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EXECUTIVE SUMMARY: KEY FINDINGS

The Mental Health Capacity Building (MHCB) initiative promotes collaboration between schools and communities to recognize and address barriers to well-being through evidence-informed mental health promotion efforts and activities.

The following outlines key findings from process and outcome measures to compare program operations in 2019/20 reporting year (June 2019 to May 2020) and 2020/21 reporting year (June 2020 to May 2021). Data is presented for all schools combined.

Key Findings: Better Health

The purpose of this evaluation objective was to demonstrate that MHCB staff had been able to provide evidence-based and innovative programming to enhance mental health and well-being in children, youth and families.

- There was a 13% decrease in the average number of unique programmed events per month; however, a substantial increase of 46% in total programmed event occurrences per month was documented, which may be attributed to the extension of programming to associate schools and a wider audience. Program delivery seemed to be gradually increasing to younger grades and about 60% of total programs delivered to younger grades resulted from extension to associate schools.

- In contrast to the previous year, the OurSCHOOL Survey showed some positive results for students in the outcome measures related to positive relationships, feeling of safety, bullying and exclusion experience, and sense of belonging. Supported by the Narrative Summary, one student said, “I've never told anyone that I cut myself before because I never felt safe enough to.”

- The qualitative data from parents and caregivers showed how students used MHCB resources in their home environment and supported the extension of the MHCB initiative to families and the community at large. One parent said, “And all of that is kind of spilled over at home as well. She has learnt so many valuable skills and she shares them with her sisters.”

Key Findings: Better Care

The purpose of this evaluation objective was to demonstrate that MHCB staff had supported early interventions and facilitated access to treatment for children, youth, and families that are experiencing or are at risk of experiencing mental health and addictions related issues.

- On one hand, the average number of incoming referrals to the MHCB team decreased from 67 per month in 2019/20 to 48 per month in 2020/21, possibly due to reduced interactions resulting from COVID-19 protocols. On the other hand, the average number of outgoing referrals to school division support and external mental health agencies recorded a 100% increase from 8 per month in 2019/20 to 16 per month in 2020/21, after school re-opening.
The peak of incoming referrals was before the COVID-19 lockdown (December 2019 to February 2020), which was mostly due to increasing self-referrals from grades 7-9. For the 2020/21 period, incoming referrals seem to be gradually spreading across other grades including PreK-6 and grades 10-12, while grades 7-9 is steadily decreasing, which could be attributed to the diversification of programs to a broader and mixed groups of audiences. In addition, teacher referrals increased in 2020/21 period while student self-referrals reduced drastically, possibly due to the reported impact of COVID-19 protocols on student attendance in schools.

Key Findings: Better Value

The purpose of this evaluation objective was to demonstrate that MHCB staff had been able to build capacity in school staff to deliver wellness presentations and programming.

Monthly trends showed the average number of co-facilitated programs increased from 14 per month in 2019/20 period to 26 per month in 2020/21. The proportion of teachers with improved confidence to deliver programs also increased to 50%, which was an 11% increase from the previous year. One teacher stated, “Most importantly, your programming gives me a way to open up more conversations with students about their mental health.”

Staff survey showed about 71% of respondents were satisfied (somewhat/very) with MHCB implementation in their schools. Similarly, 70% of respondents reported that they would recommend the initiative to other schools. This shows the need to focus the work of MHCB staff with school staff in order increase positive engagement and satisfaction levels.

Key Findings: Better Teams

The purpose of this evaluation objective was to demonstrate that the MHCB initiative had developed a network of resources that facilitated the promotion of mental well-being, and established the MHCB initiative as a resource within the mental health and addiction continuum of care.

School staff data regarding perceived barriers to mental health showed staff believed the barriers to mental health are reducing. For example, 18% of respondents (compared to 22% in the previous year) reported that students’ mental health is still considered a low priority in school, and 71% of those reported that MHCB support had helped overcome this barrier within their schools.

