Disseminating Evidence-Based Preventive Interventions to Promote Wellness and Mental Health in Children and Youth: Opportunities, Gaps, and Challenges

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ABSTRACT

Post pandemic increases in mental illness and waitlists for mental health services highlight the urgent need to prevent and mitigate mental health problems in children and youth living in Canada. We describe current dissemination and implementation strategies of evidence-based preventive interventions (EBPIs) for children and youth in Canada that are designed to improve health and well-being. Based on written case studies from 18 Canadian researchers and stakeholders, we examined their approaches to development, dissemination, and implementation of EBPIs. We also summarized the opportunities and challenges faced by these researchers, particularly in sustaining the dissemination and implementing of their evidence-based programs over time. Typically, researchers take responsibility for program dissemination, and they have created a variety of approaches to overcoming costs and challenges. However, despite the availability of many strong, developmentally appropriate EBPIs to support child and youth mental health and well-being,

systemic gaps between their development and implementation impede equitable access to and sustainability of these resources.

Keywords: mental health, child, youth, prevention, dissemination, implementation

RÉSUMÉ

L'augmentation des problèmes de santé mentale et des listes d'attente pour les services en période postpandémique met en évidence l'urgence de prévenir...Malgré les recherches approfondies visant à mettre au point des interventions préventives fondées sur des données probantes (IPFDP) destinées aux enfants et aux jeunes du Canada, ces interventions ne sont pas suffisamment connues au pays ni mises en pratique pour avoir un impact important sur leur santé et leur bien-être. À partir d'études de cas réalisées par 18 chercheurs canadiens, également auteurs du présent rapport, nous décrivons et discutons des approches qu'ils ont utilisées. Nous cherchons également à établir les opportunités et les défis auxquels les chercheurs sont confrontés concernant la diffusion et la mise en œuvre de ces programmes fondés sur des données probantes. En général, les chercheurs assument la responsabilité de la diffusion des programmes en développant une variété d'approches pour surmonter les coûts et les obstacles qui y sont associés. Cependant, malgré la disponibilité potentielle de nombreuses IPFDP solides et adaptées au développement pour soutenir la santé mentale et le bien-être des enfants et des jeunes, des lacunes systémiques entre leur développement et leur mise en œuvre entravent un accès équitable à ces ressources de même que la pérennité de ces dernières.

Mots clés : santé mentale, enfant, jeune, prévention, diffusion, implantation

Mental health concerns are increasing consistently in Canadian children and youth (Findlay, 2017; Gandhi et al., 2016). Decades of research have demonstrated that evidence-based preventive interventions (EBPI) for mental health promotion or for the prevention of mental health problems can and do have important impacts on mental health (Mental Health Commission of Canada, 2016). These include building resilience and social skills, improving academic performance, reducing symptoms of depression and anxiety, and reducing risks for bullying, peer violence, aggression, and substance use (Catalano et al., 2012). However, systemic barriers exist for the equitable and effective dissemination and implementation of EBPIs that impede the benefits of investments in EBPIs (Biglan, 2018; Parra-Cardona et al., 2021).

EBPIs include a continuum of interventions ranging from large-scale efforts designed for children or youth populations (universal preventive interventions) to targeted efforts to reduce risks or increase protective factors for individuals showing early signs of problems. EBPIs have consistently been shown to improve health and well-being by identifying risk and protective factors and evaluating the effectiveness of interventions in controlled conditions (Mental Health Commission of Canada, 2016). Considerable research and public funding are dedicated to developing and evaluating interventions for children and youth in Canada; however, the widespread and sustained scale-up of Canadian programs is rarely achieved. How to best to disseminate or implement EBPIs in real life conditions at a large scale is not well understood (Biglan, 2018).

Dissemination and implementation of EBPIs require enduring partnerships between program developers and local users, typically schools, health clinics, and primary care settings (Fagan et al., 2019). The on-the-ground practices of experts who foster the dissemination of EBPIs in Canada are not known or shared across

projects. In response, this article reports on the experiences of Canadian developers and disseminators of EBPIs. All of these people are recognized as authors of this study and each contributed to, reviewed, and consented to this report. The project was funded by a Social Sciences and Humanities Research Council (SSHRC) Partnership Engage Grant (SSHRC PEG). We describe the experiences of 18 researchers from across Canada who are involved in the development, dissemination, and implementation of EBPIs designed to improve the mental health of Canadian children and youths. Together we aim to illuminate opportunities and challenges they experience and to make recommendations for moving forward to improve access to and implementation of preventive interventions.

The questions guiding this research are: What are the on-the-ground dissemination and implementation practices of program developers? How do existing systems of dissemination and implementation bridge the gaps between program development and evaluation and efforts to disseminate and implement EBPIs in Canada? What opportunities exist and what challenges remain? We start by clarifying definitions used in this discussion and briefly review available literature on the dissemination of EBPIs in Canada and the United States.

Definitions: What is an Evidence-Based Mental Health Promotion or Preventive Intervention?

Preventive interventions can be universal (primary) or targeted (secondary). The terms mental health promotion and mental health prevention are often used interchangeably (Manwell et al., 2015). According to Watson and McDonald (2016), "MHP [mental health promotion] can be thought of as an umbrella term that includes actions to promote mental wellbeing, to prevent mental illness, and to improve quality of life for those living with mental health problems" (p. 9). In contrast, preventive interventions typically address malleable risk and protective factors (e.g., reducing peer bullying or aggression, improving parenting, resisting substance use) that are associated with the development of mental or physical health problems.

From a scientific perspective, EBPIs are manualized interventions or strategies that can be implemented with fidelity and have been systematically evaluated using scientific methods to collect evidence that demonstrate their impacts on defined outcomes. In the context of child and youth mental health, universal EBPIs are often implemented in partnership with staff in schools or communities. In contrast, targeted preventive interventions are implemented following referral for a child, youth, or family that is showing risks for developing problems (e.g., children with behavioural problems such as early aggression). "Upstream" universal or targeted preventive interventions are distinct from early identification or treatment interventions. Both are also distinct from information platforms or research-informed websites that aim to provide knowledge to users. See Table 1 for a summary of definitions.

Dissemination and Implementation

The intent of dissemination is to strategically communicate information to targeted stakeholders (e.g., policymakers, advocacy groups, school leaders, front-line providers, families, and communities) with the goal of "changing awareness, knowledge, perception and motivation" of change agents engaged in implementing high quality services (Baker et al., 2021, p. 791). The development, dissemination, and implementation of EBPIs involves recurring steps or stages, that evolve with the changing and expanding

Table 1

Definitions

Preventive interventions	Address malleable risk and protective factors (e.g., reducing peer bullying or aggression, assisting parenting, resisting substances) that are associated with the development of mental or physical health problems.
Evidence-based preventive interventions (EBPI)	Comprise manualized interventions or strategies that can be implemented with fidelity and have been systematically evaluated using scientific methods to collect evidence that demonstrate desired outcomes.
Universal preventive interventions	Target the prevention of wide-spread societal concerns and their risk and protective factors (e.g., social and emotional competence, bullying, stress-related anxiety, and mental health literacy) and aim to reach large population groups, such as all children in a school. These are designed to be delivered by educators or school counsellors, assisted by EBPI developers.
Secondary or targeted preventive interventions	Target children or youth who show risks for developing a specific negative mental health or behavioural outcome. *Targeted preventive interventions* have eligibility criteria for participation and are delivered to children and youth with an identified need (e.g., conduct problems or substance use) often in mental health organizations, but also in school settings.
Early intervention	Treat children and youth when they first start to show symptoms of a specific mental health disorder (e.g., anxiety, psychosis).
Information platforms	Provide access to knowledge about a topic (e.g., mental health promotion, concussions, and mental health disorders, etc.) to specific audiences (coaches, educators, parents, and youth). May also provide portals to services.
Dissemination	Active approaches that distribute evidence-based information "to 'intervention targets' using predetermined channels and strategies of communicating compelling and persuasive information. …effective dissemination requires active, purposeful strategies for spreading information to specific target audiences" (Baker et al., 2017, p. 2).
Implementation	Active methods to promote the systematic uptake of evidence-based practices by users. Implementation strategies operate together to affect program delivery and include measurable implementation outcomes, such as fidelity; dosage; quality, participant responsiveness, acceptance; costs, differentiation from other strategies; adaptations or modifications, and monitoring (Berkel et al., 2017; Proctor, 2013).

contexts of collaborators. Initial stages include assessing needs, clarifying objectives, creating a manual of the intervention strategies, developing training protocols, and enhancing local readiness and uptake. Stages of dissemination and implementation involves testing and assessing the feasibility of EBPIs in intended settings. Subsequent steps include evaluation of the efficacy and effectiveness of the intervention on specified program outcomes under researcher-controlled conditions that rely on the reproducibility of these steps. EBPIs may be subsequently adapted, implemented, and further evaluated in complex real-world settings (Gottfredson et al., 2015; Indig et al., 2018). The discussion among program developers and disseminators that is reported here is based on a shared understandings of these "stages" and language.

