Children and Youth Mental Health: The Role of a Collaborative, School-Based Wraparound Support Intervention in Fostering Mental Health

by

Jessica Brenda Haight

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Science

In

Health Promotion and Socio-behavioural Sciences

School of Public Health

University of Alberta

Abstract

There is an increased recognition that early mental health interventions are needed in response to a growing mental health crisis among children and youth. Schools are promising sites for early intervention because they have existing infrastructure for accessing and engaging with students. Specifically, collaborative initiatives involving community partnerships allow schools to leverage shared resources to deliver mental health support. However, more research is needed to guide the development and implementation of early interventions so that they effectively address the mental health needs of children and youth. Therefore, the present study explored the role of collaborative, school-based mental health services in fostering children and youth's mental health, through All in for Youth, a wraparound model of support in Edmonton, Canada. Three research questions were addressed: (1) What mental health concerns do children and youth experience? (2) What are the factors that impact the use of collaborative school-based mental health services? (3) Does a collaborative school-based approach to mental health services lead to perceived mental health impacts among children and youth (i.e., emotionally, psychologically, and/or behaviourally)? A multiple methods secondary analysis was conducted to address this research inquiry. Interview and focus group data generated with students (n = 51 students; grades 2 – 9) and parents/caregivers (n = 18) across seven AIFY elementary and junior high schools were analyzed to understand participants' experiences with collaborative, school-based mental health services. Additionally, school cohort data (n = 7 schools; n = 2,073 students) were analyzed with information on students' socio-demographic characteristics and use of services across schools. The quantitative findings indicated that overall, n = 885 students (42.7%) accessed any type of mental health service across the seven schools, with close to equivalent service use by gender (50.2% male, 49.5% female, 0.3% genderqueer) and grade level

(kindergarten – grade 9; M = 10%, SD = 1.9%, range = 6.3–13%). There was also high service use across diverse student statuses (Indigenous[1], 24.5%; Refugee, 9.5%; English language learner, 30.1%; specialized learning needs, 18.7%). Participants accessed mental health services in primarily individual or combined individual and group settings (72.9%) and as an informal, short-term client (75.1%). Furthermore, many service users went on to use two or more mental health services (42.2%). The interview and focus group findings revealed high mental health needs among students, which were further exacerbated by the COVID-19 pandemic. In response to these needs, a supportive school culture, adequate school communication, and a stable and well-resourced mental health workforce promoted access to collaborative, school-based mental health services. Finally, mental health services were described to support children and youth through the experience of having a supportive relationship with a safe and caring adult, developing an improved capacity to cope with school and life, and improved overall family functioning. The findings underscore the importance of developing school-based mental health services that recruit school-community partnerships on the delivery of services and take an ecological, wraparound approach to addressing students' multi-faceted mental health needs. Study implications and future directions for research are discussed.

[1]Indigenous identity status is inclusive of First Nations, Métis, and Inuit peoples (Hackett et al., 2016).

Preface

This thesis is an original work by Jessica Haight. Research ethics approval was received from the University of Alberta Research Ethics Board, under the project name “Creating a better future: School-based supports for youth mental health” No. Pro00121925 on August 3, 2022, and renewed on July 21, 2023. Approval was also received under the University of Alberta Faculty of Education Cooperative-Activities Program from Edmonton Public Schools on November 18, 2022, and Edmonton Catholic Schools on December 1, 2022.

Acknowledgements

I would like to share my appreciation to those who supported the completion of this work. First, to my supervisor Dr. Rebecca Gokiert, thank you for your mentorship and guidance throughout this research and my master's degree. Thank you for the knowledge and wisdom that you have imparted on me, the critical input you provided for my thesis at each stage of its development, as well as the abundance of opportunities I have had to grow my research knowledge and abilities under your mentorship. I am immensely grateful to have you as my supervisor and I look forward to the next stages of my journey in research together.

I would also like to acknowledge the All in for Youth evaluation team. To Dr. Jason Daniels, thank you for guiding my work as part of the evaluation team, as well as serving on my advisory committee and proving valuable input on my thesis. To Dr. Maira Quintanhila, Karen Edwards, Pamela Mellon, and Matana Skoye, thank you also for your guidance and support throughout my work with All in for Youth.

This research would not have been possible without the All in for Youth partners, to whom I am deeply grateful. Thank you to the All in for Youth partners and schools for the opportunity to complete this research, as well as for all the incredible work you do to support our families, schools, and communities each and every day.

Special thanks also to Dr. Denise Larsen, for serving as the external reviewer on my thesis committee and for providing critical input on my thesis.

I would also like to thank my friends and colleagues at the Evaluation Capacity Network and Community-University Partnership for the Study of Children, Youth, and Families. I am appreciative of the community of support that we have fostered and the encouragement I have received throughout this research and my master's degree.

I would also like to acknowledge the financial support I received from the Social Sciences and Humanities Research Council of Canada, University of Alberta Faculty of Graduate Studies and Research, and the Canadian Federation of University Women Edmonton. I am immensely grateful for the financial support I received, which has allowed to prioritize and focus on my research over the past two years.

Finally, I would like to thank my family, friends, and loved ones, for your unfaltering love and support. To my parents Jill Sacré and Jason Haight, thank you for being my biggest cheerleaders. You have provided me with advice and support, constant encouragement, and you have always believed in me. To my amazing friends, thank you for your love, encouragement, for always being a listening ear, and most of all, for creating space for fun and laughter. I am immensely grateful to be surrounded by such an incredible network of support.

Table of Contents

CHAPTER 1: INTRODUCTION **1**

CHAPTER 2: LITERATURE REVIEW **4**

CHILDREN AND YOUTH'S MENTAL HEALTH 4
The Social Determinants of Mental Health *5*
The Impact of the COVID-19 Pandemic *8*
Mental Health and Long-Term Implications *10*
SCHOOL INTERVENTIONS FOR MENTAL HEALTH 13
Integrating Mental Health Supports in School *15*
School-Based Wraparound Models of Support *16*
ALL IN FOR YOUTH PROGRAM 20
AIFY Mental Health Supports *22*
AIFY Model of Service Provision *24*
STUDY PURPOSE 25

CHAPTER 3: METHODS **26**

RESEARCH DESIGN 26
METHODOLOGICAL APPROACH 26
ETHICS APPROVAL 27
RESEARCHER REFLEXIVITY AND POSITIONALITY 27
PRIMARY DATA GENERATION 29
Qualitative Interviews and Focus Groups *29*
Quantitative School Cohort Data *32*
SECONDARY DATA ANALYSIS 33
Qualitative Interviews and Focus Groups *33*
Quantitative School Cohort Data *35*
RIGOUR 35

CHAPTER 4: FINDINGS **37**

THE CONTEXT OF MENTAL HEALTH SERVICE USE IN AIFY SCHOOLS 37
Socio-Demographic Characteristics *38*
Structure and Delivery of Mental Health Services *40*
RESEARCH QUESTION 1: MENTAL HEALTH CONCERNS EXPERIENCED BY CHILDREN AND YOUTH 43
Coping with Multi-Faceted Needs and Experiences *44*
Impact of the COVID Pandemic on Wellbeing *48*
RESEARCH QUESTION 2: FACTORS THAT IMPACT MENTAL HEALTH SERVICE USE 54
School Culture of Support *54*
School Communication *58*
Stable and Well-Resourced Staff *61*

RESEARCH QUESTION 3: IMPACTS OF MENTAL HEALTH SERVICES 64
Supported by a Safe and Caring Adult *65*
Improved Capacity for Coping in School and Life *67*
Improved Family Functioning *73*

CHAPTER 5: DISCUSSION **80**

MENTAL HEALTH SERVICE USE ACROSS SCHOOLS 80
MENTAL HEALTH CONCERNS: A CRITICAL NEED FOR SUPPORT 83
Coping with Multi-Faceted Needs and Experiences *83*
Impact of the COVID Pandemic on Wellbeing *85*
FACTORS THAT IMPACT MENTAL HEALTH SERVICE USE: ENABLERS AND BARRIERS 86
School Culture of Support and School Communication *86*
Stable and Well-Resourced Staff *90*
IMPACT OF MENTAL HEALTH SERVICES: MEANINGFUL IMPACTS ON CHILDREN'S LIVES .. 91
Safe and Caring Adult and Improved Capacity for Coping in School and Life *91*
Improved Family Functioning *93*
LIMITATIONS AND FUTURE RESEARCH 94
CONCLUSION 96

REFERENCES **100**

APPENDIX A: INTERVIEW AND FOCUS GROUP GUIDES **119**

Table 1. AIFY Supports and Services 21
Table 2. Socio-Demographic Characteristics of Service Users, Across AIFY Schools 39
Table 3. Type of Mental Health Service Use, Across AIFY Schools 42

Chapter 1: Introduction

There is growing concern surrounding the mental health of children and youth (World Health Organization, 2022). In Canada, it is estimated that over one million children and youth experience a mental disorder (Georgiades et al., 2019; Smetanin et al., 2011) and suicide is the second leading cause of death among youth aged 15–19 (Statistics Canada, 2022a). Rates of mental health concerns (i.e., mental disorders and poor socio-emotional wellbeing) are even greater among those who experience vulnerability due to socioeconomic disadvantage and/or marginalization (WHO, 2014). Furthermore, mental health concerns have been exacerbated by the COVID-19 pandemic due to increases in family stress, economic adversity, and risks for child abuse or neglect (Mental Health Commission of Canada, 2021). Despite the high prevalence and severity of mental health concerns, it is estimated that less than 20% of children and youth struggling with mental health receive proper treatment (Georgiades et al., 2019). Therefore, addressing the mental health needs of children and youth remains a significant public health challenge (WHO, 2022).

Research demonstrates that schools are ideal sites for early mental health intervention (Ali et al., 2019; Sanchez et al., 2018). Children and youth spend the majority of their time in schools, which already have existing infrastructure in place to build on for accessing and engaging with students (Sanchez et al., 2018). Additionally, the on-site provision of services reduces barriers to access that vulnerable students may otherwise face (Sanchez et al., 2018). Limited financial resources, transportation difficulties, and stigma or lack of family support are all barriers to mental health services administered outside of schools (Husky et al., 2011; Sanchez et al., 2018). In the context of schools, collaborative initiatives that offer integrated student support or “wraparound” supports are promising (Hill, 2020; Yu et al., 2020). In these

models, schools partner with community organizations on the delivery of services (Anderson-Butcher & Ashton, 2004; Hill, 2020). As schools often lack the resources and capacity to support their students' health and wellbeing, combining efforts with community organizations allows for an improved provision of services (Anderson-Butcher & Ashton, 2004). Services can be better tailored to local school contexts, service duplication is reduced among different community organizations, and families' access to support is streamlined through their school (Anderson-Butcher & Ashton, 2004). Furthermore, by leveraging the resources of different partners, collaborative initiatives can coordinate multiple, targeted supports that *wrap around* the student and family to support the "whole child," fostering students' overall wellbeing and achievement (Hill, 2020; Yu et al., 2020).

One such wraparound initiative is All in for Youth (AIFY) – a collaborative, school-based wraparound model of support in Edmonton, Alberta, Canada. AIFY represents a school-community partnership of local organizations that came together to support the success of children and youth in school and life through the provision of school-based wraparound supports since 2016 (AIFY et al., 2018). Within the model, comprehensive on-site mental health supports and services are provided for both children and their family members. The program is administered in eight high-risk school communities in Edmonton, which experience significant socio-economic insecurity, compounding the need for mental health services to support vulnerable children and youth.

Early mental health interventions are critically needed for children and youth (MHCC, 2021); however, more research is required to inform the design and implementation of these interventions (Dray et al., 2017; Van Loon et al., 2020). Research shows variability in the effectiveness of different efforts in fostering mental health, ranging from minimal to moderate

impacts (Dray et al., 2017; Sanchez et al., 2018; Van Loon et al., 2020). Therefore, the purpose of this research study is to explore how a collaborative school-based approach to mental health services delivery, as implemented through the AIFY program, serves the mental health needs of children and youth in elementary school and junior high school (kindergarten – grade 9). Three research questions guided this inquiry: (1) What mental health concerns do children and youth experience? (2) What are the factors that impact the use of collaborative school-based mental health services (i.e., enablers and barriers)? (3) Does a collaborative school-based approach to mental health services delivery lead to perceived mental health impacts among children and youth (i.e., emotionally, psychologically, and/or behaviourally)?

A multiple methods secondary analysis was conducted to address this research inquiry (Creswell & Plano Clark, 2018; Greene et al., 1989; Heaton, 2008), informed by quantitative school cohort data and qualitative description methodology (Sandelowski, 2000). Interviews and focus groups with children, youth, and families on AIFY mental health services were analyzed, along with school cohort data on mental health service use and student socio-demographics. Study findings contribute to knowledge on the development and implementation of effective mental health interventions for fostering children and youth's mental health.

The following chapter provides further context for the present study through a discussion of literature on children and youth's mental health and opportunities for early school interventions to foster positive outcomes. Additionally, a description of the AIFY program and its provision of collaborative school-based mental health services, is provided. Research methods, including methodology, theoretical grounding, data collection, and analysis, are outlined in Chapter 3. Study findings are presented in Chapter 4 and discussed in Chapter 5, including implications and recommendations for future research.

Chapter 2: Literature Review

In this chapter, through a review of the literature, important context and background for the present study is explored. First, literature on children and youth's mental health is discussed, including environmental factors that affect mental health outcomes (i.e., the social determinants of mental health), the impact of the COVID-19 pandemic on mental health, and the long-term implications of poor childhood mental health. Next, early school mental health interventions are discussed for fostering positive mental health outcomes, with a review of school-community models of wraparound support. Finally, a program description of All in for Youth, a collaborative, school-based wraparound model of support, is provided. The chapter concludes with a review of the rationale and purpose for the present study.

Children and Youth's Mental Health

Mental health is an essential, yet often overlooked, component of our everyday health (WHO, 2021; 2022). Mental health can be understood as, "a state of wellbeing in which every individual realizes [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community" (WHO, 2021, pg. 1). Importantly, mental health often presents along a continuum, ranging from optimal mental health to diagnosable mental disorders (American Psychiatric Association, 2013; WHO, 2021). The absence of mental health and experience of mental disorders can lead to significant emotional distress and behavioural impairment, which often affects multiple aspects of individuals' lives, school, and work (APA, 2013; WHO, 2021). Due to the dynamic nature of mental health, the terms "mental health concerns" or "poor mental health" will be used in the present study to refer to those with diagnosed mental disorders, as well as those who are struggling with their mental health (i.e., struggling with emotional, psychological, and social

well-being) or experiencing symptoms of disorders. “Mental disorders” and other clinical terms will be reserved for references to previous research, when appropriate.

Poor mental health is a growing crisis among children and youth, with approximately 20% of children struggling with mental health concerns at any given time (Georgiades et al., 2019). Poor mental health is associated with significant impacts on children and youth’s daily functioning, healthy development into adulthood, and long-term health outcomes (Case et al., 2005; WHO & Calouste Gulbenkian Foundation, 2014). Furthermore, disparate outcomes are seen among those who experience socioeconomic disadvantage and/or marginalization along racial, ethnic, cultural, and gendered lines (WHO & CGF, 2014). Therefore, to better understand the prevalence and severity of mental health concerns among children and youth, it is important to look at the social and environmental factors that contribute to mental health outcomes.

The Social Determinants of Mental Health

Mental health is significantly impacted by the environment around us or the “social determinants of health” (Marmot & Wilkinson, 2006; WHO & CGF, 2014). Inequitable social, economic, cultural, and environmental circumstances experienced over the lifespan place individuals at risk for poor health outcomes (Marmot & Wilkinson, 2006; WHO & CGF, 2014).

Across Canada, over 2.8 million people live in poverty, including an estimated 600,000 or 8.5% of children and youth (Statistics Canada, 2022b). Experiencing economic insecurity, poverty, and deprivation are key risk factors for poor physical and mental health outcomes (Reiss, 2013; WHO & CGF, 2014). When individuals live in poor quality conditions (e.g., overcrowded housing), work in insecure circumstances (e.g., temporary or low-income employment), and do not have their basic needs met (e.g., food insecurity), their physical and mental health suffers (Reiss, 2013; WHO & CGF, 2014). The experience of material deprivation

also leads to significant family stress, which is associated with increased family conflict and diminished parenting capacity (Ponnet et al., 2014). Therefore, financial insecurity not only affects children's mental health and wellbeing through the deprivation of needed resources (such as food, housing, clothing, healthcare, specialist services), but also through significant family stress and conflict (Ponnet et al., 2014). Furthermore, families living in poverty are more limited in their ability to access resources to treat existing and developing mental health concerns (Ponnet et al., 2014). As such, research shows that youth from families of low socio-economic status are more likely to experience symptoms of depression or anxiety (Lemstra et al., 2008), and other mental health problems, compared to their peers (Reiss, 2013).

Adverse experiences and life stressors experienced while young can also be detrimental to children's mental health, daily functioning, and healthy development in childhood (Felitti et al., 1998). Adverse childhood experiences (ACEs) refer to the experience of traumatic events during childhood, such as neglect, abuse, household dysfunction (e.g., conflict, poor caregiver mental health, substance misuse, crime), unmet needs, family separation or loss, and community violence or disasters (Blodgett et al., 2018; Brunzell et al., 2015; Felitti et al., 1998; Giano et al., 2020). Unfortunately, the prevalence of adverse childhood experiences is substantial (Afifi et al., 2014; Giano et al., 2020). A survey of 23,395 adults in Canada found 32.1% experienced abuse (Afifi et al., 2014). Additionally, a recent survey of 211,376 adults in the US found that 57.8% of adults reported experiencing at least one ACE in their childhood and 21.5% individuals experienced three or more ACEs (Giano et al., 2020). In response to trauma, children often experience emotional dysfunction and stress, which frequently manifests through disruptive or challenging conduct, such as outbursts, defiance, or withdrawn behaviours, and can make school and life difficult (Anderson et al., 2015; APA, 2013). Furthermore, exposure to adverse

childhood experiences is associated with poor health outcomes over the long-term (Felitti et al., 1998; Hughes et al., 2017). Specifically, one study found that the experience of multiple adverse childhood experiences was associated with greater risk of poor mental health (i.e., depression and suicidality), poor physical health (i.e., obesity and smoking), and unhealthy behaviours (i.e., substance misuse and sexually transmitted diseases) in adulthood (Felitti et al., 1998).

Individuals can also experience added vulnerability in their lives due to structural and systematic inequities associated with race/ethnicity, culture, and immigrant/refugee status; gender and sexual orientation; and disability status (Children First Canada, 2021; 2022; Paradies et al., 2015; WHO & CGF, 2014). This is particularly prevalent among Canada's Indigenous children and youth (Hackett et al., 2016; Kumar & Tjepkema, 2019). As a result of colonialism and ongoing marginalization, Indigenous communities have been impacted by systematic racism, social and economic inequity, and intergenerational trauma (Kumar & Tjepkema, 2019). High rates of poor mental health and suicide are seen among Indigenous communities, with the average rate of suicide being three times higher among First Nation people than non-Indigenous people (Hackett et al., 2016; Kumar & Tjepkema, 2019). Despite demonstratable mental health needs, Indigenous children frequently do not receive adequate mental health support due to systematic barriers, such as a lack of available services, services that are not accessible and culturally responsive, and distrust or stigma associated with services based on past trauma (Hackett et al., 2016; Lopez-Carmen et al., 2019). Similarly, less mental health service contact and increased systematic barriers to mental health support are seen among other minoritized groups, including children of visible minority or racial/ethnic status and/or newcomer status (Costello et al., 2014; Faber et al., 2023; Georgiades et al., 2018; Kamali et al., 2022).

While there are social, economic, and environmental risk factors for mental health concerns across the life course, the experience of such circumstances does not mean that any one individual will develop a mental disorder or struggle with their mental health, only that risks are increased (Blodgett & Lanigan, 2018). In response to added risk and vulnerability, early mental health interventions have the potential to foster protective factors and promote children and youth's capacity for resilience (Hoover & Bostic, 2021). Protective factors refer to internal and socio-environmental resources that promote resiliency and positive mental health outcomes, such as personal "self-regulation or cognitive coping strategies" (Ungar & Theron, 2019, pg. 441) and supportive "social, economic, political…environments" (pg. 444). Studies have found that individuals with more protective factors and resiliency are less likely to develop symptoms of mental disorders, even after experiencing adversity (Hjemdal et al., 2006; 2011).

The role of school mental health interventions in fostering protective factors and positive outcomes is discussed in a later section. First, the impact of the COVID-19 pandemic on children and youth's mental health is detailed. This recent and stressful event, described next, affected multiple aspects of life, school, and work, and aggravated already existing mental health disparities (Chanchlani et al., 2020; Whitley et al., 2022).

The Impact of the COVID-19 Pandemic

In March 2020, the World Health Organization declared a Coronavirus disease (COVID-19) pandemic (WHO, 2020). To prevent the spread of the disease, health restriction measures were put in place, including quarantining at home and social distancing. Non-essential services were moved to virtual delivery, limited, or ceased operation, affecting social, community, therapeutic, and recreation services. Consequently, this global crisis threatened our health and safety, as well as disrupted access to needed supports and resources; compounding existing

societal inequities as families suddenly faced limited or no access to services that were previously essential for their health and wellbeing (Chanchlani et al., 2020; Whitley et al., 2022).

Many schools moved to operate through online platforms or cycled from in-person to online learning in response to local COVID-19 outbreaks (Chanchlani et al., 2020; Engzell et al., 2021; Pfefferbaum, 2021). In response, under-resourced families often lost access to school services needed for their children, such as lunch programs to satisfy nutritional needs, physical education classes to promote exercise and healthy living, and extracurricular activities to foster socio-emotional development (Crawley et al., 2020; Pfefferbaum, 2021). As many families struggled with reduced social support networks and increased financial insecurity, this was associated with increases in family stress and parent and caregiver mental health concerns (Abrams et al., 2022; Gassman-Pines et al., 2020).