School staff reported the extent to which resources have been available for mental health emergencies since MHCB involvement in the schools. About 43% of staff reported that they have been trained on how to deal with students’ mental health emergencies, and 35% stated that people responsible to address mental health emergencies have been clearly defined. Furthermore, 34% of staff were aware of follow-up services internal to school, while 29% were aware of follow-up services external to school, since MHCB involvement. Given that all the measures were supported by less than 50% of respondents, more awareness and collaboration with school staff may be needed to better understand the available resources for students’ mental health emergencies.
The qualitative data showed reduced stigma and shifting mental health culture as a positive trend. One school staff stated, “Since the MHCB has been put at our school, the discussions around mental health are greatly improved. I am very grateful that they are a part of our school.”

In terms of COVID-19, 78% of school staff respondents rated access to resources since the pandemic as either good, very good or excellent. Additionally, the thematic analysis of qualitative data showed that some positive impacts of COVID-19 regarding the MHCB initiative were the use of larger promotional platforms, more favourable environment for one-on-one referrals due to restricted numbers in MHCB space, and reaching broader audiences. Meanwhile, the negative impacts were described as reducing unique programmed events, concerns with programming effectiveness due to remote delivery, and reduced social engagement from students in MHCB spaces, classrooms, and extra-curricular activities, resulting in reduced opportunities for students. One of the school coordinators stated, “We have had to reduce the type of programs that we offer due to pandemic protocols.”
INTRODUCTION

Mental Health Capacity Building (MHCB) is an initiative that has evolved over the last three years of implementation across Saskatchewan designated schools. Part of this evolution includes more teacher engagement, taking a more universal approach to programming, and focusing on virtual/remote delivery of programs due to COVID-19. In spite of COVID-19, the MHCB has maintained a consistent mandate of promoting collaboration between schools and communities to recognize and address barriers to well-being through evidence-informed mental health preventive and promotion activities, ultimately with a vision to shift school mental health culture.

The goal of this evaluation was to assess the following:

1. The impact on mental well-being of the children and youth engaged in the program.
2. The extent that children, youth, and families have been supported to access treatment services.
3. The extent to which collaborative networks have been developed within schools that facilitate access to community-based services across the mental health continuum.
4. The extent to which MHCB has successfully become embedded into the schools.
5. The impact of COVID-19 (since March 2020) on program delivery and access to resources.

The following data reflects the process and outcome measures taken to compare program operations between the 2019/20 and the 2020/21 school year. In addition, the data demonstrates a collective representation of all the five designated schools—John Paul II Collegiate and North Battleford Comprehensive High School in North Battleford, Dr. Martin LeBoldus High School in Regina, Greenall High School in Balgonie, and Hector Thiboutot School (K-12) in Sandy Bay.

METHODOLOGY

DESIGN

This evaluation is structured around the Four Betters: Better Health, Better Care, Better Value and Better Teams. The evaluation objectives falling under this conceptual framework each have specific research questions with associated results displayed.

Using a pre-post evaluation design, the data presented in this report reflect both process measures (i.e., the extent to which MHCB teams have been able to establish programs, events and activities in their respective schools over the evaluation period and during the COVID-19 pandemic) and outcome measures (i.e., measures of staff satisfaction with program delivery as well as high level data from OurSCHOOL Surveys that reflects self-reported levels of academic/social/emotional well-being in youth).

The methodology of this evaluation was heavily informed by the work of the Alberta Health Services’ (AHS) MHCB program.
DATA COLLECTION TOOLS

Both quantitative data and qualitative data were captured using different tools, which are further explained.

The MHCB Monthly Tracking Tool was created in REDCap™ (a secure electronic data capture tool) for the capture of information on programming and other activities initiated by the MHCB staff as well as participation rates, and referrals made to and by the MHCB staff. Comments and descriptions from this tool were integrated into the qualitative data.

For this year’s evaluation, Student Ideas Tracking and Meetings/Community Outreach Tracking, which are integral parts of the Monthly Tracking Tool, were included in the data. The descriptions from Student Ideas Tracking provided qualitative data on student-led initiatives while the Meetings/Outreach Tracking provided qualitative data on partnerships. The interviews conducted with parents and caregivers also provided qualitative data on student engagement outside the school environment.

The Narrative Tool allowed MHCB Staff to document more qualitative information and provide feedback on program successes, barriers to implementation, and emerging trends and issues in their communities.

A School Staff Satisfaction Survey Tool created in collaboration with colleagues at the Ministry of Education captured the perceptions of teaching and non-teaching staff at the schools in regards to MHCB awareness, observed barriers, access to resources, and recommendations. For this year’s evaluation, open-ended responses from the survey were captured as part of the qualitative data.

