



**2017-
2020**

*Supporting Transition Resilience of
Newcomer Groups (STRONG)*

Development & Research Case Study

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 Knowledge into Action
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Executive Summary

STRONG (Supporting Transition Resilience of Newcomer Groups) is a school-based Tier-2 intervention for newcomer students who have a refugee or immigrant background. STRONG helps these students adjust to life in Canada. Before STRONG, there were no strengths-based Tier-2 interventions for newcomer students.

STRONG development

STRONG was co-developed by Dr. Sharon Hoover (National Center for School Mental Health) and School Mental Health Ontario (SMHO) with input from newcomer communities and clinicians working with newcomer students in schools.

STRONG research

Initial research shows STRONG helps newcomer students to:

- learn important coping skills
- enhance their resilience
- develop a sense of belonging and
- meet peers and make friends

In addition to positive student outcomes, research shows clinicians report professional and personal benefits from being involved with STRONG.

During the 2019-2020 school year, SMHO implemented STRONG more broadly. They created and refined implementation supports and translated the STRONG manuals and supports into French. Current research examines the impact of the STRONG program and the value of the expanded implementation supports.

Lessons learned about STRONG training:

- Tailored, hands-on training helps even the most experienced clinicians
- Speakers who have lived experiences or have expertise with newcomers strengthen the training sessions
- Guidance on how to integrate anti-oppressive practices into mental health programming would help clinicians in schools

Lessons learned about STRONG implementation:

- Relationships are key to successful implementation
- Programs need buy-in at the school level
- Clinicians need support to build referral pathways
- Language is a critical consideration and there is no one way to approach it
- Clinicians greatly appreciate having a co-facilitator

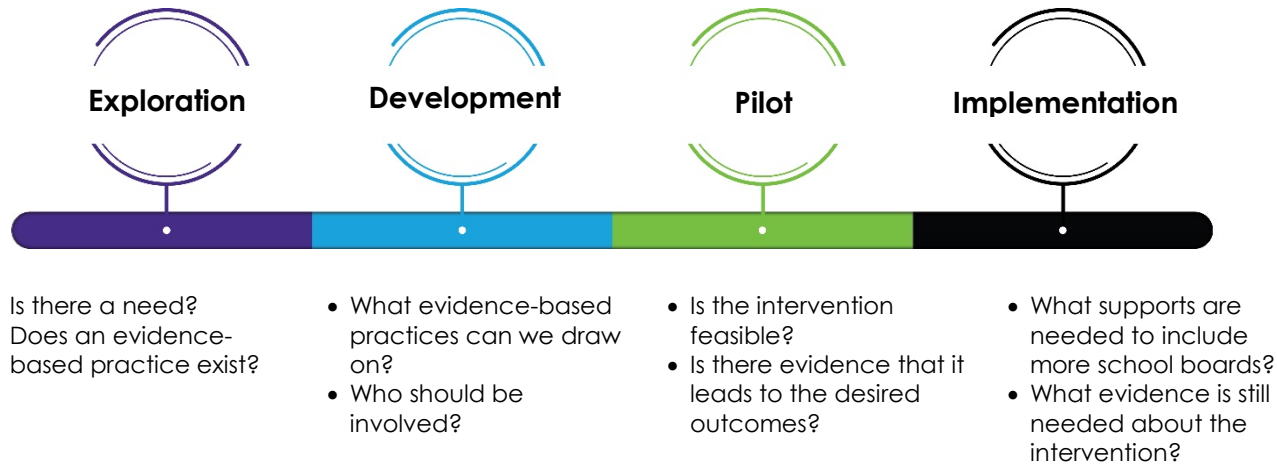


Lessons learned about STRONG research:

- Using mixed methods is essential
- Hearing from youth is crucial
- Collecting feedback at every stage may overwhelm clinicians with tasks
- Seeking input from clinicians about measuring outcomes is valuable
- Navigating research applications for multiple school boards is challenging