Additionally, remote schooling was a barrier for many vulnerable families (Engzell et al., 2021; Whitley et al., 2022). Families often struggled with inadequate access to technology and internet required to participate in online platforms (Whitley et al., 2022). Additionally, online platforms typically rely on parent involvement to facilitate and monitor children's school engagement, which is difficult for parents who struggle with economic insecurity and work full-time or experience insecure employment (Whitley et al., 2022). Parents who have less schooling themselves or who are new Canadians may also feel less equipped to support their children's learning of unfamiliar curriculum (Engzell et al., 2021; Whitley et al., 2022). Accordingly, a recent study conducted in the Netherlands including 350,000 students (grades 4–7) found that learning losses were sustained by students during periods of remote learning, with worse outcomes for children who have parents with less education (Engzell et al., 2021).

Online learning was also identified to be challenging for children due to limited opportunities to socialize with peers and make friends (Chanchlani et al., 2020; Crawley et al., 2020). Furthermore, schools can act as a refuge for vulnerable children and youth, who experience unsafe home situations (Chanchlani et al., 2020; Crawley et al., 2020). With schools closed, children may be unable to escape home situations that are abusive (Chanchlani et al., 2020; Crawley et al., 2020; Pfefferbaum, 2021). Additionally, school staff are less able to identify children who may be experiencing neglect or abuse to arrange appropriate protection services or therapeutic supports (Chanchlani et al., 2020; Crawley et al., 2020). Furthermore, greater family stress and caregiver mental health concerns during the pandemic increased risks for abuse at home (Bryant & Damian, 2020; Chanchlani et al., 2020; Crawley et al., 2020).

Unfortunately, as pandemic measures have been scaled back and schools reopened for in-person instruction, preliminary evidence has revealed that the effects of the pandemic have not simply dissipated (Abrams et al., 2022; Whitley et al., 2022). Many families continue to struggle with economic uncertainty (Abrams et al., 2022). Additionally, children and youth are demonstrating learning losses, with worse outcomes for children and youth experiencing vulnerability or marginalization (Bonal & González, 2020; Engzell et al., 2021; Whitley et al., 2022). As indicated previously, sustaining challenges and experiencing mental health concerns can have lasting effects (Fryers & Brugha, 2013). Therefore, the long-term effects of mental health concerns are discussed in the next section.

Mental Health and Long-Term Implications

The experience of poor mental health in childhood does not only affect children's immediate emotional state and functioning, but it can be a risk factor for later quality of life,

health, educational, occupational, and socio-economic outcomes (Case et al., 2005; Hale et al., 2015; Hale & Viner, 2018).

First, struggling with mental health in childhood is a risk factor for continued mental health challenges in adulthood (Fryers & Brugha, 2013). For example, one study found that individuals with moderate to high social anxiety symptoms in childhood were more likely to experience anxiety and related disorders as young adults (e.g., social anxiety disorder, general anxiety disorder, panic disorder, etc.; Krygsman & Vaillancourt, 2022). In fact, it is estimated that 70% of adults with a mental disorder experienced onset in childhood (Government of Canada, 2006).

Poor mental health in childhood is also a risk factor for later socio-economic circumstances (Case et al., 2005; Hale et al., 2015). It is well established that education and occupational training is associated with employment, higher income, and better health (Belfield & Levin, 2007; Freudenberg & Ruglis, 2007). On the other hand, not completing secondary school has a greater association with insecure employment, poor health, and increased dependence on welfare supports (Belfield & Levin, 2007; Freudenberg & Ruglis, 2007). The added barrier of untreated mental health concerns can make it more difficult for children and youth to engage in school, graduate, and become employed, which in turn, can affect later health and socio-economic security (Case et al., 2005; Hale et al., 2015; Hale & Viner, 2018). In fact, one study found an association between lower educational attainment and employment income and self-reported mental health concerns in childhood (depression, substance misuse, and other psychological conditions; Smith & Smith, 2010). Such detrimental long-term outcomes have been particularly noted for mental disorders characterized by “externalizing” or disruptive behaviours, which is a common reaction to childhood trauma (Anderson et al., 2015; APA, 2013;

Hale & Viner, 2018). For example, a study looked at the health of youth and their educational and occupational attainment as young adults and found that poor mental health was significantly associated with lower rates of post-secondary education, training, and/or employment, primarily attributed to externalizing behaviours, such as classroom disruption, challenges with social relationships, and substance use (Hale & Viner, 2018).

For these reasons, neglected mental health concerns do not only have potential for long-term implications at the individual-level, but they are also associated with significant costs to the economy (Lim et al., 2008; Smetanin et al., 2011). This is due to direct healthcare costs for mental health (e.g., visits with healthcare professionals, healthcare services, medication, and hospitalization), as well as indirect costs through a loss in work productivity (e.g., abseentism, disability claims, leaving the workforce; Lim et al., 2008; Smetanin et al., 2011). In fact, a 2003 study estimated that the cost to the Canadian economy for mental health concerns was Can $51 billion annually based on direct healthcare costs, as well as indirect costs for lost work productivity (Lim et al., 2008). Similarly, a 2011 study in Canada provided a conservative estimate of $48.6 billion in annual costs to the economy, and predicted this would rise to $623 billion by 2021 (Smetanin et al., 2011).

Accordingly, research demonstrates that investment in early mental health support interventions have the potential to save significant socio-economic spending over the long-term (Bowden et al., 2020; Smetanin et al., 2011). For example, an economic evaluation of a comprehensive support intervention in schools in Boston, Massachusetts estimated a return on investment of US $3 for every $1 invested in early supports (Bowden et al., 2020). This was based on reduced dropout rates and higher academic achievement, associated with employment

stability and reduced dependence on welfare and social supports in the future (Belfield & Levin, 2007; Bowden et al., 2020).

In summary, a diversity of factors (high mental health needs, socio-economic disparities, and economic burden) point to both the need for mental health support and potential for interventions to produce benefits on the individual and societal level (Smetanin et al., 2011; WHO & CGF, 2014). As described previously, early interventions in schools are particularly promising for meeting these needs (Hoover & Bostic, 2021). Therefore, the following section explores school-based mental health interventions to foster children and youth's mental health.

School Interventions for Mental Health

Schools are ideal sites for mental health interventions because of their key role in the lives of children and youth (Hoover & Bostic, 2021; Sanchez et al., 2018). Interventions to promote mental health and psychological wellbeing can be embedded in existing school infrastructure (Ali et al., 2019; Hoover & Bostic, 2021). Schools are also necessary sites for mental health supports because children and youth's unmet needs and trauma will inevitably surface at school (Anderson et al., 2015). Childhood trauma and psychological distress often manifests through disruptive or withdrawn behaviours, which makes it difficult for children to function and learn and may even disturb the learning of other students (Anderson et al., 2015). Therefore, teachers and school staff are constantly put in the position to support the socio-emotional learning of students, typically without adequate training or support (Sanchez et al., 2018).

Beyond the critical need for mental health support, there are many benefits to integrating formalized mental health services at school. Specifically, providing mental health services in schools makes it easier for children and families to access them, removing structural barriers

such as costs, transportation, or childcare (Hoover & Bostic, 2021; Sanchez et al., 2018). In fact, a study of 6,537 families in Ontario, Canada, found that just under half (47.2%) of children and youth struggling with a mental disorder accessed mental health services in school-based settings, as opposed to community, specialty, or general medicine settings (Georgiades et al., 2019). Similarly, another study found that students were more likely to follow up on referrals to school-based mental health services rather than community-based services, with 80.2% of students with school referrals completing at least one visit compared to 41.9% of those with community referrals (Husky et al., 2011).

The accessibility of school-based services is particularly meaningful for children and families who experience vulnerability and resource constraints (Ali et al., 2019; Hoover & Bostic, 2021; Kamali et al., 2022; Sanchez et al., 2018). Research shows that families with racial or ethnic minority backgrounds and/or who experience economic disadvantage face even more limited access to mental health services (Kamali et al., 2022); therefore, the provision of in-school services reduces inequities to mental health support (Ali et al., 2019; Hoover & Bostic, 2021). In fact, one study found that children and youth from low-income households, or who have racial or ethnic minority backgrounds, are more likely than their peers to access mental health services at school rather than other settings (Ali et al., 2019).

Finally, schools are also well positioned to identify early signs of mental health concerns among children and youth (Atkins et al., 2017; Farmer et al., 2003; Hoover & Bostic, 2021; Sanchez et al., 2018). Teachers and school staff spend a significant amount of time with students; therefore, they can play an important role in identifying concerns and referring students to in-house supports (Atkins et al., 2017; Farmer et al., 2003; Hoover & Bostic, 2021). In fact, schools

are often the most common entry point for access to mental health services for children and youth (Farmer et al., 2003).

Integrating Mental Health Supports in School

In schools, mental health interventions can range in design from universal, school-wide initiatives to more targeted supports. Universal interventions are primarily aimed at prevention and the promotion of healthy socio-emotional development and behaviours for all students in the school (Hoover & Bostic, 2021). Specifically, supports and strategies are typically adopted for teaching mental health literacy and positive behaviours to promote positive mental health and socio-emotional development among students (Hoover & Bostic, 2021). Such interventions are linked to positive impacts, including improved social-emotional skills, social relationships, academic performance, and reduced symptoms of anxiety, depression, and psychological distress (Collins et al., 2014; Durlack et al., 2011; Hoover & Bostic, 2021; Salazar de Pablo et al., 2021). However, some studies show that effects can be variable or limited, often attributed to ineffective or the inconsistent application of strategies (Dray et al., 2017; Sanchez et al., 2018; Van Loon et al., 2020). Additionally, for many students, universal, school-wide interventions alone are insufficient to address mental health needs, and instead, more intensive and targeted supports are needed (Sanchez et al., 2018).

Accordingly, another branch of school mental health interventions includes targeted supports aimed at students with the highest levels of need in schools (Sanchez et al., 2018). These programs involve more intensive and individualized mental health services for a small number of the student population and are associated with improved mental health symptoms and reduced psychological distress (Hoover & Bostic, 2021; Sanchez et al., 2018). Notably, interventions can also combine universal and targeted supports through a multi-tier approach

(Eber et al., 2002; Fazel et al., 2014; Hoover & Bostic, 2021). Such interventions have been identified as particularly promising as they address both prevention factors through the administration of school-wide supports, as well as targeted services for students struggling with mental health concerns (Atkins et al., 2017; Eber et al., 2002; Hoover & Bostic, 2021; Scott & Eber, 2003).

Despite, the potential and variety of school mental health interventions, it has proven difficult to embed mental health services in schools (Atkins et al., 2017). Schools struggle with inadequate funding and resources (Anderson-Butcher & Ashton, 2004; Atkins et al., 2017; Waddell et al., 2019). It is often the case that mental health interventions are adopted in schools over a short period of time but not sustained, referred to as, "the revolving door of initiatives" (Atkins et al., 2017, pg. 135). Additionally, in Canada, policies and efforts to support mental health services are inconsistent across municipalities, provinces, and territories (Waddell et al., 2019). Due to resource constraints, schools have increasingly partnered with community and agency partners to deliver supports in schools (Atkins et al., 2017). This allows schools and community organizations to leverage shared resources to address students' mental health needs (Anderson-Butcher & Ashton, 2004; Atkins et al., 2017). One such intervention is the school-community model of wraparound supports (Burns & Goldman, 1999). This collaborative model can be implemented in schools through a multi-tier framework, combining both universal and targeted intervention components to better address the mental health needs of students and families (Burns & Goldman, 1999; Eber et al., 2002; Fazel et al., 2014; Scott & Eber, 2003).

School-Based Wraparound Models of Support

Wraparound is an approach to service care planning that takes a collaborative, team-based process of coordinating person-centred supports (Burns & Goldman, 1999). Within

wraparound, supports and services are jointly planned by a team consisting of the child and family, agency partners and service providers, and community supports based on the identified needs of the child and family (Burns & Goldman, 1999). Therefore, wraparound is not a defined set of supports, but instead, an *approach* for coordinating holistic and targeted supports that promote positive outcomes for the "whole child" (Burns & Goldman, 1999).

Importantly, wraparound takes an "ecological" perspective, which recognizes that children and youth's wellbeing is affected by multiple contexts (Burns & Goldman, 1999). Therefore, supports are needed across multiple domains (e.g., education, healthcare, mental health, social services, recreation, etc.) for children to experience positive outcomes (Burns & Goldman, 1999). However, organizations from different sectors typically operate independently from one another, which can make it challenging for vulnerable families to navigate different systems and secure supports (Burns & Goldman, 1999). Therefore, within wraparound, inter-disciplinary teams are developed to coordinate multiple supports that *wrap around* the child and family to foster positive outcomes (Burns & Goldman, 1999). In the school context, this involves school-community partnerships with agencies and community organizations on the provision of wraparound supports (Eber et al., 2002; Yu et al., 2020).

Wraparound first originated as a system of care in mental health and child welfare settings to support children struggling with complex emotional and behavioural challenges (Burns & Goldman, 1999; Eber et al., 2002; VanDenBerg et al., 2008). The 1960s Brownsdale programs in Canada are particularly notable as an early wraparound initiative for children with complex challenges (Burns & Goldman, 1999). These programs involved group homes with targeted and "unconditional" supports for children, as an alternative to large-scale institutionalized care (Burns & Goldman, 1999, pg. 19). Since then, wraparound has become a

widespread approach for supporting children with complex needs (Sather & Bruns, 2016). In particular, it has been increasingly implemented in schools due to the key role of schools in the lives of children (Eber et al., 2002; Scott & Eber, 2003; Yu et al., 2020).

As wraparound has become more widespread, guidelines have been developed to support the implementation wraparound programs in practice (Bruns & Walker, 2008; Burns & Goldman, 1999). Specifically, Bruns & Walker (2008) developed ten principles which operationalize wraparound. The ten wraparound principles include the following (Bruns & Walker, 2008, p. 37–40):

1. *Family voice and choice*. The input and perspectives of the child and family is prioritized in the wraparound process/plan.
2. *Team based*. The wraparound team consists of team members from natural, community, and formal networks of support, approved of by the child and family.
3. *Natural supports*. The wraparound team includes members from the family's natural support systems (social, cultural, community relationships), as well as formal networks of support.
4. *Collaboration*. The wraparound team collaboratively develops, implements, monitors, and evaluates the wraparound plan, which reflects all members' input and resources.
5. *Community based*. The wraparound plan is inclusive, responsive, and accessible to the child and family, and promotes engagement in the community.
6. *Culturally competent*. The values, beliefs, and culture of the child and family is respected in the wraparound process/plan.
7. *Individualized*. The wraparound team develops strategies, supports, and services to meet the specific needs of the child and family.

8. *Strengths based*. The wraparound plan builds on the capabilities, knowledge, and skills of the child and family and the team members.
9. *Unconditional.* The wraparound team is committed to supporting the child and family and does not assign blame or reject the child/family in the face of setbacks.
10. *Outcome based.* The wraparound team monitors and evaluates the wraparound plan and makes adjustments to the plan as needed.

Overall, these principles emphasize the strength-based and collaborative nature of wraparound interventions. Wraparound is intended to recognize and build on the strengths of the child and family, rather than focus on deficits (Bruns & Walker, 2008). Furthermore, it takes a collaborative approach, involving the voice of the child and family, as well as service providers and community supports (Bruns & Walker, 2008). According to literature, wraparound programs are most effective when there is close adherence to these principles (Bruns et al., 2005).

Importantly, wraparound can also be operationalized in schools within a multi-tiered system of support (Eber et al., 2002; Scott & Eber, 2003). It is not realistic to provide highly targeted supports to all students in school settings due limitations in resources; therefore, within this framework, students receive escalating support based on identified needs (Eber et al., 2002; Scott & Eber, 2003; Prakash et al., 2008). At the primary level, universal supports are provided to all students aimed at prevention (Eber et al., 2002; Scott & Eber, 2003). At the secondary and tertiary levels, targeted supports are coordinated for children and families who are struggling the most (Eber et al., 2002; Scott & Eber, 2003).

The positive impacts of school-based wraparound programs have been demonstrated in literature (Fries et al., 2012; Lee-St. John et al., 2018; Olson et al., 2021; Yu et al., 2020). Studies have found that wraparound supports are associated with better outcomes for students struggling

with complex challenges, such as improved academic engagement and socio-emotional skills (Fries et al., 2012; Lee-St. John et al., 2018; Olson et al., 2021; Yu et al., 2020). The following section will introduce the school-community wraparound program, All in for Youth, including its collaborative school-based mental health services.

All in for Youth Program

All in for Youth (AIFY) is a collaborative, school-based wraparound model of support in Edmonton, Alberta, Canada. AIFY's mandate is to support children and youth to thrive and succeed in school and life beyond school, through the provision of integrated student supports (AIFY et al., 2018). The program is administered by a collaborative school-community partnership between Edmonton school divisions and eight community partners. This includes local service agencies, not-for-profit organizations, and municipal and community partners, who operate within AIFY as service providers, operating and management partners, and funders. Together, all AIFY partners jointly plan and deliver the AIFY model of support, through a collaborative process of shared decision-making.

AIFY was founded in 2016, when these community partners came together with the recognition that they would have greater impacts on the lives of children, youth, and families by working together in partnership than through individual efforts. The program was first implemented as a five-year pilot initiative in five schools in Edmonton. After successfully demonstrating positive impacts in the lives of children and families (see AIFY & CUP, 2022), the program was expanded to three more schools in its sixth year (2021–22 school year), leading to a total of eight AIFY schools (i.e., four elementary schools, two combined elementary/junior high schools, one junior high school, and one high school).

AIFY schools represent some of the most socially vulnerable communities in Edmonton, experiencing high rates of poverty, mobility, under-resourced single-parent households, and complex home environments (AIFY & CUP, 2022; 2023). Such vulnerability can impact children's wellbeing, ability to learn in school, and future opportunities (WHO & CGF, 2014). To remove barriers to success and support students and families, three broad categories of in-school services are provided through the AIFY program, including (1) nutrition supports (snacks and meals), (2) mental health services (mental health therapy, success coaching, and in-home family support), and (3) enrichment programming (mentoring and out-of-school time programming). These supports and services are outlined in Table 1. AIFY schools have dedicated on-site agency staff responsible for the provision of each service type (i.e., nutrition support workers, mental health therapists, success coaches, in-home family support workers, mentoring coordinators, out of school time programming coordinators).

Table 1.

AIFY Supports and Services

AIFY Support/Service	**Description**
Nutrition Supports	School snacks and meals program to provide students with nutrition needed to learn and thrive.
Mental Health Supports	
Mental Health Therapy	Mental health therapy for students and families to address complex needs and support socio-emotional development.
Student Success Coaching	Success coaching to support students with school success management, socio-emotional wellbeing, and resilience.
In-home Family Support	In-home family supports to help caregivers foster overall family wellbeing and receive access to needed resources.

AIFY Support/Service	Description
Enrichment Programming	
Student Mentoring	Mentoring to support academic and/or socio-emotional growth, with peer, community, and corporate mentors.
Out of School Time (OST) Programming	After school programming focused on arts and culture, mental and physical wellness, leadership, or academics.

AIFY Mental Health Supports

Mental health services are provided in AIFY schools in partnership with The Family Centre (TFC), a local counselling and therapy center in Edmonton. Specifically, three services are offered: mental health therapy, success coaching, and in-home family support. TFC mental health therapists hold master's or doctoral degrees in psychology, pastoral counselling, social work, or related fields and are registered psychologists, provincial psychologists, registered counsellors, registered social workers, and/or registered clinical social workers. TFC success coaches and in-home family support workers have bachelor's degrees in a human services field or equivalent education. Staff work part- or full-time in AIFY schools to support children, youth and families. These three services differ in orientation; however, there is also significant overlap between them:

- *Mental health therapy* supports students in navigating complex needs and fostering healthy socio-emotional development. The service is available for both students and their family members, in individual and/or group settings.
- *Success coaching* supports students with school success, including class management, goal setting, and positive child-adult engagement, as well as overall socio-emotional wellbeing and resilience. The service is primarily intended for children and youth;

however, staff also connect with families as needed (e.g., to mediate student-family conversations, check in on caregiver mental health), and is also available in individual and/or group settings. Significant overlap is typically seen between the care provided by a mental health therapist and success coach.

- *In-home family supports* help parents and caregivers to foster overall family wellbeing, including increased parenting capacity, stable at-home environments, positive social networks, and access to needed resources (e.g., housing, food, clothing). In-home family support workers complete in-home visits to connect with families in primarily individual settings and make supportive plans in collaboration with the family.

Beyond these primary services and mental health supports, school culture is a fundamental aspect of the AIFY model to support students and families. Specifically, AIFY schools have distinctive cultures of collaborative, strength-based and supportive practices (AIFY et al., 2018). This is supported by professional development, evidence-based practices, and shared learning among school leadership and frontline staff (AIFY et al., 2018). Specifically, staff at AIFY schools (i.e., AIFY agency staff, teachers, and school administrators) receive training centered on understanding childhood adversity and trauma and integrating care and practices that are trauma-informed and promote family resilience (AIFY et al., 2018; AIFY & CUP, 2023). The implementation of trauma-informed and resilience practices function to promote positive child-adult engagement and create a safe and supportive school environment for students with complex experiences and needs (AIFY et al., 2018; AIFY & CUP, 2023; Ungar, 2011). Furthermore, school leadership (i.e., school principals and agency staff) participate in professional development opportunities to refine and consolidate supportive AIFY practices and processes on an ongoing basis (AIFY et al., 2018).

AIFY Model of Service Provision

Overall, the AIFY model operates through a multi-tier framework of support and service provision (Scott & Eber, 2008). At the primary level, all students receive universal supports, in which they are supported by a school culture of trauma-informed and resilience practices. All students also receive access to nutrition supports to support their everyday health and functioning. At the secondary and tertiary levels, targeted supports (i.e., mental health therapy, success coaching, in-home family supports, mentoring, out of school programming) are triaged by school wraparound teams based on identified individual needs. For the secondary level, this may take the form of low-level or group services (e.g., group success coaching), whereas at the tertiary level, supports are highly individualized to *wrap around* and support the student and family's unique context and needs to support positive outcomes (e.g., student mental health therapy and comprehensive in-home family support).

