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Supporting Transition Resilience of Newcomer Groups (STRONG)

Pilot Report

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Background

Canada has welcomed over 40,000 Syrian newcomers since November 2015, many of whom experienced significant trauma prior to coming to Canada. In addition to the influx of Syrians, many refugees from other countries have also migrated over the past five years. As a result, thousands of newcomer children and youth are now in Canadian schools, and many continue to struggle with symptoms of distress and trauma. Research suggests that the presence of traumatic stress can negatively affect not only a student's mental health, but can also interfere with the ability to regularly attend and actively engage in the learning process. Even those newcomers who are not experiencing acute trauma symptoms may struggle with psychosocial adjustment.

During the 2015-2016 school year, the Ontario Ministry of Education asked School Mental Health ASSIST (SMH ASSIST) to monitor and address the mental health needs of students arriving in Ontario schools from Syria. As part of this effort, SMH ASSIST created a School Mental Health Newcomer Advisory Network (comprised of Canadian research and practice leaders in the area of refugee mental health) and a School Mental Health Newcomer Resource Team that met twice monthly from December 2015 through June 2016, and then monthly for the next school year. Approximately 30 Mental Health Leaders and Superintendents attended these meetings that were focused primarily on monitoring school and student response and the identification of needed resources and supports. This team assisted with the development of a Newcomer Mental Health InfoSheet for educators, a more detailed guidance document for school mental health professionals, and a video that was designed for use in professional learning by educators. Over time, Mental Health Leaders identified that students with refugee backgrounds were beginning to show more signs of trauma response at school and requested more support in this area. SMH ASSIST worked with the Centre for Addiction and Mental Health (CAMH) to provide access to a 12 hour on-line course for mental health professionals, and to co-design and co-deliver a full day Special Interest Group workshop on the topic of Immigrant, Refugee, Ethnocultural and Racialized School Mental Health. School mental health professionals, equipped with this background knowledge, then began to request some practical tools for intervention support with students with refugee backgrounds that would safely and effectively address the significant trauma that many students on their caseloads had experienced. SMH ASSIST reached out to the Center for School Mental Health in Maryland, and Dr. Sharon Hoover in particular, an international leader in trauma-informed intervention to discuss the possibility for co-development of a cognitive-behavioral intervention tailored to the needs of students with refugee backgrounds. The present study arose from these early discussions in 2017.

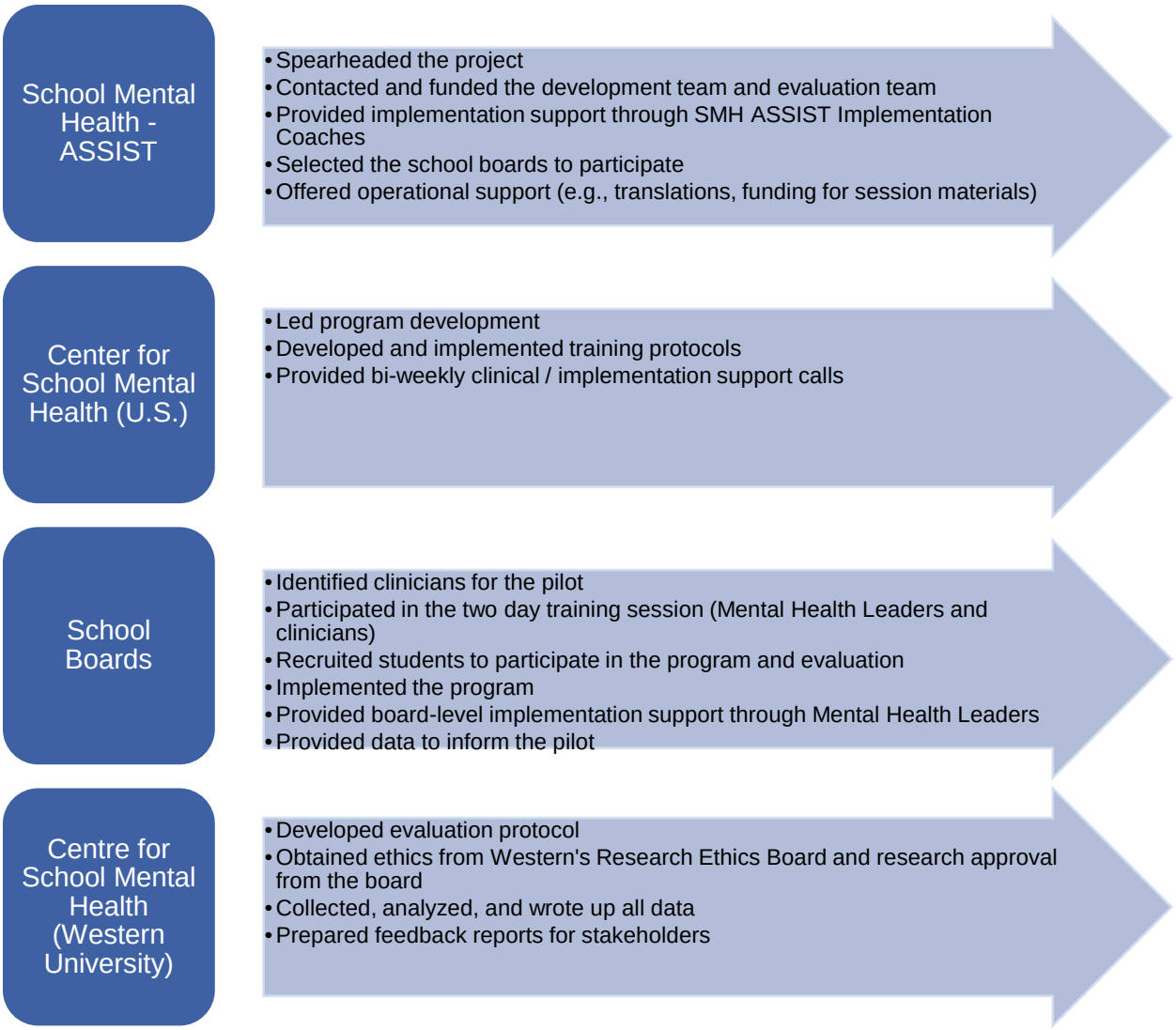
Purpose

The purpose of this report is to present findings from a feasibility study conducted on the pilot of the Supporting Transition Resilience of Newcomer Groups (STRONG) intervention in the Spring of 2018. STRONG was developed to promote resilience and reduce distress among newcomers. STRONG was implemented in a small pilot from April to June 2018. The pilot took place at 5 schools in each of two large, urban school districts (also called school boards in Ontario). The STRONG intervention is a manualized approach that includes 10 weekly sessions, and aims to strengthen newcomer groups transition resilience, promote individual strengths and skills to make positive choices, and provide a positive sense of self and

belonging. The sessions draw on cognitive-behavioural therapy approaches. Practice assignments are provided each week as homework. In addition to the group sessions, clinicians facilitate an individual session with each participant to help them process their journey narrative. Participants subsequently share parts of their journey narrative with the larger group. Clinicians are also encouraged to facilitate a parent meeting as part of the intervention.

This pilot was undertaken as a partnership including SMH ASSIST, the Center for School Mental Health in the U.S. (and some of their partners), two school boards in southern Ontario, and the Centre for School Mental Health at Western University. Roles for each of these partners are depicted in Figure 1. The roles were not as distinct as shown below; in reality there was significant collaboration on all tasks. For example, although our team at Western University's Centre for School Mental Health oversaw the evaluation, we received input on methodology from all partners, and the Mental Health Leaders at the two boards were instrumental in helping us navigate the external review process at their institutions under tight timelines. In addition, all partners had the opportunity to review previous drafts of this report and make suggestions.

Figure 1: Project partners and roles



Approach

Overall, our methodology involves mixed methods grounded in a perspectivism framework, which recognizes the importance of contexts and enlists partners as co-producers of knowledge[i]. Because this is a feasibility study, we investigated the acceptability, implementation, practicality / integration, and adaptation of the *STRONG* program. In addition, we looked at efficacy (or more accurately, impact) in a very preliminary way. In Textbox 1, we provide descriptions of these factors, which we have adapted from Bowen and colleagues[ii]. We also collected data across the entire pilot process, starting with the clinician training and continuing through the completion of the groups.

Textbox 1: *Potential focus areas of a feasibility study*

Acceptability considers how the intended individual recipients – both targeted individuals and those involved in implementing the programs – react to the intervention. In this case, it includes the acceptability of the program from the perspectives of the students, clinicians, and school board Mental Health Leaders.

Demand for the intervention can be assessed by gathering data on estimated use or by actually documenting the use of selected intervention activities in a defined intervention population or setting. For the STRONG project, demand includes the ease with which clinicians and students were recruited, and clinicians' stated intentions to implement the program in the future.

Implementation concerns the extent and manner in which an intervention can be fully implemented as planned and proposed. For the STRONG pilot we evaluated the extent to which the sessions were delivered as written and any challenges that ensued.

Practicality and Integration refers to the extent to which an intervention can be delivered when resources, time, commitment, or some combination thereof are constrained in some way, while integration is the extent to which a new program can be integrated within an existing system. For this pilot we looked at logistics related to recruitment and implementation as well as the supports that were provided at the school or board level.

Adaptation focuses on changing program contents or procedures to be appropriate in a new situation. For the STRONG pilot we were curious about any cultural or language challenges that might emerge in utilizing cognitive behavioural principles with newcomers.

Limited efficacy testing. Many feasibility studies are designed to test an intervention in a limited way. For this project we looked at clinician ratings of progress and some self-report data, as well as qualitative reports of improvement among participants.