EBPIs for Child and Youth Mental Health and Well-Being in Schools and Communities

With the demand for individual, face-to-face mental health treatments increasing beyond the capacity of available services, new approaches for delivery of integrated mental health services and preventive interventions are needed (Wolk et al., 2022). Key factors for effective dissemination and implementation of EBPIs include engaging key stakeholders or rightsholders, examining the fit of resources, and balancing local knowledge, capacity, and expertise with the implementation requirements. Adding mental health and prevention services into school or community settings can be difficult. Overarching barriers include challenges with workforce capacity, competing priorities, physical space, and financial considerations for offering mental health services when they have not traditionally been a part of the service (Wolk et al., 2022).

Disseminating and Implementing EBPIs

Not surprisingly, all provinces and territories are struggling to meet the increasing mental health needs of children and youth in their jurisdictions. In Canada, as elsewhere, healthcare costs for the treatment of physical health concerns absorb most health resources. Mental health promotion and risk prevention efforts can also face barriers at federal and provincial or territorial levels that stem from lack of support for a culture of prevention or "upstream" services. The dissemination and implementation of EBPIs are typically funded by time-limited federal research grants, and (in contrast to pharmaceuticals or medical innovations) there are no national, provincial, or territorial, infrastructures or sustainable funding strategies that can review the efficacy or support the dissemination and implementation of EBPIs. The delivery of child and youth mental health promotion, prevention, and healthcare by independent ministries including health, education, child welfare and protection, substance abuse and mental health, and juvenile justice also can create silos, duplication, inequities, and competition for funding.

Establishing developmentally and culturally appropriate systems or organizations that streamline pathways for the dissemination and implementation of existing EBPIs requires a better understanding of current successful practices and barriers. Advances in the integration, oversight, and widespread use of selected EBPIs have been made through the establishment of infrastructures connecting to schools in some provinces (e.g., Child Health Manitoba). In Ontario, a centralized intermediary organization (School Mental Health Ontario [SMHO]) supports the dissemination of EBPIs in schools, with funding going directly to school districts. Other intermediary organizations work to disseminate information about EBPIs to schools (e.g.,

Centre de transfert pour la réussite éducative du Québec (CTREQ), Institut national de la santé publique du Québec (INSPQ), Humanov-is (Social and Community Innovation).

The need for bridges between developers and users of innovations is well recognized in the US. For example, the National Center for Advancing Translational Sciences (NCATS) was established by the US National Institutes of Health (NIH) in 2012 with a mandate to improve and coordinate translational science processes so that funded research would be implemented to improve the health of the public. In an effort to overcome inequities in access to the benefits of research, translational research focuses on understanding how to ensure proven interventions are integrated into practice and policy on a large scale and sustainable across target populations and settings (Spoth et al., 2021; Shelton et al., 2021). Many organizations have been developed as delivery systems for dissemination and implementation of EBPIs, such as community coalitions (e.g., Johnson et al., 2017); the US Center for Disease Control's VetoViolence platform; Communities that Care (Hawkins et al., 2002); university-community partnerships (e.g., Spoth et al., 2021), and collaborations with intermediary organizations (Proctor et al., 2019). These organizations help individual communities engage in prevention and health promotion by empowering them to increase targeted planning, fostering needs assessments and choosing appropriate EBPIs, as well as bringing together local resources and building capacity to target community-defined concerns over a sustained period. Establishing and maintaining collaborations to support child and youth mental health are variously funded by cities or communities, but may also operate through sustained collaborations among community, state, and university-based teams. For example, the Prevention Technology Transfer Network (https://pttcnetwork.org) supports 14 regional services that assist in increasing workforce capacity to deliver preventive interventions. These organizations show promise in enhancing equitable access to EBPIs that can target community concerns and evaluate their widespread impact (Fagan et al., 2019).

To increase knowledge about how EBPIs are currently developed, disseminated, and implemented in Canada, we need to know more about what opportunities and challenges are encountered in the dissemination of these interventions. As a result, we engaged university-based developers of Canadian EBPIs that were designed to promote mental health or to prevent mental illness or behavioral problems in children and youth. We used an open-ended questionnaire to elicit information (that we named "case studies") from the developer of these EBPIs. We focused on interventions that could be categorized as evidence-based *universal preventive interventions* or *targeted preventive interventions*.

METHODS

Because knowledge of the process used to disseminate and advance implementation of EBPIs in Canada typically remains within the research team, we involved developers of EBPIs directly in reporting on their own approaches. The SSHRC PEG grant holders (who are also experts in program development and dissemination) invited 20 developers of EBPIs addressing child and youth mental health across Canada to participate as collaborators in this study. Two did not respond to our invitation. To gather systematic information about the development, dissemination, and implementation of EBPIs, we developed a questionnaire (contact first author) asking each researcher to summarize in writing their (1) approaches to the development and evaluation of the preventive interventions, (2) current practices for dissemination and implementation, (3) challenges and barriers to dissemination experienced, and (4) recommendations for improving the dissemination and

implementation pathways. We also asked each (1) how they continued to operate financially and reach out to potential users, (2) how their programs are accessed and implemented, and (3) how they maintain training, fidelity, and scale-up efforts. Each case study was summarized by the SSHRC PEG researchers and staff (see Tables 2a, 2b, and 3). We also reviewed the interventions' websites to obtain additional information and called researchers when necessary to complete tabled information.

Entries in Tables 2a, 2b, and 3 give an overview of the type of program, dissemination and implementation practices, development costs, and evaluation references. Tables also include website addresses and, where available, references describing how programs were developed and evaluated. Each summary was sent back to the researchers for their review and approval for publication.

Based on responses to the case studies, themes related to opportunities and challenges were identified and agreed on by Walker and Leadbeater. When saturation was reached these themes were summarized and presented to the SSHRC PEG grant holders (listed as the authors on this report). Each reviewed, discussed, and endorsed the identified opportunities and challenges in two online meetings or in writing. Opportunities included the creation of a variety of dissemination efforts and intervention specific partnerships (described below). All developers had created websites to help engage users. Challenges identified differed for universal and targeted interventions. For universal preventive interventions challenges related to sustaining funding for dissemination and implementation, outreach to schools, costs of training, sustaining programs and partnerships for implementation over time. For targeted preventive interventions, reliance on developer teams to disseminate and implement programs, and scale up for widespread access to interventions were cited as additional challenges. Subsequently, all participating researchers endorsed the themes identified.

Several information platforms that are housed on websites were submitted in response to our requests for resources addressing children's mental health. These provide access to research-based mental health information to individuals, parents, and practitioners. Case studies that reflected information platforms, but did not relate to a specific intervention, are summarized in the supplemental information (see Supplements A and B) but were not examined further.

Universal Preventive Interventions

Overview. The EBPIs included school-based prevention programs with a published research base that established their effectiveness; namely, the Fourth R, Healthy Relationships Plus, Mental Health Literacy, MindUP, and the WITS Programs (Table 2A). In the category of universal interventions, we also reviewed examples of widely disseminated programs including Supporting Transition Resilience of Newcomer Youth (STRONG) and Everyday Anxiety Strategies for Educators (EASE) that are not evaluated formally but suggested successful dissemination strategies (see Table 2b) by the British Columbia Ministry of Education.

Table 2a

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Fourth R Format: Whole-school prevention approach; manual-based classroom curriculum and school-wide participation in program. Lessons vary in amount and length depending on which program selected. Language adaptations: English, French, Spanish Cultural adaptations: First Nations; Catholic and non-Catholic curricula Contact: thefourthr@uwo.ca	Build awareness of different types of violence, impacts, and relationship to mental health Improve relationship skills (e.g., communication, help-seeking) Improve peer resistance skills. Support healthy decision-making skills.	Program delivered by: Teachers and community members. Training requirements: Organizations interested in Fourth R can purchase it and arrange training through World Discoveries at Western University. Optional: in-person and online training. Materials can be purchased without training.	Development and evaluation costs: > 5 million from 2004–2018 (sources including CIHR, SSHRC, PHAC, and private donors). Training costs: Online recorded training is free, and in-person is quoted based on the circumstances. Materials costs: E-copy $90 Hard copy curriculum $150 Hard copy curriculum kit $250. No ongoing costs.	Evaluation tools available from Western's Centre for School Mental Health. Program evaluation references: Cluster randomized trial (Wolfe et al., 2009). Cluster randomized trial (Crooks et al., 2015). Observational study on skills development (Wolfe et al., 2012). Cluster RCT in Texas (Temple et al., 2021). Mixed methods longitudinal evaluation on First Nations mentoring (Crooks et al., 2017).