School wraparound teams consist of a core team of school administrators (e.g., principal, assistant principal, etc.) and the dedicated AIFY agency staff responsible for providing supports and services (i.e., mental health therapists, success coaches, in-home family support workers, out-of-school time coordinators and staff, and mentoring facilitators). These teams connect weekly through meetings, referred to as huddles, to triage targeted supports for individual students and families with identified needs. All team members work together to actively identify and respond to students who require supports and coordinate services to support the student and family. Additionally, school wraparound teams have established community networks to connect families with additional external supports, as needed. Through this ecological approach (AIFY et al., 2018; Bronfenbrenner, 1979), school wraparound teams recognize multiple contexts that

impact students' wellbeing and collaboratively coordinate accessible, school-based services to respond to their needs.

Study Purpose

Children and youth's mental health remains a significant public health challenge, and early interventions are required to foster healthy developmental outcomes (WHO, 2022). The AIFY program administers collaborative, school-based mental health supports in school through a wraparound model of integrated supports. The present study explores the role of collaborative, school-based mental health services in fostering children and youth's mental health. The following research questions are addressed: (1) What mental health concerns do children and youth experience? (2) What are the factors that impact the use of collaborative school-based mental health services? (3) Does a collaborative school-based approach to mental health services delivery lead to perceived mental health impacts among children and youth (i.e., emotionally, psychologically, and/or behaviourally)? Findings contribute to knowledge on effective mental health interventions for supporting children and youth's mental health. The following chapter outlines the research methods used for this research inquiry.

Chapter 3: Methods

Research Design

The role of collaborative, school-based mental health services in fostering children and youth's mental health was explored using a multiple methods secondary analysis (Creswell & Plano Clark, 2018; Greene et al., 1989; Heaton, 2008). Data included in the study were previously generated for the program evaluation of the AIFY initiative during the 2021-2022 school year (year 6 of the AIFY program). The evaluation assessed the impacts of the AIFY initiative, with an in-depth focus on the mental health of school communities, lending naturally to this secondary analysis.

Interview and focus group data generated with students and families (i.e., children, youth, parents, and caregivers) were analyzed to understand their experiences with mental health services in their schools. Additionally, quantitative school cohort data were analyzed with information on students' socio-demographic characteristics and use of services across schools. Reviewing multiple sources of data (i.e., qualitative and quantitative) allowed for a more robust description of the presenting mental health concerns and how mental health services are being delivered and impacting student mental health in schools (Creswell & Plano Clark, 2018; Greene et al., 1989).

Methodological Approach

Qualitative description methodology guided the analysis of the interview and focus group data (Sandelowski, 2000; 2010). Qualitative description is used to develop a comprehensive description of data in "everyday terms" (Sandelowski, 2000, pg. 1). With this approach, data are interpreted and described using straightforward summaries, as opposed to taking a highly theoretical or conceptual framework (Sandelowski, 2000). Accordingly, qualitative description is

well-suited for the development of a comprehensive description of collaborative school-based mental health services.

Furthermore, the theoretical paradigm underlying this analysis is constructivism (Allen, 1994; Mayan, 2016; Mertens, 2020). The constructivist perspective proposes that knowledge is "socially constructed by people active in the research process and that researchers should attempt to understand the complex world of lived experience from the point of view of those who live it" (Mertens, 2020, pg. 11). This is a departure from the positivist framework which assumes that there is a single, objective reality that the researcher has authority over (Allen, 1994; Mayan, 2016; Mertens, 2020). Instead, from a constructivist perspective, study participants and the researcher actively co-create knowledge together, in the context of their lived realities (Allen, 1994; Mayan, 2016; Mertens, 2020).

Ethics Approval

Ethics approval was received from the University of Alberta Research Ethics Board, under the project name "Creating a better future: School-based supports for youth mental health" No. Pro00121925 on August 3, 2022, and renewed on July 21, 2023. Approval was also received under the University of Alberta Faculty of Education Cooperative-Activities Program, which oversees research conducted with Edmonton school districts, from Edmonton Public Schools on November 18, 2022, and Edmonton Catholic Schools on December 1, 2022.

Researcher Reflexivity and Positionality

In all research, it is essential to critically appraise our approach, processes, and outcomes, and how our position as researcher interacts with, and informs, these elements (Berger, 2015). Importantly, our different backgrounds, lived experiences, and world views influence the process of research and knowledge creation (Berger, 2015). Reflexivity is "the process of a continual

internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, pg. 220). By practicing reflexivity, we can gain awareness of our positionality in different research contexts and take a more intentional approach to research engagement (Berger, 2015). With this in mind, I spent time reflecting on my own positionality in this research project.

There are layers of privilege I have as a white, Canadian-born woman from a middle-class background, with post-secondary education. I do not have first-hand experience of some of the adversities that AIFY families have experienced. For this and many reasons, I feel honoured, along with my research team, to have been entrusted by AIFY families with their personal stories, experiences, and perspectives. To further my understanding of AIFY school communities and build relationships with AIFY and school partners, I have taken the opportunity to immerse myself in the AIFY initiative over a prolonged period of time.

For the past two years, I have been working with the AIFY partnership as a graduate research assistant. In this role, I took part in conducting the annual program evaluation of the AIFY initiative. This involved collaborating on evaluation and research plans with the AIFY partners (i.e., leadership from the school divisions, service provider agencies, and operating partners and funders), generating primary data with schools (i.e., completing interviews and focus groups with children, youth, families, AIFY agency staff, and school staff and administrators), and reporting on findings in the annual evaluation reports (see AIFY & CUP, 2022; 2023). This close engagement with AIFY and school partners meaningfully shaped my approach to this secondary analysis. I was able to develop a rich understanding of how supports

and services operate from the experiences of frontline school partners, as well as from a leadership perspective.

Finally, it should be noted that the analysis presented in this paper is secondary to the original purpose of the AIFY evaluation, which was to report on the AIFY initiative more broadly, with a close look at the mental health of school communities. With secondary analyses, there is the potential for distance between original data and later interpretation (Heaton, 2008); however, in the case of this research, I was involved in all stages of the primary data collection. I was fortunate to hear first-hand what these mental health services meant to diverse school partners, as well as how partners use and deliver these services.

Primary Data Generation

Qualitative Interviews and Focus Groups

Interview and focus group data were previously generated for the AIFY evaluation between April and June 2022. During primary recruitment, students and families were invited to participate in interviews and focus groups through a purposeful sampling method; whereby, participants were sampled based on their experiences with, and ability to speak to AIFY services (Mertens, 2020). Purposeful sampling aligns with qualitative description, which places value on participant inclusion based on the richness of insights they have to offer (Mertens, 2020; Sandelowski, 2000). This recruitment process was facilitated by agency staff and school administrators who have relationships with students and families, and staff, and invited potential participants to share their perspectives in the research activities. These partners played a critical role in bridging connections between the research team and families; however, all participants were made aware that their participation was entirely voluntary and would not affect their existing relationships or standing with their school communities.

Interviews and focus groups were conducted with school groups across all eight AIFY schools; however, due to the focus on the mental health and experiences of children and youth in elementary and junior high (Kindergarten – Grade 9), only data from the seven AIFY elementary and junior high schools were included in this analysis, excluding the high school. Specifically, data from four elementary schools, two combined elementary-junior high schools, and one junior high school were included. Six schools are Edmonton Public schools, and one school is an Edmonton Catholic school. Across the seven schools, partners had differing abilities to take part in data generation activities due to limited time and competing commitments; therefore, the number of sessions vary by school. The research team made themselves flexible to accommodate the availability of school partners and to not disrupt school activities.

Students. A total of 51 individual students were engaged through focus groups and one-on-one interviews across seven schools, with some students participating in both focus groups and interviews (n = 4). Focus groups took place at all seven schools (n = 8 focus groups, approximately 6 students per group, n = 45 students; grades 2–9). Two focus groups took place at one of the combined elementary/junior high schools for both an elementary and a junior high group, whereas an integrated elementary and junior high focus group took place at the other elementary/junior high school. Interviews were conducted with junior high students (n = 10 students; grades 7–9) at the combined elementary/junior high schools and the junior high school. All focus group and interview sessions took place in person at school sites. Refreshments were brought to the sessions for students.

Parents and Caregivers. Parents and caregivers were engaged through one-on-one interviews (n = 18). These interviews took place with parents, and/or individuals who were considered the primary caregiver in their child's life (e.g., grandparents, stepparents, aunts,

uncles). Parents and caregivers were provided the option to do the interview in-person, over the phone or virtually. Most participants elected to be interviewed over the phone (n = 14), a few chose to do it in person at school sites (n = 3), and one was done over the video communication platform Google Meets. Following the interviews, parents and caregivers were provided with a $25 gift card (by e-mail or mail) as a thank you for sharing their time and perspective.

Interviews and focus groups were semi-structured, allowing facilitators to have greater flexibility to explore participants' remarks (Gill et al., 2008). In semi-structured sessions, an interview guide with key questions is used; however, facilitators also have the space to, "diverge in order to pursue an idea or response in more detail" (Gill et al., 2008, pg. 1). Interviews and focus groups were conducted by four members of the AIFY research team (including the project director, evaluation lead, a research assistant, and myself). In some cases, school administrators co-facilitated student focus groups with the research team (n = 4 focus groups). This was done to build the capacity of school leadership in research and evaluation, as well as bridge relationships between the students and research team. In this context, students were made aware that they could provide their honest feedback, in the presence of school administrators. Additionally, one interview with a caregiver was conducted in Spanish, with the support of an interpreter.

All participants were provided with information letters detailing the research and evaluation activities and consent forms. Before sessions, the researcher reviewed the information letter, and obtained written consent (from parents of participating children in interviews and focus groups, and interview participants) and verbal consent from student participants in the form of assent. Sessions were audio-recorded, with the exception of one caregiver who preferred not to be recorded. In this case, the researcher took notes during the interview. Sessions were

transcribed with the support of the transcription service Otter.ai (2023), with personal identifying information removed from transcripts.

Discussions from these interviews and focus groups centered on participants' experiences with the AIFY initiative, with an in-depth focus on engagement with mental health services (see interview and focus group guides for semi-structured sessions attached as Appendix A). Therefore, the interview and focus group data addressed all the guiding research questions on (1) what types of mental health concerns children and youth are experiencing, (2) the factors that impact mental health service use, and (3) the perceived mental health impacts of the collaborative school-based mental health services.

Quantitative School Cohort Data

School cohort data were provided to the AIFY evaluation team from Edmonton Public and Edmonton Catholic schools between November and December 2022 for the seven AIFY elementary and junior high schools. These data provide information on individual students' socio-demographic characteristics and their use of mental health services, in each school during the 2021–22 year. This information is completed by the school administrators and AIFY agency staff at schools who know each student and the services they accessed during the year.

Socio-demographic characteristics. Students' school level (elementary, junior high) and gender (female, male, gender non-binary or gender queer) were reported. Population sub-group status was also reported based on whether students were self-identified First Nation, Métis, and/or Inuit (FMNI) or refugee. Special education was also indicated in cases where students were English language learners (ELL) or had identified specialized learning needs (i.e., emotional, behavioural, cognitive, learning, speech, hearing, vision, physical, or medical needs that require specialized programming).

Mental health service use. The use of mental health services was reported for each student. This was categorized by type of service, including by mental health therapy, success coaching, and/or in-home family supports. It was also categorized by type of client, including whether students received support as a formal client over the long-term or as an informal client on a short-term or as-needed basis. Finally, mental health services were also organized by type of delivery, including whether students received support in individual one-on-one sessions or in group settings.

The school cohort data provided important context surrounding the use of mental health services in schools, across schools and student socio-demographic characteristics. Socio-demographic information was not tracked across interview and focus group participants; therefore, this information is used to reflect trends among mental health service users. All data were anonymized to ensure the confidentiality of participants.

Secondary Data Analysis

Qualitative Interviews and Focus Groups

Reflexive thematic analysis (RTA; Braun & Clarke, 2006; 2019) was used for the analysis of interviews and focus groups. RTA is an approach to data analysis that recognizes the active role of the researcher in developing themes and findings (Braun & Clarke, 2006; 2019). Themes are not simply said to "emerge" from the data, instead it is acknowledged that they "reflect considerable analytic 'work,' and are actively created by the researcher at the intersection of data, analytic process and subjectivity" (Braun & Clarke, 2019, pg. 594). Consequently, value is placed on the researcher's reflexive engagement with data as a strength and source for knowledge (Braun & Clarke, 2019). The researcher takes a thoughtful and intentional approach to data analysis, recognizing their own perspectives, subjectivity, and

skillset, in developing a rich interpretation of data (Braun & Clarke, 2019). Thematic analysis is also frequently paired with qualitative description (Sandelowski, 2010).

RTA was implemented according to Braun and Clarke's (2006) multi-phase process of (1) immersing yourself in the data, (2) generating initial codes, (3) developing preliminary themes, (4) reviewing themes, (5) defining themes, and (6) writing out findings. To become familiar with the data, transcripts were re-read multiple times. The analysis was also conducted across two stages. First, data from school groups were analyzed separately by groups of students, and parents and caregivers for each school and assessed for divergence and convergence. Next, student and parent and caregiver data were integrated together. An inductive approach was taken to analysis, in which observations were primarily data-driven, as opposed to being guided by pre-existing theory or conceptualizations (Braun & Clarke, 2006). As previously described, constructionism was the research paradigm informing this analysis (Allen, 1994; Mayan, 2016; Mertens, 2020).

The analysis process resulted in the development of eight themes and nine subthemes, addressing all three research questions on (1) the mental health concerns that children and youth experience, (2) the factors that impact the use of collaborative school-based mental health services, and (3) the perceived mental health impacts of collaborative school-based approach to mental health services delivery. Themes were peer-reviewed by my supervisor to promote critical thinking and the richness of interpretation (Braun & Clarke, 2019). Additionally, an audit trail was maintained of key decisions throughout data analysis to enhance the trustworthiness of the research (Lincoln & Guba, 1985).

Quantitative School Cohort Data

Descriptive analyses were applied to school cohort data, using Microsoft Excel to develop summaries of students' socio-demographic characteristics and mental health service use. Data were first analyzed separately for each school, and then aggregated across schools. Quantitative results are presented as total sums (*n*) and proportions in percentages (%) in the following chapter to provide context surrounding mental health service use in AIFY schools.

Rigour

Rigour is the process of demonstrating how effective and coherent research methods result in the development of meaningful results (Mayan, 2016). For this research, Lincoln and Guba's (1985) criteria were used as a guideline for establishing rigour and trustworthiness, based on credibility, transferability, dependability, and confirmability.

The criterion *credibility* refers to accurately representing the data, participants, and research context (Lincoln & Guba, 1985; Mayan, 2016). Credibility was supported by my prolonged engagement with the AIFY initiative. By establishing relationships with AIFY and school partners and being embedded in the initiative over the past two years, I was able to develop a rich understanding of partner perspectives and school contexts, so that findings credibly represented participants and school communities. Additionally, multiple sources of qualitative data and quantitative school cohort data were analyzed, which serves to foster a more robust description of the research context, and in turn, triangulate or verify findings (Greene et al., 1989).

Similarly, *confirmability* is concerned with the researcher's objectivity, or accurately representing the data as opposed to putting forward the viewpoints of the researcher (Cope, 2014; Lincoln & Guba, 1985). Confirmability was addressed through engaging in reflexive

processes (Berger, 2015), including reflecting on my positionality in the research and my perspectives, reactions, or observations. Peer discussions were frequently held with my research team and supervisor to promote critical analytic processes. Additionally, an audit trail was maintained with key decision-making to ensure a logical and clear progression throughout the research project.

Transferability refers to the applicability of findings to other settings (Lincoln & Guba, 1985; Mayan, 2016). The transferability of this research is informed by the detailed description of AIFY school communities provided in this paper, including the environmental context, school services, and population socio-demographic characteristics. This contextual information can be used by other researchers to assess the transferability of both research techniques used and associated findings to related contexts.

Finally, *dependability* is concerned with the reliability of the research or its ability to be replicated (Cope, 2014; Lincoln & Guba, 1985). Maintaining an audit trail with decision-making overtime was a key mechanism to address dependability, with a clear record of steps taken at each stage of the research. Furthermore, comprehensive descriptions are provided in this thesis on methodology, data generation, and analyses. This information can be used by researchers to conduct research in similar contexts.

Chapter 4: Findings

In this chapter, study findings are presented on the role of collaborative, school-based mental health services in fostering children and youth's mental health. Findings from discussions with students (n = 51) and parents and caregivers (n = 18) are presented across eight themes and nine subthemes that address the three guiding research questions on (1) the mental health concerns that children and youth experience, (2) the factors that impact the use of collaborative school-based mental health services, and (3) the perceived mental health impacts of collaborative school-based approach to mental health services delivery. Findings contribute to knowledge on effective school-based mental health interventions for fostering children and youth's mental health. First, to frame the context for the use of mental health services within the AIFY program, descriptive statistics are presented, outlining mental health service use across AIFY schools, as well as socio-demographic characteristics of students who accessed services.

The Context of Mental Health Service Use in AIFY Schools

Across the seven AIFY schools included in this secondary analysis, 2,073 students were enrolled during the 2021/22 school year. Of this total enrolment, 885 individual students and/or their families accessed any type of school mental health service during the year, representing 42.7% of the school population. This includes the use of any mental health service offered at school (mental health therapy, success coaching, and in-home family supports) on a short-term or long-term basis, and in an individual or group setting.

These results show high mental health service use, representing a little under half the total enrolment for the use of any mental health service (42.7%). To break this down further, service use was calculated for mental health services, excluding the use of in-home family support as the only service accessed (i.e., excluding cases where students and families only used

an in-home family support worker, and did not also access mental health therapy and success coaching). Engagement with in-home family support typically has a more general focus on overall family wellbeing, with some exceptions; therefore, this calculation allows for a more targeted estimate of children and youth's use of mental health services. With this adjustment, the level of service use remains high, with a similar number of 795 individual students who used mental health services, representing 38.4% of total enrolment.

Socio-Demographic Characteristics

Data were explored for socio-demographic characteristics of students who used mental health services. Among students who accessed services, 50.2% were male, 49.5% were female, and 0.3% were gender non-binary or genderqueer (see Table 2). This reveals a nearly equivalent distribution of service use by male and female students, with a lower proportion of identified genderqueer students using services.

Additionally, over two-thirds of students (69.9%) who used mental health services were in elementary school (kindergarten – grade 6), with the remaining nearly one-third (30.1%) in junior high school (grades 7 – 9). The distribution of service use by elementary and junior high students corresponds to the number of schools of each level in the sample (i.e., four elementary, two combined elementary-junior high, and one junior high school). To break this down further, data were explored by grade level. The proportion of service use was similar across all 10 grade levels (kindergarten – grade 9; M = 10%, SD = 1.9%, range = 6.3–13%), showing equivalent numbers of younger and older students accessing mental health services. As younger children are typically less able to advocate on their own behalf, this high service use likely reflects the responsiveness of AIFY schools and wraparound teams to identify and connect with students who they believe need additional supports.

Service use was also calculated for specific population sub-group statuses. Almost a quarter (24.5%) of service users were self-identified First Nations, Métis, and Inuit (FNMI) persons. Additionally, close to one-tenth (9.5%) of service users had refugee status. Furthermore, a substantial portion of students who accessed mental health services were identified to have special education considerations, including 30.1% who were English language learners and 18.7% with specialized learning needs (i.e., emotional, behavioural, cognitive, learning, speech, hearing, vision, physical, or medical needs that require specialized programming). These measures reflect the diversity of students who access mental health services, with different strengths, experiences, and needs. Furthermore, this also demonstrates the responsiveness of school wraparound teams to connect with students who may benefit from support to navigate different experiences (e.g., transitioning to a new community, establishing social connects, and supporting complex needs).

Table 2.

Socio-Demographic Characteristics of Service Users, Across AIFY Schools

Socio-Demographic Variable	**Individual Students, *n***	**Proportion of Service Users, %**
School Level		
Elementary (Kindergarten – Grade 6)	619	69.9%
Early Elementary (Kindergarten – Grade 3)	312	35.3%
Upper Elementary (Grade 4 – 6)	307	34.7%
Junior High (Grade 7 – 9)	266	30.1%

Socio-Demographic Variable	Individual Students, *n*	Proportion of Service Users, %
Gender		
Female Gender	438	49.5%
Male Gender	444	50.2%
Gender Non-Binary or Genderqueer	3	0.3%
Sub-Group Status		
Self-identified First Nations, Métis, and/or Inuit (FNMI)	217	24.5%
Refugee Status	84	9.5%
Special Education Considerations		
English Language Learner (ELL)	266	30.1%
Specialized Learning Needs (SLN)	166	18.7%

Overall, mental health services were accessed at roughly equivalent rates by female and male students, as well as elementary and junior high students. High proportions of FNMI (24.5%), refugee (9.5%), ELL (30.1%), and specialized learning needs (18.7%) students were also identified to have accessed mental health supports, demonstrating the diversity among service users and the importance of responsive mental health supports.

Structure and Delivery of Mental Health Services

Mental health service use was also explored by the type of service delivery and client type to determine if students were receiving support in primarily individual or group settings, and as an informal client on a short-term basis or formal client on a long-term basis. Of students who accessed services, over one-quarter (27.1%) participated in group sessions as their only form of service delivery (i.e., they did not also participate in one-on-one mental health therapy,

success coaching, or in-home family support; see Table 3). Group services can be an essential form of support; however, in some cases group services can also be less targeted to individual needs. When excluding students who accessed group sessions as their only form of service delivery, 72.9% of students used mental health services in individual settings or a combination of individual and group settings, representing close to three-quarters of service users. However, it should also be noted that there was variability in service delivery across schools, with some schools offering more opportunities for group sessions than others (i.e., two schools offered two types of group sessions, four schools offered one type of group session and one school did not offer group sessions). This likely reflects the capacity of mental health staff to host different types of service delivery opportunities.

In terms of client type (i.e., informal, short-term client or formal, long-term client), 7.7% of students accessed mental health services as a formal client, only; 17.2% as both a formal and informal client; and 75.1% as an informal client, only. The majority of students received support as an informal client, suggesting that most mental health services were accessed on a short-term or as-needed basis. This likely also reflects the limited capacity of mental health staff to take on formal clients and a greater tendency to work with students on a short-term basis.

Students' use of multiple mental health services was also explored. Of service users, 42.2% used two or more of any type of mental health service during the year. A typical combination of multiple service use was meeting one-on-one with a mental health worker, as well as taking part in group sessions. The use of multiple services arguably implies a high level of need among students and families, with more than one service accessed to address mental health needs. It also demonstrates the responsiveness of the school wraparound model to triage students' mental health needs with different opportunities for accessing support, as appropriate.

