School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

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Knowledge Request

1. What school–based programs or initiatives for youth aged 12–18 with mild to moderate mood and anxiety concerns have been shown to be effective in improving functioning?

2. What programs or initiatives for parents of youth aged 12–18 with mild to moderate mood and anxiety concerns have been shown to be effective in improving parents' knowledge and understanding of typical youth development, as well as mental health concerns?

Knowledge Response

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Skills for Academic and Social Success (SASS)	
Program Developer	Developed by Dr. Carrie Masia–Warner at NYU Child Study Centre.
Target Group	Youth experiencing social anxiety.
Program Description	SASS is a cognitive–behavioural school–based program designed to reduce youth anxiety through group meetings and social events. The program involves 5 components that follow the core concepts of CBT. The 5 components include psychoeducation, realistic thinking, social skills training, exposure, and relapse prevention.

Program Structure and Delivery	SASS program lasts 3 months, and is structured as follows:
	• 12, 40–minute weekly group sessions. Group sessions cover 5 components:
	  • Psychoeducation (1 session) – discussion of commonly feared social situations and cognitive, somatic, and behavioural symptoms of social anxiety.
	  • Realistic thinking (1 session) – discussion of relationship between thoughts, feelings, and behaviour and the overestimation of negative outcomes.
	  • Social skills training (4 sessions) – Emphasis on initiating conversations, maintaining conversations and establishing friendships, listening and remembering, and assertiveness through role discussion and role–play.
	  • Exposure (unknown # of sessions) – Addressing the need for exposure to situations, including the development of fear hierarchy of avoided situations by youth. During each exposure session, group leaders select items from the fear hierarchy to gradually address the youth's fear. After the session, the youth discuss the experience and are provided with feedback.
	  • Relapse prevention (unknown # of sessions) – Preparation for potential setbacks.
	• 2 booster sessions where youth progress is monitored. These booster sessions occur monthly for 2 months after the group sessions.
	• 2, 15–minute individual meetings where youth can discuss goals and issues that interfere with progress.
	• 4 weekend social events with prosocial peers. These are intended to be fun activities (bowling, picnics, etc) to provide youth an opportunity to practice social skills. The social events are aided by teacher–nominated youth who have exhibited helpful, friendly, and or kind behaviour. These youth create a positive experience during the social event as well as helping the youth practice their skills during the week.

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Skills for Academic and Social Success (SASS)	
Program Structure and Delivery	• 2, 45–minute parent group meetings. Meetings include information about symptoms, psychoeducation, common reactions, and encouragement to refrain from being excessively reassuring to their child and allowing them to avoid situations. • 2, 45–minute teacher meetings. Meetings include education about social anxiety, collaboration on areas of social difficulty, and progress feedback. Sessions are usually co–led by a behaviourally trained clinical psychologist and a clinical psychology graduate student.
Program Training and Cost	Facilitators are required to attend training, which consists of a 1–day, interactive workshop with the program developer or another senior SASS psychologist. In addition, follow–up consultation calls to assist with program implementation are recommended. For more information on training and costs, contact Dr. Warner at masiac@wpunj.edu
Evaluation Findings	Two randomized control studies were conducted to evaluate the program with a sample of 35 New York youth in grades 9 through 11 in two high schools, all of whom experience social anxiety (mean age of 14.8 years). Youth were randomly assigned to the SASS intervention (n=18), or to a wait–list control group (n=17). Assessments on anxiety and mood disorders, social phobic disorders, depression, and loneliness were administered at pre–test and post–test by an observer, a parent, through self–reporting. Key findings include: • At post–test, treatment group youth had significantly lower observer–rated anxiety disorders, social phobic disorder, social anxiety, and total functioning when compared with control group. Treatment group youth also had significantly lower self–reported social avoidance and distress when compared with control group. They also had significantly lower parent–reported social avoidance and distress. • There was no impact on parent–reported fear of negative evaluation. • There was no impact on self–reported social phobia and anxiety, social anxiety, fear of negative evaluation, depression, or loneliness.
Sources of Information	Fisher, P. H., Masia–Waner, C., Klein, R. G. (2004). Skills for Social and Academic Success: A School–based Intervention for Social Anxiety Disorder in Adolescents. 7(4), 241–249. doi: 10.1007/s10567–004–6088–7

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Skills for Academic and Social Success (SASS)	
Sources of Information	Child Trends (2009). Skills for Academic and Social Success (SASS). Retrieved from https://www.childtrends.org/programs/skills-for-academic-and-social-success Cuncic, A., & Gans, S. (2017, November 13). Skills for Social and Academic Success (SASS) Description of a School-Based Program for Social Anxiety Disorder. Retrieved from https://www.verywellmind.com/sass-to-overcome-social-anxiety-at-school-4056850 Clearinghouse for Military Family Readiness (n.d.). Skills for Academic and Social Success (SASS). Retrieved from https://lion.militaryfamilies.psu.edu/programs/skills-academic-and-social-success-sass

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

My FRIENDS Youth Skills for Life	
Program Developer	Developed by Dr. Paula Barrett at the University of Queensland (Director of Pathways Health and Research Centre)
Target Group	Youth attending grades 7–10.
Program Description	My FRIENDS Youth Skills for Life program is a group–based early intervention and prevention program that addresses risk and protective factors for anxiety, depression, and healthy emotional development. It aims to equip participants with the tools to cope with new challenges that students experience in early adolescence. The program aims to support participants in dealing with stressful situations by normalising the state of anxiety and utilizing the 'Emotional Thermometer' concept to teach participants to regulate their emotions. It is also designed to provide problem solving strategies, self–confidence, and resilience. The program has a firm theoretical basis in the prevention and early intervention of anxiety and depression which addresses attachment (emotions), physiological (body), cognitive (mind), and learning (behaviour) processes which interact in the development, experience, and maintenance of anxiety. The program addresses each of these processes by teaching specific skills and techniques targeted to each domain. • **Learning:** Problem solving, coping, peer support, identification of rewards for practicing (brave) behaviour. • **Attachment:** Understanding feelings, emotional self–regulation, self–soothing, empathy skills, developing confidence. • **Cognitive:** Attention training, identification and expression of inner thoughts, techniques for challenging unhelpful self–talk, self–reward, expectations. • **Physiological:** Awareness of body clues, deep breathing exercises, relaxation activities and mindfulness, self–awareness, importance of sleep and healthy eating. The program has been founded on a peer and experiential learning model where group learning processes and interactions are required for participants to practice new skills in a safe environment and actively participate, reflect on, and learn from their own experience.
Program Structure and Delivery	The program is comprised of 5 sessions that last 2–2.5 hours per session, using the following curriculum:

