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OLUWASEGUN BANKOLE HASSAN, ALI BELL, STACEY ALEXANDRE, AND BRENT RIOUX

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Qualitative Evaluation of Mental Health Capacity Building Pilot Project in Saskatchewan Schools

Oluwasegun Bankole Hassan,[1] Saskatchewan Health Authority, Canada
Ali Bell, Government of Nova Scotia, Canada
Stacey Alexandre, Saskatchewan Health Authority, Canada
Brent Rioux, Saskatchewan Health Authority, Canada

Abstract: School-based programs have been recommended as an effective way to tackle stigma and mental health burden among children and youth. As the Mental Health Capacity Building (MHCB) initiative was piloted across five Saskatchewan schools, this study sought to capture in-depth reflections from different stakeholders and provide experiential evidence of the initiative's impacts. Semi-structured interviews were conducted with MHCB staff, teaching staff, student-leaders, and parents engaged in the initiative. A directed content analysis was used to synthesize the data and categorize them into four areas, further explained. The experiential evidence of the MHCB initiative showed improving mental health literacy, and positive emotional and social engagement for students (better health). The platform bridged the gap of care for some at-risk students in need of support or having difficulty reaching out (better care). The initiative inspired teacher integration of mental health programming into classrooms (better value) and created a wide network for mental health promotions (better teams). Overall, the MHCB initiative demonstrated encouraging evidence of improved mental health knowledge for engaged students and capacity building for engaged teachers in the schools and surrounding communities; hence, this study contributes to a deeper understanding of the impacts of universal mental health intervention for school-aged children.

Keywords: Mental Health, School-Aged Children, Evaluation

Background

Evidence suggests that mental illness can affect all people at some point in life. From a lifelong perspective, global evidence shows that more than half the cases of mental illnesses start during early adolescent stage, with many of them left untreated till later in life (WHO 2014). In Canada, school-aged children face serious implications from mental health disorders, as intentional self-harm is the second leading cause of mortality among youth (Statistics Canada 2020). Historically, societal acceptance for mental disorders has been low and many people suffering from chronic mental conditions are often marginalized, as shown in a systematic review (Kaushik, Kostaki, and Kyriakopoulos 2016). Studies show that a large proportion of youth having difficulty with mental health do not receive the needed support (Erskine et al. 2017; Green et al. 2013). Consequently, the evidence is becoming paramount to focus on the prevention of mental illness among children and youth (Caldwell et al. 2019).

School-based mental health programs have been globally recommended to address mental health misconceptions and reduce the public health burden among children and youth (McLaughlin 2017; Weare and Nind 2011; Weist et al. 2017). In Canada, focus has been shifting to the improvement of school-based mental health literacy, which is the knowledge and self-awareness to identify, manage, and prevent mental conditions (Kutcher, Bagnell, and Wei 2015; Thai and Nguyen 2018). Canada represents one of the leading countries in school-based interventions due to the mental health literacy efforts and capacity building for educators (Weist et al. 2017). Researchers have also opined that improving mental health literacy among students, teachers, and parents can inspire early interventions for mental health conditions in schools (Kelly, Jorm, and Wright 2007).

[1] Corresponding Author: Oluwasegun Bankole Hassan, 2180 - 23rd Avenue, Research Department, Saskatchewan Health Authority, Regina, Saskatchewan, S4S 0A5, Canada. email: Oluwasegun.Hassan@saskhealthauthority.ca

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School-based interventions generally require school leadership engagement and development of networks for communication and services (Hudson, Lawton, and Hugh-Jones 2020; Weist et al. 2017). For example, an international study provided this perspective via collaborations between the educational system, such as school administration, and the support system, such as mental health services (Weist et al. 2017). Through these collaborations, existing barriers are alleviated, and support systems are structured in a multitier system involving preventive approaches at Tier 1, and early intervention at Tier 2 (Weist et al. 2017).

Studies show that effective school-based programs are characterized by access to knowledge, sound promotional practices, development of networks for mutual support, and behavioral and policy changes (Weist et al. 2017; Xu et al. 2020). These features are particularly evident when programs are integrated into existing curriculum involving student participation (Xu et al. 2020). The reported benefits of school-based interventions are numerous, ranging from the prevention of symptoms occurrence (Cuijpers et al. 2008; Merry et al. 2012), to the alleviation of cognitive and behavioral symptoms before they reach an advanced stage (Werner-Seidler et al. 2017). Despite these benefits, studies have shown that intervention approaches should be carefully considered, as they play a major role in deriving effective health outcomes for the target populations within the school system (Caldwell et al. 2019; Werner-Seidler et al. 2017).

Researchers have discussed the different approaches to school-based interventions which range from universal to targeted approaches, and in their unique ways associated with positive mental health outcomes (Kutcher, Bagnell, and Wei 2015; Salazar de Pablo et al. 2021; Weare and Nind 2011; Werner-Seidler et al. 2017). For example, "targeted" approaches would tend to focus on assisting individuals with either subclinical symptoms or elevated risk of mental disorders (Werner-Seidler et al. 2017). For specific conditions such as depression, a targeted approach was shown to be effective in reducing the mental health burden among young people (Werner-Seidler et al. 2017). Targeted approaches focusing specifically on students experiencing mental health difficulties tend to produce long-lasting mental health benefits (Werner-Seidler et al. 2017). Meanwhile "universal" approaches, with more focus on promotion and prevention strategies, tend to improve mental health literacy in general (Fazel et al. 2014). Universal approaches, which may involve the delivery of programming to the whole school, a full grade, or an entire class (Neil and Christensen 2009), have been shown to reach wider audiences and produce a positive effect on stigmatization (Hudson, Lawton, and Hugh-Jones 2020).

