A PATHWAY FOR COMING TOGETHER:

Exploring Collaborative Approaches to Address School Mental Health Promotion in Ontario

LOCALLY DRIVEN COLLABORATIVE PROJECT
FUNDED BY PUBLIC HEALTH ONTARIO

A special thank you to the participants who made this project possible. Thank you for sharing your time, insights, and vision with us.

Abstract

This project aimed to answer the question: “How can system level collaboration between Public Health Units and School Mental Health Ontario support equitable tier 1 mental health promotion post COVID-19?” The objectives included identifying feasible implementation strategies and the creation of causal pathway models. This study is rooted in the principles of phenomenology and participative action research. It was completed through four iterative, thematically coded workshops. Workshop participants consisted of Public Health representatives from across Ontario, and School Mental Health Ontario staff. Participants identified challenges within the field of school mental health promotion, as well as possible strategies to overcome these challenges. The results informed the creation of three models to facilitate action towards addressing these concerns. This report recommends the creation of a shared vision for school based mental health promotion, the identification of shared indicators to plan, monitor and evaluate the tier 1 mental health promotion work in schools and the creation of data sharing templates to support enhancing system broad collaboration and data driven decision making within the Province of Ontario.

Project Overview

There is an increased need for student mental health promotion following the COVID-19 pandemic. With multiple organizations mandated to improve student mental health promotion there is ample opportunity for system level collaboration, and service delivery. This project aimed to answer the question: “How can system level collaboration between Public Health Units and School Mental Health Ontario support equitable tier 1 mental health promotion post COVID-19?". This study employed implementation science to construct causal pathways aimed at examining strategies for collaborative tier one mental health promotion practices.

Objectives:

- Identify Feasible Implementation Strategies:
  - The project identified strategies to enhance partnership collaboration in the delivery of tier 1 school mental health promotion.
- Design Causal Pathway Models:
  - The study aimed to design causal pathway models of cross-ministry system collaboration in school mental health promotion.
  - These models considered strategies, mechanisms, preconditions, moderators, and proximal outcomes impacting successful implementation.

Contextualizing the Mental Health Impact of COVID-19:

The literature demonstrates that COVID-19 had a considerable impact on students' mental health. Studies indicate that students suffered: heightened stress, increased depressive and anxiety symptoms, and a significant decline in psychological well-being (Elharake et al., 2023;

Bonsaksen et al., 2022). In addition to acute care resources available in tertiary centres and community settings, there exists a clear need for sustained mental health promotion interventions.

Significance of School-Based Mental Health Promotion:

School mental health interventions and supports align with a multi-tiered system of support, that increases in intensity and individualization of support; from tier 1 (mental health promotion and prevention interventions aimed at the whole population), to tier 2 (focused supports for individuals and small groups demonstrating increased mental health needs), and tier 3 (intensive individualized intervention for diagnosed individuals) (Fabiano & Evans, 2019). Population-level mental health interventions, such as those Local Public Health Agencies (LPHAs) are mandated to provide, fall into the category of tier 1 (Ministry of Health and Long-Term Care, 2018). Given the number of students who attend educational facilities, schools are an ideal location to support student well-being and health outcomes (Canadian Healthy School Standards, 2021). With the introduction of the Ontario Ministry of Education Policy/Program Memorandum 169 in 2023, Ontario schools are also mandated to provide multi-tiered supports for student mental health. Currently, the mandates and efforts of LPHAs and schools in Ontario are not systematically coordinated. Coordination holds great promise to improve the implementation and outcomes of tier 1 mental health promotion efforts for students. This project will provide a framework to enhance collaboration across sectors, ensuring optimal delivery of tier 1 mental health support for students.

Rationale for Collaborative Efforts:

LPHAs and SMH-ON share mandates to advance school mental health promotion but lack systematic collaboration strategies. LPHAs are under the jurisdiction of The Ministry of Health, while school boards, and SMH-ON are under the jurisdiction of The Ministry of Education. The Council of Ontario Directors of Education and Council of Ontario Medical Officers of Health have a partnership to “contribute to the well-being of Ontario’s students through: informing public policy at the provincial level; enhancing public health agency and school board partnerships; optimizing the delivery of mandated programs; and providing strategic support to innovative efforts of others whose goal is the well-being of Ontario’s students” (https://www.ontariodirectors.ca/CODE-COMOH.html). Moreover, both the Ministry of Education and the Ministry of Health recognize the importance of school mental health promotion (ministry of Education, 2000; Ministry of Health and Long-Term Care, 2018). This project aims to illustrate a framework for coordinated effort between public health units, school boards, and School Mental Health-Ontario that facilitate implementation of coordinated efforts to provide tier 1 school mental health services and interventions.

Data Analysis and Causal Pathway Development:

To evaluate how system level collaboration may improve equitable access to tier 1 mental health promotion within schools we conducted four phenomenological workshops. These

workshops explored the lived experiences of those working in school mental health promotion, as well as their organizational leaders. From these perspectives we used implementation science to develop causal pathway models. Implementation science offers methodologies to enhance successful implementation through causal pathway modeling, aligning implementation strategies with contextual factors (Lewis et al., 2018). The result was causal pathway models which can inform the future collaborative work of LPHAs and SMH-ON.

Project Team

Locally Driven Collaborative Project Core Team

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Disclaimer

The views expressed in this publication are the views of the project team, and do not necessarily reflect those of Public Health Ontario.

Background

Student Mental Health Following the COVID-19 Pandemic

The COVID-19 pandemic resulted in significant deterioration in the mental health of children and youth (Boak et al., 2021; Cost et al., 2022; PHO, 2021; Vaillancourt et al., 2021; Wolf & Schmitz, 2023). According to the Well-Being of Ontario Students Report (Boak et al., 2021), nearly 40% of students feel that the pandemic negatively affected their mental health "very much" or "extremely". A recently published scoping review of 69 peer-reviewed articles found children and youth worldwide experienced deterioration in psychological well-being, heightened stress, and increased depressive and anxiety symptoms over the pandemic (Wolf & Schmitz; 2023). A study of 385 Canadian youth aged 10 to 18 years old found more than two-thirds reported deterioration in mental health (Cost et al., 2022). Cost and colleagues (2022) also found high rates (e.g., 31 to 53%) of attention problems, hyperactivity, and obsession/ compulsions among study participants. Many of these participants had no known pre-COVID mental health or neurodevelopmental challenges. According to Vaillancourt and colleagues (2021) virtually all aspects of children's development have been affected. A rapid review by Public Health Ontario (2021) found increases in conduct problems, suicidal ideation, alcohol consumption, sedentary behavior, screen time, food insecurity, and negative educational outcomes, as well as a decrease in physical activity. Ultimately, the COVID-19 pandemic disrupted the settings in which children live that had been structured and safe, making it difficult for young people to thrive (Vaillancourt et al., 2021). Deterioration in mental health across the student population has resulted in significant demands to promote and protect student mental health (Vaillancourt, et al., 2021).

Schools as Centers for Population Health Interventions

Schools are ideal environments to support (w)holistic health as they reach large groups of students during their formative years of cognitive, emotional, and behavioral development (Canadian Healthy School Standards, 2021; Manitoba Education and Early Childhood Learning, n.d). As schools provide a near-universal setting for students with trusted trained professionals, they are a crucial setting for supporting student mental health and overcoming inequities in mental health service provisions (Johnson et al., 2016; Lyon et al., 2013). Failing to address mental health in schools could have irreversible detrimental consequences (Halladay et al. 2020; Kutcher & Wei 2020; NASEM 2021; Ontario Ministry of Education 2013).

Tier 1 Mental Health Promotion

LPHAs and SMH-ON have mutually reinforcing mandates to advance school mental health promotion. However, LPHAs and SMH-ON currently lack a collaborative, systematic strategy for tier 1 mental health promotion in schools. According to the SMH-ON's aligned and integrated

model there are three levels to mental health services: tier 3 (intensive individualized intervention for diagnosed persons), tier 2 (focused for individuals and small groups demonstrating increased mental health needs), and tier 1 (mental health promotion and prevention interventions aimed at the whole population) (SMH-ON, n.d). Population mental health interventions, such as those that LPHAs are mandated to provide, fall into the category of tier 1 (Ministry of Health and Long-Term Care, 2018).

The Use of Implementation Science

Many evidence-based health practices fail to achieve their aims when implemented in the field. When explicit implementation strategies are deployed, they may not fit the context of the community. *According to Eccles & Mittman (2012) implementation science* is "…the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practice into routine practice and, hence, to improve the quality and effectiveness of health services". Causal pathway modeling is one implementation science methodology which has proven to be successful in enhancing implementation (Lewis et al., 2018). Causal pathway models represent the relationships between desired outcomes and the mechanisms to achieve them. They operate as "road maps" to outline the process to achieve a desired outcome. In this way causal pathways map how theory can become practice (Lewis et al. 2018).

