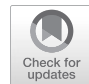

17 The Fourth R: Implementing Evidence-Based Healthy Relationships and Mental Health Promotion Programming in Diverse Contexts

Claire V. Crooks, Debbie Chiodo, Caely Dunlop, Alicia Lapointe, and Amanda Kerry

Abstract

There is an increasing awareness that youth mental health problems and violence are public health concerns that require public health approaches to prevention. Simply put, these are not challenges that we are going to treat or arrest our way out of but rather are more effectively approached through a public health lens for several reasons. The *Fourth R* is an approach that includes an array of evidence-based and evidence-informed programs designed to develop youth's healthy relationship skills, promote positive mental health, and prevent violence. This chapter describes the *Fourth R*, its evidence base, and lessons learned regarding successful school-based program implementation.

There is an increasing awareness that youth mental health problems and violence are public health concerns that require public health approaches to prevention. Simply put, these are not challenges that we are going to "treat" or "arrest" our way out of but rather are more effectively approached through a public health lens for several reasons. First, the prevalence of both mental health problems and relationship violence among adolescents warrants a public health approach. Second, both mental health problems and violence become more entrenched the longer they go unrecognized; without intervention, youth mental health problems predict ongoing challenges into adulthood. Depression during adolescence, for example, is a predictor of later mental health challenges, even if it does not meet diagnostic criteria. In one large, community-based study with adolescents, researchers found that youth with minor depressive disorders had an elevated risk for a range of psychiatric disorders during adulthood (Johnson, Cohen, & Kasen 2009). Similarly, relationship violence during adolescence is a strong predictor of ongoing interpersonal violence in adulthood, as both perpetration and victimization can increase the likelihood of victimization and perpetration later in life (Cui, Finchman, Gordon, & Ueno, 2013; Exner-Cortens, Echenrode, Bunge, & Rothman, 2017; Manchikanti Gomez, 2011). Third, there are effective health promotion and prevention programs that can reduce the prevalence of these challenges when implemented universally. Finally, these health promotion and prevention

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A. W. Leschied et al. (eds.), *Handbook of School-Based Mental Health Promotion*,
The Springer Series on Human Exceptionality, https://doi.org/10.1007/978-3-319-89842-1_17

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initiatives can be implemented from a strength-based perspective within schools. This approach to building capacities and resilience fits well with other educational frameworks such as social and emotional learning (note the advocacy of organizations such as the Collaborative for Academic, Social, and Emotional Learning at casel.org) and can benefit all youth, not just those demonstrating challenges.

The *Fourth R* is an approach that includes an array of evidence-based and evidence-informed programs designed to develop youth's healthy relationship skills, promote positive mental health, and prevent violence. This chapter describes the *Fourth R*, its evidence base, and lessons learned regarding successful school-based program implementation. We are conceptualizing implementation in a broad sense, including adaptation for specific populations. We begin the chapter by discussing our *Fourth R* classroom-based programming. We then turn to several extensions and adaptations that were developed to meet the needs of specific youth populations and/or settings. We include a discussion of our work with Indigenous youth, our small group programming, and extensions of our small group program for both LGBTQ2+ and justice-involved youth. For each of these programs, we briefly describe the rationale for adapting the programming, the modification process, and our current evaluation findings. We then identify considerations for implementing school-based programming with diverse youth in several areas, including the adaptation process, program implementation, research and evaluation, and organizational capacity and sustainability. We provide recommendations in each of these areas.

Overview of the Fourth R

The original Fourth R programming was developed as a dating violence prevention program designed to be implemented by teachers in standard health classes (Wolfe, Jaffe, & Crooks, 2008). The Fourth R refers to "relationships" and is based on the contention that relationship skills are equally important for schools to teach as are the first three R's (i.e., reading, 'riting, and 'rithmetic). The Fourth R began with a dating violence prevention focus, but it also applies a broader social-emotional learning framework with a strong emphasis on skill development. Furthermore, it looks at adolescent behavior in a holistic way, by addressing the overlaps among healthy relationships, different types of relationship violence, sexual health, and substance use and misuse. To cover these topics, the original grade 9 version consisted of 21 sessions, each 75 min in length, and matched to curriculum requirements (Wolfe et al., 2009).

Since initial development of the grade 9 program in the early 2000s, there are now many other Fourth R program options available, most of which continue to align with curriculum expectations to minimize barriers to implementation (i.e., as compared to add-on programs). In addition, over the past 5 years, all of the programs have been revised to have a stronger focus on mental health promotion since the field in general has come to view the complementarity of social and emotional learning and mental health (e.g., Zins, Weissberg, Wang, & Walberg, 2004). Beyond the original grade 9 program, other Fourth R programs include healthy living curricula for grades 7–8 and English curricula for grades 9–12. There are slightly different versions of these curricula that align with jurisdictional educational expectations to ensure that educators across Canada and the USA can meet their teaching requirements by implementing the program. The Fourth R offers various in-person and online teacher training options, including opportunities for educators and service providers to become master trainers, in order for school districts and community organizations to develop their own trainers certified in the Fourth R. Numerous translations of the Fourth R are also available (for more information regarding the Fourth R training, see www.youthrelationships.org).

Fourth R as an Evidence-Based Program

Over the past decade, a number of studies have demonstrated a range of positive benefits for the *Fourth R* across multiple settings. In the original

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cluster randomized trial in Ontario, students in the *Fourth R* reported reduced dating violence and increased condom use among sexually active youth 2 years after intervention, compared to youth in regular, usual service health classes (Wolfe et al., 2009). Secondary analyses with the original RCT data demonstrated a protective effect on violent crime among maltreated youth (Crooks, Scott, Ellis and Wolfe, 2011). Beyond reducing negative outcomes, the *Fourth R* has been shown to develop positive peer relationship skills. A subset of youth from the original RCT (n = 200) participated in role-play tasks in an observational study, where they demonstrated improved peer resistance skills to interpersonal pressure compared to peers who had not participated in the *Fourth R* (Wolfe, Crooks, Chiodo, Hughes, & Ellis, 2012). A subsequent RCT of the grade 7 and 8 program with 57 schools in Saskatchewan found youth in *Fourth R* classrooms had an increased awareness regarding the impact of violence on others and improved awareness of healthy coping strategies (Crooks, Scott, et al., 2015). Finally, a recent analysis of the costs and benefits of the *Fourth R* has shown significant cost savings based on averted costs related to delinquency at a low cost per student (Crooks, Zwicker, et al., 2017).

Fourth R Implementation Considerations

There are a number of features of the *Fourth R* that have facilitated this scale-up success. The *Fourth R* was one of the first programs to align with Ministry of Education curriculum expectations such that teachers could implement the program within a credit-based course. Furthermore, we developed different versions to align with Ministry expectations in different provinces and also with different educational systems (i.e., making modifications so that it could be endorsed in the Catholic school system). The integrated nature of the programming (i.e., that it is taught by teachers during class time) has also made it robust against job action. Even during a work-to-rule situation or an impending strike, educators continue to implement the program as part of their typical workload. Beyond matching to the organizational system, the *Fourth R* training and curriculum materials are well-liked and highly regarded by educators. The importance of high levels of satisfaction among implementers should not be overlooked because teachers maintain complete autonomy over what they teach in their courses as long as they meet curriculum expectations.

One aspect of the *Fourth R* that has contributed to effective implementation is that, because it is comprehensive in nature, it can bring together multiple stakeholders. For example, in Alaska, statewide implementation was undertaken by a coalition that included numerous government departments and nongovernmental organizations. Education saw themselves as a major stakeholder but so did public health (mainly due to the link to healthy sexuality) and anti-violence community-based organizations and governmental bodies (Crooks, Exner-Cortens, Siebold, Moore, et al., 2018). In Alberta, continued implementation of the *Fourth R* has been embedded in a province-wide strategy to end domestic violence (see www.preventdomesticviolence.ca). Conversely in Atlantic Canada, it has been integrated into a regional effort to embed social and emotional learning across the lifespan.

In addition to the numerous implementation successes we have documented, there are also significant challenges. In 2011, we surveyed approximately 200 teachers examining their continued use of the *Fourth R* between 2 and 8 years after training (Crooks, Chiodo, Zwarych, Hughes, & Wolfe, 2013). Results indicated high levels of satisfaction with the program and relatively strong implementation fidelity among respondents. In addition, teachers' feelings of preparedness training, support, and accountability predicted sustained high-quality implementation. Respondents identified time frames as the most among the most significant barriers, followed by challenges with the skill-based role-play activities. Since 2013, we have been tracking implementation data from sites across Canada within the context of a Public Health Agency of Canada funded project focusing on scale-up and sustainability.

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Implementation challenges related to the *Fourth R* have remained remarkably similar over time (Chiodo, 2017). The most consistently reported challenges continue to be related to time, with educators identifying difficulty both in fitting all the activities into the time frames (although that improves with successive implementation cycles for particular teachers) and in protecting the days that are hypothetically allotted to health classes. In our experience, it has been difficult to distinguish between "not enough time to complete the program" versus a lack of prioritization and/or adequate scheduling (i.e., districts not actually scheduling the required number of hours for health class). Perhaps it is due to a lack of accountability (i.e., students do not receive a mark for health class alone), since health class appears to be the first activity sacrificed for external assemblies or time lost to snow days. After 15 years of implementing and researching the *Fourth R*, we have a good sense of major implementation successes and challenges. As we began to develop programming for more specific populations and settings, we also wanted to examine the degree to which implementation considerations were comparable to our original classroom-based *Fourth R* work.

