Propelling the Global Advancement of School Mental Health

Mark D. Weist[1] · Sharon A. Hoover[2] · Brian P. Daly[3] · Kathy H. Short[4] · Eric J. Bruns[5]

Abstract
Rates of mental health problems and disorders in children and youth have been increasing for at least three decades, and these have escalated due to the pandemic and multiple other societal stressors. It is increasingly recognized that students and families frequently struggle to receive needed care through traditional locations such as specialty mental health centers. Upstream mental health promotion and prevention strategies are gaining support as a public health approach to supporting overall population well-being, better utilizing a limited specialty workforce, and reducing illness. Based on these recognitions, there has been a progressive and escalating movement toward the delivery of mental health support to children and youth "where they are," with a prominent and more ecologically valid environment being schools. This paper will provide a brief review of the escalating mental health needs of children and youth, advantages of school mental health (SMH) programs in better meeting these needs, example model SMH programs from the United States and Canada, and national and international SMH centers/networks. We conclude with strategies for further propelling the global advancement of the SMH field through interconnected practice, policy, and research.

Keywords Mental health needs · Children and youth · School mental health · International networks · Model programs · Practice · Policy · Research

Mental health needs among school-aged children and youth are at historically high levels and rising. For example, data from a national survey of high school students revealed increases between 2009 and 2019 in having persistent feelings of sadness or hopelessness (26.1 to 36.7%), having seriously considered attempting suicide (13.8 to 18.8%), and having attempted suicide (6.3 to 8.9%; Centers for Disease Control and Prevention, 2022). A study conducted by the Health Resources and Services Administration (HRSA), found that between 2016 and 2020, the number of children ages 3–17 years diagnosed with anxiety grew by 29% and those with depression by 27% (LeBrun-Harris et al., 2022).

The United States (U.S.) Substance Abuse and Mental Health Services Administration (SAMHSA) recently emphasized that the COVID-19 pandemic only intensified what was already a significant youth mental health concern. The report underscored calls from national leaders in the United States, including the U.S. President, the U.S. Office of the Surgeon General (2021), and the American Academy of Child and Adolescent Psychiatry (2022) to escalate efforts to address child and youth mental health concerns with a sense of urgency. The SAMHSA (2022) report highlighted significant unmet mental health and substance-related needs for children and youth prior to the pandemic (Centers for Disease Control and Prevention, 2021; Perou et al., 2013; Welsh et al., 2020), with problems including higher numbers of youth screening positive for suicidal ideation and increasing rates of anxiety and depression since the pandemic (Lantos et al., 2022; Mayne, 2021; Office of the Surgeon General, 2021).

The mental health concerns arising and escalating among children and adolescents is not limited to the U.S. Mental health problems affect 10–20% of children and adolescents worldwide, and up to 40% in some low-income countries (Kieling et al., 2011). A recent meta-analysis by Racine and colleagues (2021) examined the global prevalence of clinically elevated child and adolescent anxiety and depression

✉ Mark D. Weist
WEIST@mailbox.sc.edu

1 University of South Carolina, Columbia, USA

2 University of Maryland School of Medicine, Baltimore, USA

3 Drexel University, Philadelphia, USA

4 School Mental Health Ontario, Toronto, Canada

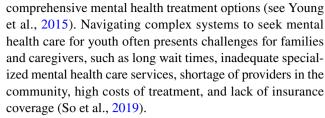5 University of Washington, Seattle, USA

symptoms during COVID-19. The review included 29 studies totaling 80,879 youth globally and found prevalence estimates of clinically significant depression (23.8%) and anxiety symptoms (18%) to be significantly higher than the estimates reported prior to the onset of COVID-19 and subsequent lockdowns. These data highlight the impacts of the pandemic; however, rates of mental health disorder were already high and rising. For example, worldwide prevalence estimates of mental disorders in youth prior to COVID-19 was estimated to be around 13%, with estimates of any anxiety disorder at 6.5% (CI 95% 4.7–9.1), any depressive disorder at 2.6% (CI 95% 1.7–3.9), attention-deficit hyperactivity disorder at 3.4% (CI 95% 2.6–4.5), and any disruptive disorder at 5.7% (CI 95% 4.0–8.1; Polanczyk et al., 2015).

In the U.S. and across the globe, historically underserved youth populations have been disproportionately affected by the COVID-19 pandemic, and underlying inequities related to the social determinants of health, which have exacerbated mental health concerns for these young people. For example, the SAMHSA (2022) report called for increased attention to underserved populations in the U.S. based on the findings that non-Hispanic American Indian, and Alaskan Native youth lead all other groups in rates of suicide, and LGBTQ adolescents attempt suicide four times more often than non-LGBTQ youth (Johns et al., 2020). Further, there has been a clear escalation in suicide attempts by Black youth, with rates rising faster than that of any other racial/ethnic group, and Black children under the age of 13 being twice as likely to die by suicide than White youth even before the pandemic (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Lindsey et al., 2019). Children from racially and ethnically minorized populations and those from low-income households experienced the greatest amount of missed learning during the pandemic (Goldhaber et al., 2022).

The extant literature from international studies similarly reveals that youth from low socioeconomic backgrounds living in low-income or middle-income countries, and especially those from disadvantaged and historically marginalized families, experience mental health disparities. For example, in a systematic review by Reiss (2013), nearly all the international studies included in the review (52/55) revealed an inverse association between at least one marker of socioeconomic status and mental health problems. In another review that examined the social determinants of mental health in adolescents and young adults from Western nations, findings revealed that disparities present in marginalized communities were correlated with worse mental health outcomes in these populations (Jalla et al., 2020).

Compounding the sense of rising mental health concerns is that many communities, especially those located in urban or rural settings with high concentrations of historically underserved youth populations, lack accessible, high quality, comprehensive mental health treatment options (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 (So et al., 2019).

Like the access to care issues in the U.S., the majority of youth and families around the world who need mental health care lack access to high-quality services (Rowling & Weist, 2004; Wainberg et al., 2017). Factors such as stigma, shortages of qualified mental health professionals, and fragmented service delivery models contribute to the current mental health treatment gap (Wainberg et al., 2017). The result is that needed mental health services are difficult to access with children and families often waiting extensive time for specialty care or instead utilizing expensive emergency department services that are unprepared to care for these children. There are many ways to improve access to identity affirming, culturally responsive mental health care, with moving these services to youth "where they are," in a more ecologically valid and accessible setting of schools gaining significant momentum (see Ghuman et al., 2002; Hoover & Bostic, 2021).

The Rationale for School Mental Health (SMH)

Comprehensive school mental health (SMH) systems, involving a multi-tiered system of support and services (MTSS) in schools, are increasingly recognized as a vital component of the child and adolescent mental health system (Hoover & Bostic, 2021). Research indicates that integrating mental health promotion, prevention, early intervention, and more intensive intervention in schools holds promise for improving both academic (Durlak et al., 2011; Kase et al., 2017; Walker et al., 2010) and psychosocial functioning (Fazel et al., 2014a, 2014b). Evidence is accumulating for the positive impact of school mental health on academic success (Kase et al., 2017). A series of meta-analyses on universal social-emotional-learning programs in schools points to their positive impact on several academic indicators, including reading and math achievement, standardized test scores, school grades, and teacher-rated academic competence (Durlak et al., 2011; Sklad et al., 2012; Taylor et al., 2017; Wiglesworth et al., 2016). School-based targeted interventions for students exhibiting mental health concerns have also demonstrated a range of positive academic outcomes for students (Kase et al., 2017). Others point to the promise of school-based care for promoting overall positive mental health and well-being (Cefai et al., 2022). Mental health promotion for all students—including programming

focused on the promotion of positive behavior (e.g., Positive Behavioral Interventions and Supports [PBIS]) and building social-emotional- competencies—has been associated with positive skill development (Durlak et al., 2011; Greenberg et al., 2017; Sklad et al., 2012), reduced conduct problems and disciplinary action (Bradshaw et al., 2008, 2010), lowered student anxiety and depression (Calear & Christensen, 2010; Neil & Christensen, 2009) and improved academic performance (Durlak et al., 2011). Positive school climate, which can be improved with programming to foster supportive relationships and physical and emotional safety in schools, is related to positive mental and emotional health, especially for youth most vulnerable to mental health challenges (Ancheta et al., 2021). A growing body of research demonstrates that early intervention and treatment in schools can reduce mental illness, including substance use (Antshel, 2015; Carney et al., 2014; Langley et al., 2015).