Groups and Participants

Between the two boards, 10 groups were implemented as part of the pilot. An 11th group started, but the facilitator discontinued due to reasons not directly related to the program. The groups varied with respect to size, co-facilitation, composition, and use of interpreters.

Table 1. Characteristics of pilot groups

Division	Group Size	Co-facilitator	Gender	Age range*	Language/Interpreter Use
Elementary	5	No	All male	8-9	English was primarily spoken/Some use of interpreter
Elementary	5	Yes (ELL teacher)	All male	12-14	English was spoken/ No use of interpreter
Elementary	6	Yes	All male	9-12	Equal combination of English and use of interpreter
Elementary	6	Yes	4 males/ 2 females	10-12	English was primarily spoken/ Some use of interpreter
Secondary	4	Yes	All male	14-16	English was spoken/ No use of interpreter
Secondary	5	Yes	2 males/ 3 females	15-18	English was spoken/ No use of interpreter
Secondary	6	Yes	All female	15-17	English was primarily spoken/ Some use of interpreter
Secondary	7	Yes (settlement worker)	4 males/ 3 females	14-18	English was primarily spoken/ Some use of interpreter
Secondary	9	Yes	7 males/ 2 females	15-20	English was spoken/ No use of interpreter
Secondary	9	Yes	All female	15-19	No English/Everything was interpreted

**Note that there are two versions of the program, one designed for elementary students and one for secondary students*

The majority of the data were collected from clinicians. Demographics for the clinicians (as reported in the training feedback survey) showed that most were female (87.5%), half of the sample was social workers, 25% were psychologists, there were two Mental Health Leaders, and a few people in other roles.

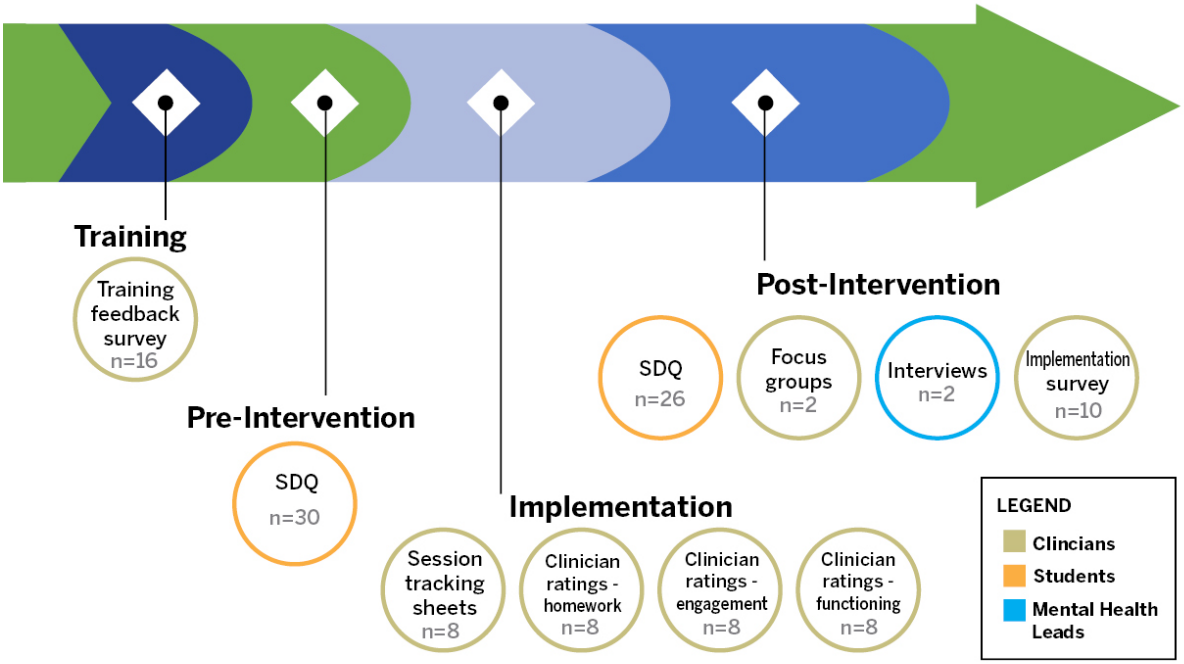
Consent to participate in the research was obtained for 47 of the 62 students involved in the pilot groups (75.8%). Demographics for students who provided consent indicated that there were slightly more males (51.1%) than females, and students ranged from 9 to 20 (M = 14.9, SD = 3.3) years old.

Measures and Procedure

Data were collected at every stage of the pilot from clinician training, through implementation, to post-implementation reflection. Measures included a combination of surveys, interviews, tracking sheets, and focus groups. The timing, source, and numbers for each data source are shown in Figure 2 below. Despite considerable buy-in to the evaluation process from clinicians,

there was significant missing data at each point (with the exception of the training feedback surveys). The missing data appeared to be directly related to the intense timeframes for implementation and evaluation, as noted in the limitations and caveats section on page 6.

***Figure 2**:* Sources and timing of data collection during the pilot



Before implementation:

Training feedback questionnaires (clinicians): Clinicians completed a 27-item survey designed for this pilot. It included Likert scale ratings, open-ended questions, and retrospective pre- and post-questions asking clinicians to reflect on their knowledge (e.g., "I understand the mental health needs of newcomer students") and their self-efficacy (e.g., "I am confident I can teach newcomer students about common reactions to stress").

During implementation:

Session tracking sheets (clinicians). Clinicians completed a session tracking sheet for each intervention session. Clinicians checked which activities were completed, and identified any challenges or activities that were particularly well received. They also noted how much time was spent on each session.

Student ratings (clinicians). Clinicians rated students' engagement in sessions, overall functioning, and whether they had completed homework or practice for each session, using anchors provided to them (see Appendix A). Although clinicians were encouraged to track this information for all participants, they shared de-identified ratings with the researchers only for students that had the appropriate consents completed.

Strengths and Difficulties Questionnaire (SDQ). The Strengths and Difficulties Questionnaire (SDQ) is a 25-item measure that assesses both positive and negative behavioural attributes[iii]. It includes four problem subscales (i.e., emotional symptoms, conduct problems, hyperactivity / inattention, and peer problems) that can be summed to form a total difficulties score. There is also a prosocial behaviour scale. The SDQ self-report was completed by youth who were 11 or older (n=15)[1][iv]. In five cases, teachers completed the SDQ-teacher version for students who were younger than 11. The SDQ was completed both prior to and after the intervention; however, in the case of one group, the pre-intervention SDQ's were not completed until the 5th session (n=8). The SDQ was chosen it part because of the wide number of language versions available, including Arabic. Furthermore, there is some evidence of adequate psychometric properties for the Arabic language version of the SDQ[v].

After implementation

Implementation surveys (clinicians). Clinicians completed an online implementation survey after finishing the program. The survey included rating scales and open-ended questions that addressed a wide range of topics including recruitment and consent, implementation successes and challenges, issues with interpreters, and perceived benefits for students and clinicians. All together there were 10 surveys completed; in one case co-facilitating clinicians completed a survey together, in another case co-facilitating clinicians each completed a survey, and in other cases only one facilitator completed it. Overall, nine of the ten groups were represented in the implementation survey data.

Focus groups (clinicians). Two focus groups were conducted with clinicians at the end of the school year. One was held at each school board office. The first had seven participants (all female) and the second eight participants (one of whom was male). Although a couple of clinicians were not able to attend the focus groups, all of the STRONG groups were represented (i.e., had at least one co-facilitator present). Focus groups followed a semi-structured format in that the focus group facilitators had a series of questions to identify strengths and challenges of the pilot, but there was flexibility to follow up on new areas introduced by participants. Focus groups lasted approximately 90 minutes and were audio recorded and transcribed.

Interviews (Mental Health Leaders). Individual interviews were held with both Mental Health Leaders. These took approximately 30 minutes and were audio recorded and transcribed. The Mental Health Leaders were provided with their transcripts and given the opportunity to revise their comments. Interviews were conducted at the school boards on the same day as the clinician focus groups.

Ethical Considerations and Processes

All evaluation protocols were approved by Western University's Research Ethics Board. In addition, both school boards provided approval through their external research application processes. Active consent was obtained from clinicians and Mental Health Leaders. De-identified information was provided about students for whom parent / guardian consent was obtained. Students who were 18 or older provided consent for their own participation. Youth assent was obtained for students ages 11-17.

[1] There were 15 students form whom both pre- and post SDQs were available; 23 students did a pre- or post-only.

Limitations and Caveats

There are some methodological limitations that provide important context for the findings of this pilot. First, the sample size was small, both in terms of the number of groups, and also with respect to the number of individuals providing data. The groups were diverse, but it was still a relatively small number upon which to base major decisions. Second, age and gender of the groups were somewhat confounded in that there were some all boys elementary groups and some all girls secondary school groups, but not vice versa. Thus, it is difficult to disentangle whether some of the activities worked better for boys versus girls or elementary versus secondary students. In addition, two of the all boys elementary groups were particularly young (e.g., 8-9 years old in one group and 9-12 in another). Finally, we utilized only one student self-report measure (the Strengths and Difficulties Questionnaire), chosen largely because of its availability in multiple languages. However, the SDQ might not be the most relevant measure for the intervention. Indeed, resilience and connectedness might be better outcomes for future evaluations.