Causal pathway models consist of several key elements: strategies, pre-conditions, mechanisms, moderators, proximal and distal outcomes. Strategies are starting points, the theme or concept which will begin the work of the model. Mechanisms are the actions, or the steps of the model. They are the tangible actions which move the work forward. Pre-conditions are factors that must occur before a mechanism can be actioned (Lewis et al, 2018). Moderators influence the implementation strategy, for better or worse, they are outside occurrences that effect the system (Lewis et al, 2018). While distal outcomes can be large systematic changes or ideal states, proximal outcomes are tangible "small wins" that indicate progression towards the goal or distal outcome (Lewis et al, 2018). They are achieved as a direct result of the mechanisms (Lewis et al, 2018). Refer to Figure 1 to view an illustration of a base causal pathway model.

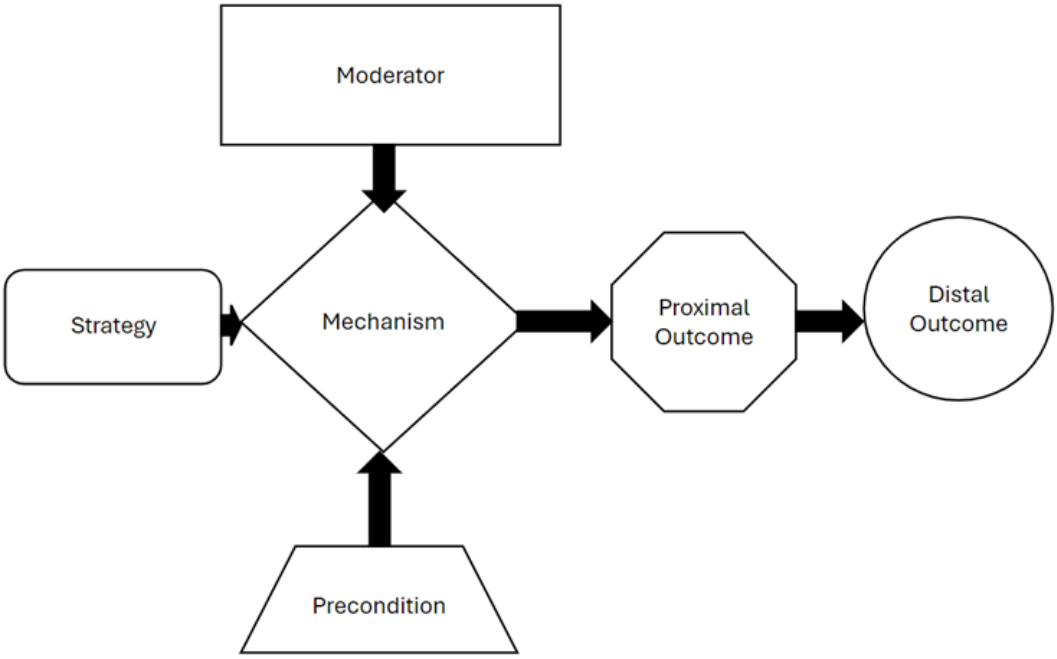


Figure 1 A Base Model for Implementation Science

Implementation science can be used to enhance collaborations within the space of tier one school mental health promotion by outlining the steps required to move towards system collaboration. In this project we have sought to better understand the challenges which exist within the field of tier 1 mental health promotion so that we could provide partners with causal pathway models inclusive of: proximal outcomes, pre-conditions, mechanisms, moderators, proximal and distal outcomes. The use of implementation science in this way can help to align partners and provide a joint vision for achieving tier 1 mental health promotion in schools.

Methods

Design

The study research question was: “How can system-level collaboration between LPHAs and SMH-ON support equitable tier 1 mental health promotion post COVID-19?”. Qualitative data was collected through four semi-structured discussion-based workshops using the Objective, Reflective, Interpretive, Decision (O.R.I.D) method. O.R.I.D is a process of facilitated engagement which walks participants through the process of sharing objective facts about the topic, followed by reflective feelings about the topic, then it encourages participants to integrate the two and finally asks participants to come to decisions on next steps (Stanfield, 2013). The semi-structured format of the workshops allowed for flexibility, encouraging participants to express themselves freely and elaborate on their unique viewpoints. The dynamic nature of the

discussions aims to uncover rich narratives to answer the research question and meet the study objectives.

The research team also engaged in iterative discussions, using these qualitative findings to develop causal pathway models that authentically represent participants' lived experiences and their visions for successful tier one student mental health promotion.

This study reflects the principles of phenomenology, recognizing the significance of knowledge derived from lived experiences and individual perspectives.

Ethics

This project has undergone a scientific and methodological quality review by Public Health Ontario as part of the locally driven collaborative process and received ethics clearance from the Public Health Ontario Ethics Review Board. File Number 2023-034.01

Participants and Recruitment

Workshops 1 and 2 consisted of participants from various LPHAs and SMH-ON who work directly in the field of tier 1 school mental health promotion. The intent of these workshops was to get a firm understanding of the strengths, weaknesses and barriers that exist when implementing tier one mental health promotion. In contrast, the final two workshops brought together participants in a leadership role who influence organizations mandated to provide tier 1 mental health promotion. The final workshops' intent was to find organizational and system-level solutions to the implementation problems identified in the first two workshops.

Participants were recruited through the Ontario School Health Managers Network and SMH-ON. Efforts were made to recruit participants with diverse experiences. LPHA representatives were recruited through presentations at the Ontario School Health Managers Network and through email invitations, which network members could then disseminate among their staff. LPHA leadership was recruited through email invitations and using a snowball technique (whereby a school health manager would agree to participate then work to recruit their leadership). SMH-ON participants (in all four workshops) were recruited through a presentation provided to their organization and email invitations.

Below are the inclusion and exclusion criteria for participation in the workshops:

Inclusion Criteria:

- Ability to speak, read and understand English.
- Ability to provide written consent to participate in the workshop.
- Ability to use, and access to, a computer with video and audio capabilities.
- An understanding of the relationship between Public Health Units and the school boards they service.

- An understanding of the Public Health School Health Standards as they apply to mental health promotion.
- A basic knowledge of who School Mental Health Ontario is.
- Employed by either Public Health or School Mental Health Ontario
- Agrees to participate in the workshops.
- *Workshop three and four specifically:* Takes a leadership role, that is responsible for school mental health promotion, within their organization.

Exclusion Criteria

- Inability to speak, read and understand English.
- Inability to provide written consent to participate in the workshop.
- Inability to use, and access to, a computer with video and audio capabilities.
- Lacking an understanding of the relationship between Public Health Units and the school boards they service.
- Lacking an understanding of the Public Health School Health Standards as they apply to mental health promotion.
- No knowledge of School Mental Health Ontario
- Not employed by either Public Health or School Mental Health Ontario.
- Disagrees to participate in the workshops.
- *Workshop three and four specifically:* Does not hold a leadership role, that is responsible for school mental health promotion, within their organization.

Procedure

Workshops

The four workshops were divided into two sections. Workshops 1 and 2 were designed to elicit strategies to improve collaboration and sought to hear perspectives from participants with lived experience working in tier 1 school mental health promotion. These workshops consisted of facilitated conversations around what participants believed was going well in the space of tier 1 school mental health promotion, what could be improved upon, and to gain insights into their ideas on what improvement would look like. Participants were then asked to vote on which strategies they felt were the most important, and the most feasible to implement.

Workshops three and four delved deeper into understanding the barriers and facilitators for implementing these strategies within their organizations and the broader system, contributing valuable insights for creating the causal pathway. During these workshops, participants were prepped on causal pathway models and asked to reflect on chosen strategies and discuss what barriers and facilitators existed to implementing them within their own organization and the system as whole. Through facilitated conversation participants reflected on the chosen strategies, and answered questions including:

- What needs to happen before this work takes place?
- What influences our ability to do this work?
- What actions need to be taken?
- What will success look like?

Workshops 1 & 2

Workshops took place virtually over the Zoom platform. They were transcribed by the zoom platform and checked for errors by a third-party data analyst. The data analyst attended workshops and made notes on relevant words, phrases, and body cues. These notes were used to ensure accuracy in the transcripts and the participant's intent. During these workshops participants generated strategies to enhance future collaborations between partners in the field of tier 1 school mental health promotion. Participants voted on the strategies in terms of importance and feasibility prior to the end of the workshop. The strategies outlined in these workshops, as well as the participants' votes facilitated the selection of the strategies for workshops three and four. The qualitative data analysis software NVIVO was utilized to organize and support the analysis.

Data Analysis

Workshop discussions were analyzed by a third-party data analyst, using an iterative thematic analysis, following the approach outlined by Renjith et al. (2021). This method aims to mitigate potential researcher bias and facilitate the inductive identification of data, coding, and common themes from the verbatim transcripts (Pope & Mays, 2020).

Strategy Selection

The strategies identified in workshops one and two were shared with the project team. After a thorough review and open dialogue among team members, considering participant votes, the frequency of strategy mentions in the workshops, and their understanding of tier one mental health promotion context, two strategies were chosen to advance into the third and fourth workshops.

Workshops 3 & 4:

Data from workshops three and four took place virtually on Zoom as well. Data was transcribed using the same process. During workshops three and four participants used a virtual white board to facilitate their discussion of causal pathway components. This white board was also analyzed by the third-party data analyst. Participants in workshops three and four voted on mechanisms and pre-conditions which they felt were the most important and the most feasible. The transcribed discussion, coded analysis, white board and votes were used to clarify and construct the final causal pathway models. The qualitative data analysis software NVIVO was utilized to organize and support the analysis.