Table 3.

Type of Mental Health Service Use, Across AIFY Schools

Service Use	Individual Students, *n*	Proportion of Service Users, %
Total Use of Any Mental Health Service	885	
Type of Delivery		
Used Individual Service(s)	422	47.5%
Used Individual and Group Services	225	25.4%
Used Group Service(s)[a]	240	27.1%
Type of Client		
Formal, Long-Term Client Status	68	7.7%
Formal and Informal Client Status	152	17.2%
Informal, Short-Term Client Status[b]	665	75.1%
Multiple Service Use		
Used One Type of Service	512	57.9%
Used Two or More Services	373	42.2%

[a]The delivery of group services reflects group programming for mental health therapy and success coaching. Group programming for in-home family support was not provided during the 2021–22 year.

[b]Informal, short-term client status also includes clients who accessed group programming, based on the assumption that groups were typically conducted over a short period of time (e.g., a semester).

Overall, mental health services were accessed more often in individual or combined individual and group settings (72.9%) and as an informal client on a short-term basis (75.1%), with variability observed between different school contexts, likely due to staffing capacity. Furthermore, a significant portion of students who accessed services used two or more services

(42.2%), reflecting both high levels of need, as well as AIFY schools' responsiveness with multiple, targeted opportunities for mental health support.

In summary, these findings show high mental health service use among the student population (i.e., 38.4% of total enrollment across the seven schools), as well as substantial diversity among service users. As socio-demographic information was not tracked across interview and focus group participants, this information reflects trends among mental health service users and provides context for how mental health services were accessed in schools.

In the remaining sub-sections of this chapter, findings from focus groups and interviews with students (n = 51) and parents and caregivers (n = 18) are presented together. These findings explore the role of collaborative, school-based mental health services for fostering children and youth's mental health in order to inform the development and implementation such mental health interventions. Overall, eight themes and nine subthemes are presented in response to the three guiding research questions. To start, two themes and two subthemes are presented that address the first research question on the mental health concerns experienced by children and youth. Next, three themes and two subthemes are presented that address the second research question on factors that impact the use of collaborative school-based mental health services. Finally, three themes and five subthemes are presented that address the third research question on the mental health impacts of collaborative school-based mental health services.

Research Question 1: Mental Health Concerns Experienced by Children and Youth

To understand how collaborative, school-based mental health services are responsive to the needs of children and youth, it is important to identify the mental health concerns that children and youth present with, and the support that is needed to navigate these concerns. Therefore, students and caregiver participants were asked about their mental health and

challenges they face in their lives. Data were analyzed to address the first research question: What mental health concerns do children and youth experience? Two themes (*Coping with Multi-Faceted Needs and Experiences* and the *Impact of the COVID Pandemic on Wellbeing*) and two subthemes (*Coping at School* and *Navigating Social Relationships*) were identified in response to this inquiry, which are described below. Student and caregiver quotes are incorporated in these descriptions, with personal information removed to maintain the anonymity of participants. Student participants are identified by the level of school that is applicable to them (elementary or junior high) and the type of data generation activity they participated in (interview or focus group, written as "FG"; e.g., Elementary FG Student or Junior High Interview Student). As all caregivers participated in interviews, caregiver participants are identified only by the level of school applicable to their child (e.g., Elementary Caregiver or Junior High Caregiver). Additionally, the term "caregiver" is used to refer to both participants who are parents and/or individuals who take on the primary caregiver in their child's life (e.g., grandparents, stepparents, aunts, and uncles).

Coping with Multi-Faceted Needs and Experiences

When asked about mental health, and challenges in life, students and caregivers made it clear that childhood and adolescence is often a difficult period of development which, even in the best of circumstances, can be overwhelming. As described by one student, "You will face everything you are going through… because it's your teenager-age, right?" and gave the examples of "drama, relationships, growth, mental health, parents, everything" (Junior High Interview Student). Therefore, students often talked about feeling inundated with personal and school-related challenges which meant that it was difficult to process emotions and experiences.

Specifically, students often spoke about struggling with personal challenges and mental health (e.g., depression, anxiety), family dynamics (e.g., parent relationships, transitions), peer relationships (e.g., relationship management, bullying), and learning difficulties (e.g., focus, academic pressures). With these challenges, students shared that they often did not feel well-equipped to process their emotions and cope with situations. For example, one student commented, "…People are hiding their feelings. They're actually emotions and just covering it up" (Junior High FG Student). When asked if this was helpful, another student explained, "No, it's not helpful at all. It's a coping mechanism" (Junior High FG Student).

Processing emotions and coping was described to be particularly difficult when children and youth did not feel like they had a safe space or support to do so. One student explained, "I think that most people hide their emotions because they're afraid of being judged for them. So, they hide their emotions so that they don't get judged and then if they do… they're just gonna break down" (Junior High FG Student). Another student shared, "Some people at home they get in trouble for having feelings. And so, they just shut it out" (Junior High FG Student). Another student explained, "You don't want to get hurt. You don't want to let your guard down. So, you just turn it off [emotions]. It's the easiest thing in the world" (Junior High FG Student).

Unfortunately, experiencing environments that are unstable or unsafe is not uncommon. On top of daily challenges during childhood and adolescence, many students and caregivers shared about the experience of complex and challenging circumstances, such as unmet needs (e.g., housing and food insecurity), complex transitions (e.g., newcomer or refugee status, partner separation, loss of a family member), and exposure to maltreatment (e.g., abuse, neglect, substance misuse). Students and caregivers appreciated that such experiences are difficult to process at a young age. For example, one caregiver shared that her child struggled with mental

and physical health challenges (seizures), while their family also underwent a difficult transition, “Me and her [other caregiver] split up…And she [child] wasn't allowed to see him for over a year. She's now able to see him again and everything…And he's all sobered himself up… So, she dealt with a lot of stuff.” (Elementary Caregiver). The caregiver went on to comment on the burden of multiple challenges, “So really, how much can a kid take, right?”

Many caregivers also spoke of struggling with economic insecurity and not having access to needed resources such as housing, food, and clothing. This was often related to complex situations such as leaving abusive home environments, experiencing newcomer or refugee status, and sustaining employment setbacks. Caregivers described working hard to provide for their family during periods of deprivation, such as “living in a women’s shelter” (Elementary Caregiver), “not getting [work] hours” (Elementary Caregiver), and “…sleeping in my car” (Elementary/Junior High Caregiver). Caregivers stressed that these experiences can be hard on children. For example, one caregiver described the challenge of not getting coverage for his child’s medication for a period of time, “I didn't have the medication covered. So, he [child] was not on his meds. So, he was kind of really, you know, not all there” (Elementary Caregiver). Another caregiver described living in a women’s shelter with her child, “He [child] will do more greater once we have our own place. … Living in a shelter is not easy, right?” (Elementary Caregiver). She went on to share, “…I'm gonna work hard to give him the best.”

Additionally, some caregivers described exposure to unsafe home situations (i.e., abuse, neglect, substance misuse). Caregivers recognized that these experiences can be traumatic for children and youth. For example, one caregiver shared that her child experienced neglect with her former caregivers who “are both meth addicts,” as well as abuse, such as when a former caregiver “pulled out a taser on us” (Elementary Caregiver). In response to this trauma, her child

continues to struggle with disruptive behaviours and self-management, “She [child] doesn't listen even to the Principal, to anybody. She runs around in the hallway…She's getting into fights with other kids.” The caregiver also shared, “…One day the teacher phoned me that she [child] threw a toy and it hit a teacher. And when she come home, and I talked to her about it… She said, it wasn't a toy. It was a rock.” The caregiver also added, “[She] will not open up about her feelings. She'll talk about anything else but her feelings. … When it comes to her feelings, she shuts down.” A similar experience was also shared by another caregiver, who escaped violence with her children. The caregiver shared that they were times when her and her children all, “coped with suicidal thoughts” while living in her car (Elementary/Junior High Caregiver). In response to overwhelming stress and trauma, her children gained a significant amount of weight and displayed challenging behaviours, such as “…respond[ing] to teachers in a very disrespectful and aggressive way.”

Therefore, students and caregivers emphasized that when children and youth do not have mental health support to help them process emotions, cope with complex and challenging experiences, and develop coping and self-management skills, it can lead to suffering over the long-term and mental health concerns may become worse. One student explained this:

> Like from my understanding if you're going to hide your emotions, you're going to sit there and suffer and suffer more until it comes to the point where you're going to have an emotional breakdown and then you're not gonna have anyone to help you because you've never wanted to show your emotions to that person. (Junior High FG Student)

Another student added:

> Or like… your feelings like built up so much inside of you that even if it's like the littlest thing, but someone gets on your nerves at one point, you're just going to explode on them. And just you don't mean it. (Junior High FG Student)

Consequently, participants indicated that mental health support is needed to help with both functioning in daily life, as well as with coping in response to complex and challenging circumstances or adverse childhood experiences. As stated by one student, support is needed to help process "things you've been holding in" (Elementary FG Student). Furthermore, participants revealed that this need is even greater following the COVID-19 pandemic, which is discussed next.

Impact of the COVID Pandemic on Wellbeing

The challenge children and youth faced with processing emotions and coping was described to be aggravated by the COVID-19 pandemic. It was made clear by students and caregivers that the pandemic had far reaching and ongoing effects in their lives. Specifically, students and caregivers said that *Coping at School* and *Navigating Peer Relationships* was made more difficult due to the ongoing effects of the pandemic, and in response, children and youth experienced significant pressure and stress.

Coping at School. During the 2021-22 year, most students returned to in-person instruction after a prolonged period of remote learning from home[2]. Students recounted their experiences with online schooling and described the transition back to in-person classes. They

[2]In-person classes in Alberta were first cancelled in response to the outbreak of COVID-19 in March 2020. During the following 2020–21 school year, students and families were given the option for remote or in-person learning; however, all in-person instruction was moved online in response to provincial emergency health measures, as well as local COVID outbreaks throughout the school year (see AIFY & CUP, 2021). Most students returned to in-person instruction during the 2021–22 school year, which marks the third school year impacted by the pandemic.

said that remote learning was often difficult due to barriers in technology and resources, with many children and youth struggling with limited access to electronic devices. For example, one caregiver struggled with an unreliable computer, "…sometimes the Chromebook wasn't working" (Elementary Caregiver). Another student described competing for access to electronic devices with other family members who were also trying to do school or work from home:

> It was hard for me because my mom and my two sisters we were all trying to do online at the exact same time. And we only have so many devices. So, like we had to do rotating from sharing the computers to going on the phones which is really small, you can't do a lot of work when you're on a phone. (Combined Focus Group Student[3])

Students and caregivers also described struggling with the technological knowledge required for remote schooling. One student explained, "People always think, right, that like young people are like good at computers, I'm not like that great at computers…it still took me two hours to download a file [with] my cousin's help" (Combined Focus Group Student). Another caregiver also expressed frustration, "the homework wasn't online when it was supposed to be… I would look for up to two hours on my app" (Elementary Caregiver). Furthermore, students said it was more difficult to get individualized learning support. One student explained, "You aren't just getting as much help as when you are in person" (Combined Focus Group Student). Another student remarked, "You'd send an email and have to wait like 3-5 business days" (Combined Focus Group Student).

Notably, students and caregivers also discussed the disruption in routine that came with remote learning from home. Many students explained that this disruption to their routine made

[3]At one combined elementary/junior high school, a blended focus group was held with elementary and junior high students. Students were not identified by grade level each time they contributed to the discussion; therefore, the identified "combined focus group" is used.

learning difficult and it was challenging to self-motivate and self-regulate. Students often described 'slacking off' on schoolwork. One student commented: "…I feel like just online, was kind of bad because I had a lot of time. I had kind of even made a choice, which isn't right, to like sleep instead" (Combined Focus Group Student). Another student added, "I was just playing games in the background" (Combined Focus Group Student). Caregivers also emphasized the difficulty of online schooling for children. One caregiver explained, "…they didn't want to sit there and be on the computer with their teachers…it was hard to get them to focus, being at home and doing it online" (Elementary/Junior High Caregiver). Another caregiver shared that her child, "…just really struggled. She [child] wasn't able to concentrate, she wasn't able to grasp concepts that were being taught. She was very tired. And just worn out" (Elementary Caregiver).

Due to the challenges described with remote learning, some students observed learning gaps that accumulated over the pandemic, which made it stressful and challenging to keep up with school curriculum. One student explained, "…I've usually barely gotten C's. But then when COVID hit, all I got was C's. Pretty much" (Junior High FG Student). Another student remarked, "So I told my mom…I'm not doing online school again. That's why I don't know my math because I missed half of grade eight. So did my sister" (Junior High FG Student).

Furthermore, students and caregivers explained that the transition back to in-person school was often difficult. For some, it was challenging to get back into a routine, with one caregiver sharing that her child, "…has a really hard time going to school…I literally will phone them [school staff] and say she's refusing to go" (Elementary Caregiver). The caregiver went on to explain, "…the pandemic helped her stay home more. And then the more she stayed home, the harder it is for me to get her to go." Another caregiver shared:

> He [child] didn't want to go back to in-person school. … The transition was a little tough. We had a few—the first few months, he tried to leave the school, walk out of the school and stuff. And that was kind of scary. (Elementary Caregiver)

Students also said that in-person school meant an increase in academic pressures and expectations and some felt that they did not have the coping and self-regulations skills that was required of them. One student described this:

> I feel like a lot of people…haven't been able to find, like, strategies to cope with stress. And then like, for me, when I came back to school, in person like this, mainly this year, because last year, you know, we didn't really have to do much, but this year, like, restrictions are getting loose, and teachers are obviously going to expect more. I have been really like, kind of sensitive to things. Like a lot. And I think it's because I haven't really had like encounters with like those things. And I haven't been able to find a way to like kind of help me cope with it. (Junior High FG Student)

Navigating Social Relationships. Beyond coping with academics and in school, students also described struggling with social relationships, attributed to isolation and remote learning experienced during the pandemic. Students described what it was like to socially distance and learn at home during the pandemic, in which they were typically only able to see their friends through virtual platforms. One student explained:

> When COVID happened we all had to stay home. And because of staying home, you have to do online school instead of going to school. And, uh, and we can see our friends usually. We couldn't hang out with them usually. But the only way to hang out with them was from virtually from the computer. (Elementary FG Student)

Social isolation was described as a difficult and lonely experience. One student commented, “I died with no socialization. Soon as I got back to school, I mean, I talked to so many people” (Junior High FG Student). Students also said that it was easy to become disconnected from friends due to the challenge of not being able to see them regularly. One student explained, “I'd say definitely it's like, yeah, you definitely lose some friends… Like I think every friendship has gone like further apart” (Junior High FG Student). As described by one caregiver, this is understandably challenging from a developmental perspective, “Because socialization for young children is of utmost importance, so that they’ll know how to be civilized and the proper citizens of the community” (Elementary Caregiver).

After returning to school, some students expressed relief or gratitude at being able to socialize with friends again. One student said, “…I guess coming out of COVID, it makes me glad that like, I can actually go out and hang out with people like with no problem and all. And, uh, just like it makes me really thankful of what we have” (Junior High FG Student). However, at some schools, students continued to express frustration at not being able to see friends in other classes due to health measures, such as social distancing and cohorting,[4] which were described to make it more difficult for maintaining friendships. One student explained, “…I'm not able to like be with my other like 25 classmates from last year, the year before, that I've grown up with” (Elementary FG Student). Another student explained that you are not able to make as many friends due to cohorting measures, “…You only have this one group of kids to be with instead of a whole group of elementary” (Elementary FG Student).

[4]“Cohorting” refers to a health measure implemented by schools to restriction the spread of COVID-19, in which students were restricted to interacting with peers in the same classroom or “cohort,” and were not able to see or play with friends in different cohorts to reduce virus transmission.

Although some students expressed relief that they were back in school and able to socialize with peers, many students also described feeling overwhelmed or stressed. Students often spoke about experiencing social anxiety after being at home for so long and struggling to navigate peer interactions. One student stated, “It's scary, it's really scary coming back” (Junior High FG Student). Another student explained:

> I think that just because COVID because we were all isolated for so long, a lot of people have gotten social anxiety to the point where they like don't want to be around anyone and don't want to talk to anyone. That could, play a factor in it, I guess. Just not wanting to be at school. (Junior High FG Student)

Another student described experiencing anxiety in situations she previously would not have, before the pandemic:

> It also, for me, it kind of changed the way I am in public, I guess. Because in grade seven, when I used to, I used to like [go] to the mall and everything. I used to be completely fine being in big spaces with a lot of people. But now I just I can't do that. Like even coming to school, sometimes it's really hard to. (Junior High FG Student)

In fact, one caregiver explained that one of her children decided not to return to in person school, “So one of my children decided to stay online because she had some disabilities. So her social anxiety has completely stopped her from even really leaving the house” (Junior High Caregiver).

For these reasons, many students said that coping in school and navigating peer relationships was difficult following the pandemic. The impacts of the collaborative, school-based mental health services for supporting children and youth are discussed in the later section. Prior to this, factors identified by students and caregivers that facilitate or mitigate access to school-based mental health services are discussed.

Research Question 2: Factors that Impact Mental Health Service Use

Due to high needs among children and youth, it is important for school-based mental health supports to be accessible for students. Therefore, data were analyzed for the second guiding research question: What are the factors that impact the use of collaborative school-based mental health services (i.e., enablers and barriers)? Three themes (*School Culture of Support*, *School Communication*, and *Stable and Well-Resourced Staff*) and two subthemes (*Staff Resources* and *Staff Stability*) were identified, which are described below.

School Culture of Support

In talking to students and caregivers it became clear that school culture plays a significant role in access to school-based mental health services. As described previously, AIFY schools have distinctive cultures of collaborative, strength-based and supportive practices. Staff at AIFY schools (i.e., AIFY agency staff, teachers, and school administrators) receive training centered on understanding childhood adversity and trauma, which fosters shared school practices and student care that is trauma-informed and promotes family resilience. Within this supportive and strength-based school culture, students and caregivers described feeling comfortable to reach out to trusted adults for support, who are receptive to their needs and able to connect them with care.

This school culture of supportive student care is reflected by how students spoke about their schools. For example, one student described school as a, "…very kind, caring environment," where students are, "getting the support we need" (Junior High Interview Student). Another student described school as "kind and supportive" and that "people are nice here" (Elementary FG Student). This culture was further characterized by the presence of trusted and supportive adults in schools (i.e., AIFY agency staff, teachers, and school administrators). One student stated that adults in the school are, "…just really there to help" (Junior High

Interview Student). Another student explained that if you are struggling, you can, "…literally just go to any teacher that you trust" (Junior High FG Student).

Accordingly, this supportive school culture was described to promote children and youth's access to mental health supports because it builds positive child-adult relationships, from which students can feel comfortable to go to trusted adults in their building for support. As stated by another student, "Pretty much anyone in school you can really talk to" (Elementary FG Student). Caregivers also described feeling comfortable reaching out to school staff. For example, one caregiver explained, "I can literally phone and tell them anything" (Elementary Caregiver). Another caregiver shared, "I feel secure and safer that someone is out there who's, who's able to give me a value and respect and care for me, right? Like, if I need something like I know who to ask" (Elementary Caregiver).

Additionally, within a supportive school culture, school staff were described to be receptive to, and understanding of, children and youth's mental health needs. For example, one caregiver explained that "…the teachers [were] understanding [of] her kids' limitations when they were fleeing home and the abusive situation" (Elementary/Junior High Caregiver). The caregiver shared that, due to living in a car, her children were severely sleep deprived and, "…teachers understood that [when] they got to class…it was a time when they actually rested their heads on their arms and fell asleep" (Elementary/Junior High Caregiver). Another caregiver explained that school staff are understanding of her child's challenging behaviours and reluctance to go to school:

> …If I phone [the school] crying and upset with my [child] in the morning, I can tell you that I'm smiling by the time I get off the phone with them [school staff]. So, that's not

> just one time this year, I would have to say at least 12 [times that this happened]. … I love [name of school], I really do. (Elementary Caregiver)

Similarly, a student also described a teacher's responsive attitude to their classmates' mental health and wellbeing in class:

> Well, [name of teacher], if anybody in her class was feeling down or something… she would give us like, breathing exercises to do and just things to help us calm down. And then when we were calm, she would talk to us and stuff. And that was really helpful. Yeah, she would always like realize if a kid was like upset or scared or sad. And she was like, let them take a break until they were ready to chat. (Elementary FG Student).

Furthermore, supportive school staff were described as able to facilitate students' access to mental health supports. Specifically, students talked about being able to excuse themselves from class to seek support from mental health staff, without receiving objections from their teacher or other school staff. For example, one student described accessing mental health supports for the first time because her teacher permitted her to leave class:

> I was having a really bad day one day. And then my friends were like, 'ask the substitute teacher if you can go to [the mental health and wellbeing room]'[5] and of course she said yes. And yeah, it really helped. Because some days, you're just like, not really having it. (Junior High Interview Student)

Similarly, another student said that teachers are always supportive of students seeing mental health staff, "[The mental health and wellbeing room] is like a place where you could go and

[5]Schools have office spaces where the mental health staff are located, some of which have specific room names that students can use to refer to them. These room names are often representative of the school community, such as based on school logos or mascots. To protect the privacy of students in terms of which school they attend, these names are replaced with "mental health and wellbeing room."

calm down and take a break. And ask teachers and they're always supportive for you" (Elementary FG Student).

This supportive culture was further emphasized to be particularly meaningful when students and caregivers spoke about negative experiences at non-AIFY schools. For example, a student commented on the supportive culture, explaining that it was different from another school where the teachers, "were very like mean and strict" (Junior High Interview Student). Furthermore, some caregivers shared experiences at other schools where school staff were not understanding of their children or families' mental health or complex needs. For example, one caregiver shared that her older children who "are special needs" were treated poorly at another school:

> …They [school staff] could not deal with any special needs. In fact, my two [children] were not only bullied by their peers, but by the staff members there. … I had to fight for everything that my two [children] got. And then in the end, it was worth nothing because they pretty much destroyed my kids' self-worth and self-confidence. (Elementary Caregiver).