Beyond specific methodological limitations, there are two important caveats:

- First, this entire pilot was conducted in a very condensed timeframe. Most notably, training for clinicians occurred on March 27, 2018, after which clinicians had to identify and recruit participants, develop relationships with families, obtain guardian consent, and implement the 10 session program (in addition to individual sessions) prior to the end of the school year. Furthermore, because this opportunity was not known to clinicians at the outset of the school year, there was no accommodation for this project in their negotiated workloads. It is a testament to the dedication of these clinicians and their Mental Health Leaders at the board that they were able to complete groups. However, the intensity with which they had to work to successfully complete these groups was very taxing, and likely caused some of the challenges they encountered. The compressed timeframe likely also interfered with some of the clinicians submitting all of their evaluation paperwork, despite their interest in contributing to the process.
- Second, there is widespread recognition in the program development and evaluation field that the first time implementing a new program is always the most difficult and that many aspects that seem untenable the first time might seem less problematic in future implementation cycles as clinicians increase their familiarity with the program. Thus, it is important to learn from the feedback provided by the first round of pilot groups, but it is also important to not over-react on the basis of a small number of first-time implementations.

Findings

In this section we first present key findings across each phase of the project: training, implementation, and impact. In each section we draw on the different measures to triangulate data. We then provide a summary of findings organized by each of the key feasibility domains. After the summary of each domain, we present data about benefits experienced by clinicians.

Training

Clinicians completed the training survey at the conclusion of the two-day training. A paired samples t-test was conducted to examine whether facilitators pre-knowledge/self-efficacy scores differed from their post-knowledge/self-efficacy scores. The difference was significant, in that the ratings on the post scale (M=3.70, SD=0.33) were higher than ratings on the pre scale (M=3.07, SD=0.41), $t(15) = -6.58$, $p < 0.001$. This perceived knowledge gain is notable in light of this group being experienced clinicians, all of whom had participated in prior training on cognitive behavior therapy. In addition, 40% reported that they had experience utilizing CBT approaches with traumatized youth. Furthermore, the clinicians as a group were very experienced. On the implementation survey, the average experience reported by clinicians was approximately 19 years (range = 6 years to 33 years).

According to the training feedback surveys (n=16), all clinicians who participated believed that the training was very well organized and coherent. Furthermore, the findings revealed that all facilitators believed that trainers were knowledgeable with relevance to the content of the training, and were able to hold their attention throughout the training. With respect to knowledge gained, 94% of the clinicians believed that their level of understanding increased as a result of the training, and indicated they would share what they learned with colleagues/trainees. In addition, 88% of the clinicians believed the training will greatly impact their work related to youth and families. Upon completion of the training, 94% of clinicians reported feeling prepared to implement the STRONG program, while one rated their preparation as neutral.

Open-ended questions on the feedback training survey focused on the most valuable aspects of the training, as well as the concerns that clinicians had about implementing the program. Based on the clinicians' responses, valuable aspects included specific aspects of the training (i.e., activities, trainers), general program and materials, narrative role plays, knowledge and new skills gained, networking, and increased confidence. Clinician comments included:

- "*Having a program that targets the needs of newcomers and having it packaged into 10 sessions is remarkable."*
- *"A great, uncomplicated and manageable program!"*
- *"The delivery is very easy to understand."*
- *"I also enjoyed the small group setting."*

At the same time, results showed that 87.5% of clinicians identified concerns about implementing the program at the time of training. The projected timeline for the STRONG program was the most prevalent concern (identified by 81% of clinicians). Other concerns included support (13%), finding participants (13%), language barriers (13%), and materials (6%).

Implementation

Clinicians were asked a number of questions on the implementation survey and in the focus group about the successes and challenges faced across the entire implementation cycle, including recruitment, obtaining consent, logistics, attendance and engagement, challenges with session content, including homework or practice, co-facilitation, and language considerations. They were also asked about implementation supports and systems issues. Detailed session-by-session feedback was provided through tracking sheets. In addition, clinicians provided weekly engagement ratings for those students that had consent to participate in research. We have organized the findings into a number of implementation domains, as shown in Figure 3. Although we discuss each of these factors separately, they were not independent. For examples, some of the logistics challenges were related to systems considerations. In addition, recruitment and consent were often discussed together.

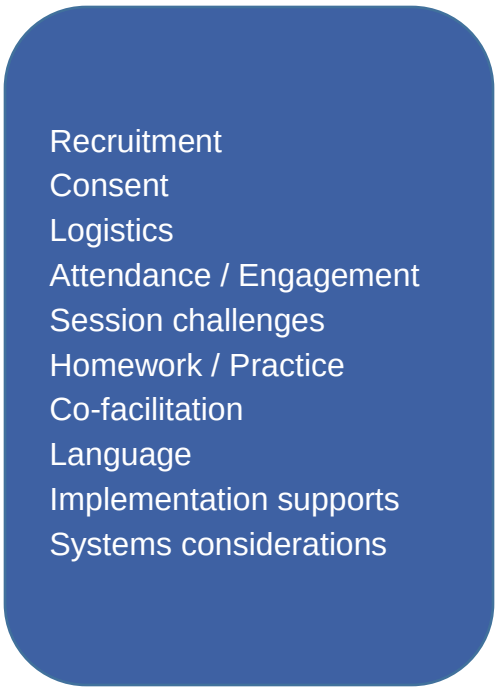


Figure 3. Implementation domains

Recruitment

The late start to the pilot meant that clinicians had very little time to identify and recruit appropriate participants for the program. Clinicians described a number of avenues through which they identified and recruited participants for the group. In some cases they relied on school personnel (including principals, guidance teachers, student success teachers, and ESL teachers). Some relied more on school records. One reported a multi-pronged strategy that included consultation with the In School Review Committee, asking the settlement worker for her input, and reviewing the school social worker's caseload to determine candidates that best fit the criteria. In one case the clinician noted that the country of origin was a key factor in identifying appropriate participants because they had decided to implement with pilot with students who were all from the same country.

Clinicians were asked on the implementation survey whether they encountered any challenges with recruitment. Of the 10 clinicians who responded, 40% indicated that they had some challenges (although in some cases the challenges described related more to consent than recruitment). The nature of the challenges differed and included having a relatively small number of newcomer students in one school and difficulty obtaining buy-in from families who were worried about missed instructional time.

During the focus group, one clinician indicated that she had begun recruiting participants at one of her schools, but subsequently realized that the newcomer students at that school were too transient to successfully complete a 10 session group, and had to begin the process again at another school:

"One thing that I found is that I had a school I really wanted to do it in because of the density of newcomers, like at least probably 40% of the school. Something that I learned is it's not a great community because they're very new, and they're very transient… we had a group sort of in mind already and then a lot of them were moving. And I was ready to go. So just even picking a school- Although it's filled with newcomers, lots and lots of trauma and hard stories, it wasn't the right community at the end of the day because it wasn't a permanent sort of spot for them. Whereas then my other school was much less in terms of population of newcomers but a much more stable population." – Elementary clinician, focus group

Clinicians offered a number of strategies for successful recruitment. Although the pathways differed, the underlying theme of relationship-based recruitment was important regardless of the pathway. Figure 4 provides the specific recruitment advice that clinicians offered through the implementation survey.

***Figure 4**:* Recruitment advice from facilitators

Work with community leaders	*"Found the community leader among the parents and he promoted the groups to create the excitement about the group. Had a parent meeting at the school with pizza to gain informed consent at that meeting and it allowed for a smoother transition to begin."*
Gather widespread school support	*"Begin preparing early in the school year. Attain the support of a school-based staff to assist with logistics, buy in, making connections with parents and students."* "*Attend a staff meeting to discuss what the group will be about."*
Engage staff who have pre-existing relationships with families	*"Having school staff who have pre-existing relationships with the families support the process."*
	"Connecting with support staff such as youth workers, settlement workers and guidance counsellors as well as ESL staff to recruit students who would be a good fit."
Engage parents individually	*"[It is] important to meet with parents individually as they had private concerns."*

One thing that was apparent from the advice about recruitment both in the survey and the focus groups, was that it was a process that required time and multiple steps for maximum effectiveness:

> *Having a dialogue with the participants individually and then with the parents over the phone was very important. These conversations were facilitated by the School Social Worker in Arabic and it provided opportunity for her to review the purpose of the group and clarify any questions and concerns the parents and students might have. We have found that with referrals to Social Work or additional supports that taking the time to process with these families ahead and not rushing through has proven to be very valuable and resulted in greater uptake (as opposed to a school personnel simply telling or suggesting that the intervention needs to happen).*- Secondary clinician, implementation survey

Consent

The majority of clinicians reported that obtaining consent was not challenging. Three of the ten clinicians who completed the implementation survey did experience some challenges with obtaining consent. The main challenge was time, and not having adequate time to establish trust because the pilot started so late in the school year. In addition, some parents were unsure they wanted their children pulled out of class. In some cases, the ability to obtain consent was predicated on group composition; specifically, some parents preferred single sex groups.

> *"…They [parents] wanted to know if it was boys or girls. …- when I went to get the consent they were prefacing they prefer to just be all boys or all girls. Not mixed."* – Elementary clinician, focus group

> *"Actually a lot of the parents that we did the consents for in the beginning, they were asking, "Is it just going to be strictly boys or girls?" Because the preference was just one gender."* – Secondary clinician, focus group

Interestingly, the preference for single-sex groups was not universal. In another case, the clinician received feedback from parents that a co-ed group worked because the students were from different countries, but that a co-ed group from a single country of origin would have been problematic.