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My FRIENDS Youth Skills for Life	
Program Structure and Delivery	Session 1: Introduction to the group. Session 2: Understanding feelings and practicing empathy. Session 3: Let's focus on confidence. Session 4: Learn to relax. Focus on the present and become more aware. Session 5: Your attention flashlight – your powerful thoughts. Session 6: More attention flashlight and thought challengers. Session 7: Exploring solutions and step plans. Session 8: Another way to solve problems. Session 9: When the going gets tough – making and keeping friends. Session 10: Using the FRIENDS skills to help ourselves and others. Training is required for all professionals who wish to use the program with groups of young people. Trained group leaders (teachers, school counsellors, psychologists, etc.) are crucial to the effectiveness of the program. It is recommended that there is an assistant leader for groups larger than 10, and that groups are formed of similar ages. Group leaders can create their own scripts for explaining concepts to participants and they may consider delivering the program over a longer time–frame, especially in school settings where the program is delivered in accordance with aspects of the curriculum or as a way of improving classroom or whole–school behaviour management. Research has shown that including parents and family members in the program ensures the program's effectiveness. Thus, the involvement of parents and caregivers is encouraged. Seminars are offered on how best to achieve this in schools.
Program Training and Cost	FRIENDS Programs Online Training is $334.50 USD for two streams: My Friends Youth (12–15 years) and Adult Resilience (16–18+ Years). The training provides participants with knowledge about the program skills and strategies, and demonstrates how to implement the program with youth in a classroom or small–group setting. Online training is delivered in an interactive, online format using GoToMeeting software (4 hours). During the training, participants are able to communicate with the trainer using microphones, webcams, screen–sharing or instant messaging.
Evaluation Findings	An uncontrolled before and after study of the program involving 213 youth aged 9–10 years old from 6 elementary schools was conducted. Key findings include: • The program significantly lowered rates of anxiety and significantly improved levels of self–esteem.

My FRIENDS Youth Skills for Life	
Evaluation Findings	An uncontrolled before and after study of the program involving 213 youth aged 9–10 years old from 6 elementary schools was conducted. Key findings include: • The program significantly lowered rates of anxiety and significantly improved levels of self–esteem. • Significant improvements were obtained in over half of participants with the most severe emotional concerns. • When participants completed a qualitative assessment of acceptability, 81% of participants thought it was fun, 77.4% would recommend it to a friend, 72.8% thought they had learned new skills, and 41.1% had helped someone else with their new skills. Another study evaluated the long–term effectiveness of the program in reducing anxiety and depression in a sample of youth from grade 6–9 in comparison to a control condition. Longitudinal data from a universal prevention trial was presented, along with data from 12 month, 24 month, and 36 month follow–up. Key findings include: • Intervention reductions in anxiety reported in the universal prevention trial were maintained for students in Grade 6, with the intervention group reporting significantly lower ratings of anxiety at long–term follow–up. • Girls in the intervention group reported significantly lower anxiety at 12 and 23 month follow–up, but not at 36 month follow–up in comparison to the control condition. • Results demonstrated a prevention effect with significantly fewer high–risk students at 36 month follow–up in the intervention condition than in the control condition.
Sources of Information	MindMatters (n.d.). Program Title: My Friends Youth – Skills for Life. Retrieved from https://www.mindmatters.edu.au/ Pathways Health and Research Centre (n.d.). Fun FRIENDS Youth Program (12–16 years old). Retrieved from https://www.pathwayshrc.com.au/my–friends–youth/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Adolescents Coping with Depression (CWD-A)	
Program Developer	Developed by Dr. Paul Rohde at the Oregon Research Institute.
Target Group	Youth aged 12–18.
Program Description	Adolescent Coping with Depression is a therapeutic group intervention designed to reduce or prevent major depression or chronic depression among adolescents, including those whose depression co-occurs with a conduct disorder. The program aims to address problems with discomfort and anxiety, irrational and negative thoughts, poor social skills, and low rates of pleasant activities. The program is based on cognitive-behaviour therapy, and teaches adolescents the skills to monitor their moods, increase pleasant activities, improve communication, and resolve conflict. The group therapy sessions involve skill training to better relax, control thoughts, and resolve conflict.
Program Structure and Delivery	Groups of 7–14 adolescents meet with therapists over an 8-week period in 16, 2-hour sessions. The adolescent sessions can be supplemented with 9, 2-hour sessions involving a therapist and a group of parents. The intervention sessions may be followed by 1 to 2 booster sessions over 2 years following the intervention. The booster sessions focus on how skills learned in the intervention can be applied to new or continuing problematic situation. The sessions are conducted by a trained interventionist that has at least a master's degree in a mental health field. The therapists follow a detailed manual to ensure protocol compliance and fidelity, and adolescents and parents receive workbooks consisting of homework assignments, forms, short handouts, and readings to complement the therapy sessions.
Program Training and Cost	On and off-site training lasts 1 or 2 days for groups of therapists, costing $2,000 USD per day. The training is conducted by either Dr. Paul Rhode or his colleague Janel Jorgenson. In terms of materials, detailed checklists are available at no cost from the developers to assess treatment adherence and therapist competence.
Evaluation Findings	A series of randomized control trails evaluated the Adolescent Coping with Depression program with three groups of adolescents. The first study recruited adolescents with major depression or chronic depression,

Adolescents Coping with Depression (CWD–A)	
Evaluation Findings	the second recruited adolescents who exhibit a high risk for depression and who have a depressed parent, and the third recruited adolescents with depression and a conduct disorder. Adolescents were assigned to an intervention therapy condition for adolescents only, an intervention therapy condition for adolescents and parents, and a waitlist control group. Adolescents in the intervention groups were also randomly assigned to conditions that differed on follow–up access to booster sessions and the number of follow–up assessments. Assessments were evaluated at baseline, at post–intervention, at 6 months follow–up, and at 24 months follow–up. Key findings include: • The program significantly reduced self–reports and clinician ratings of depression, primarily by changing values on a mediating variable that measures negative thoughts. • Adolescents of white ethnicity, with recurrent major depressive disorder, and with good coping skills benefited most from the program. • The program appears to help prevent the occurrence of major depression among youth at risk of developing the disorder. • For adolescent children of a parent with severe depression and who have moderate symptoms of depression but not a clinical diagnosis of depression, the therapy did better than the control in preventing major depression, at least in the short–term. • The program aids recovery of youth with depression only. • Separate group therapy for parents and booster sessions following the acute therapy had limited benefits beyond the core program. • The program does not improve conduct disorders. • The program provides no benefits beyond the comparison group at the 6–month follow up assessment.
Sources of Information	Blueprints (n.d.). Adolescent Coping with Depression. Retrieved from https://www.blueprintsprograms.org/factsheet/adolescent–coping–with–depression Promising Practices Network (2013). Adolescent Coping with Depression Course. Retrieved from http://www.promisingpractices.net/program.asp?programid=152