Furthermore, it has been recommended that school-based approaches focus on features such as: finding a balance between universal and targeted programming; liaising with different partners and agencies; working within a whole school approach; and building teaching skills and curriculum design for positive mental well-being (Weare and Nind 2011). While research shows that school-based approaches have been supported by public policy (McAllister et al. 2018), they have been heterogeneously inconclusive in terms of their effects (Caldwell et al. 2019; Werner-Seidler et al. 2017), and prevention approaches have been widely recommended for addressing the mental health burden in the school environment (Caldwell et al. 2019). The MHCB initiative evaluated in this study takes an innovative approach that combines mental health promotion for literacy and self-management skills, with an integrated process of channeling referrals for at-risk students to appropriate mental health support and services.

Mental Health Capacity Building Initiative

The MHCB initiative is a universal programming initiative that promotes collaboration between schools and communities to recognize and address barriers to well-being through evidence-informed mental health promotion and to support at-risk students to connect with appropriate

services (Bell and Hassan 2020).[2] This initiative was heavily informed by the work of Alberta Health Services MHCB program (Alberta Health Services, n.d.). Hudson, Lawton, and Hugh-Jones (2020) explained that the formal integration of implementation leaders within the schools is warranted for a successful execution of an early intervention program. The implementation of this initiative involves the concerted efforts of MHCB staff employed specifically for this initiative, such as MHCB School Coordinators (MHCB-SC) and MHCB Wellness Promoters, as well as preexisting supports such as school administrators, school social workers, and project directors at the health authority.

The promotional activities are not prescriptive in nature but rather based on the unique needs of each school community. The initiative's programming is embedded into the school's daily activities such as mindfulness moments, lunch and learn sessions, and classroom literacy presentations. They are also embedded into the after-school time period such as family and community involvement. The MHCB staff, consisting of the coordinators and promoters, become part of the school system and receive in-kind school support such as office space and access to technology. In addition, they are supported provincially by the health authority and work collaboratively with the school and community mental health services to establish the initiative as a resource for mental health promotion and prevention activities.

This initiative was piloted at five designated school divisions in Saskatchewan from January 2018 to December 2020, and delivered to students from prekindergarten to Grade 12, with more focus on high school students for the pilot initiative. The details of the participating schools and their characteristics are provided in the original report (Bell and Hassan 2020). The evaluation of the MHCB pilot was conducted through a mixed methods approach. Being a part of the evaluation team that conducted the first phase of the study (Bell and Hassan 2020), and having no prior relationship with the participants in this study, the primary author was tasked with conducting a follow-up qualitative study. This article focuses on a follow-up qualitative aspect of the evaluation, developed to build a deeper understanding of the project indicators.

Purpose and Research Questions

The purpose of this study was to capture in-depth reflections from different stakeholders involved in the project and provide experiential evidence on how the MHCB initiative impacts the wellness of students in the schools and communities. This study also sought to consult different stakeholder groups to address the following questions:

1. What are the perceptions of stakeholders concerning the provision of innovative programming to enhance children's well-being?
2. What are the perceptions of stakeholders concerning the support of early intervention and access to treatment for children at risk of mental health concerns?
3. What are the perceptions of stakeholders concerning the building of capacity in school staff for program delivery?
4. What are the perceptions of stakeholders concerning the strengths and challenges of the initiative?

Methods

Theoretical Framework

As part of a larger mixed methods evaluation (Bell and Hassan 2020), the qualitative research design was integrated into the study to address the gaps that arose from the quantitative phase with respect to experiences and stories on the impacts of the initiative. A directed content

[2] All the original quotes in this article come from the source material in Hassan (2021).

analysis, which is a research technique that builds upon an existing framework or prior research (Hsieh and Shannon 2005), was undertaken to provide a more in-depth understanding. This approach was deemed suitable to address the research questions because it delved into the descriptions of prior indicators derived in the MHCB initiative.

This research was based on the Quadruple Aim Project Framework (Figure 1) that ensured all the data collected, the analysis, and the findings were grouped according to "four betters"—better health, better care, better value, and better teams. The framework was derived from an evidence-informed strategic plan of the Saskatchewan healthcare system (Government of Saskatchewan, n.d.), and evidently utilized by studies measuring healthcare-related indicators (Goodridge et al. 2015; Kinsman et al. 2014; Kryzanowski et al. 2019).

