described below include reflections from participants on some lessons learned by those involved in SMH, as well as suggestions for how to be more efficient, effective, scalable, and sustainable when implementing SMH.

Promote sustainability/feasibility for implementation, and provide appropriate implementation supports

Participants cautioned against the use of "Cadillac" models of school mental health intervention programs which are expensive and inflexible manualized demonstration and pilot programs that frequently come and go and ultimately service few schools and young people. Instead, participants emphasized the importance of seeking out programming and supports that provide, and have evidence for, scalability and sustainability from the beginning. In addition, participants noted that decision-makers should build in and cost out implementation supports as part of any new programming.

Best practices for adapting programs for diversity across settings

The demographics across the globe are rapidly changing and young people within schools are becoming increasingly more diverse. Yet, many of the mental health programs used in schools were developed on socioeconomically and culturally homogenous populations, highlighting the need for programs that are more reflective of, and responsive to, different cultures and thereby most likely to increase equitability and sustainability. Participants noted that the use of an Identity Affirming SMH frame (https://smho-smso.ca/about-us/identity-affirming/) could be helpful which is based on the idea that we need to decenter Western approaches and instead use an "affirm, adapt, abandon, and add" approach.

Leaning into measurement-based care, progress monitoring, and evaluating outcomes/effectiveness

Although there is compelling evidence to support the utility of MBC to improve mental health service quality, participants noted that the use of MBC in school mental health remains minimal. Findings from a recent study that included mental health experts across the USA revealed six top-rated implementation strategies for MBC in schools, including: (1) assess for

readiness and identify barriers and facilitators; (2) identify and prepare champions; (3) develop a usable implementation plan; (4) offer a provider-informed menu of free, brief measures; (5) develop and provide access to training materials; and (6) make implementation easier by removing burdensome documentation tasks (Connors et al., 2022). Participants concluded that MBC has not been a central construct in the development of the SMH field, and now is the time to broadly increase emphasis on it.

The reward of sharing resources in a coordinated/responsive matter during crises.

As highlighted in the section on effective leadership, in times of crisis that impact the mental health of young people, such as geographically proximal natural disasters or school shootings, participants emphasized that school leaders must be prepared to communicate effectively with various stakeholders, disseminate information, and strategize about how to support the mental health of those affected by the crisis, including guidance from other communities experiencing past crises. Although disasters or crises are often local (e.g., flooding), coordination and collaboration among professionals should extend beyond the local community.

The risks of participating in over-inflation/sensationalism of mental health pathology after a crisis

In the heroic phase of a disaster or crisis (see Figure 1), there is a natural inclination for mental health professionals to want to contribute to the disaster response by providing immediate mental health support to youth and their families. This reaction is based on well-established knowledge that crises and disasters can affect the mental health of individuals (Goldmann & Galea, 2014). Participants noted the importance of practitioners and first responders being sensitive when conducting an initial needs assessment of behavioral health to identify at-risk

young people who should be targeted for outreach. Once those young people are identified, decisions can then be made about how to effectively allocate resources, and appropriately target interventions to help promote recovery of young people after a crisis or for those living and attending schools in disaster-affected communities.

When a crisis or disaster occurs, there often is a large media presence and extensive reporting. While participants noted the importance of media calling attention to the mental health needs of young people after a crisis or disaster, they also emphasized how some media reports can be inaccurate or even serve to further stigmatize mental health challenges. Participants cited the need for SMH leaders and practitioners to develop relationships with the media to quickly correct erroneous reports and combat stigma. There are some organizations such as Stigmawatch (https://www.sane.org/get-involved/advocacy/stigmawatch) in Australia, and Like Minds, Like Mine (https://www.likeminds.org.nz/individuals/media-watch/) in New Zealand who encourage relationships with the media to promote positive coverage about mental health while also calling out inaccurate media coverage.

Leadership that seeks to understand and effectively respond to rapidly changing needs of schools

As noted previously, senior decision makers such as superintendents or school principals carry the greatest level of responsibility and have the authority to make changes within their roles. Participants noted that leaders who seek to understand and effectively respond to the rapidly changing needs of schools are skilled at gathering and utilizing feedback from key stakeholders such as educators, students, parents and caregivers, and community partners before enforcing any changes. Distributing leadership, and amplifying stakeholder voice in meaningful ways, creates a sense of shared responsibility, ownership, and community during challenging

times. Participants commented that because school leaders can be changemakers, they should seek to ensure that the adoption and success of any innovations or initiatives within their schools are in alignment with the goals of the school and the success of all students.