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Coping with Stress Course (CWS)	
Program Developer	Developed by Dr. Gregory N. Clarke at the Kaiser Permanente Centre for Health Research.
Target Group	Youth aged 13–18.
Program Description	The CWS program targets youth at risk for depression who are experiencing elevated depressive symptoms. The program involves cognitive restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts that may contribute to the development of future mood disorders such as depression. CWS is an adaptation of the Adolescent Coping with Depression Course. The theoretical background of CWS is that teaching youth new coping strategies and strengthening their current coping skills provide them with some measure of "immunity" or resistance against the development of mood disorders later in life. The aim of CWS is to enhance at-risk youths' resilience in order to counteract their vulnerability to depression and other mood disorders.
Program Structure and Delivery	The CWS program divides youth into groups of 6–10. Each group attends 15, 45–60 minute sessions, where they participate in role-playing and group discussions oriented to the developmental level of the youth. Separate parent information meetings occur at the beginning, middle, and end of the program. During these sessions, parents are informed about the general topics discussed, the skills taught in the groups, and the rationale for the use of the selected techniques. The CWS program is led by specially trained school psychologists and counsellors who have a minimum of a master's degree in clinical, counselling, or educational psychology, and who have previous experience in conducting psychoeducational groups with youth.
Program Training and Cost	Counsellors are provided with 40 hours of training, including mock intervention sessions, role-playing youth responses to exercises, homework, and videotaped feedback. Cost is unknown.
Evaluation Findings	One randomized control trial (involving 222 9th and 10th grade students experiencing elevated depressive symptoms from three high schools in Oregon) was conducted to evaluate the effectiveness of the program. Assessments were conducted immediately after the intervention, as well as at 6-month and 12-month follow-up points. Youth were measured

Coping with Stress Course (CWS)	
Evaluation Findings	on 3 diagnostic interview tests (the global Assessment of Functioning Scale, the K–SADS–E, and the Longitudinal Interval Follow–up Evaluation). Adolescent self–reports of depression were assessed on the CES–D. Key findings include: • On the K–SADS–E and Longitudinal Internal Follow–up Evaluation, a significant advantage was found for the CWS group at 12 months, with incidence rates for affective disorder of 15% compared with 26% for the control group. • GAF scores indicated a significant effect favouring the treatment group from pre–test to initial post–test, but no significant effects when the entire study period was examined (pre–test to 12–month follow–up). • Outcomes on the self–reported CES–D showed significantly fewer cases of either major depression and/or dysthymia for the treatment group compared with the control group from pre–test to initial post–test. No significant differences were detected when outcomes were measured from pre–test to 12–month follow–up.
Sources of Information	Promising Practices Network (2013). Coping with Stress Course. Retrieved from http://www.promisingpractices.net/program.asp?programid=151

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Brief Intervention for School Clinicians (BRISC)	
Program Developer	Developed by Dr. Elizabeth McCauley at the University of Washington.
Target Group	High school students.
Program Description	BRISC is a result of a research project that aimed to develop, document the feasibility of, establish fidelity measures for, and pilot test a school–based mental health intervention designed for high schools. The BRISC intervention is characterized by 5 primary elements: • A systematic problem–solving approach to assist mental health providers with identifying key intervention targets, testing solutions, and supporting positive student development. • A modularized approach to delivering specific mental health intervention components common to evidence–based practice (e.g., coping strategies, mood changing skills, cognitive restructuring, communication analysis, and problem solving). • A stepped care/tiered structure in which a brief empirically based intervention is implemented prior to more intensive, extended, or expensive treatments. • Culturally informed treatment engagement and motivation strategies. • Systematic assessment and monitoring of student behaviours and emotional states including checks of symptoms, mood, academic success, completion of practice activities, and satisfaction with the treatment process. This school–based, stepped–care model is designed to effectively assess and triage students while identifying an immediate and specific problem that students can actively address. It provides a flexible structure with up to 4 sessions to assess, engage, identify, and begin to address student challenges that are distressing and impacting academic performance/ behaviour and overall functioning. This intervention can be implemented as a 'Tier 2' approach within a larger framework of multi–tiered system of support. The intervention is informed by recent developments in common approaches to psychotherapy with youth, and therefore includes the identification of "top" problems, use of a problem solving framework, and the inclusion of routine progress monitoring using standardized approaches. It is intended to be applicable to the majority of student presenting problems commonly encountered in educational settings. In addition, all intervention elements are evidence–based, and are aimed at efficiency so that the clinician can get to the next student in need.

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Brief Intervention for School Clinicians (BRISC)	

Program Structure and Delivery	The BRISC intervention is intended for use by existing school–based professionals, including masters–level social workers and doctoral–level psychologists. In order for students to attend the BRISC intervention, administrative staff send passes to participating students' classrooms, excusing them to attend their session. The BRISC protocol outlines 4 sessions that last between 30–60 minutes. The sessions are as follows:
	
	Session 1
	• Administration of and feedback on brief standardized assessment measures.
	• Psychoeducation about the BRISC intervention.
	• A brief functional assessment (targeting school, family, peers).
	• Problem identification (listing problems, identifying the top 3 problems, and introducing the cognitive triangle).
	• Introduction to informal symptom or behavioural monitoring.
	• Conveying helpfulness and plan for working together.
	
	Session 2:
	• Review of information monitoring.
	• Focusing on the identified top problem and introduction to problem solving.
	• Psychoeducation on anxiety, depression, and stress.
	• Discussion of stress and obtaining stress rating.
	• Identification of barriers and planning to address these barriers.
	• Creating a plan for the week.
	
	Session 3:
	• Individualized approach based on identified problems and barriers to solution implementation.
	• Revision of problem solving.
	• Asking for stress rating.
	• Continuing problem solving, and incorporate new skill as/if needed from the following modules:
	  • Cognitive restructuring ('dealing with a hard situation I can't change).
	  • Motivation enhancement ('I just don't feel like it') .
	  • Communication skills ('getting along with other people').
	  • Stress and mood management ('handling hard feelings').
	• Creating a plan for the week.

Brief Intervention for School Clinicians (BRISC)	

Program Structure and Delivery	Session 4:
	• Assessing the outcome of the solution developed in previous session.
	• Asking for stress rating.
	• Administering and reviewing brief standardized assessment measures.
	• Revision of progress and continued use of problem solving skills.
	• Collaborative review of progress and identification of next steps:
	  • Return for school mental health services if the student determines it is needed.
	  • Supporting monitoring involving regular brief check–ins with the therapist or another school school–based helper.
	  • Continuing BRISC or other treatment from the school mental health provider.
	  • Referral to more intensive services that are often external to the school.