Phases of Development and Research

This case study addresses four phases of the STRONG project as described below:



Phase 1: Exploration

Ontario schools experienced a substantial increase in newcomer students in recent years, in part due to the federal government's refugee settlement initiative during the Syrian crisis. According to Immigration, Refugees and Citizenship Canada, nearly 100,000 refugees resettled in Canada. Just under half (43%) were under age 18 (The Child and Youth Refugee Coalition, 2018). Statistics indicate many newcomer students in Canadian schools have experienced multiple adversities and may continue to experience distress upon arrival in Canada (Ellis, Murray, & Barrett, 2014).

Establishing a need. During the 2015-2016 school year, the Ontario Ministry of Education asked School Mental Health Ontario (SMHO) to monitor and address the mental health needs of students arriving in Ontario schools from Syria. As part of this effort, SMHO created a School Mental Health Newcomer Advisory Network and a School Mental Health Newcomer Resource Team. Approximately 30 Mental Health Leaders and Superintendents met regularly to (a) monitor school and student responses and (b) identify needed resources and supports. The team helped develop Tier 1 supports, including an InfoSheet and professional learning video for educators, and a detailed guidance document for school mental health professionals.

Over time, some students with refugee backgrounds began to show more challenges at school and Mental Health Leaders requested additional support for these students. SMHO worked with the Centre for Addiction and Mental Health (CAMH) to provide access to a 25-hour online course for mental health professionals. They also co-designed and co-delivered a full day workshop on the topic *Immigrant, Refugee, Ethnocultural and Racialized School Mental Health*. Equipped with this knowledge, school mental health professionals began to request practical tools for intervention support with newcomer students.

Key Point: Ontario schools needed a Tier 2 intervention to address the unique needs and struggles of newcomer students.

Exploring options. SMHO worked closely with Dr. Sharon Hoover from the National Center for School Mental Health to explore options to address newcomers' needs. They looked at (a) evidence-based strategies for newcomer students, and (b) evidence-based strategies for addressing trauma and distress.

Evidence-based strategies for newcomer students. There are very few examples of evidence-based mental health interventions for newcomer students who have experienced multiple adversities (Fazel, 2018). Programs that do support the mental health needs of newcomer youth rely primarily on cognitive behavioural strategies (Murray, Davidson, & Schweitzer, 2010; Sullivan, & Simonson, 2016; Tyrer & Fazel, 2014).

Evidence-based strategies for addressing trauma and distress. There are some evidence-based strategies for school-based intervention addressing trauma and distress. One example is Cognitive Behavioural Intervention for Trauma in Schools (CBITS; Jaycox, Kataoka, Stein, Langley, & Wong, 2012). CBITS is a school-based group intervention for multi-ethnic youth exposed to traumatic, stressful, and violent events. Because CBITS aims to reduce symptoms of trauma and depression, youth must experience at least moderate levels of trauma and depression to be eligible to participate (Allison & Ferreira, 2017). However, leaders in the field of refugee mental health caution against delivering services based on a Westernized trauma model with youth who have refugee backgrounds (Bracken, 2002; Summerfield, 1999). Trauma models that assess for and treat trauma psychopathologies (such as post-traumatic stress disorder) may emphasize individuals' lingering and severe stress reactions to a traumatic event, without acknowledging external post-trauma factors or individuals' resilience and coping skills (Gozdziak, 2004). Rather than focussing on trauma-processing, strength-based interventions for refugee youth should foster strength, capacity, and resilience (Murray, Davidson, & Schweitzer, 2010; Papadopoulos, 2007).

Key Point: The exploration phase revealed there were no evidence-based interventions focussed on promoting resilience and coping skills among newcomer students.