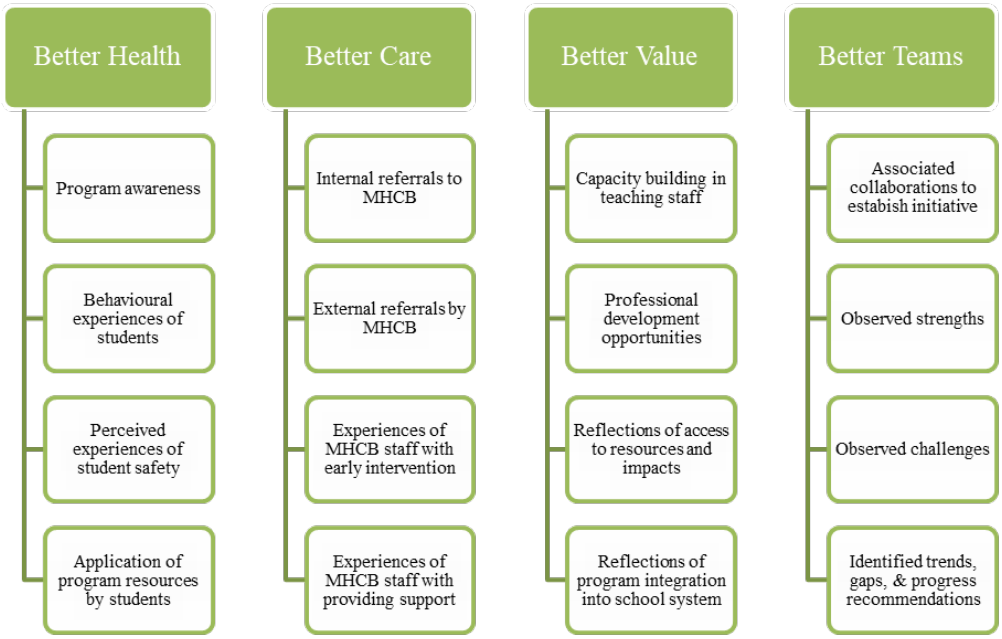

Figure 1: Quadruple Aim Project Framework
Source: Hassan et al.

Recruitment of Participants

A combination of purposive and convenience sampling was used to recruit participants for this study (Andrade 2021). A purposive sampling technique was taken as an appropriate nonprobability approach to recruit participants with experiences that demonstrate the impacts of the initiative. Participant selection was focused mainly on stakeholders with direct engagement in the programming (i.e., MHCB-SCs and teachers), and program end users (i.e., students and parents). School superintendents granted approval to conduct interviews within their jurisdiction and then connected the researcher to the MHCB-SCs. Using convenience sampling, the MHCB-SCs identified and facilitated connection to the teachers, parents, and student-leaders (i.e., students who inspire and advocate for their colleagues). Even though the MHCB-SCs facilitated the convenience sampling process, the researcher confirmed direct engagement in the programming from each participant as the interviews began, as this was the criterion for participant selection.

In total, fifteen participants were selected, which comprised of four MHCB-SCs (representing all five pilot schools; one coordinator overseeing two schools), seven teaching staff, and two

student-leaders with their parents. At least one teacher was recruited from each school to cover perspectives across the designated schools, and multiple teachers participated in two schools solely based on expression of interest. The participants were selected from towns and cities, as the initiative is targeted toward communities of varying population density. All adult participants completed a consent form and the students an assent form before the interviews were conducted. This study was ethically approved by the Research Ethics Board of Saskatchewan Health Authority. As part of the ethical considerations, participants were informed that discussing sensitive topics such as mental health could be emotionally distressing and that the interview would be stopped and continued only with their approval, if that happened. They were also informed of counseling services available within the MHCB initiative.

Data Collection

The interview guide was developed from a set of pre-determined indicators deduced from the project framework (Figure 1). The questions were categorized with relevance to the "four betters." The interview guide was sent to the participants beforehand in order to capture rich information about their lived experiences. The interview questions were open-ended, nonsuggestive, and nonrestrictive (Creswell and Creswell 2017). For example, the participants were asked, "Please tell me about your experience as an MHCB staff in referring at-risk children to needed services," "How has MHCB impacted students' behavior in schools?" The interview guide was piloted by conducting a test interview with an MHCB-SC.

In addition to the interview data, narrative summaries of trends, innovations, and challenges associated with the initiative, which are provided annually by MHCB-SCs were also included as qualitative data for triangulation. The narrative summary was guided by a set of open-ended questions and included anonymized feedback comments from students, teachers, and parents.

Virtual semi-structured interviews were conducted with the participants. The interviews were conducted via a WebEx conferencing platform licensed to Saskatchewan Health Authority. Student-leaders were interviewed separately from their parents in order to reduce social desirability bias. The interview process occurred from August to October 2020, and the duration of the interviews ranged from forty to sixty minutes. All the interviews were audio-recorded and transcribed verbatim. The transcribed data were further sent to each participant for member checking and verification of data. Participants' characteristics were drawn from the transcripts (Table 1), as participants were given the opportunity to introduce themselves. This approach was important in establishing participants as being in control of the specific demographic information they revealed.

Table 1: Characteristics of Study Participants

Study Participants	*Characteristics*
MHCB School Coordinator (MHCB-SC)	There were three female participants and one male participant. All MHCB-SC had academic backgrounds in health or social sciences with some experience working in promotion and prevention of addictions and mental health.
School Teachers (ST)	There were four female participants and three male participants. Some of the classes the teachers taught include history, wellness, physical education, English as an Additional Language (EAL), and mathematics.
Student-Leaders (SL) *Parents (P)*	There was one female and one male participant. One of them was a Grade 5 student while the other was a Grade 12 student. The two parents interviewed were females. One family resides in a town and the other family resides in a city.

Source: Hassan et al.

Conceptual Analysis

A directed content analysis was used to synthesize the data. This involved an inductive analytical approach guided by preexisting indicators derived from the project framework (Figure 1), which played an important role for constructing contextual reality (Hsieh and Shannon 2005). First, some preexisting categories were created around the "four betters" to guide the analysis through a deductive reasoning (Hsieh and Shannon 2005). Second, inductive analysis adapted from the work of Braun and Clarke (2006) was used to synthesize the large bulk of data, which further aligned to the preexisting categories, while remaining open to emergent categories. NVivo computer software for qualitative data analysis was used through the process. The detailed breakdown of the analysis is further explained later.