Program Training and Cost	Unknown
Evaluation Findings	A study evaluated feasibility, acceptability, and appropriateness of the BRISC intervention administered to 11 participants (using mixed qualitative and quantitative analysis). Key findings include following: • Feasibility: Clinicians generally reported being able to deliver most session components. • Acceptability: Participants were significantly more satisfied overall than those receiving usual care. Participants also reported higher satisfaction with counsellor qualities, counsellor ability to meet their needs, and lower ratings of counsellor conflict. Participants indicated a high motivation to participate in the intervention, and that engagement was driven be a basic desire to get help for their problems. Other comments focused on the motivational value of therapist characteristics. For students who began accessing the intervention with lower motivation rating and higher hesitation, motivation increased as they attended additional sessions. Participants indicated that investing in expanding the intervention to encompass a greater breadth, depth, or length would improve the intervention. Participants also expressed a desire for therapists to focus on more than one target issue, and have more options or alternatives for the activities. • Appropriateness: Due to a small sample size, a lack of a control group, and brevity of the intervention, the following information is only **a very preliminary assessment** of change in coping, symptoms, and

Brief Intervention for School Clinicians (BRISC)	
Evaluation Findings	• functioning over time. There was positive support for a significant increase in the relative use of 'Planful Problem Solving', and a borderline significant increase in 'Seeking Social Support'. Qualitative findings indicated that approximately half of the participants who sought services for a particular problem indicated improvement in that specific problem. However, participants rarely reported gains in areas that were not identified as problems at the outset of BRISC. Lessons learned from the implementation of BRISC in an Ontario pilot site were also identified in a presentation (see 'Sources of Information' section below). Outcomes and lessons learned included: • Improved functioning among youth who accessed BRISC intervention (n=29). This improvement was stronger than the one experienced by youth accessing 'treatment as usual'. • Positive outcomes of BRISC include high clinician–rated feasibility of the intervention, higher rates of student satisfaction than 'services as usual', as well as superior mental health outcomes (depression and anxiety).
Sources of Information	Lyon, A. R., Bruns, E. J., Ludwig, K., Stoep, A. V., Pullmann, M. D., Dorsey, S., Eaton, J., Hendrix, E., Mccauley, E. (2015). The Brief Intervention for School Clinicians (BRISC): A Mixed–Methods Evaluation of Feasibility, Acceptability, and Contextual Appropriateness. School Mental Health, 7(4), 273–286. doi:10.1007/s12310–015–9153–0 Fortier, A., Short, K., Bruns, E., Whitaker, K., Nicodimos, S., Ludwig, K., Lyon, A., McCauley, E. (2016). BRISC IN ONTARIO! Pilot test of an engagement, triage, and brief intervention strategy to prevent and treat MH problems. San Diego, CA. Retrieved from http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Conferences/21st–Annual–Conference–/Wave–2–Presentations/1117/7.9.pdf Institute of Education Science (n.d.). IED Grant: Brief Intervention for School Clinicians. Retrieved from https://ies.ed.gov/funding/grantsearch/details.asp?ID=1236

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Teaching Kids to Cope	
Program Developer	Developed by Dr. Kathryn R. Puskar at the University of Pittsburgh.
Target Group	Youth in high school aged 15–18. Youth in early adulthood aged 18–22.
Program Description	Teaching Kids to Cope is a 10–session psychoeducational group intervention. It is designed to reduce depressive symptoms and stress by enhancing the coping skills of youth. Sessions guide youth through a process to discover any distorted thinking patterns they exhibit, and to test their thinking against reality using suggested approaches. Youth also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways or reacting. The program develops behavioural techniques that aim to improve coping skills, which include activity planning, social skills training, assertive training, bibliotherapy, role–playing, conflict resolution, and relaxation training. The program also includes cognitive components that are employed through techniques such as the externalization of negative voices, reframing, establishing idiosyncratic meaning, and cognitive rehearsal. The program incorporates experiential exercises such as trust–falls, buddy assignments, and role–playing situations from school and home. Art is also incorporated into the sessions through drawing exercises.
Program Structure and Delivery	The 10 sessions are structured in the following manner: • Establishing a group contract (developing rules, reviewing purpose of the group, trust–falling activity). • Implementation of group contract (getting acquainted with the group, members share ups and downs). • Beginning group cohesiveness (coping, sharing life styles, evaluating stress level). • Group cohesiveness/working phase (coping styles, personal, peers, family, resources). • Group cohesiveness/working phase (day–to–day coping, cognitive and affective options to deal with specific problems). • Working phase (the school as a problem–solving environment). • Working phase (the family as a problem–solving environment, move towards independence). • Working phase (peer relationships as problem–solving environments). • Termination (assessment of group experience). • Group wrap–up (written contract for using information gained).

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Teaching Kids to Cope	
Program Structure and Delivery	Each session lasts 45 minutes, and is offered during regular school days. Eligible students should score in the mid-range on the Reynolds Adolescent Depression Scale, and the intervention is implemented by a psychiatric nurse in collaboration with the school nurse or guidance counselor. Group leaders of the program are usually master's-level nurses with psychiatric mental health experience, including group therapy and youth work.
Program Training and Cost	Group leaders are to be trained in group skills such as facilitating communication, adolescent behaviour, and content of each session. The training consists of viewing videos on Conducting Groups with Adolescents, Yalon (Expert on Group Therapy) Principles of Group Therapy, Adolescent Development, and Establishing Rapport Issues of Working with Adolescents. Several articles on facilitating adolescent groups will be provided. Training is 1-day long at a cost of $1,000 USD plus travel expenses, for up to 16 participants. Manuals are $15.00 USD each.
Evaluation Findings	Three evaluations of the Teaching Kids to Cope program were conducted using similar study designs. The studies were randomized controlled trials, involving youth with high scores on depressive measures. Youth were recruited from 3 rural high schools located in the southwest region of Pennsylvania, the University of Jordan, and from one rural high school. All three studies employed small sample sizes of 89, 84, and 46. Participants were randomly assigned to the intervention or control group. Assessments were administered at baseline, and 10-12 weeks following baseline at post-test. One study also administered assessments at 6 months and 12 months after the end of the intervention, while another study administered an assessment only 3 months after post-test. Key findings include the following significant program effects on the intervention group in comparison to the control group: • Short-term decrease in depressive symptoms and stress levels. • Decrease in depressive symptoms for female intervention participants. • Increase in the use of beneficial coping strategies such as seeking guidance and support, seeking social support, planful problem solving, positive reappraisal, support and coping style. • Decrease in avoidance coping behaviour.
Sources of Information	Blueprints (n.d.). Teaching Kids to Cope. Retrieved from https://www.blueprintsprograms.org/factsheet/teaching-kids-to-cope Puskar, K. R. (n.d.). Teaching Kids to Cope with Stress. Retrieved from http://www.pitt.edu/~krp12/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Sources of Strength	
Program Developer	Developed by Mark LoMurray, in partnership with rural communities in several Northern Plains tribes in North Dakota.
Target Group	Middle school, high school, or college students.
Program Description	'Sources of Strength' is a strength–based comprehensive wellness program that focuses on suicide prevention, but also impacts other issues such as substance use and violence. The program's mission is to move upstream in the prevention cycle and work to build resilience, increase connection, change unhealthy norms around help–seeing, break down codes of secrecy and silence, and teach healthy coping strategies to ultimately prevent the onset of suicidality. 'Sources of Strength' focuses on developing protective factors. It explores 8 protective factors to develop resilient students and communities. Protective factors include mental health, medical access, spirituality, generosity, healthy activities, mentors, positive friends, and family support. The program believes that attitudes, behaviours, and beliefs spread through a social network, so it utilizes the power of peer social networks to spread messages of hope, help, and strength. The program is peer–led, where peers are empowered to leverage their social influence as an agent of change in their school. Therefore, peer leaders are mentored by adult advisors to alter social norms among peers about help–seeking. In addition, the program uses art, storytelling, small group sharing, and games. The program is implemented in urban, rural, and tribal settings. The program is currently running in 16 states and Washington, DC. It has also been implemented with 7 Tribes and Nations across the United States, and in several Canadian First Nations. The program has begun a comprehensive partnership to bring the program to schools and communities throughout Canada as well.
Program Structure and Delivery	The program is often initiated as a 3–6 month project, but is designed as a multi–year project with ongoing peer messaging and contacts growing over time. The program is divided into phases, as follows: 'pre–training', 'training', 'messaging', and 'transition'. Pre–training: The pre–training phase includes buy–in, nomination, and recruitment processes. The buy–in process educates the community on the 'Sources