Offering a range of mental health services directly in schools has several advantages over community mental health and hospital settings (Stephan et al., 2015). Children and adolescents are more likely to initiate and complete care when offered in schools than in mental health clinics (Rones & Hoagwood, 2000). Efforts by school staff to build mental health literacy can promote early identification of youth problems, before they rise to the level of a diagnosable mental disorder (Whitley et al., 2012). Specifically, as educators learn more about mental health and mental illness, signs of common mental health problems, and supportive actions they can take within their role, they become better equipped to notice and respond when students demonstrate emotions and behavior that might benefit from mental health intervention (Yamaguchi, et al., 2020). Further, youth and families often favor receiving services in school, citing fewer logistical barriers and decreased stigma (Nabors & Reynolds, 2000).

Advancing SMH Policy and Practice

Growing evidence for the positive impact of SMH on youth well-being and academic outcomes has led to several international policy and practice shifts. A recent legislative guide documents several recent policy efforts in the U.S. to advance SMH, including recommended ratios of clinicians to school size, required integration of mental health literacy into the K-12 curriculum, enhancing screening for social-emotional-behavioral concerns, and expanding state and federal Medicaid funding (Hopeful Futures Campaign, 2022a). In the United Kingdom, a national report on 'Transforming children and young people's mental health provision' established SMH as a national priority (Department of Health and Social Care and Department of Education, 2017). As a result, the National Health Service and Department for Education now collaborate on an initiative to train and hire up to 500 educational mental health practitioners, whose job description is to work across education and healthcare to provide mental health support for youth. Educational mental health practitioners provide cognitive behavioral therapy-based group and individual interventions while also teaming with school staff to implement school-wide strategies to prevent mental health problems. Multi-tiered systems of mental health support in schools have also expanded in low- and middle-income countries (Fazel et al., 2014a, 2014b), with estimates that the world's largest SMH programs have reached and supported close to 30 million children over the last decade (Murphy et al., 2017). Several nations have leveraged SMH policy momentum to advance practice improvement, with Canada and the U.S. providing examples that reflect this growth. Below, we describe these nation-specific examples of SMH practice advancement, followed by a description of cross-nation SMH efforts, and conclude with discussion of how global networking in SMH has propelled the field forward.

Canada

In 2010, two pivotal projects were initiated to take stock of SMH research and practice in Canada. The School-Based Mental Health and Substance Abuse Consortium worked alongside the Mental Health Commission of Canada to conduct an evidence review, national survey, and practice scan to understand and describe the current state of the field (SBMHSAC, 2013). Concurrently, within Ontario, a policy-ready paper called *Taking Mental Health to School* was developed to support government decision-making related to advancing student mental health across the province's 5000 schools and two million students. Both efforts highlighted a significant research-to-practice gap in SMH. For example, while the evidence was clear about what was needed, there were significant barriers to uptake (e.g., gaps related to organizational/infrastructure, knowledge and capacity, implementation support, programming to meet the needs of diverse student populations, meaningful engagement, etc.).

In response, the Ontario Ministry of Education made several critical investments. First, they created a new position in each of the 72 school districts in the province, a Mental Health Leader, responsible for developing and implementing a mental health strategy and action plan for all schools in the district. This senior clinician works alongside a core mental health leadership team, co-led with a designated Superintendent of Education with responsibility for mental health. Together this team provides input to the strategy, supports implementation, monitors progress, and oversees related decision-making. This foundational district-level infrastructure (e.g., dedicated leadership positions, district mental health leadership

team, overarching three-year strategy and one-year action plan, embedded implementation and monitoring support) helps to ensure coherence in approach and consistent, evidence-based programming across schools within each region.

Secondly, a provincial implementation support team was formed to provide guidance, resources, training, and ongoing coaching support to district mental health leadership teams, called School Mental Health Ontario (formerly School Mental Health ASSIST). This team aims to enhance the uptake of evidence-informed, identity-affirming practices () in schools by (1) sourcing empirically supported programming that can be easily introduced, scaled and sustained within busy and diverse school settings, (2) contextualizing / co-creating and field-testing programming using rapid implementation cycles, (3) walking alongside mental health leadership teams to support implementation, (4) co-creating tools and resources designed to optimize uptake amongst school staff and SMH professionals, and (5) monitoring progress over time.

Sourcing Evidence-Informed, Implementation-Sensitive Programming

School Mental Health Ontario has benefited from international SMH networks in the identification of high-yield implementation-sensitive programming across the multi-tiered system of support that aligns with, and supports, mental health practice in Ontario schools. Many programs and resources now in use in Ontario have been drawn from the excellent work of colleagues in other jurisdictions. For instance, international partnerships have led to systematic provincial scale out of Tier 2 (early intervention) evidence-informed approaches like the Brief Intervention for School Clinicians (BRISC) and Supporting Transition Resilience of Newcomer Groups (STRONG), described below. At Tier 1 (whole school prevention/promotion), by way of example, core elements of established mental health promotion programs tested across many countries were distilled to create a flexible classroom resource, co-created alongside teacher unions, made up of dozens of daily practices to affirm student strengths and identities and support *Everyday Mental Health* (Peddigrew et al., 2022; School Mental Health Ontario & the Elementary Teachers Federation of Ontario, 2023). By selecting implementation sensitive interventions that are "fit for purpose," identity-affirming for students, and deemed acceptable by stakeholders, School Mental Health Ontario is able to optimize the potential for uptake and sustainability of evidence-informed programming (Crooks et al., 2022).

Rapid Implementation Cycles

The Innovation and Scale Up Lab within School Mental Health Ontario (https://www.csmh.uwo.ca/smho-lab/index.html) is a partnership with the Centre for School Mental Health at Western University. Through this Lab, aspects of SMH implementation are studied, with a view to enhancing uptake and sustainability of evidence-informed programming. For example, engagement with a new evidence-informed protocol introduced during the pandemic, Brief Digital Interventions, was tracked (Cwinn et al., 2022). The Lab team followed clinician participation from expression of interest, through training, to engagement with a range of implementation supports (e.g., learning collaborative, office hours to support measurement-based care). This allowed School Mental Health Ontario to observe points at which clinicians disengaged with the intervention (and why) and ways in which uptake was enhanced (Weisz & Short, 2022). Data gathered through rapid implementation cycles is used to iteratively advance program elements and implementation support techniques.