Promoting and engaging with Mental Health-Education partnerships

Participants emphasized the importance of developing and engaging in opportunities to learn what is happening in each other's sectors, the need for shared language, being open to new ways of working together, the use of shared measurement strategies, and real engagement with a joint mental health strategy and action plan. Participants noted that the integration of education and mental health will be advanced when these partnerships agree on shared goals that support the well-being of all young people.

Future Considerations

The Match sessions concluded with a discussion on school mental health workforce development, how to enhance and promote research, practice, and policy impacts, and the advantages of global collaboration and connection. Related to workforce development, there is currently an inadequate supply of behavioral health practitioners to support the increasing need for mental health services, including in schools. Participants noted the following considerations when thinking about how to recruit, retain, and ultimately expand the behavioral health provider workforce: 1) leverage non-specialist service providers to offer early identification and promotion work; 2) the need to begin building the workforce in high school to prepare for the future; 3) the need to attract more diverse young people to the SMH field; and 4) to consider changes to training programs to graduate more practice-oriented professionals.

In thinking about how to advance the agenda of supporting young people with mental health needs in schools, participants noted the importance of engaging people with lived and

current experience, referenced communities of practice as opportunities to exchange knowledge, and underscored the opportunity to apply what works well in other countries.

Finally, participants highlighted the value of international discussions and collaborations as a source of strength during challenging times, the benefit of gaining guidance around how things translate locally, and as a great opportunity to enhance international clinical, research, and policy partnerships. As one example, in 2022, a SMHILE member in Poland, Dr. Robert Porzak, reached out to the network requesting resources and assistance to support the large number of refugees crossing the border from Ukraine as the war escalated. Several members provided evidence-based materials on crisis response and trauma which were translated into Polish, Ukrainian, and Russian and put to immediate use. In addition, SMHILE members Dr. Eric Bruns and Dr. Sharon Hoover mobilized a team from the USA to travel to eastern Europe to provide direct assistance. This team offered *Health Support Team* and *PsySTART* training to local service providers and community volunteers to help them be effective first responders for children and families displaced and impacted by the war in Ukraine. *Health Support Team* training teaches laypeople how to respond to those affected by a traumatic event and offers guidance related to referrals for more intensive supports. *PsySTART* helps lay people to triage children to identify those facing the most acute trauma symptoms. Further, Drs. Brun and Hoover trained school administrators, teachers, and volunteers in multi-tiered school support for refugees, including STRONG programming. At that time, the Polish public education system had welcomed thousands of Ukrainian children into their schools and requested psychological training to support these students. Through international connections, strong relationships, and generous spirit, global SMH leaders came together to answer the call. This example of international collaboration highlights the value of mobilizing networks and activities to share

knowledge and bring experience and expertise around research-informed strategies and practices that are responsive to local efforts to deliver effective school mental health efforts.