Finally, outcome measure results are available from the Learning Bar’s OurSCHOOL Survey, which was provided by the Ministry of Education. These survey data integrated into this evaluation were administered in December 2019 & December 2020. The recent OurSCHOOL Well-Being Module which was administered to three of the MHCB schools was also included.

DATA NOTES: OurSCHOOL Survey

All comparisons were made to the Canadian High School average (Can Norm), Provincial High School average (Prov Norm) and a ‘replica’ cohort of schools (Replica pop) created based on Learning Bar/OurSCHOOL data.

Changes over time (from 2019/20 survey results to 2020/21 results) are presented. Actual normative data for 2020/21 was provided for contextual comparisons of recent data between MHCB sites combined and reference populations. The extracted OurSCHOOL statistics are based on estimations drawn from the charts published as findings.

The survey is self-reported in nature, anonymous, and voluntary. Each measure is assessed using a multidimensional approach that combines multiple questions to establish students’ perceptions of each concept. The MHCB has limited control over the original data collection process.
ANALYSIS

Descriptive statistics were used to analyse the quantitative data which included Tracking Tool, Staff Satisfaction Survey, and OurSCHOOL Survey data. Highlights and comparisons of monthly trends in program development and referral patterns over time were made, where possible. Comparisons were made between the two reporting periods (i.e., the 2019/20 period ranging from June 2019 to May 2020, and the 2020/21 period ranging from June 2020 to May 2021).

Thematic content analysis was used to synthesize the narrative summary, the survey open-ended responses, and comments from the student ideas tracking and meetings/outreach tracking. The data was structured around the evaluation objectives for conceptual relevance to the evaluation framework, as applicable. The data was transferred to NVivo qualitative analysis software where the coding and categorization of data were done. The data was coded for line by line meaning before moving the codes into categories. Descriptive quotes were used to reflect originality and patterns developed from the data.

Data is presented for all schools combined.
MEASUREMENT CONCEPT – BETTER HEALTH

Evaluation Objective 1: Provide evidence-based and innovative programming to enhance mental health and well-being

Evaluation Question 1: Are children receiving the knowledge/skills they need for optimal mental well-being?

This was assessed by investigating the changes over time in the following process measures:

- a. The number of programs/events/activities offered in schools
- b. Participation rate of children in mental health promotion activities

RESULTS - TRACKING TOOL: NUMBER OF PROGRAMS, EVENTS AND ACTIVITIES

Unique programs (reported monthly on tracking tool) refers to different program content or same content that is delivered to a different age group of children or staff. In total, 685 unique mental health programs, events or activities were run across the five MHCB schools combined, from June 2019 to May 2021. The monthly breakdown (Figure 1) shows that program delivery peaked in February 2020 before COVID-19 lockdown, followed by a substantial drop in program delivery when the lockdown began which further extended into the summer (March to August 2020). With the resumption of school, the delivery of unique programs increased steadily to a consistent rate through the 2020/21 period. The period of October to February in each reporting period recorded a programming rate that is consistently above average. Although this correlates with schools being in session, efforts should be made to maintain consistency in programming rates particularly as the end of the school year draws near.

Overall, the average number of unique programs run per month decreased by 13% from the 2019/20 reporting period (n = 31 programs/month) to 2020/21 reporting period (n = 27 programs/month).
Since programs, events or activities, classified as ‘unique programs’ could be repeated within a month, the total number of programs, event or activity occurrences were also recorded. A total of 2590 programs, events or activities have occurred in all pilot MHCB sites combined, from Jun 2019 – May 2021.

Overall, it should be noted that even though there was a slight decrease in the average number of unique programs per month (Figure 1), a substantial increase in program occurrences per month was recorded (Figure 2). Despite pivoting with COVID-19, the average number of program occurrences increased by 46% from 2019/20 period (n=88/month) to 2020/21 period (n=128/month), which may be attributed to the extension of programming to associate schools and a wider audience, as further described in the following section.
RESULTS – TRACKING TOOL: PARTICIPATION IN PROGRAMS, EVENTS AND ACTIVITIES

The quantitative data (Figure 3) on program audience showed three major notable changes when comparing the 2019/20 to the 2020/21 reporting period.