Model Construction

Following the workshops researchers reviewed workshop data to ensure that the participants' ideas were correctly labelled as pre-conditions, moderators, mechanisms, proximal and distal outcomes. Researchers created models following a review of the strategies, voted on components, the social and political context, and background literature review.

The transcriptions, coded analysis, white board, and votes were reviewed by the research team. The research team reviewed the contributions of the participants. Researchers also considered the political and system context of tier 1 school mental health promotion, as outlined by the discussions in workshops one and two. Through a reiterative process researchers clarified the models identified by workshop participants, resulting in three causal pathway models.

Results

Workshops 1 & 2

Workshop one had eight participants, with three from SMH-ON and five from LPHAs. Similarly, workshop two also had eight participants, with three from SMH-ON and five from LPHAs.

Participants in workshops one and two participated in structured conversations using the O.R.I.D method to identify strengths, weaknesses, and barriers to implementing tier 1 school mental health. The themes they identified in Table 1.

Table 1. Strategies Derived from Workshops 1 and 2, with Indicative Quotes	
Strategy	**Example Quote**
1. Establishment of Joint Planning Mechanisms	*"Permission, and encouragement from leadership to do joint planning between our organizations and sharing of mandate, sharing of plans... so that we can start to see those connections that can be made."* [W1: 14:36:26]
2. Initiate Resource Mapping and Current State Analysis	*"I heard a couple of people talk about those monthly mental health meetings with their manager, maybe school health, mental health lead, and maybe even the coach in our area."* [W1: 14:18:1] "*We were blown away by the number of resources that had been created, such as from School Mental Health Ontario. So, we don't need to spend nearly that much time [on resource development] anymore, which is amazing.*" [W1: 14:03:5]
3. Standardization of Approaches and Expectations	"*Anytime we can standardize either the approach or some of the expectations across health units, it's helpful because then you're not spending all this time saying, well, what did you do? What did you do?*" [W1: 14:01:03]
4. Leverage Existing Platforms and Networks	"*Collaborating more with them and we have started ….we have instituted regular meetings together so we can collaborate and better align with our school boards.*" [W2: 10:22:24]
5. School Administrator Support	"*Again, I would like to build on those comments. I always think that the administrator is the one that sets the weather in the school, right?*" [W1:13:44:16]
6. Board level support	"*It really facilitates the process when we have school board buy-in and when they're engaged in the planning process*." [W1: 13:41:34]
7. Consistent and Standardized Data Sharing Practices	"*If there was a consistent school climate survey and then data sharing agreements so that we could all use that for our planning, and maybe the analysis was done at a provincial level*." [W1: 14:03:13]
8. Establish Data Sharing Agreements	"*If there was a consistent school climate survey and then data sharing agreements so that we could all use that for our planning*." [W1:14:02:45]
9. Ensure Consistency in Shared Indicators	"*If we had indicators that were shared, supported by the province, I think that would really advance the partnership and collaboration*." [W1:14:05:34] "*Clarity around shared indicators, data that is consistent across the province... standardized set of questions for school climate surveys would be extremely helpful*."[W1: 14:45:29]
10. Promote Success Stories and Collaborations	"*Profiling, exposure to successful projects and collaborations across the province... helps to know that down the road in Fort Francis and further down the highway in Thunder Bay, there are some really great things happening with partnerships*."[W1: 14:43:05]
11. Emphasize the Value of Partnerships	"*I would really like to see us approaching school boards, not just with the perspective of the people who are at that mental health table, but all of the people who work within the school board.*" - [W1:14:23:48]
12. Enhance Understanding of Public Health Roles	"*As a coach to watch to see if public health is named as a partner or initiative in the action plans going forward together is another opportunity to spark that discussion*." [W1: 14:19:54]
13. Creation of Institutional Continuity Resource Documents	"*Creating that document that could easily then be accessed when you're new in the role because there's so much new stuff when you come into this role*." [W2: 14:37:56]

Strategy Selection

At the end of the workshop participants were asked to vote, using the chat or hand raising function on Zoom, on which themes they wanted to bring forward as strategies to the final two workshops. Taking this into consideration, along with political and system level context, as well as background findings project team ultimately selected two themes to bring forward to workshops three and four. They were:

1) Consistent and Standardized Data Sharing Practices
2) Establishment of Joint Planning Mechanisms

Workshop 3: Consistent and Standardized Data Sharing Practices

Workshop three consisted of eleven participants. Three from SMH-ON and nine from LPHAs. Participants in this workshop reviewed the strategy - Consistent data sharing practices.

Prior to forming consistent data sharing practices participants believed that they would need:

- **Agreed Upon Indicators**
  "But it would be one if there were some agreed-upon indicators and it doesn't have to be a lot, a couple of indicators about tier one mental health service and substance use." W3Time Stamp: 14:13:40
- **Capacity to Collect Data**
  "*I think one of the challenges in terms of reviewing existing data indicators is, you know, research departments that* [all] *boards are not created equal."* W3Time Stamp: 14:15:48
- **Partnership Agreements & a Trusting Relationship**
  "*So having actually a formal agreement between a health unit and the board as to, you know, what, what this kind of shared work is."* W3 Time Stamp: 14:17:42

When asked what influences the participants' ability to do this work, they responded with:

- **Role Clarity**
  "So one other item that we had talked about as a precondition was role clarity. So having all key partners at the table understand what is a mandate for public health, the different applicable legislation that would apply for us to seek certain pieces of data." W3 Time Stamp: 14:20:31
- **Clarifying Mandates**
  "*It is really important that we provide a united front in terms of what our understanding of mental health promotion is within public health to provide clarity*." W3 Timestamp: 14:23:32

When asked what actions need to be taken participants responded with:

- **Development of Data Sharing Template**
  "The process to get into the agreement is the mechanism. So what would it take to get a template for data sharing?" W3 Time Stamp: 14:11:29
- **Role of Provinces in Mechanism**
  *"It would give that permission, the data sharing's okay because it came provincially, who would say this has been done elsewhere, but it also works through some of the hurdles of, well, how should we do that?"*W3 Time Stamp: 14:11:48
- **Identifying Existing Data Sharing Agreements and Shared Indicators**
  "So like you can, you're not starting from scratch. There's lots of good work that's already been done." W3 Time Stamp: 14:11:55
- **Collaboration at Ministerial Level**
  "*The ultimate mechanism for all of this would really be collaboration at the ministerial level and agreement across Ministry of Health and Ministry of Education*."W3 Timestamp: 14:25:23
- **Shared Priorities**
  Ideas arose such as shared language, shared mandates, understanding shared goals, shared priorities.
- **Data Use and Availability & Tools To Inform The Relationship**
  "*We're, the usefulness of the data, whether, you know, is it timely to be able to get the data, is it mutually beneficial?"* W3Timestamp: 14:26:31
- **Consent Considerations**
  "*Consent considerations around data and collection of data and the big debate between active and active consent and trying to navigate that within the school boards..."*W3Timestamp: 14:27:19
- **Political Environment**
  "*The political system or the political environment may be a factor when we're talking about this..."*W3 Timestamp: 14:28:36

From these actions participants voted on the most important to their organizations, and the most feasible. Participants were instructed to vote for their top two options. Some participants chose only to vote for one option. The results of their votes were:

- Reviewing existing data sharing agreements, 6 votes.
- Reviewing existing data indicators, 6 votes.
- Accessing and sharing blueprints, 5 votes.
- Tools to inform relationships, and work done together (e.g., templates for data-sharing agreements), 1 vote.
- Role Clarity: all key partners at the table understand what the applicable legislation that applies, 1 vote.

When asked to identify what success will look like participants of workshop three, consistent data sharing practices, shared the following ideas:

- **Definition of Data Sharing Agreement**
  "*So one of the mechanisms that I think would be really helpful is that we have many health units and school boards that have data sharing agreements, but we have many that don't".* W3 Time Stamp: 14:10:24
- **Provincial Data Sharing Agreement Template (Provincially approved data sharing agreements)**
  "If there was a provincially provided vetted kind of data sharing agreement that other boards and health units could use specific, I think you know in this instance it could be specific to substance use and tier one mental health." W3 Time Stamp: 14:10:34
- **Collaboration**
  "Somewhere along this system or this pathway that we're creating, it would be helpful to have some other tools of how we can use data to drive those decisions..."W3 Timestamp: 14:33:09
- **Common Vision for Data/ Shared Measures of Effectiveness**
  "*We're all being tasked to show value for money to show that this work is making a difference, but yet we're not all singing from the same playbook about what data we're using..."* W3 Timestamp: 14:34:37

Participants were asked to vote on which idea of success was the most important and the most feasible for their organizations. Again, participants were told they could vote twice, though not all participants chose to. They voted as follows:

- Provincially approved data sharing agreements, 4 votes.
- Shared measures of effectiveness: common vision of what the data would tell us, 3 votes.
- Understanding shared goals, language, and mandates, 1 vote.

Workshop 4: Joint planning mechanisms

Workshop 4 consisted of ten participants: four from SMH-ON and six from LPHAs.