Implementation Support

Over the past decade, School Mental Health Ontario has established a strong provincial community of practice, made up of mental health leadership teams from all 72 school districts, through which co-designed resources, and role-specific professional learning, is cascaded to every school. An overarching evidence-informed, three-year SMH strategy (School Mental Health Ontario, 2022a, 2022b) provides the 'north star' for district action plans, facilitating provincial coherence and cross-district sharing of ideas and resources. In addition to direction and support provided through provincial and regional meetings, every district has a School Mental Health Ontario Implementation Coach who helps with nuancing programming, resources, and professional learning materials for the local context and student populations served. Regular feedback loops, through coaches and via the community of practice, have been an essential element for ensuring timely and responsive supports in schools. Having this established infrastructure and working relationship proved particularly helpful when mobilizing to provide needed supports during the pandemic (Short et al., 2022).

Co-Design and Co-Creation of Resources

All resources developed within School Mental Health Ontario are co-designed and co-created with stakeholder partners. For example, when developing mental health literacy tools for teachers, or classroom resources for daily wellness, practicing educators are engaged to plan both the content and delivery of the materials. During the pandemic,

this meant creating easy to implement, plug-and-play, identity affirming classroom resources to assist in building student stress management skills, such as through a series of K-12 Virtual Field Trip lesson plans and videos co-created with partners at the Ontario Physical and Health Education Association. Similarly, students are routinely consulted as the provincial three-year strategy is developed (e.g., Wisdom2Action, 2021), and a student reference group, ThriveSMH, works alongside School Mental Health Ontario program leaders and clinicians to bring student inputs to life in meaningful ways (e.g., the inclusion of tools like a *Circle of Support Pocket Guide* within the *Student MH LIT* modules for secondary classrooms; School Mental Health Ontario, 2022a, 2022b, 2023a, 2023b).

Progress Monitoring

School Mental Health Ontario works in partnership with colleagues at McMaster University / Offord Centre for Child Studies to monitor progress over time. Every year, school districts complete a mental health and addictions scan where proximal impacts of provincial and local strategy efforts are tracked (e.g., implementation of mental health promotion programming, reach of educator mental health literacy efforts, etc.). In addition, school districts submit data related to prevention and early intervention services provided by SMH professionals at regular intervals. Efforts towards the introduction of measurement-based care within a stepped care SMH suite of services have been initiated as an emerging priority focus.

A cross-cutting enabler associated with the School Mental Health Ontario model relates to establishing and maintaining strong partnerships. This extends beyond the essential collaboration across boards and with School Mental Health Ontario and the Ministry of Education, to include partnerships with provincial education stakeholders like teacher unions, principal associations, and school mental health professional organizations.

One of the most critical partnerships contributing to the success of the School Mental Health Ontario approach is a steadfast and continuous effort to maintain strong cross-sectoral relationships to advance a shared vision for a robust child and youth mental health system of care (see Biglan et al., 2020). Working alongside leaders in community mental health, School Mental Health Ontario has helped to lead an initiative designed to build coherence in the system of care for child and youth mental health service delivery, which culminated in a vision document, *Right Time, Right Care: Strengthening Ontario's mental health and addictions system of care for children and young people* (School & Community System of Care Collaborative, 2022). This consensus document builds on a MTSS model and an updated version of the system of care framework

(American Academy of Child and Adolescent Psychiatry, 2022; Stroul et al., 2021), to further articulate the relative roles for school and community mental health partners, with a view to maximizing efficiencies, optimizing role-specific expertise and setting benefits, and centering identity affirming mental health care for children, youth, and families. The aspirational vision articulated for the Ontario context emphasizes the critical upstream role that schools play in mental health promotion, prevention, early identification, and early intervention, and the need for strong bridging to, from, and through more intensive treatment supports delivered within the community mental health setting.

United States

As confirmed by a recent meta-analysis, it is increasingly recognized that schools are the most common venue for U.S. youth to access mental health care (Duong et al., 2021). In 1995, the federal Health Resources and Services Administration (HRSA) funded centers at the University of California, Los Angeles (UCLA) and the University of Maryland School of Medicine (UMSOM; see Adelman et al., 1999) to provide guidance and accountability to states and local communities as they expanded SMH supports and services. These centers have worked for over two decades to contribute to, gather, translate, and disseminate knowledge to SMH implementers across the nation. Other centers, such as the University of Washington School Mental Health Assessment, Research, and Training (SMART) Center, generate and mobilize research evidence regionally via funds from SAMHSA, statewide using The American Rescue Plan Act's (ARPA) Elementary and Secondary School Emergency Relief (ESSER) funds, and many other sources.

National SMH Performance Standards

In 2014, the UMSOM National Center for School Mental Health (NCSMH, see www.schoolmentalhealth.org) established a set of national performance standards for comprehensive SMH (Connors, et al., 2016) and created a free, online portal for any school or district to measure their quality and engage in continuous quality improvement with technical assistance support (see www.theSHAPEsystem.com). Beyond simply hiring more credentialed mental staff to work in schools, national performance standards guide states and districts to invest in systemic approaches such as MTSS to systematically promote mental well-being for all students, identify those with mental health concerns, assure continuity and effectiveness of care, and track progress across all levels of effort. The national SMH performance standards have been widely adopted, with over 15,000 schools and districts engaged in the SHAPE system, and evidence from several states of related improvements in SMH quality (Connors

et al., 2020). The national standards also spurred the publication of an *America's School Mental Health Report Card,* documenting each state's performance on quality domains with guidance for state action to advance policy (Hopeful Futures Campaign, 2022b).

State-District Learning Collaboratives

One successful mechanism for utilizing the national performance standards to improve SMH system quality is Learning Collaboratives. Several successful Learning Collaboratives have paired national Training and Technical Assistance partners with state and district partners to engage in long-term, data-driven quality improvement processes. From 2016 to 2018, the NCSMH facilitated two national Learning Collaboratives with a total of 25 school districts in 14 states. Engaging in an adapted version of the institute for Health Care Quality Breakthrough Series Model and the Model for Improvement, districts participated in regular cross-site virtual learning sessions and data-driven practice improvement to ultimately achieve more mental health screening in schools, increased number of students receiving Tiers 2 (early intervention) and 3 (more intensive intervention) SMH services, and expanded psychosocial and academic data monitoring systems for students in receiving Tier 3 programming (Connors et al., 2020). Building from the success of district-focused Learning Collaboratives, HRSA then invested in state-district Learning Collaboratives, with the NCSMH recently concluding its third cohort of five states and about 25 districts per cohort to advance SMH quality.

School-Community Partnerships

As in Canada, it is increasingly recognized that responsibility for providing mental health care to youth is shared by school and community providers. Use of such integrated strategies is supported by research that shows rates of youth treatment in clinic-based specialty mental health care is nearly as common a venue as schools (Duong et al., 2021), and that youth receiving care in clinics have distinct profiles of need, including having higher levels of impairment and being more likely to have an identified mental health disorder and suicidal ideation (Ali & Gibson, 2019).

Thus, as in Canada, to facilitate the sharing of responsibility, some U.S. states, such as Washington, have invested in centers of excellence that systematically train joint school-community teams on models such as the Interconnected Systems Framework (ISF; Barrett et al., 2013; Eber et al, 2020). The Interconnected Systems Framework uses explicit installation steps and assessment tools to facilitate partnerships among schools and community resources, with the goal being to achieve a true public mental health model for youth. In this framework, schools can serve as a venue

for screening and identifying youth in need, use school-employed staff such as counselors and nurses as a first line for supporting students with mental health needs, and refer to community providers when a student requires more intensive or specialized care.