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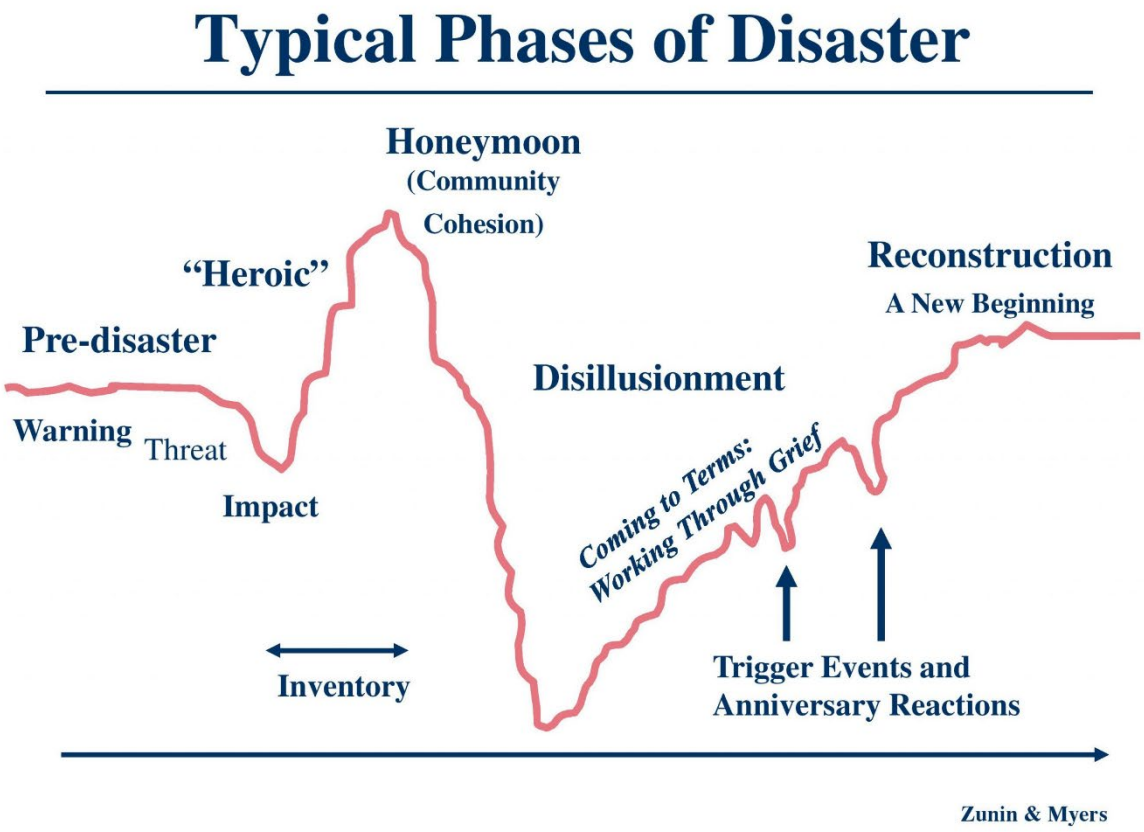
Table 1. International Initiative for Mental Health Leadership (IIMHL), School Mental Health (SMH) Match, Themes and Resources

Theme	Resource
Effective school leadership in times of complexity, change, and crisis	Cann, R.F., Riedel-Prabhakar, R. & Powell, D. (2021). A model of positive school leadership to improve teacher wellbeing. *International Journal of Applied Positive Psychology, 6*, 195–218. https://doi.org/10.1007/s41042-020-00045-5 Day, C., Sammons, P., & Gorgen, K. (2020). *Successful school leadership*. Education Development Trust. Pont, B., Nusche, D., & Moorman, H. (Eds.) (2008). *Improving School Leadership Volume 1: Policy and Practice*. Paris: OECD. Williamson, R., & Blackburn, B. (2022). Effective school leaders are prepared for crisis: https://www.middleweb.com/48050/effective-school-leaders-are-prepared-for-crisis/
Strategies to advance uptake and sustained implementation, and adapt programs for diversity across settings	https://ies.ed.gov/ncee/edlabs/regions/northeast/pdf/handout19_Adopt-adapt-abandon.pdf https://smho-smso.ca/about-us/identity-affirming/
Meaningful stakeholder engagement	*Co-designing for social good: The role of citizens in designing and delivering social services, Part One*. Dr. Ingrid Burkett, Social Design Fellow, Centre for Social Impact, University of NSW 2012 https://www.yacwa.org.au/wp-content/uploads/2016/09/An-Introduction-to-Co-Design-by-Ingrid-Burkett.pdf https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Voices-Mental-health-needs-1_0.pdf. *Children's voices: A review of evidence on the subjective wellbeing of children with mental health needs in England.*
Collaboration across sectors and disciplines including during a crisis	Substance Abuse and Mental Health Services Administration: *Communicating in a Crisis: Risk Communication Guidelines for Public Officials*. SAMHSA Publication No. PEP19-01-01-005. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2019.

	Mental Health Education Integration Consortium (MHEDIC): https://cayci.osu.edu/initiatives/mental-health-education-integration-consortium-mhedic/ Right Time, Right Care model, developed in Ontario, Canada (see https://cmho.org/wp-content/uploads/Right-time-right-care_EN-Final-with-WCAG_2022-04-06.pdf).
Behavioral health workforce development	Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research, 46*, 689–695. https://doi.org/10.1007/s10488-019-00963-w Center for Mental Health Services, *Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders*, Substance Abuse and Mental Health Services Administration,2019 https://www.nasmhpd.org/sites/default/files/TAC_Paper_3_508C_0.pdf
Interconnected measurement with a focus on research, practice, and policy impact	Connors, E. H., Lyon, A. R., Garcia, K., Sichel, C. E., Hoover, S., Weist, M. D., & Tebes, J. K. (2022). Implementation strategies to promote measurement-based care in schools: evidence from mental health experts across the USA. *Implementation Science Communications, 3*(1), 67. https://doi.org/10.1186/s43058-022-00319-w