As suggested by Braun and Clarke (2006), the transcribed data and narrative summaries were read and reread for immersion into the data. This was followed by initial coding, which involved giving a line-by-line meaning to the data, and each code was represented as nodes in NVivo. Then, each code was reviewed for relevance to the preexisting categories, which were merged in NVivo as hierarchical nodes (Hsieh and Shannon 2005). The codes that were unmerged were reviewed and synthesized into emergent categories. Themes and subthemes were then created to demonstrate relationships that emerged from the categories and their associated codes and data.

Rigor and Trustworthiness

The study ensured triangulation of data for empirical contextual knowledge by integrating multiple sources of data (Creswell and Creswell 2017). First, the study used both semi-structured interviews and narrative summaries as sources of open-ended data. Second, four different stakeholder groups were interviewed, including MHCB-SCs, teaching staff, student-leaders, and parents.

For trustworthiness, which refers to the integrity of the research work, dependability and credibility were ensured though several processes (Graneheim and Lundman 2004). The use of an interview guide, adherence to ethical guidelines, and drawing descriptive meanings from participants' perspectives was used to establish dependability. For credibility, member checking was conducted by sending the transcribed data to participants to verify, add, or remove any information before beginning the analysis. The derived findings were reviewed by the project advisory group for contextual relevance to the MHCB scheme. In other words, the themes, subthemes, and their associated features were shared with the project committee to confirm whether the findings produce a deeper understanding of the impacts.

Findings

The themes and subthemes are further presented to address the research questions by explaining under the "four betters" that guided the study. These were presented with associated quotes and described for better understanding.

Health Outcomes

Created Awareness for Mental Health Literacy

The findings showed that school coordinators created awareness through promotional activities such as physical in-class presentations, social media communication, and word of mouth. Participants described the role of mental health promotional activities in the advancement of mental health literacy in the schools. One teacher stated, "Okay, like for example, there are

some resources in my classroom. I posted a big poster on the classroom wall on stress coping skills for everyday life. They took a picture of it and they are sharing it" (ST5). A student-leader also said:

> And we have a little presentation or whatever. And we can show what happens or how things all evolve to the teachers [so they can understand] that sometimes we actually can't do stuff [due to mental health conditions]. And this is helping the teachers understand that they can't get mad at something because they can't control it, you know. (SL2)

From the excerpt, the student-leader described that the awareness created through continued mental health conversations within the school tends to improve the perceived understanding of schoolteachers in relation to their students' health and well-being.

Reflections on Positive Interests and Positive Behavior

Students demonstrated positive interest toward the initiative by their consistent use of the designated MHCB spaces. They also showed interest through follow-up after programming to seek self-management resources, as described by the participants. Students described following up with MHCB staff to acquire coping resources subsequently after an in-class mindfulness programming. In other cases, students freely connected with invited guest presenters after the sessions. Teachers also reflected on positive interest from students, as in-class requests were made for wellness activities, as described, "during my Wellness class, I did have students request, 'Hey Ms. Katrine, can we do like a mindfulness moment today?' and I say yeah, for sure. So I think that shows a huge engagement for students" (ST6).

The participants described how the MHCB initiative influenced students' behavior. In particular, they described that the MHCB space served as a place for students to self-regulate and avoid unhealthy behaviors. For example, one student-leader stated:

> Sometimes I feel mad because people are teasing. But then I get over it. And when teacher asks me, "Who was that one boy you were mad at in the last grade?" Then I say, "Forget about that. That was a long time ago." Then he's like, "Good for you that you got over it." Then he gives a good thumbs up. (SL1)

From the quote, the student-leader demonstrated how he was able to overcome a negative practice of fighting bullies by walking away due to positive involvement in the MHCB initiative. Another student emphasized the impact on self-regulation by saying, "Once I've given myself enough time to recharge a little bit, I'm able to go and deal with it without getting overwhelmed and yelling when it's not needed" (SL2). Generally, the findings revealed that the MHCB initiative positively impacted relationships and behaviors for engaged students.

Reflections on Social Engagement

The data revealed that the MHCB initiative created social engagement opportunities for students. These include peer engagements, receptiveness to class presentations, and student-initiated mental health promotions. For example, the MHCB space served as a place for students to freely communicate with MHCB staff and connect with peers. Further, student-leaders promoted mental health events within their student associations, through their direct involvement with the initiative. Despite COVID-19 disruptions, the interviewed student-leaders and school staff demonstrated interest in reestablishing engagement in the initiative as school reopens.

Using Coping Skills and Self-Management Skills

The teachers and MHCB staff taught coping skills, while the students derived some positive outcomes as they learned and utilized the coping skills. The MHCB staff demonstrated how they encouraged the students to engage in mental health conversations. For example, one school coordinator said, "And we offer such a variety of activity where we do something fun such as giant jenga or cookie decorating or an art session as well as talking about mental health issue and keep the repetitive coping skills going" (MHCB-SC3). Then the teachers also described how they taught coping skills through classroom activities such as mindfulness, and stress management techniques. As described by a teacher, "And you know I try and bring that into the classroom too. Slow things down, maybe turn one bank of lights off so it's not always so bright. And just take the opportunity to be a little more relaxed" (ST4). Another teacher stated, "I always tell them, 'You don't have to shoulder it because there are people around you who will help' " (ST5). Consequently, there were some positive outcomes for the students, as they used the acquired coping skills to manage personal needs such as coping with stress, applying relaxation techniques, and developing academic competence, as described here:

> Bryan [the School Coordinator] here help me a lot about mental health and he taught me a lot. He taught me about my anger issues and that's good…He is helping other kids like me…Yea, I like coming here [MHCB room] because it helps me control my anger issues…Sometimes I get mad and I do this real hard (*clamps hands together*). I squeeze my knuckles and I breathe in and out. Sometimes when I feel angry, I go in my room and I calm down. (SL1)

From the quote, the student-leader acknowledged the role that MHCB played in helping to deal with an unhealthy behavior. He also described the coping skills he had been applying for that situation. Supported by his parent, she described that:

> It has helped a lot because before when John [my son] would get angry, he would want to fight. He would want to lash out and talk back. Sometimes, swear. Whereas now, he will just tighten up, or he'll crumple up paper in his hands, and not like react right away by swearing or getting angry at people. He's learning to like control his anger. (P1)

Another student-leader who dealt with anxiety explained some of the techniques acquired from MHCB. She explained how she had worked with the MHCB staff to apply journaling technique for effective results:

> In the [MHCB] room, Sandra [the MHCB staff] has told me things about writing skills because I told her about my journal, so she gave me some ideas. So I created a book journal whereby every day I write down different things to help you cope with what's going on through that day or just a to-do list so that you know what's going on through that day. So it doesn't seem so stressful once it's all written down…And that helped me at home because when I was super-stressed about something, I could write it down, and I wouldn't be taking it out on my sisters or my parents. (SL2)

In addition, several teaching staff also described some observed mental health outcomes for their students including getting more relaxed for academic comprehension. For example, a teacher stated that her students are a little more chilled as a result of the programming delivered in the classroom. In the process of describing some positive outcomes for students, school

coordinators also explained that students use MHCB resources to manage periodic stressors such as upcoming exams.

Reflections on Self-Esteem

Teachers, students, and parents had some positive reflections on the role that MHCB plays in students' self-esteem. They believed that as mental health literacy increases, the more students learn the necessary coping skills which ultimately builds self-confidence. As described by a teacher:

> If students know that it's okay to be stressed, or it's okay to be anxious, or it's okay to be nervous, they learn skills to help them walk through that and cope through that. I think they just feel like they are okay. And anytime you can just feel good about yourself. I don't know, I think that just builds positive self-esteem. (ST4)

The parents also provided experiential data that demonstrated how the initiative has positively impacted their children's self-esteem. For example, the parent below reflected on outcomes related to self-esteem by describing some observed changes in relation to her child's perceived self-concept. She said:

> Sometimes, he is trying to plait his hair to the side to look cool all the time and the way he presents himself. But now, he'll say, "I'm just going to be myself. I'm not going to worry how anybody thinks I am today"… He is just a whole different person just using those things [MHCB resources]. And even if it's just that little chart [zones of regulation] on the fridge. (P1)

Another parent, whose daughter was dealing with anxiety emphasized the impact of MHCB on her self-confidence by stating that, "I believe the MHCB has influenced her behavior in a lot of positive ways. At school, she has achieved a level of self-confidence that she had yet to find at that point" (P2) Overall, the data showed evidence supportive of a positive impact on the children's self-esteem, possibly resulting from increased awareness, education on coping skills, and provision of self-management materials.

Reflections on Feeling of Physical and Psychological Safety

The feeling of safety was thematically reflected by all participants. As described, having an MHCB space within the school provided a reliable safe place for students. It was revealed that the way in which students used the safe space can be subdivided into categories, as further described.

First, it was identified as a safe space for disclosure, as it enabled students to reveal any mental health concerns discreetly in order to receive the needed support. One student-leader said, "And anything that was said in there stayed in there. They just have a way of helping you be yourself and know that it doesn't really matter what anyone else thinks" (SL2).

Second, the MHCB space was identified as a safe space for students to be heard, which is important for overcoming societal stigma and developing a sense of belonging. As described by a student-leader, "Well in the [MHCB] room, we talk to the two educators there, and we told them our feelings, and they gave us ways to deal with it…And everybody could go in there and talk" (SL2). Another student-leader said, "I love that we are getting more acceptance and we are able to talk more about our problems in the school without being ridiculed by many of the students or teachers" (SL1).

Third, it was a safe space for positivity. In several schools, Place of Positivity (POP) was a name given to the MHCB space in consultation with students. Fourth, it was identified as a safe

space for supporting at-risk children. School coordinators reflected that they continued to experience an increasing number of self-referrals to the program, including students dealing with social exclusion within the school environment. For example, the term "slipped through the crack" was used by one of the coordinators to describe marginalization, with an emphasis on the MHCB space serving the needs for these groups of students.

Lastly, it served as a safe space for students to learn by attending organized educational sessions and doing free-time studying. The "lunch and learn sessions" also created educational opportunities and encouraged students to invite and support each other through the sessions. Interestingly, the findings revealed that that the MHCB space also served teachers, particularly in relation to having a safe place for relaxation.

Care Outcomes

Reflections on Incoming Referrals

The increasing awareness of MHCB within the schools and the communities led to more incoming referrals to the MHCB room, especially student self-referrals. The more students understood what MHCB was all about, the more inclined they were to access and seek the resources. As described by a student-leader:

> Um, I had one friend. She was going through a really hard time and she didn't want to go talk to the teachers. So I had told her to go to the POP room and talk to Pat and Nick [the MHCB staff] because they are very understanding and they offer ways to help. (SL2)

Most incoming referrals were not targeted at therapeutic intervention but rather to support students' self-regulation. Teachers also played a crucial role in referring students who were in need of self-regulation when having a difficult day. Referrals from teachers were mostly directed to the MHCB staff before the full school referral team or counseling team. The teachers and MHCB staff developed a positive relationship that encouraged discussion of options for students who may need an alternative environment for their academics as opposed to the regular classroom.