- Firstly, program delivery gradually increased for more younger grades. In comparison to grades 10-12, there was an increase in programs delivered to PreK-3, grades 4-6, and grades 7-9. Although data from all schools were analysed collectively, the bulk of the programs delivered to younger grades were mainly from two schools, one of them reporting a substantial amount of classroom presentations delivered to associate schools, which accounted for about 60% of total programs delivered to PreK-6.

- Secondly, program delivery to the whole school continued to be the largest proportion of program audience, i.e., via public announcement, assemblies) but did see a slight reduction from 28% to 23%, likely attributable to COVID-19 restrictions.

- Finally, the evidence points to increased reach of a wider audience. Data labeled as “other” indicates greater reach to mixed groups of program audiences (e.g., reaching parents, staff, students, and community via presentations or social media promotions).

In total, there was an estimated 86348 total audiences during the 2020/21 period which was a 6% increase (n=4723) in comparison to the 2019/20 total audiences (n=81625).

For the 2020/21 reported data, total audiences was differentiated in the reporting requirement and classifieds as direct audiences and promotional/awareness audiences. Direct audiences participated in programming such as presentations, mindfulness groups, and other opportunities where interaction was possible either in-person or virtually. Promotional/awareness audiences were based on social media interactions and recipients of mass emails, newsletters, and information physically handed out.
Figure 4 below showed that the estimated promotional/awareness audiences represents a significantly larger proportion of the total audiences (direct audiences – 16416; promotional audiences – 69932). This could indicate an increasing need, during the COVID-19 school year, for diversification of delivery methods and reaching of broader audiences through promotional activities, given more direct interactions were more difficult. Only 26% of unique programs offered in 2020/21 were focused towards promotional/awareness audiences; however, 81% of the total audiences were from promotion/awareness related programming.

Furthermore on Figure 5, social media programming took the highest proportion of promotional activities, representing 38% of unique awareness/promotional programming. This highlights the transition to remote delivery for reaching a wider audience, while the MHCB initiative pivoted with COVID-19. Data labelled as ‘other’ mostly represents mixed types of promotion, which may include a combination of social media, hand outs, and bulletin boards.
**Evaluation Question 2:** Are children obtaining outcomes associated with positive mental health? (Outcome measure)

This was assessed by showing changes in outcomes from four areas of the OurSCHOOL Survey:

a. Social engagement  
b. Institutional engagement  
c. Emotional health  
d. Overall quality of life (New Well-Being Module)

**DATA NOTES: OurSCHOOL Survey**

All comparisons were made to the Canadian High School average (Can Norm), Provincial High School average (Prov Norm) and a ‘replica’ cohort of schools (Replica pop) created based on Learning Bar/OurSCHOOL data.

Changes over time (from 2019/20 survey results to 2020/21 results) are presented. Actual normative data for 2020/21 was provided for contextual comparisons of recent data between MHCB sites combined and reference populations. The extracted OurSCHOOL statistics are based on estimations drawn from the charts published as findings.

The survey is self-reported in nature, anonymous, and voluntary. Each measure is assessed using a multidimensional approach that combines multiple questions to establish students’ perceptions of each concept. The MHCB has limited control over the original data collection process.