Workshop 4 centered around the theme of joint planning mechanisms. Like workshop 3, participants who were leaders in their organizations were asked the following questions:

- What needs to happen before this work takes place?
- What influences our ability to do this work?
- What actions need to be taken?
- What will success look like?

When asked what would need to happen before this work takes place participants responded with:

- **Timing and Permission**
  "Having the time/permission to attend these meetings and be involved." W4: 09:49:14

- **Collaboration Across Boards**
  "Collaboration across multiple boards and health units within one geographical region." W4: 09:52:10
- **Access to Data**
  "Access to data to help set our priorities." W4: Timestamp 10:11:30
- **Leadership Buy-In**
  "It's getting the buy-in, I guess, back at my health unit. Right, leadership buy-in from your own individual." W4: Timestamp: 09:49:28

When asked what would influence the ability of their organizations to partake in the work participants responded with:

- **Relationships and Shared Values**
  "One of the things that I had also written down and I'm not sure if it falls in the category precondition or moderator, but it's about relationships themselves." W4: Timestamp: 10:01:25
- **Professional Designations**
  "*Professional designations - And I've heard a lot around professional designations coming into the conversation. So is, you know, is this work appropriate for a public health nurse versus for an educator and what's the educator's role versus for an educator's role versus a social worker's role or another, you know, mental health*" W4: Timestamp 10:07:52
- **Differences in Systems and Partners**
  "*Each system is set up differently with multiple partners that overlap on this work*." W4: Timestamp 09:59:09
- **Collaboration Challenges**
  "Collaboration across public health units and with co-terminus boards together to have a larger planning table rather than public health having to do it with 2 or 3 school boards." W4: Timestamp: 09:52:35

  "There's something about collaboration there across public Catholic French boards and also around units that might cross over those boundaries." W4: Timestamp: 09:53:06
- **Resource Allocation**
  "A precondition being budget or resource allocation. Just making sure that we have, you know, the people on the ground to do the work." W4: Timestamp: 09:53:11

When asked what actions needed to be taken by their organizations to address the strategy participants responded with the following:

- **Joint Action Planning**
  "Where we identify some common goals, then that might provide a map for where we're going and how we're doing the work." W4: Timestamp: 09:31:47
- **Clear Timelines**
  "*And so I think one of the things that we've always struggled with is an example of*

making sure that our planning timelines align as an example with our school boards, which we know, you know, 2 school years crossed every single calendar year." W4: Timestamp09:34:44

- **Partnership Agreements**
  "*Each board, by board, by region partnership agreement. Yeah, cause without that then it would be obviously difficult"* W4: Timestamp: 09:50:10
- **Provincial Level Shared Vision/Right Time Right Care**
  "*A statement that has been supported by both ministries, to me, that's a proximal. It's not distal; it doesn't get the work done; it's a step along*." W4: Timestamp: 09:46:19
- **Professional Designations and Role Clarity**
  "I've heard a lot around professional designations coming into the conversation... being very clear on what fits best within someone's scope of practice." - W4: Timestamp: 10:07:52

Participants voted on which actions they saw as the most important and feasible to their organizations. Participants were instructed to vote for their top two options. Some participants chose only to vote for one option. Their votes were as follows:

- Joint action planning, 6 votes.
- Provincial level shared vision/ Right Time Right Care, 4 votes.
- Professional designations and role clarity, 2 votes.
- Clear timelines, 2 votes.
- Partnership Agreements, 1 vote.

Finally, participants were asked, "What will success look like?" They described the following outcomes:

- **Framework Implementation**
  "The meetings that happen are an outcome. So, and that's exactly the sort of proximal outcome that we want to be clear about… Like a framework for meetings. [What would] the meetings [that] have actually occurred be? That's what I mean about sometimes it might seem obvious what the outcome is, but we just want to be as explicit as possible and establishing the model." W4: Timestamp 10:36:27
- **Repository For LPHA Models**
  "I can see a repository of the various models. Like, I think it's probably important for us to have…With the range that even came up on Tuesday, in terms of public health models across the province, for school health teams to have [models] documented somewhere to inform [ongoing practice]." W4: Timestamp 10:34:24
- **A Mechanism to Share the Wealth**
  "*Kind of that planning because you know if we if we're going to share something back we need to be sure that it works within the frame of existing models."* W4: Timestamp 10:34:24
- **A Plan for Intentional Work**
  "And so I think one of the things that we've always struggled with is an example of making sure that our planning timelines align as an example with our school boards,

which we know, you know, 2 school years crossed every single calendar year." W4: Timestamp 09:34:45

- **Collaboration Across Boards**
  "*Buy-in or engagement at school boards and I would kind of extend that not just at a board level but also at school leadership level*." Timestamp: 09:49:45

Participants were asked to vote on which versions of success were the most important and feasible to their organizations. Participants were instructed to vote for their top two options. Some participants chose only to vote for one option. Their responses are as follows:

- A plan for intentional work, 5 votes.
- A framework for implementation and collaboration, 4 votes.
- A mechanism to share the wealth, 3 votes.
- A repository for models in LPHAs, 3 votes.

Participants in workshop four were able to answer the additional question of "is there anything we can do in our organizations to set this path in motion?". From this discussion, the participants of workshop four provided the following insights.

- Commitments to collaboration and partnerships going forward
- Addressing existing challenges
- Creating a sense of urgency and purpose
- Learning from past initiatives
- Creating recommendations for action
- Recognizing and building on existing foundations
- Intentional knowledge translation and advocacy work
- Recognition for realistic time frames.

Model Construction

The project team reviewed and discussed the workshop results. The team used this data, as well as their contextual understanding of political and system influences, to develop three casual pathway models: one for the theme of joint planning mechanisms and the second for the theme of consistent data practices. These models are expanded on in the discussion section below.

Discussion

Following the COVID-19 pandemic the need for tier 1 mental health promotion interventions within schools became more evident. Both LPHAs and SMH-ON are mandated to provide tier 1 mental health promotion interventions, the aim of this project was to answer the question: "How can system level collaboration between Local Public Health Agencies (LPHAs) and School Mental Health Ontario (SMH-ON) support equitable tier 1 mental health promotion post COVID-19?" The study's objectives included: identifying feasible implementation strategies and to design a causal pathway for those implementation strategies. This section will review the identified implementation strategies and the causal pathway models developed. It will also discuss challenges within school mental health promotion that participants identified and provide recommendations addressing them.

The first model, "creating a shared vision," addresses the strategy of establishing joint planning mechanisms by focusing on a co-developed vision for tier 1 mental health within Ontario schools. This model's objectives are to clarify roles and responsibilities across the system of care and improve the experience of students through a shared vision and intentional joint planning. A shared vision for collaborative work would include SMH-ON, LPHAs and engage local school boards.

The second and third models are related to support enhanced "consistent data sharing strategies." Models two and three are critical to monitor the impact of tier 1 mental health promotion. These models represent the processes of identifying consistent indicators which could be shared across organizations and creating a standardized data sharing template. Together these models help align data sources and metrics across the system. Implementation of these models will result in more consistent planning, monitoring, evaluation, and ultimately more informed decision making.

The three models reflect the challenges which exist within tier 1 mental health promotion currently experienced within the school context. The models also reflect the opportunities to move forward together towards a more unified and effective practice in school mental health promotion. These models represent starting points for partners to streamline and improve collaborative tier 1 mental health promotion within schools. They can build off each other or be used independently. While they are a start, we hope that organizations grow their partnerships to expand beyond these models, to address the other strategies identified in the workshops and to overcome new challenges as they appear.

Model 1: Creating a shared vision.

The first model, "creating a shared vision," focuses on developing a clear vision for tier 1 mental health within Ontario schools. The end goal, or distal outcome, of this model is improved tier 1 school mental health service within the province of Ontario.

Workshop participants commented on the multiplicity of partners working on school mental health promotion, each bringing their own vision. Without a clear shared vision, it increases the difficulty of creating co-ordinated and effective services. Participants talked about the value of the "Right Time, Right Care" document (School and Community System of Care Collaborative, 2022) . This document defines a vision for school-community system of care for young people experiencing mental health concerns. Its focus is on improving the experience of students and families navigating tier 2 and 3. During our workshops, participants highlighted the necessity of a similar vision for tier 1 student mental health promotion. It was also noted that a shared vision would support the implementation of Policy and Program Memorandum (PPM) 169. PPM 169 outlines requirements for school boards and school authorities to provide culturally responsive, evidence informed, student mental health promotion that respects students as complex individuals and provides them with the appropriate supports (PPM 169, 2023).

Participants identified that to achieve an implementation framework, several steps would be required: specifying mandates and roles, reviewing existing school board and LPHA partnership agreements, establishing joint planning tools, and developing a framework for implementation and collaboration.

Roles and mandates were a re-occurring theme throughout all four workshops. Participants understood that to better understand the scope of the work, allocate resources, and provide the best care, partners needed to be informed on who operated within the space, what mandates they followed, and which specialized skills they used.