Sources of Strength	
Program Structure and Delivery	of Strength' program, obtaining key admin support, and conducting a brief protocol review of handling distressed or suicidal students. The nomination and recruitment processes involve the nomination and recruitment of a diverse group of Adult Advisors (2–20) and Peer Leaders (10% of school) who will carry out messaging activities. Training: The training phase includes the Adult Advisor training process and the Peer Leader training process. The Adult Advisor training process trains Adult Advisors in the 'Sources of Strength' process and philosophy, peer leader recruitment, and their role in meeting and guiding peer teams. The Peer Leader training involves Peer Leader teams of 10–50 who undergo initial Peer Leader training by a certified 'Sources of Strength' trainer in a 4–6 hour highly interactive training process. Messaging: The messaging phase involves the delivery of messaging goals and the core messaging campaigns. The messaging goals stage involves the administration of one meeting within 10 days of Peer Leader Training, meetings that happen at least twice a month, the completion of the first messaging activity within three weeks, the completion of 3–7 messaging campaigns in the first year, the start of three core campaigns, and reaching 80–90% of the school population. There are 6 core messaging campaigns. Transition: The transition phase includes a celebration activity, evaluation, and recruitment. The celebration activity brings peer groups, trusted adults, and parents together to honor Peer Leaders and recognize their prevention efforts and accomplishments. The evaluation and recruitment processes involve the completion of a 'Team Assessment Tool' and evaluating the overall health and quality of the peer–lead efforts. Peer Leaders are also recruited for the next year, and planning starts for the first three campaigns that will kick off the new year.
Program Training and Cost	Base level costs are $5,000 USD per school. Additional components, such as community and parent trainings may be an additional cost. Meanwhile, the 'Train the Trainer' certification process is a 10–month process costing $4,000, with semi–annual recertification required ($1,000). Adult Advisors can expect to spend approximately 40 hours in training

Sources of Strength	
Program Training and Cost	over a 3–6 month program. This includes a 3–6 hour orientation training and brief monthly teleconference support meetings with 'Sources of Strength' staff. Adult Advisors can also expect to spend around an hour per week working with 'Sources of Strength'. Peer Leaders can expect to spend from 15–50 hours over a 3–6 month program, including a four–hour initial peer training.
Evaluation Findings	A randomized control study was conducted, involving 18 high schools in metropolitan and rural settings. Schools were randomly assigned to immediate intervention or wait–list control, and assessments were administered at baseline and 4 months post–program. Key findings include: • Trained Peer Leaders reported more positive expectations that adults at school help suicidal students, more rejection of codes of silence, and decreased maladaptive coping attitudes. • Training increased norms for help–seeking from adults at school, use of 'Sources of Strength' coping resources, and the number of identified trusted adults. • Trained Peer Leaders showcased increased school engagement. • Training of Peer Leaders increased their support to peers. • Trained Peer Leaders in larger schools were 4 times as likely as untrained Peer Leaders to refer a suicidal friend to an adult. • Among students, there were positive and significant effects on perceptions of adult help for suicidal peers, and on norms for help–seeking from adults. • There was no significant change in the 'Sources of Strength' coping measure. A 6–year randomized control study was conducted, involving more than 40 high schools. The study evaluated the impact of 1,500 Peer Leaders on approximately 15,000 students. This ongoing study is being funded by the National Institute of Mental Health (NIMH) as part of the National Peer Leadership Study. Additional research and evaluation efforts in collaboration with Stanford University, Johns Hopkins University, University of Manitoba, and The Black Dog Institute in Australia are currently being conducted.
Sources of Information	Sources of Strength. (n.d.). Retrieved from https://sourcesofstrength.org/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

C.A.T. Project	
Program Developer	Developed by Dr. Philip C. Kendall at Temple University.
Target Group	Youth aged 12–18.
Program Description	The C.A.T. Project is a program for youth with anxiety. It is similar to the 'Coping Cat' program that is designed for children aged 7–13, but made relevant to an older age group. It is cognitive–behavioural in nature, requires exposure tasks, and provides psychoeducation. The focus of the program is to provide education about anxiety, skills for identifying and managing anxiety, and an approach to face one's fears and develop mastery. The program addresses distressing anxiety of multiple sources such as a diagnosed anxiety disorder, or an interfering anxiety that is not specifically diagnosed. The overall goal of the program is to promote emotional adjustment in youth.
Program Structure and Delivery	The program consists of 16 sessions with the following essential components: • Psychoeducation about anxiety. • Changing youth's self–talk. • Exposure tasks that provide youth with mastery of anxiety. • Learning that anxiety is not overwhelming, is normal, and can be managed. • Optional 'Parent Companion' that describes the program for parents and prepares them for the experiences that their adolescent will have, as well as informs them of preferred/optimal ways to respond to the anxious adolescent. The program helps the parent be prepared for the exposure tasks and assists them through the process, and helps parents see different ways to address youth anxiety. • Homework (weekly tasks of varying intensity to help the youth apply what is learned in their own real work setting). • Therapist manual and youth workbook. Sessions typically run for one hour every week, for a total of 16 sessions that can be conducted at school. It is preferred that the service providers that implement this program have a Master's degree–level education. The program requires service providers to read the treatment manual, have access to it throughout treatment, and have the youth workbook.
Program Training and Cost	There is optional training available for this program (contact Philip C. Kendall at pkendall@temple.edu). A minimum of half a day training provides an introduction, although a 1 or 2 day training would be