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Healthy Relationships Plus Format: 14-18 one-hour sessions depending on the version. HRP is suitable for universal implementation. HRP-Enhanced addresses more high-risk behaviours, is more trauma-informed, and includes a greater focus on dating violence and harm reduction. Language adaptations: English, French. Cultural adaptations: identity-affirming version available for gender, sexual and romantic minority youth (HRP for 2SLGBTQIA+ Youth). Contact: thefourthr@uwo.ca	Improve healthy relationship skills. Improve healthy coping. Improve help-seeking. Support safety planning skills. Affirm identities (2SLGBTQIA+ version specifically).	Program delivered by: Community members, mental health professionals, public health nurses. Training requirements: Organizations interested in the HRP can purchase it and arrange training through World Discoveries at Western University. Optional: in-person and online training. Materials can be purchased without training.	Development and evaluation costs: > 5 million from 2004–2018 (sources including SSHRC, PHAC, and private donors). Material costs: E-copy $60 Hard copy $100. Training costs: Free asynchronous training available online. Synchronous training is recommended and can be arranged online or in-person for a cost-Training ranges from ½ day to 2 full days depending on the needs and preferences of the organization.	Program evaluation references: Cluster randomized control trial (Exner-Cortens et al., 2020). Pre- post-evaluation (Lapshina et al., 2019). Pilot evaluation on 2SLGBTQIA+ Youth version (Lapointe & Crooks, 2018.

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Mental Health Literacy Format: Varied based on program selected. Target group: Varied based on program selected. Contacts: Andrew Baxter andrew.baxter@albertahealth-services.ca Dr. Yifeng Wei yifeng.wei@ualberta.ca Dr. Wendy Carr wendy.carr@ubc.ca	Provide knowl-edge about common men-tal illnesses and treatments, and how to achieve and maintain good mental health. Reduce stigma about mental illness. Increase help-seeking efficacy.	Program delivered by: Educators. Training require-ments: Educator profes-sional develop-ment session (or, at a minimum, completion of online LEARN Teach Mental Health). Those who wish to educate col-leagues take the "Go-To" Educator or Core Trainer ProD series (2 to 3 day training ses-sions); the latter includes ongoing access to Core Trainer Resources Portal.	Development and evaluation costs: Development of the Guide: $100,000. Evaluation of the Guide is ongo-ing; initially included a 5-year randomized controlled trial in 36 Canadian schools: $200,000. Training costs: In-person training typically $150–250 per person for "Go-To" Educator Professional Development and Core Trainer Professional Development (less if offered online). Materials costs: Curriculum resource is free: https://mhlcurriculum.org/about-the-guide/download-the-guide/ Online version is free: https://www.teachmentalhealth.org/teach (optional certification available for $50). Website resources: https://men-talhealthliteracy.org/	Pre- & post-intervention instruments Examples of district evaluations in BC & other provinces BC curriculum correlations. Program evaluation references: Cross-sectional survey (Kutcher et al., 2016). Randomized controlled trial (Milin et al., 2016). Pre- and post-training survey (Wei, Kutcher, Baxter, et al., 2021).

TEACH Mental Health

Format: Class-room-based modularized cur-riculum (called "the Guide").

Target group: 12–19 yrs.

Language adap-tations: English, French, Spanish, Chinese, Ger-man, Bengali.

Cultural adapta-tions:

Indigenous youth in development (CIHR-funded 6 yr project.

Other adapta-tions: elementary curriculum pilot-ing in 2022.

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
LEARN Mental Health Format: Online modular course (total 6 to 8 hours). Target group: Educators, pre-service educators, interested public.	Developmental health literacy	Program delivered by: Teacher educators or self-guided. Training requirements: N/A.	Development and evaluation costs: Development and evaluation funded over 5 years by private granting agency: $400,000. In-kind contributions from scholar-educators at 4 Cdn universities. Training costs: N/A. Materials costs: Online course is free: https://www.teachmentalhealth.org/learn (optional certification available for $50).	Pre- & post-intervention instruments available: https://mentalhealthliteracy.org/product/prepost-student-evaluations-curriculum-guide/ Program evaluation references: Pre- and post-training survey (Gilham et al., 2021). Quasi-experiment (Wei et al., 2020). Prospective cohort study (Carr et al., 2018).
Know Before You Go Format: Re-source. Target group: Grade 12 students transitioning to post-secondary &/or employment. Language adaptations: English and French.	Learn about finances, study skills, identity questions, etc. Maintain good mental health and seek help as needed. Improve knowledge, help-seeking, and perceived stress.	Program delivered by: Educators.	Development and evaluation costs: Development and evaluation funded over 3 years by RBC Foundation: $90,000. Training costs: N/A. Materials costs: Resources are free: https://mentalhealthliteracy.org/product/know-before-you-go/ Know Before You Go Teachers' Guide https://mhlcurriculum.org/professional-learning/kbyg-teachers-guide/	Assessment instruments described in Gilham, C., Wei, Y., & Kutcher, S. (In press.)

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Transitions Format: Resource. Target group: First-year students in post-secondary institutions adjusting to (often) living away from home for the first time. Language adaptations: English and French.	Learn about time management, relationships, sexual activity, mental illness, suicide, addictions. Improve knowledge, help-seeking efficacy, perceived stress, and general well-being.	Program delivered by: N/A. (App used by post-secondary students).	Development and evaluation costs: Development costs: $100,000. Evaluation funded over 5 years by Medavie Foundation: $300,000. Training costs: N/A. Materials costs: Resource is free: https://mentalhealthliteracy.org/product/transitions/	Program evaluation references: Naturalistic cohort study (Wei, Kutcher, Austen, et al., 2021). (Potvin-Boucher et al., 2010).

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
MindUP Format: Classroom-based lessons and activities. Target group: Ages 2–13. Language adaptations: English, Spanish. Contact: Molly Stewart Lawlor, PhD, Director of Curriculum and Research. mlawlor@mindup.org	Improve social and emotional skills. Improve attention (executive functioning). Improve academic performance. Improve peer relationships and classroom environment. Improve well-being.	Program delivered by: Teachers (MindUP Facilitators who receive extensive training). Training requirements (options): Virtual live training (4 sessions). Online self-paced training (5 Modules)Partner district train-the-trainer (6 Week Course).	Development and evaluation costs: Privately funded by founder and university partnership for development. Ongoing funding as a not-for-profit organization through fundraising and private donations. Training costs: Train the Trainer: $1,500 per participant. Fees: Base Package: Introductory + Memberships (30 people) = $2,500. Additional Training Sessions (60 minutes) = $500. Online Memberships: $50–$100 based on the number of participants. Material costs: Included in training (includes 17 lessons and additional resources to support implementation).	Program evaluation references: Canadian quasi-experimental trial (Schonert-Reichl & Lawlor, 2010). Canadian randomized control trial (Schonert-Reichl et al., 2015). Quasi-experiment (Thierry et al., 2016). Quasi-experiment (de Carvalho et al., 2017). Feasibility study (Matsuba et al., 2021). Canadian quasi-experiment (Crooks, Bax, et al., 2020).

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention / Adaptations / Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
PROGRAMME L'ALLIÉ/ THE ALLY PROGRAM Format: Bundle of resources (online or physical) including: Support guide to help with implementation; Animation guides for both parents and children; Activity booklets; An illustrated story; Educational videos; Promotional material. Target group: Children ages 5–12 presenting behavioral difficulties; Peer helpers; Parents of the children presenting these difficulties. Language adaptations: English, French. Contacts: Nadia Desbiens, PhD. info@projet-allie.ca	Prevent the crystallization and the worsening of behavioural difficulties in school-aged children. Develop social skills in children with behavioural difficulties (e.g., mutual aid, conflict resolution) and prevent violence in a school setting by setting up a network of allies whose goal is to support the child.	Program delivered by: School staff (e.g., psycho-educator, social worker). Training requirements: 5 hours of training for the school staff in charge of implementation.	Development and implementation costs: The development of the project was funded by multiple funds over the years, including Public Safety Canada. Materials and training costs: For material and training: $850 per school up to 4 schools of the same district. 5 to 9 schools of the same district benefit from a 20% discount, and 10+ schools get a 25% discount. For material only: For schools that would like access to an electronic version with reproduction rights within their own district, the price is $1,000. For material, training, and support throughout the implementation: $1,500 per school. Additional material and training: Support and extra bundles can be purchased based on needs for $50–$600.	Program evaluation references: Quasi-experiment (Desbiens et al., 2009).