Another potential challenge was having the adding requirement of asking for consent for the research process. However, as with identification and recruitment, pre-existing relationships facilitated the consent process. Important relationships included pre-existing relationships between families and social work clinicians, as well as relationships with influential community members.

> *"… I don't know that there's anything that can be done differently in terms of just obtaining consent and just the reluctance around signing a piece of paper… for the research. I think like a couple of the kids I already had a relationship with because I had referrals for them… so that was easier…but just- just like because you're signing this for social work, then your signing this consent, and that consent."*- Secondary clinician, focus group

> *"… the principal chose our people, but one of the parents was like a community leader - not, like, just within the community. He was known as being strong and when he advocated this was a good idea, all the rest of those parents signed those consents for the kids- their kids to come into the group. So if you happen to know that ahead of time, that's so handy because they can kind of you know help with the process, I found."*- Elementary clinician, focus group

In one case, the availability of a special education teacher who spoke two of the languages spoken by parents was an important asset in recruitment and obtaining consent.

> *"I would echo a lot of the same things about the logistics and whatnot. We at our school, our special education teacher speaks Armenian and Arabic. And I don't think the group would have got off the ground without her because to be honest there were some convincing to the parents… And these parents know the school pretty well, a group of them. And the Special Ed teacher has worked closely with them just in terms of that settlement and everything in the community because she speaks the language, and they trust her I think… And still there was a little bit of convincing that this group was a good idea. Because a few of the parents were really questioning why their kids needed it and things like that. So I don't think we would have got the group up and running and I was close to not being able to pull it off. And just trying to get permission is this, the real truth. It was the paperwork, it was forms, it was having the parents understand."*- Elementary clinician, focus group

Logistics

Clinicians at different schools held the program at different times. Some groups ran once a week and others ran twice. A couple of groups staggered or rotated the time to ensure that students missed different coursework rather than always missing the same class. Some groups ran entirely during instructional time and others spanned instructional time and lunch. Finally, one secondary school group ran during the same period every week because it coincided with the ESL class that most of the group participants were involved in.

Finding a suitable time and space for the group was a challenge for 90% of facilitators. Sometimes a booked room needed to be used for another purpose and clinicians were left scrambling to find another location at the last minute, which cut further into the previous time available. Other clinicians noted frequent interruptions, even once a place was located.

> *"Space in schools is always at a premium and even when you do find space there are sometimes interruptions by staff entering their classroom to gather items etc."* – Secondary clinician, implementation survey

> *"Respect of the space-people opening the door and looking in even though door was closed."* – Elementary clinician, implementation survey

Another scheduling consideration was finding a time that was least intrusive to classroom instruction. Missed instructional time can be a concern for many psychosocial interventions, but it is particularly salient with this group of students because many of them have missed years of formal schooling due to their migration experiences.

"We had some challenges at the school- they were adamant that we could only run it during the lunch time which didn't give us, I think, enough time at times. We were able to provide food which was a real benefit…And ours of course that's a big challenge, was yes during Ramadan. So that- and also then it went into practice or right before exams so that- we were still getting them coming out and showing commitment. But I think that it would have been- it's the timing. We know that, that was a big challenge."
–Secondary clinician, focus group

On the implementation survey, 100% of clinicians identified timeframes as a significant barrier to implementation. In some cases, clinicians felt there was simply too much material for each session. This time pressure was exacerbated in elementary school settings because the periods are shorter than in secondary school.

"Every one session was more than a 45 minute chunk, I think it was supposed to be 45 minutes. But in reality if you were to do everything in that thing [manual]*, it would take an hour and a half like realistically. So that's- that's too much, like kids can't pay attention for that long."*- Elementary clinician, focus group

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Some clinicians felt that extending the program would be beneficial, but others felt it would be very difficult to commit more than ten sessions to one group. This concern was echoed by one of the Mental Health Leaders, who noted that increasing the length of the program might make it less feasible to implement:

"The other piece was that- and I heard it a couple times too- this is 10 sessions and some of the folks here were saying well it should be 15 sessions, and I'm like I don't know, like I know the argument for lengthening it, but in schools I don't know if you could find 15 sessions so… I would say keep it to ten."- Mental Health Leader, interview

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In other cases, the time constraints seemed more related to the additional pieces involved with organizing and running the group then with the actual sessions:

"…obviously just not enough time to do this properly as intended or hoped. Just logistically getting a bunch of teenagers to do things really quickly and get paperwork back on time is not going to happen. They love coming, they love attending, they love participating. Paperwork not happening. So that was challenging. We didn't have

language because-…I don't believe I would have been able to do even half the sessions if I needed to try to get an interpreter in my language and in time…So yeah logistics, just paperwork back. Not enough time. I think doing it in high school where you're not just negotiating with one teacher, you're negotiating with let's say five students, times 4 teachers, times whatever." – Secondary clinician, focus group

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Some clinicians felt that simply starting earlier in the year would lead to more success, in part because the STRONG program could be planned as part of the workload for the year:

"I think in elementary school things tend to start off a bit quieter at the beginning of the year… I can see it being hugely successful at the beginning of the year when you could put that time into a school. It does really take away from your time being able to do other things in a school. So it's also the school's commitment too- their okay with this is how you use your time at the school."- Elementary clinician, focus group

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In addition to overall time challenges, 60% of clinicians identified external disruptions and influences as an implementation barrier on the implementation survey.

"We tried to stagger [the sessions], but some days you went in and it was the ride for cancer or something, and so it was like oh we can't do it today now. So we ran into those- and that was probably we should've checked it out [scheduling] a bit better than we did." –Secondary clinician, focus group

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In terms of ensuring logistics work well, the importance of a small group size came up several times in both focus groups:

"We only had five group members and I think most of the time it was okay, but we did have to kind of like start talking really quickly at the end. But I think if we had like 8 or 10 students and we did like one full period which is 75 minutes in order for everybody to have a voice and say what they wanted to just say and share what they wanted to share it was- It was tight at times. It was really tight. I think just kind of managing number of members and the time that you have because then there are going to be those that don't have a chance to share." –Secondary clinician, focus group

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Clinicians did have some suggestions about how to schedule for maximum success. Two clinicians recommended avoiding Ramadan. Two others suggested exploring the possibility of an after-school group. A couple of clinicians felt that mornings worked better than afternoons. Other advice included coinciding with an ESL class, rotating the group so that the same class is not missed every time, and scheduling the group whenever you can obtain consistent space.

Attendance and Engagement

Clinicians reported generally good attendance on their implementation surveys. On a scale of 1-5 (from very poor to excellent), student attendance was rated high (*M*= 4.25, *SD* = 0.62). In addition, for the 47 students for whom individual level data were available, the approximate mean number of sessions attended for elementary students was 9, and the approximate mean number of sessions attended for secondary students was 8.

Beyond attendance, engagement was rated by clinicians at each session on a scale of 1 to 5 (see Appendix A for individual anchors on the rating scale). For the elementary programs, ratings ranged from 1 to 5. For secondary, they were slightly higher and ranged from 2 to 5. The mean engagement ratings for each session are provided in Table 2. The session tracking sheets also included comments on which activities clinicians found engaged students particularly well. In general, activities that were well-received in both elementary and secondary groups included the following: Warm-up Activities; Relaxation Exercises; Measuring and Managing Feelings/Feelings thermometer; Reactions to Stress/Body Map; Act it Out; Sharing Journey Narratives; and S.T.R.O.N.G Bingo/Trivia.

Table 2. Mean engagement ratings (and standard deviation) for each session

Session	Elementary School Ratings (n= 15)	Secondary School Ratings (n= 32)
1 Inside Strengths and Outside Support	3.67 (0.72)	4.26 (0.69)
2 Understanding the Stress Response	4.00 (0.85)	4.00 (0.83)
3 Common Stress Reactions and Identifying Feelings	3.87 (0.52)	3.96 (0.96)
4 Measuring and Managing Feelings	3.53 (0.83)	4.21 (0.90)
5 Using Helpful Thoughts	4.00 (0.71)	4.24 (0.85)
6 Steps to Success	4.27 (0.65)	4.12 (1.04)
7 Problem-solving	3.57 (1.09)	4.71 (0.63)
8 Journey Narrative Part I	4.50 (0.76)	4.54 (0.66)
9 Journey Narrative Part II	4.30 (0.82)	4.55 (0.76)
10 Graduation	4.55 (0.52)	4.79 (0.50)

The engagement ratings for the i**ndividual student sessions** were particularly high (Elementary *M*= 5.00, *SD*= 0.00; Secondary *M*= 4.80, *SD*= 0.50), indicating that these individual meetings were well-received by students. Clinician comments included the following:

- "Students seemed open and wanting to share story"
- "Students appreciated discussing their journeys (loved speaking of what Canada and being in Canada has done for them)"

The importance of the individual student session emerged from the other data sources too.

> *"They were powerful for all involved and positive overall. Provided opportunity to better understand and develop a more holistic view of students and also strengthened the relationships between facilitators and students. The students seemed to appreciate having opportunity to talk about their experiences and also for someone to ask them and be curious."* Secondary clinician, implementation survey

The focus groups also highlighted the engaging nature of the program at both the elementary and secondary levels:

> *"…the student engagement with the activities, just how they kind of all came together as a group. You could really see the relationships kind of developing. So I thought that was really positive amongst them and they actually- they really looked forward to coming. So you could tell that, just again amongst, as a group, and just the activities they were really looking forward to and always eager and excited to participate."* – Elementary clinician, focus group

> *"And our kids were active participants, in terms of going through the program. They weren't reluctant- the four that we had weren't reluctant to participate and contribute, and so they encouraged one another which was helpful. And in their feedback from the students, because we asked at the end, there was a lot of positive feedback about the program and what components of it were helpful…"*- Secondary clinician, focus group

> *"…The kids came every single time, even when they had expressed that they had other things, or assignments, or ISU's, or something else was really falling apart. I was thinking oh so and so's not going to come, because I know this and this is happening for her. And boom there she is. I'm like, "Welcome." So really I think it really spoke to- I think they found it really helpful just to be with each other…"*- Secondary clinician, focus group

Session Challenges

The most consistent criticism of the program, particularly among elementary clinicians was the language required for the group.