Figure 1. Typical Phases of Disaster (Zunin & Myers, 2000)



Appendix A

Disaster Support

https://healthsupportteam.org/

School Mental Health Programs

https://sparklers.org.nz/

https://sparklers.org.nz/documents/23/SparklersEvalnReportFinal180718.pdf

https://drive.google.com/file/d/1RCm3irRY4JHf2xSeG1Z7imGoMq2dbOkQ/view

https://www.csmh.uwo.ca/RESEARCH/STRONG.HTML

BRISC: https://smartcenter.uw.edu/brisc-research/

BDI: https://www.csmh.uwo.ca/docs/publications/isulabpublications/barry--cwinn--2021---brief-digital-interventions-in-ontario-schools.pdf

Resources related to War

https://www.childrenandwar.org/

https://sesamestreetincommunities.org/subtopics/resources-in-ukrainian/

https://www.youtube.com/playlist?list=PL8TioFHubWFtb3SmM8D4ApXtktrzC36c8

https://profilaktycy.pl/index.php/produkty/nctsn

https://profilaktycy.pl/index.php/article01/84-eric-bruns-i-zespol-smhile-w-lublinie

https://docs.google.com/document/d/e/2PACX-1vQJ7i2Si7n-P_y4VBudfKZ-o2yQDVIVEJp_XfV43xC4FqKpKtxwQ19ueAjBuBthm64pPqI1I8Z-OOGU/pub

https://lublin.caritas.pl/helping-ukraine-current-informations/

https://www.wsei.lublin.pl/

https://profilaktycy.pl/index.php/produkty/diagnoza/stres-trauma

Self-Care, Wellbeing, Professional Development

https://www.mindfulteachers.org/blog/self-care-resources

https://supereval.com/blog/school-leaders-and-the-importance-of-self-care/

https://www.edweek.org/leadership/sel-for-principals-how-a-professional-development-program-serves-their-high-stress-needs/2021/09

International School Mental Health Organizations

https://smhile.org/

https://www.iimhl.com/

Technical Reports and articles related to SMH

https://www.sane.org/about-sane/advocacy/stigmawatch

https://smho-smso.ca/blog/?id=11406

https://www.sciencedirect.com/science/article/pii/S2214782921000373

https://www.schoolmentalhealth.org/Resources/Foundations-of-School-Mental-Health/

https://tuturu.org.nz/assets/Tuturu-TOC-NZCER2016.pdf

Appendix B

Overview of School Mental Health Ontario

"How can we establish a comprehensive, systematic and evidence-informed approach to school mental health service delivery that is scalable and sustainable at a provincial level?" That was the question posed by School Mental Health Ontario in 2012 when the Ministry of Education announced funding for this implementation support team that would support efforts to enhance student mental health across the province's 72 school districts, 5000 schools, and two million students. Recent Canadian practice scans and surveys had shown: (1) significant reported student mental health needs; (2) a practice landscape with considerable service variability, fragmented mental health programming and sporadic initiatives; and (3) a strong desire for a more coordinated and comprehensive system of care with a well-equipped school-based workforce (Froese-Germain, Riel, & Canadian Teachers' Federation, 2012; Santor et al., 2009; SBMHSA Consortium, 2013). While the research literature was clear about effective school mental health practice (e.g., Kutash, Duchnowski, & Lynn, 2006; SBMHSA Consortium, 2013; Weist et al., 2014), it was evident that pockets of excellence that existed in Canada at that time were not being scaled or sustained. A new approach was needed to bridge the gap between research, policy, and practice. School Mental Health ASSIST (now known as School Mental Health Ontario) was tasked with establishing and enacting this approach within the province of Ontario.

The natural starting place was to establish a framework for action drawing on the best available research evidence. The empirically supported Multi-Tiered Systems of Support (MTSS) approach (see Eber et al., 2020) offered a coherent way of organizing resources, supports and services across the province and was adopted as a foundational frame of reference.

School districts were invited to engage in a resource mapping exercise to identify existing and needed evidence-informed, locally relevant supports across the tiers - mental health promotion (tier one), prevention and early intervention (tier two), and intensive therapeutic supports (tier three). While the elements could vary and would manifest differently in different regions and school communities, all districts across the province were able to use MTSS as an organizing frame to conduct their local needs assessment. School Mental Health Ontario provided guidance to help to inform evidence-informed decision-making across the tiers.