The caregiver went on to explain that her experience was different at her current AIFY school:

> Everything has been positive. …I have six kids, and they've all been in the school system. And I'll tell you, I have never experienced anything like this before. Like [name of school] is a cut above all the rest of the schools.

Similarly, another caregiver also shared that previous schools failed to support her older child with autism, "They just didn't listen to the parent, right? And my [child] because of those, those teachers, my [child] started running away at 16 years old" (Elementary Caregiver). Therefore, the caregiver explained that when she came to her current AIFY school for her other

child, "…I had my guard up like you wouldn't believe. Honestly, I can't help it now." However, this has since changed, "they helped me out a lot. Like I've never trusted schools before. … So they've made me see the school system a lot different actually."

Consequently, the supportive culture at AIFY schools was described as special or unique, and this supportive culture was said to facilitate students' access to mental health supports because students and caregivers are made to feel comfortable to reach out to staff in school buildings. Additionally, school staff were described as receptive and understanding of the mental health needs of children and youth and can support and facilitate their access to, and use of, mental health services.

School Communication

Students and caregivers also discussed the importance of school communication when it comes to accessing mental health services. It was emphasized that when there is clear communication from the school about what mental health services are available and how to access mental health services, families are better able to reach out for support when they need it.

Specifically, students and caregivers commented on their knowledge of mental health staff and services in schools. Some participants knew about the mental health services in their school and how to receive support. For example, one student stated, "I knew where to go," when asked about how he first accessed support for mental health needs (Junior High Interview School). In such cases, students described being familiar with mental health staff whose presence was known in the school and who connected with students and visited classes. For example, one student shared, "[Success Coach] does smudging[6] like every morning and sometimes at other

[6]Smudging is a ceremony traditional to many Indigenous peoples which involves the burning of medicines and provides the opportunity for "people to stop, slow down, and become mindful and centred" (Government of Manitoba, 2019, pg. 4).

times [during the day] with every class in school. … In our class…after lunch every Wednesday she comes, and she takes us smudging" (Elementary FG Student). Another student shared:

> [Mental health therapist] came in [to class] like almost like every second Friday and stuff. And like she would teach us like all this stuff. … Like how to calm down when something's happening and stuff like that. It was fun to learn about too. (Elementary FG Student)

Alternatively, some participants shared gaps in their knowledge about mental health support available at their schools. For example, one student commented, "I never knew about [mental health therapist]. I knew about this other guy, whatever his name was. Yeah, then I didn't know about [mental health therapist]" (Junior High FG Student). Another student remarked, "I don't know [about] this [mental health and wellbeing room]" (Elementary FG Student). In fact, even some students working with mental health staff shared that they did not have the knowledge about how to access supports themselves. For example, one student shared that she had a friend reach out for help on her behalf, "I had a friend reach out to me and tell her [mental health staff] what was going on" (Junior High Interview Student). When asked "if you didn't have the friend reach out, would you have known who to go to?" the student replied "no."

Accordingly, participants indicated that when they are aware of mental health services, they are better equipped to reach out for support if needed. Alternatively, a lack of this knowledge can mitigate service access, as explained by a caregiver:

> Well, we didn't even know that these programs existed until we had a family issue occur… I think if we had known about it sooner, it would have helped to know that there was support there. To a point I even let some of the other parents they know who are having issues with stuff. I let them know, like, 'Hey, did you guys know if there was free

> program in the school?' And none of them had any idea that it was even there. (Junior High Caregiver)

Therefore, as illustrated above, clear school communication is needed about what supports are available in the school for students and families to know about supports, and in turn, access supports, if needed.

Furthermore, it was suggested that school messaging is needed both around what mental health services are available, as well as how to access mental health services. Within the AIFY model of support, wraparound teams actively work to identify students and families with additional needs and coordinate mental health supports, as needed. That being said, students and caregivers who are struggling can also self-refer themselves for these supports, and do not need to wait to be identified by school wraparound teams. However, according to one student, it is not always well understood by students that they can refer themselves for supports:

> Especially some of the younger kids, they don't know when it's okay to go to ask for help. Because when I was in younger grades, I'd seen [the success coach] like, pull some kids out. And I'm just like, 'is she going to pull me out next?' And I was kind of like, wanting her to pull me out. Because I knew that they would like, get all these things and like get like talked with and I was like, 'huh, like, how do I have to get in trouble to be able to go with her?' Because usually it was like those kids. (Junior High FG Student)

Therefore, communication is needed so students who are struggling are made aware that they can reach out for support and do not have to wait to be identified by the school or mental health staff. The student stressed this importance, "With younger grades… make sure to talk more about [mental health supports]. …Like, 'it's okay to come'… Even if you don't get in trouble. Like if you need to talk to somebody." Overall, students and caregivers indicated that

clear school communication and messaging about what mental health services are available and how to access them better enabled families to reach out for support when needed.

Stable and Well-Resourced Staff

Finally, students and caregivers also spoke about the importance of mental health staffing when it comes to accessing mental health services. Specifically, participants emphasized that adequate *Staff Resources* and *Staff Stability* facilitate access to mental health services, and that when these are lacking, this inhibits use of support.

Staff Resources. Many students talked about mental health staff capacity at their schools. Most schools (n = 6) had three part-time mental health staff (i.e., mental health therapist, success coach, and in-home family support worker), while some schools (n = 2) had only two staff due to funding constraints (i.e., mental health therapist and in-home family support worker, only). It was made clear by students that multiple mental health staff (i.e., all three types of staff) are needed in schools to meet the demand for mental health support. Specifically, in schools with less mental health staff, students said that the demand for support frequently exceeded staff available. One student in a school with only two mental health staff explained, “Yeah, we definitely need another counselor. Because like they're always just so busy. So you don't get to see them that much” (Elementary FG Student). Another student shared, “My friend sees [mental health therapist]… But like she was saying that she wished she saw [mental health therapist] a little more or someone else a little more. Because she hasn't seen her in a while” (Elementary FG Student). Another student discussed the challenge of needing someone to talk to but not having any mental health staff available that day:

> I think maybe we should get maybe another counselor because I know for me because there's some times in my life where I need someone to talk to but I felt like the counselor

> here was really busy… So I feel like maybe with another counselor it'll free up the space for [the mental health therapist] right now. And also it'll be another person to talk to you in case you need it the most, and I think maybe like it'll be easier for families to talk to feel more open, and because it'll be much quicker until the next time. (Elementary FG Student)

As illustrated by the above students, a lack of available mental health staff means that students may not be able to see mental health staff on days when they feel that they need someone to talk with. They may also experience longer wait-times between appointments, all of which are added barriers to receiving needed support, building trusting relationships with mental health staff, and making progress in therapy. Furthermore, even at schools which had access to three mental health staff (i.e., mental health therapist, success coach, and in-home family support worker), some students also expressed the need for additional support:

> I mean, it's pretty good [referring to mental health services], but also, I feel like we could use more like people, because like, after all, there's only one success coach and like, sometimes when people need to—like I've seen kids who need to talk to her, but like, she's busy and all that. So, I feel like if we had, really like, two more people, you know? (Junior High Interview Student)

Therefore, participants indicated that more mental health staff is required to meet the high volume of student needs, even in schools with three mental health staff. Without adequate staff resourcing, students experience limitations in their access to support.

Staff Stability. Similarly, students and caregivers spoke about the stability of mental health staff. In some cases, students and caregivers had long standing relationships with mental health staff. For example, one caregiver shared that their children received mental health support

for the past three years, “They've been going to therapy at [name of school] since 2019 I'm pretty sure” (Elementary Caregiver). Another student had a two-year relationship with a mental health staff, “I've known [Success Coach] since grade seven” (Junior High Interview Student).

Alternatively, some schools experienced high turnover among mental health staff. This was described by participants to be a barrier to mental health service access. Specifically, when there is staff turnover, participants explained that they temporarily loose access to mental health services. One caregiver described this challenge for her child:

> …Her counselor [name of mental health staff] had left. So, there was a little bit of time where she didn't have a counselor. And I have to say, I really noticed that. She came home and she would tell me, ‘I flat out notice this mummy.’ You know what I mean? (Elementary Caregiver)

Furthermore, due to the importance of these safe and caring relationships for children and families, participants may experience stress when mental health staff leave. For example, one caregiver interviewed recently learned that the mental health staff supporting her child was leaving and anticipated a negative reaction from her child:

> Well, [the mental health therapist] just called me today to… let me know that she's leaving, so we were talking about how my how [name of child] is going to, you know, not take that news very well. (Elementary Caregiver)

Similarly, caregivers may also feel the change when mental health staff leave. One caregiver whose child also received mental health services commented, “I'm probably more sad like she'll [mental health staff] won't be around. Cuz she's really been supportive to me too” (Elementary Caregiver). For some participants, this change may cause significant distress. One caregiver

shared, “I feel cheated” when the mental health staff working with her family “disappeared” (Elementary/Junior High Caregiver).

Furthermore, it may be difficult for participants to become comfortable with a new mental health staff. The same caregiver explained that it was an adjustment to work with a new mental health staff who was male, after her family experienced abuse at the hands of a male family member, sharing that it was “harder… to trust him” because of the abusive relationship.

Therefore, participants indicated that turnover among mental health staff can be challenging, in which they temporarily loose access to support and may experience stress. It was made clear in discussions that access to mental health services is best supported when schools have a stable and well-resourced mental health staff workforce, with multiple, full-time staff available for students over the long-term.

Research Question 3: Impacts of Mental Health Services

Finally, students and caregivers were asked about the impacts of mental health services. To determine how school-based mental health services support students and families, it is important to understand how families feel about these services, and if they make a difference in their daily lives. Therefore, data were analyzed for the third guiding research question: Does a collaborative school-based approach to mental health services delivery lead to perceived mental health impacts among children and youth (i.e., emotionally, psychologically, and/or behaviourally)? Three themes (*Supported by a Safe and Caring Adult*, *Improved Capacity for Coping in School and Life*, and *Improved Family Functioning*) and five subthemes (*Improved Coping with Life*, *Improved Coping with School*, *Healthy Action*, *Family Relationships*, and *Family Wellbeing*) were identified in response to this research inquiry, which are described below.

Supported by a Safe and Caring Adult

Over and over again, when asked about the impact of mental health services, students said that their mental health staff was their safe and caring person that they could go to when needed. Mental health staff were described as "someone who will listen to you" (Elementary FG Student) and who will support you. This supportive relationship was something that many students expressed that they were looking for, and for some, had not experienced elsewhere. For example, one student stated, "I just wanted to have somebody to talk to" (Junior High Interview Student). Another student explained, "…you can actually have someone, who like, listens to your struggles and stuff" (Junior High Interview Student).

Students spoke of feeling a sense of safety with mental health staff. They felt like they could confide in mental health staff, share their thoughts and emotions, and be received without judgement or consequence. For example, one student stated that her success coach is, "…the one person that I would choose to talk to about anything" (Junior High Interview Student). Similarly, another student remarked, "it makes you feel safe" (Elementary FG Student).

Students also saw mental health staff as someone they trusted to provide them with helpful and supportive guidance. Students described working with mental health staff on skills for navigating challenges and moving towards goals in life and school. A student described this support, "…you can tell her [mental health staff] anything and then she'll give you really good advice" (Junior High Interview Student).

Caregivers echoed these sentiments shared by students. One caregiver shared that it was helpful for her child to know that there are safe people to talk to, "And I think it's just helped him to, to know that there are people that like, that could help. And, like, not be so shy to ask for help" (Junior High Caregiver). Another caregiver shared:

> She's [mental health staff] like a confidant for him is how I would best describe it. Like, he's not typically in the past, he was never a child that would give you a hug… He was so inside himself, like, and like, I don't know how to explain it. But now he'll just run up to you and give you a hug. And then he'll do that with [mental health therapist], which is not something he just does to anybody. (Elementary Caregiver)

Additionally, one caregiver illustrated the impact that the supportive relationship had on her child's self-esteem:

> It helped her with her [child's] self-esteem… finding someone in the school that you can confide in and not feel judgment, you know? An adult that, you know, would just listen and try to give feedback… You know, if you say something, it'll be like private, unless it's like life threatening, right? (Elementary Caregiver)

The impact of this relationship with a caring adult is significant because, as described by one caregiver, not all children and youth have support systems at home that they can depend on, "…There's a lot of kids here that really have nobody. And [the mental health staff] might be their only person. And that's really important to have in your life" (Elementary Caregiver). This is further illustrated by students who described their relationships with mental health staff as special or unique from other relationships and life experiences or as a safe resource among otherwise challenging environments. For example, one student explained that life without a mental health staff, "…would be more challenging because I would have no one else to open up to…And I would just keep my emotions in and get depressed again" (Junior High Interview Student). Another student shared:

> I feel like if the [mental health staff] weren't here, I feel like I just be a lot more angry because I wouldn't have anybody to talk to… like an adult, because I could always talk to

my friends. But sometimes…I want something from like an adult's point of view. (Junior High Interview Student)

In fact, for some students, they were more willing to go to school on days they knew that they would be able to see mental health staff. For example, one caregiver shared, "It kind of motivates him [child] a bit to go to school…he doesn't really like school overall and he usually grumbles. But he'll get out the door on his own to get to school bus" (Junior High Caregiver). This reflects the impact of these meaningful relationships, as well as the support children and youth receive to navigate school and life, which is presented next.

Improved Capacity for Coping in School and Life

Another foundational impact of mental health services described by students and caregivers was help with processing and regulating emotions and developing skills and tools to navigate school and life. Students explained that with mental health support, they felt less overwhelmed and better able to process their emotions and experiences. They also said that their capacity for coping improved with tools and skills developed with their mental health staff. This included *Improved Coping with Life*, *Improved Coping with School*, as well as taking *Healthy Action* to foster positive outcomes.

Improved Coping with Life. Students spoke of feeling better equipped to deal with life's challenges, having received mental health support. This ranged from navigating everyday experiences to coping with complex and challenging life circumstances. As stated by one student, with this support, "…you can process what's going on in your life" (Junior High Interview Student). Another student stated, "She [mental health staff] was able to help me through a really tough time in my life…" (Junior High Interview Student).

By talking to mental health staff, students felt that they were better able to understand, process, and regulate their emotions. One student explained, "…I can let all my emotion out that I've been keeping in for a while" (Junior High Interview Student). Another student shared, "I'm able to express myself more. I'm able to release a lot of things" (Junior High Interview Student).

Students also spoke about developing skills and tools with their mental health staff to navigate different challenges in life. One student spoke about struggling with peer relationships and shared that the mental health staff, "…slowly showed me… the way to escape all of this hate and negative everything" (Junior High Interview Student). Another student who struggled with anxiety said the mental health staff, "… helped me because she taught me some strategies, on ways to not be so anxious all the time" (Junior High Interview Student). For some students, this improved capacity for coping represented a meaningful change in their lives. For example, another student who experienced significant stress and anxiety shared, "…I used to have really bad anxiety attacks. But now it doesn't bug me anymore" (Junior High Interview Student).

Caregivers also reflected on changes they observed with their children before and after receiving mental health support. They often shared a noticeable improvement in their child's self-esteem, emotions, and ability to cope. One caregiver commented that her child is, "…a lot more comfortable in her own skin, and willing to be more open and talk about things" (Elementary/Junior High Caregiver). Another caregiver shared:

> She's [mental health staff] definitely helped him [child] navigate through all of that emotion. And it's definitely helped every week you just see him grow, grow more patience and grow… Just grow. Literally just grow in emotional intelligence, and… it's been great. (Elementary Caregiver).

Another caregiver reflected on the change in her child's ability to regulate emotions after experience loss and abuse:

> Initially, he [child] had such a difficult time expressing his emotions…Now he can fully explain and express those things and tell me '…I'm stressed out about something.'…Like he's really grown up and shows so much maturity in his emotional regulation too. And he used to bang his head on the table because he couldn't express himself. (Elementary Caregiver)

When asked what life would be like without mental health support, many students expressed concern that they would not be able to regulate their emotions as well or have the coping tools that they currently have. One student explained, "…I'd be so overwhelmed because there's so much so many things going on… I feel like I just be like, really overwhelmed without it" (Junior High Interview Student). Another student shared:

> Maybe I'd be a little bit more depressed, or I'd be a little bit more anxious about certain things, but now I have actually a way to process my emotions and someone to go to if I ever have a problem. (Junior High Interview Student)

For one caregiver, who's child experienced abuse and trauma, she expressed concern that her child would struggle even more with self-management and disruptive behaviours without mental health support, "It would be total disrespect. Total loath. Total ignorance on [name of child's] part" (Elementary Caregiver). Another caregiver shared similar concerns, explaining that without mental health supports, "I would probably have truancy officers at my door constantly. I honestly would" (Elementary Caregiver)

Therefore, students and caregivers expressed that it was significant and impactful for students to be able to unpack emotions and experiences in a safe space and learn coping tools for

navigating challenges in life. Furthermore, this support and skill development appeared to have a particular impact on students' success in school, which is discussed next.

Improved Coping with School. Students said that when they were able to share and process their emotions with mental health staff, they were better able to focus and engage in school. One student explained, "When I express my feelings to them it makes me, I guess, focus more on school because I don't have to worry…" (Junior High Interview Student). Another student remarked, "It would make me concentrate more on my work…Because you're calmer…your academic reflexes are higher" (Elementary FG Student).

This is significant because it is more difficult and often not realistic to concentrate in class and engage in school when experiencing emotional distress or challenges. A student explained, "…for kids who are going through like really tough times, at times, maybe they can't learn at the moment and it's just nice to go there [to see mental health staff]" (Elementary FG Student). Another student remarked:

> That's really nice [referring to mental heath supports] because, I guess, when you're like having a really hard time, and like, you can't really work, and going to talk about it – it's just nice to get off your chest. So that's what I like because you can get it off your chest. And then you go back to class and you feel like you can actually do work. (Elementary FG Student).

Students also spoke of receiving guidance in setting specific goals and developing skills and tools for managing classes and school. One student explained, "My focus used to be like really difficult for me to like focus on one thing and then [Success Coach] and [school staff] … helped me with that and now I can like pay attention" (Junior High Interview Student). This support is also important because, through improving school management, children and youth

are able to practice life skills and tools such as goal setting and time management that can benefit them in school, as well as life beyond school. A student described this support from mental health staff:

> They have like really good strategies that they use for each individual student. That depends on like, what you're going through. And so mostly [Success Coach] focuses on goal management. And so we create these goals. And we give ourselves like some time, like reasonable time, to complete our goals, and it helps a lot with your time management skills and so forth. (Junior High FG Student)

Some caregivers reflected on the impact of support for their children's progress in school. For example, one caregiver shared that during a difficult period of time her child fell behind in school, however, after receiving support, "She [child] is at her grade level in all subjects, even though she missed half a year" (Elementary Caregiver).

Furthermore, students described receiving support in navigating transitions between schools (i.e., going from elementary to junior high or junior high to high school) or graduating from high school. For example, one student explained that her success coach is, "… helping with high school registrations and getting ready for high school" (Junior High Interview Student). This was described to make students feel more confident and better equipped for the next step in their schooling. The student further explained, "it has built a lot of courage for me…just like get more confident and being able to go make friends and have a good high school experience."

Consequently, students emphasized that mental health supports helped them to develop coping strategies that supported their engagement and success in school. These skills for school management could also be applied to other life experiences. In terms of improved skill

development and coping, students also discussed how this learning translated into healthy action and behaviours in their lives, which is discussed next.

Healthy Action. Another aspect of improved coping shared by students was feeling better supported and equipped to take action that fostered their health and safety. This represents a change in behaviours for some vulnerable students, who, by confiding in a trusted mental health staff, were able to receive the support they needed to work on action that promoted their health and wellbeing and protected their safety.

By talking to a trusted mental health staff, students had the opportunity to share challenges in their life for which they needed support. This could be seen as the first step towards healthy change and making safe decisions. For example, one caregiver explained that by talking to the mental health staff her child, "opened up" and was able to, "…talk about like, things like addiction, like things that he needs to work on…" (Elementary/Junior High Caregiver)

Students and caregivers further shared that mental health staff were able to help students make plans and decisions to support their health and safety. For some students, this might be support and guidance from mental health staff on how to protect their own wellbeing and set boundaries amidst external pressures and environmental factors, such as the role modelling of substance use or unhealthy relationships. This might also involve making safety plans when children are experiencing significant emotional distress or experiencing suicidality. One caregiver commented on the impact of this support for her child:

> …At one point she [child] was…considering self-harm. Right. And, of course, you know, [it was] the success coach who told us about it. …But like without that, you know…maybe like things would have gone downhill instead of getting better. (Elementary Caregiver)

Similarly, a student shared that mental health staff prevented him from, "…going down a bad road" by "…trying to talk me out of doing a lot of things" (Junior High Interview Student). The student explained that without this support, "…I don't think I'd probably be here right now." This was echoed by another student, who also shared that without support, "…I don't think I'd be here right now. Honestly" (Junior High Interview Student).

Consequently, mental health supports were described as critical for helping children and youth to take healthy action and make safe decisions, often amongst challenging circumstances. Overall, with mental health support, students and caregivers explained that they were better able to unpack and regulate their emotions, develop skills and tools to navigate school and life, and take healthy action that benefitted their health and wellbeing.

Improved Family Functioning

Improved family functioning was another key impact of mental health supports discussed by students and caregivers. For some families, this involved support in navigating *Family Relationships* and fostering child-parent dialogue. For other families, this involved support in accessing needed resources to improve overall *Family Wellbeing*.

Family Relationships. Students shared that mental health supports helped them to navigate family dynamics and relationships, such as changes in family structure, complex relationships, or stress and conflict. Students said that this support helped them to unpack and process family dynamics and better navigate their home environments.

For example, one student described receiving support to process changes in family structure and dynamics, following the separation of his parents:

> Well, because my parents aren't together anymore. So [mental health therapist] was always there. Like she's like, she picked me up all the time just to check on me. So, I've

> seen her since I was in grade one. So, she helped me with some mental stuff that was happening. (Elementary FG Student)

Another caregiver shared that mental health staff helped her child with processing the terminal illness and expected passing of a family member:

> There isn't a word, or even a phrase that could even begin to explain my immense gratitude for what's going on. [Family member] is terminally ill. And I've been raising my [child]… And I don't think without the support that we have from the school, and not just even the [in-home family support worker] and the mental health counselor, but the entire staff have really surrounded us and embraced us and supported us. And it's huge. Like, I've never had an experience like this before. Where there's just an outpouring of support. (Elementary Caregiver)

The caregiver further explained, “My [child] sees [mental health therapist]. And she’s helping to prepare [child] for what’s coming.” With mental health support, “we’ve been able to establish a routine. [Name of child] is thriving in her school environment.”