Importance of Extending Evidence-Based Practices (EBP) for Diverse Settings

The move toward endorsing evidence-based practices (EBP) in violence prevention and mental health promotion in general has been somewhat hampered by the lack of EBP, particularly for marginalized groups (Claussen, Exner-Cortens, Abboud, & Turner, 2016). One major working group concluded that "Little research has addressed the question of how transportable evidence-based interventions developed for one ethnic group are to a range of ethnic and cultural groups" (O'Connell, Boat, Warner, & National Research Council, 2009, p. 336). This gap is particularly concerning given that many identifiable ethnic and cultural groups experience disproportionate rates of negative mental health and violence outcomes.

In our review of the state of gender-based violence prevention programs in Canada, for example, we concluded that virtually all EBPs were delivered either in high schools or postsecondary settings (Jaffe, Crooks, Dunlop, & Kerry, 2016). There was a stark lack of EBP for specific marginalized groups (including Indigenous women and girls, LGBTQ2+ youth and adults, and women with disabilities). Furthermore, there were no EBPs for vulnerable youth in specific settings, such as youth justice. There is clearly a need to develop programs that meet the needs of these populations within their unique settings for service delivery.

Although some educators and practitioners choose to develop programs without drawing on available evidence, there are significant advantages to adapting an existing program that has strong research evidence. O'Connell et al. (2009) have identified numerous advantages and disadvantages to implementing evidence-based programs in a "one-size-fits-all" manner, versus implementing an adapted version and versus implementing a community-driven initiative. For example, adaptation of such programs increases the program's relevancy to characteristics of a population while also increasing the likelihood of achieving a positive impact based on previous findings with the program (O'Connell et al., 2009). The comparison of three approaches is shown in Fig. 17.1 (O'Connell et al., 2009).

There is an emerging emphasis on hybrid prevention programs that include adaptation to enhance the fit for particular groups while maximizing fidelity of implementation (Barrera, Berkel, & Castro, 2017; Castro, Barrera, & Martinez, 2004; Castro & Yasui, 2017). In this approach, adapted programs borrow from the strengths of the evidence of evaluation research conducted with the original prevention program (Aarons, Sklar, Mustanski, Benbow, & Brown, 2017), but these adaptations need to occur carefully and be evaluated in their own right.

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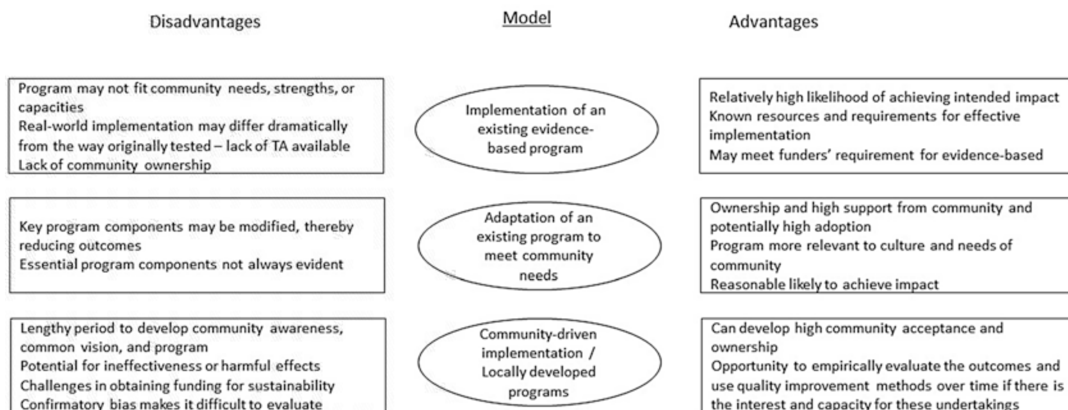

Fig. 17.1 Comparison of implementing evidence-based programs, adapted evidence-based programs, and locally developed programs. (Adapted from O'Connell et al. (2009))

Expansions and Adaptations for Diverse Youth and Settings

Over recent years, our *Fourth R* team has focused on developing new expansions by working closely with partners to adapt programming for particular settings and groups. Specifically, we have developed a range of program options for Indigenous youth, a small group version of the *Fourth R* with an enhanced mental health focus, and a small group version specifically for LGBTQ2+ youth. We have also piloted our classroom-based and small group-based programs with youth in corrections and have developed versions of our programming that have a more trauma-informed lens for that group (known as the HRP-Enhanced). All of these programs share core *Fourth R* components but have additional programming considerations based on the specific needs of the group or setting (see Table 17.1). The top panel of Table 17.1 identifies core components of *Fourth R* programming on the left and enhancements for different groups in the other columns. The bottom panel compares implementation details for the original *Fourth R* classroom-based programs to those in the enhanced versions. We turn now to a brief description of our programming for diverse youth, highlighting the need for adaptation, the adaptation process, and corresponding evaluation findings.

Programming for Indigenous Youth

Collectively, Indigenous[1] youth in Canada experience disproportionate health challenges and threats to well-being as compared to non-Indigenous peers. Indigenous youth are at greater risk for poor mental health, suicidality, substance use, violence and victimization, and these issues are exacerbated by an increased likelihood of experiencing food, water, and housing instability and poverty (First Nations Information Governance Centre, 2012; Health Canada, 2014; Ning & Wilson, 2012). The health disparities and systemic inequity that burden many Indigenous youth in Canada reflects the enduring impacts of more than 100 years of colonial policies and practices enacted by the Canadian government. These systematic attempts at extinguishing Indigenous culture contribute to the deleterious outcomes experienced by Indigenous peoples in

[1]The program described in this chapter was developed in Canada, and as such, references to Indigenous peoples are reflective of the Canadian context. We use the term Indigenous to refer to the First Peoples of Canada, specifically, peoples who identify as First Nations, Métis, and Inuit (FNMI). We use these terms (Indigenous and FNMI) interchangeably, as the term FNMI has recently been used in the educational policy context where the program was developed. We acknowledge that these are umbrella terms that denote overarching commonalities among Indigenous peoples, but that do not reflect the diversity of Indigenous individuals or their communities.

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Table 17.1 Common elements and program-specific features across Fourth R programs

	Common components of all Fourth R programs	Program specific content and structure			
		Uniting our Nations	Healthy Relationships Plus	HRP for LGBTQ2+ Youth	HRP- Enhanced
Program content	Emphasis on healthy relationships	Cultural identity as an underlying framework	Stronger focus on mental health	Queer and trans-informed approach	Increased attention to high-risk scenarios
	Focus on skills development (particularly SEL competencies)	Use of culturally appropriate teaching methods	Lower demands for reading and writing in activities	Affirms gender, sexual, and romantic diversity	Trauma-informed lens
	Positive youth development framework	Greater focus on mentorship		Focuses on managing minority stress	
		Greater focus on youth voice		Greater focus on youth voice	
Implementation structure	Matches curriculum expectations	Community inclusion	Can be delivered in schools or community settings	Can be delivered in schools (through gender and sexuality alliances (GSAs) or community settings	Can be implemented in academic or program components in youth justice settings
	Delivered by teachers	Some components match curriculum expectations and others do not	Flexibility around delivery		
	Manualized components		Accommodates a range of ages in one group		

Canada to this day and, as a result, were deemed "cultural genocide" by the *Truth and Reconciliation Commission of Canada* in 2015 (TRC, 2015).

To address these disparities, researchers and community members have directed considerable attention to the development and evaluation of culturally appropriate programming for Indigenous youth. Protective factors including cultural identity and connectedness, and engagement in traditional cultural activities, have been associated with more positive mental health outcomes and well-being among Indigenous youth and have been recognized as an essential focus of prevention and intervention efforts developed for this population (Kenyon & Hansen, 2012; Kirmayer, Simpson, & Cargo, 2003; MacDonald, Ford, Wilcox, & Ross, 2013; Snowshoe, Crooks, Tremblay, & Hinson, 2017). In recent years, numerous initiatives have been developed to promote well-being among Indigenous youth by operationalizing these protective factors and incorporating culturally relevant content (including local and/or tribal specific beliefs, traditions, and practices). *The Fourth R: Uniting Our Nations* is one such program. Over the past decade, the *Fourth R* team has worked with youth, the local school board, and three local First Nations communities to develop and evaluate school-based, culturally relevant, relationship-focused programming for Indigenous youth in grades 7 through 12 (Crooks & Dunlop, 2017).

The Fourth R: Uniting Our Nations program comprises multiple components developed specifically for Indigenous youth (with the exception of the Indigenous Perspectives[2] *Fourth R*, which was

[2]This program was originally known as the Aboriginal Perspectives Fourth R, but the names of our program have evolved as preferred terminology has evolved. Indigenous is all-encompassing of first peoples in the same way that Aboriginal was intended to be but has emerged as the preferred term.