MTSS served as a helpful research-based foundation, offering an organizing system for ***what*** can and should be offered as part of school-based service delivery. However, as noted above, knowing what to do according to evidence does not easily translate into coordinated, embedded and sustainable practice. ***How*** this programming can be offered to promote fidelity, scalability, and sustainability within and across school districts in the province required equal consideration. Canadian survey data indicated that the research-to-practice gap was fueled by barriers related to perceived gaps in organizational infrastructure, workforce capacity, implementation support, equity, meaningful engagement, and system collaboration (SBMHSA Consortium, 2013). In response, School Mental Health Ontario sought to explicitly surface and address barriers to uptake of evidence-informed practices. Implementation science provided the guidance and vehicles for navigating this to overcome the obstacles to effective and sustainable school mental health practice - intentionally, explicitly, and systematically (Short, 2016).

In addition to having strong evidence-informed interventions across the tiers, implementation science identifies two other key elements needed for effective, scalable, and sustainable school mental health: foundational infrastructure and ongoing implementation support (Fixsen et al., 2005).

Infrastructure + Interventions + Implementation = Effective and Sustainable SMH

Schools were not historically built to support robust school mental health service delivery. This reality was reflected in survey responses from Canadian school district and school leaders (SBMHSA Consortium, 2013) as they identified several gaps in structures and processes that interfered with effective practice. For instance, respondents noted that even when school mental health leadership and implementation teams exist, there were gaps with respect to system commitment, role clarity, protocols, communication and shared language, funding, and implementation support. It was clear that most districts and schools lacked the ***infrastructure*** needed for effective school mental health practice. Working alongside the Council of Ontario Directors of Education and the Ministry of Education, School Mental Health Ontario drew on the readiness and change management literature to establish a "top 10 list" of organizational conditions needed for effective school mental health service delivery. This initial list included elements like visible leadership commitment, the presence of a mental health leadership team, and clear protocols and processes (e.g., for program decision-making, suicide prevention and postvention, cross-sectoral collaboration; Short et al., 2017). For the most part, establishing these conditions rests with district and school leaders. As such, School Mental Health Ontario has prioritized relationship-building with provincial stakeholder groups that hold influence with these groups, like principal associations and superintendent networks, to collaboratively build and deliver supports to develop needed district and school infrastructure and to empower their mental health leadership. Placing a strong and equal focus on foundational infrastructure serves to increase the likelihood of uptake and sustainability of evidence-informed mental health programming.

As noted, however, infrastructure and intervention are only part of the story. Ongoing ***implementation*** support is essential for programming to be delivered as intended and sustained over time. Implementation scientists have articulated a range of strategies most likely to inspire uptake of evidence-informed practices in schools. For example, Cook and colleagues (2019) and compiled a list of 75 implementation support strategies in their *School Implementation Strategies, Translating ERIC Resources (SISTER)* project (e.g., provide interactive assistance, adapt and tailor programming to context, train and educate stakeholders). Over the past decade, School Mental Health Ontario has iteratively developed an implementation support approach, rooted in MTSS (***what***) and implementation science (***how***), that provides eight key services, briefly described below.

1. **Provincial leadership and guidance**

   In consultation with the Ministry of Education and other key provincial stakeholders, School Mental Health Ontario creates a provincial research-informed, practice-relevant 3-year strategy and 1-year action plan to guide school board mental health leadership teams in their local strategy and action planning. School districts use provincial directions to help with defining key areas of focus across the tiers of school-based intervention. This leadership cascade creates a unified and coherent approach to school mental health across the province.

2. **Implementation coaching**

   Every school district in Ontario has a School Mental Health Ontario Implementation Coach who offers tailored district-specific support. Coaches typically carry 6-8 school boards in a region. Each of the six regions in the province has at least two coaches, one who is a senior clinician, and one who is a system leader (Director or Superintendent of Education). Large regions may have as many as four coaches assigned. In addition to individual board

coaching, these teams facilitate regular regional meetings where common issues are discussed. Coaching is offered in both official languages, English and French.

3. **Co-created classroom and targeted resources**

   All resources, tools, and programming offered through School Mental Health Ontario are co-developed with stakeholders. Relationships with teacher federations, principal associations, and social work / psychology organizations have resulted in the co-development and shared dissemination of a range of classroom-ready materials built to respond to identified needs. For example, during the pandemic, educators called for "plug and play" lesson plans to assist students with stress management, which led to the design of a series of Virtual Field Trips alongside partners at Ophea (Ontario Physical and Health Education Association).