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
PROGRAMME VERS LE PACIFIQUE/THE PACIFIC PATH PROGRAM Format: Bundle of resources (online or physical) including: Support guide to help with implementation; Animation guides for both parents and children; Activity booklets; An illustrated story; Educational videos; Promotional material. Target group: Whole-school approach, (all children, ages 5–12, universal prevention); Peer mediators (selected among the children, ages 9 to 12); Parents of the children presenting these difficulties; Community group members (whose role is to promote the program to parents and others). Language adaptations: French. Contacts (dissemination and intervention): Isabelle Boissé, directrice générale	Promote SEL (social competence and awareness, inclusion) focusing on the peaceful conflict resolution. Prevent victimization and bullying. Facilitate help seeking in victimized children. Promotes peer mediation both as a means of supporting peaceful conflict resolution among children, but also as a role model for them.	Program delivered by: School staff (mainly teachers supported by special educators, psychoeducator and school day-care educators). Training requirements: Material can be bought without basic training since every activity is detailed in every guide. That being said, basic training is highly recommended. The basic training is 3 hours for every program except the peer mediator program, which lasts 10 hours for the children and 2 hours for the teachers of school educators.	Development and implementation costs: Training costs: Between $125 and $195 per participant for basic training Group cost vary between $475 and $550 for basic training. For parents awareness workshop, the cost is $375 for an illimited number of participants. Schools can choose to receive consultation services that can last up to 10 months. The cost varies between $1,500 to $3,200. Some consultation services and trainings can be free when funding is granted. Transportation costs can apply when the client choose face-to-face instead of online training. Former-collaborators are trained at the expense of the Institute. Materials costs: The pacific path program bundle costs between $140 to $220 depending on the school level. The peer mediator program bundle costs $118.	Program evaluation references: Quasi-experiment for the First version (Corriveau et al., 1998)

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Institut pacifique iboisse@institutpacifique.com Contacts (reaserch/evaluation): François Bowen, Ph.D. francois.bowen@umontreal.ca		The parents' work-shop is 2 hours.	The My culture in respect program bundle cost $129. Each item of every bundle can be bought separately.	

Table 2a, continued

Universal School-Based Interventions (evaluated)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
WITS PROGRAMS Format: Whole-school approach. Target group: Ages 5–9 (WITS, DIRE, DIGA) Ages 10–12 (WITS LEADerS and MENTOR). Language adaptations: English (WITS/WITS LEADerS), French (DIRE/ MENTOR), Portuguese (DIGA/MENTOR, www.programadiga.com.br). Cultural adaptations: Canadian Indigenous Communities (SPEAKup). Contacts: Bonnie Leadbeater, PhD. bleadba@uvic.ca Paweena Sukhawathanakul. paweenas@uvic.ca François Bowen (DIRE-MENTOR). francois.bowen@umontreal.ca	Promote social responsibly and community engagement. Promote SEL (social competence and awareness, inclusion). Prevent victimization and bullying. Facilitate help seeking in victimized children.	Program delivered by school staff and parents. Training requirements: WITS, WITS LEADers train the trainer. Whole school training 3–6 hours. Community training 2 hours. Training requirements (DIRE/ MENTOR: Whole school training, first year of the implementation, varying 4–8 hours. (Some meetings during a school year). Community training, 2 hours (first year). Whole school training, following year of the implementation, varying 2–4 hours (booster sessions).	Development and implementation costs: Online training and coaching for start-up $100/hour. Training costs: Face-to-face training $400–$800 for trainer plus transportation costs. Materials costs: "WITS Picks" books for lesson plans delivery $200–$400. "DIRE/MENTOR Picks" books for lesson plans delivery $1,000–$1,500 (from Kindergarten to sixth Grade, the price of the books needed).	Program evaluation references: Quasi-experimental (Hoglund et al., 2012; Leadbeater et al., 2003; Leadbeater & Sukhawathanakul, 2011). Randomized Control Trial (Leadbeater et al., 2021). Quasi-expérimental (Bowen et al., in préparation).

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Table 2b

Universal School-Based Interventions (under evaluation)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
ACES (Trauma-informed) Practice / Compassionate Learning Communities Format: Manual-based workshops (1-4 available as stand-alone presentations or as a suite for professional development). Workshops vary in length. Target group: Elementary and secondary educators and school staff, early childhood education staff, and parents Contact: Dr. Linda O'Neill loneill@unbc.ca	Support schools and districts to affirm their current trauma-informed practice. Present trauma-informed lens and understanding of impacts of ACES (adverse childhood experiences). Help educators reframe behaviours they are seeing from children and youth and understand through a trauma-informed lens.	Program delivered by Dr. Linda O'Neill. Educators wanting to host professional development workshops. Training requirements: N/A.	Development and evaluation costs: Originally locally funded by schools requesting the workshops. Continuing funding through partnership with Ministry of Education. Training costs: N/A. Materials costs: No cost, available online.	Individual schools implemented surveys following each workshop.
EASE (Everyday Anxiety Strategies for Educators) Format: Online training and resources Target group: Teachers can take online courses that are available (one for grades K–7 and the other for grades 8–12). Language adaptations English and French (for K–7), English (for 8 to 12, in progress) Contact: Kelly Angelius mcf.everydayanxietystrategiesforeducators@gov.bc.ca	Teach K–12 educators effective everyday anxiety management skills for students. Understand anxiety and recognize it both in students and educators. Understand the difference between everyday and problem anxiety. Understand the psychological theory that informs EASE and the cognitive behavioural therapy (CBT) principles on which EASE is based. Strengthen educators' mental health literacy	Program delivered by: Educators Training requirements: Online self-administered course Pro–D and resources available for educators completing the course. Resources available online EASE at Home – Healthy Minds BC (gov.bc.ca)	Materials costs: supplied by MCFD with training books required for program.	Developed and assessed with satisfaction and implementation surveys, focus groups, and surveys included in online course. Wide reach in BC schools since 2019. Program evaluation references: Pre- post- evaluation in progress

Table 2b, continued

Universal School-Based Interventions (under evaluation)

Name of Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
STRONG (Supporting Transition Re-silience of Newcomer Youth) Format: Manual-based group sessions. 10 sessions of 60 mins each plus 1 individual session. Target group: Ages 5–19, Youth who are struggling with their adjustment following their transition to Canada in the domains of school, peers, and psychosocial adjustment Language adaptations: English, French Contact: School Mental Health Ontario (for Ontario schools) Outside of Ontario or for community-based organizations contact: ccrooks@uwo.ca	Promote individual strengths and coping skills, and fostering a positive sense of self and belonging: Increase coping and relax-ation strategies Build problem solving and goal setting strategies Increase connectedness to other students	Program Delivered by: Registered mental health professional Often co-facilitated with an educator or youth worker Training requirements: 2-day training (in-person or virtual)	Development and evalu-ation costs: Development funded by School Mental Health Ontario (cost not available). Evaluation $500,000 as of 2022 funded through Public Health Agency of Canada and School Mental Health Ontario. Further evaluation is underway. Training costs: Training for school-based clini-cians in Ontario is free (through SMHO) Training can be arranged through the Centre for School Mental Health at Western University for community-based organizations and schools in other provinces and territories. Materials costs: manuals are free to users online at https://www.strong-forschools.com/	Request evalua-tion materials from Western's Centre for School Mental Health. Program evaluation references: Feasibility and im-plementation study (Crooks, Hoover, & Smith, 2020) Mixed methods evaluation (Crooks, Kubishyn et al., 2020).

EBPIs for schools often target multiple risk or protective factors simultaneously (e.g., bullying, dating violence prevention, healthy dating relationships, and anxiety) with age-appropriate activities and strategies. For example, Fourth R programs address overlapping strategies to support healthy relationships, diminish relationship violence, improve sexual health, and reduce substance use and misuse. Universal preventive interventions also take a positive youth development approach to developing key assets for healthy youth development and resilience to hardships. MindUP uses social emotional learning (SEL) and fosters positive learning environments. The WITS Program provides resources for the British Columbia social awareness and social responsibility curriculum to reduce bullying and emotional problems and aggression in elementary school children. Mental health literacy (MHL) aims to increase teachers' understanding of mental disorders, their treatments, and how to obtain and maintain good mental health, decrease stigma, and enhance student help-seeking efficacy.

The development and evaluation of universal preventive interventions are typically led by university researchers in partnership with users including community organizations, and representatives of the target population (e.g., educators, youth, and families). On average, EBPIs for schools take many years to develop and evaluate (range 6 to 23 years). Costs of development ranged from approximately $800,000 to CAD$6 million. Funding sources for the development and dissemination of school-based EBPIs typically included research grants and contracts and occasionally private or corporate donors. For example, scale-up funding for MindUP comes from private donors, grants, and school district partnerships, and also from the British Columbia Ministry of Education.

STRONG and EASE were developed in provincial collaborations that include educational leaders, university-based researchers, and provincial ministries responsible for education (e.g., British Columbia Ministry of Education, British Columbia Ministry of Child and Family Development). Development costs are not well known as they are absorbed by the ministries and work is led by ministry staff, collaborating with school leadership teams. These ministry funded programs have the advantage of providing quick responses to a public concern (e.g., trauma-informed practice, consent to sexual activities). They can also take advantage of pre-existing centralized and coordinated infrastructures for quickly scaling up resources to school districts.