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adapted from the original *Fourth R* program). These programs share the *Fourth R*'s strength-based, positive youth development framework and focus on healthy relationships and social-emotional skill development yet differ from the original *Fourth R* program in their emphasis on cultural identity development and mentoring, utilization of culturally appropriate teaching methods, and inclusion of Indigenous community members and locally relevant teachings. Over the past decade, the *Fourth R* team has worked in close, ongoing partnership with local community partners to co-develop, implement, and evaluate multiple initiatives and program components comprising *The Fourth R: Uniting Our Nations* program for Indigenous youth, including (1) Elementary Mentoring Program, (2) Peer Mentoring for Secondary Students, (3) Cultural Leadership Course, (4) Cultural Leadership Camp, (5) FNMI Student Leadership Committee, and (6) Indigenous Perspectives *Fourth R* (Crooks & Dunlop, 2017). Research to date has demonstrated that the programs are engaging (Crooks, Chiodo, Thomas, & Hughes, 2009) and are perceived to provide a wide range of benefits for youth (Crooks, Burleigh, Snowshoe, et al., 2015). A longitudinal mixed-methods evaluation demonstrated significant gains in positive mental health and cultural connectedness for youth involved in 2 years of mentoring (Crooks, Exner-Cortens, Burm, Lapointe, & Chiodo, 2017). Program participants also achieved higher credit accumulation compared to peers involved in 1 or no years of mentoring.

Programming for Small Groups with an Enhanced Mental Health Focus

The *Fourth R Healthy Relationships Plus* (*HRP*) is an evidence-informed small group program that aims to equip students with the skills they need to build healthy relationships and help themselves and their peers reduce risky behaviors. The *HRP* consists of 14 1-h sessions covering topics such as peer pressure, help-seeking, media literacy, healthy and unhealthy peer and dating relationships, healthy communication, mental health and well-being, suicide prevention, and the impacts of substance use and abuse. We developed this small group program in response to a significant need to target the prevention of violence through the promotion of positive, healthy relationships in settings outside of the classroom, with more flexibility around program delivery and group composition.

The *HRP* is best considered evidence-informed in that it applies the evidence-based *Fourth R* strategies and has preliminary evidence of effectiveness, but does not have the same evidence base as the *Fourth R*. Results from our national implementation study (described below) suggest that teachers view the program favorably and describe positive impacts in their students. In this study, 96% of facilitators rated the program as beneficial for youth. Overall, almost all program facilitators had a positive experience delivering the program to youth, would recommend the program to their colleagues, and believed that the program was beneficial to youth. Furthermore, facilitators described seeing changes in the students and the way they relate to each other and adults in their lives:

> I have observed my students discussing healthy and unhealthy relationships, and they are also able to identify 'red flags' in a relationship. I have also overheard students apologizing to friends, and the students who I delivered the *HRP* to will ask the other person to make eye contact, talk to them in a private locations, etc. To me, this translates as students not only becoming aware of what constitutes a proper apology, but also becoming self-advocates. They are aware to voice their emotional needs. Students are also much more knowledgeable about mental illness and mental health. They are practicing some of the strategies they have learned to reduce their on stress and anxiety.
> (Facilitator response, implementation survey)

The *HRP* was more formally evaluated in a small RCT that followed youth longitudinally for 18 months after intervention (Exner-Cortens, Wolfe, Crooks, & Chiodo, 2017). Although this study was hampered by a small sample size and relatively low-risk youth participants, there was a decrease in bullying victimization among intervention youth at 12 months post-intervention that appeared to be mediated by increased help-seeking immediately following intervention.

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There were no benefits in depression or substance use, which may, in part, be due to low base rates of these outcomes in both intervention and control youth.

Finally, between 2014 and 2017, Health Canada's Drug Strategy Community Initiatives Fund supported the implementation, evaluation, and scale-up of the *HRP* in three provinces and one territory. This initiative was a field trial that sought to explore implementation of the *HRP* in real-world settings in diverse contexts. Pre- and post-intervention data were collected from youth (although there were no comparison groups); facilitators provided implementation data and feedback. Analysis of pre- and post-intervention scores on depression showed a main effect for time, indicating that depression decreased overall (Lapshina, Crooks, & Kerry, 2018). Furthermore, latent class growth analysis was used to identify patterns of pre-post change and indicated that it was the youth who were most depressed at pretest that had the most benefit. Without a control group, these results must be considered preliminary, but they suggest that the program is promising and requires further evaluation.

Table 17.2 Key concepts in understanding discrimination faced by LGBTQ2+ youth

Homophobia	Refers to anti-gay bias (Walton, 2006). Involves prejudice and discrimination directed toward people who are or are perceived to be queer (Taylor et al., 2011)
Heterosexism	"…the institutionalized belief that heterosexual attraction and relationships are considered valid and natural, whereas same-[gender] attraction and relationships are not" (Serano, 2013, p. 114)
Heteronormativity	The naturalization and normalization of heterosexuality in society (Britzman, 1995)
Transphobia	"The irrational fear or hatred of all individuals who transgress or blur the dominant gender categories in a given society" (Airton & Meyer, 2014, p.)
Cissexism	"…the double standard that leads people to view, interpret, and treat trans people differently (and less legitimately) than…cis counterparts" (Serano, 2007/2016, p. xviii)
Cisnormativity	The normalization and naturalization of cisgender identities and gender conforming expressions

Programming for LGBTQ2+ Youth

The *Healthy Relationships Program (HRP) for Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and Two-Spirit Youth (LGBTQ2+)* was adapted from the *Fourth R*'s *Healthy Relationships Program (HRP)*. LGBTQ2+ youth generally experience mental health disparities to a greater extent than their straight and/or cisgender peers as a result of social and systemic homophobia, heterosexism, heteronormativity, transphobia, cissexism, and cisnormativity, as defined in Table 17.2 (Grace & Wells, 2015; Russell & Fish, 2016). The *HRP for LGBTQ2+ Youth* is an 18-session program that promotes positive mental health and well-being and healthy relationship development among LGBTQ2+ youth. The program was designed to affirm gender, sexual, and romantic minority identities and experiences and enhance youth's ability to cope with sexual- and gender-based oppression (Meyer, 2003; see also Rood et al., 2016). Since there is a dearth of evidence-informed positive mental health programming for LGBTQ2+ youth (Craig, Austin, & McInroy, 2013; Heck, 2015), the *HRP for LGBTQ2+ Youth* fills significant programmatic gaps.

The *HRP for LGBTQ2+ Youth* pilot was developed by an American dating violence researcher in 2013–2015 and was first implemented in 2015–2016 in one community group and eight Canadian public secular high school gay-straight alliances (GSAs) because schools have been found to be effective sites for offering mental health promotion programs for LGBTQ2+ youth (Heck, 2015). GSAs or clubs that go by other names, but have similar mandates (e.g., gender and sexuality alliances (GSA); queer-straight alliances (QSA); gender, sexuality, and trans alliances (GSTA); or other student-developed acronyms), are school-based groups whose roles fluctuate between safety, social/support, education, and activism (Griffin, Lee, Waugh, & Beyer, 2004).

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Qualitative feedback was collected on the pilot and was utilized to revise the program during the summer of 2016 (see Lapointe, 2017; Lapointe, Dunlop, & Crooks, in press). GSA facilitators and youth participants were hired as consultants to guide significant changes to the program. The revised program was implemented at eight GSAs and one community organization from December 2016 to June 2017. Most sites that delivered the revised program were new, except two schools and the community organization. In both years, facilitators attended a 1-day training session where they developed their understanding of mental health and wellness and LGBTQ2+ topics and were introduced to the *HRP for LGBTQ2+ Youth*. Early qualitative evaluation of the revised program suggests that youth enjoyed participating in a structured program within their school-based clubs, partly because it enabled them to explore topics that they might otherwise overlook or fail to examine in-depth. They also appreciated the program's identity affirmative focus, and the skills were very applicable to their lives, particularly for those who were experiencing challenges associated with coming out (Lapointe & Crooks, 2018).

Programming for Youth in Correctional Settings

Juvenile offending has been linked to numerous negative outcomes for youth including psychological, emotional, health, social, academic, and employment challenges. In addition to individual impacts, youth delinquency is associated with significant societal costs, including a strain on finances and resources (de Vries, Hoeve, Assink, Stams, & Asscher, 2015). The prevalence of youth offending, as well as the individual and societal impacts of these behaviors, highlights the importance of supporting the needs of these youth. In order to reduce the likelihood of negative outcomes for youth and society as a whole, stakeholders must carefully choose appropriate prevention and intervention programs. Historically, programs have been risk-focused; however, preventing risk factors alone is not sufficient to address the challenges that these youth face (Krohn, Lizotte, Bushway, Schmidt, & Phillips, 2014). Current research suggests that effective prevention and intervention programs should aim to simultaneously prevent or reduce multiple risk factors while also promoting the development of protective factors (Knight et al., 2017).

A meta-analysis identifying empirically based ingredients of programs that reduce offending behaviors in youth recommended that programs aim to develop social skills (i.e., positive communication) and cognitive skills (i.e., problem solving and perspective taking). Programs should also be highly structured and include a manual, staff training and supervision, and a measure of program compliance (Latimer, Dowden, Morton-Bourgon, Edgar, & Bania, 2003). Consistent with these effective ingredients of programming, the *Fourth R* classroom curricula and the *HRP* are manualized programs that target multiple risk factors (i.e., substance use, risky sexual behavior) and promote protective factors through social and cognitive skill building (i.e., communication skills, help-seeking). Based on the needs of youth offenders, and the program objectives of the *Fourth R* curricula and the *HRP*, we believed that a clear and compelling rationale existed for implementing these programs in youth justice settings.