Students and caregivers also described receiving support from mental health staff to navigate family relationships. For example, one student described making a change in her approach in how she interacts with her caregiver in order to ease tension:

> When like my mom's like, trying to argue with me like I just like don't argue back and like just do what she says. And this saves a lot of energy instead of like arguing and going back and forth. (Junior High Interview Student)

Similarly, a caregiver shared that this support helped with family tension, explaining, “it’s definitely been a weird year… He [child] and his step-[parent] aren’t getting along anymore. There’s definitely a wedge between them. There's a wedge between my partner and myself”

(Junior High Caregiver). The caregiver went on to share that mental health support, "… has made things smoother and more tolerable. And we can figure out where we're going and what we want and how can we get there?"

Mental health staff also helped to mediate child-family conversations to promote productive dialogue and positive child-adult relationships. For example, one student explained that the mental health staff was able to help facilitate conversations about sensitive topics, "She [mental health staff] was able to let my parents know what was going on. And I was able to talk to them about it with her in the room, so I was in a safe place" (Junior High Interview Student). Another caregiver shared how mental health staff helped their family meditate conflict:

> [Mental health therapist's] very skillful at handling difficult situations, and difficult personalities. Like she has no trouble with people that like, are argumentative or hostile. Like she can bring them down really well. (Elementary Caregiver)

Furthermore, mental health staff were described as helping to equip children and youth with a voice and a path forward for navigating family dynamics. For example, one caregiver explained that her child was exposed to abuse and the mental health staff, "…advocated so much for him [child]… If she hadn't been there for him, and for me, I'm not sure the situation that he would be in right now" (Elementary Caregiver). The caregiver emphasized that because children are young, their "voice isn't as strong as an adult's [voice]" and that the mental health staff "was his voice" for her child. Therefore, mental health staff can be a key resource for children and youth to navigate complex dynamics, and in some cases, they are children's only support system.

Family Wellbeing. Students also shared that mental health supports improved overall family wellbeing, through supporting family's access to needed resources. As described by one

student, the mental health staff, "…help us get food or like beds or something that we need" (Junior High Interview Student).

While the focus of this research inquiry was the mental health of children and youth, this overlaps with family wellbeing as children and youth's home environment impacts their mental health and wellbeing. Additionally, the wraparound approach of the AIFY model means that multiple supports are triaged in response to child and family needs, with interconnectedness between these supports (e.g., overlap between mental health and other wellbeing-related supports). Therefore, when families receive access to needed resources, this promotes overall family wellbeing and stable home environments for children and youth.

One caregiver described how mental health staff helped their family with needed resources, "I got support for my clothes, my child's school stuff, books, stationery" (Elementary Caregiver). Another caregiver shared:

> They have the person there [that] helps us to go to resources [in-home family support worker]. And [they] helped with clothing and food. Like going to the food bank. And the person that works there, he's really helpful. And he's very support of our family. (Elementary Caregiver)

Another caregiver remarked, "…So far everything I've ever needed that I have gone to [name of school] for has been met" (Elementary/Junior High Caregiver).

This type of support was emphasized to be critical to sustain family wellbeing and access to essential needs, as one caregiver shared:

> We've had a couple of emergencies like with regarding food insecurity. You know, so after the [in-home family support worker] helped us get food bank, we are a bit more secure in food. And that's good for our family and seeing with the clothing, the

> secondhand clothing resources, it's been really good for the kids because they grow fast. And so it's really helped us during our financial, uh, stressful financial time. (Elementary Caregiver)

Additionally, for some families, support was needed to navigate external services or systems, which at times can be confusing and difficult to do without specialized knowledge. One caregiver explained, “She [mental health staff] really helped us to get support… She helped me to give me the motivation to help apply for his [child] disability tax credit stuff… She was super super supportive” (Elementary Caregiver). Furthermore, for caregivers who are newcomers, this support was particularly meaningful. One caregiver shared:

> …My work permit is expiring. Because if my child and I don't have a permit, he can't go to school, and I can't work at the same time. So like that was my fear I still have that fear. But and the school has tried to help me in the immigration, like, make a good support letters and everything so I'm grateful for that. (Elementary Caregiver)

Another caregiver, who is also a newcomer and an English language learner, described receiving support from mental health staff with food, “fruits and vegetables” and also applying “for funds so [child] can keep on playing in the [soccer] club” when their family could no longer afford the soccer fees (Junior High Caregiver). Furthermore, mental health staff went above and beyond to help the caregiver contest a traffic ticket:

> I got a ticket—like a transit ticket. And I got to the judge. And [in-home family support worker]… will come with me. To talk to the judge and explain to him the reason for the infraction. And this will…help. I didn’t ask for it, it just came from [success coach] and [in-home family support worker]. It shows that they are very worried about everything that is related to the family…

The caregiver reflected on the impact of this support, sharing that "We only have thankfulness for [name of school] and all the community" and at one time, "…We had the option to go in another house. But we want to remain in this community so that [our] kid can keep on studying [at] the same school."

Furthermore, although parent and caregiver mental health was not the focus of the study, it was indicated that when caregivers receive mental health support[7], they are able to foster a more stable environment which can promote overall family wellbeing. For example, one caregiver shared that mental health support, "just helped me to be a stronger parent…" (Junior High Caregiver). For another caregiver, mental health supports helped her after leaving an abusive situation, "I had just left my [partner]. …they helped me basically re-find myself" (Elementary Caregiver). Additionally, another caregiver shared the impact of support:

> Like without them, I wouldn't be as good of a parent. … They're very, very helpful… [It] makes me like teary eyed because it's very, very helpful. Like, because I'm a single parent and with their help is made me stronger as a single parent. Yeah, yeah, you guys got some good workers. (Elementary/Junior High Caregiver)

A student also commented on the benefit of mental health supports for her caregiver, "…It's been a good way for my [caregiver]. Because my [caregiver], like, she has like, issues like mental issues… They're like best friends [caregiver and mental health staff]" (Junior High Interview Student).

Consequently, students and caregivers said that mental health supports improved family functioning, through help in navigating child-family relationships, as well as facilitating access

[7]Mental health therapy at AIFY schools is available for both students and their family members.

to needed external resources. Furthermore, it was made clear that when supports help the whole family, children and youth benefit from more stable home environments.

Overall, students and caregivers shared impacts that were integral to the lives and mental health and wellbeing of children and youth. It was made clear that with mental health supports, students are better equipped to navigate daily life and cope with complex circumstances and overall family wellbeing and stability is improved. Students and caregivers emphasized that these supports made significant differences to their lives, and expressed concern that without these supports, children and youth may have experienced more negative outcomes overtime.

In the following chapter, these findings on (1) the mental health concerns that children and youth experience, (2) the factors that impact the use of collaborative school-based mental health services, and (3) the perceived mental health impacts of collaborative school-based approach to mental health services delivery, are discussed in greater detail. Implications and recommendations for future research are outlined.

Chapter 5: Discussion

Effective early mental health interventions are needed to address growing mental health concerns among children and youth and promote healthy development outcomes (WHO, 2022). Therefore, the present study explored the role of collaborative, school-based mental health services in fostering children and youth's mental health. Findings from school cohort data outlined the context and use of mental health services across seven schools. Findings from interview and focus group discussions with students and caregivers addressed three guiding research questions on the mental health concerns experienced by children and youth; factors that facilitate and/or mitigate the use of collaborative, school-based mental health services; and the perceived impact of mental health services. In this chapter, findings are discussed in terms of their significance and implications for research and practice. Study limitations and directions for future research are also presented.

Mental Health Service Use Across Schools

The findings from school cohort data across seven schools indicate high mental health needs among children and youth, as well as a responsiveness in the school wraparound model of support for meeting these needs. Overall, the proportion of students who used mental health services during the 2021–22 school year was substantial, with a little under half the student population (42.7%) indicated to have used any mental health service. The level of service use remained high after calculating students' use of mental health services excluding in-home family support as the only service accessed (38.4%; i.e., excluding cases when in-home family support was not used in combination with other services to allow for a more targeted estimate of service use focused on children and youth's mental health).

The substantial level of service use during the 2021–22 school year suggests that there is a high uptake of, and demand for, mental health services among children and youth. These data indicate that when mental health services are available in schools, children and youth will make use of these supports, likely as a function of them being available. The high use of supports also suggests that many students may have struggled with their mental health and required support. This aligns with existing literature, which documents significant mental health concerns among children and youth, with higher risks for children who experience social vulnerability or marginalization (Georgiades et al., 2019; Smetanin et al., 2011; WHO & CGF; WHO, 2022). Evidence for high mental health needs among students was further reinforced by the finding that 42.2% of students and families who used services went on to access two or more services. This implies that more than one service was needed to address high levels of mental health needs.

The above findings also reflect a responsiveness of the school wraparound model in meetings students' mental health needs. The high level of service use among students and families indicates that school and mental health staff were able to respond to and coordinate appropriate mental health services for students who needed them. Furthermore, the substantial proportion of students accessing multiple services reflects the wraparound approach, in which staff are able to triage multiple support services as needed to support the mental health and development of the whole child (Burns & Goldman, 1999).

Among students who accessed mental health services, rates of service use were equivalent between female and male students (50.2% male, 49.5% female, 0.3% genderqueer). This is interesting to note because gender differences are often seen in mental health service use, with less use among male clients, typically attributed to greater perceived stigma (Chandra et al., 2006; Pattyn et al., 2015). Equivalent mental health service use was also seen among elementary

and junior high students (kindergarten – grade 9; M = 10%, SD = 1.9%, range = 6.3–13%). As younger children are typically less equipped to advocate for their mental health, this likely meant that staff identified younger students who they believed needed additional supports.

Additionally, high service use was reported among students with FNMI (24.5%) refugee (9.5%), ELL (30.1%), and specialized learning needs (18.7%) statuses. This is notable because it is demonstrated in literature that children and youth who are newcomers or have minoritized identifies often face added barriers to accessing mental health services (Faber et al., 2023; Kamali et al., 2022). Common barriers may include economic disadvantage, a lack of knowledge about available supports, fear of stigma, and/or language barriers (Ali et al., 2019; Faber et al., 2023; Statistics Canada, 2019; Zifkin et al., 2021). Therefore, high rates of service use among these groups may reflect the responsiveness of school and mental health staff to identify and reach out to vulnerable students who could benefit from support.

Another factor to consider when looking at service use rates is the structure and delivery of mental health services. Mental health services were accessed most often in individual or combined individual and group settings (72.9%) and by informal clients on a short-term basis (75.1%). As the majority of students received support as an informal client, this suggests most mental health services were accessed on an as-needed basis, in response to emerging needs or critical incidents. This likely reflects a limited capacity among mental health staff to address the needs of all students and take on long-term clients, a challenge that is well-documented in previous literature (Canadian Psychological Association, 2022; People for Education, 2019; Zifkin et al., 2021). Therefore, by working with students on a short-term basis, mental health staff may have been able to leverage limited staff capacity and resources to support larger numbers of students and families and meet a high demand for mental health support.

Mental Health Concerns: A Critical Need for Support

Findings from interview and focus group discussions built on school cohort data to shed light on the experiences of students and caregivers in accessing collaborative-school based mental health services. The first research question explored the mental health concerns experienced by children and youth. In response, two overarching themes were identified, including *Coping with Multi-Faceted Needs and Experiences* and the *Impact of the COVID Pandemic on Wellbeing*.

Coping with Multi-Faceted Needs and Experiences

In interviews and focus group discussions, study participants shared that children and youth often struggled with complex and multi-faced mental health concerns. In turn, they said mental health supports are critically needed to help children and youth with coping and functioning in school and life, as well as with complex and challenging experiences. These findings build on previous literature which outlines the burden of unmet mental health needs on children and youth and the need for early mental health supports (Costello et al., 2014; Georgiades et al., 2019; Smetanin et al., 2011; WHO & CGF, 2014).

The study participants shared personal examples of struggling with mental health, such as symptoms of anxiety, depression, and trauma. For some students, their mental health was affected because they felt overwhelmed with different personal, school, friend, and family challenges, and needed help to process and navigate their experiences. For other families, they experienced the added burden of unmet needs and/or adverse childhood experiences. This included experiences of poverty and instability, such as living in a car or women's shelter and not being able to afford needed medication. It also included cases of physical or emotional abuse and neglect, as well as the role modelling of unhealthy behaviours such as substance misuse.

Unfortunately, as indicated by participants, these experiences are not uncommon and a high prevalence of childhood poverty (8.5%) and abuse (30%) is documented across Canada (Afifi et al., 2024; Statistics Canada, 2022b).

Study participants also spoke about the emotional distress associated with poor mental health. This included feelings of stress, suffering, and being at the brink of an emotional breakdown. Not all children and youth felt that they had a safe place, at home or elsewhere, to understand and process these emotions. Furthermore, study participants also expressed concern for children and youth's long-term outcomes if mental health concerns are left unsupported. These concerns are validated by literature (Shonkoff et al., 2009). Specifically, it is well-established that childhood involves a sensitive period of social, emotional, and cognitive development, in which children undergo the process of learning from their peers, adults, and experiences, and make a transition into adulthood (Shonkoff et al., 2009). Adversity and poor mental health can be disruptive to healthy developmental mechanisms (Shonkoff et al., 2009; 2012). In turn, untreated mental health concerns are associated with increased risks for distress, impaired functioning in school and life, and long-term health and socio-economic risks in adulthood (Hale et al., 2015; Shonkoff et al., 2009; 2012; WHO & CGF, 2014).

Therefore, the study findings underscore the critical need for early supports to meet the mental health of children and youth in order to relieve emotional distress, and promote functioning in school and life, healthy development, and long-term health outcomes (Costello et al., 2014; Georgiades et al., 2019; Smetanin et al., 2011; WHO, 2014). Additionally, due to the complex interplay between mental health and adverse environmental factors (e.g., unmet needs, abuse), findings also emphasize the value of wraparound interventions, which take an ecological approach and consider children and youth's mental health needs in relation to the different

contexts that affect them, such as family wellbeing, home stabilization, and access to critical resources (Bruns & Walker, 2008; Burns & Goldman, 1999).

Impact of the COVID Pandemic on Wellbeing

The detrimental impact of the COVID-19 pandemic on children and youth's mental health was also evident in discussions with students and caregivers. Study participants explained that the pandemic made their experiences in school and life more difficult and compounded the need for mental health supports. This builds on emerging literature exploring the effects of the pandemic (Brooks et al., 2020; Chanchlani et al., 2020; Crawley et al., 2020).

Study participants spoke to challenges sustained during the pandemic with remote learning and isolation. They said school was challenging due to barriers in technology and access to online learning platforms, disruption to their routines, and reduced access to social support. Recent literature has affirmed these challenges, with effects being the most pronounced for families facing social vulnerability and economic disadvantage (Abrams et al., 2022; Bonal & González, 2020; Crawley et al., 2020; Engzell et al., 2021; Whitley et al., 2022). Furthermore, the stress and challenges experienced during the pandemic have been linked to a greater prevalence of abuse at home and worsened mental health outcomes among children, youth, and families, including increased symptoms of depression, anxiety, and suicidality (Abrams et al., 2022; Bryant & Damian, 2020; MHCC, 2020; MHCC, 2021).

Study participants also said that the transition back to in-person instruction was difficult after prolonged periods of remote learning and isolation. Participants cited concerns such as diminished regulation and coping skills, increased school pressure, academic learning gaps, and social anxiety. Early research affirms that children and youth faced challenges in their transition back to in person school (Bonal & González, 2020; Engzell et al., 2021). Some early literature

has also noted changes in emotional regulation skills and social anxiety associated with the pandemic (Bonal & González, 2020; Charmaraman et al., 2022; Kindred & Bates, 2023). Additionally, emerging research shows evidence for learning gaps, with greater losses for socially vulnerable children and youth (Bonal & González, 2020; Engzell et al., 2021; Whitley et al., 2022). In response to these findings, many authors have expressed concern that learning losses could result in decreased school performance and graduation rates, and ultimately lead to increased social and health disparities overtime (Bonal & González, 2020; Engzell et al., 2021; Whitley et al., 2022).

Consequently, these findings reveal that the pandemic has aggravated mental health concerns among children and youth and often made school experiences more difficult (Brooks et al., 2020; Chanchlani et al., 2020; Crawley et al., 2020). This further underscores the critical need for early interventions to support children and youth and promote positive outcomes.

Factors that Impact Mental Health Service Use: Enablers and Barriers

To understand how collaborative, school-based mental health services can be most responsive to the needs of children and youth, the second research question explored the factors that facilitate and/or mitigate the use of mental health services. In response, three overarching themes were identified, including a *School Culture of Support*, *School Communication,* and *Stable and Well-Resourced Staff*. All of these themes were both facilitators and barriers to mental health service use because their presence promoted access to services, while the absence of one of these factors mitigated service use.

School Culture of Support and School Communication

Students and caregivers indicated that a school culture of support and trauma-informed care promoted their access to mental health services because children, youth, and families felt

safe to reach out to supportive school staff for help who, in turn, are receptive to their needs and able to connect them with mental health support. This finding aligns with existing literature, which demonstrates the benefit of trauma-informed care and positive child-adult relationships in schools for students' functioning and wellbeing (Anderson et al., 2015; Shonkoff et al., 2012), as well as their access to mental health support (Halladay et al., 2020; Mariu et al., 2011).

As shared by participants, it is often the case that children are exposed to significant adversity in their lives (Giano et al., 2020). In response to overwhelming trauma, children frequently experience emotional dysfunction and cope in maladaptive ways, such as with disruptive or withdrawn conduct (Anderson et al., 2015; Shonkoff et al., 2012). Without training on the mechanisms of trauma and supportive strategies, school staff may respond to these maladaptive behaviours with punitive action, due to perceived disrespect or defiance rather than recognizing behaviours as a trauma-response and a sign of adversity at home (Anderson et al., 2015; Brunzell et al., 2015). For example, a study found that, even after preliminary trauma-informed training, school staff often felt that it was "necessary" to take disciplinary action to quell challenging student behaviours (Anderson et al., 2015, pg. 129). Alternatively, research demonstrates that when schools fully embrace and integrate trauma-informed care, this functions to foster a safe, predictable, and supportive environment for all children, promoting student resilience, as well as positive child-adult relationships (Anderson et al., 2015; Brunzell et al., 2015; Shonkoff et al., 2012).

Participants in the study noticed the supportive culture cultivated by their school and described feeling safe to reach out to school staff for support, who they said were receptive to their mental health needs. This builds on previous literature noting the connection between supportive school relationships and help-seeking behaviours for mental health (Halladay et al.,

2020; Mariu et al., 2011). Specifically, a recent study conducted with 31,120 students from 248 schools in Ontario found that students (grades 6–12) reported a greater intention of seeking mental health support when students perceived their teacher to be responsive to their emotional needs and felt that they had a quality relationship with their teacher (Halladay et al., 2020). Consequently, study findings underscore the importance of robust and ongoing school training in trauma-informed care and supportive practices to foster and maintain a school culture of support (Anderson et al., 2015; Ko et al., 2008) and promote help-seeking behaviours (Halladay et al., 2020; Mariu et al., 2011).

Students and caregivers also emphasized that clear communication and messaging from the school about what mental health services are available further enabled their access to mental health services. As indicated by participants, it may not be obvious to families that school can be a place that they can turn to for support. This is because the role of school has been to provide academic instruction, rather than support the development of the whole child (Yu et al., 2020). Therefore, participants indicated that without clear communication from their school, students and families are often unaware of the supports available.

A lack of knowledge about available mental health supports has been confirmed in literature to be a significant barrier to receiving mental health support (Statistics Canada, 2019). For example, a study in 2018 found that 78.2% of Canadians with unmet mental health needs reported personal barriers to receiving mental health support, including not knowing where to go for support and not being able to pay for mental health services (Statistics Canada, 2019). This has been suggested to be particularly the case for children and youth (Zifkin et al., 2021). In fact, in a recent 2021 study, youth (aged 12–18) identified a lack of knowledge as a key barrier they experienced in getting support for their mental health (Zifkin et al., 2021).

It should also be noted that limited school communication about available mental health services could potentially, in some cases, be intentional by the school in order to limit the caseload of mental health staff and preserve capacity for students with the highest levels of needs. Although it is necessary to protect mental health staff against becoming overburdened by caseloads and burnt out (Morse et al., 2012), the act of gatekeeping knowledge about available mental health services runs the risk of excluding students with severe mental health needs. In such cases, it becomes the role of school and mental health staff to identify students with mental health needs, which can be difficult to do with limited time, and for school staff, inadequate training and support (Halladay et al., 2020). Therefore, according to study participants, their mental health needs were best served when they had the opportunity to self-refer for mental health supports and did not need to rely on being identified to require support by school staff.

Overall, a school culture of support and communication was described to promote trust and connectedness between students, families, and their school. This may be particularly meaningful for vulnerable school communities. As discussed by some participants, many families and communities feel distrust towards schools due to past maltreatment at the hands of these institutions (Hackett et al., 2016). Based on these dynamics, families may be hesitant to trust their school for support. In fact, struggling families may intentionally become more disconnected from school for fear of consequence (e.g., fear that the school may become aware of unstable home situations and call child welfare services). However, by building positive school connections, through supportive relationships and communication, families may feel more comfortable to rely on schools as a resource for support, and in turn, access mental health services (Halladay et al., 2020; Mariu et al., 2011).

Stable and Well-Resourced Staff

Students and caregivers also explained that staff resourcing, and stability, is critical to mental health service access. When there are sufficient mental health staff available at schools over the long-term, children and families are better able to access mental health supports when needed. However, participants said that when this is lacking, the availability of support becomes more limited and restrictive.