Individual and Group Interventions

Use of system-level strategies such as MTSS and the Interconnected Systems Framework also require development and testing of individual and group SMH treatment strategies that are appropriate to the school context and facilitate "stepped care" strategies that actively connect to resources in the broader community. One such example, Brief Intervention for School Clinicians (BRISC), developed at the UW SMART Center, is a research-based engagement, assessment, brief intervention, and triage strategy (Bruns et al., 2019). BRISC provides a framework for a wide variety of SMH practitioners (e.g., school counselors, nurses, social workers, and psychologists) to understand a student's needs; provide initial support using engagement and problem-solving strategies; apply straightforward, evidence-based strategies based on cognitive-behavioral skill-building when needed; and measure progress at every step. BRISC also actively encourages determination of appropriate next treatment steps within four sessions, including referral to community providers when needed.

A large efficacy study showed that practitioners found BRISC feasible and acceptable, were able to achieve adequate fidelity to the model, and were better able to retain students in treatment at two months (Bruns et al., 2023). BRISC-trained practitioners were also more likely to refer students to outside providers and to complete treatment by 6 months as compared to services as usual, providing support for the efficiency of BRISC and its potential to be used within a multi-tiered model. Finally, BRISC-enrolled students made more progress on their top problems than services as usual and made equivalent progress on symptom measures (Bruns et al., 2023). As described below, research results and practical appeal for schools have made individual treatment models such as BRISC—and group-based models such as *Support for Transition Resilience of Newcomer Groups* (STRONG)—a locus for collaboration among international SMH partners.

Recent Increases in Federal SMH Investment

In the U.S., 70% of school districts have reported an increased rate of students seeking or referred to mental health services since the onset of the COVID-19 pandemic (Institute for Education Sciences, 2022). Recognizing that schools are the primary source of mental health care for youth in the U.S., the federal government has responded by

providing unprecedented levels of resources to U.S. states to distribute to districts to help schools establish or expand provision of SMH. However, because of the enormous disruptions to educational systems and the associated spike in mental health concerns for students due to the pandemic, much of the initial funding was used to support crisis intervention efforts at Tier 3 (Diliberti & Schwartz, 2021). As we have slowly moved away from the acute nature of the pandemic, there are opportunities within schools to re-focus the resources on school mental health programming at Tier 1 (school-wide universal) and Tier 2 (early intervention) (United States Department of Education, 2022).

Increases in school-connected gun violence in the U.S. also have spurred federal and state efforts to bolster SMH supports that may prevent or address the impacts of gun violence. Via sources such as The American Rescue Plan Act's (ARPA) ESSER program and the Bipartisan Safer Communities Act funding, U.S. school districts are, for example, hiring more SMH staff, establishing school-based health centers that include a SMH component, and investing in technologies such as telehealth and text-based smartphone apps for students and parents (The Commonwealth Fund, 2022).

However, in spite of these investments, many workforce challenges are being confronted. For example, at a recent meeting (December, 2022) of diverse national leaders in SMH, there was a conclusion that (a) mental health needs for children and youth are unprecedented, and (b) there is also an unprecedented allocation of resources for the field. However, (c) stresses borne of the pandemic and other factors have led many school staff (teachers, administrators, counselors, clinicians) to leave the field (see "the great resignation"), and (d) it is very hard to promote or sustain effective comprehensive SMH implementation as in many schools there has been "a retreat to the essential."

Developing and Connecting Global SMH Networks

There are remarkable similarities in issues, needs, and strengths across nations and jurisdictions, and successful ideas in one region often can be transferred to another with close attention to contextual differences. While the approaches, structures, and processes used in one region may not be feasible in their entirety in other places, the value of global school mental health is in its ability to inspire and to iteratively guide possibilities for the local context. Global leaders in SMH often both share and borrow from practices in other countries and regions, with a view to advancing services and supports for students everywhere.

Several structures and activities have facilitated global SMH networks to advance cross-nation sharing and collaboration. The NCSMH began to hold annual national conferences on advancing SMH in 1996, and by the late 1990s this conference began to attract more international participants and presenters, and networking among leaders across nations. This led to the establishment of the International Alliance for Child and Adolescent Mental Health and Schools (INTERCAMHS), with some funding support provided by SAMHSA. INTERCAMHS operated from the early 2000s until 2011, when the group disbanded related to leadership changes. Soon after, the School Mental Health International Leadership Exchange (SMHILE, see www.smhile.com) was established and has worked to actively build global collaboration to promote enhanced leadership and innovation in the field (Weist et al., 2016). This includes supporting world conferences on SMH held in London in 2014 and in South Carolina in 2015. In 2018, SMHILE assisted the International Initiative for Mental Health Leadership (IIMHL, see www.iimhl.org) in hosting the first ever Match (reflecting an innovation theme) on Mental Health and the Education Sector in Sweden. This was followed by support for a Match in Washington, DC (2019), and a recent (October 2022) virtual Match in Christchurch, New Zealand, with in-person regional "hub" meetings in Christchurch, Dublin Ireland, and Washington, DC.

The virtual Match facilitated by SMHILE and New Zealand IIMHL hosts provided a platform for established and emerging leaders supporting SMH implementation and research in over 10 countries (Australia, Canada, Germany, Ireland, Israel, Jamaica, New Zealand, Norway, Poland, UK, and U.S.) to convene to discuss current pressing research, practice, and policy issues focused on what works in leading systems for mental health. The organizing theme for the in-person "hub" meetings was *Valuing inclusion, resilience, and growth*. The program was organized around seven brief, interactive ignite sessions delivered by experts in the field, on topics informed by participant interests and loosely structured across MTSS, including promotion/prevention (Tier 1), early intervention (Tier 2), and more intensive intervention (Tier 3). Speakers focused on issues of leadership in developing, implementing, refining, and scaling evidence-based SMH practices across the tiers. Presentations included examples of classroom-wide strength-based programming delivered in different structures and modalities (e.g., programmatic, modular, curriculum-linked, on-line), and intensive intervention related to effective response to significant challenges such as natural disasters, school shootings, and war, most recently, the Russian invasion of Ukraine.

All of these global networking efforts have inspired international collaboration and leveraging of innovations and knowledge to support the global advancement of SMH. Below we describe a few examples of how global SMH networking structures have resulted in productive outreach and collaboration between nations.
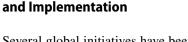
Examples of International Outreach and Collaboration

Supporting Newcomers from Syria

The relationships, expertise, and resources of SMHILE collaborators has enabled rapid translation, adaptation, and implementation of school mental health efforts across national borders in times of need. As one example, since 2017, leaders from School Mental Health Ontario spearheaded the development of a Tier 2 intervention for newcomer youth, Supporting Transition Resilience for Newcomer Groups (STRONG; https://www.csmh.uwo.ca/research/strong.html), in response to the Syrian refugee crisis. STRONG has been implemented in schools across Canada and the U.S., with positive impacts found for students' coping and resilience skills, and improvements in connectedness to school and peers (Crooks et al., 2020a, 2020b). STRONG has been rapidly translated and adapted for Czech, Polish, and Ukrainian schools, with plans to train and offer implementation support in a virtual format to schools across Ukraine.

Outreach to Ukrainian Refugees

Since the Russian invasion of Ukraine in February 2022, over 20 million Ukrainians have been displaced. Close to 14 million refugees have crossed into other countries, with the majority (8 million) entering Poland. During refugee crises, schools are recognized as an ideal setting to welcome newcomer students and families, to facilitate early identification of mental health and other needs, and to provide interventions to maximize cognitive, emotional, and social development (Tyrer & Fazel, 2014). Early in the Ukrainian refugee crisis, academic and policy leaders in Poland convened with colleagues from SMHILE to consider strategies for supporting countries receiving refugees. In March 2022, a small team of SMHILE colleagues traveled to eastern Poland to provide rapid first responder training using the Health Support Team (HST; see https://healthsupportteam.org) model, to train school administrators and staff using principles of trauma-informed schools (Kataoka et al., 2018) and to provide direct support to Polish and Ukrainian students and families. This initial training series has expanded to additional trainings in the Czech Republic, including for both Czech and newly arrived Ukrainian school mental health professionals. Leveraging the existing relationships, expertise, and resources of SMHILE colleagues and partners enabled rapid translation, adaptation, and implementation of SMH efforts across national borders in a time of great need.