Currently, there are a limited number of programs for youth offenders that are deemed evidence-based (Guerra, Kim, & Boxer, 2008). Consequently, in 2015, we partnered with Manitoba Corrections to address this gap by examining the feasibility and fit of the *Fourth R* classroom-based program and *HRP* in youth correctional facilities. It was understood that the programs were not designed specifically for youth offenders and the existing programs would require adaptations to make the content more applicable to the youth justice population and the constraints of a correctional setting. During the first year, the original programs were piloted to examine feasibility and fit and subsequently make program adaptations based on facilitator and administrator feedback. Results of this pilot indicated that, although the content was a fairly good fit for the needs of the participants, the *HRP* was a better fit for the setting than the classroom-based version. Subsequent revisions to the program added higher-risk scenarios, increased

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cognitive-behavioral restructuring activities, and added a trauma-informed lens. The revised program (i.e., th *HRP-Enhanced)* is currently being piloted in five correctional settings in Manitoba and Ontario.

Outside of the justice system, the *Fourth R* and *HRP* programs have been implemented with high-risk youth in diverse settings. Interestingly, two of the authors implemented the *HRP* with adolescent mothers who attended an alternative education program. Many of these young women are identified as high risk in terms of past or current mental health challenges, engagement in substance use, and experiences of family and relationship violence. In addition, many of these adolescent mothers were at risk of becoming or currently involved in the justice system. Although these implementations were not formally evaluated, according to facilitator, teacher, and student feedback, the program was well received. The authors observed that the young women were engaged by the content and activities and anecdotally reported that they had used the knowledge and skills they learned with each other to deal with difficult situations in their lives in a healthy way. Based on these experiences, and preliminary data from the youth justice pilot, we hypothesized that the *HRP-Enhanced* may also be a good fit for high-risk youth more generally, and we are currently piloting it in numerous community mental health settings. Moreover, we are in the process of piloting and further adapting the *HRP-Enhanced* to match the needs of groups of high-risk adolescent girls.

Implementation Considerations for Diverse Settings: Applying the Quality Improvement Framework

The last 15 years has seen a number of conceptual frameworks that have been developed to guide quality implementation (e.g., Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; DuBois, Holloway, Valentine, & Copper, 2002; Durlak & DuPre, 2008; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Rogers, 2003; Wandersman et al., 2008). Most of these frameworks, however, do not focus on the specific actions or the "how to" that can be employed to foster high-quality implementation. One notable exception is the quality implementation framework (QIF; Meyers, Durlak, & Wandersman, 2012). The QIF was designed from an extensive synthesis and review of leading implementation frameworks in the literature and extends this work by allowing researchers and practitioners to think about the "how to" of implementation. The QIF delineates the critical factors deemed most important for implementation success and identifies 4 phases and 14 critical steps along with specific actions that can be considered during the implementation process to achieve quality implementation (Meyers, Durlak, & Wandersman, 2012). Several studies have provided support for each of the QIF critical steps (see Durlak & DuPre, 2008; Gottfredson & Gottfredson, 2002; Fixsen et al., 2005), and scholars have argued that more attention needs to be paid to factors that lead to high-quality implementation (Domitrovich et al., 2008; Payne & Eckert, 2010). Meyers, Katz, et al. (2012) also developed a tool called the quality implementation tool (QIT) to assist stakeholders in communities and organizations in their efforts to implement with quality. The content of this tool was developed from the QIF and was designed to be completed through a collaborative process among members of the implementation team to help enhance the likelihood that desired outcomes of programs or interventions are achieved (Meyers, Katz, et al., 2012).

In our work with prevention programs delivered in diverse contexts, using an effective implementation framework like the QIF has helped to maximize the full benefits of the programs and practices by considering strategies, attributes, and facilitators that helped to guide and execute our implementation efforts. Moreover, employing QIF has allowed us to identify factors that could threaten implementation quality and inhibit successful implementation and desired outcomes. A particular strength of the QIF is that it organizes actions into a temporal sequence of four phases. The framework describes describes the sequential and necessary phases for successful implementation, as well as the specific actions. The phases

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include initial considerations regarding the host setting (Phase 1), creating a structure for implementation (Phase 2), ongoing structures once implementation begins (Phase 3), and improving future applications (Phase 4). In total, 14 steps are identified in the implementation process (Meyers, Durlak, & Wandersman, 2012). These phases and steps provide a useful framework for describing the implementation process of the various *Fourth R* initiatives that have been undertaken with diverse populations and in diverse contexts. The use of the QIF provides a conceptual guide to utilizing effective implementation practices (Meyers, Durlak, & Wandersman, 2012). In the section below, we describe each phase of the QIF and the implementation considerations for prevention programming in diverse contexts.

Phase 1: Initial Considerations Regarding the Host Setting and Specific Population

The first phase, *Initial Considerations Regarding the Host Setting*, focuses on activities related to the specific intervention host setting and identifies activities related to fit, adaptability, and readiness. Meyers, Durlak, & Wandersman (2012) describe this first phase of implementation primarily focusing on the ecological fit between the innovation and the host setting. Phase 1 includes eight critical steps: conducting a needs and resources assessment, conducting a fit assessment, conducting a capacity/readiness assessment, possibility for adaptation, obtaining explicit buy-in from critical stakeholders and fostering a supportive climate, building general/organizational capacity, staff recruitment/maintenance, and effective pre-innovation staff training (Meyers, Durlak, & Wandersman, 2012). Our implementation manual offers a number of checklists and tools for addressing these issues with our general curriculum-based health education *Fourth R* programs (Crooks, Zwarych, Burns, & Hughes, 2015), but there are numerous additional considerations when implementing in diverse contexts. We discuss three of these here – the process of obtaining buy-in, establishing fit and alignment, and considering the possibility for adaptation. Specific recommendations for the adaptation process are included in Textbox 17.1.

Textbox 17.1. Recommendations for Initial Considerations Regarding the Host Setting and Target Population

1. Program adaptation and implementation are best undertaken in the context of authentic, reciprocal relationships with the community or setting for whom the adaptation is being made. These partners provide critical guidance on both content and implementation structure.
2. Ensuring that programs or interventions are compatible with the existing values, experiences, and needs of the host setting, community, and individuals and implementing the intervention are critical factors in the adoption of programs for that particular setting or target group and are also pivotal in maximizing implementation success.
3. Adaptation is an iterative process that requires patience. It is essential to build feedback loops into this process so that successive iterations better meet the needs of the youth and settings.
4. Youth who have been marginalized (and their adult allies) are better engaged in strength-focused approaches that affirm a range of identities and expressions. They are less engaged in problem-focused approaches that reinforce stereotypes.

Obtaining Explicit Buy-In from Critical Stakeholders and Fostering a Supportive Climate

Although the QIF identifies the importance of obtaining "buy-in" from key stakeholders, our experience has been that the importance of authentic and enduring partnerships goes far

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beyond obtaining buy-in. Authentic partnerships are about co-creating programming and also co-creating areas of inquiry for research projects (Janzen, Ochocka, & Stobbe, 2016). In addition, it is critical to engage different stakeholders in this process; administrators provide important input about context and, in many cases, have final decision-making authority, educators work closely with youth and are responsible for program implementation, and youth are the ultimate experts of their experience and what fits for them. It is important to create opportunities for youth voice, because their input has historically been lacking from program development (Edwards, Jones, Mitchell, Hagler, & Roberts, 2016). We have been successful in creating opportunities for youth to help shape program adaptation in different ways, sometimes as volunteers and sometimes as paid consultants. For example, youth developed the skill-based video resources that support our Indigenous programming materials. Youth consultants also engaged in a workshop-facilitated process to provide feedback and direction on an earlier version of the LGBTQ2+ manual (see Lapointe, 2017). Their contributions played a critical role in establishing fit for specific groups.

Fit and alignment There is significant research to support the importance of creating an environment that enhances implementation success, which includes ensuring that the program or intervention aligns with the existing values, experiences, and needs of the adopting organization as well as the individuals implementing the intervention. Rogers (2003) in his seminal work on the *Diffusion of Innovations Model* describes the degree of fit between the innovation (e.g., program, intervention, or policy) and the setting and target population as *compatibility*. Compatibility implies that the more in line the innovation is with the current value system and way of life of possible adopters, the more acceptable and accommodating are the adopters. Many studies support the degree of fit between the innovation and the setting and target population. Durlak and DuPre (2008) reviewed 542 quantitative implementation studies in the field of prevention and promotion targeting children and adolescents across a diverse set of programs, providers, and settings. In their review, they found that providers (e.g., individuals implementing the program and/or the implementing organization) who recognized a specific need for the innovation were more likely to implement a program at higher levels of dosage or fidelity than providers who did not see an immediate need for the innovation. Moreover, Durlak and DuPre also found that providers and organizations implement new programs more effectively when they fit with the organization's current mission, priorities, and existing practices. Research with the *Fourth R* has also supported the finding that when an innovative program is perceived as fitting the culture of the school and practices of individual teachers, it was perceived as more compatible and acceptable by teachers and school administrators. For example, Chiodo, Exner-Cortens, Hughes, and Crooks (2015) identified the integration of the *Fourth R* within existing school frameworks and priorities as a key factor in the implementation success and scale-up of the program across Canada. Teachers that were able to align the *Fourth R* with other safe school and health education priorities did not view the program as competing for time with other academic priorities (Chiodo et al., 2015). In other works, Chiodo (2017) found that teachers were more likely to implement the *Fourth R* program with high quality when they perceived the content of the program as aligning with what adolescents should be learning about and how they should be learning.