> *"…there's like a lot of a lot of language and I'm being honest we didn't read the scripts. Seriously, if we read this script, like they are off, they're going to run on us. They are not listening to me, it's too much language."* – Elementary clinician, focus group

> *"The curriculum, lots of English concepts that for grades 3 and 4 I think were kind of above their understanding. The boys in my group were just learning how to write in English, learn English language, speaking English, so I'm glad I had the interpreter there. Otherwise it would have been absolutely going nowhere fast. So for example, the thoughts-feelings-triangle, great concept. I get it, but the boys- it just- we spent three sessions on it and I'm still not sure if they understand…and the writing and the drawing. I think was- the writing for sure was a big challenge. They would visibly become distressed in the group, during any of the writing tasks…* - Elementary clinician, focus group

Although it was more pronounced in elementary groups, facilitators of secondary groups also found the language burdensome:

> *"I think if there is one recommendation it's- and maybe it's just if you can do the same program with fewer words."* –Secondary clinician, focus group

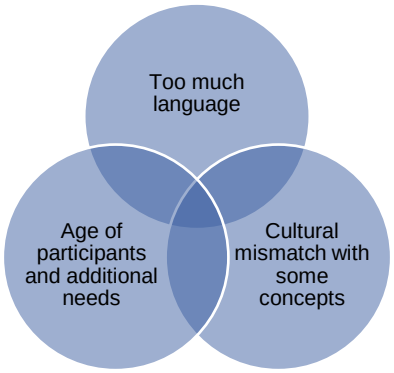
Beyond simply understanding the meaning of particular words, some of the concepts were difficult either because of the developmental stage of the students and/or cultural context.

> *"I asked the interpreter because I had a consistent interpreter that had come every time and I said so in Arabic, or culturally, can you tell me what we should do here? She's like, 'there really isn't a word in Arabic to describe this'. So she too was trying to figure out and we were talking about mindfulness and the term mindfulness, and she's like what do you mean? So I think it's just an introduction of a lot of new terms. But I also think my boys didn't- it was too much language piece. They didn't understand."* – Elementary clinician, focus group

> *"No I was doing the stuff, like the interpretation with them, but I find it like also challenging because some of the concepts are new to them. So the same idea, like mindfulness. That's a whole new concept. I had to explain it and introduce it, to let them actually buy into it as well, because that was a challenge. Yeah a lot of them just felt that it was not really for them but we encouraged you know for them to try it out and see. And some of them have been coming back and saying oh I've tried the reading exercise last week for example, it has been working. Others saying no it did not really work for me. So just dealing with these kinds of new concepts I think for me was a challenge given the fact that it's all new to the culture as well."* –Secondary clinician, focus group

Additional challenges related to specific clinical needs experienced by some of the students. In one particular group all three of these challenges appeared to converge, making the experience less successful than in other groups as shown in Figure 5.

Figure 5: Impact of challenges that could co-occur



Homework / Practice

Among the five secondary groups that provided implementation survey data, three clinicians indicated that homework was understood and completed, one said it was not, and one was unsure. All four of the elementary groups indicated that homework was not understood or completed. Elementary clinicians tried to incorporate review of concepts into the next session, recognizing that there would not have been any independent review between sessions.

"The writing. Writing is- It's just not an option. Like there cannot be homework. I was sort of like reticent at the beginning, when we went through the training and like what we're giving homework… So we only gave homework one time and they didn't return it, and it's like there's no point in me giving homework. We just need to review it in the sessions, and writing is a trigger for a lot of them."- Elementary clinician, focus group

"No, we tried, but honestly you can't- it doesn't matter what you call it [homework]. They didn't want it to take something home. So we would do it, we'd talk about it at the end and go over it again." – Elementary clinician, focus group

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Although secondary clinicians reported more success with homework in general, they also utilized in-session time for reviewing concepts:

"I think it was hard for them to do some of the written practice assignments so we very rarely had completed practice and that was fine we would just say okay well why don't we just talk about it or if you think back on your week, and give us an example. We just kind of managed it that way. We- I think came to kind of just not even expect there to be anything written. Yeah. And then having all the materials translated was important as well." Secondary clinician, focus group

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At one secondary school, clinicians used some of their implementation resources to provide incentives for homework completion, and found homework completion rates to be very high.

Co-facilitation

As shown in Table 1, all but one group involved co-facilitators. In most cases it was two clinicians, but in two groups a clinician co-facilitated with a teacher in the school who was well connected to the youth (i.e., an ESL or settlement worker).

All clinicians spoke highly of the benefits of a co-facilitator. One clinician noted the importance of moral support, given the nature of the work.

> *"I think [co-facilitation] is a big piece. I think it's important to have somebody else there with you. That's just me."* – Secondary clinician, focus group

It also helped logistically to have two facilitators, in that one facilitator could still conduct the group if the other was not available. This was particularly important in the current pilot because there was not time to re-schedule groups to accommodate unexpected commitments.

> *"I think the other challenge is [clinician name] did group a couple times- twice on her own because I needed to do unexpected things for the school. So that was- thank you. I wouldn't have been able to do it without [name] for sure- for sure. So having someone you know that you can work with."* – Secondary clinician, focus group

Finally, clinicians and the Mental Health Leaders noted that the opportunity to work with a colleague is relatively rare in the school boards, and that the clinicians enjoyed both the connection with a colleague and the opportunity to learn with each other.

> *"I made the comment- it can be a very lonely kind of experience delivering this- this stuff a lot of the time. So teaming up with a colleague and you know actually getting to know them a little bit better on a professional- it's very rewarding."* Secondary clinician, focus group

> *"I think that the opportunity for clinicians to co-facilitate and learn from each other, and support each other's practices…I've heard about the richness of relationships, typically in school boards clinicians work in isolation. So to have that opportunity and to see that professionalism and learning together was great."*- Mental Health Leader, interview [speaking about successes]

Language of Facilitation

The two boards took different approaches in that one utilized interpreters and the other elected to recruit students whose English was sufficient for them to participate in that language. The decision to not use interpreters was in part driven by resources; although the board indicated they could provide interpreters for STRONG during the pilot year, the Mental Health Leader would have had to find the resources moving forward.

> *"I think at first we weren't sure about our language direction. So at first we toggled around conceivably having three languages in a group…I was like we'll get three interpreters and not recognizing that's probably not going to be feasible for any therapeutic delivery model. You know let alone this kind of intimate content. Luckily we kind of dialogued as a group and it became very clear to each of us that we needed to get English speaking folks who had some facility in English. Not that that was a solid rule for our groups but that was- and that took us- there were some stumbling there. We did maybe lose a little bit of time as we were negotiating which direction to go and that was an eligibility factor."* –Mental Health Leader, interview

Beyond resources, there were simply not as many recent newcomers in some of the schools:

> *"We didn't have an interpreter so we actually chose the students who did not have the language issue. Not that we refused anybody- like there was nobody that had really just arrived…We tried to bring the interpreter for the parents, we couldn't find an interpreter. So it just had to be like that."*- Secondary clinician, focus group

Of the five groups that used interpreters, only one noted challenges. In this case, the co-facilitator did the interpretation and the challenge related to the additional time required to cultural interpretation of key concepts:

> *"Having my co-facilitator be the School Social Worker and also speak Arabic was incredibly valuable with the group however it does take time and slow down the process as it is not merely straight language translation that is needed. In addition, there are explanations of North American concepts and nuances that need to be addressed."*- Secondary clinician, implementation survey

Some clinicians noted that having an interpreter was absolutely necessary. Others indicated a preference for the program to be less language based to avoid the need for an interpreter.

Implementation supports

Implementation supports included calls hosted by the program developers and SMH ASSIST, as well as some financial resources to support implementation. In addition, at one of the boards the Mental Health Leader hosted regular calls with her clinicians. Overall, 80% of clinicians reported that they accessed implementation supports during the pilot. In addition, 50% indicated

that they would like additional supports. Some of the desired supports were very specific, such as a USB or link to online mindfulness exercises / tools to share with the group. Another clinician noted that the opportunity for face-to-face meetings to augment or replace the implementation calls would be appreciated. Yet another clinician indicated that having more support from the school regarding organization challenges would be helpful. One clinician offered specific feedback about how the implementation calls could have been more helpful:

> *We mainly accessed the Mental Health Leader and SMH ASSIST support around translation of materials and to clarify pieces related to the research. I appreciated having a co-facilitator and see this as important. I would have liked the calls to be somewhat more clinical and reflective about the experiences that we were sharing. I enjoyed hearing others' experiences. I would have liked alternative questions to guide the dialogue however as we moved forward rather than continuing with the same ones again and again. The focus group combined elementary and secondary and was really helpful and enjoyable for connecting and learning.* –Secondary clinician, implementation survey

Other criticism of the implementation supports included the lag in getting the calls started:

> *"Supports kind of came a little bit later. So that was a challenge if you were kind of going in the journey of the group. It kind of felt like they came after the fact. But I know the implementation was kind of later on in the year too so I know sometimes it's hard to pull that stuff together."* – Elementary clinician, focus group

Some clinicians did not feel that proactive implementation support was necessary, but appreciated the opportunity to access support or resources when needed:

> *"…in terms of like the group content or facilitating the group- I didn't feel like- I mean don't think most of us needed support maybe. Like that was very comfortable. I really appreciated though when I would reach out for clarification around process pieces or like the research stuff or you know like either [Mental Health Leader] was responding right away, or she would reach out to [research team] and the responses came so super-fast. I mean I continuously was asking for stuff in Arabic and it was happening like that for us. So that was really helpful."* – Secondary clinician, focus group

The implementation supports offered from SMH ASSIST were also identified as important.