C.A.T. Project	
Program Training and Cost	preferred to be ready for implementation. In the 2–day training, there are videos to watch, and role–play exercises to try, along with content presentation and session–by–session summaries. There is also a training DVD available. The therapist manual describes session–by–session content. Each session's description begins with the goals/targets for that session. When checking on fidelity, tapes of sessions are listened to in order to check that the goals/targets for the session were addressed. Although they require a person familiar with the model, there are forms that can be used to assess fidelity when listening to the session. The fidelity form also has places for the supervisor to rate the therapist on several dimensions. Costs are unknown, but can be obtained by contacting Dr. Philip C. Kendall at pkendall@temple.edu
Evaluation Findings	A randomized control trial was conducted to evaluate the relative efficacy of the C.A.T. Project, sertraline, a combination of the two therapies, and a placebo drug. The study involved 488 youth aged 7–17 with anxiety disorders. Youth were randomly assigned to receive one of the four conditions for 12 weeks. Key findings include: • The C.A.T. Project and sertraline reduced the severity of anxiety in youth with anxiety disorders. • A combination of the two therapies had a superior response rate. Another study evaluated remission rates in the 488 anxious youth aged 7–17 who were randomly assigned to the 4 conditions described in the aforementioned randomized control trial. The primary definition of remission was loss of all study–entry anxiety disorder diagnoses. Predictors of remission were also examined. Key findings include: • Remission rates after 12 weeks of treatment ranged from 46–68% for the combination treatment, 20–46% for C.A.T. Project, 34–46% for sertraline, and 15–27% for placebo. • Youth who received the combination treatment had significantly higher rates of remission compared to all other treatment groups. • Both monotreatments (C.A.T. Project and sertraline) had higher remission rates compared to placebo, but rates were not different from each other. • Predictors of remission were younger age, non–minority status, lower baseline anxiety severity, absence of other internalizing disorders, and absence of social phobia.

C.A.T. Project	
Evaluation Findings	Another study evaluated whether clinical improvements and treatment type (from the original randomized control trial listed above) predicted remission of anxiety and improvement in global functioning at follow–up an average of 6 years after randomization. The study also examined the predictors of outcomes at follow–up. Key findings include: • 46.5% of youth were in remission at the 6–year follow up and had less severe anxiety symptoms and higher functioning. • There were no differences in outcome at the 6–year follow up across the 4 interventions. Another study evaluated the predictors and moderators of treatment outcomes among youths meeting criteria for diagnoses of separation anxiety disorders, social phobia, or generalized anxiety disorder (from the original randomized control trial listed above). Key findings include: • Youth with lower levels of baseline symptoms of severity and less caregiver strain had better outcomes independent of the type of treatment received. • Having more severe and impairing anxiety, greater caregivers strain, and a principal diagnosis of social phobia were associated with less favourable outcomes. Another study evaluated how parental anxiety predicted change in pediatric anxiety symptoms across four treatments (from the original randomized control trial listed above). Key findings include: • Parental anxiety was not associated with youth's pre–treatment anxiety symptom severity, nor did it significantly influence youth anxiety trajectories in the C.A.T. treatment condition. Another study evaluated changes in treatment trajectories following the introduction of three specific CBT components in the original randomized control trial listed above. Key findings indicated that within the C.A.T. Treatment: • Introduction of cognitive restructuring (changing self–talk) and exposure tasks significantly accelerated the rate of progress on measures of symptom severity and global functioning moving forward in treatment. • Introduction of relaxation training had limited impact. • No strategy altered the rate of progress in the specific domain of anxiety that it was intended to target.

C.A.T. Project	
Sources of Information	The California Evidence–Based Clearinghouse for Child Welfare (2018). C.A.T. Project. Retrieved from http://www.cebc4cw.org/program/c–a–t–project/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Cool Kids	
Program Developer	Developed by Dr. Ronald M. Rapee at the Centre for Emotional Health at Macquarie University (Australia).
Target Group	Youth aged 7–17.
Program Description	The Cool Kids program is a structured 10 session program run over a minimum of 10 weeks that teaches youth and their parents how to better manage a youth's anxiety. The program is based on cognitive–behavioural therapy, involves the participation of youth and parents, and focuses on teaching practical skills. The goals of the program are to reduce symptoms and amount of life interference caused by anxiety, reduce avoidance, reduce family distress, increase confidence, improve peer relationships, and increase engagement in extra–curricular activities.
Program Structure and Delivery	Topics covered in the program include: • Psychoeducation: Understanding the components, presentation, and nature of anxiety, as well as factors involved in its development. Understanding the relevant components to treatment and their purpose. • Cognitive restructuring: Learning to act like a detective and gather evidence about whether feared events are really highly likely. • Parent skills: Helping parents to manage their anxious child better and reducing their urge to control and overprotect. Includes teaching parents strategies to help manage their own anxious feelings. • In–vivo exposure: Developing step–ladders for the youth that allows them to gradually face their fears and learn that feared events are unlikely to happen and that they can cope. • Social skills: Learning how to act in a more skilled manner and engage better with people and to act more assertively with peers. • Improved coping strategies: Dealing more effectively with teasing and bullying, developing a range of coping strategies such as relaxation and reducing poor coping such as drug–taking, and problem solving.
Program Training and Cost	Any professional wishing to run the Cool Kids program must meet these qualification requirements: • 4 year undergraduate or 2 year post–graduate degree in health (psychology, counselling, social work, occupational therapy) or education, AND • Additional training in cognitive–behavioural therapy (dedicated post–graduate subject, introductory workshop, or online training from recognised provider)

Cool Kids	
Program Training and Cost	If individuals do not meet criteria, they are welcome to make a case by outlining their qualifications and experience and a determination about suitability will be made on a case–by–case basis. To become an accredited provider, one must complete training. Training can be completed online or face–to–face. Face–to–face training is held at Macquarie University campus in Australia. Accreditation requires professionals to demonstrate their ability and skill through a series of assessment tasks. The assessment tasks include: • A multiple choice quiz. • Answering questions around two case studies. • A 30 minute supervision session to receive feedback on your case studies. • Another two case studies with questions. The online training consists of approximately 5–6 hours of video and activity. There are 12 modules in total, and the user can navigate the training at their own pace. Meanwhile, the completion of the accreditation tasks should take approximately 3 hours, but participants will need to wait for feedback on their assessment tasks which means that the accreditation process takes approximately 6 weeks to complete. Accreditation is valid for 5 years and allows the professional to promote themselves as a Cool Kids Accredited provider. The cost to complete e–training is $300 AUD/person, and the cost to complete accreditation is $300 AUD/person. If a not–for profit or community organization would like to get a large number of employees accredited (15 or more staff), a $100 discount is applied per person. Cool Kids materials consist of a therapist manual, a parent workbook, and a youth workbook.
Evaluation Findings	A pre–test post–test control group study was conducted to evaluate the outcomes from a 9 session group treatment of the Cool Kids program. This study involved 95 participants aged 7–16 (participants were children with anxiety disorders and their parents) who were assigned to active treatment or a waitlist control. Key findings include: • Youth in the intervention group improved significantly more on several measures of anxiety than wait–list controls. Improvements maintained, and in several cases increased at 1–year follow–up. Limitations include the lack of randomization to the intervention and control groups.