The Adaptation Process

Alignment and fit of *Fourth R* programs with the values, beliefs, and priorities of the district, school, organization, community, or individual teacher have not only been critical factors in the adoption of the program for that particular setting or target group but also pivotal in maximizing implementation success. For example, our *Uniting Our Nations* programming was developed to align with culturally appropriate teaching methods, as well as protective factors noted to improve the well-being of Indigenous youth,

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such as a program focused on cultural identity development and mentoring.

Moreover, in addition to culturally relevant content, research suggests that locally relevant cultural content is an important component of programming efforts with Indigenous youth (Moran & Reaman, 2002). The *Uniting Our Nations* program was developed and adapted in close partnership with neighboring First Nations communities to reflect local knowledge and traditions. This shift in ownership to the local community in which the program has been adapted and designed to fit the local context may help to sustain our programs long-term. Maximizing the contextual fit between the *Uniting Our Nations* programming and the needs of both the school and community has helped to enhance implementation.

It is important to note that these adaptions are often only applicable and relevant for the context in which they were developed. Significant problems have been associated with attempts to create content that is "pan-Aboriginal" or applies to all Indigenous peoples (Proulx, 2006). In light of these challenges, the *Fourth R* team has worked with partners to develop materials adapted for additional contexts (including an Anishinabe-informed version, a Cree-informed version, and a Dene-informed version of the *Indigenous Perspectives Fourth R* curriculum) and has developed a template and set of guidelines to assist other nations in further adapting the materials for their own local contexts (Crooks, Hughes, & Sisco, 2015). Because of the importance of local context, the scale-up process is slow and relationship-based. It is not feasible to develop a program that can be readily disseminated across Indigenous contexts in the same manner as our programming for non-Indigenous youth nor should that be the goal.

Another lesson for us with respect to working with historically marginalized populations is that youth and their adult allies prefer strength-based approaches versus a deficit-based approach or focusing solely on preventing negative outcomes. This has been true in all three of our areas. Our programming for Indigenous youth employs a holistic model of well-being that explicitly emphasizes cultural pride, cultural connectedness, and cultural identity development as a means of promoting positive mental health and resilience (Crooks, Burleigh & Sisco, 2015). Program content is delivered using culturally appropriate teaching methods and is connected to the medicine wheel, which is a locally relevant teaching related to health promotion. In the elementary and secondary mentoring programs, for example, beginning in the fall, which includes the west/spiritual quadrant, sessions address student interests, the creation story which reflects the locally relevant understanding of how a particular nation came to be, and creating positive attitudes and atmospheres. In the winter which represents the north/physical quadrant, sessions address bullying, healthy eating, and First Nations' representations in media. In the spring, the east/emotional quadrant, sessions address sharing and listening, goal setting, and positive decision-making skills. In the summer, the south/mental quadrant, sessions address communication skills, peer pressure, personal strengths, and handling peer conflicts. Thus, the key components of mental health promotion and violence prevention are still present, but they are embedded in a cultural framework. As one educator shared, this strength-based approach, which allows Indigenous youth to explore and develop their cultural identities, is a key factor in engaging youth and promoting positing outcomes:

> *Unfortunately, our Aboriginal youth are feeling left out and excluded and are not knowing who they are. So having a program specifically to teach the pride and power is something we need to build on in order to increase their graduation rates and show them that school is a good thing. School will empower them and being proud of who they are is what the Fourth R is helping to teach the kids.* (Crooks et al., 2015, p. 108)

Similarly, there is a clear need for strength-based and affirming approaches with LGBT2Q+ youth because queer sexualities are commonly positioned as abnormal, unnatural, and immoral (Britzman, 1995), and trans and gender diverse identities and expressions are largely erased (Namaste, 2000). The *HRP for LGBT2Q+ Youth* fills important gaps in validating and affirming

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LGBTQ2+ youth's identities and experiences. When working with youth, including vulnerable youth and those involved in the justice system, it is important to remember that in most cases, youth are coping the best way they know how, based on the available resources. To a well-adjusted adult, it may appear that delinquent youth have made bad choices and engaged in maladaptive behaviors. In many cases, youth are making decisions within the confines of their environment. While they are accountable for their actions, it is critical to recognize the resilience and strength that is often hidden beneath their behaviors (Ungar, 2004). The *HRP Enhanced*addresses the risk and protective factors among this population and highlights their resilience, which is too often overlooked.

Phase 2: Creating a Structure for Implementation

Meyers, Durlak, & Wandersman (2012) describe the second phase of quality implementation as ensuring that there is an organized structure developed to oversee the implementation process. This includes establishing a clear plan and timeline for implementation. This second phase also includes the importance of a team of committed and qualified individuals who will take responsibility for issues that may arise during implementation as well as individuals responsible for delivering the intervention. For this phase, we discuss the importance of establishing a clear plan and timeline for implementation, the structural challenges that impact implementation in schools, and the importance of implementation teams in enhancing implementation quality.

Establishing a clear plan and timeline for implementation Purposeful attention to implementation requires an organized structure developed to oversee the implementation process, which includes establishing a clear plan and timeline for implementation. An implementation plan for school-based prevention programs reflects a breakdown for each implementation activity into identifiable steps and assigns steps within a timeline to one or more implementation team members. An implementation plan should also clearly articulate what success looks like and identify any implementation challenges that may arise. To illustrate, during initial implementation when a program is being used for the first time in a school, an implementation plan might include the steps needed to accommodate and support teachers as they "try out" the new program. This could include regular check-ins by implementation team members or other school or district staff who have some involvement with implementation to discuss challenges or share success stories. The plan at this stage may also reflect a timeline around additional training sessions that may be required or ensuring access to materials or other resources are available to facilitate implementation. While implementation plans are effective in supporting the delivery of programs in schools, creating them is challenging. A useful implementation plan requires that implementation teams know each step required to facilitate implementation, have an understanding of how long each step may take to be realized, and also have a vision for what successful implementation looks like, none of which are easy tasks in school-based implementation of prevention programs.

Fourth R programs are predominantly funded through provincial or national granting agencies or service contracts through the local school board. Typically, implementation plans and timelines are established within the submission of grants or service contracts and are revised and updated frequently to reflect the realities of implementation stages throughout the project. Implementation plans for our work with marginalized populations have, in some ways, been more critical in supporting quality implementation than it has been for our universal classroom-based programming. For example, our programming for specific populations has been more resource-intensive than our classroom-based *Fourth R* programs, requiring us to draft highly specific plans that focus on what tasks will be accomplished, who will accomplish them, and when. With respect to our programming for Indigenous youth, identifying areas for improv-

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ing program implementation as well as prioritizing tasks for our team was important. Remaining flexible and adaptable to timelines and stages of implementation has not only been important for successful implementation but has also been an important component of our school board partnerships.

Structural challenges associated with implementation in schools or organizations The complexity necessary to achieve strong implementation fidelity in schools is well documented. Many initiatives are implemented well on a small scale or when programs are externally driven by outside researchers with external funding to support the implementation. However, the majority of these falter under real-world conditions, in part due to common implementation challenges. Some examples of the barriers to high-quality implementation in schools include a mismatch between class time and the delivery of the program, administrative priorities, teacher skills and beliefs about the perceived need for the intervention, organizational capacity, and acceptability of the program or intervention (e.g., Durlak & DuPre, 2008; Gottfredson & Gottfredson, 2002; Han & Weiss, 2005). The complexity involved in implementation of school-based prevention is also why there are significant variations in fidelity observed across programs, components, schools, and teachers. Identifying and understanding the barriers to implementation can highlight potential points of entry for addressing problems and drivers for improvement.

For our school-based programming, understanding the complexity of prevention program implementation in school settings has required us to be creative in knowing when and how programs are delivered, taking advantage of implementing programs within pre-existing formal structures and groups (e.g., GSAs), and advocating for the prioritization of prevention programming for specific groups within school timetables and calendars. Implementing *Fourth R* programs in settings outside of school, such as youth justice, has also required implementation flexibility and adaptability. For example, in the youth justice system, the transient nature of youth entering and leaving custody facilities at different times makes *Fourth R* program implementation uniquely difficult as knowledge and skill development in each lesson builds upon the content from preceding lessons. The pilot implementation of the *HRP* in youth justice was a good fit for the target group and setting because the program is short (14 lessons), and with youth entering and being released at different times, the likelihood of youth completing the program was higher with *HRP* than it was for the longer *Fourth R* curriculum-based program (27 lessons). Additionally, the *Fourth R* curriculum-based program was not compatible with the youth justice setting because youth attending school in custody typically complete independent work and they found partner/group work a challenge. Finally, in youth custody education programs, youth are working toward earning different credits (i.e., some youth may be completing grade 8 curriculum, while others are working on grade 10), and the *Fourth R* curriculum-based program did not allow for all youth who participated to earn their required credits.

Our *Uniting Our Nations* peer mentoring program for high school students has always been offered during the lunch hour at schools which has been both an advantage and disadvantage. School administrators and school staff are often reluctant to allow high school students to miss class time for participation in non-curriculum-based programming, making the lunch hour the only viable option for the mentoring program. In some program years, there have times where high school students have been less willing to sacrifice their lunch hour to attend programming. Providing lunch for students during the program has sometimes helped with program attendance. At times, the balance of wanting to spend lunch hour with other friends has interfered with the desire to attend the mentoring program. Lunch hour programming is also hampered by students who may not arrive on time as they travel through the busy halls to attend programming. On the other hand, with the increasing pressure for students to not lose instructional time for extracurricular programming, offering the program

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during the lunch hour has been a necessary alternative. Scheduling has been the bane of many prevention program implementation efforts, and experimenting with alternative models to implement new programs could be beneficial.