> *"Well we were given some financial support. And again I know that's because this was a pilot. I don't know if- but that's always helpful, right…so that's something that definitely helps… Incentives, foods, there was some office supplies that were needed*

by some groups I understood. So all of those three categories I think were covered." – Mental Health Leader, interview

Systems considerations

There were a number of challenges experienced by clinicians that related to systems-level support. Even the space issues discussed under logistics could be addressed by a clearer school-level commitment to the program. In addition, without a shared understanding among all school staff about the importance and objectives of the program, some clinicians faced significant resistance from classroom teachers about students missing instructional time. In one case, clinicians indicated that a lack of understanding about the program led to resistance about the activities.

"Well we had teachers upset that we were rewarding these troublesome children with treats …and we would have interruptions. We'd have the teacher- and the teacher would open the door and say something like don't do this to us, don't- don't have that happen next time. So it's just like, get out. So it's lots of things about safe groups, and you're doing a therapeutic group, again it's an issue of safety." – Elementary clinician, focus group

Both secondary and elementary school clinicians noted the importance of engaging the larger school community to develop a common understanding of the importance of the program and its purpose, as well as the importance of a supportive administrator:

"I think maybe a larger staff meeting. So I think that was one of our learnings, we would maybe have a large staff meeting. And I also think we would also spend a bit more time not just with the principal, but with the entire admin team, like the two VP's as well. And I think moving into next year should we be running it again, I think we'll sit down with them and have some deeper dialogue."- Secondary Clinician, focus group

"I think meeting an administrator or having administrator that really supports this and gets this- like would go and approach those teachers or that teacher and say hey you know what this is really important, because space for me- I wasn't sure if I was going to have space. And then when I did and people would be knocking on the door wanting it, she would- I would go tell her and she would address it immediately, our administrator. So I think it's so important, to have an administrator, that really promotes it, buys into it, whatever she needs to do or he needs to do I think is important." – Elementary clinician, focus group

Clinicians also reiterated the importance connecting with adults in the school who already have connections to the students. In some cases these adults were ELL teachers and in another case it was the settlement worker. Several clinicians provided examples of how these adult allies were instrumental in creating a successful program experience, regardless of whether the ally co-facilitated the program or simply supported it:

"I think one of the biggest successes that we found was the ELL teacher is the person who did the co-facilitating with me… the fact that she had a relationship with the kids beforehand because I had only worked with one of them previously, so there was some cohesiveness to start with because she could bring them together pretty easily in conversation, and that was a huge help facilitating things with the school because she always sort of knew what was going on. They tried to keep me up to date, but when you're only there once a week it's hard to know if the schedule is changing and stuff. So for me that was a huge component to the success, I think, to a school based person involved in it." – Elementary clinician, focus group

"…so when I initially just sent out an e-mail asking about would this be a good program for us to work with, one of that ESL teachers was very much on board. And I think without her I don't think we would've done it. She suggested names of kids and she checked up on them and even kids that she hadn't taught, but through meeting other kids, they had gotten to know her. So I think she was really amazing and I think I don't think we would have been able to do it without her support."- Secondary clinician, focus group

"Training the settlement workers if they are available to come to training- that would be very helpful because they can be a great resource and a great communication with the parent community."- Secondary facilitator, focus group

The Mental Health Leaders had some clear ideas about how a more intentional communications and implementation plan (with adequate time) could better support the program:

"Build a communication plan in a cascading manner so that you know that you've got good solid support of your senior team and that you're working- that the Mental Health Leader or the clinical manager is working with the superintendent and the principals of the clinicians, and that everybody is giving it a good solid green light. Everybody understands the impact on service delivery when a clinician is committing to 10 weeks of the group. So that- that kind of thing. And that would take quite some time to kind of get that up and running. So school mental health assist- if we thought about a package, if we've thought about a slide deck, you know and just kind of how do we get in front of the senior team, let them know what it is, and then kind of move from there would be good. A commitment from the school. If you want this you are guaranteeing space, you are guaranteeing time on the staff meeting and a clear understanding and a commitment from the staff that they will support the work. That we recognize we need to build educators capacity to know that when we intervene early we can change the trajectory for mental illness. Clinical intervention at school means time missed from class. With support educators will become comfortable with this model and school teams will find a balance to support clinical work and academic achievement…"-Mental Health Leader, interview

Moving forward, School Mental Health-ASSIST could play a key role in developing and supporting these communication plans.

Impact

Clinician Ratings of Functioning

Clinicians provided functioning ratings for students at each session (see Appendix A for rating anchors). To look at possible changes in ratings over time, for each student we computed three aggregate scores. These included an early clinical rating (based on the mean rating of sessions 1-3), a mid-clinical rating (based on the mean rating of sessions 4-7), and a late clinical rating (based on the mean rating of sessions 8-10). The means and standard deviations for these aggregate ratings are shown in table 3. They are not reported separately for elementary and secondary students because they did not differ. First, it should be noted that the early clinical ratings are quite high (i.e., approximately 4 on a scale of 1 to 5). This suggests that perhaps the scale or anchors were not a good match for the presenting challenges of these youth (i.e., youth were not visibly, acutely distressed, but were seen to be good candidates for the program for other reasons). Despite the high level of functioning at the outset, there was still a statistically significant increase across the three time points, as shown by a repeated measures general linear model ($F(1) = 50.13$, $p < .001$). There were no gender differences in aggregated clinical rating scores at any of the phases or with respect to main effect for time.

Table 3: Aggregate clinical rates during the early, mid, and late phases of the program (n=44)

Phase	Mean Clinical Rating	SD
Early	3.98	0.64
Mid	4.29	0.61
Late	4.69	0.52

Strengths and Difficulties Questionnaire Data

Although clinicians attempted to collect SDQ data, we did not end up with enough data to look at them a systematic way. Only 15 students did both pre- and post- surveys, and half of those students did their pre-tests in week 5. There were some barriers to collecting SDQ's at the outset: initially school board research approval had not been obtained, and consent forms were not available in the languages necessary.

Clinician Perceptions of Impact

Clinician perceptions generally suggested that the STRONG program had a positive impact on students. On the implementation survey, 80% of clinicians agreed *somewhat* to *very much* with the statement that students experienced lower levels of distress after participating in the STRONG program, while 20% indicated feeling *neutral*. In addition, 80% of clinicians specifically indicated that students benefited *very much* from the STRONG program, and 20% indicated that students benefited *somewhat*. Based on the perceptions of the clinicians, possibly the greatest success for students was the connections they developed to other students in the group and the support system that resulted. All clinicians who completed an implementation survey agreed that students supported each other, and 90% of clinicians believed that students developed a cohesive group experience. Furthermore, in the focus group, it was evident that students were supportive of each other not only in the group, but also outside of the group.

"Even though some of them do live in the same buildings, they didn't know each other. So it's nice at school to see some of them now buddying up together and playing together." –Elementary clinician, focus group

"…the networking and the support they were giving to each other, and connections even though they had been in some of the same classes, like- but they came to be friends and when they come in they'd say oh so and so has a test, he's texting us, he's going to come later. Like they were making those connections at the side…"- Secondary clinician, focus group

"…a lot of them live in some of the same apartment blocks but weren't necessarily friends or didn't really know each other that well. But really feeling connected and you could see especially in our last session with the celebration how they all came together wanting to bring food and even though we said that we would provide the food. That was very important to them…"- Secondary clinician, focus group

The connections formed between the students and clinicians were another success of the program. It was apparent that students felt clinicians were safe adults with whom they could express their concerns and access support from. Clinicians acknowledged the impact they were having on students as a result of being able to form relationships with them.

"like for example…one of the students- they received- their refugee claim had been denied. And that just really put the whole family in a tail spin. So her accessing just even, just what am I going to do. That was something that she came straight to us with. Not that we could change the decision, but in connecting with resources, the lawyers and things outside of school, she was able to kind of come immediately and start talking about that."- Secondary clinician, focus group

"And then for me, I didn't realize the impact we were having on them in terms of our relationship with them and theirs with ours, until they started to say certain things and you know invite us to come over to their home and I was like oh like they are feeling connected to us as well because I was watching it happen amongst them but I hadn't really realized the impact that we were also having."- Secondary clinician, focus group

"…it was neat watching them grow as a group and I wouldn't have known four of the five kids had we not run the group, and again a few of them came with a few things or would pop in and say hi and that was a neat dynamic to see for kids who are maybe not typically ones who would be referred to social work for example. So growing connections and outside supports came out of it." –Elementary clinician, focus group

Clinicians also observed that some students were beginning to feel more comfortable at school and were developing a sense of belonging in the school community. They approached teachers more regularly for guidance, and signed up for clubs or teams at school.