Opportunities

To disseminate EBPIs, university-based researchers have created their own strategies for scale-up within and across provinces independently. Each aims to increase reach while maintaining fidelity and assisting in local adaptations and sustainability. Examples include:

Regional hubs were used to link Certified Master Trainers (trained by the program staff) to local trainers. Continuous adaptation of EBPIs was accomplished in collaboration with users, leading to updating of programs, increases in the variety of audiences targeted (educators, youth, preservice teachers), as well as Francophone- and Indigenous-led adaptations of the programs. International (multilingual) versions of some of these EBPIs (MindUP, WITS) are available. There were a few efforts to train preservice teachers in university programs.

Partnerships with provincial ministries aid dissemination of some EBPIs (Fourth R, MHL, MindUP). For example, dissemination of MHL was facilitated in 2018–19 by a province-wide steering committee

from British Columbia school superintendents, teachers' federation, principals and vice principals, school trustees, Foundry BC, ministries of education and mental health/addictions, and BC Children's Hospital. The processes of discovery and implementation varies across schools and typically involves a local champion who discovers and tries out the program before recommending it to others in the school (Crooks et al., 2015; Leadbeater et al., 2012). Coordination, sustainability planning, ongoing training, and local evaluation are often left to school or teacher champions (Leadbeater et al., 2015; Wood et al., 2020).

Accessible websites provide considerable information on EBPIs' goals, training, and contacts. Train-the-trainer models of implementation are used for many of the school-based prevention programs (Fourth R, MindUP, MHL, and STRONG), whereas open access online training supported by program staff characterizes others (WITS). The development and dissemination of EBPIs are funded through ongoing research grants, private donors, or users. For example, WITS Programs had funding from private donors and fundraising, SSHRC, Canadian Health Institutes of Health Research (CIHR) and Public Health Agency of Canada (PHAC). New partnerships for the distribution of the WITS International Programs are benefiting from dissemination research grants from SSHRC (in BC and Québec) and the Templeton Foundation (Brazil).

Challenges

Challenges associated with the researchers' efforts to disseminate and implement the EBPIs that they had developed were similar across projects.

Costs of training. Costs are particularly high in rural and remote locations for delivering program materials, hiring professional trainers, and paying for travel to certify local trainers. While still in demand, the costs and adaptability of paper manuals have pushed developers to create online downloadable program manuals and resources as well as training hubs.

Reaching out to schools. Schools that are not associated directly with the development of the EBPIs are typically targets of disseminators of universal interventions. However, program developers described challenges in securing operational funding to hire program trainers and to produce and distribute materials in schools. A few programs disseminated their work in partnership with provincial ministries of education (e.g., School Mental Health Ontario; Child Health Manitoba). However, gatekeepers in these organizations may not represent all that is available to schools and can be highly selective in what is offered. Additional infrastructures are emerging that support scale-up of evidence-based programs. For example, the Fourth R program can be purchased, and training can be arranged, through a university owned and run intermediary called *World Discoveries*.

Creating and sustaining partnerships for dissemination. Partnerships with not-for-profit organizations have in some cases been used to assist and sustain scale up of EBPIs (e.g., in MindUP and WITS). Sustaining these relationships over a long period can be challenging due to changes in donors and administrative leadership. In one case (WITS), collaborations with a not-for-profit group broke down after 20 years due to disagreements about ownership following staff changes in the organization. This breakdown created program problems for funding, use of copyrighted materials, and ensuring the fidelity of implementation of the program. The program dissemination had to be pulled back into a university-only dissemination arrangement.

Targeted Preventive Intervention Programs

Overview. The four preventive intervention programs reviewed exemplify strong EBPIs that target risk and protective factors for children and youth who have already identified prodromal concerns for mental illnesses or behaviour problems (e.g., aggression, early substance use, negative parent-child interactions, anxiety, depression, and oppositional behaviours). Each intervention has extensive published research evidence of its effectiveness in halting or preventing the escalation of these problems. Reviewed are *Connect, PreVenture, SNAP,* and *Strongest Families* (see Table 3 for references). Each of these interventions was developed by a university-based research team including psychologists or psychiatrists and each was extensively evaluated with the support of time-limited federal grants from SSHRC, CIHR, or private donors. Development and evaluation occurred over many years in a project-by-project basis (10 to 20 years), and costs of the development of the programs ranged from CAD$600,000 to $10.2. Each showed evidence of effectiveness in a randomized control trial, similar to what is required for a clinical approach to a clinical or pharmacological treatment for children or youth. These preventive interventions target broad numbers of children and youth who are identified as "at risk" and aim to halt early problems or to increase protective behavioural strategies and supports to prevent the escalation of mental illness, behaviour problems, and/or substance abuse concerns. An example is Stop Now and Plan (SNAP) to reduce disruptive behaviour and aggression by increasing self-control, emotional regulation, and problem-solving with the long-term aim of preventing academic problems and criminal offending. While targeted prevented interventions shared opportunities and challenges similar to universal preventive interventions (e.g., funding outreach to schools, sustaining partnerships) some additional themes were identified.

Opportunities

Reaching out to supportive settings. Typically, secondary preventive interventions are disseminated and scaled up through partnerships with health clinics, practitioners, and school districts using either an affiliate or train-the-trainer model (e.g., SNAP, Connect). Organizations with certified staff can then deliver the program, train new staff, apply for funding, and build community support to sustain the program. Alternatively, training may remain the responsibility of the development team who license trainers to deliver training to qualified practitioners in communities.

Leadership for dissemination and implementation of preventive interventions is typically found within the development team and lead researchers (e.g., Connect). This requires pivoting the teams' development and evaluation research to translational research or knowledge mobilization. Translational research assesses implementation outcomes (e.g., training effectiveness and fidelity) as well as treatment outcomes (e.g., improved parent-child relationships) as EBPIs are scaled up. Responding to the demand for accessible preventive interventions, all developers have created online versions that can deliver resources directly to users. For example, online sessions are supported by supervised, non-professional coaches (Strongest Families) or by counsellors in schools (PreVenture and Connect). PreVenture, Strongest Families and SNAP have established not-for-profit organizations to support dissemination and implementation operations typically to highly qualified staff.

Funding for dissemination and implementation. To support dissemination, researchers applied for competitive federal or provincial grants or contracts, or raised funds through not-for-profit organizations (e.g., Strongest Families, Institute for Child Development Institute). Ongoing funding to support dissemination and implementation also came from revenue from sales of the materials, charges for training, and user licencing fees. Dissemination funding also came from provincial or federal organizations targeting a specific concern for a short period (e.g., Safety Canada; National Crime Prevention Centre). Additionally, corporate sponsorships such as Bell Canada's Let's Talk have enhanced the sustainability of EBPIs, such as Strongest Families, which has successfully marketed the interventions to some provinces (British Columbia, Nova Scotia, and Ontario).

Challenges and Solutions

Reliance on researchers for dissemination, research and evaluation. Dissemination, implementation fidelity and sustaining EBPIs are challenged by reliance on a developer "push" model that requires considerable effort on the part of each developer to make interventions available to those who need them the most. Investments in technology, fundraising, and marketing must be undertaken by each program thereby increasing costs to users. Research and evaluation are integral to the success of dissemination and implementation.

Fragmented and decentralized dissemination. Without centralized provincial or federal support for delivery, each user organization or school must individually locate, access, and fund training for the EBPIs that they believe address their specific needs and audiences. Inequities in access to the benefits of these tested programs are acute for vulnerable populations (Shelton et al., 2021). A centralized system of dissemination of EBPIs could better support program developers to understand and navigate province-specific pathways for funding and dissemination support, engaging interested professionals, and adapting interventions to the needs of multi-cultural, rural, or remote communities.