Implementation teams Implementation teams are responsible for the purposeful, active, and effective implementation work – the "making it happen" phase when it comes to program implementation (Fixsen et al., 2005). Typically, members of implementation teams have special skills and expertise regarding programs and often understand the program very well, reflecting both formal and practice knowledge. Implementation team members also have at least some practice in implementing programs or interventions with fidelity and often have a vested interest, ensuring that the program's intended outcomes are achieved. Individuals who are part of implementation teams are accountable for assuring that the interventions and effective implementation methods are in use by the implementers. An implementation team should not be mistaken for an advisory committee or group that meets periodically and receives updates and provides inputs on decisions. In contrast, an implementation team is actively involved on a daily basis with the implementation, addresses challenges that may arise, is committed to ensuring the full use of the innovation, and communicates successes and challenges of the implementation effort (Blasé, Fixsen, Sims, & Ward, 2015). Several scholars have argued that implementation efforts are more likely to be successful with the active engagement and accountability of implementation teams (e.g., Fixsen, Blasé, Duda, Naoom, & Van Dyke, 2010; Sugai & Horner, 2006).

In settings that have delivered *Fourth R* programming for specific populations, we have somewhat better success with implementation team setups than we have experienced in our universal classroom-based programming. For example, for the local implementation of the *Uniting Our Nations* programming, implementation team members have included *Fourth R* staff members, *Fourth R* researchers, *Fourth R* educators, the local superintendent responsible for FNMI programs and services, and another school board staff member responsible for FNMI programming and services. While the day-to-day challenges that arise during implementation are typically resolved with internal *Fourth R* staff, having external school board staff as part of the implementation team has helped with the prioritization of the program at the school level, has provided some internal accountability to school administrators who are implementing the program in their schools, and helps the program connect to additional programs and services that are offered at a district level that may help youth succeed. We have identified recommendations for creating implementation structure in Textbox 17.2 below.

Textbox 17.2. Recommendations for Creating the Structure of Implementation

1. Establish a clear plan for implementation with timelines, but be flexible and adaptable in the steps that are required for successful implementation, with the understanding that delays and setbacks are a normal part of the process.
2. Be creative in knowing when and how programs can best be delivered, and take advantage of implementing programs within formal structures and groups that exist in settings.
3. Advocate for the prioritization of prevention programming implementation for specific groups within school timetables and calendars.
4. Establish an implementation team that can be actively involved on a daily basis with implementation and are able to address challenges that may arise during implementation.
5. Select implementation team members who have accountability and a genuine interest in the success of a program.

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Phase 3: Ongoing Structure Once Implementation Begins

Meyers, Durlak, & Wandersman (2012) describe Phase 3 of their model as the stage where implementation begins. This phase includes providing ongoing technical assistance to those implementing the intervention, ongoing monitoring of implementation quality, and the importance of establishing feedback mechanisms so that all stakeholders involved can understand how implementation is progressing. During Phase 3, Meyers, Durlak, & Wandersman (2012) suggest that implementation teams have a clear plan in place for the needed technical assistance, coaching, and training that is necessary for delivering the intervention with fidelity. Moreover, the development of a feedback system is critical and must be accurate and specific enough for successes and challenges to be recognized easily and changes put in place to improve implementation. While technical assistance and coaching is one way to bridge the gap between research and practice, across a wide variety of evidence-based interventions, technical assistance is not typically delivered systematically, and the tasks performed by technical assistant providers vary widely across studies (see Katz & Wandersman, 2016, for a review).

There is significant research support for the activities in Phase 3 that lead to better implementation (e.g., Durlak & DuPre, 2008; Fixsen et al., 2005). Even when individuals receive intervention training, a manualized program, and/or organizational support for implementation, these factors alone are often not sufficient to maximize implementation efforts. It is useful to include ongoing supervision and coaching and provide a high level of technical assistance to ensure fidelity of implementation and staff retention. In their randomized control study of SafeCare, an evidence-based program to reduce child neglect, Aarons et al. (2009) found that implementing a supportive/coaching model as part of their fidelity monitoring to supervisors who were providing a high standard of care for children and families leads to higher staff retention over a 29-month period compared to conditions in which the coaching model was not present. Providing technical assistance will also allow for the ongoing assessment and progress of implementation and provide suggestions for future improvement. Wandersman, Chien, and Katz (2012) argue for proactive technical assistance as an approach that is both anticipatory and responsive to recipient needs and provides specific knowledge and skills to recipients but also helps them to adopt and use the information and skills effectively.

Providing training, ongoing support, coaching, and technical assistance has been widely practiced with *Fourth R* programming in general but has been particularly critical in our work in diverse contexts. An essential ingredient of coaching and technical assistance is relationships (Wandersman et al., 2012). Collaborating with our partners, building trust, being strength-based, and prioritizing our attention to our partnership relationships has been particularly relevant when providing programming to youth in diverse settings. For example, when implementing the *HRP for LGBTQ2+ Youth*, our team engaged in frequent opportunities for interaction and feedback with staff implementing the program, usually via email, to hear about the challenges and strengths with implementation and to address some of these changes as the program went along. Because the process of implementation was very collaborative among staff implementing the program, youth participants, and the *Fourth R* team, everyone involved was learning and growing, and staff and youth were an invaluable resource to others in future implementation and training sessions.

Finally, our work with marginalized populations has been more resource-intensive than our universal classroom-based programming. With our programming for Indigenous youth, for example, we initially developed and implemented the programming for the local school district. After several years of this arrangement, the program stabilized, and the indication was that our support was no longer needed to implement the programming. The district hired their first Indigenous coordinator at this time and envisioned the implementation of the mentoring programs as part of the new internal role. Within months the local board contracted us to do the programming, which we now do on an ongoing basis. The reason for the change in plan was that the logistics were too time-intensive for the coordinator, in part, because the coordinator has a much larger portfolio than implementing the

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program. Some of the logistical challenges associated with this type of programming were highlighted in the early study of the feasibility and fit of the *Uniting Our Nations* mentoring program (Crooks et al., 2009). Challenges associated with successful implementation of the mentoring program included coordinating appropriate staffing and supervision for programming, provision of space, supplies and resources, and organization of student participants (ensuring sufficient numbers to run programs, facilitating return of consent forms, tracking attendance, arranging transportation, and appropriately matching participants). Although all programs have these requirements, our experience has been that there are additional challenges in this case. For example, facilitating the return of consent forms can require more attempts to contact guardians and even driving to someone's home to obtain consent. Additionally, challenges were noted in finding Indigenous adult role models and elders to commit time to the program, as these individuals were often quite busy in their own organizational or community roles. It has been a full-time job for one of our team to facilitate mentoring in four elementary schools and three secondary schools and to coordinate the student leadership committee, where another school district employee might be expected to facilitate mentoring across 60 elementary schools.

Textbox 17.3. Recommendations for Ongoing Structure Once Implementation Begins

1. Establish a clear plan and organizing framework for technical assistance and coaching.
2. Provide frequent opportunities for interaction and engagement with staff implementing a program to hear successes and challenges with implementation.
3. Relationships are an essential part of technical assistance and coaching. Having a trusting relationship can expand the ways in which support can be helpful.
4. Logistics may be more resource-intensive for programming with diverse populations, and these supports need to be built into the implementation plan.

Phase 4: Improving Future Applications

The final phase of the QIF addresses the question of what can be learned about quality implementation from a particular program effort (Meyers, Durlak, & Wandersman, 2012). Being able to learn from an experience requires ongoing data collection and feedback loops; throughout this chapter, we have highlighted different lessons that we have learned from collecting these data. In this section, we reflect on the process of building in evaluation from the outset and three potential pitfalls.

First and foremost, it is critical to build in evaluation from the outset of developing new program components. Although program adaptations for specific populations can borrow strengths from existing evidence-based programs (Aarons et al., 2017), there is still a very real possibility that an initial attempt at adaptation will not be successful. For example, in our first iteration of our *HRP for LGBTQ2+ Youth*, facilitators and participants identified significant issues with its content. Rather than exploring LGBTQ2+-based stereotypes and reiterating how LGBTQ2+ youth are marginalized in school and society, youth suggested that the program should focus on LGBTQ2+ validation and affirmation, be trauma-informed, include a wider range of relationships (i.e., family and non-romantic relationships), and adopt a youth-led approach (Lapointe, Dunlop, & Crooks, in press). Without these feedback mechanisms, we could have relied overly on the assumption that core components from one program were being framed adequately for a different context.

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A related potential pitfall is the demand that can arise for a new program expansion when the program and research team has developed a strong track record for quality programming. In all of our expansions discussed in this chapter – those for Indigenous youth, those for LGBTQ2+ youth, and those for youth in the justice system – as soon as organizations heard about our new endeavors, we were approached with requests for materials to implement the new versions, irrespective of any evaluation being completed. We have chosen to navigate these by offering pilot versions only to organizations who have the capacity and interest to partner with us on the evaluation component. For those organizations who simply want to implement the new and untested programs, we view it as an ethical responsibility to delay dissemination until the most basic process evaluation has been completed. Furthermore, we maintain clarity about the state of the evidence for each program component such that when new programs are offered, there is an understanding that educators and service providers only apply core components from an evidence-based intervention while indicating that they themselves have not been thoroughly evaluated.