"I think one of the things, she did really start I think to talk about accessing outside support, she really did begin to- to really use you know like guidance from this teacher and that teacher, and this club, and not the recreational ones, but like the mountain club. "-Secondary clinician, focus group

"I also noticed at that the end and I don't know if this fits in there but as we went along around goals and around different things that can be strengths in your outer circle and- they started to access more extracurricular school stuff. So you'd hear if I joined the soccer team and I'd say oh great. And then I'd say when do you play and they'd say we play tomorrow at 3. And so I'd go to the field and they'd be like oh hey. Where I don't know, I'm not saying it's necessarily STRONG, but the opportunity to have those discussions and say oh did you know that there was a drama club or there is- oh really where and then you know I joined and I like it." – Secondary clinician, focus group

In addition, one Mental Health Leader also recognized the significance that the STRONG program had in terms of **connecting students and their families to community providers within the school system**.

"The biggest successes happened in the school. I heard that clinicians experienced an increased ability to engage a vulnerable population or potentially vulnerable population, to get to know the parents, and to build those trusting bridges between the community and the school. We are hearing that offering clinical intervention at school was much more comfortable for families. We know that it's hard for our students and families to reach our community providers. It was affirming and great to hear that students and families were comfortable with the intervention…" –Mental Health Leader, interview

All clinicians agreed (somewhat to very much) that students **learned both about the impact of stress and the thoughts-feelings-behaviour triad**. Furthermore, 90% of the clinicians agreed (somewhat to very much) that students learned relaxation strategies, learned positive self-talk, and processed their own journey narratives. Clinicians shared that **students were using specific skills and strategies that they learned** outside of the group, and also spoke of how having learned such skills and strategies has helped students to process and make sense of their journey experiences.

"Yes especially around things in the mindfulness exercises. Some girls shared that they've been using the breathing exercises more, right now it's been actually helping to calm them down. One student shared in the entire session of problem solving and the steps we take- and she shared an actual personal example where she had to use the steps and do the pros and cons and how that helped her to make the proper choice that best fitted her right now for. So some stories like that were positive." – Secondary clinician, focus group

> *"…they were able to say to us that they felt like they had learned a lot and they were talking about things they would never have typically spoken about or learned about in everyday life. So I think that kind of broadened their understanding of what was happening for themselves and being comfortable to speak about that."*- Secondary clinician, focus group

Finally, reports from clinicians suggested that the **STRONG program appeared to change the way that students viewed themselves and their future**. Specifically, 90% of clinicians agreed (somewhat to very much) that students developed optimism for the future. In focus groups clinicians stated that students were able to reflect on their journey using a strengths-based approach and reframed their view of themselves to be more positive and strong.

> *"So I think it kind of gave them some insight into their journey and what a challenge it was: "But look I survived this." And how brave they are in terms of being able to manage all of the challenges that they've had because they've had a lot of challenges in their journey. And that they have survived it and that look we're- we're sitting here today- you're in school, you are managing, right, so it kind of reinforces to them that they have some of those strengths even though they might not have known that they have those strengths to survive."* – Secondary clinician, focus group

> *"…they realized how strong they were and how they got through that. They can get through the challenges that they're facing here in this country, right, and so that was really nice to see them- to see them support each other and to see them feel like more empowered which was really nice because very different from when they first came in and we first met them and they were not all- not all were happy about being in Canada. And then by the end we were talking about yeah you know what we could do this- we could do this. So it was kind of- it was that- that part really affected me. I thought that was great."* – Secondary clinician, focus group

> *"One of my students, I noticed from when she first came here…she kind of- she just physically looked sad, and down, and then throughout the group and towards the end, she really shared that this never happened in Chicago or even back home…And she said I was- I've been to so many different places. I wasn't expecting to make connections. I wasn't expecting people to care about me. I wasn't expecting any of this. And you know no matter what happens you know to kind of have met the people I've met, the friends that I've met, and the supports that have been given to me, I'm so grateful to God she would say all the time, that this has happened because I didn't think it existed. So even just her well-being and her mindset from day one to the end of school was a complete shift and there was hope for her."* Secondary clinician, focus group

Although most clinicians spoke of the positive impact that the program had on students, it is important to note that one clinician noticed the behaviours of some students to be worsening:

> *"And some of it had the opposite effect. It's hard to know- like their- their behaviors escalated. So I'm sure- I'm not sure but when you look at pre and post, I wouldn't be surprised if it's the same or maybe their behaviors worsened. But I don't know if that has- I don't know what that's a function of. It could be the group, it could be that it was during Ramadan and they were really not doing well during that period of time. And just completely dysregulated and getting into a lot of conflict at recess. So but yeah that's the teacher reports, like their actually getting worse. I'm like sometimes in treatment, things get worse, before they get better*.- Elementary clinician, focus group

Notably, this particular group was considered challenging by the facilitators in part because two of the students had tier 3 behavioural needs.

Summarizing Findings by Feasibility Domain

Acceptability

Overall, levels of acceptability were high among students and clinicians. Clinicians rated the program implementation as a positive experience and indicated that they would recommend it to colleagues (*M*=4.9, *SD* = 0.32) for both questions on a 5-point scale from *not at all* to *very much.* Focus group data echoed that this program had a high degree acceptability to implementers and participants, with the exceptions noted earlier in this group (and largely pertaining to one particular intervention group).

Demand

To some extent, the demand for this program was documented prior to the pilot, and was the precursor to the pilot:

> *"So in around February 2017, we were coming off of our first year of absorbing and welcoming a high volume of Syrian newcomers, and in that school year we knew that we weren't properly equipped to serve their needs on a Tier 2 kind of level perspective. We were seeing students in the classroom either sharing traumatic incidences with caring teachers who didn't really know how to respond. As a result for our younger students we saw a lot of behavioral displays of what they were feeling internally. At the secondary school, we saw a lot of academic issues, some behavioral issues, and some social issues."* – Mental Health Leader, interview

During the pilot, demand for the STRONG program was demonstrated by the boards' ability to identify clinicians willing to take on such an intensive process so late in the year. Of clinicians who completed the online survey, 90% indicated that they would likely or definitely implement the program again in the future if possible. Demand was further demonstrated by the success clinicians had in recruiting participants and obtaining guardian consent. Finally, the interest in the program expressed by additional clinicians within the two pilot boards as well as by other boards speak to the demand for the intervention.

Implementation

Overall, the program was implemented as intended, with a few modifications related to homework. Some clinicians had to skip a session and /or the parent meetings did not happen uniformly; however, these omissions were due to time constraints rather than preference. The biggest challenge was related to sufficient time, which is likely a function of the late start in the school year and also the challenge of implementing a new group for the first time.

Practicality and Integration

The STRONG pilot worked well, especially in light of the tight timelines; however, the support provided by school mental health leads at each board and also by SMH ASSIST was essential. Clinicians in both focus groups noted the importance of implementation support (from the school board mental health lead and/or the consultation team). The resources provided by SMH ASSIST that paid for supplies were highly valued by clinicians.

There are some practicality and integration considerations that require attention for future implementation:

1. There was a lot of background work required to implement this program, including relationship-building with families and community, and advocating within the school setting for the importance of the group.
2. Access to interpreters for students may be uneven across boards.
3. Most of the clinicians expressed the wish for the program to be identified as part of their workload (i.e., to have reduced expectations in other areas to accommodate the significant work involved with implementing STRONG).
4. Although the clinicians spoke about the resilience of students, they were also deeply affected by the stories they heard. It might be important to consider how to provide support for clinicians who might be at increased risk for vicarious trauma while implementing this program.

Adaptation

Although this program was not adapted from an existing program, there was still the issue of adapting CBT principles for newcomer groups. Overall the content appeared to work well, although there was some concern about cultural equivalency of concepts. One focus group raised the issue about whether the content was more suited to individualistic cultures than collectivist ones. Overall, the variability of the success of particular concepts across groups suggests that the material warrants another try, although perhaps in some activities there could be a couple of options from which clinicians could choose.

Limited-efficacy testing

The evidence of the program conferring benefits for youth is very preliminary given the small sample size, the lack of a comparison group, and limited self-report data. Session-by-session functioning ratings indicated that as a group the students were not exhibiting clear signs of distress at the outset. Furthermore, their functioning was seen to increase over the duration of the program. Clinicians identified a number of specific benefits for students on their post-implementation survey. Qualitative data from pilot groups also described clinicians' observations of significant improvements for many participants.

Additional Considerations

Two additional considerations were explored in this pilot study. First, we evaluated the perceived professional and personal benefits of the program for clinicians themselves. Second, we asked clinicians for their advice on which outcomes should be measured in program evaluation moving forward. These data are presented below.

Benefits for Clinicians

Although the focus of this pilot was on potential benefits for students, we did have opportunities to ask and learn about benefits for clinicians. As a result of participating in the training, clinicians reported increased confidence in their understanding of mental health needs for newcomer students. Clinicians also felt more confident in terms of their therapeutic skills sets and ability to teach newcomer students the following: common reactions to stress, relaxation techniques, how to measure and manage their feelings, how to challenge unhelpful thinking, how to set goals, how to problem solve, how to process their journey narratives, and how to identify inside strengths and outside supports.

On the implementation survey, 100% of clinicians indicated that they experienced professional and/or personal benefits as a result of facilitating the STRONG program. With respect to their professional skills sets, 90% of the clinicians felt confident about helping individual clients develop and process personal narratives. In addition, 70% felt they had learned new strategies for supporting stressed or traumatized children and youth, and felt more confident about their ability to use CBT strategies. Results from the surveys and focus groups also suggested that many clinicians valued the opportunity to get to know students more intimately than they typically do in their jobs in order to provide them with support.