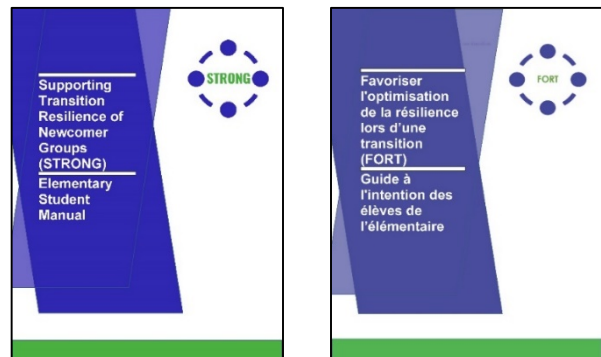
Phase 2: Development Phase

In response to the identified need and lack of current options, Dr. Hoover (National Center for School Mental Health) led the co-development of STRONG (Hoover, Bostis, Orenstein, & Robinson-Link, 2019) for SMHO. The intervention was developed using:

- current literature on school-based mental health interventions
- input from stakeholders with lived refugee and immigration experiences, and
- input from clinicians working with newcomer students in schools

Description of STRONG Intervention. The STRONG intervention aims to strengthen newcomer students' resilience following their transition to Canada. Specifically, STRONG was designed to promote individual strengths and coping skills and foster a positive sense of self and belonging. The manualized intervention includes ten group sessions and one individual session.

STRONG manuals. STRONG includes separate manuals for elementary (kindergarten to grade 8) and secondary (grades 9 to 12) students. Core concepts are similar across the two manuals, with adaptations to match participants' developmental stage. For example, the primary manual uses more pictorial content and the secondary manual includes more higher-order thinking activities.



Group sessions. All group sessions begin with warm-up activities that promote connectedness, social inclusion, and cultural identity. Examples of warm-up activities include identifying commonalities, sharing rituals, and describing traditions. Sessions draw on cognitive-behavioural approaches that are effective with school-based intervention for trauma in general (Allison & Ferreira, 2017) and with refugee and immigrant students in particular (Sullivan & Simonson, 2016; Tyler & Fazel, 2014). Students practice their newly learned skills during and between sessions. Example coping skills include relaxation, measuring and managing distress, and cognitive coping.

Individual sessions. As part of the intervention, clinicians facilitate an individual session with each STRONG participant. Rather than focussing on one trauma, the individual session helps students process their journey narrative. During the session, clinicians ask students a series of questions to elicit students' experiences in their home country, during migration, and post-migration. Clinicians help students tell their stories in a way that is cohesive and focused on strengths. They support students in choosing part of their narrative to share with the group. Clinicians also screen students for PTSD during the session and make referrals to community-based services as indicated.

Meetings with parents and educators. As part of the STRONG intervention, clinicians can facilitate parent and educator meetings, as appropriate.

Key Point: The STRONG intervention is a group-based, manualized approach that aims to strengthen newcomer students' resilience following their transition to Canada.

Phase 3: Year 1 & 2 Pilot and Evaluation

In the spring of 2018, clinicians from two pilot school boards received training in the STRONG intervention. At the same time, the feasibility and implementation evaluation began. Dr. Claire Crooks and her team at the Centre for School Mental Health (CSMH) at Western University led the evaluation in partnership with SMHO, the National Center for School Mental Health in the United States (and some of their partners), and the school boards involved in the pilot. All evaluation protocols were approved by Western University's Research Ethics Board. The CSMH team also obtained research approval from all school boards involved in the evaluation.

In the first year, clinicians and school mental health leaders gave feedback on training, feasibility, and implementation (Crooks, Hoover, & Smith, in press). In addition, the initial impact of the program was evaluated. The year-one evaluation used a mixed-methods approach grounded in a perspectivism framework, which recognizes the importance of contexts and enlists partners as co-producers of knowledge. Data were collected from clinicians through training feedback forms, an implementation survey, and a post-program focus group. Clinicians also provided session tracking data, and rated student engagement and affect at each session. In addition, mental health leaders from participating boards were interviewed individually.