"Having all the key partners at the table, understand what is the mandate of public health, the different applicable legislation that would apply for us to seek certain pieces of data" W3 time stamp: 14:20:31

"It is really important that we provide a united front in terms of what our understanding of mental health promotion is" W3 Timestamp: 14:23:32

"…being very clear on what fits best within someone's scope of practice" W4 Timestamp: 10:07:52

Workshop participants highlighted the review of existing agreements between schools and public health units as a potential step toward establishing a shared vision for tier 1 mental health services. Participants noted that the mandate of public health units in schools is broad. At the time of the study there were 34 public health units across the province with differing capacities and tier 1 services in schools. To better understand the work occurring between public health and school boards workshop participants recommended reviewing existing partnership agreements that currently exist between local public health units and school boards. Not only are the agreements a rich source of information about the working relationships and tier 1 services that currently exist within the province; there is an opportunity to update those

agreements in future to support the implementation of a shared vision for tier 1 mental health work once that vision is established.

By aligning on a shared vision, mandates, and role clarity, agencies can collaboratively engage in joint planning. Actively identifying or creating opportunities for joint planning will bolster the successful implementation of mandates and foster the continued development of our shared vision. One participant stated that joint planning served as an opportunity to

> *"Identify common goals … that might provide a map for where we're going and how we're doing the work" W4: Timestamp: 09:31:47.*

Another participant noted that.

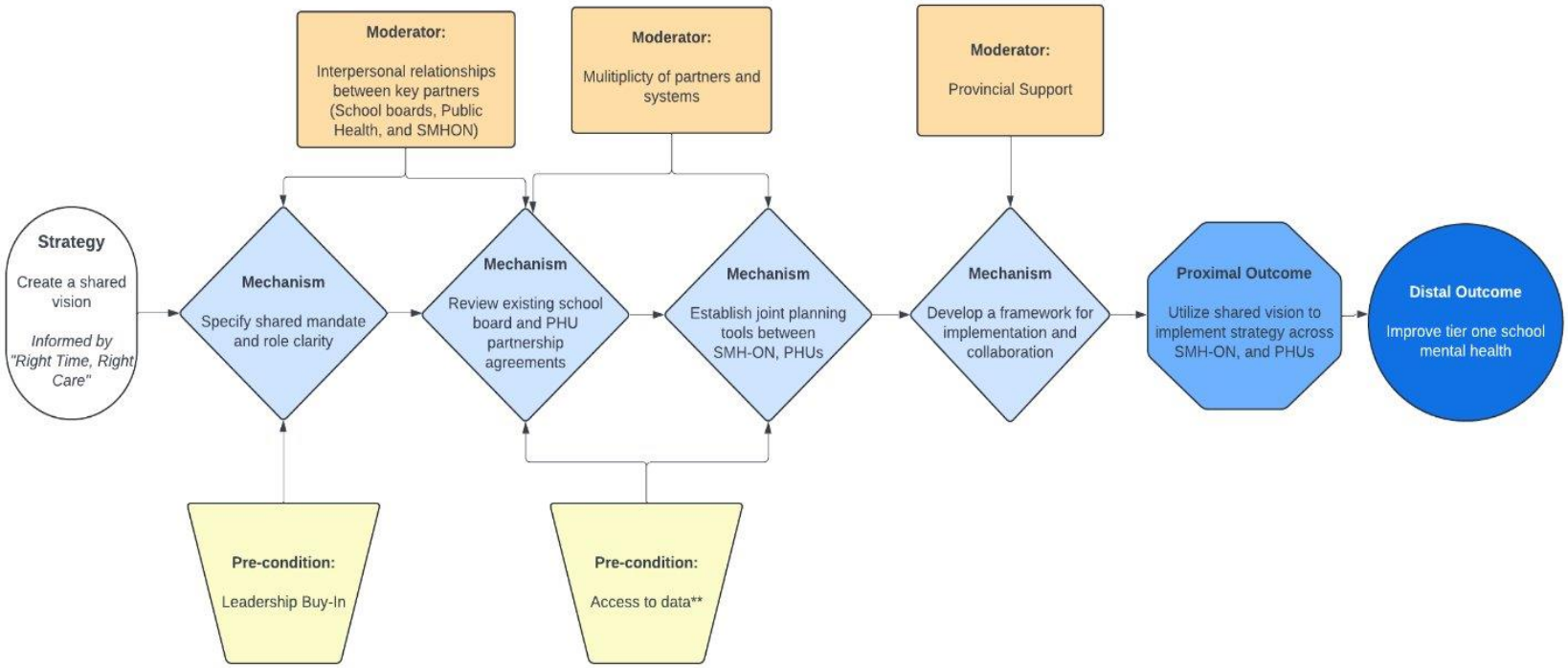
> *" …one of the things that we've always struggled with is, an example, of making sure that our planning timelines align, as an example, with our school boards, which we know, you know, two school years crossed every single calendar year" W4 Timestamp: 09:34:45*

Having a shared vision and clear understanding of overlapping or complementary mandates, roles, and responsibilities will result in enhanced partnerships. Further, engaging in joint planning opportunities will support a coordinated approach to care, and improve the overall experience for students.

Pre-conditions, factors that must occur before these mechanisms can be taken, are leadership buy-in and access to data. Without leadership buy-in, participants anticipated that it would be difficult to have the time and resources for prioritizing this work. Leadership buy-in is a key component of acquiring data for this model (such as access to existing partnership agreements). Data sharing and identification of consistent tier 1 mental health indicators were a significant theme from workshop stakeholders. The data is a critical step to prioritizing tier 1 mental health services and evaluating the impact of the work.

Moderators, factors that influence the system, (in a positive, negative, or neutral way) include: interpersonal relationships between key partners, multiplicity of partners, and provincial support for such initiatives.

Model 1: Creating a shared vision.



** indicates research participator contributions

Recommendation: Create a vision for tier 1 school mental health promotion that explicitly outlines the scope of tier 1 school mental health promotion within schools.

1.1 To improve the provision of tier 1 mental health programs and services in schools, it is recommended to establish a leadership table with representatives from SMH-ON, local public health units, and other key agencies. The aim of this table is to identify and discuss shared mandates, provide direction on role clarity, and facilitate effective collaboration among different agencies.

1.2 Review existing school board and public health partnership agreements to better understand the scope of work occurring across the province.

Recommendation 2: Create a provincial joint planning group comprised of SMH-ON and agencies mandated for tier 1 school mental health in schools. The group's responsibilities include identifying existing agency-specific planning and reporting documents, as well as exploring new or coordinated opportunities to enhance tier 1 mental health promotion.

Recommendation 3: Implement SMH-ON and LPHA-specific tangible joint planning opportunities such as

3.1 Public Health Units be included as collaborative partners when school boards complete School Mental Health Action Planning with SMH-ON.

3.2 Communicate mental health action planning timelines/deadlines to PHUs; allowing them to build these timelines into their planning cycles.

3.3 SMH-ON coaches encourage school board mental health leads to pursue partnerships with public health.

3.4 Have SMH-ON coaches share examples of successful collaborations between PHUs and Boards of Ed to expand on successful strategies.

<u>Models Two and Three: Consistent Data Sharing Practices</u>

Consistent data sharing practices was identified in multiple workshops as key success factors in system-wide collaboration and evidence informed practice. Data is used for a variety of purposes when planning, implementing, monitoring, and evaluating mental health promotion programming within schools. However, data sharing is limited and made more complex with the multiplicity of partners. One key complexity is the differences in data collected by each partner. Partners must collect data on their populations according to their mandates. This results in different types and styles of data collected.

Public health units collect data related to population health from a variety of sources such as the Ontario Drug Use and Student Health Survey, the census, hospitalization rates, internally created health reports, and data reported as part of program offerings (i.e, immunization rates, the rates of infectious disease, etc.). Where partnership and data sharing agreements exist, they also make use of their partner's data; an example would be a School Climate Survey or Student Census completed by a school board partner.

Many school board partners have their own research and ethics teams which are in control of their own data collection and analysis. There is not one consistent School Climate Survey Tool

or Student Census Survey Tool in the Province of Ontario. The result is diverse data sets across school boards.

School board data overlaps with the data that SMH-ON collects. SMH-ON works as an implementation support agency providing guidance to the school boards on topics related to implementation of identity-affirming student mental health supports and services. SMH-ON conducts an annual scan of local school boards' self-assessment of six mental health implementation foundations. These foundations are:

1) leadership commitment
2) engagement and collaboration
3) vision and strategy
4) dedicated infrastructure
5) protocols and processes
6) evidence and monitoring

In addition to these self-assessments, SMH-ON also inquires about key elements of their School Mental Health Strategy 2022-2025, which includes several tier 1 elements:

1) identity-affirming school mental health.
2) parent, caregiver, and community connections/ support.
3) system, school, classroom mental health leadership.
4) strength-based mental health promotion.
5) mental health literacy and stigma reduction.
6) student leadership, participation, and agency.

In order for data-informed practices to be coordinated between partners and across the system, agreed upon data sets need to be established. Therefore, the final model focuses on the need for consistent data indicators and data sharing practices.