Table 3

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Connect (Birth Parents) Language adaptations: English, French, Swedish, Italian, Mandarin, Spanish; Dutch forthcoming. Format: Manualized 10-week program, in-person or online. Target group: Parents and caregivers of youth ages 8–18 months with complex behavioral and mental health problems. Language adaptations: English, French, Swedish, Italian, Mandarin, Spanish. Additional Adaptations: Connect for Kinship & Foster Parents. Languages: English; French and Spanish forthcoming. Transforming Connections (Parents of Gender Diverse Youth). Language: English Reclaiming Connections (Indigenous parents and caregivers). Language: English. Contact: Marlene Moretti. marlene_moretti@sfu.ca	To promote caregiver mentalization, emotion regulation, sensitivity and responsiveness, and youth attachment security, social, emotional, and behavioural adjustment.	Program delivered by Connect Parent group facilitators. Training requirements: Connect Parent group facilitator: 3-day training workshop or 6 half day virtual training workshop. Connect course (10 sessions) of supervision by Connect Supervisor. Train the supervisor: Shadowing and immersion with a certified Connect Supervisor. Trainees shadow their Connect Supervisor in the supervision of a Connect Parent Group through weekly review of videotaped sessions and weekly teleconference or in-person supervision.	Development and evaluation costs: Ongoing not-for-profit through Dr. Marlene Moretti's research lab, and funded through provincial ministries, public and non-profit health agencies. Approximately $10.2 million from 1986–2022, grant funding from CIHR, SSHRC, PHAC plus in-kind health agency contributions. Current funding $1.4 million 2015–2022 from CIHR. Training: No trainer charge within British Columbia under MCFD. No trainer charge outside of BC and Canada if linked with collaborative research. Otherwise training workshop $800–$900 inclusive of training manuals/materials plus $1,250 supervision per trainee. Cost	Within BC, Connect groups are evaluated through standardized protocols including the BCFPI. Nationally and internationally, connect groups complete manualized feedback and integration session" with standardized feedback form and semi-structured interview. Program evaluation forms Connect Feedback Form and Connect Integration and Feedback Interview comments. Four Connect training manuals/guides inclusive of parent handouts; virtual adaptations of all programs completed. Program evaluation references: Canadian Publications: Randomized or uncontrolled clinical trial or evaluation: Moretti et al. (2015); Moretti et al. (2012); Moretti & Obsuth (2009); Moretti & Obsuth (2013); Moretti & Pasalich (2018); Obsuth et al. (2006); Pasalich et al. (2021). International Publications: Randomized or uncontrolled clinical trial or evaluation:

Table 3, continued

Targeted Preventive Interventions

	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Intervention Adaptations Contact		Trainees also received an additional half hour of supervision per session. Train the co-trainer: Practitioners must be certified, highly skilled and experienced Connect Supervisors. They must also possess a high degree of knowledge in the field of attachment, trauma and intervention and the ability to effectively engage trainees in the workshop process. Eligibility and approval to train as a Connect Co-Trainer remains the decision of Connect developer, Dr. Marlene Moretti.	dependent on location, trainer profession etc., sliding cost for developing countries. Fees: No licensing fees; Connect facilitators/host agencies are required to submit an annual report tracking implementation and parent feedback, and to remain up-to-date in terms of program developments. Materials: Included in training cost.	Barone et al. (2021); Barone et al. (2020); Gianotta et al. (2013); Hogstrom et al. (2016); Osman et al. (2021); Osman et al. (2017); Rooth et al. (2017); Stattin; et al. (2015). Publications specifically for Kinship & Foster Parents program: Moretti et al. (2020); Pasalich et al. (2021). Independent Program Review: California Evidence-Based Clearinghouse for Child Welfare (CEBC): Supported Program.

Table 3, continued

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
PreVenture Format: Manualized intervention; 1 youth self-report and two 90 minute workshops. Target group: Ages 12–25. Language adaptations: English, French, Dutch, Spanish, Romanian, Czech. Cultural adaptations: high-school, university, Indigenous communities (Canada), youth in care. Contact: Dr. Patricia Conrod. patricia.conrod@umontreal.ca	To promote mental health and delay substance use. To reduce alcohol, cannabis, and drug use. To reduce the symptoms of depression, anxiety, and conduct problems. To reduce distress following a bullying victimization.	Program delivered by mental health practitioner, counsellor, teacher, social worker, or prevention specialist. Training requirements: Low-fidelity facilitator certification: 16 hours. High-fidelity Level 1 facilitator certification: 20 hours. High-fidelity Level 2 facilitator certification: 24 hours. Supervisor certification: 32 hours. Trainer certification: 40 hours.	Development and evaluation costs: Ongoing not-for-profit basis through Dr. Patricia Conrod's research lab and support from Montreal hospitals. Locally funded through private and public funding (health authorities; education authorities; charitable donations). *Estimated development costs are not available.* Training: Basic facilitator training begins at $700/person and can increase to $3,700/person for full trainer certification. Fees: Ongoing licensing fees apply annually and range from $120/year to $1,000/year depending on certification level. Materials: Intervention manuals and screening tools cost on average $12/child and vary based on volumes purchased.	Program evaluation references: Cluster-randomized controlled trial (Slade et al., 2021). Cluster-randomized controlled trial (O'Leary-Barrett et al., 2017). Cluster-randomized controlled trial (Teesson et al., 2017). Cluster-randomized controlled trial (Newton et al., 2016).

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Table 3, continued

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
SNAP® (Stop Now And Plan) Format: 3 options: Level 1 – full Clinical Service Model: child and concurrent family core groups, family and child counselling and/or mentoring, school advocacy, Social Emotional Education School Advocacy Groups (SEESA) Level 2 – Group Focused, time limited (predetermined length of time, approximately 6–9 months) Level 3 – School-wide (Grades 3–6) delivers SNAP to all students within the classroom. Target group: Ages 6–11 Language adaptations: English, French, Dutch, Cree Contact for details: Nicola Slater, Senior Manager, SNAP® Business Development & Affiliate Relations. NSlater@childdevelop.ca Contact for information on SNAP Model: Leena Augimeri, PhD, Director, SNAP Scientific, Program Development & HQ. LAugimeri@childdevelop.ca	To reduce disruptive, antisocial, and criminal behaviour as well as anxiety and depression To strengthen self-regulation, emotion regulation, self-control, and problem-solving skills while increasing social competencies (e.g., positive peer interactions, social skills) To improve parental self-efficacy and child management skills.	Program delivered by SNAP Affiliates: SNAP Affiliates are an organization that has entered an annual, renewable licensing agreement with Child Development Institute (CDI) to deliver SNAP programming. SNAP Affiliates enter a multi-year process that includes assessing site readiness, ongoing training and consultation, and a regulated quality assurance process. Training requirements: SNAP Lead Staff Training (2–3 days) for members from the agency's leadership. SNAP Core Staff Training (up to 9 days) for frontline	Development and evaluation costs: SNAP was developed over 30 years ago within an applied community-based mental health centre. Various funders from 1985-2002 (Dept of Justice, donor, Hospital for Sick Kids)—\$621,625. Ongoing funding through LEAP and Centre for Children Committing Offences. Training: Training costs vary depending on the SNAP service delivery level & context of the implementation Fees: The SNAP License is mandatory, and fee is paid annually to CDI (~\$6,500). Includes program materials, initial consultation, and SNAP Implementation Tool (SNAPiT) data system access. Materials: Included in fee.	SNAP Affiliate Sites are expected to participate in fidelity review activities as well as an evaluation of service delivery outcomes: Fidelity assessments include pre-implementation and implementation assessments (i.e., FIT & Feasibility & Readiness); participation in training and consultation; monitoring/scoring of adherence levels and competency skills through video reviews; and outcome evaluation of service delivery. All fidelity/evaluation tools are in the SNAPiT system and available to licensed sites. Program evaluation references: Initial Pilot Randomize Controlled Study. Randomized controlled trial (Burke & Loeber, 2015). Quasi-experiment (Pepler et al., 2010) Randomized controlled trial (Augimeri et al., 2007).

Table 3, continued

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
		staff and managers/ supervisors. Ongoing consultation and coaching support provided by SNAP Trainers/Consultants.		
Strongest Families Format: E-learning; phone support; handbooks. Target group: Varied by program. Language adaptations: English, French. Contact: Patricia Lingley-Pottie ppottie@strongestfamilies.com Theresa Cunningham TCunningham@strongestfamilies.com	To promote effective parenting skills (e.g., notice the good, transitional warnings, rewards systems, strengthening relationships at home and school, problem-solving, self-care).	Program delivered by Strongest Families Coaches Training requirements: Strongest Families Coaches are hired based on demonstrated level of competency with interpersonal communications skills, ability to problem-solve and voice quality. Most Coaches have post-secondary education with relevant experience working with children or families. Coaches must	Development and evaluation costs: Primarily funded through CIHR grants approximately \$9.7 million. An additional funding through Innovacorp – Intelligent Research and Intervention Software (IRIS): Strategy for Commercialization and implementation \$49,948. Ongoing funding as non-profit through revenue and charitable donations through partnership with Bell Let's Talk. Training: N/A Fees: SFI has a dynamic pricing model that is flexible to fit various sized contracts (ranging from	Randomized clinical trial and 2-year follow-up (Sourander et al., 2018; Sourander et al., 2016) Randomized controlled trial (PEK and Chase Worries Away) (Mc-Grath et al., 2011).
Parents Empowering Kids (PEK) Target group: Parents and caregivers of youth ages 3–12 (age is corrected for children with developmental delays or neurodevelopmental disorders).				