Cross-Jurisdictional Program Design and Implementation

Several global initiatives have been launched as a result of the noted international connections. For example, through SMHILE, BRISC was conceived as a cornerstone of stepped care SMH service delivery in Ontario (ON). Over the past eight years, almost 1000 Ontario school clinicians have been trained on BRISC. An accreditation process was developed, so that there are now five BRISC-ON trainers who can deliver the training and provide ongoing coaching within the province. Similarly, following the most recent IIMHL meeting, a connection was made between leaders of the Sparklers initiative (https://sparklers.org.nz) in New Zealand and School Mental Health Ontario, to explore synergies and opportunities for co-creation given a common focus on core elements of everyday mental health practice in school classrooms. SMHILE's approach to "thinking globally and acting locally" allows for identification of common issues and gaps, and broad thinking and partnership towards creative solutions that can be adapted for the local context.

Priorities to Further Propel Global SMH

From the IIMHL SMH Match emerged priorities that are pertinent for the further advancement of SMH globally: (1) effective leadership in times of complexity, change, and crisis; (2) strategies to advance uptake and sustained implementation of SMH programming; (3) meaningful engagement with diverse stakeholders (emphasizing family and student voice and leadership); (4) improved collaboration across sectors and disciplines; (5) workforce development; and (6) interconnected measurement with a focus on research, practice, and policy impacts. These key priorities, implications, strategies, and associated resources are further described in Table 1.

Conclusion

Related to the pandemic and other severe societal stressors, there is an unprecedented mental health crisis for children and youth, especially for vulnerable, disadvantaged populations. In recognition of this crisis there is historic policy support and investment in SMH, but also significant system dysfunction, and schools and other sites of prevention and care experiencing staff "retreating to the essential." The priorities that emerged from the 2022 International Initiative for Mental Health Leadership SMH Match demonstrate the power of international networking and dialogue for providing opportunities to share and learn from leaders in different regions. As described in

Table 1 Priorities to further advance global school mental health

Priorities	Strategies	Resources
Effective leadership	(1) Leaders need to maintain and promote their own wellbeing to meet the complexities and inevitable changes associated with school and system leadership (2) Well-designed and comprehensive systems of supports for students and school personnel should be responsive to emerging mental health needs and pressures (3) Conceptual frameworks 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	Cann et al. (2021) Day et al. (2020) Pont et al. (2008) Williamson and Blackburn (2022)
Sustained implementation with adaptation for diversity	(1) Needs assessment and programming selection should be informed by school context and in alignment with school and board strategy and priorities (2) Co-design and co-creation of interventions should occur with key stakeholder audiences (3) Role specific training for school and system personnel should be fit for purpose, rather than one size fits all (4) There are benefits to ongoing iterative learning and coaching support	*Adopt, adapt, abandon flow chart* https://ies.ed.gov/ncee/edlabs/regions/northeast/pdf/handout19_Adopt-adapt-abandon.pdf *Identity-affirming school mental health: a frame for reflection and action* https://smho-smso.ca/about-us/identity-affirming/ Substance Abuse and Mental Health Services Administration (2019a, 2019b) Gaias et al. (2022) Duong et al. (2020)
Meaningful stakeholder engagement	(1) SMH service providers must be invested in understanding from stakeholders how best to contribute skills and knowledge to ensure that services are provided in a way that works best for the school and community context	*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 *Children's voices: A review of evidence on the subjective wellbeing of children with mental health needs in England* https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Voices-Mental-health-needs-1_0.pdf
Collaboration across sectors and disciplines	(1) Professionals and stakeholders across sectors should foster collaborative relationships that promote the establishment of shared visions to meet the mental health needs of students (2) 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	Substance Abuse and Mental Health Services Administration (2019a, 2019b) 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)

Table 1 (continued)

Priorities	Strategies	Resources
Expand and improve the behavioral health workforce	(1) Leverage non-specialist service providers to offer early identification and promotion work, including efforts to offer trainings for paraprofessionals such as family and peer support workers (2) Begin building the workforce in high school to prepare for the future (3) Attract more diverse young people to the SMH field (4) Consider changes to pre-professional training programs to graduate more practice-oriented professionals, and advocate for addressing limitations around credentialing across states or provinces (5) Ensure that agencies have well-coordinated and ongoing support for staff as well as more competitive salaries paired with clear career pathway ladders	Covino (2019) Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2019) Lyon et al. (2011) National Academy for State Health Policy (2021)
Effective, interconnected data systems	(1) Measurement in SMH 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	Connors et al. (2022)

Table 1, critical themes are being discussed through cross-nation, cross-jurisdictional collaboration including effective leadership; effective and sustained implementation; meaningful engagement of all stakeholder groups; workforce development; and interconnecting policy, practice and research strategies. Through such connection points, areas of commonality can be identified, and promising and best practices identified in one nation/jurisdiction can be examined, adapted, and implemented for another nation/ locale. Often, there are common challenges to be managed, and learning how others have addressed these, even when the context is different, is instructive, and promoting of scaling of effective practices. However, it must be acknowledged that a key limitation of the school mental health movement at a global level is that many of the involved countries are mostly wealthy, highly developed, and English-speaking (Fazel et al., 2014a, 2014b). A key direction for leaders of the school mental health movement at a global level is to acknowledge and address this disparity by reaching out to, bringing together, and forming partnerships with individuals representing low- and middle-income countries (Fazel et al., 2014a, 2014b) and those from non-English speaking countries in an effort to be more representative of the global population. Increasingly, the School Mental Health International Leadership Exchange (SMHILE) is interacting with these countries, including documenting early SMH development in Liberia (Weist et al., 2017), and assisting in the development of this field in other nations such as India and Turkey.

Inclusive international school mental meetings can engender a sense of global solidarity on the potential for SMH as a critical element for pandemic recovery, for all groups—students, families, school administrators, educators and school staff, and collaborators from other youth-serving systems (particularly the mental health system)—from all countries. Moreover, there are additive benefits in the way that international SMH leaders speak with a singular voice on future policy, practice, and research directions. Similar to the importance and benefits of working together across systems of care to support the mental health needs of young people, we must remain committed to advancing progress in school mental health across the globe by working together, sharing insights and best practices, and developing roadmaps for change.

Declarations

Ethical approval This paper did not involve research with human subjects, so there was no review by an Institutional Review Board.