Supporting At-Risk Students

The MHCB staff supported at-risk students by referring them to the appropriate services. In many cases, the MHCB-SCs described that at-risk students dealing with anxiety, depression, addiction, or suicidal thoughts were generally referred to the school social worker or counselor, and then to outside mental health agencies appropriately.

The MHCB-SCs reflected on experiences of dealing with disclosure when a student opened up about self-harm or suicidal thoughts. As described, "I mean there are some students that come asking for a glass of water and then it ends up being a totally different conversation of disclosure that they are wanting to self-harm" (MHCB-SC3). Dealing with suicidal disclosure was described as a challenging experience due to the unpredictability and sensitivity involved. However, they described the use of supportive and plain language as an effective approach taken to deal with these circumstances.

Bridging the Gap of Care

The MHCB served as a platform that bridges the gap of care in the mental health and addiction continuum of care, by guiding students who may require support or treatment services but are

undecided how or whether to do so. Students who felt reluctant discussing some issues with their counselors, felt safer reaching out first to MHCB staff for support.

The MHCB-SCs consistently established supportive relationships to guide the students during the incoming and outgoing referrals. In terms of incoming referrals, students who were having a difficult day depended on the relationship they had developed with the MHCB staff for self-regulation. As stated, "I guess there's a lot of rapport building before that, right. Just kind of figuring out what's going on in their situation" (SC4). In terms of outgoing referrals, supportive relationships were established with the students from the point of initial contact of gaining trust, to the transfer process of walking together to the counselor's office, and to the follow-up stage of maintenance through the school year. A student with a recurring visit to the MHCB room who eventually needs a referral may find the referral process smoother if there was an established relationship, as described by the coordinators.

Setting Boundaries to Balance between Supporting and Counseling

This theme was commonly demonstrated by the MHCB-SCs as part of the processes associated with care for at-risk students. To maintain mandate fidelity, the MHCB-SCs had to create some measures to mitigate the possibility of transitioning to therapeutic relationships with students. The measures taken by the coordinators included the use of language that aligns with the MHCB mandate as well as their ability to adapt over time. One of the school coordinators describing how she managed this stage of care stated, "But I think I adapted quite quickly to cross that line. I think it's a learning experience too. And having that experience of knowing when it's therapy and when it's not" (SC4). Another school coordinator stated:

> But then as I started to understand my role more, and adapted more, you just kind of know your lines, and say…okay, this has kind of reached that point…Not that you can't use the program, but for that in-depth discussion, we really need to refer you to the appropriate people. (SC1)

Value Outcomes

Building Teachers' Capacity

The evidence showed capacity building through classroom presentations delivered by MHCB staff. The presentations tend to create opportunities for teachers to begin incorporating mental health literacy into their regular classroom activities. The data also showed some evidence of capacity building via virtual professional development programs offered by the MHCB staff. As described, "Lately we have been taking the online training and we have also taken the Mindful Schools. So that's another one we are able to offer to staff and we had a number of staff take that" (MHCB-SC2). Finally, awareness for school staff, created particularly at professional development (PD) days was collectively described as a driver for improved staff involvement.

Reflections on Positive Teacher Engagement and Integration

This theme was reflected by all the MHCB staff and teachers recruited for this study. The reflections from the teachers showed that there was a positive experience for the engaged teachers as it pertains to embedding MHCB programming and resources into their classroom teaching. Teacher integration of programming was either a collaborative delivery with the MHCB-SC or sole delivery by the MHCB staff in their classrooms. The purpose of integrating programs into teaching was broken down into three categories.

First, they showed integration for curriculum impact. The teachers reflected on the degree of curriculum integration as an average of four to five hours of content per subject. Some of the teachers showed that mental health programming may also fit into unique classes such as English as an Additional Language (EAL) and mathematics classes.

Second, they showed integration to teach coping skills for optimal mental health. One of such strategies was the zones of regulation, described as an important tool empowering students to deal with acute mood swings. One teacher stated:

> She [MHCB staff] did a lot of really good work around the zones of regulation. How to recognize if you are feeling sluggish, if you are feeling excited, if you are feeling just right, or if you are getting to that angry state. And starting to develop some of those tools for self-regulation…Sometimes they [students] would refer to the resources in the classroom. Like we kept the zones of regulation up on the wall. (ST3)

Lastly, excerpts from schoolteachers showed integration of mental literacy through promotional resources, scheduled MHCB presentations, and sharing of personal experiences. One of the teachers stated:

> and when they understand that teacher has bullied, teacher has been bullied, and it hurts teacher's feelings, they start to see the humanity in each other…and guess what, teacher sometimes is in the red zone. Now we have to all try and work together again to help teacher get to the green zone. (ST2)

Developing Teachers' Confidence to Deliver Programming

Teachers who were engaged with the initiative demonstrated some improved confidence to deliver programming either independently or collaboratively. They developed confidence from witnessing classroom presentations delivered by MHCB staff. As described, "because I have seen one of Brenda's presentation maybe two or three times now, that I do have the ability and the knowledge in order to do the presentation" (ST6).