Model Two: Identification of Consistent Data Indicators

Model 2, titled "Consistent data indicators", focuses on establishing standardized tier 1 mental health indicators to ensure consistent data collection throughout the province. These findings are aligned with the results from the 2017, Children Count Locally Developed Collaborative Project, which found that 94% of LPHAs surveyed said that current available data does not meet needs for assessment, planning and evaluation. Moreover, 88% of LPHAs underscored the need for a coordinated system to monitor child and youth data across Ontario.

Workshop participants discussed the utilization of diverse school climate surveys by school boards, leading to variations in mental health indicators across the province.

> *"Clarity around shared indicators, data that is consistent across the province… standardized set of questions for school climate surveys would be extremely helpful." W1 Timestamp: 14:45:29.*

It was noted that collating existing indicators would be a good starting point to developing a standard set of indicators.

> *"You're not starting from scratch. There's lots of good work that's already been done". W3 Timestamp: 14:11:55.*

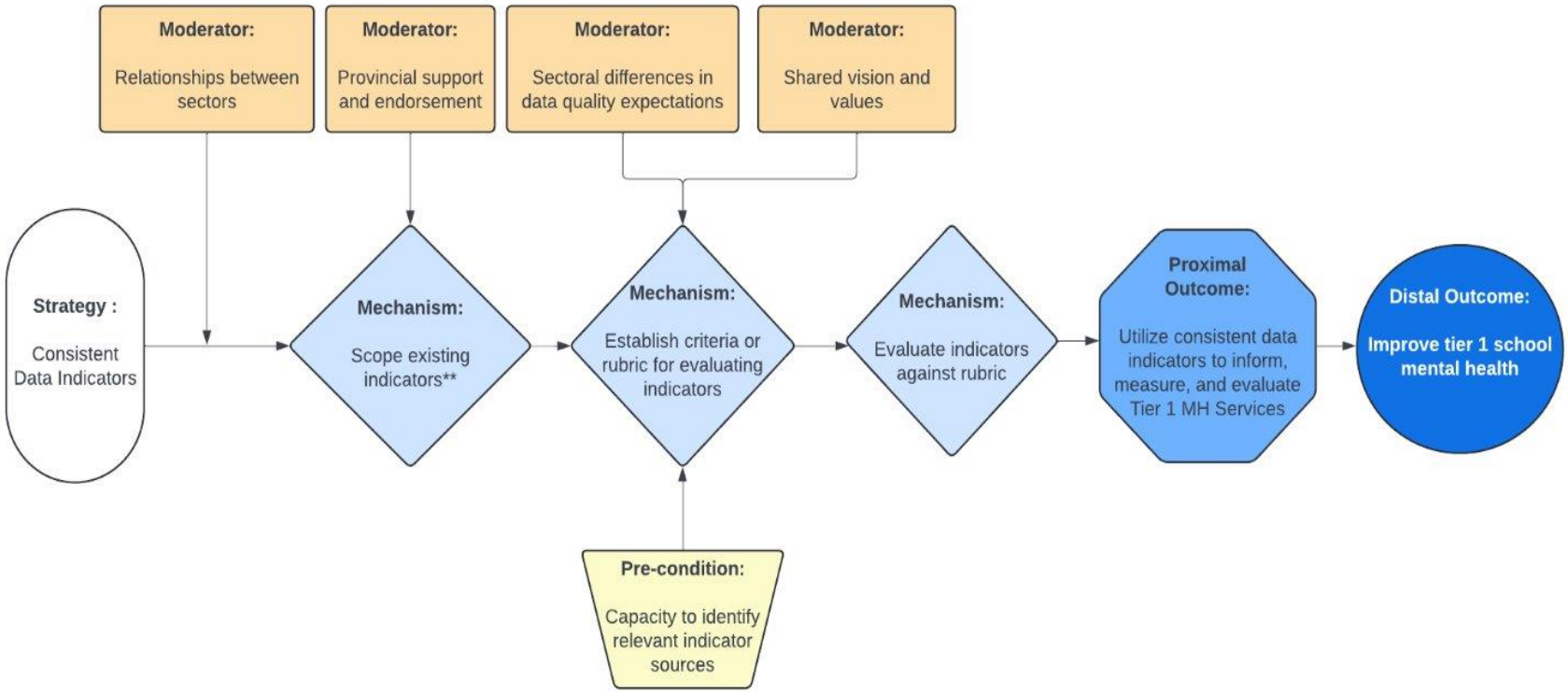
Examples of data collection tools with tier 1 mental health indicators include the Healthy Living Module published in the Children Count LDCP Report (Children Count Task Force, 2019.), COMPASS and school climate surveys.

The consolidation of existing indicators, coupled with a thorough review and the suggestion of additional or alternative indicators, should be carried-out by a team comprising of individuals from diverse sectors who are mandated to provide tier 1 mental health programs and services in schools. These may include, but are not limited to SMH-ON, School Boards, and Public Health. It is crucial that these indicators embody a shared vision and remain pertinent to all stakeholders, reflecting the guiding philosophies of each partner and prove valuable within their respective scopes of work.

A consistent set of indicators will allow for partners to begin the conversation around data sharing, align partner priorities, form expectations around data use and availability, and finally ensure that programs are effective across the province.
Establishing a consistent set of indicators for regionally collected data offers numerous advantages in assessing the well-being of the child and youth population. Firstly, having standard indicators across the province enables benchmarking and the identification of trends and disparities across regions, facilitating targeted, and equitable interventions where they are most needed. A set of common mental health promotion indicators will allow policymakers and stakeholders to gauge progress over time and ultimately improving tier 1 mental health services.

The end goal, or distal outcome, of this model is improved tier 1 school mental health service within the province of Ontario. This work will be influenced by a range of factors. The capacity to find, use and evaluate existing indicators is a pre-condition to this work. Several moderators could influence the success of this work, including existing relationships between partners, the ability to overcome sectoral differences in data needs and collection, the creation of a shared vision and aligned values, and finally whether the project is endorsed by the province and made widely available for use.

Model Two: Identification of Consistent Data Indicators



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Recommendation 4:

Establish a *Provincial Child Mental Health Indicators* workgroup, consisting of representatives from various partners, with the objective of identifying, evaluating, and drafting consistent data indicators for use in tier 1 mental health promotion.

4.1 Collate existing tier 1 data indicators used by local school boards and public health.
4.2 Explore the feasibility of using indicators identified through Children Count as past Locally Developed Collaborative Project.

Establish guidelines or criteria for the evaluation of current indicators and the formulation of new ones.

Recommendation 5:

Establish a *Provincial Child Mental Health Indicator Implementation Workgroup.*

5.1 Formulate advocacy strategies aimed at securing support from the Ministries of Health and Education, as well as garnering endorsement at the school-board level to support and implement the data collection for identified indicators
5.2 Develop a comprehensive dissemination strategy to share the identified indicators.

<u>Model Three: Implement Data Sharing</u>

Model 3, titled "Implement Data Sharing", focuses on creating a template data sharing agreement and process to achieve the sharing of data. During the workshops, the idea of establishing data sharing agreements came to the forefront.

> *"If there was a consistent school climate survey and then data sharing agreements so that we could all use that for our planning" W1 Timestamp: 14:02:45.*

Participants also noted that having a standard data sharing agreement would overcome some concerns regarding data sharing, and would help organizations:

- Navigate the creation of data sharing agreements with multiple partners,
- Set expectations around data use.
- Provide timelines which could assist with joint planning.
- Identify potentially useful dataset for sharing.
- Address capacity constraints that exist due to varying school board and LPHA capacity.

Participants noted that a review of existing LPHA and School Board data sharing agreements would be an important first step in creating a template data sharing agreement. In addition, it was noted that these agreements should be reviewed with the partners and organizations who successfully negotiated, with the aim of gaining insights to inform the development of a standard data sharing agreement. Key questions to address include:

- What strengths, and weaknesses have been identified within their existing agreements?