In the second year (2018-2019), one school board (six STRONG groups) participated in further pilot evaluation. This evaluation was expanded to include youth participants; STRONG participants were invited to complete pre- and post-surveys and share their perspectives through student focus groups (with parent/guardian consent).

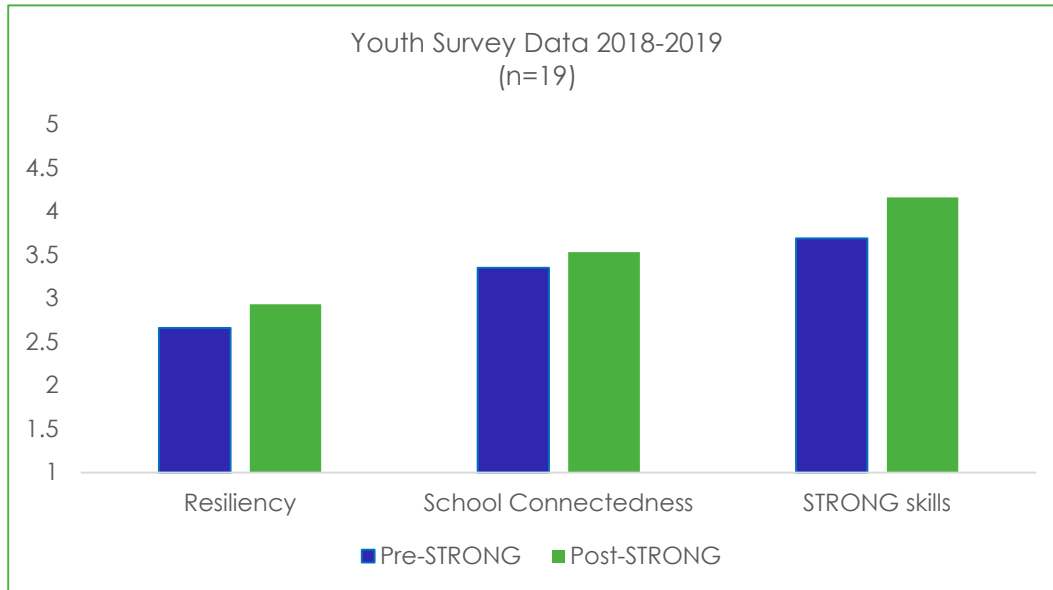
Summary of Findings from Pilot.

Intended Outcomes: Student Impact

Findings from the first two years of the pilot indicated that the STRONG program helped newcomer students build trust, increase confidence, and develop a sense of belonging. STRONG participants demonstrated statistically significant improvements in resiliency and coping skills (n=19). Skills taught in the program included managing thoughts, feelings, and actions; reducing stress; practicing relaxation; and listing steps to achieve goals. In the focus groups, students described STRONG as a welcoming group where they met other newcomer students, socialized, shared stories, and strengthened peer connections. Some students said the STRONG group provided an encouraging environment to practice English.

"As a newcomer, you have a lot of negative thoughts, a lot of situations with people you don't even know, you've never even met before, you've never been in this community before. But the program is welcoming you and giving you more helpful thoughts and gives you examples." - Student participant

“The coping skills are what will stay with you forever. Whenever you are in a stressful situation, you will always remember what to do, and what advice they gave you on how to handle situations, look at it from a different point of view, and how to make yourself stronger.” - Student participant



Unexpected Outcomes: Benefits for Clinicians

Although the evaluation was designed to measure intended student outcomes, the findings from the pilot revealed some unexpected professional and personal benefits for clinicians who implemented the STRONG program. Clinicians reported increases in knowledge and self-efficacy to work with newcomer students after STRONG training. They felt confident STRONG offered an evidence-informed approach that they could use with students who needed significant support. They appreciated learning from and with other professionals involved in the implementation, both within and outside individual schools. Among personal benefits, clinicians enjoyed learning from students about their cultures and journeys, and they felt awe at uncovering the students' resilience.