Finally, establishing accurate and timely feedback mechanisms to highlight successes and address implementation challenges has been an important part of *Fourth R* implementation. Internally, our team meets often to discuss program implementation at various sites, and we discuss and systematically review the feedback that has been received from youth receiving the program or staff implementing the program. We provide our schools or districts with summary reports typically once or twice a year. These summaries are visually appealing and easy to read to share findings related to the process of implementation, program feedback, and program outcomes. Where possible, we also find opportunities to share feedback on implementation with our partners face-to-face so that real-time conversations around progress and challenges can be addressed quickly and openly with each other.

Textbox 17.4. Recommendations for Improving Future Applications

1. It is important to build in process feedback measures from the outset of adapting an evidence-based program for a new population or setting.
2. It is critical to not let demand for a new program component create pressure for dissemination prior to evaluation.
3. Providing summaries in an ongoing manner to partners in accessible language contributes to a shared understanding of the project successes and challenges and promotes continued investment from partners.

Summary

There is a strong movement toward the funding and use of evidence-based programs for promoting mental health and preventing violence among youth. Unfortunately, our evidence about what works for vulnerable populations in real-world settings remains scarce. As noted by O’Connell et al. (2009), “Despite multiple dissemination venues, evidence-based interventions have not been implemented on a wide-scale basis. Where interventions have been implemented, they are often not implemented with fidelity, with cultural sensitivity, or in settings that have the capacity to sustain the effort” (p. 335). Indeed, youth who are at the highest risk for negative mental health outcomes are often members of specific groups for whom evidence-based school mental health promotion approaches are not readily available. In this chapter, we have described our efforts to expand one such evidence-based program, the *Fourth R*, to other groups and settings. By undertaking this work within an implementation framework from the outset, we have been better able to identify real-world challenges and successes associated with the programming. Furthermore, working closely with key stakeholders has ensured that fit and feasibility considerations are

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built into these program efforts from the start, which in turn provides a more effective basis for sustainability of these interventions.

References

Aarons, G. A., Sklar, M., Mustanski, B., Benbow, N., & Brown, C. H. (2017). "Scaling-out" evidence-based interventions to new populations or new health care delivery systems. *Implementation Science, 12*(1), 111.

Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal of Consulting and Clinical Psychology, 77*(2), 270.

Airton, L., & Meyer, E. J. (2014). Glossary of terms. In E. J. Meyer & A. Pullen Sansfaçon (Eds.), *Supporting transgender and gender creative youth: Schools, families, and communities in action* (pp. 217–224). New York, NY: Peter Lang.

Barrera, M., Berkel, C., & Castro, F. G. (2017). Directions of the advancement of culturally adapted preventive interventions: Local adaptations, engagement, and sustainability. *Prevention Science, 18*, 640–648.

Blase, K. A., Fixsen, D. L., Sims, B. J., Ward, C. S. (2015). Implementation science: Changing hearts, minds, behavior, and systems to improve educational outcomes. Wing Institute's Ninth Annual Summit on Evidence-Based Education, Berkeley, CA. Retrieved from http://nirn.fpg.unc.edu/resources/implementation-science-changing-hearts-minds-behavior-and-systems-to-improve.

Britzman, D. (1995). Is there a queer pedagogy? Or, stop reading straight. *Educational Theory, 45*(2), 151–165.

Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science, 5*(1), 41–45.

Castro, F. G., & Yasui, M. (2017). Advances in EBI development for diverse populations: Towards a science of intervention adaptation. *Prevention Science, 18*, 623–629.

Chiodo, D. (2017). A qualitative study of the fidelity of implementation of an evidence-based health relationships program. (Doctoral dissertation). Available from Electronic Thesis and Dissertation Repository. 4405. http://ir.lib.uwo.ca/etd/4405.

Chiodo, D., Exner-Cortens, D., Crooks, C. V., & Hughes, R. (2015). *Scaling up the Fourth R program: Facilitators, barriers, and problems of practice, Report prepared for the Public Health Agency of Canada*. London, ON, Canada: The University of Western Ontario.

Claussen, C., Wells, L., Exner-Cortens, D., Abboud, R., & Turner, A. (2016). The role of community-based organizations in school-based violence prevention programming: An action research project. *Cogent Social Sciences, 2*(1), 1–11.

Craig, S. L., Austin, A., & McInroy, L. B. (2013). School-based groups to support multiethnic sexual minority youth resiliency: Preliminary effectiveness. *Child and Adolescent Social Work Journal, 31*(1), 87–106.

Crooks, C. V., Burleigh, D., & Sisco, A. (2015). Promoting First Nations, Métis, and Inuit youth wellbeing through culturally-relevant programming: The role of cultural connectedness and identity. *International Journal of Child and Adolescent Resilience, 3*(1), 101–116.

Crooks, C. V., Burleigh, D., Snowshoe, A., Lapp, A., Hughes, R., & Sisco, A. (2015). A case study of culturally relevant school-based programming for First Nations youth: Improved relationships, confidence and leadership, and school success. *Advances in School Mental Health Promotion, 8*(4), 216–230.

Crooks, C. V., Chiodo, D., Zwarych, S., Hughes, R., & Wolfe, D. A. (2013). Predicting implementation success of an evidence-based program to promote healthy relationships among students two to eight years after teacher training. *Canadian Journal of Community Mental Health, 32*(1), 125–138.

Crooks, C. V., Chiodo, D. C., Thomas, D., & Hughes, R. (2009). Strengths-based programming for First Nations youth in schools: Building engagement through healthy relationships and leadership skills. *International Journal of Mental Health and Addiction, 8*(2), 160–173.

Crooks, C. V., & Dunlop, C. (2017). Mental health promotion with Aboriginal youth: Lessons learned from the uniting our nations program. In J. R. Harrison, B. K. Schultz, & S. W. Evans (Eds.), *School mental health services for adolescents* (pp. 306–328). London, ON, Canada: Oxford University Press.

Crooks, C. V., Exner-Cortens, D., Burm, S., Lapointe, A., & Chiodo, D. (2017). Two years of relationship-focused mentoring for First Nations, Métis, and Inuit adolescents: Promoting positive mental health. *Journal of Primary Prevention, 38*(1–2), 87–104.

Crooks, C. V., Exner-Cortens, D., Siebold, W., Moore, K., Grassgreen, L., Owen, P., Rausch, A., & Rossier, M. (2018). The role of relationships in collaborative partnership success: Lessons from the Alaska Fourth R project. *Evaluation and Program Planning*, 67, 97–104. https://doi:10.1016/j.evalprogplan.2017.12.007.

Crooks, C. V., Hughes, R., & Sisco, A. (2015). Fourth R: Uniting our Nations case study: Lessons learned from adaptation and implementation in Ontario and the Northwest Territories. London, ON: Centre for School Mental Health.

Crooks, C. V., Scott, K., Ellis, W., & Wolfe, D. (2011). Impact of a universal school-based violence prevention program on violent delinquency: Distinctive benefits for youth with maltreatment histories. *Child Abuse and Neglect, 35*(6), 393–400.

Crooks, C. V., Scott, K. L., Broll, R., Zwarych, S., Hughes, R., & Wolfe, D. A. (2015). Does an evidence-based healthy relationships program for 9th graders

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show similar effects for 7th and 8th graders? Results from 57 schools randomized to intervention. *Health Education Research, 30*(3), 513–519.

Crooks, C. V., Zwarych, S., Burns, S., & Hughes, R. (2015). *The fourth R implementation manual: Building for success from adoption to sustainability*. London, ON, Canada: University of Western Ontario.

Crooks, C. V., Zwicker, J., Wells, L., Hughes, R., Langlois, A., & Emery, J. C. H. (2017). Estimating costs and benefits associated with evidence-based prevention: Four case studies based on the Fourth R program. *The School of Public Policy, SPP Research Papers, 10*(10), 1–27.

Cui, M., Ueno, K., Gordon, M., & Fincham, F. D. (2013). The continuation of intimate partner violence from adolescence to young adulthood. *Journal of Marriage and Family, 75*(2), 300–313.

de Vries, S., Hoeve, M., Assink, M., Stams, G., & Asscher, J. (2015). Practitioner review: Effective ingredients of prevention programs for youth at risk of persistent juvenile delinquency- recommendations for clinical practice. *Journal of Child Psychology and Psychiatry, 56*(2), 108–121.

Domitrovich, C. E., Bradshaw, C. P., Poduska, J. M., Hoagwood, J. A., Buckley, J. A., Olin, S., … Ialongo, N. S. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotions, 1*(3), 6–28.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology, 30*(2), 157–197.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3–4), 327–350.

Edwards, K. M., Jones, L. M., Mitchell, K. J., Hagler, M. A., & Roberts, L. T. (2016). Building on youth's strengths: A call to include adolescents in developing, implementing, and evaluating violence prevention programs. *Psychology of violence, 6*(1), 15.

Exner-Cortens, D., Eckenrode, J., Bunge, J., & Rothman, E. (2017). Revictimization after adolescent dating violence in a matched, national sample of youth. *Journal of Adolescent Health, 60*(2), 176–183.

Exner-Cortens, D., Wolfe, D., Crooks, C.V., Chiodo, D (2017). A randomized controlled evaluation of a universal health relationships promotion program for youth. Manuscript submitted for publication.