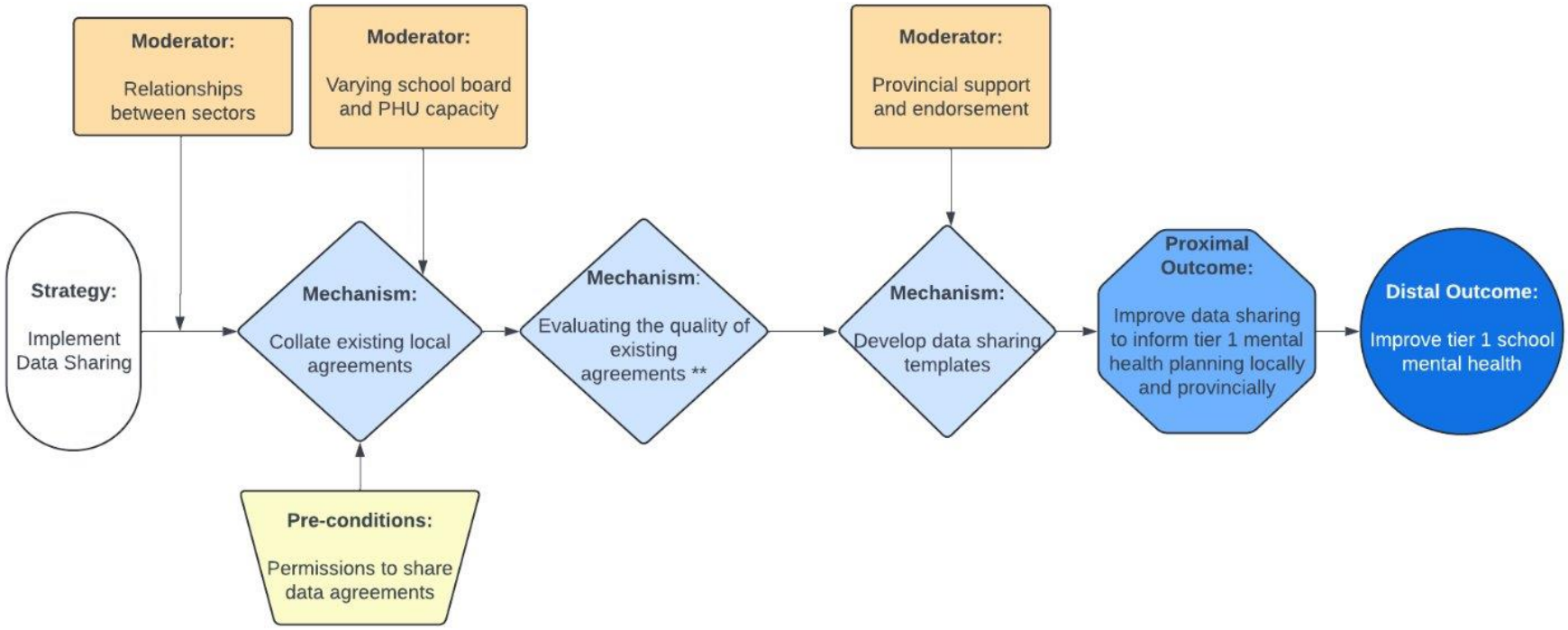
- How can the local learnings be incorporated into a standardized or template data sharing agreement to support and enable consistent data sharing across the province thereby strengthening tier 1 mental health services?

Developing a consistent standardized data sharing agreement will improve data sharing to inform local and provincial tier 1 mental health services. It will also normalize the collection and sharing of data across multiple organizations, ultimately facilitating ongoing collaboration towards joint goals. It will be important to recognize that data sharing agreements will need to be adapted to represent the needs of local organizations and the communities they serve.

The pre-condition for model three is the ability to obtain data sharing agreements to review.

The ability to create a template for data sharing is influenced by several moderators. As with the other models, the existence of positive relationships between leadership will allow for increased trust and more productive collaborations. Provincial endorsement of this initiative would increase participation and distribution. Finally, it is important to recognize that each organization has differing capacity to collect, analyze and use data according to its resources, size, and other factors.

Model Three: Consistent Data Sharing



** indicates research participator contributions

Recommendation 6:

Establish a provincially supported data sharing agreement review committee, with the mandate to create a standardized data sharing template.

6.1 To optimize data sharing practices, standards and protocols, establish a provincially supported Data Sharing Agreement Review Committee.
6.2 Create a standardized data sharing template by reviewing existing data sharing agreements and obtain insights from partners and organizations who successfully negotiated agreements.
6.3 Ensure the template is reviewed by PHUs and School Boards across the province to identify and assess potential risks associated with data sharing initiatives and ensure its usefulness and applicability.

Recommendation 7:

Develop a dissemination strategy to share standardized data sharing template and a process to help support uptake.

7.1 Identify key collaborators within the realm of school mental health data collection who are responsible for implementing local LPHA and School Board data sharing agreements.
7.2 Promote the template to provincial organizations such as the Council of Directors of Education (CODE) and Council of Medical Officers of Health (COMOH), Provincial School Managers, School Board Mental Health Leaders to normalize the collection and sharing of data to support tier 1 mental health service planning and evaluation.
7.3 Continuously evaluate and refine the effectiveness of data sharing practices.

In conclusion, the two strategies brought forward to workshops three and four were joint and consistent data sharing practices. Three models were then created: 1) creating a shared vision, 2) creating consistent data indicators, and 3) creating a template for data sharing agreements. Users have the flexibility to utilize these three models either sequentially, independently, or jointly. Ultimately, for a vision document to be effective it will need to be embedded within the work of models 2 and 3. However, this work is iterative in nature and if partners must wait for the linear fashion of model 1, 2, 3 it may stagnate local work that is already advancing. There are many strong partnerships that exist between local LPHAs, SMH-ON and local school boards. The intent of this project and accompanying findings is not to slow the local work but rather to try and enhance and support the provincial work of tier 1 mental health. The intent of these models is to form a broad guideline to how partners in tier 1 mental health promotion may overcome some of the common challenges in tier 1 school mental health promotion, as identified by workshop participants. The models, their following recommendations, and actions, are informed by the workshops and the context of tier 1 mental health promotion as it currently stands within Ontario.

Limitations

Limitations of this project include: a tight funding timeline, organizational changes, inability to complete sustainability evaluation, and geographical limitations.

This project was funded for a period of nine months, with an extension of two months by Public Health Ontario. Having additional time would have allowed us to explore implementation models for more strategies; and to create a framework for how these models work together.

During this project LPHAs across the province were experiencing budgetary constraints and potential merger requests. This resulted in changes to the project team, and a lack of certainty regarding the outcomes of the project. Unfortunately, these changes to Public Health will impact evaluation going forward as staffing changes at participating LPHAs, along with limited project timelines, prevented sustainability evaluations to be completed on the models.

Given the vast geographical expanse of participants and partner organizations involved in this project it was not feasible to meet in person for workshops. This resulted in reduced nuanced in participation and response coding.

Finally, although participants in workshops three and four were briefed on causal pathway modelling workshop time was inadequate in building their skills to the point where they could draft their own models. Consequently, co-designing models was not feasible resulting in the project team having to interpret the identified themes and create the final causal pathway modeling.

In future iterations of this work, we would recommend ensuring adequate time for participants to understand causal pathway modelling, and meeting in person. It will be important for adequate time to be allotted to the workshops and for the model construction. We suggest that future work focuses on building out models for the other themes identified in workshops one and two. We also suggest putting the models created into action to test their usability and effectiveness in the field of tier one student mental health promotion.

Next Steps

To provide a meaningful and collaborative approach to tier 1 school mental health promotion across Ontario, a further investment in joint planning and data sharing at the local, regional and the provincial level is needed.

The continued partnerships between LPHAs and SMH-ON will provide an invaluable opportunity to further support the mental health and wellbeing of the students of Ontario. However, additional partners, such as school boards, need to be considered in future steps. As partnerships form, they will experience their own unique set of challenges. Our hope is that by initiating these discussions and laying out the groundwork partnerships can begin and gain momentum.

Both regional and provincial partnerships are needed to move this work forward. As one compliments the other. This work is relational based and requires strong leadership and organizational trust in the potential benefits to both the system and to the students in which it serves.

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Appendix A: Identified Strategies

Strategies to Improve Collaboration in Tier 1 School Mental Health Promotion:

1. **Establishment of Joint Planning Mechanisms:**
    - Participants proposed the encouragement and permission from leadership to engage in joint planning between organizations. This strategy involves sharing mandates, plans, and documents to identify common goals and avoid duplication of efforts.
2. **Creation of Institutional Continuity Resource Documents**
    - The idea of creating resource documents, similar to an extensive guide or a concise one- to two-pager, was suggested. This document would introduce newcomers to the roles, mandates, and collaborative possibilities within mental health promotion, providing a practical and useful reference.
3. **Consistent and Standardized Data Sharing Practices:**
    - Participants called for consistent and standardized data sharing practices, emphasizing the importance of shared indicators and a standardized set of questions for school climate surveys. This strategy aims to establish uniformity in data collection and reporting across different regions.
4. **Establish Data Sharing Agreements:**
    - Advocate for the development of data sharing agreements between health units, school boards, and relevant stakeholders to prevent duplication of work.
    - Highlight the efficiency gained through shared data analysis, leading to more informed decision-making.
5. **Promote Success Stories and Collaborations:**
    - Encourage the sharing of successful mental health projects and collaborations across different regions in the province.
    - Create a platform or mechanism to profile and expose successful initiatives, providing inspiration and examples for others.
6. **Emphasize the Value of Partnerships:**
    - Stress the importance of valuable partnerships between health units, school boards, and other organizations.
    - Make explicit the significance of these partnerships, ensuring they are highlighted and recognized at the provincial level.
7. **Ensure Consistency in Shared Indicators:**
    - Advocate for clarity around shared indicators and consistent data collection methods across the province.
    - Propose the development of standardized sets of questions for school climate surveys, allowing flexibility for individual boards while maintaining uniformity.

8. **Leverage Existing Platforms and Networks:**

   - Encourage the use of existing platforms, such as the Ontario School Health Managers Network and CODE-COMO, for collaboration and information exchange.
   - Explore the possibility of an annual matchmaking service to ensure alignment between organizations.

9. **Enhance Understanding of Public Health Roles:**

   - Emphasize the importance of a deeper understanding of public health roles, particularly among implementation coaches.
   - Propose initiatives or training programs to enhance awareness and collaboration between different stakeholders.