“It is always great to learn from our students, to be able to discover with them their inside skills or resilience and to see them bloom. It is especially rewarding when the ESL teachers talk of the changes they have seen. I particularly like learning about their cultural rites, customs and traditions.” – STRONG clinician

“Confirmation that it is the relationships you build vs the content...that is most important. Content is also good, and it helped professionally to have this template as a model for other similar groups.” – STRONG clinician

Key Point: The feasibility and implementation evaluation showed STRONG had a positive impact on newcomer students *and* mental health clinicians.

Phase 4: Year 3 Implementation and Evaluation

Following two years of successful piloting, SMHO implemented STRONG more broadly during the 2019-2020 school year. Because interventions with newcomer students are most successful when stakeholders are engaged and implementation supports are available (Crooks, Smith, Robinson-Link, & Orenstein, 2020), SMHO and the development team refined and created additional implementation supports. For example, SMHO

- arranged three community of practice calls for STRONG clinicians to consult with STRONG developers
- invited mental health leaders and program managers to join regular calls with SMHO to seek support, share experiences, and problem-solve implementation challenges
- developed French versions of the STRONG manuals (i.e., FORT: Favoriser L'optimisation de la Résilience lors d'une Transition)
- translated all training and support materials into French
- hosted STRONG training in English (in late 2019)
- hosted bilingual French/English STRONG training (in early 2020)

Evaluating Effectiveness and Implementation Supports

More boards, including a French-language board, joined the evaluation during the 2019-2020 school year. Eleven boards indicated an interest in STRONG; eight were willing to review an external research application. Due to labour contract issues, several boards delayed their research review. At the time of clinician training, five boards had given research approval. However, one board could not send anyone to the training, and another could send only mental health leaders.

In year 3, the evaluation team added the following measures to the evaluation:

- a revised referral form
- a measure of social alienation
- questions on the clinician implementation survey to measure the acceptability and utility of the implementation support materials, and
- focus group questions asking for clinician feedback on the expanded implementation supports

Ultimately, the COVID-19 pandemic interrupted programming and data collection during the 2019-2020 school year, through school closures. It is anticipated that the same research protocol will be used in the 2020-2021 school year, assuming schools are operating as usual.

As STRONG scales up, the evaluation team will continue to collect data on additional supports that clinicians need to successfully implement the program in schools.

Lessons Learned

Over the course of the first 3 years of STRONG, clinicians, researchers, and other stakeholders have identified numerous lessons related to training, implementation, and research. Key lessons are described below.

Lessons learned about training:

Tailored, hands-on training helps even the most experienced clinicians

As a group, clinicians during the first two years of piloting were highly experienced and most indicated they had previous training in CBT approaches. Some even had trauma-focused CBT training. Nonetheless, *all* clinicians rated the training highly and identified gains in skills and knowledge. They appreciated walking through the manual step-by-step and practicing activities. They also actively discussed possible implementation challenges and brainstormed potential strategies at the training sessions.

Speakers who have lived experiences or have expertise with newcomers strengthen the training sessions

Training sessions included speakers who were newcomers, or worked with newcomers, and were of similar cultural background to their clients. These speakers helped set the stage about newcomer experiences in Canada. In the third year, the trainers expanded this section to include more information about different pathways to Canada and the consequences. Clinicians greatly appreciated this part of the training.

Guidance on how to integrate anti-oppressive practices into mental health programming would help clinicians in schools

Clinicians have a growing awareness of the need for equity in mental health programming, and they asked trainers how to apply an anti-oppressive stance in the STRONG program. These questions led to fruitful group conversations at the training sessions. In year 3, the research team added questions about anti-oppressive practices to the implementation survey and clinician focus groups. The data will be used to generate a list of clinician-identified anti-oppressive strategies.