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Table 3, continued

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Chase Worries Away 6–12-year-olds. Target group: Ages 6–12 with pediatric anxiety. Defeat Anxiety 13–17-year-olds. Target group: Ages 13–17 with pediatric anxiety.	To learn about the youth's specific anxiety issues. To teach youth and parents/ caregivers to practice and effectively implement cognitive and relaxation techniques (e.g., belly breathing, deep muscle relaxation with and without tension, mini relaxation, changing thoughts, imagery). To implement gradual exposure using a hierarchal process.	demonstrate applicable abilities and meet SFI training coach competencies. The Strongest Families Institute (SFI) proprietary training and certification programs are intensive and includes competency testing to ensure protocol fidelity and a skill level that will yield positive outcomes.	$500 to $875 per referral). Volume discounts are available to organizations or government with a large referral base or an interest in a full eMH system of care. Materials: N/A	

Table 3, continued

Targeted Preventive Interventions

Intervention Adaptations Contact	Key Objectives	Program Delivery Training Requirements	Costs (Start up, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
ICAN Adult anxiety and depression program for 18+. Target group: Ages 18+ presenting with anxiety problems (with or without depressive symptoms).	To teach adults to implement relaxation techniques and self-care. To recruit a close friend or family member to act as a supporter. To implement gradual exposure using a hierarchal process.			A worry diary is used to track improvement.

DISCUSSION

As Flay and colleagues (2005) state, "It is only when effective prevention practices are widely disseminated that society will reap the potential benefits of the research conducted so far" (p. 152). The promotion of child and youth mental health is urgent, but there are critical gaps between the development of effective preventive interventions and their dissemination and implementation. EBPI dissemination and implementation in Canada is ad hoc and depends on developers' efforts to promote local buy-in. This results in severe inequities in access to EBPIs. Many community organizations are unable to address their growing needs for mental health promotion and prevention efforts that can impact serious and prevalent mental health problems (Wolk et al., 2022). Both opportunities and barriers to dissemination and implementation are evident from this review of Canadian practices in dissemination.

Summary and Discussion of Opportunities

There are strong Canadian EBPIs that show effectiveness in the promotion of mental health and prevention of illness for children, youth, and their families. Developmentally and culturally appropriate EBPIs exist for children and youth from elementary to high school. Together preventive interventions may be synergistic in promoting mental health across the lifespan. EBPIs developed in Canada have many advantages in terms of relevance, open access, and low-cost delivery methods. These programs are developed in partnership with users and are based on Canadian values promoting inclusivity, multiculturalism, peaceful resolution of conflicts, healthy relationships, and building strengths and resilience. Because EBPIs are developed in partnerships with representative users, their feasibility, acceptability, and adaptability are typically enhanced for Canadian users. EBPIs respond to the need for cultural adaptations to guide changes in both content and workforce capacity. When scaled-up, they are adapted often for use with new Canadian, Francophone, and Indigenous communities. To meet the commitments of provinces and territories to improve the health outcomes of children and youth, stable infrastructures are needed to coordinate the dissemination and implementation of EBPIs and to test the extent to which they meet the needs of the populations utilizing them. The contributions of large-scale implementation of EBPIs to child and youth mental health also needs to be independently and systematically evaluated.

Summary and Discussion of Challenges

Challenges to the dissemination of existing EBPIs can, at least in part, be found in the division between federal and provincial/territorial commitments to, and responsibilities for, the prevention of mental illness. The development and evaluation of EBPIs typically occurs in university settings, often in partnership with representatives of local communities and in response to local needs. Yet, without targeted provincial funding or participation of ministries of education or mental health, potential users may not know about EBPIs or be reluctant to fund EBPIs that do not address their immediate priorities. Without overarching provincial coordination of access to EBPIs, each community and school district is left to seek out, fund, and implement EBPIs on their own. No single organization or institution is responsible for disseminating EBPIs for children and youth nationally or in most Canadian provinces and territories, leading to fragmentation of EBPIs delivered and inequities in access and support for implementation (McGihon et al., 2018; Wolk et al., 2022).

Scale-up requires new partners. The widespread uptake of these EBPIs requires new partnerships, adaptations, and buy-in from individuals who were not involved in the development and evaluation process. Dissemination requirements for scale-up across provinces can overwhelm developers as they assume the roles of advocates, marketers, and ongoing evaluators of the program implementation and outcomes (Leadbeater, 2010). Outcome evidence and implementation requirements are often reported in academic peer-reviewed journals or in websites that are difficult for potential users to access and interpret relative to their local needs.

Cost burden is absorbed by users. In the absence of coordinated provincial or territorial efforts to disseminate and implement EBPIs, the operational costs for wide-spread implementation, scale-up, and sustainability of EBPIs that is incurred by developers must often be passed on to users. User-pay models discriminate, particularly, against rural and remote communities that face challenges in relation to staff turn-over (retraining) and workforce capacity (readiness) as well as high levels of concerns, and recurring crises. Without the establishment of new infrastructures (e.g., training institutes or not-for-profit organizations), the developers of EBPIs compete with each other for user attention and funding from commercialization or donor support.

Inequities in access to EBPIs are common. Reliance on a developer-push and user-pull system of dissemination in Canada also gives rise to inequities in access to the benefits of EBPIs (Leadbeater, 2010). Developer-led dissemination models may be unable to provide long-term, sustained support for operating within schools once research funds are depleted. The cycle of small-scale program development, local implementation, and a lack of sustained dissemination or scale-up reduces the effectiveness of EBPIs in addressing wide-spread problems. This can also lead to school or health services staff burnout, resistance to new programs and flavour-of-the-day approaches, and fears that their investments in EBPIs will not be sustained before they are replaced by the next crises-oriented demand for action.

Fragmentation and replication. With no centralized and trusted clearing house, suitable EBPIs are hard to find and access. This gives rise to the appearance of a lack of resources, which fuels action in provincial governments and schools to create and recreate policy frameworks, select costly alternatives, or replicate work already done. The perception that nothing is available to address a problem results in attempts to create "innovative" resources that are untested or that engage researchers to start the evaluation cycle yet again.

Crisis responses overwhelm prevention efforts. Efforts to respond to crises in child and youth mental health and addictions have spurred the development of several online information platforms (websites) that compile extensive information about child and youth mental health promotion or illness prevention. However, these often grow organically and need to be sorted through and translated into action plans by individual educators or youth-serving agencies.

Multicultural and language adaptations of EBPIs are slow to develop. An additional challenge to the dissemination of EBPIs in Canada relates to our multicultural, widely spread and diverse cultures and communities. Adaptations are needed to improve the fit of EBPIs both culturally and in terms of workforce capacity and readiness (Zayas et al., 2012). Although the core components of an intervention can be maintained across local adaptations, challenges to implementation go beyond a need for surface cultural adaptations and include the impetus to actively engage community and cultural leaders as partners to ensure the safety, respect, and relevance, as well as sensitivity in the use of languages, local priorities, ongoing training needs,

funding, and sustainable delivery systems. Many EBPIs have been successfully adapted and implemented within Indigenous communities; however, few have been widely disseminated, leading to inequities in access to EBPIs in Indigenous contexts (Dickerson et al., 2020). Jernigan et al. (2020) identify the pressing need for expanding an understanding of what constitutes evidence and how to incorporate Indigenous knowledge while accounting for the significant cultural, political, and geographical diversity across Indigenous communities.

Widespread impacts of EBPIs are unknown. Evaluations of the outcomes of EBPIs often include small numbers of participants and are program centric. These may evidence local impacts on targeted outcomes as part of the research process, but widespread effects are typically not investigated. This also makes it hard to determine the collective or synergistic effects of all provincially led efforts to promote child and youth mental health. It is not possible to show that any or all approaches make a difference for child and youth mental health in the long term without coordinated and sustained monitoring at a provincial level.

Limitations

While 18 leading researchers in the field of mental health promotion and prevention participated in this collaborative review and discussion, our insights may be limited to the provinces represented by the authors (British Columbia, Ontario, Québec). Research is needed to evaluate the reach and implementation success of organizations that have begun to coordinate and fund access to EBPIs within provinces. Additional systematic dissemination strategies for EBPIs may exist that have not been identified here.

Ongoing discussion of the quality of scientific evidence needed to support program outcome claims is the subject of debate in the scientific literature (Gottfredson et al., 2015; Tanner Smith et al., 2018). Implementation quality and sustainability of intervention strategies can also affect outcomes in real world efforts (Baker et al., 2021; Domitrovich et al., 2008; Johnson et al., 2017). A few systematic reviews and meta-analyses also show that preventive interventions that are marketed to potential users have limited effects on targeted outcomes or, actually, may be ineffective or harmful (e.g., Guzman et al., 2022; Werner-Seidler et al., 2021). This further demonstrates the need for knowledge brokers or highly qualified individuals who can navigate the gap between science and practice to ensure the safety and effectiveness of programs targeting children and youth.