References

Adelman, H. S., Taylor, L., Weist, M. D., Adelsheim, S., Freeman, B., Kapp, L., Lahti, M., & Mawn, D. (1999). Mental health in schools: A federal initiative. *Children's Services: Social Policy, Research, and Practice, 2*, 95–115. https://doi.org/10.1207/s15326918cs0202_3

Ali, A., & Gibson, K. (2019). Young people's reasons for feeling suicidal: An analysis of posts to a social media suicide prevention forum. *Crisis: the Journal of Crisis Intervention and Suicide Prevention, 40*(6), 400–406. https://doi.org/10.1027/0227-5910/a000580

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Community-Based Systems of Care and AACAP Committee on Quality Issues. (2022). Clinical update: Child and adolescent behavioral health care in community systems of care. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2022.06.001

Ancheta, A. J., Bruzzese, J. M., & Hughes, T. L. (2021). The impact of positive school climate on suicidality and mental health among LGBTQ adolescents: A systematic review. *The Journal of School Nursing, 37*(2), 75–86. https://doi.org/10.1177/1059840520970847

Antshel, K. M. (2015). Psychosocial interventions in attention-deficit/hyperactivity disorder: Update. *Child and Adolescent Psychiatric Clinics of North America, 24*(1), 79–97. https://doi.org/10.1016/j.chc.2014.08.002

Barrett, S., Eber, L., & Weist, M.D. (2013). *Advancing education effectiveness: An interconnected systems framework for Positive Behavioral Interventions and Supports (PBIS) and school mental health.* Center for Positive Behavioral Interventions and Supports (funded by the Office of Special Education Programs, U.S. Department of Education). Eugene, Oregon, University of Oregon Press.

Biglan, A., Elfner, K., Garbacz, S. A., Komro, K., Prinz, R., Weist, M. D., Wilson, D., & Zarling, N. A. (2020). A strategic plan for strengthening America's families: A brief from the Coalition of Behavioral Science Organizations. *Clinical Child and Family Psychology Review, 23*(2), 153–175.

Bradshaw, C. P., Koth, C. W., Bevans, K. B., Ialongo, N., & Leaf, P. J. (2008). The impact of school-wide positive behavioral interventions and supports (PBIS) on the organizational health of elementary schools. *School Psychology Quarterly, 23*(4), 462–473. https://doi.org/10.1037/a0012883

Bradshaw, C. P., Mitchell, M. M., & Leaf, P. J. (2010). Examining the effects of schoolwide positive behavioral interventions and supports on student outcomes: Results from a randomized controlled effectiveness trial in elementary schools. *Journal of Positive Behavior Interventions, 12*(3), 133–148. https://doi.org/10.1177/1098300709334798

Bruns, E. J., Pullmann, M. D., Nicodimos, S., Lyon, A. R., Ludwig, K., Namkung, N., & McCauley, E. (2019). Pilot test of an engagement, triage, and brief intervention strategy for school mental health. *School Mental Health, 11*(1), 148–162. https://doi.org/10.1007/s12310-018-9277-0

Bruns, E. J., Lee, K. E., Davis, C., Pullmann, M. D., Ludwig, K., Hoover, S. M., Sander, M., Holm-Hansen, C., & McCauley, E. M. (2023). Effectiveness of a brief engagement, problem-solving, and triage strategy for high school students: Results

of a randomized study. *Prevention Science*. https://doi.org/10.1007/s11121-022-01463-4

Calear, A. L., & Christensen, H. (2010). Systematic review of school-based prevention and early intervention programs for depression. *Journal of Adolescence, 33*(3), 429–438. https://doi.org/10.1016/j.adolescence.2009.07.004

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

Carney, T., Myers, B. J., Louw, J., & Okwundu, C. I. (2014). Brief school-based interventions and behavioural outcomes for substance-using adolescents. *The Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD008969.pub2

Cefai, C., Camilleri, L., Bartolo, P., Grazzani, I., Cavioni, V., Conte, E., Ornaghi, V., Agliati, A., Gandellini, S., Tatalovic Vorkapic, S., Poulou, M., Martinsone, B., Stokenberga, I., Simões, C., Santos, M., & Colomeischi, A. A. (2022). The effectiveness of a school-based, universal mental health programme in six European countries. *Frontiers in Psychology, 13*, 925614. https://doi.org/10.3389/fpsyg.2022.925614

Centers for Disease Control and Prevention. (2021). *Youth Risk Behavior Survey: data summary and trends report 2009–2019*. Atlanta, GA: US Department of Health and Human Services. Retrieved, from https://www.cdc.gov/healthyyouth/d*a**t*a/yrbs/pdf/YRBSDataSummaryTrendsReport2019-508.pdf

Connors, E. H., Stephan, S. H., Lever, N., Ereshefsky, S., Mosby, A., & Bohnenkamp, J. (2016). A national initiative to advance school mental health performance measurement in the US. *Advances in School Mental Health Promotion, 9*(1), 50–69.

Connors, E. H., Smith-Millman, M., Bohnenkamp, J. H., Carter, T., Lever, N., & Hoover, S. A. (2020). Can we move the needle on school mental health quality through systematic quality improvement collaboratives? *School Mental Health, 12*, 478–492.

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

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

Crooks, C. V., Hoover, S., & Smith, A. C. (2020a). Feasibility trial of the school-based STRONG intervention to promote resilience among newcomer youth. *Psychology in the Schools, 57*(12), 1815–1829. https://doi.org/10.1002/pits.22366

Crooks, C. V., Kubishyn, N., Syeda, M. M., & Dare, L. (2020b). The STRONG resiliency program for newcomer youth: A mixed-methods exploration of youth experiences and impacts. *International Journal of School Social Work*. https://doi.org/10.4148/2161-4148.1059

Crooks, C. V., Dunlop, C., & Short, K. H. (2022). A structured conceptualization of implementation-sensitive interventions for school mental health. *Canadian Journal of Community Mental Health, 41*(3), 22–38. https://doi.org/10.7870/cjcmh-2022-018

Cwinn, E., Barry, E. A., Weisz, J. R., Bailin, A., Fitzpatrick, O. M., Venturo-Conerly, K., & Crooks, C. V. (2022). Brief digital interventions: An implementation-sensitive approach to addressing school mental health needs of youth with mild and emerging mental health difficulties. *Canadian Journal of Community Mental Health, 41*(3), 157–175. https://doi.org/10.7870/cjcmh-2022-026

Day, C., Sammons, P., & Gorgen, K. (2020). *Successful school leadership*. Education Development Trust.

Department of Health and Social Care and Department of Education. Transforming Children and Young People's Mental Health Provision: a Green Paper. (2017). Retrieved, from https://www.gov.uk/government/consultations/transforming-children-and-young-peoplesmental-health-provision-a-green-paper

Diliberti, M. K., & Schwartz, H. L. (2021). *The K-12 pandemic budget and staffing crises have not panned out-yet: Selected findings from the third American school district panel survey. Data note: Insights from the American Educator Panels.* Research Report. RR-A956–3. RAND Corporation. https://doi.org/10.7249/RRA956-3

Duong, M. T., Cook, C. R., Lee, K., Davis, C. J., Vázquez-Colón, C. A., & Lyon, A. R. (2020). User testing to drive the iterative development of a strategy to improve implementation of evidence-based practices in school mental health. *Evidence-Based Practice in Child and Adolescent Mental Health, 5*(4), 414–425. https://doi.org/10.1080/23794925.2020.1784052

Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2021). Rates of mental health service utilization by children and adolescents in schools and other common service settings: A systematic review and meta-analysis. *Administration and Policy in Mental Health, 48*(3), 420–439. https://doi.org/10.1007/s10488-020-01080-9

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x

Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R., Splett, J., & Weist, M. D. (2020). *Advancing education effectiveness: Interconnecting school mental health and school-wide PBIS.* Volume 2: An implementation guide. Center for Positive Behavioral Interventions and Supports.

Emergency Taskforce on Black Youth Suicide and Mental Health. (2019). *Ring the alarm: The crisis of Black youth suicide in America.* A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health. Retrieved, from, https://theactionalliance.org/resource/ring-alarm-crisis-black-youth-suicide-america

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014a). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry, 1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Fazel, M., Patel, V., Thomas, S., & Tol, W. (2014b). Mental health interventions in schools in low-income and middle-income countries. *The Lancet Psychiatry, 1*(5), 388–398.