Lessons learned about implementation:

Relationships are key to successful implementation

Different relationships were key throughout the implementation process. Relationships within the school were necessary for recruitment, possible co-facilitation, and finding space and time in the school to run the program. Additionally, relationships with communities were critical for buy-in. Relationships with settlement workers, guidance counsellors, and English Language Learner educators were all important for success.

Programs need to build buy-in at the school level

For successful implementation, STRONG clinicians need administrators and teachers to understand the importance of the intervention and to facilitate students' attendance. During the pilot implementation, many students received messages from their teachers that undermined their participation in STRONG (mostly due to concerns about missed

instructional time). Schools must offer a consistent and private space for STRONG sessions. Finally, some financial resources to offer food and other materials to participants can enhance the whole group experience.

Clinicians need support to build clear and consistent referral pathways

During the first two years of the pilot, referrals depended largely on the decisions of individuals (e.g., an ESL teacher decided to involve the whole class, and a school administrator selected a group of adolescent boys he found troublesome). In year 3, a more precise referral form was developed, and school boards were encouraged to connect STRONG referral into existing referral pathways and procedures in schools.

Language is a critical consideration and there is no one way to approach it

Decisions about the language of the group will have implications for who can participate (i.e., Must students be proficient in English? Must students be from the same language group?). Requiring interpretation can slow the group down or contribute to disengagement among some students. While some students wished they had more access to interpreters, others identified practicing English in a safe environment as a benefit of STRONG. Some groups had a clinician who spoke the same language as the participants; other groups relied on some peer interpretation; still others hired an interpreter. Hiring interpreters for STRONG sessions may in part depend on resources available at different school boards.

Clinicians greatly appreciate having a co-facilitator

Although not all pilot groups involved co-facilitators, some clinicians worked with other colleagues or school personnel to deliver the program. Those who had a co-facilitator greatly appreciated the support. They described benefits for the group and personally, given the opportunity to learn with and from a colleague. Teams that included both a social worker and psychologist expressed benefits from being able to work with a colleague from a different discipline.

Lessons learned about research:

Using mixed methods is essential

Using mixed methods is always good practice in research. Given the lack of validated measures for newcomer students, a mixed method approach was particularly important in the pilot evaluation of STRONG. Collecting quantitative and qualitative data from multiple perspectives allowed researchers to triangulate the results and build confidence in the findings. The evaluation team will continue to use a mixed method approach to evaluate STRONG in the future.

Hearing from youth is crucial

Youth focus groups brought an important perspective through youth voice. However, hosting focus groups in English may have limited the extent to which some students could share their perspective. In year 3, the STRONG evaluation team intends to conduct some student focus groups in languages other than English and to have multi-lingual co-facilitators.

Collecting feedback at every stage may overwhelm clinicians with tasks

During the first two years of the pilot, STRONG evaluators used a variety of measures to collect data at every step of the process. Clinicians completed weekly feedback sheets and student ratings. Clinicians were also the gatekeepers for youth data: they facilitated consent and assent as needed. Some Quality Improvement (QI) measures were completed regardless of youth involvement in research, other measures were research-focused, and in some cases QI measures were shared with the research team (if consent was obtained). This multifaceted approach resulted in an incredible amount of useful and actionable feedback. However, the complexity of reporting was a huge burden for clinicians. In some cases, administration errors made some data unusable.

Drawing on clinicians' expertise about measuring outcomes is valuable

In the first year, some students completed Strengths and Difficulties Questionnaires (SDQ) as QI measures, and clinicians gave weekly ratings for students' affect on a scale of 1 to 5 (based on explicit rating criteria). Through the implementation survey, evaluators asked clinicians what outcomes they thought should be measured (i.e., where did they really see changes?). Their responses indicated the SDQ was not an ideal measure because it did not capture the type of challenges experienced by newcomer students. Similarly, the affect rating scale did not capture students' needs or gains well. In comparison, clinicians identified *resilience* and *connectedness* as key outcomes. Subsequently, measures for these outcomes were added in year 2.