Unfortunately, participants indicated that the capacity of mental health staff was rarely adequate for their schools, even when their school had a complete workforce of three part-time mental health staff (i.e., mental health therapist, success coach, and in-home family support worker). This is consistent with literature across Canada suggesting that school mental health supports are generally insufficient (CPA, 2022; People for Education, 2019). For example, as of 2019 only 33% of schools in Ontario reported receiving regular access to a school psychologist (i.e., based on psychologists spending approximately 5 hours a week in schools) and 21.5% of schools reported receiving no access to a psychologist (People for Education, 2019). Additionally, evidence shows that mental health services provided outside of schools (i.e., community-based centers) are also failing to meet the demands for support (Children Mental Health Ontario, 2020; Faber et al., 2023). A 2020 study of close to 100 mental health centers across Ontario found that children and youth were waiting on average over two months for services, with wait times reaching up to 2.5 years (Children Mental Health Ontario, 2020).

According to study participants, limited staff capacity meant that children and families who are struggling may not be able to see mental health staff when needed. Additionally, mental health staff may quickly become overburdened in trying to address the needs of students beyond their capacity (CPA, 2022; Morse et al., 2012). This is linked to burn out and an increased

potential for staff to leave their workplace or field (CPA, 2022; Morse et al., 2012). Likewise, students and caregivers observed high turnover among mental health staff at their schools. Participants indicated that this was often disappointing or challenging when they temporarily lost access to mental health support.

Therefore, study findings suggest that resources need to be invested in school mental health supports, so that mental health staff are better equipped with the capacity and resources to support students, in turn, promoting students' access to mental health support. School-community models, such as the AIFY model, have been noted in literature as cost effective strategies for delivering mental health services, because they involve leveraging shared resources between schools and community partners (Anderson-Butcher & Ashton, 2004; Atkins et al., 2017). That being said, study participants identified significant constraints for resources and funding. Therefore, a critical need for investing in early mental health supports remains a priority. This recommendation has also been validated by a substantial body of research and echoed by advocacy groups throughout Canada (see CFC, 2022; Children Mental Health Ontario, 2020; CPA, 2022; Faber et al., 2023; People for Education, 2019; Waddell et al., 2019).

Impact of Mental Health Services: Meaningful Impacts on Children's Lives

Finally, the third research question explored the perceived mental health impacts of collaborative school-based mental health services among children and youth. In response, three overarching themes were identified, including being *Supported by a Safe and Caring Adult*, *Improved Capacity for Coping in School and Life*, and *Improved Family Functioning*.

Safe and Caring Adult and Improved Capacity for Coping in School and Life

Study participants discussed the ways in which mental health services affected their lives. First and foremost, students consistently shared that mental health staff was often their safe and

caring person that they could go to when needed. For some, this may be one of the few trusted adults in their lives. This is a significant impact because research shows that positive child-adult relationships are key for healthy childhood development and can function as a protective factor that promotes resilience (Armstrong et al., 2005; Bernat & Resnick, 2006). Positive child-adult relationships are also shown to protect against poor mental health outcomes and risky behaviours, such as emotional distress, suicidal ideation, peer bullying, substance misuse, and unsafe sexual practices (Bernat & Resnick, 2006; Brown et al., 2016; Sieving et al., 2017; Steiner et al., 2019). As such, the experience of a safe and caring relationship with mental health staff may benefit students alone (Bernat & Resnick, 2006), regardless of the actual skills and tools they are able to acquire through mental health sessions.

That being said, participants also described acquiring coping skills through working with mental health staff, which were also emphasized to have a significant impact. After receiving mental health support, students explained that they experienced less emotional distress and were better able to process their emotions, engage in school, cope with life circumstances, and take action that fostered their health and safety (e.g., make safe decisions, set boundaries, etc.). Similar findings have been proposed by previous literature exploring the effects of school mental health interventions (Fazel et al., 2014; García-Carrion et al., 2019; Hoover & Bostic, 2021). These impacts are meaningful because reduced emotional distress and improved functioning can vastly improve children's quality of life (WHO, 2022).

Additionally, these findings are also significant because they have several long-term implications. As described previously, most mental disorders have their onset in childhood; therefore, by developing tools and coping strategies young, children and youth may be better equipped with self-management tools to cope with later life circumstances and to manage mental

health concerns before they manifest in more serious ways (Government of Canada, 2006). Additionally, through improved engagement in school, students may also be better positioned to succeed academically and graduate, which are linked to later positive health and socio-economic outcomes (Belfield & Levin, 2007; Case et al., 2005; Hale et al., 2015). Consequently, these findings have the potential to not only help children and youth in the short-term, but also to shape their transition into adulthood (Lim et al., 2008; Smetanin et al., 2011).

Improved Family Functioning

Students and caregivers also shared that support from mental health staff helped to improve overall family functioning, including family relationships and access to needed resources (e.g., food, clothing, shelter). This is impact is significant because literature shows that children and youth are best able to achieve mental health and wellbeing in home environments that are stable and secure (Armstrong et al., 2005).

Study participants shared different examples of how mental health supports helped their families. For some, this involved support in navigating complex child-family dynamics, such as relationship conflict, abuse or child maltreatment, and/or changes in family structure through separation, divorce, or the loss of a loved one. Participants said that mental health staff helped to mediate child-family conversations, foster productive dialogue, and develop tools for managing tension, conflict, and change. For other families, support was received to access resources to address unmet needs, such as food, clothing, shelter, and medication. This sometimes involved support in navigating external service systems, which can be difficult and confusing for families due to barriers such as lack of knowledge, limited time, or ELL status (Sanchez et al., 2018).

Overall, participants indicated that a whole-family engagement approach to mental health support was meaningful for promoting overall family wellbeing and child and youth's mental

health. This builds on previous literature which demonstrates the value of home stabilization for positive children and youth mental health outcomes (Armstrong et al., 2005; Bernat & Resnick, 2006). Specifically, the presence of economic stability, family cohesion, and caregiver mental health and parenting capacity are noted to benefit children and youth's wellbeing, while the lack or reverse of these factors (e.g., economic insecurity, family conflict, poor caregiver mental health, and ACEs) are risk factors to healthy development and mental health (Armstrong et al., 2005; Bernat & Resnick, 2006; Cappella et al., 2008). Consequently, these findings reaffirm the value of the wraparound approach in fostering children and youth's mental health, which takes an ecological approach to considering family and environmental contexts in the provision of support (Bruns & Walker, 2008; Burns & Goldman, 1999). This is also reinforced by growing body of literature on ecological approaches to mental health interventions (Atkins et al., 2017; Cappella et al., 2008; García-Carrion et al., 2019). For example, a recent systematic review found that school interventions focusing on interactions with school and family and community contexts were associated with decreased symptoms of anxiety and improved social skills and personal wellbeing among children and youth (García-Carrion et al., 2019). Therefore, findings reinforce the importance of a whole-child approach to mental health support, which centers the child in the context of their environment and family needs (Bruns & Walker, 2008; Burns & Goldman, 1999).

Limitations and Future Research

It is important to reflect on the limitations of the present study and potential directions for future research. First, the participant sample included in this study was substantial, with 69 participants across seven schools, allowing for the inclusion of a wide array of unique and diverse participants experiences. However, socio-demographic variables were not tracked across

interview and focus group participants. Instead, school cohort data was used to assess overall trends in mental health service use and associated socio-demographics. Due to this, interview and focus group data were not analyzed from a health equity lens. Future research could focus on the experiences of equity-deserving groups, including FNMI, racially/ethnically diverse, and visible minority students, as well as minoritized students based on gender, sexual orientation, or disability. This would help to inform the cultural responsiveness of school mental health interventions and its ability to support students with different backgrounds.

Additionally, although the study sample was large and diverse, the study is situated in the local context of the AIFY school-community wraparound program in Edmonton, Canada. Therefore, contextual factors need to be considered when applying findings to other settings. According to literature, programs and practices should be adapted according to their local context, as this allows programs to build on the strengths and experiences of local partners (Brun & Walker, 2008; Burns & Goldman, 1999). The findings of the present study will be most relevant to similar mental health interventions that involve school-community partnerships of wraparound support serving children and families in communities with high social vulnerability.

Finally, the present study was completed as a secondary analysis. Although, I was involved in the primary data generation, which allowed me to gain a rich understanding of the context of the AIFY program and school partners' experiences, the secondary design involved limitations because data were collected according to prescribed standards for the purpose of evaluating the overall impact of the AIFY program (Heaton, 2008). Original data generation would be recommended in the future to address this research inquiry. In particular, future research could measure and track changes in students' scores for mental health before and after engagement with mental health support. This would build on participants' lived experiences

shared through interviews and focus groups, and provide more insight into the impacts of collaborative, school-based mental health services.

Conclusion

Responding to the mental health needs among children and youth remains a critical public health challenge (Georgiades et al., 2019; WHO, 2022). The lack of early and effective mental health supports for children across Canada has been called a "national failure" (Vaillancourt, 2021, pg. 1630). Additionally, more research is needed to guide the development and implementation of early interventions so that they effectively address the mental health needs of children and youth (Dray et al., 2017; Sanchez et al., 2018; Van Loon et al., 2020). Therefore, the present study explored the role of collaborative, school-based mental health services in fostering children and youth's mental health, as implemented through the AIFY program. Using a multiple methods secondary analysis, school cohort data were analyzed across seven schools and students and caregivers were engaged through interviews and focus groups.

The findings from the present study confirm that many children and youth experience complex mental health concerns (Georgiades et al., 2019; Smetanin et al., 2011; WHO & CGF, 2014), which have been compounded by the recent COVID-19 pandemic (Brooks et al., 2020; Chanchlani et al., 2020; Crawley et al., 2020). This emphasizes the critical need for effective and early mental health supports to address child and youth mental health concerns (Georgiades et al., 2019; Smetanin et al., 2011; WHO & CGF, 2014). Furthermore, due to the multi-faceted and interconnected nature of many children and youth's mental health concerns, findings also underscore the need for wraparound interventions which take an ecological approach and consider the wider contexts that affect mental health needs, such as home life, family stability, and access to critical resources (Bruns & Walker, 2008; Burns & Goldman, 1999).

Several factors were identified in the study that make school-based mental health services more accessible for children and families. First, a supportive school culture was indicated to foster safe and positive child-adult relationships, in which children and youth can feel comfortable to share their mental health concerns with staff, and in turn, seek mental health support (Halladay et al., 2020). Due to this, providing consistent and comprehensive training in trauma-informed care is important for maintaining supportive school practices (Anderson et al., 2015). Additionally, clear communication and messaging from the school about what mental health services are available was also identified to be important for removing barriers to support (Statistics Canada, 2019; Zifkin et al., 2021). Specifically, with adequate school communication, children and families were equipped with knowledge about the supports available so that they could self-refer for support if needed, improving their access to mental health services (Statistics Canada, 2019; Zifkin et al., 2021).

Sufficient funding and resources for mental health staff was another critical factor identified as important for access to mental health supports. School-community models, such as the AIFY model, have been noted in literature as cost effective strategies for delivering mental health services because they involve leveraging shared resources between schools and community partners (Anderson-Butcher & Ashton, 2004; Atkins et al., 2017). That being said, study participants continued to experience resource constraints as a barrier to accessing support because mental health staff had a limited capacity for taking on additional clients and experienced burnout and staff turnover. Therefore, greater funding needs to be invested in early intervention programs so that they are better equipped to support children and youth's mental health (CFC, 2022). This call for investment has been echoed by research and advocacy groups across Canada (CFC, 2022; CPA, 2022; People for Education, 2019; Waddell et al., 2019).

Finally, the study findings also provided insights into the impacts that school-based mental health supports have on the lives of children and youth. Study participants explained that mental health staff were safe and caring persons in the lives of children. This is significant because positive child-adult relationships are key for healthy child development, as well a protective factor again poor mental health outcomes and risky health behaviours (Armstrong et al., 2005; Bernat & Resnick, 2006). Additionally, after receiving mental health support, children and youth described feeling better equipped to process their emotions, cope in school and life, and take action that fostered their health and safety (e.g., make safe decisions and set boundaries). This is also significant because developing healthy coping skills may have meaningful short-term and long-term effects (Belfield & Levin, 2007; Case et al., 2005; Hale et al., 2015). Improved self-regulation and coping skills in the short-term can reduce immediate distress and improve functioning in school and life (Belfield & Levin, 2007; Case et al., 2005; Hale et al., 2015). Over the long-term, improved coping may promote positive effects on health and socio-economic outcomes (Belfield & Levin, 2007; Case et al., 2005; Hale et al., 2015).

Participants also said that the mental health supports helped to support children and youth's mental health and wellbeing through home stabilization. Participants described receiving support for navigating family relationships and complex dynamics, as well as access to critical resources, such as food, medicine, clothing, and housing. These findings, again, underscore the value of taking an ecological, wraparound approach to fostering children and youth's mental health, in which students' mental health is considered within the different contexts that affect them (Bruns & Walker, 2008; Burns & Goldman, 1999; García-Carrion et al., 2019). Through this holistic, whole-child approach to mental health support, students and families experienced improved family relationships, parenting capacity, and access to needed resources, which

ultimately benefits children's everyday functioning and mental health (Armstrong et al., 2005; Bernat & Resnick, 2006).

Overall, the study findings demonstrate that school-based mental health services which recruit school-community partnerships on the delivery of services and take an ecological, wraparound approach are beneficial and important for meeting the mental health needs of children and youth. This research adds to the evidence base on the potential for early mental health supports to create meaningful change in the lives of children and youth (Fazel et al., 2014; García-Carrion et al., 2019; Hoover & Bostic, 2021). Importantly, this research also reinvigorates the call to action for a greater investment of funding and resources in early mental health supports in order to support children and youth in reaching their full potential (CFC, 2022; CPA, 2022; People for Education, 2019; Waddell et al., 2019).

References

Abrams, E. M., Greenhawt, M., Shaker, M., Pinto, A. D., Sinha, I., & Singer, A. (2022). The COVID-19 pandemic: Adverse effects on the social determinants of health in children and families. *Annals of Allergy, Asthma & Immunology*, *128*(1), 19–25. https://doi.org/10.1016/j.anai.2021.10.022

Afifi, T. O., MacMillan, H. L., Boyle, M., Taillieu, T., Cheung, K., & Sareen, J. (2014). Child abuse and mental disorders in Canada. *Canadian Medical Association Journal*, *186*(9), E324–E332. https://doi.org/10.1503/cmaj.131792

Ali, M. M., West, K., Teich, J. L., Lynch, S., Mutter, R., & Dubenitz, J. (2019). Utilization of mental health services in educational setting by adolescents in the United States. *Journal of School Health, 89*(5), 393–401. https://doi.org/10.1111/josh.12753

Allen, J. A. (1994). The constructivist paradigm: Values and ethics. *Journal of Teaching in Social Work*, 8(1/2), 31–54. https://doi.org/10.1300/J067v08n01_03

All in for Youth, The Community-University Partnership, & The University of Alberta Faculty of Extension. (2018). *AIFY Year 1 (Sept. 2016 – Jul. 2017): Final Report*.

All in for Youth & The Community-University Partnership. (2022). *AIFY Year 5 Evaluation Report*. https://ualberta.ca/community-university-partnership/research/evaluation/cup-aify-year-5-report_final_mar-2022.pdf

All in for Youth & The Community-University Partnership. (2023). *AIFY Year 6 Evaluation Report*. https://www.ualberta.ca/community-university-partnership/research/evaluation/aify_y6_evalreport_mar-2023.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). https://doi.org/10.1176/appi.books.9780890425787

Anderson-Butcher, D., & Ashton, D. (2004). Innovative models of collaboration to serve children, youths, families, and communities. *Children & Schools, 26*(1), 39–53. https://doi.org/10.1093/cs/26.1.39

Anderson, E. M., Blitz, L. V., & Saastamoinen, M. (2015). Exploring a School-University Model for Professional Development with Classroom Staff: Teaching Trauma-Informed Approaches. *School Community Journal*, *25*(2), 113–134. https://files.eric.ed.gov/fulltext/EJ1085667.pdf

Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. T. (2005). Pathways between social support, family well being, quality of parenting, and child resilience: What we know. *Journal of Child and Family Studies*, *14*, 269–281. https://doi.org/10.1007/s10826-005-5054-4

Atkins, M. S., Cappella, E., Shernoff, E. S., Mehta, T. G., & Gustafson, E. L. (2017). Schooling and children's mental health: Realigning resources to reduce disparities and advance public health. *Annual Review of Clinical Psychology*, *13*, 123–147. https://doi.org/10.1146/annurev-clinpsy-032816-045234

Belfield & Levin (Eds.). (2007). *The price we pay: Economic and social consequences of inadequate education*. Brookings Institution Press. https://www.jstor.org/stable/10.7864/j.ctt126269

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bernat, D. H., & Resnick, M. D. (2006). Healthy youth development: Science and

strategies. *Journal of Public Health Management and Practice*, *12*, S10–S16. https://doi.org/10.1097/00124784-200611001-00004

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly*, *33*(1), 137–146. https://doi.org/10.1037/spq0000256

Bonal, X., & González, S. (2020). The impact of lockdown on the learning gap: family and school divisions in times of crisis. *International Review of Education*, *66*, 635–655. https://doi.org/10.1007/s11159-020-09860-z

Bowden, A. B., Shand, R., Levin, H. M., Muroga, A., & Wang, A. (2020). An economic evaluation of the costs and benefits of providing comprehensive supports to students in elementary school. *Prevention Science*, *21*, 1126–1135. https://doi.org/10.1007/s11121-020-01164-w

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, *395*(10227), 912–920. https://doi.org/10.1016/S0140-6736(20)30460-8

Brown, S. M., & Shillington, A. M. (2017). Childhood adversity and the risk of substance use and delinquency: The role of protective adult relationships. *Child Abuse & Neglect*, *63*, 211–221. https://doi.org/10.1016/j.chiabu.2016.11.006

Bruns, E. J., Suter, J. C., Force, M. M., & Burchard, J. D. (2005). Adherence to wraparound principles and association with outcomes. *Journal of Child and Family Studies*, *14*, 521–534. https://doi.org/10.1007/s10826-005-7186-y

Bruns, E. J., & Walker, J. S. (Eds.). (2008). *The resource guide to wraparound*. National Wraparound Initiative. https://nwi.pdx.edu/NWI-book/Chapters/COMPLETE-RG-BOOK.pdf

Brunzell, T., Waters, L., & Stokes, H. (2015). Teaching with strengths in trauma-affected students: A new approach to healing and growth in the classroom. *American Journal of Orthopsychiatry*, *85*(1), 3–9. https://psycnet.apa.org/doi/10.1037/ort0000048

Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S193–S194. https://doi.org/10.1037/tra0000711

Burns, B., & Goldman, S. K. E. (Eds.) (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of Care, Promising Practices in Mental Health, 1998 Series, Volume IV*. Center for Effective Collaboration and Practice, American Institutes for Research. https://eric.ed.gov/?id=ED429422

Cappella, E., Frazier, S. L., Atkins, M. S., Schoenwald, S. K., & Glisson, C. (2008). Enhancing schools' capacity to support children in poverty: An ecological model of school-based mental health services. *Administration and Policy in Mental Health and Mental Health Services Research*, *35*, 395–409. https://doi.org/10.1007/s10488-008-0182-y

Canadian Psychological Association. (2022). *Mental health care for Canadian children and youth: The role of school psychologists*. https://cpa.ca/docs/File/Position/Mental%20Health%20Care%20for%20Canadian%20Children%20and%20Youth%20-%20FINAL%20EN.pdf

Case, A., Fertig, A., & Paxson, C. (2005). The lasting impact of childhood health and circumstance. *Journal of Health Economics, 24*(2), 365–389. https://doi.org/10.1016/j.jhealeco.2004.09.008

Chanchlani, N., Buchanan, F., & Gill, P. J. (2020). Addressing the indirect effects of COVID-19 on the health of children and young people. *Canadian Medical Association Journal*, *192*(32), e921–e927. https://doi.org/10.1503/cmaj.201008

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of adolescent health*, *38*(6), 754-e1–754.e8. https://doi.org/10.1016/j.jadohealth.2005.08.011

Charmaraman, L., Lynch, A. D., Richer, A. M., & Zhai, E. (2022). Examining early adolescent positive and negative social technology behaviors and well-being during the COVID-19 pandemic. *Technology, Mind, and Behaviour, 3*(1). https://doi.org/10.1037/tmb0000062

Children First Canada. (2021). *Raising Canada 2021 – Top 10 threats to childhood in Canada: Recovering from the impacts of COVID-19*. https://childrenfirstcanada.org/wp-content/uploads/2021/11/CFC-RC-Report-2021_Final.pdf

Children First Canada. (2022). *Raising Canada 2021 – Top 10 threats to childhood in Canada: Inequity and the Impacts of COVID-19*. https://childrenfirstcanada.org/wp-content/uploads/2022/09/RC2022_CFC_RC-Report_09-02.pdf

Collins, S., Woolfson, L. M., & Durkin, K. (2014). Effects on coping skills and anxiety of a universal school-based mental health intervention delivered in Scottish primary schools. *School Psychology International*, *35*(1), 85–100. https://doi.org/10.1177/0143034312469157

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89–91. https://doi/org/10.1188/14.ONF.89-91

Costello, E. J., He, J. P., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2014). Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey–Adolescent. *Psychiatric services*, *65*(3), 359–366. https://doi.org/10.1176/appi.ps.201100518

Crawley, E., Loades, M., Feder, G., Logan, S., Redwood, S., & Macleod, J. (2020). Wider collateral damage to children in the UK because of the social distancing measures designed to reduce the impact of COVID-19 in adults. *BMJ Paediatrics Open*, *4*(1). http://dx.doi.org/10.1136/bmjpo-2020-000701

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Sage Publications.