They also gained confidence through access to resources. They further described the important role that the MHCB staff play as the resource themselves. As described, "But by having the MHCB in the school and opening that discussion, made it possible for me to carry on that discussion even without MHCB staff" (ST5). Finally, the teachers developed confidence by getting involved with MHCB and by realizing how their lived experiences in dealing with mental health situations throughout their lives has impacted their sense of understanding.

Teams Outcomes

Networking

The MHCB staff depended on different levels of partnerships to establish the initiative as a resource within the mental health and addiction continuum of care. These include partnerships with student-leaders, teachers, community agencies, school administration, school associations, other provincial MHCB staff, and partners from Alberta Health Services. The findings showed that there were some partnerships between teachers who shared the common interest of integrating programs into their classrooms.

The relationship between MHCB staff and teachers was demonstrated as the most significant partnership for the success of the program. The MHCB staff also relied on community agencies for mental health promotion, including Royal Canadian Mounted Police, sexual health organizations, and Indigenous partner organizations. MHCB staff collaborated

with local community leaders to deliver presentations and inspire students via modeling. Additionally, few MHCB-SCs described their connection to specific associations including student associations, religious institutions, and multicultural associations.

Strengths

The strengths can be broadly viewed from three subcategories, which are themes that emerged from the perspectives of teachers, coordinators, and student-leaders and their parents. From the teachers' perspectives, having the physical presence of an MHCB staff within the school as a resource person was described as a strength. One teacher said, "So I think the presence of MHCB staff as the resource person providing direct information. We must really have an MHCB staff at school. For me that's really the strength of the program" (ST5).

From the MHCB-SCs' perspective, the distinctiveness of the initiative and its mandate, which include shifting from a reactive to a proactive approach was described as a strength. Finally, the students and parents described the strength as the unfolding of mental health conversations within the school as well as the demonstrated impact on children's behavior, as stated below:

> I feel like having a place directly in the school where students can go and are free to be themselves or free to talk about their problems without any judgment placed upon them…I think that's extremely important. (P2)

Challenges

First, from the MHCB-SCs' perspectives, they stated being fully immersed and effectively embedded within the high school system, and aligning programming to specific curricula as challenges. As described by a teacher, "I think the challenges with the program is not the program itself, it's the teachers [within the school] who don't see the value in the program" (ST6). In addition, getting many teachers on board was challenging, as well as achieving the aim of having teachers become independent facilitators.

Other participant groups described stigma around mental health as the major perceived challenge that hindered engagement. This was a theme from the responses of teachers, students, and parents. A student-leader stated, "Some of the challenges I observed with the program is that sometimes it's really hard to get people interested or to want to participate in it because there is so much stigma around it [mental health] still" (SL2). One of the teachers also said, "I think the struggle not only with the program but just with mental health generally is just fighting the stigma" (ST4). Finally, there were some reflections on challenges related to COVID-19, as several teachers described that their levels of confidence were developing to the extent of independently facilitating programs in their classrooms before the early pandemic disruptions.

Discussion

The study took a directed content analytical approach to assess the impact of the MHCB initiative on the mental well-being of children, youth, and families by delving into the perspectives of MHCB staff, schoolteachers, student-leaders and parents engaged in the program. Most participants, including students, described that mental health promotional activities such as classroom presentations and online promotions played a key role in developing mental health literacy in the schools. Similarly, a recent study on secondary school intervention found that classroom activities and use of mobile apps have higher tendencies of improving youth mental well-being (Punukollu et al. 2020). Besides the MHCB staff, teachers and students also engaged in mental health promotional activities. This was similarly found in another post-secondary study

which showed that student-led mental health promotions, particularly those aimed at educating peers, can develop student health and promote a sense of community (Saheb et al. 2021). Therefore, this study contributed to the evidence supporting the role of mental health awareness and promotion as an impactful intervention for younger people in schools.

There were reflections demonstrating a positive engagement and behavior from students due to MHCB programming and resources. This was evidently described by the student-leaders who experienced emotional stability such as dealing with anger, anxiety, and stress. Research has shown that self-esteem is an outcome that can positively influence the mental well-being of students (Lee 2020). In a similar manner, this study showed a positive impact on the student's self-esteem, resulting particularly from the impact of MHCB awareness, access to resources, and trust in the support process. This study demonstrated that MHCB aided students' feelings of physical and psychological safety because the MHCB space served as a safe place for students to disclose emotional concerns, be heard, receive support, derive positive energy, and learn. The "lunch and learn" sessions organized in the MHCB space provided opportunities for students to learn and even support one another. Akin to the findings of this study, another similar program that focused on awareness and signposting to appropriate services showed that the program opened up discussion about sensitive topics such as self-harm within the schools (Punukollu et al. 2020). This current study hereby demonstrated that students engaged in the MHCB program experienced favorable outcomes associated with changing mindsets, suggesting more positive outcomes for the youth population if this type of program was extended to a more substantial cohort.

Research has shown that students tend to engage in mental health programs when they have control and power of choice (Gronholm, Nye, and Michelson 2018). Similarly, this study showed that the more there is program awareness, the more student self-referrals are being made to MHCB for support. However, a majority of the self-referrals were not described as therapeutic intervention but rather as ways to support students' self-regulation of their emotions. This corresponds with other studies showing that students engaged in help-seeking behavior due to the impact of the school-based mental health intervention (Gronholm, Nye, and Michelson 2018; Punukollu et al. 2020). Therefore school-based interventions that focus on ways to promote self-referrals may result in improved emotional regulation and mental well-being for the students, with further implications for overcoming stigma and developing a sense of belonging.