First Nations Information Governance Centre (FNIGC). (2012). *First nations regional health survey (RHS) 2008/10: National report on adults, youth and children living in first nations communities*. Ottawa, Canada: FNIGC. Retrieved from: http://fnigc.ca/sites/default/files/docs/first_nations_regional_health_survey_rhs_2008-10_-_national_report.pdf

Fixsen, D. L., Blase, K. A., Duda, M. A., Naoom, S. F., & Van Dyke, M. K. (2010). Implementation of evidence-based treatments for children and adolescents: Research findings and their implications for the future. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 435–450). New York, NY: Guilford Press.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, The National Implementation Research Network.

Gottfredson, D. C., & Gottfredson, G. D. (2002). Quality of school-based prevention programs: Results from a national survey. *Journal of Research in Crime and Delinquency, 39*(1), 3–35.

Grace, A. P., & Wells, K. (2015). *Growing into resilience: Sexual and gender minority youth in Canada*. Toronto, Canada: University of Toronto Press.

Griffin, P., Lee, C., Waugh, J., & Beyer, C. (2004). Describing roles that gay-straight alliances play in schools: From individual support to social change. *Journal of Gay & Lesbian Issues in Education, 1*(3), 7–22.

Guerra, N., Kim, T., & Boxer, P. (2008). What works: Best practices with juvenile offenders. In N. Hoge & P. Boxer (Eds.), *Treating the juvenile offender* (pp. 79–102). New York, NY: Guilford Press.

Han, S. S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*(6), 665–679.

Health Canada. (2014). *A statistical profile on the health of first nations in Canada: Determinants of health 2006–2010*. Ottawa, Canada: Health Canada. Retrieved from: http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2010-stats-profil-determinants/index-eng.php

Heck, N. C. (2015). The potential to promote resilience: Piloting a minority stress-informed, GSA-based, mental health promotion program for LGBTQ youth. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 225–231.

Jaffe, P. G., Crooks, C. V., Dunlop, C., Kerry, A. (2016). Primary prevention of gender-based violence: Current knowledge about program effectiveness and priorities for future research. Invited policy paper prepared for the Government of Canada, Status of Women. Ottawa, ON.

Janzen, R., Ochocka, J., & Stobbe, A. (2016). Towards a theory of change for community based research projects. *The Engaged Scholar Journal: Community-Engaged Research, Teaching and Learning, 2*(2), 44–64.

Johnson, J. G., Cohen, P., & Kasen, S. (2009). Minor depression during adolescence and mental health outcomes during adulthood. *The British Journal of Psychiatry, 195*(3), 264–265.

Katz, J., & Wandersman, A. (2016). Technical assistance to enhance prevention capacity: A research synthesis of the evidence base. *Prevention Science, 17*(4), 417–428.

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Kenyon, D. B., & Hansen, J. D. (2012). Incorporating traditional culture into positive youth development programs with American Indian/Alaska native youth. *Child Development Perspectives, 6*(3), 272–279.
Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian aboriginal peoples. *Australasian Psychiatry, 11*, 15–23.
Knight, A., Shakeshaft, A., Havard, A., Maple, M., Foley, C., & Shakeshaft, B. (2017). The quality and effectiveness of interventions that target multiple risk factors among young people: A systematic review. *Australian and New Zealand Journal of Public Health, 41*(1), 54–60.
Krohn, M., Lizotte, A., Bushway, S., Schmidt, N., & Phillips, M. (2014). Shelter during the storm: A search for factors that protect at-risk adolescents from violence. *Crime & Delinquency, 60*(3), 379–401.
Lapointe, A. (2017). *Teen relationship violence and wellbeing among LGBT2Q+ youth*. London, ON, Canada: University of Western Ontario. Retrieved from: https://www.edu.uwo.ca/csmh/docs/hrpp/knowledge_summary/teen-relationships-violence-and-wellbeing-among-lgbtq-youth.pdf
Lapointe, A. & Crooks, C. V. (2018). GSA members' experiences with a structured program to promote wellbeing. *Journal of LGBT Youth*. https://doi.org/10.1080/19361653.2018.1479672
Lapointe, A., Dunlop, C., & Crooks, C. V. (In press). Feasibility and fit of an evidence-informed mental health promotion program for LGBTQ+ youth. *Journal of Youth Development*.
Lapshina, N., Crooks, C. V., & Kerry, A. (2018). Changes in depression and anxiety among youth in a healthy relationships program: A latent class growth analysis. *Canadian Journal of School Psychology*. https://doi.org/10.1177/0829573518777154.
Latimer, J., Dowden, C., Morton-Bourgon, K., Edgar, J., & Bania, M. (2003). *Treating youth in conflict with the law: A new meta-analysis*. Ottawa, ON: Department of Justice Canada.
MacDonald, J. P., Ford, J. D., Willox, A. C., & Ross, N. A. (2013). A review of protective factors and causal mechanisms that enhance the mental health of indigenous circumpolar youth. *International Journal of Circumpolar Health, 72*(1.), 21775), 1–18.
Manchikanti Gómez, A. (2011). Testing the cycle of violence hypothesis: Child abuse and adolescent dating violence as predictors of intimate partner violence in young adulthood. *Youth Society, 43*(1), 171–192.
Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.
Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology, 50*(3–4), 462–480.
Meyers, D. C., Katz, J., Chien, V., Wandersman, A., Scaccia, J., & Wright, A. (2012). Practical implementation science: Developing and piloting the quality implementation tool. *American Journal of Community Psychology, 50*(3–4), 481–496.
Moran, J. R., & Reaman, J. A. (2002). Critical issues for substance abuse prevention targeting American Indian youth. *Journal of Primary Prevention, 22*(3), 201–233.
Namaste, V. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. Chicago, IL: The University of Chicago Press.
Ning, A., & Wilson, K. (2012). A research review: Exploring the health of Canada's aboriginal youth. *International Journal of Circumpolar Health, 71*(1), 1–10. https://doi.org/10.3402/ijch.v71i0.18497
O'Connell, M. E., Boat, T., Warner, K. E., & National Research Council. (2009). Implementation and dissemination of prevention programs. In *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* (pp. 297–336). Washington, DC: National Academies Press.
Payne, A. A., & Eckert, R. (2010). The relative importance of provider, program, school, and community predictors of the implementation quality of school-based prevention programs. *Prevention Science, 11*, 126–141.
Proulx, C. (2006). Aboriginal identification in North American cities. *The Canadian Journal of Native Studies, 26*(2), 405.
Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York, NY: Free Press.
Rood, B. A., Reisner, S. L., Surace, F. I., Puckett, M., Pantalone, M. R., & D. W. (2016). Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health, 1*(1), 151–164.
Russell, S. T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology, 12*, 465–487.
Serano, J. (2007/2016). *Whipping girl: A transsexual woman on seism and the scapegoating of femininity* (2nd ed.). Berkley, CA: Seal Press.
Serano, J. (2013). *Excluded: Making feminist and queer movements more inclusive*. Berkley, CA: Seal Press.
Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for first nations youth. *The Journal of Primary Prevention, 38*(1–2), 67–86.
Sugai, G., & Horner, R. H. (2006). A promising approach for expanding and sustaining school-wide positive behavior support. *School Psychology Review, 35*(2), 245–259.
Taylor, C., Peter, T., McMinn, T. L., Elliott, T., Beldom, S., Ferry, A., … Schachter, K. (2011). Every class in every school. In *The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools*. Toronto, Canada: EGALE Canada Human Rights Trust. Retrieved from: https://egale.ca/wp-content/uploads/2011/05/EgaleFinalReport-web.pdf
Truth and Reconciliation Commission of Canada (TRC). (2015). *Honoring the truth, reconciling for the future: Summary of the final report of the TRC of Canada*. Winnipeg, Canada: Truth and Reconciliation

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Commission of Canada. Retrieved from: http://www.trc.ca/websites/trcinstitution/index.php?p=890

Ungar, M. (2004). *Nurturing hidden resilience in troubled youth*. Toronto, Canada: University of Toronto Press Incorporated.

Walton, G. (2006). *H-Cubed: A primer on bullying and sexuality diversity for educators* (pp. 13–20). Canadian Teachers Federation Newsletter.

Wandersman, A., Chien, V. H., & Katz, J. (2012). Toward an evidence-based system for innovation support for implementing innovations with quality: Tools, training, technical assistance, and quality assurance/quality improvement. *American Journal of Community Psychology, 50*(3–4), 445–459.

Wandersman, A., Duffy, J., Flaspohler, P., Noonan, R., Lubell, K., Stillman, L., … Saul, J. (2008). Bridging the gap between prevention research and practice: The interactive systems framework for dissemination and implementation. *American Journal of Community Psychology*, *41*(3–4), 171–181.

Wolfe, D. A., Crooks, C. V., Chiodo, D., Hughes, R., & Ellis, W. (2012). Observations of adolescent peer resistance skills following a classroom-based healthy relationship program: A post-intervention comparison. *Prevention Science, 13*(2), 196–205.

Wolfe, D. A., Crooks, C. V., Jaffe, P. G., Chiodo, D., Hughes, R., Ellis, W., … Donner, A. (2009). A universal school-based program to prevent adolescent dating violence: A cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine, 163*(8), 693–699.

Wolfe, D. A., Jaffe, P. G., & Crooks, C. V. (2008). *Adolescent risk behaviors: Why teens experiment and strategies to keep them safe*. New Haven, CT: Yale University Press.

Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York, NY: Teachers College Press.

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