Dray, J., Bowman, J., Campbell, E., Freund, M., Hodder, R., Wolfenden, L., Richards, J., Leane, C., Green, S., Lecathelinais, C., Oldmeadow, C., Attia, J., Gillham, K., & Wiggers, J. (2017). Effectiveness of a pragmatic school-based universal intervention targeting student resilience protective factors in reducing mental health problems in adolescents. *Journal of Adolescence, 57*(1), 74–89. https://doi.org/10.1016/j.adolescence.2017.03.009

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The

impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child development*, *82*(1), 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x

Eber, L., Sugai, G., & Smith, C. (2002). Wraparound and positive behavioral interventions and supports in the schools. *Journal of Emotional and Behavioural Disorders*, *10*(3), 171–180. https://doi.org/10.1177/10634266020100030501

Engzell, P., Frey, A., & Verhagen, M. D. (2021). Learning loss due to school closures during the COVID-19 pandemic. *Proceedings of the National Academy of Sciences*, *118*(17). https://doi.org/10.1073/pnas.2022376118

Faber, S. C., Osman, M., & Williams, M. T. (2023). Access to mental health care in Canada. *International Journal of Mental Health*, 1–23. https://doi.org/10.1080/00207411.2023.2218586

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric services*, *54*(1), 60–66. https://doi.org/10.1176/appi.ps.54.1.60

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, *1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fryers, T., & Brugha, T. (2013). Childhood determinants of adult psychiatric disorder. *Clinical Practice and Epidemiology in Mental Health, 2013, 9*, 1–50. https://doi.org/10.2174%2F1745017901309010001

García-Carrión, R., Villarejo-Carballido, B., & Villardón-Gallego, L. (2019). Children and adolescents mental health: a systematic review of interaction-based interventions in schools and communities. *Frontiers in Psychology*, *10*, 918. https://doi.org/10.3389/fpsyg.2019.00918

Gassman-Pines, A., Ananat, E. O., & Fitz-Henley, J. (2020). COVID-19 and parent-child psychological well-being. *Pediatrics*, *146*(4). https://doi.org/10.1542/peds.2020-007294

Georgiades, K., Paksarian, D., Rudolph, K. E., & Merikangas, K. R. (2018). Prevalence of mental disorder and service use by immigrant generation and race/ethnicity among US adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(4), 280–287. https://doi.org/10.1016/j.jaac.2018.01.020

Georgiades, K., Duncan, L., Wang, L., Comeau, J., Boyle, M. H., & 2014 Ontario Child Health Study Team. (2019). Six-month prevalence of mental disorders and service contacts among children and youth in Ontario: Evidence from the 2014 Ontario Child Health Study. *Canadian Journal of Psychiatry, 64*(4), 246–255. http://doi.org/10.1177/0706743719830024

Giano, Z., Wheeler, D. L., & Hubach, R. D. (2020). The frequencies and disparities of adverse childhood experiences in the US. *BMC Public Health*, *20*(1327). https://doi.org/10.1186/s12889-020-09411-z

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in

qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), 291–295. https://doi.org/10.1038/bdj.2008.192

Government of Canada. (2006). *The human face of mental health and mental illness in Canada*. Canada Minister of Public Works and Government Services of Canada. https://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf

Government of Manitoba. (2019). *Smudging protocol and guidelines*. Manitoba Education and Training. https://www.edu.gov.mb.ca/iid/publications/pdf/smudging_guidelines.pdf

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11*(3), 255–274. https://doi.org/10.3102/01623737011003255

Hackett, C., Feeny, D., & Tompa, E. (2016). Canada's residential school system: Measuring the intergenerational impact of familial attendance on health and mental health outcomes. *Journal of Epidemiology & Community Health*, *70*(11), 1096–1105. http://dx.doi.org/10.1136/jech-2016-207380

Hale, D. R., Bevilacqua, L., & Viner, R. M. (2015). Adolescent health and adult education and employment: a systematic review. *Pediatrics*, *136*(1), 128–140. https://doi.org/10.1542/peds.2014-2105

Hale, D. R., & Viner, R. M. (2018). How adolescent health influences education and employment: investigating longitudinal associations and mechanisms. *Journal of Epidemiology & Community Health*, *72*(6), 465–470. http://dx.doi.org/10.1136/jech-2017-209605

Halladay, J., Bennett, K., Weist, M., Boyle, M., Manion, I., Campo, M., & Georgiades, K.

(2020). Teacher-student relationships and mental health help seeking behaviors among elementary and secondary students in Ontario Canada. *Journal of School Psychology*, *81*, 1–10. https://doi.org/10.1016/j.jsp.2020.05.003

Heaton, J. (2008). Secondary analysis of qualitative data: An overview. *Historical Social Research* (2008), 33–45. https://www.jstor.org/stable/20762299

Hill, R. A. (2020). Wraparound: a key component of school-wide culture competence to support academics and socio-emotional well-being. *Peabody Journal of Education, 95*(1), 66–72. https://doi.org/10.1080/0161956X.2019.1702424

Hjemdal, O., Friborg, O., Stiles, T. C., Rosenvinge, J. H., & Martinussen, M. (2006). Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *13*(3), 194–201. https://doi.org/10.1002/cpp.488

Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship between resilience and levels of anxiety, depression, and obsessive–compulsive symptoms in adolescents. *Clinical Psychology & Psychotherapy*, *18*(4), 314–321. https://doi.org/10.1002/cpp.719

Hoover, S., & Bostic, J. (2021). Schools as a vital component of the child and adolescent mental health system. *Psychiatric services*, *72*(1), 37–48. https://doi.org/10.1176/appi.ps.201900575

Hughes, K., Bellis, M., Hardcastle, K., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne,

M. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Husky, M. M., Sheridan, M., McGuire, L., & Olfson, M. (2011). Mental health screening and follow-up care in public high schools. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(9), 881–891. https://doi.org/10.1016/j.jaac.2011.05.013

Kamali, M., Edwards, J., Anderson, L. N., Duku, E., & Georgiades, K. (2022). Social Disparities in Mental Health Service Use Among Children and Youth in Ontario: Evidence from a General, Population-Based Survey. *The Canadian Journal of Psychiatry, 2022.* https://doi.org/10.1177/07067437221144630

Kindred, R., & Bates, G. W. (2023). The Influence of the COVID-19 Pandemic on Social Anxiety: A Systematic Review. *International Journal of Environmental Research and Public Health*, *20*(3), 2362. https://doi.org/10.3390/ijerph20032362

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396. https://psycnet.apa.org/doi/10.1037/0735-7028.39.4.396

Krygsman, A., & Vaillancourt, T. (2022). Elevated social anxiety symptoms across childhood and adolescence predict adult mental disorders and cannabis use. *Comprehensive Psychiatry*, *115*. https://doi.org/10.1016/j.comppsych.2022.152302

Kumar, M. B., & Tjepkema, M. (2019, June 28). Suicide among First Nations people, Métis and Inuit (2011-2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC). *Statistics Canada – Catalogue no. 99-011-X*.

https://www150.statcan.gc.ca/n1/en/pub/99-011-x/99-011-x2019001-eng.pdf?st=QKbo1EDt

Lee-St. John, T. J., Walsh, M. E., Raczek, A. E., Vuilleumier, C. E., Foley, C., Heberle, A., Sibley, E., & Dearing, E. (2018). The long-term impact of systemic student support in elementary school: Reducing high school dropout. *American Educational Research Association (AERA) Open*, *4*(4). https://doi.org/10.1177/2332858418799085

Lemstra, M., Neudorf, C., D'Arcy, C., Kunst, A., Warren, L. M., & Bennett, N. R. (2008). A systematic review of depressed mood and anxiety by SES in youth aged 10–15 years. *Canadian Journal of Public Health*, *99*, 125–129. https://doi.org/10.1007/BF03405459

Lim, K. L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C. S. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases Canada*, *28*(3), 92–98. https://publications.gc.ca/pub?id=9.505086&sl=0

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Lopez-Carmen, V., McCalman, J., Benveniste, T., Askew, D., Spurling, G., Langham, E., & Bainbridge, R. (2019). Working together to improve the mental health of indigenous children: A systematic review. *Children and Youth Services Review*, *104*. https://doi.org/10.1016/j.childyouth.2019.104408

Marmot, M., & Wilkinson, R. (Eds.). (2006). *Social determinants of health* (2nd ed.). Oxford University Press.

Mariu, K. R., Merry, S. N., Robinson, E. M., & Watson, P. D. (2012). Seeking professional help

for mental health problems, among New Zealand secondary school students. *Clinical child psychology and psychiatry*, *17*(2), 284–297. https://doi.org/10.1177/1359104511404176

Mayan, M. (2016). *Essentials of qualitative inquiry*. Taylor & Francis Group.

Mental Health Commission of Canada. (2020). *COVID-19 and suicide: Potential implications and opportunities to influence trends in Canada: Policy brief*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2020-11/covid19_and_suicide_policy_brief_eng.pdf

Mental Health Commission of Canada. (2021). *COVID-19 and early childhood mental health: Fostering systems change and resilience – Policy brief*. https://mentalhealthcommission.ca/wp-content/uploads/2021/09/COVID-19-and-Early-Childhood-Mental-Health-Fostering-Systems-Change-and-Resilience-Policy-Brief.pdf

Mertens, D. M. (2020). *Research and Evaluation in Education and Psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (5th ed.). Sage Publications.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*, 341–352. https://doi.org/10.1007/s10488-011-0352-1

Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullmann, M. D., Suter, J. C., & Bruns, E. J. (2021). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *60*(11), 1353–1366. https://doi.org/10.1016/j.jaac.2021.02.022

Otter.ai. (2023). *Otter.ai* (Version No. 3.23.0). https://otter.ai

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS ONE*, *10*(9). https://doi.org/10.1371/journal.pone.0138511

Pattyn, E., Verhaeghe, M., & Bracke, P. (2015). The gender gap in mental health service use. *Social Psychiatry and Psychiatric Epidemiology*, *50*, 1089–1095. https://doi.org/10.1007/s00127-015-1038-x

People for Education. (2019). *Supporting students' mental health: A collective responsibility*. https://peopleforeducation.ca/wp-content/uploads/2019/11/People-for-Education-report-on-supporting-students-mental-health-2019.pdf

Pfefferbaum, B. (2021). Challenges for child mental health raised by school closure and home confinement during the COVID-19 pandemic. *Current Psychiatry Reports*, *23*(65). https://doi.org/10.1007/s11920-021-01279-z

Ponnet, K. (2014). Financial stress, parent functioning and adolescent problem behavior: An actor–partner interdependence approach to family stress processes in low-, middle-, and high-income families. *Journal of Youth and Adolescence, 43*(2014), 1752–1769. https://doi.org/10.1007/s10964-014-0159-y

Prakash, M., Bisanz, J., Chalmers, G., Daniels, J., Gokiert, R., McNeil, D., Michailides, M., Schnirer, L., Varnhagen, S., Walker, C., & Wosnack, N. (2010). *Integrated supports for children, youth, and families: A literature review of the wraparound process*. https://www.ualberta.ca/community-university-partnership/media-library/community-university-partnership/research/policy/literature-review-of-the-wraparound-process.pdf

Reiss, F. (2013). Socioeconomic inequalities and mental health problems in children and

adolescents: A systematic review. *Social Science & Medicine, 90*, 24–31. https://doi.org/10.1016/j.socscimed.2013.04.026

Salazar de Pablo, G., De Micheli, A., Solmi, M., Oliver, D., Catalan, A., Verdino, V., Di Maggio, L., Bonoldi, I., Radua, J., Baccaredda Boy, O., Provenzani, U., Ruzzi, F., Calorio, F., Nosari, G., Di Marco, B., Famularo, I., Montealegre, I., Signorini, L., Molteni, S. … Fusar-Poli, P. (2021). Universal and selective interventions to prevent poor mental health outcomes in young people: systematic review and meta-analysis. *Harvard Review of Psychiatry*, *29*(3), 196–215. https://doi.org/10.1097/hrp.0000000000000294

Sanchez, A. L., Cornacchio, D., Poznanski, B., Golik, A. M., Chou, T., & Comer, J. S. (2018). The effectiveness of school-based mental health services for elementary-aged children: A meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 57*(3), 153–165. https://doi.org/10.1016/j.jaac.2017.11.022

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What's in a name? qualitative description revisited. *Research in Nursing & Health, 33*(1), 77–84. https://doi.org/10.1002/nur.20362

Sather, A., & Bruns, E. J. (2016). National trends in implementing wraparound: Results of the state wraparound survey, 2013. *Journal of Child and Family Studies*, *25*, 3160–3172. https://doi.org/10.1007/s10826-016-0469-7

Sieving, R. E., McRee, A. L., McMorris, B. J., Shlafer, R. J., Gower, A. L., Kapa, H. M.,

Beckman, K. J., Doty, J. L., Plowman, S. L., & Resnick, M. D. (2017). Youth–adult connectedness: A key protective factor for adolescent health. *American Journal of Preventive Medicine*, *52*(3), S275–S278. https://doi.org/10.1016/j.amepre.2016.07.037

Scott, T. M., & Eber, L. (2003). Functional assessment and wraparound as systemic school processes: Primary, secondary, and tertiary systems examples. *Journal of Positive Behavior Interventions, 5*, 131–143. https://doi.org/10.1177/10983007030050030201

Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *Journal of the American Medical Association* (*JAMA)*, *301*(21), 2252–2259. https://doi.org/10.1001/jama.2009.754

Shonkoff, J. P., Garner, A. S., Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner, A. S., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232–e246. https://doi.org/10.1542/peds.2011-2663

Smetanin, P., Briante, C., Stiff, D., Ahmad, S., Khan, M. (2011). *The life and economic impact of major mental illnesses in Canada*. RiskAnalytica, on behalf of the Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHCC_Report_Base_Case_FINAL_ENG_0_0.pdf

Smetanin, P., Stiff, D., Briante, C., & Khan, M. (2012*). Life and Economic Impact of Hypothetical Intervention Scenarios on Major Mental Illness in Canada: 2011 to 2041*. Risk Analytica, on behalf of the Mental Health Commission of Canada.

https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHCC_Life_Economic_Impact_Scenarios_FINAL_ENG_0_0.pdf

Smith, J. P., & Smith, G. C. (2010). Long-term economic costs of psychological problems during childhood. *Social science & medicine*, *71*(1), 110–115. https://doi.org/10.1016/j.socscimed.2010.02.046

Statistics Canada. (2019, October 7). Mental health care needs, 2019. *Statistics Canada – Catalogue no. 82-625-X*. https://www150.statcan.gc.ca/n1/pub/82-625-x/2019001/article/00011-eng.htm

Statistics Canada (2022a, January 24). *Deaths and age-specific mortality rates, by selected grouped causes – Table 13-10-0392-01* [Data set]. Retrieved April 12, 2023. https://doi.org/10.25318/1310039201-eng

Statistics Canada (2022b, November 9). Census in Brief: Disaggregated trends in poverty from the 2021 census of population. *Census of Population, 2021*. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021009/98-200-x2021009-eng.pdf

Steiner, R. J., Sheremenko, G., Lesesne, C., Dittus, P. J., Sieving, R. E., & Ethier, K. A. (2019). Adolescent connectedness and adult health outcomes. *Pediatrics*, *144*(1). https://doi.org/10.1542/peds.2018-3766

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry*, 81(1), 1–17. https://doi.org/10.1111/j.1939-0025.2010.01067.x

Ungar, M., & Theron, L. (2020). Resilience and mental health: How multisystemic processes

contribute to positive outcomes. *The Lancet Psychiatry*, *7*(5), 441–448. https://doi.org/10.1016/S2215-0366(19)30434-1

Vaillancourt, T., Szatmari, P., Georgiades, K., & Krygsman, A. (2021). The impact of COVID-19 on the mental health of Canadian children and youth. *FACETS*, *6*(1), 1628–1648. https://doi.org/10.1139/facets-2021-0078

van Loon, A., Creemers, H., Beumer, W. Y., Okorn, A., Vogelaar, S., Saab, N., Miers, A., Westenberg, M., & Asscher, J. (2020). Can schools reduce adolescent psychological stress? A multilevel meta-analysis of the effectiveness of school-based intervention programs. *Journal of Youth and Adolescence*, *49*, 1127–1145. https://doi.org/10.1007/s10964-020-01201-5

Waddell, C., Georgiades, K., Duncan, L., Comeau, J., Reid, G. J., O'Briain, W., ... & 2014 Ontario Child Health Study Team. (2019). 2014 Ontario child health study findings: policy implications for Canada. *The Canadian Journal of Psychiatry*, *64*(4), 227–231. https://doi.org/10.1177/0706743719830033

Whitley, J., Beauchamp, M. H., & Brown, C. (2021). The impact of COVID-19 on the learning and achievement of vulnerable Canadian children and youth. *FACETS*, *6*(1), 1693–1713. https://doi.org/10.1139/facets-2021-0096

World Health Organization & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

World Health Organization. (2020, March 11). *WHO Director-General's opening remarks at the*

media briefing on COVID-19 - 11 March 2020. https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

World Health Organization. (2021). *Comprehensive Mental Health Action Plan, 2013–2030*. https://www.who.int/publications/i/item/9789240031029

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. https://www.who.int/publications/i/item/9789240049338

Yu, R., Haddock, A., & Womack, T. (2020). Integrating supports for students with wraparound. *Contemporary School Psychology* (2020). https://doi.org/10.1007/s40688-020-00284-y

Zifkin, C., Montreuil, M., Beauséjour, M. È., Picard, S., Gendron-Cloutier, L., & Carnevale, F. A. (2021). An exploration of youth and parents' experiences of child mental health service access. *Archives of Psychiatric Nursing*, *35*(5), 549–555. https://doi.org/10.1016/j.apnu.2021.06.006

Appendix A: Interview and Focus Group Guides

AIFY Student Focus Group Guide

Hello, my name is _____, and I am a researcher from the University of Alberta. We are doing a project to learn how your schools and their supports affect you and your family. Hearing from you all is so important because you are the only one who can tell us what it's like at your school and if you and your family are getting the support you need from your school. If you agree to take part in this project, you will be asked to answer questions about yourself, your family, and your school. You can skip any questions that you don't want to answer, and we will not tell anyone your name or any information that could identify you. You get to decide whether you want to talk to us or not. It is completely ok if you don't want to be part of the project, or if you agree to talk to us and change your mind later.

- *Do you have any questions about the project?*
- *Would you like to be a part of the project? (If yes/thumbs up, continue; If no, end the interview.)*
- *Is everyone okay if we record this conversation?*

Questions:

1. If there was a new student who was going to come to your school next year, who didn't know anything about your school, how would you describe your school to them? What would you tell them about your school and what they can expect?
    a. People who work at the school?
    b. Classes you like?
    c. Programs you like?
2. What school programs have you been part of and how have they helped you?
3. Which adults in your school have made the biggest difference in your life [this past year]?
    a. How did they help you?
4. In the past year, what made you feel good about yourself and your life?
5. How did the people in your school (e.g., teachers, success coaches, therapists) help you when you needed it?
    a. What about mental health or success coach services could be changed/improved?
6. What has changed in how you talk and play/hangout with your friends because of covid?
7. **For junior high/high school students ONLY**, how do you feel about your emotions and feelings at this point in your student life?
8. What could make school more fun and interesting in the next school year?

AIFY Student-Alumni Interview Guide

Hello, my name is _____, and I am a researcher from the University of Alberta. We are doing a project to learn how your schools and their supports affect you and your family. Hearing from you all is so important because you are the only one who can tell us what it's like at your school and if you and your family are getting the support you need from your school. If you agree to take part in this project, you will be asked to answer questions about yourself, your family, and your school. You can skip any questions that you don't want to answer, and we will not tell anyone your name or any information that could identify you. You get to decide whether you want to talk to us or not. It is completely ok if you don't want to be part of the project, or if you agree to talk to us and change your mind later.

- *Before we start, do you have any questions about the project or interview?*
- *Would you like to be a part of the project? (If yes, continue; If no, end the interview)*
- *Is it okay if we record this conversation?*
- *Okay, to start, how old are you and (if applicable) what grade are you in?*
- *How long did you attend your school or previous school (since what grade)?*

Questions:

1. When you think about [name of school or former school], what comes to mind?
    a. What did you like/dislike about your school or former school?
2. How did _____ [something they mentioned in the previous question] help you?
    a. How would it have been without it/them [i.e., person or service]?
3. What impact did the adults in your school, such as teachers, school and AIFY staff, have on your life? To what extent did they also touch on your family's lives?
4. Thinking about your health (physical, emotional, mental and spiritual), how have AIFY supports impacted how you felt in the past?
5. **For those who mention receiving support from a mental health therapist or success coach:**
    a. How would you describe your experience accessing those supports through your school? How did you know who to reach out to if you needed support?
    b. How did talking to a mental health therapist or success coach impact you? Did it help you, and if so, how?
    c. What could be changed or improved about mental health therapists' and success coaches' services?
6. What do you think would be different about your life without the AIFY supports you received in your school? What examples can you share with us?
7. Is there anything else we haven't discussed that you would like to share with us regarding your experience with AIFY?

AIFY Parents/Guardians Interview Guide

Hello, my name is _____ and I am part of a research team from the University of Alberta. We are working with your child /children's school to better understand how the supports and services offered by the school are helping students and their families. Hearing from parents and caregivers is so important because you are the only ones who can tell us if you are getting the supports and services you need from the school. So, thank you for being here and taking the time to speak with us today.

Before we start, we just want to remind you that everything we talk about today will be kept private. We will replace any names you mention with a fake name so everyone's identity will be protected. If you don't want to answer a question or you want to skip a question and come back to it later, just let us know. Before we get started, Do you have any questions? and is it okay if we record this conversation?

Questions:

1. What programs or services did you or your family access through the school? (e.g., mentoring, out-of-school programming, nutrition programming, success coaching, mental health therapy, family supports)?
    a. How did these supports impact you and your family?
    b. What has changed in your life or your family's life as a result of having these supports? [Examples of this could be change in children's behaviour, change in family relationships, improved communication]

2. What AIFY supports have had the greatest impact on your mental health and the mental health of your family? *Note: We consider mental health to include a state of emotional, mental, and social wellbeing wherein students generally feel comfortable, able to cope, and valued in their everyday lives. It's not only the absence of mental illness but also students' capacity to experience and express emotions in the context of their families, schools and communities.
    a. What did you notice throughout the school year about your child's overall mental health?
    b. [For those who mention that a family member received support from a mental health therapist or success coach] How did AIFY mental health therapy or success coaching impact your family?

3. What would you and your family's life be like if you didn't have extra supports through the school?

4. Thinking about this last school year, are there any experiences or moments that stand out to you? [Good memories or challenges?]

5. Is there anything else we haven't discussed that you would like to share with us regarding your experience with AIFY?

Those were all the questions we had. Thank you for participating in this interview. We really appreciate you taking the time to do this! Ask for email address for e-gift card!