This study further showed that at-risk students who needed help were supported through referral to external mental health agencies. The MHCB staff supported at-risk students by establishing relationships that encouraged favorable early intervention. Given that stigma-related challenges can occur at multiple stages of the intervention process (Gronholm, Nye, and Michelson 2018), the MHCB platform bridges the gap of care between initial identification of warning signs to therapeutic intervention through supportive relationships. Students who felt reluctant seeking counseling services were comfortable reaching out to MHCB staff as an initial point of therapeutic contact. The supportive relationship from MHCB staff in turn proved helpful for the students at the initial stage of gaining trust, to the student transfer stage, and to the final connection to appropriate mental health agencies. Interestingly, the MHCB staff found themselves regularly balancing between supporting and counseling. They understood that they were mandated to support the students while cautiously refraining from shifting to counseling services, but rather refer students appropriately.

The role of teacher delivery in the augmentation of mental health outcomes has been emphasized (Werner-Seidler et al. 2017). In this study, the evidence supported teacher integration of MHCB programming into their classrooms. Their main reasons for integration were targeted toward curriculum impact, teaching coping skills, and mental health literacy. Given that part of teaching mental health literacy involves educating students on behavioral normality, MHCB staff and the teachers in this study constantly educated students on what may

be considered normal feelings within the society. Consequently, students understood the normality concept of "it is okay not to be okay."

As equally reported by Punukollu et al. (2020), the teachers in this study demonstrated some improved confidence to deliver mental health programming and information either independently or collaboratively. Their confidence developed from MHCB presentations they witnessed, access to MHCB resources, and personal mental health experience over an extended period of time. Despite the negative impact of Covid-19 lockdowns, the teachers demonstrated willingness to continue integrating resources and building their capacity moving into the upcoming school year by using the "I do, we do, and you do model."

Expectedly, partnerships between MHCB staff, school staff, student-leaders, and community agencies contributed to establishing the MHCB initiative as a resource. However, partnerships with school administration, school associations, and teacher-to-teacher partnerships also emerged from the analysis as part of the networking processes. On the one hand, teacher-to-teacher partnerships were directed toward promotional activities, student support, and collaborative classroom activities such as walking together or listening to a mental health talk. On the other hand, teachers used this type of partnership to support themselves, especially those without prior mental health experience who wish to integrate programming into their classrooms.

Besides the physical presence of MHCB staff as resource people within the schools and the uniqueness of the MHCB initiative and its mandate, a major strength of the MHCB initiative was the awareness raised for opening up mental health conversations in the schools and surrounding communities. In terms of challenges, the MHCB-SCs believed that being accepted into the high school system as well as getting most teachers involved was a challenge; while the teachers, parents, and student-leaders collectively described the general stigma attached to mental health as the main barrier preventing more people from accessing the programming and resources. Despite some positive outcomes highlighted from this initiative, it should not go unmentioned that a few teachers also identified lack of awareness of MHCB resources and inadequate numbers of MHCB staff for teacher requirements as some of their challenges. Finally, the need for time, more collaborative effort, mandate fidelity, strategic communication, and expansion to larger cohorts were recommended by the participants as ways to advance the initiative and promote a mental health culture within the schools and communities.

Strengths and Limitations

The strength of this study lies in capturing students' voices in a school-based mental health intervention program that is focused on promoting mental well-being of children and youth. However, there are some caveats with the study. The study is part of a larger mixed method evaluation, and the experiences described are not intended as an absolute representation of MHCB impact within the schools, but rather to provide experiential views from the stakeholders directly engaged in the implementation. Due to sampling challenges, only two student-leaders and two parents were recruited, and this may have limited the extent of transferability of findings to other student settings, such as those where they was a rejection of MHCB services or negative coping experiences. The study was conducted just as the school year commenced in 2020; therefore, the full extent of MHCB adjustment to Covid-19 was not captured.

Conclusion and Implication for Future Studies

The perspectives captured in this study provided a deeper understanding of the manner in which school-based universal programs such as MHCB may influence the overall well-being of the engaged children and their families. The importance of creating awareness and providing a safe environment for disclosure in schools was described under better health and better care outcomes. In terms of better value and better teams, the MHCB initiative contributed to the

knowledge on building program delivery capacity in teachers and supported different levels of partnership in establishing the initiative as a resource for optimal wellness. Therefore, mental health interventions in schools and communities could focus on promoting awareness and self-referrals for younger people to address stigma and improve a sense of belonging, especially as we all navigate the post-Covid-19 era. Additionally, school administration should inspire pedagogical practices that embed mental health programming into the system. Future studies could focus on outcomes associated with mental health stigma not only within the school settings but in other community settings. Given that time is a determining factor in mental health behavioral change, the level of MHCB uptake and impact can be further investigated over a longer study period. Overall, the MHCB initiative demonstrated encouraging evidence of mental health improvement for engaged students and capacity building for engaged teachers in the schools and surrounding communities.

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ABOUT THE AUTHORS

Dr. Oluwasegun Bankole Hassan: Research Scientist, Research Department, Saskatchewan Health Authority, Regina, Saskatchewan, Canada

Ali Bell: Policy Analyst, Public Health, Department of Health & Wellness, Government of Nova Scotia, Halifax, Nova Scotia, Canada

Stacey Alexandre: Population Health Promotion Practitioner, Population and Public Health Department, Saskatchewan Health Authority, Saskatoon, Saskatchewan, Canada

Brent Rioux: Health Promotion Manager, Population and Public Health Department, Saskatchewan Health Authority, Saskatoon, Saskatchewan, Canada

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