Gaias, L. M., Arnold, K. T., Liu, F. F., Pullmann, M. D., Duong, M. T., & Lyon, A. R. (2022). Adapting strategies to promote implementation reach and equity (ASPIRE) in school mental health services. *Psychology in the Schools, 59*, 2471–2485. https://doi.org/10.1002/pits.22515

Ghuman, H. S., Weist, M. D., & Sarles, R. M. (2002). *Providing mental health services to youth where they are: School- and other community-based approaches.* Brunner-Routledge.

Goldhaber, D., Kane, T. J., McEachin, A., Morton, E., Patterson, T., & Staiger, D. O. (2022). The consequences of remote and hybrid instruction during the pandemic. *National Bureau of Economic Research.* https://doi.org/10.3386/w30010

Greenberg, M. T., Domitrovich, C. E., Weissberg, R. P., & Durlak, J. A. (2017). Social and emotional learning as a public health approach to education. *The Future of Children, 27*(1), 13–32.

Hoover, S., & Bostic, J. (2021). Schools as a vital component of the child and adolescent mental health system. *Psychiatric Services, 72*(1), 37–48. https://doi.org/10.1176/appi.ps.201900575

Hopeful Futures Campaign (2022a). State legislative guide for school mental health. Retrieved, from https://hopefulfutures.us/wp-content/uploads/2022a/09/State-Legislative-Guide-for-School-Mental-Health-1.pdf

Hopeful Futures Campaign (2022b). America's school mental health report card. Retrieved, from https://hopefulfutures.us/wp-content/uploads/2022b/02/FINAL-EDITS-Master_022322.pdf

Institute for Education Sciences. (2022). School responses to COVID-19. National Center for Education Statistics (NCES). Retrieved, from https://ies.ed.gov/schoolsurvey/

Jalla, R., Baral, D., & Pithadia, D. (2020). Social determinants of mental health in adolescents and young adults in Western nations – a literature review. *International Journal of Mental Health Psychiatry, 6*, 3. https://doi.org/10.37532/ijmhp.2020.6(3).181

Johns, M. M., Lowry, R., Haderxhanaj, L. T., Rasberry, C. N., Robin, L., Scales, L., Stone, D., & Suarez, N. A. (2020). Trends in violence victimization and suicide risk by sexual identity among high school students - Youth Risk Behavior Survey, United States, 2015–2019. *MMWR Supplements, 69*(1), 19–27. https://doi.org/10.15585/mmwr.su6901a3

Kase, C., Hoover, S., Boyd, G., West, K. D., Dubenitz, J., Trivedi, P. A., Peterson, H. J., & Stein, B. D. (2017). Educational outcomes associated with school behavioral health interventions: A review of the literature. *The Journal of School Health, 87*(7), 554–562. https://doi.org/10.1111/josh.12524

Kataoka, S. H., Vona, P., Acuna, A., Jaycox, L., Escudero, P., Rojas, C., Ramirez, E., Langley, A., & Stein, B. D. (2018). Applying a trauma informed school systems approach: Examples from school community-academic partnerships. *Ethnicity & Disease, 28*(2), 417–426. https://doi.org/10.18865/ed.28.S2.417

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L. A., Srinath, S., Ulkuer, N., & Rahman, A. (2011). Child and adolescent mental health worldwide: Evidence for action. *Lancet, 378*(9801), 1515–1525. https://doi.org/10.1016/S0140-6736(11)60827-1

Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology, 83*(5), 853–865. https://doi.org/10.1037/ccp0000051

Lantos, J. D., Yeh, H.-W., Raza, F., Connelly, M., Goggin, K., & Sullivant, S. A. (2022). Suicide risk in adolescents during the COVID-19 pandemic. *Pediatrics, 149*(2), e2021053486. https://doi.org/10.1542/peds.2021-053486

Lebrun-Harris, L. A., Ghandour, R. M., Kogan, M. D., & Warren, M. D. (2022). Five-year trends in US children's health and well-being, 2016–2020. *JAMA Pediatrics, 176*(7), e220056. https://doi.org/10.1001/jamapediatrics.2022.0056

Lindsey, M. A., Sheftall, A. H., Xiao, Y., & Joe, S. (2019). Trends of suicidal behaviors among high school students in the United States: 1991–2017. *Pediatrics, 144*(5), e20191187. https://doi.org/10.1542/peds.2019-1187

Lyon, A. R., Stirman, S. W., Kerns, S. E., & Bruns, E. J. (2011). Developing the mental health workforce: Review and application of training approaches from multiple disciplines. *Administration and Policy in Mental Health, 38*(4), 238–253. https://doi.org/10.1007/s10488-010-0331-y

Mayne, S. L., Hannan, C., Davis, M., Young, J. F., Kelly, M. K., Powell, M., Dalembert, G., McPeak, K. E., Jenssen, B. P., & Fiks, A. G. (2021). COVID-19 and adolescent depression and suicide risk screening outcomes. *Pediatrics, 148*(3), e2021051507. https://doi.org/10.1542/peds.2021-051507

Murphy, J. M., Abel, M. R., Hoover, S., Jellinek, M., & Fazel, M. (2017). Scope, scale, and dose of the world's largest school-based mental health programs. *Harvard Review of Psychiatry, 25*(5), 218–228. https://doi.org/10.1097/HRP.0000000000000149

Nabors, L. A., & Reynolds, M. W. (2000). Program evaluation activities: Outcomes related to treatment for adolescents receiving

school-based mental health services. *Children's Services: Social Policy, Research, & Practice, 3*(3), 175–189. https://doi.org/10.1207/S15326918CS0303_4

National Academy for State Health Policy. (2021). *State strategies to increase diversity in the behavioral health workforce.* Retrieved, from https://nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce/

Neil, A. L., & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. *Clinical Psychology Review, 29*(3), 208–215. https://doi.org/10.1016/j.cpr.2009.01.002

Office of the Surgeon General. (2021). *Protecting youth mental health:* The U.S. Surgeon General's Advisory. U.S. Department of Health and Human Services. Retrieved, from https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Peddigrew, E., Andrews, N., Al-Jbouri, E., Fortier, A., & Weaver, T. (2022). Mechanisms supporting students' social and emotional learning development: Qualitative findings from a teacher-led intervention. *Canadian Journal of Community Mental Health, 41*(3), 39–56. https://doi.org/10.7870/cjcmh-2022-019

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., Hedden, S. L., Crosby, A. E., Visser, S. N., Schieve, L. A., Parks, S. E., Hall, J. E., Brody, D., Simile, C. M., Thompson, W. W., Baio, J., Avenevoli, S., Kogan, M. D., Huang, L. N., Centers for Disease Control and Prevention (CDC). (2013). Mental health surveillance among children–United States, 2005–2011. *MMWR Supplements, 62*(2), 1–35.

Polanczyk, G. V., Salum, G. A., Sugaya, L. S., Caye, A., & Rohde, L. A. (2015). Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 56*(3), 345–365. https://doi.org/10.1111/jcpp.12381

Pont, B., Nusche, D., & Moorman, H. (2008). *Improving school leadership policy and practice volume 1.* OECD.

Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. *JAMA Pediatrics, 175*(11), 1142–1150. https://doi.org/10.1001/jamapediatrics.2021.2482

Reiss, F. (2013). Socioeconomic inequalities and mental health problems in children and adolescents: A systematic review. *Social Science & Medicine, 90*, 24–31. https://doi.org/10.1016/j.socscimed.2013.04.026

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*(4), 223–241. https://doi.org/10.1023/a:1026425104386

Rowling, L., & Weist, M. D. (2004). Promoting the growth, improvement and sustainability of school mental health programs worldwide. *International Journal of Mental Health Promotion, 6*(2), 3–11. https://doi.org/10.1080/14623730.2004.9721925

School-based Mental Health and Substance Abuse Consortium. (2013). *School-based Mental Health in Canada: A Final Report.* Mental Health Commission of Canada. Retrieved, from https://www.mentalhealthcommission.ca/sites/default/files/ChildYouth_School_Based_Mental_Health_Canada_Final_Report_ENG_0.pdf

School and Community System of Care Collaborative. (2022). *Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people.* Retrieved, from https://smho-smso.ca/wp-content/uploads/2022/04/report-right-time-right-care.pdf

School Mental Health Ontario. (2022a). School mental health strategy focuses on pandemic response, recovery. Retrieved, from https://smho-smso.ca/blog/school-mental-health-strategy-focuses-on-pandemic-response-recovery/

School Mental Health Ontario. (2022b). My circle of support pocketbook – student help-seeking resource. Retrieved, from https://smho-smso.ca/blog/online-resources/my-circle-of-support-pocketbook-student-help-seeking-resource/

School Mental Health Ontario. (2023a). Identity-affirming school mental health: a frame for reflection and action. Retrieved, from https://smho-smso.ca/about-us/identity-affirming/

School Mental Health Ontario. (2023b). MH LIT: Student mental health in action. Retrieved, from https://smho-smso.ca/blog/online-resources/mh-lit-student-mental-health-in-action/

School Mental Health Ontario and the Elementary Teachers Federation of Ontario. (2023). Everyday mental health classroom resource. Retrieved, from https://smho-smso.ca/emhc/

Short, K. H., Bullock, H. L., Crooks, C. V., & Georgiades, K. (2022). Using implementation science to optimize school mental health during the COVID-19 pandemic. *Canadian Journal of Community Mental Health, 41*(3), 5–21. https://doi.org/10.7870/cjcmh-2022-021

Sklad, M., Diekstra, R., De Ritter, M., Ben, J., & Gravesteijn, C. (2012). Effectiveness of school-based universal social, emotional, and behavioral programs: Do they enhance students' development in the area of skill, behavior, and adjustment? *Psychology in the Schools, 49*(9), 892–909. https://doi.org/10.1002/pits.21641

So, M., McCord, R. F., & Kaminski, J. W. (2019). Policy levers to promote access to and utilization of children's mental health services: A systematic review. *Administration and Policy in Mental Health, 46*(3), 334–351. https://doi.org/10.1007/s10488-018-00916-9

Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. *Child and Adolescent Psychiatric Clinics of North America, 24*(2), 211–231. https://doi.org/10.1016/j.chc.2014.12.002

Stroul, B.A., Blau, G.M., & Larsen, J. (2021). *The evolution of the system of care approach.* The Institute for Innovation and Implementation, School of Social Work, University of Maryland. Retrieved, from https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

Substance Abuse and Mental Health Services Administration (2019a). *Guidance to states and school systems on addressing mental health and substance use issues in schools.* Retrieved, from https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf

Substance Abuse and Mental Health Services Administration (2019b). *Communicating in a crisis: Risk communication guidelines for public officials.* SAMHSA Publication No. PEP19-01-01-005. Retrieved, from https://store.samhsa.gov/sites/default/files/d7/priv/pep19-01-01-005.pdf

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2019). *Developing a behavioral health workforce equipped to serve individuals with co-occurring mental health and substance use disorders.* Retrieved, from https://www.nasmhpd.org/sites/default/files/TAC_Paper_3_508C_0.pdf

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2022). *National guidelines for child and youth behavioral health crisis care.* Retrieved, from https://store.samhsa.gov/product/national-guidelines-child-and-youth-behavioral-health-crisis-care/pep22-01-02-001

Taylor, R., Oberle, E., Durlak, J. A., & Weissberg, R. P. (2017). Promoting positive youth development through school-based social and emotional learning interventions: A meta-analysis of follow-up effects. *Child Development, 88*, 1156–1171.

The Commonwealth Fund. (2022). *Using new federal funding to meet children's behavioral health needs in school.* Retrieved, from https://www.commonwealthfund.org/blog/2022/using-new-federal-funding-meet-kids-behavioral-health-needs-school

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. *PLoS ONE, 9*(2), e89359. https://doi.org/10.1371/journal.pone.0089359

United States Department of Education (2022). Draft bipartisan Safer Communities Act stronger connections frequently asked questions – nonregulatory guidance. Retrieved, from https://oese.ed.gov/files/2022/11/BSCA_Stonger_Connections_FAQs_11-2022-FINAL.pdf

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current Psychiatry Reports, 19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

Walker, S. C., Kerns, S. E. U., Lyon, A., Cosgrove, T. J., & Bruns, E. J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health, 46*(3), 251–257. https://doi.org/10.1016/j.evalprogplan.2009.05.014

Weist, M. D., Short, K. H., McDaniel, H., & Bode, A. (2016). The School Mental Health International Leadership Exchange (SMHILE): Working to advance the field through opportunities for global networking. *International Journal of Mental Health Promotion, 18*(1), 1–7. https://doi.org/10.1080/14623730.2015.1079420

Weist, M. D., Bruns, E., Whitaker, K., Wei, Y., Kutcher, S., Larsen, T., Holsen, I., Cooper, J., Geroski, A., & Short, K. H. (2017). School mental health promotion and intervention: Experiences from four nations. *School Psychology International, 38*(4), 343–362. https://doi.org/10.1177/0143034317695379

Weisz, J. R. & Short, K. H. (2022). *Scalable, available youth mental health care: Little interventions with big reach. Paper presented at the IIMHL School Mental Health Match.*

Whitley, J., Smith, J. D., & Vaillancourt, T. (2012). Promoting mental health literacy among educators: Critical in school-based prevention and intervention. *Canadian Journal of School Psychology, 28*(1), 56–70. https://doi.org/10.1177/0829573512468852

Wiglesworth, M., Lendrum, A., Oldfield, J., Scott, A., ten Bokkel, I., Tate, K., & Emery, C. (2016). The impact of trial stage, developer involvement and international transferability on universal social and emotional learning programme outcomes: A meta-analysis. *Cambridge Journal of Education, 46*, 347–376.

Williamson, R., & Blackburn, B. (2022). Effective school leaders are prepared for crisis. Retrieved, from https://www.middleweb.com/48050/effective-school-leaders-are-prepared-for-crisis/

Wisdom2Action (2021). *#HearNowON 2021: Student Voices on Mental Health – Final Report.* Retrieved, from https://smho-smso.ca/blog/online-resources/hearnowon-2021-student-voices-on-mental-health-final-report/

Yamaguchi, S., Foo, J. C., Nishida, A., Ogawa, S., Togo, F., & Sasaki, T. (2020). Mental health literacy programs for school teachers: A systematic review and narrative synthesis. *Early Intervention in Psychiatry, 14*(1), 14–25.

Young, L., Mulloy, M., Huckabee, S., Landoll, R., Miller, E., Miller, M., & Weist, M. D. (2015). Child and adolescent mental health and the schools. In B. Cook, M. Tankersley, & T. J. Landrum (Eds.), *Advances in learning and behavioral disabilities*, (Vol. 28, pp. 197–224). Bingley, UK: Emerald Group Publishing Limited.