CONCLUSIONS

Given systemic gaps in the development, dissemination, and implementation of EBPIs, it is not surprising that, despite substantial investments in their development, EBPIs are not well used to improve mental health in Canada. In contrast to the effective dissemination systems that exist for physical health treatment guidelines, medical equipment, or pharmacological products, there are no clear national or provincial pathways or infrastructures for accessing or implementing EBPIs developed in Canada. Local efforts to respond to rising mental health concerns give rise to duplication of resources, unwarranted expenditures, and the use of strategies that are unproven, culturally indifferent, or that have harmful or null effects.

While many innovative universal and secondary prevention interventions already exist and continue to be developed, challenges to the dissemination of EBPIs in Canada are malleable. Increasing the pathways to access, centralized funding to support uptake of local choices and adaptations, and support for long

term implementation and sustained commitments would help to realize the investments in the development of EBPIs. Extensive research and discussion in the United States suggests that moving forward requires prevention approaches that are embedded in social systems and adapted to local contexts (Crowley et al., 2021; Fagan et al., 2019; Hoagwood, 2020; Hoare et al., 2019, Komro, 2020). Canada clearly lags in efforts to coordinate the infrastructures and pathways that ensure equitable dissemination and implementation of the many existing, developmentally and culturally appropriate EBPIs to improve the mental health of all Canadian children and youth (Shelton et al., 2021).

SUPPLEMENT A

Public Health Information Platforms

Several information platforms were submitted in response to our request for resources addressing children's mental health and were reviewed: *Anxiety Canada, BC Injury Research and Prevention (including Concussion Awareness Training Tool (CATT), Active & Safe. Outdoor Play!, The Community Against Preventable Injuries (aka Preventable),* and *The Period of PURPLE Crying), Foundry Central, Key Principles and Strategies for K-12 Mental Health Promotion (gov.bc.ca),* and *Kelty Mental Health Resource Centre.* See Supplement B. These were identified in this project as important resources for children and youth's mental health and included some direct educators or youth and families using services who provided reliable information on mental health topics. For example, Anxiety Canada and Foundry Central offer programs and evidence-based resources. However, the reach and effectiveness of platforms in promoting well-being and reducing mental illness is not evaluated. These resources serve as online information sources that seek to provide research-based knowledge about a topic (e.g., mental health promotion about concussions, mental health disorders, etc.) to targeted audiences (coaches, educators, parents). Information platforms are built with funding from a variety of organizations including non-profits as well as within government ministries. These differ from the above category of public health promotion because they serve as resource databases on a number of topics as opposed to focusing on specific concerns. These are distinct from the EBPIs reviewed in this article as they are not evaluated; however, they are often widely disseminated.

SUPPLEMENT B

Public Health Information Platforms

Name of Intervention (website hyperlink) Adaptations Contact	Key Objectives	Delivered By Training Requirements	Costs (Development, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
Concussion Awareness Training Tool (CATT) Format: Online educational modules and resources. Target Group: Ages 13–65. Language adaptations: English, French. Contact: F508 – 4480 Oak St. Vancouver, British Columbia, Canada V6H 3V4. concussion@bcchr.ca	To educate, recognize, diagnose, treat, and manage concussions.	Anyone can self-identify on the website and take a free e-learning course that matches with their position.	Development cost: $ from BC Children's Hospital Foundation, Child Health BC, Provincial Health Services Authority, Ministry of Health and Nationally from the Public Health Agency of Canada, Parachute, USport.	Pre- and post-evaluation results are available on the BC Injury Research and Prevention Unit website: https://www.injuryresearch.bc.ca/ Program evaluation references: Pilot evaluation(Turcotte et al., 2020). Quality assurance assessment (Babul et al., 2020).
Active & Safe Format: Online resource Target Group: Ages 11–19 Contact: Dr. Ian Pike ipike@bcchr.ca	To educate and prevent injury using a guided evidence-based resource for over 50 sports and recreational activities.	Anyone (youth, healthcare professionals, coaches, teachers, and administrators) can access the free online resource.	Development cost: $500,000 from BC Alliance for Healthy Living Society. $500,000 of in-kind support by stakeholders. Ongoing cost: $50,000/year from the BC Ministry of Health.	Program evaluation references: Development (Richmond et al., 2019) Development and post-launch evaluation (Pike et al., 2018).
Outdoor Play! Format: Online, guided resource. Target Group: Ages 0–18. Language adaptations: English and French. Contact: Dr. Mariana Brussoni 604-875-2433 (fax) 604-875-3569 playoutside@bcchr.ca	To promote safe and positive outdoor play for children. To change behaviours and perceptions of risk among adults.	Adults, parents, caregivers, educators can access the free online tool that contains guided self-reflection questions and a guided plan for change.	Development cost: $250,000 (for the website) and $80,000 (for the educator tool) from the Lawson Foundation, Government of Canada, BCCHRI, and the VSB. Ongoing cost: The sustainability of Outdoor Play! relies on a lower cost of funding.	Program evaluation references: Randomized controlled trial (Brussoni et al., 2021).

SUPPLEMENT B, continued

Public Health Information Platforms

Name of Intervention (website hyperlink) Adaptations Contact	Key Objectives	Delivered By Training Requirements	Costs (Development, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
The Community Against Preventable Injuries (aka Preventable) Format: Public information campaign via social marketing Target Group: All ages Language adaptations: English, Cantonese, Punjabi, Hindi, French Contact: Preventable BC F-508, 4480 Oak Street Vancouver, BC V6H 3V4. Preventable AB RTF, 8308-114 Street Edmonton, AB T6G 2E1. info@preventable.ca	To shift British Columbians attitude, perspective, and behaviours towards injury prevention.	N/A (social marketing organization aimed at ages 25–54 including those who are parents and caregivers of children, youth, and young adults).	Development cost: $ from Parachute, BC Injury Research and Prevention Unit, Injury Prevention Centre, Shaw Media, WorkSafe BC, Telus, London Drugs, BC Ministry of Labour, Canadian Red Cross, JIBC, BC Hydro, and Pacific Blue Cross.	Ad tracking and recall of specific advertising campaigns is ongoing (~3–4 times/year). Monitoring Knowledge, Attitudes and Behaviours is ongoing (~3–4 times/year). Overall campaign is evaluated in association with annual injury hospitalization and death incidence in BC.

SUPPLEMENT B, continued

Public Health Information Platforms

Name of Intervention (website hyperlink) Adaptations Contact	Key Objectives	Delivered By Training Requirements	Costs (Development, Training, Ongoing)	Program Evaluation (how it is evaluated) and References (label with type of evaluation)
The Period of PURPLE Crying Format: Videos and booklets Target Group: Parents and caregivers of infants and young children Language adaptations: English, French, Spanish, Arabic, Cantonese, Hebrew, Punjabi, Vietnamese, Somali, Korean, Japanese, and Portuguese Contact: Karen Sadler karen.sadler@bcchr.ca	To prevent the incidence of SBS/AHT through 1 3-dose education program directed at parents, caregivers, and community members on the natural developmental nature of increased infant crying and the dangers of shaking a child.	Public health and maternity health specialists. Training requirements: Public Health and Maternity Health specialists complete free online training. The course consists of lessons and a quiz assessment that solidifies understanding of PURPLE Materials are available for early childhood educators, foster parents, adoptive parents, and community members (e.g., babysitters, grandparents).	Development cost: Ongoing cost: $188,000/year from BC Ministry of Child and Family Development and the BC Ministry of Health.	Case reviews are conducted to determine the association of the program with the incidence of SBS/AHT cases in BC. Program evaluation references: Longitudinal post-implementation outcomes (Barr et al., 2018).

SUPPLEMENT B, continued

Information Platforms

Platform	Key Objectives	Target Group	Resources offered
Anxiety Canada: Website: https://www.anxiety-canada.com/	Provide free online, self-help for anxiety.	All ages	Free online self-help Evidence-based resources MindShift CBT app My anxiety plan (MAP)
BC Injury Research and Prevention	Injury prevention knowledge and integration. Support the development of programs and policies.	All ages Health professionals School professionals	Webinars Factsheets Report and publications Programs Courses Curriculum
Foundry: Website: https://foundrybc.ca/	To transform how young people access health and social services throughout BC. Integrated health and social service centres.	Young people ages 12–24 needing mental health support or substance use support and caregivers.	Information about health and wellness Tools Online resources Connection to services Foundry pathfinder – 3 step tool to help users find personalized support
Kelty Mental Health Resource Centre: Website: https://kelty-mentalhealth.ca/	Help families navigate mental health system, connect with peer support, and access tools and resources to support well-being.	Children, youth, and young adults and their caregivers. Health professionals School professionals	How-to videos and resources for connecting to support. Videos Information about healthy living Information about challenges and disorders Information about medication and therapy Resource library

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