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Cool Kids	
Evaluation Findings	A randomized control trial involved 112 participants (youth aged 7–16 with a principal anxiety disorder not including depressive symptoms, and their parents) was conducted. Youth were randomly assigned to either Cool Kids, or a control condition (group support and attention). Parents and youth participated in completing assessments at pre–intervention, post–intervention, and at 3–month follow–up. Key findings include: • Cool Kids was significantly more effective compared with the control condition. • At post–treatment and follow–up, a significantly greater proportion of youth in the Cool Kids condition no longer met criteria for any anxiety diagnoses, compared with youth in the control condition. • Limitations include a significant lack of congruence between parent and child reports.
Sources of Information	The California Evidence–Based Clearinghouse for Child Welfare (2018). Cool Kids. Retrieved from http://www.cebc4cw.org/program/cool–kids/detailed Macquarie University (2018). Cool Kids Anxiety Program. Retrieved from https://www.mq.edu.au/about/campus–services–and–facilities/hospital–and–clinics/centre–for–emotional–health–clinic/cool–kids–anxiety–program–for–professionals

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Coping and Support Training (CAST)	
Program Developer	Developed by Reconnecting Youth Inc.
Target Group	Middle school or high school students.
Program Description	CAST is a school–based counselling program that engages small groups of at–risk youth. The program aims to improve mood, decrease drug use, and improve school smarts. Features of the program, include: • Skills training, with a focus on building self–esteem, monitoring and setting goals, decision making and personal control, including help and support seeking strategies. • A group context of adult and peer support, developed to enhance the personal and social protective factors of youth. • A crisis response plan that includes both school and community–based strategies and resources for responding to a range of suicide–risk behaviours. • Parent involvement, including active parental consent, support of the CAST goals for their children, and awareness of school and community support resources.
Program Structure and Delivery	Cast consists of 12, 55–minute sessions that are facilitated by an adult who works well with at–risk youth, and who is trained to implement the CAST program. The 12 CAST sessions are offered 2 times per week in a middle or high school setting, or outside of the school setting by youth–serving agencies, mental health professionals, and community centres. Sessions are administered to small groups of 6–8 students who are invited to participate in the program. The program can be offered to an entire population as a universal prevention program, to a high–risk group as a selective prevention program, or to specific at–risk students as an indicated prevention program. The CAST curriculum includes the following sessions: 1. Welcome and orientation. 2. Group support and self–esteem. 3. Setting and monitoring goals. 4. Building self–esteem and beating the blues. 5. Decision making and taking STEPS. 6. Anger management #1

Coping and Support Training (CAST)	
Program Structure and Delivery	7. Anger management #2 8. Drug use control – making healthy decisions 9. School smarts 10. Preventing slips and relapses 11. Recognizing progress and staying on track 12. Celebrating graduation
Program Training and Cost	**Training:** CAST Teachers/Facilitator Training (groups of up to 9 hosted at preferred site) – $9,900 USD. This is a 4–day in–depth and interactive training that covers program theory, prevention model, structure of class sessions, and an overview of the entire curriculum. Each participant prepares and teaches at least one lesson and receives immediate and personalized supervision and feedback. Administrator Online Tutorials: $49 USD /participant. This training program provides essential program overview for those in leadership positions planning to promote or implement the CAST program. Self–paced tutorials prepare participants to support the CAST program in their setting, and include guidelines for creating a supportive infrastructure for the program. CAST Coordinator Training: $800 USD /participant (include access to the CAST Administrator Online Tutorial listed above). Participants must complete the prerequisite CAST Teacher/Facilitator Training prior to the CAST Coordinator Training. This training is a 1–day advanced training that prepares the coordinator that is assigned to supervise and support the program to ensure implementation fidelity. The training prepares the participant for important supportive tasks related to coaching and supervision. **Materials:** CAST Curriculum Kit (single) – $448.65 USD CAST Student Notebook (single copy) – $31.50 USD CAST Leader Behaviour Posters (set of 2) – $49.99 USD High School Questionnaire (set of 8) – 56.47 USD Student Outcomes Inventory (set of 24) – $46.91 USD Personal and Social Skills Inventory (set of 24) – $29.32 USD CAST Content Evaluation Form (electronic copy) – $25 USD Group Social Support Checklist: Group Evaluations (set of 8) – $11.72 USD Drug Involvement Scale for Adolescents (set of 24) – $69.19 USD

Coping and Support Training (CAST)	
Evaluation Findings	A 3–group, repeated measures, randomized preventive trial, involving 460 high–risk youths from 8 high schools from 2 Pacific Northwest urban school districts, was conducted. The first group received the CAST intervention, the second received another intervention called C–CARE, and the third group received a control intervention that represented 'usual care'. Assessments were administered at baseline, 4 weeks into the intervention, at the conclusion of the intervention at 10 weeks, and 9 months after baseline. Key findings include: • All study groups showed some reduction in suicide risk behaviours and emotional distress immediately following the intervention and at the 9–month follow up. However, the CAST and C–care interventions were more effective than usual care in sustaining reduction in suicidal ideation, depression, and hopelessness across time. • Females participating in the CAST intervention showed the steepest rates of decline in anxiety and anger–control problems, compared with those receiving usual care. However, there was no difference between the CAST intervention and usual care for males. • Youth receiving the CAST intervention showed significantly greater rates of change in problem–solving, coping, and personal control at program exist, with continued gains at follow up, in comparison to usual care controls. A 3–group, repeated–measures, randomized intervention trial, involving 341 high–risk youth in 7 high schools from two Pacific Northwest urban school districts, was conducted. The first group received the CAST intervention, the second received another intervention called C–Care, and the third group received a control intervention that represented 'usual care'. Assessments were administered at baseline, 4 weeks into the intervention, at the conclusion of the intervention at 10 weeks, and 9 months after baseline. Key findings include: • Youth in all three groups showed significant reductions in suicide–risk behaviours (thoughts, threats, attempts), depression (feelings of depression, hopelessness, and anxiety), and drug involvement (frequency of alcohol, marijuana and hard–drug use, drug use control problems, adverse drug use consequences). However, the CAST group and C–Care groups produced greater reduction in depression than usual care. • All three interventions influenced reductions in drug involvement, with the strongest effect in reduced hard drug use. Preliminary findings suggest that participation in the CAST program seemed to produce more favorable reductions in alcohol use and drug–use control