10. **Initiate Resource Mapping and Current State Analysis:**

    - Support the initiation of a comprehensive resource map to understand the current state of mental health promotion resources and services.
    - Advocate for a focused effort in defining the existing landscape to inform future strategies.

11. **School and School Board Support:**

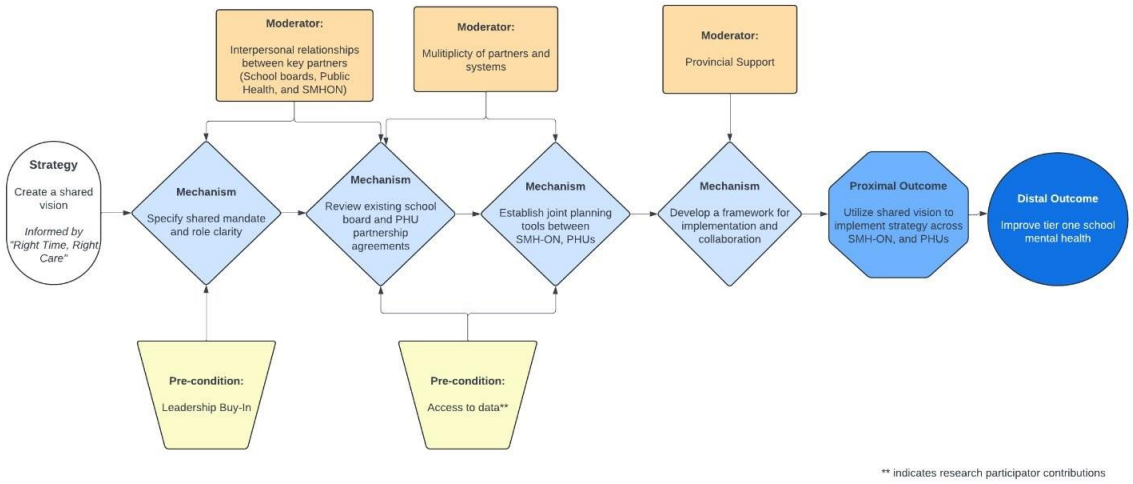
    - Enhance relationships between schools/ school boards and LPHAs to facilitate tier one mental health promotion interventions within the school environment.

12. **Standardization of Approaches and Expectations**

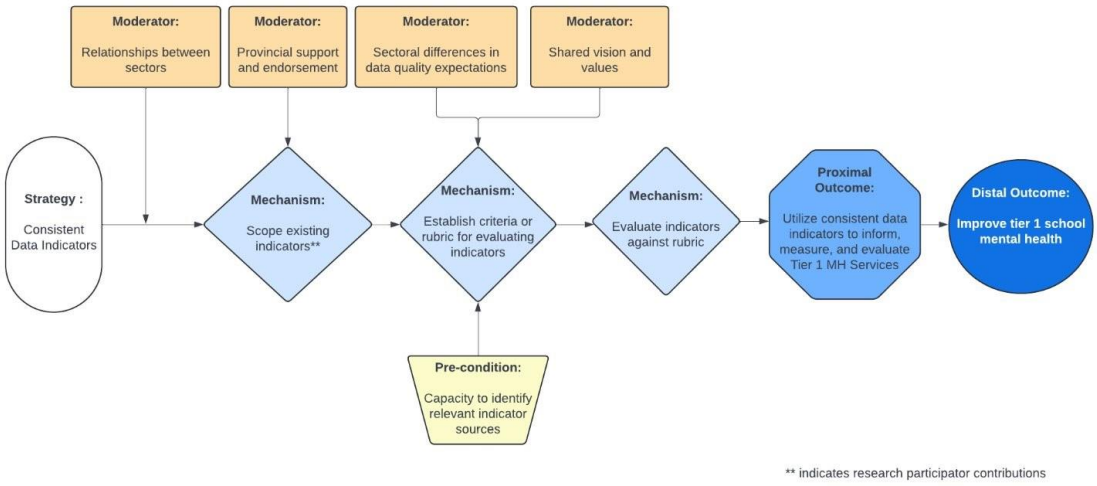
    - Consistency of approaches to tier one mental health promotion between and across LPHAs to ensure quality, and evidence based practice.

Appendix B: Model Diagrams

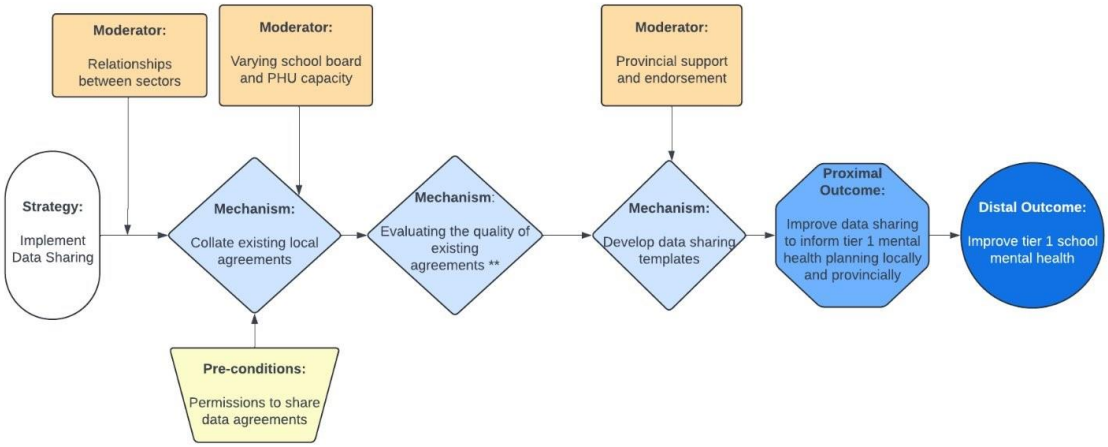
Model 1: Create a Shared Vision/ Establish Joint Planning Mechanisms



Model 2: Consistent Data Sharing Strategies, Template



Model 3: Consistent Data Sharing, Shared Indicators



** indicates research participator contributions

Appendix C: Recommendations and Tangible Next Steps

Recommendation 1: Create a vision for tier 1 school mental health promotion that explicitly outlines the scope of tier 1 school mental health promotion within schools.

- To improve the provision of tier 1 mental health programs and services in schools, it is recommended to establish a leadership table with representatives from SMH-ON, local public health units, and other key agencies. The aim of this table is to identify and discuss shared mandates, provide direction on role clarity, and facilitate effective collaboration among different agencies.
- Review existing school board and public health partnership agreements to better understand the scope of work occurring across the province.

Recommendation 2: Create a provincial joint planning group comprised of SMH-ON and agencies mandated for tier 1 school mental health in schools. The group's responsibilities include identifying existing agency-specific planning and reporting documents, as well as exploring new or coordinated opportunities to enhance tier 1 mental health promotion.

Recommendation 3: Implement SMH-ON and LPHA-specific tangible joint planning opportunities such as

- Public Health Units be included as collaborative partners when school boards complete School Mental Health Action Planning with SMH-ON.
- Communicate mental health action planning timelines/deadlines to PHUs; allowing them to build these timelines into their planning cycles.
- SMH-ON coaches encourage school board mental health leads to pursue partnerships with public health.
- Have SMH-ON coaches share examples of successful collaborations between PHUs and Boards of Ed to expand on successful strategies.

Recommendation 4:
Establish a *Provincial Child Mental Health Indicators* workgroup, consisting of representatives from various partners, with the objective of identifying, evaluating, and drafting consistent data indicators for use in tier 1 mental health promotion.

- Collate existing tier 1 data indicators used by local school boards and public health.
- Explore the feasibility of using indicators identified through Children Count as past Locally Developed Collaborative Project.
- Establish guidelines or criteria for the evaluation of current indicators and the formulation of new ones.

Recommendation 5:
Establish a *Provincial Child Mental Health Indicator Implementation Workgroup.*

- Formulate advocacy strategies aimed at securing support from the Ministries of Health and Education, as well as garnering endorsement at the school-board level to support and implement the data collection for identified indicators.
- Develop a comprehensive dissemination strategy to share the identified indicators.

Recommendation 6:
Establish a provincially supported data sharing agreement review committee, with the mandate to create a standardized data sharing template

- To optimize data sharing practices, standards and protocols, establish a provincially supported Data Sharing Agreement Review Committee.
- Create a standardized data sharing template by reviewing existing data sharing agreements and obtain insights from partners and organizations who successfully negotiated agreements.
- Ensure the template is reviewed by PHUs and School Boards across the province to identify and assess potential risks associated with data sharing initiatives and ensure its usefulness and applicability.

Recommendation 7:
Develop a dissemination strategy to share standardized data sharing template and a process to help support uptake.

- Identify key collaborators within the realm of school mental health data collection who are responsible for implementing local LPHA and School Board data sharing agreements.
- Promote the template to provincial organizations such as the Council of Directors of Education (CODE) and Council of Medical Officers of Health (COMOH), Provincial School Managers, School Board Mental Health Leaders to normalize the collection and sharing of data to support tier 1 mental health service planning and evaluation.
- Continuously evaluate and refine the effectiveness of data sharing practices.