"Although time of year was rough in terms of workload, running the STRONG program and connecting with the newcomer students early in their Canadian journey (for the majority of them - year 1), brought me a lot of job satisfaction. I looked forward to these sessions and felt after a couple sessions, students saw me as a support and didn't hesitate to ask for help or guidance regarding situations not directly related to group. Learning about the beauty and diversity in each and every one of their lives was so rewarding, not only for them but for me…I also was motivated to provide such a structured, well designed intervention that I felt was user friendly. I learned a lot throughout this process and can apply new techniques, ideas and knowledge in my practice with newcomer students of all types." – Secondary clinician, implementation survey

"It was nice to be able to form relationships with the students. Like as a staff member, being able to form relationships with the students and also being able to give feedback to teachers about, you know, as a psychologist, things that I've noticed about possibly their learning and their attention, and it was like another bird's eye view also about what could also be contributing to their problems at school."- Elementary clinician, focus group

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Clinicians also specifically enjoyed connecting with newcomer communities and learning about their cultures, hearing student's migration stories, and learning how resilient newcomers truly are.

"I feel I didn't really know much about the community and now having done this group I think there is more respect there for the parents and vice versa…The resiliency blew me away. And how close the family unit is you know, and so no matter what they had experienced- I didn't have any post-traumatic stress disorder concerns regarding any of the boys in the end. But just that they experienced so many things but the resiliency just shone and a very strong family unit was nice…"- Elementary clinician, focus group

"The benefits included a greater understanding of the culture, plight, and norms of the group of girls we had participating in the group. I was incredibly humbled by their experiences and the attitudes they have regarding these. While the group built upon their resiliency, I learned that they are and have been resilient throughout their pre-migration, migration, and post. I was also moved by the strength of the family relationships and their reliance on faith/beliefs to guide them through challenging times."- Secondary clinician, implementation survey

Finally, observations made by school mental health leads echoed similar benefits for clinicians, and included expanding their professional skill set, job satisfaction that resulted from having the opportunity to implement the STRONG program, and advantages from pairing up with a colleague to work together.

"…the clinicians thrived even in a situation that was less than perfect for them…they were energized and excited and they valued the opportunity to do that learning and to make the connections to other clinical work that they've done. They're looking for more opportunity to do more..." –Mental Health Leader, interview

"Well I think they rarely get a chance to work together, and I hear and have seen great value in them pairing up together…I think for them that broadened their skill set. Whenever you can work with someone your learning is exponentially increased."- Mental Health Leader, interview

Recommendations for Future Evaluation

Clinicians were asked on the implementation survey to identify possible outcomes for future evaluation. Not surprisingly, their responses echoed the impacts that they observed and corresponded with skills and strategies, community and connection, and self-concept (see Figure 6).

Figure 6: Recommendations for outcomes to measure in evaluation

Skills and strategies	Ability to learn about thoughts, feelings and actions.
	Development of relaxation and coping strategies.
	Ability to manage stress and recognize its impacts; improvement in self-regulation (incl. anxiety and anger management).
	Increase of English vocabulary about Mindfulness strategies; Participating in opportunities to practice mindfulness exercises.
Community / connection	Sense of belonging in the school community; Interest in joining other school based activities/community events.
	Students felt that they were heard and that their story is important, whether they chose to share their past or their Canadian journey.
	Sense of belonging increased.
Self-concept	Understanding their inner strengths and how resilient they are.
	Normalization of responses as compared to their experiences now as opposed to prior to the group.
	Enhanced ability to recognize personal strengths and abilities.

A word cloud of clinicians' responses puts students at the centre and emphasizes the importance of both a strengths-based approach and one that emphasizes connectedness (see Figure 7).

Figure 7: *Word cloud reflecting outcomes that clinicians think should be measured in future evaluations of the STRONG program*

Key lessons

Over the course of this report we have presented our findings first by the stage of implementation and subsequently summarized by feasibility domain. In this section we identify 10 lessons emerging from the pilot data:

1. **There is a clear need for a resilience-focused program for newcomer students and the STRONG program was an excellent fit in general.** There was a lot of enthusiasm for the program among clinicians, and many indicated that they felt the program gave them tools to provide support to a group that they had previously had trouble supporting.
2. **Although there were many program components that were beneficial, clinicians felt that the opportunity for students to share their migration stories in a safe and supportive environment was really important.** According to clinicians, some students had never shared their stories before. For some students, sharing their stories and having clinicians help them identify their strengths changed their image of themselves in a positive direction.
3. **Starting earlier in the year is crucial.** An earlier start would provide adequate time for engaging families, recruiting and obtaining consent, and providing some flexibility for re-scheduling sessions when external influences intrude. It would also give individual clinicians the opportunity to extend beyond ten sessions if they chose to do so.
4. **Some activities and concepts did not work well with some groups.** There were no criticisms of the program that were uniform across ages and groups; however, some groups did have challenges with some activities. More pilot groups are needed to gain a clearer picture of the range of responses to different concepts and make modifications.
5. **Homework was generally not successful as a home-based written activity**. Students mostly did not complete written work between sessions, but did engage in practice. Homework / practice was more successful at the secondary school level. Many facilitators incorporated practice review into sessions.
6. **Relationships are key for successful implementation.** Different relationships were key throughout the implementation process: relationships within the school for recruitment or possible co-facilitation, and relationships with community for buy-in.
7. **Group composition matters**. Some of the challenges clinicians shared were related to group characteristics. In general clinicians indicated that a small group was preferable (i.e., 5-6 students). Decisions about mixed or uniform gender and country of origin groups should be made with reference to therapeutic needs and of school and community preference. Students with Tier 3 needs might present additional challenges for group process.
8. **Clinicians described significant benefits to co-facilitation**. Although not all pilot groups involved more than one clinician, those who had a co-facilitator greatly appreciated the support. Clinicians worked with other clinicians, but also with other school personnel to deliver the program. They described benefits for the group and also personally, in terms of the opportunity to learn with and from a colleague.

9. **Decisions around language are important**. The decision whether or not to utilize interpreters may in part depend on resources available at different school boards. However, decisions about language of the group will have implications for who can participate (i.e., whether student will have to be proficient in English, whether students will need to be from all one language group). Requiring interpretation can slow the group down, which might make a small group size even more important or require extra sessions. As more groups are offered, the consideration about language for the group can be explored further.
10. **The STRONG program requires intentional systems support.** To be successful the program requires administrators and other teachers to understand the importance of the intervention and facilitate students' attendance. Schools need to be able to offer a consistent and private space. Finally, some financial resources to offer food and other materials to participants can enhance the whole group experience.

Summary

This report presents our findings of the spring 2018 STRONG pilot in ten schools. Despite extremely tight timeframes, the pilot had many successes.

> *"The biggest successes in my opinion would be having the courage to dip our toe into this as a province, to really acknowledge that newcomers require a unique approach of intervention, for us to think deeply, to reach out and collaborate with experts in the US who have done this work, to develop relationships, and think together about it. The work is complex and multilayered and we need to work collaboratively. I think that it has been a huge success. I think that the partnerships and the collaboration, bringing Western onboard, speaks to how far we've come as a province to be meeting the needs of students and families. Other successes would be an opportunity for training clinicians, to be able to learn from experts to think differently about their practice, to help educators to think differently about children and behavior that we're seeing. There's great richness in this work."* –Mental Health Leader, interview

As described by the mental health lead in the quote above, participants felt that the STRONG program met an important need that had been identified by the schools. Overall clinicians recognized the complexity of the work and saw room for improvement in both the program and the implementation processes. Despite some challenges, clinicians felt that the program basics were a good fit with the needs of the students and appreciated having something specific in their toolkit for newcomer students.

Appendix A: Anchors for clinician ratings

Student Engagement, Practice and Clinical Functioning Ratings

Student Name	Engagement Rating (1-5)	Practice Rating (1-3)	Clinical Rating (1-5)

Engagement Ratings:

1 Refused to participate in the activities.

2 Did not contribute to discussions but went through the motions of activities. Child was co-operative but it was difficult to determine their level of understanding and insight due to minimal participation.

3 Minimal contributions to discussions, but contributions during activities were on topic.

4 Verbal contribution to discussions and participation in activities clearly showed an understanding of the topic.

5 Several verbal contributions to the group discussion and participation in activities that showed an understanding of the topic. Child also showed personal insight, meaning they related the topic to their own life in some way

Practice Ratings:

1 Did not complete / practice assigned activity.

2 Somewhat completed / practiced assigned activity.

3 Practiced / completed assigned activity.

Clinical Ratings:

1 Demonstrating signs of distress

2 Appears flat or sad but not overtly distressed

3 Neutral affect

4 Some positive affect

5 Positive affect and signs of optimism / hopefulness

References

[i] Tebes, J. K., Thai, N. D., & Matlin, S. L. (2014). Twenty-first century science as a relational process: From Eureka! to team science and a place for community psychology. *American Journal of Community Psychology*, *53*(3-4), 475-490.

[ii] Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., ... & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine*, *36*(5), 452-457.

[iii] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, **38**, 581-586.

[iv] Goodman R, Meltzer H, Bailey V (1998) The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, **7**, 125-130.

[v] Woerner, W., Fleitlich-Bilyk, B., Martinussen, R., Fletcher, J., Cucchiaro, G., Dalgalarrondo, P., ... & Tannock, R. (2004). The Strengths and Difficulties Questionnaire overseas: evaluations and applications of the SDQ beyond Europe. *European Child & Adolescent Psychiatry*, *13*(2), ii47-ii54.