Coping and Support Training (CAST)	
Evaluation Findings	problems than the usual care and C–care conditions.
Sources of Information	CAST Program. (n.d.). Retrieved from http://www.reconnectingyouth.com/programs/cast/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Triple P – Positive Parenting Program	
Program Developer	Developed by Dr. Matt Sanders and his colleagues at University of Queensland.
Target Group	Parents of youth aged 12–16.
Program Description	Triple P is a parenting and family support system designed to prevent, as well as treat, behavioural and emotional problems in children and teenagers. It aims to prevent problems in the family, school, ad community before they arise, and to crate family environments that encourage children to realize their potential. The program draws on social learning, cognitive behavioural and developmental theory, as well as research into risk factors associated with the development of social and behavioural problems in children. It aims to equip parents with the skills and confidence they need to be self–sufficient and to be able to manage family issues without ongoing support. Although Triple P is delivered to parents of children up to 12 years old, a modified program called Teen Triple P is for parents of 12–16 year olds. The program can be delivered as a public health initiative, to create a meaningful impact at a population level, or its interventions can be selected specifically to target a particular demographic or parenting group according to an organization's priorities and budget. The program content is relevant to most cultures and socio–economic groups, encouraging parents to choose their own parenting goals, with regard to their own beliefs and values. The program has been translated into 21 languages other than English.
Program Structure and Delivery	The program isn't a single program, but rather a suite of interventions of increasing intensity for parents of children. Within each level, there is also a choice of delivery methods. Each level of the program can be delivered in a range of ways, including private consultations, small groups, large seminars, or online self–help. Triple P can also be delivered by a wide range of different professionals, making it easier for parents to access the programs. Level 1: Universal Tripe P is a communications strategy designed to reach a broad cross–section of the population with positive parenting information and messaging. It is not a course or personal intervention delivered directly to parents.

Triple P – Positive Parenting Program	
Program Structure and Delivery	Level 2: a "light touch" intervention providing brief one–time assistance to parents who are generally coping well but have one or two concerns with their child's behaviour or development. Delivered as selected seminar series or brief one–on–one consultation of 15–30 minutes with parents to target a specific issue. Level 3: Targeted counseling for parents of a child with mild to moderate behavioural difficulties. Delivered as four individual consultations lasting 15–30 minutes, or through 2–hour small group sessions targeting a specific problem behaviour or issue. Level 4: For parents of children with severe behavioural difficulties. Delivered as 5 group sessions and three phone counselling sessions, individual counselling delivered over 10, 1–hour sessions, comprehensive 8–session web–based program that guides parents, or ten week self–help program based on a workbook. Level 5: Intensive support for families with complex concerns. All Triple P interventions are supported with comprehensive, professionally produced resources for both practitioners and parents. The resources have all been clinically trialled and tested. The parent resources have been translated, variously, from English into 21 languages.
Program Training and Cost	Practitioners can be trained to deliver the program. Practitioners can come from a wide range of professions and disciplines and include family support workers, doctors, nurses, psychologists, counselors, teachers, teacher's aides, police officers, social workers, child safety officers and clergy. All Triple P Provider Training Courses are conducted by Triple P Trainers in compliance with the Quality Assurance Requirements specified by the University of Queensland. Training courses contain a maximum of 20 participants per course. And Triple P Trainers come to you – running training sessions at a location of your choice. Otherwise, you may send individual practitioners to open–enrollment training sessions, which are organized by Triple P. A skills–based training approach is used to introduce participants to the range of consultation skills necessary for the effective delivery of the program. Various methods are used, including instructive presentation

Triple P – Positive Parenting Program	
Program Training and Cost	video demonstration, clinical problem solving, rehearsal of consultation skills, feedback and peer tutoring. Practitioners are required to attend a minimum of 80% of each course to be eligible for accreditation. At the training sessions, each practitioner is provided with a comprehensive set of the relevant training resources such as Participant Notes, which outline the days' sessions and also help prepare practitioners for accreditation, and Practitioner or Facilitator Kits (which include the manuals needed to deliver Triple P to parents). Costs vary depending on needs and levels selected.
Evaluation Findings	Triple P has been part of more than 900 trials, studies and published papers, including more than 300 evaluation papers, 155 of which are randomized controlled trials. 50% (154) of evaluation studies have no developer involvement. Triple P's programs are tested both independently and in conjunction with the Parenting and Family Support Centre, University of Queensland. More than 1343 different authors across 419 institutions in at least 36 countries worldwide have contributed to the Triple P evidence base. Key findings include: • Program reduces problem behaviour in children and improves parents' wellbeing and parenting skills. • Program has been shown to slow rates of child abuse. • In communities where Triple P is widely available, children have fewer behavioral and emotional problems. • Parents using Triple P say they are less stressed, less depressed, and don't use harsh discipline.
Sources of Information	Blueprints (n.d.). Triple P System. Retrieved from https://www.blueprintsprograms.org/factsheet/triple-p-system Triple P (2018) Retrieved from https://www.triplep.net/glo-en/find-out-about-triple-p/

School-Based Programs for Youth with Mild to Moderate Mood and Anxiety Concerns

Mental Health First Aid for Adults who Interact with Youth	
Program Developer	Hosted by Mental Health First Aid Canada and the Mental Health Commission of Canada. The program originates from Australia.
Target Group	Adults who interact with youth aged 14–25.
Program Description	This course focuses on the basics, and more specifically on mental health problems and first aid for young persons aged 12–25. This 14–hour course aims to help adults recognize the symptoms of mental health problems or crises as they develop in youth (including eating disorders and non–suicidal self–injury), provide initial help when facing a mental health problem or crisis, guide youth and/or adults who support them toward appropriate professional help, and learn how to accommodate young people who are in distress or are recovering from a crisis. Topics covered include mental health and stigma, mood–related disorders, anxiety and trauma–related disorders, psychotic disorders, substance–related disorders, eating disorders, and deliberate self–injury. The course provides training in crisis first aid interventions for suicidal behaviour, overdose, self–harm, psychosis, acute stress reactions, and panic attacks.
Program Structure and Delivery	This 14–hour course is designed for parents and family members, social workers, counsellors, teachers, law enforcement, coaches, babysitters, first responders, healthcare providers, and community leaders. The course is designed for a group of 8–25 individuals.
Program Training and Cost	$350/individual
Evaluation Findings	Mental Health First Aid is an international program that has been evaluated by various peer–reviewed studies across the world that have indicated that individuals trained in the program: • Increase their knowledge of signs, symptoms, and risk factors of mental health problems. • Decrease the social distance between themselves and someone with a mental health problem. • Increase their confidence to help someone experiencing a mental health crisis. • Can identify professional and self–help resources for individuals with a mental health problem. • Show increased mental wellness themselves.

Mental Health First Aid for Adults who Interact with Youth	
Sources of Information	Mental Health Commission of Canada (2018). Adults who Interact with Youth. Retrieved from https://www.mhfa.ca/en/course-type/adults-who-interact-youth