4. **Training and professional learning**

   Role-specific training and professional learning is offered according to a carefully crafted system calendar designed to meet identified knowledge needs. In 2022-2023, cornerstone learning includes a focus on identity affirming school mental health within a stepped care model (school clinicians), leadership in school mental health (directors, superintendents, principals), early identification and support (student support workers), and mental health literacy (educators). Training is provided **face-to-face** (when possible) (e.g., *Brief Intervention for School Clinicians, BRISC*, 2-day training sessions), by **webinar or podcast** (e.g., *Leading Mentally Healthy Schools* for principals and vice-principals), and in an **on-line course format** (e.g., *MH LIT* mental health literacy course for educators). All learning opportunities are role-specific, practice-oriented, and evidence-informed. In most cases, offerings feature stakeholder voices and examples delivered using a co-facilitation model.

5. **Uptake networks**

School Mental Health Ontario creates a range of platforms for sharing across school boards, with a view to identifying enablers to uptake, anticipating barriers, and showcasing exemplars of successful uptake. For example, after initial self-directed training and an onboarding webinar, the use of *Brief Digital Interventions (BDIs)* is further facilitated using a Learning Collaborative format where clinicians using this protocol come together to discuss issues arising in practice. Similarly, superintendents with responsibility for mental health meet regularly in a community of practice setting, sharing best practices for overcoming identified challenges. This culture of articulating enablers and barriers to uptake also happens routinely in regional coaching meetings and has begun to occur in more ad hoc ways as Mental Health Leaders from across boards come together to work through common problems of practice.

6. **Research, evaluation, and monitoring**

In addition to being good consumers and ambassadors of research, School Mental Health Ontario engages in study to support the selection and refinement of evidence-informed, implementation-sensitive, locally relevant programming. The Innovation and Scale Up Lab is a partnership between the Centre for School Mental Health at Western University and School Mental Health Ontario. The Lab sources, curates, and tests evidence-informed, implementation-sensitive programming that meets the needs of Ontario's diverse student population. Many of the innovations tested in the Lab come to the attention of School Mental Health Ontario through global networks like SMHILE and IIMHL and are further adapted for the provincial context. In addition, through a partnership with the Offord Centre for Child Studies at McMaster University, School Mental Health Ontario is engaged in the development of systems for measurement-based care and impact monitoring.

7. **Engagement of student and parent/caregiver reference groups**

School Mental Health Ontario values and invites student and parent/caregiver voice and leadership in child and youth mental health. To gather student input into developing school mental health strategy, an initiative called #HearNowON was established in 2019. This input-gathering initiative was co-led with Wisdom2Action and involved a student survey and series of regional focus groups. Findings informed the School Mental Health Ontario strategy and supported the work of the ThriveSMH Student Reference Group. #HearNowON 2021 built on these findings, and included pandemic-focused questions and a series of topic-centered forums. One of the key findings from this latest initiative is that students wanted their parents and caregivers to know more about mental health so they could support them better. In response, a Parent Caregiver Collaboration Group has recently been formed.

8. **System of care collaboration**

School mental health does not exist in a vacuum. It is a part of the system of care. Just as local relationships must be nurtured for successful cross-sectoral service delivery, so too do provincial organizations need to find ways to complement their services. School Mental Health Ontario has been working alongside other provincial intermediary groups, like the Knowledge Institute for Child and Youth Mental Health, Youth Wellness Hubs Ontario, Children's Mental Health Ontario, Kids Help Phone, and Jack.org, to build a strong network of support for young people. Most recently, School Mental Health Ontario partnered with the Lead Agency Consortium, the Knowledge Institute, and Children's Mental Health Ontario to bring forward a research-based aspirational vision and blueprint towards the system of care for child and youth mental health in Ontario (Right time, right care, 2022).

In summary, School Mental Health Ontario is situated in the space between research, policy, and practice and draws on MTSS and implementation science to provide a range of supports to Ontario school districts in support of student mental health. These supports have evolved in an iterative manner, using rapid implementation cycles and feedback loops. Central to the success of the service has been a strong focus on relationships with provincial stakeholders, in addition to proximity to policy officials and researchers who help in shaping directions for the field. Global relationships and partnerships established through SMHILE, IIMHL and other leadership networks have been a core driver and inspiration towards scalable and sustainable school mental health in the province of Ontario.

Questions?

Visit School Mental Health Ontario

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