Seeking consent for research versus consent for programming adds complexity

In the first year, all participants under 18 required guardian consent to participate in the program and the research. As a result, clinicians had an opportunity to review the research consent forms at initial parent meetings, either individually or in a group. Interpreters were available for these meetings. In the second and third year, some boards began allowing youth to consent to their own services. This autonomy for youth reduces barriers to service. However, not requiring guardian consent for services means clinicians might not meet with all guardians. When youth access services without confiding in their guardians, seeking guardian consent for the research component would be inappropriate.

Navigating research applications for multiple school boards is challenging

The research team encountered many challenges with board research applications. Across school boards, research application processes differ widely, and the sequencing of approvals is tricky. University approval is required before a school board is approached. If a school board requests even a minor change, the changes must be approved by the university ethics committee as an amendment. This back and forth can lead to multiple versions of the same consent form. In some cases, research departments seemed to conflate the intervention with the research and rejected the research application because of objections to the intervention (which had already been adopted by their board's mental health leaders). During the 2019-2020 school year, challenges with contract negotiations made research application processes even more difficult; many boards suspended their review processes completely.

References

- Allison, A. C., & Ferreira, R. J. (2017). Implementing cognitive behavioral intervention for trauma in schools (CBITS) with Latino youth. *Child and Adolescent Social Work Journal, 34*(2), 181-189.
- Bracken, P. J. (2002). *Trauma: Culture, meaning and philosophy*. Whurr Publishers: London.
- Crooks, C. V., Hoover, S., & Smith, A. (In press). Feasibility trial of the school-based STRONG intervention to promote resilience among newcomer youth. *Psychology in the Schools*.
- Crooks, C. V., Smith, A. C. G., Robinson-Link, N., Orenstein, S., & Hoover, S. (In press). Psychosocial interventions in schools with newcomers: A structured conceptualization of system, design, and individual needs. *Child and Youth Services Review*.
- Ellis, B. H., Murray, K., & Barrett, C. (2014). Understanding the mental health of refugees: trauma, stress, and the cultural context. In *The Massachusetts General Hospital textbook on diversity and cultural sensitivity in mental health* (pp. 165-187). Springer New York.
- Fazel, M. (2018). Psychological and psychosocial interventions for refugee children resettled in high-income countries. *Epidemiology and Psychiatric Sciences, 27*(2), 117-123. doi:10.1017/S2045796017000695
- Gozdziak, E. M. (2004). Training refugee mental health providers: Ethnography as a bride to multicultural practice. *Human Organization, 63*, 203-210.
- Hoover, S., Bostic, J., Orenstein, S., & Robinson-Link, N. (2019). *Supporting Transition Resilience of Newcomer Groups (STRONG)*. Ellicott City, MD: Hoover Behavioral Health, Inc.
- Jaycox, L. H., Kataoka, S. H., Stein, B. D., Langlely, A. K., & Wong, M. (2012). Cognitive behavioral intervention for trauma in schools. *Journal of Applied School Psychology, 28*, 239-255.
- Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry, 80*(4), 576-585. doi:10.1111/j.1939-0025.2010.01062.x
- Papadopoulos, R. K. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling, 9*, 301-302.
- Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. *PloS one, 9*(2), e89359.

Sullivan, A. L., & Simonson, G. R. (2016). A systematic review of school-based social-emotional interventions for refugee and war-traumatized youth. *Review of Educational Research, 86*(2), 503-530.

Summerfield, D. A. (1999). A critique of seven assumptions behind psychological trauma programmes in war affected areas. *Social Science and Medicine, 48*, 1449-1462.

Additional Resources:

STRONG Annual Reports (2017-2019)

<https://www.csmh.uwo.ca/research/strong.html>

STRONG Website

<https://www.strongforschools.com/>

STRONG Impact Videos

<https://www.strongforschools.com/impact>

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