### RESULTS – TABLE 1: SOCIAL ENGAGEMENT AND INSTITUTIONAL ENGAGEMENT MEASURES

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>% students with a positive sense of belonging</td>
<td>57%</td>
<td>60%</td>
<td>↑ 5%</td>
<td>BELOW Can Norm</td>
<td>BELOW Can Norm</td>
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<td></td>
<td></td>
<td>BELOW Prov Norm</td>
<td>BELOW Prov Norm</td>
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<td></td>
<td></td>
<td>BELOW Replica pop</td>
<td>BELOW Replica pop</td>
</tr>
<tr>
<td>% children with positive relationships</td>
<td>73%</td>
<td>76%</td>
<td>↑ 4%</td>
<td>SIMILAR Can Norm</td>
<td>SIMILAR Can Norm</td>
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<td></td>
<td></td>
<td>SIMILAR Prov Norm</td>
<td>SIMILAR Prov Norm</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>SIMILAR Replica pop</td>
<td>SIMILAR Replica pop</td>
</tr>
<tr>
<td>% students that value schooling outcomes</td>
<td>68%</td>
<td>68%</td>
<td></td>
<td>SIMILAR Can Norm</td>
<td>SIMILAR Can Norm</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SIMILAR Prov Norm</td>
<td>SIMILAR Prov Norm</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>BELOW Replica pop</td>
</tr>
<tr>
<td>% students with positive behaviour at school</td>
<td>92%</td>
<td>93%</td>
<td>↑ 1%</td>
<td>SIMILAR Can Norm</td>
<td>SIMILAR Can Norm</td>
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<td>BELOW Prov Norm</td>
<td>BELOW Prov Norm</td>
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<td></td>
<td>SIMILAR Replica pop</td>
<td>SIMILAR Replica pop</td>
</tr>
</tbody>
</table>
From Table 1 above, the social engagement measures showed a slightly positive change from the 2019/20 to the 2020/21 reporting period. In comparison to reference populations, the proportion of students with a positive sense of belonging was below the normative data by 3%-5%, while those with positive relationships were similar to the normative data. Finally, the overall institutional engagement measures showed no major changes when comparing the reporting periods; however, slightly below the normative data by 2%-5%.

### RESULTS – TABLE 2: EMOTIONAL HEALTH MEASURES

<table>
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</thead>
<tbody>
<tr>
<td>% students with moderate or high levels of anxiety</td>
<td>33%</td>
<td>32%</td>
<td>-3%</td>
<td>ABOVE Can Norm</td>
<td>ABOVE Can Norm (28%)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (28%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>ABOVE Replica pop (27%)</td>
</tr>
<tr>
<td>% students with moderate or high levels of depression</td>
<td>34%</td>
<td>33%</td>
<td>-3%</td>
<td>SIMILAR Can Norm</td>
<td>ABOVE Can Norm (28%)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>ABOVE Replica pop (27%)</td>
</tr>
<tr>
<td>% students with a positive self-esteem</td>
<td>63%</td>
<td>65%</td>
<td>3%</td>
<td>BELOW Can Norm</td>
<td>BELOW Can Norm (70%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BELOW Prov Norm</td>
<td>BELOW Prov Norm (73%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BELOW Replica pop</td>
<td>BELOW Replica pop (73%)</td>
</tr>
</tbody>
</table>

From Table 2 above, all three emotional health measures showed no major changes when comparing between 2019/20 and 2020/21 periods. In addition, the 2020/21 data for MHCB schools trend below the normative data for proportion of students with positive self-esteem, while above the normative data for students with anxiety and depression, as shown in the table above. The lack of any major changes in emotional health measures is understandable given the COVID-19 context; however, the total percentages of students with specific mental health concerns, as shown in table 2 above, reflect measures in need of targeted improvement.

### RESULTS – TABLE 3: GENERAL WELL-BEING MEASURES

**DATA NOTES: OurSCHOOL Survey**

The well-being section of the OurSCHOOL survey was recently introduced in December 2020; therefore, there were neither any previous year’s data nor normative data for comparisons.

Three of the MHCB schools (North Battleford Comprehensive, John Paul II Collegiate, and Dr. Martin LeBoldus) participated in all the measures, one school (Hector Thiboutot Community School) participated only in measures related to life satisfaction and cultural awareness, while Greenall High School was not represented in the data. This data can be taken as a baseline for ongoing monitoring of well-being outcome measures.
Notably, the proportion of students with positive hedonic well-being (pursuit of pleasurable activities) was distinctly high at 84%. However, students with positive self-regulation, positive goal orientation, sense of purpose in life, and understanding of personal culture were all less than 60%. This represents areas that can be targeted for improvement by the MHCB initiative.

**Evaluation Question 3**: Does the MHCB initiative create a culture of connectedness, psychological and physical safety? (Outcome Measure)

This was assessed by showing changes in outcomes from two areas of the OurSCHOOL Survey:

a. School context  
b. Educational context
From Table 4 above, the school context measures showed some promising results. There was a notable positive change characterized by lower proportion of students experiencing bullying and exclusion collectively, as well as in combination with harassment. These measures were also either similar or better than the normative data by 3%-9%. Similarly, the measure related to the students’ feelings of safety within the school also showed a positive change characterized by a higher proportion of students feeling safe; although, lower than the normative data by 9%-12%.

QUALITATIVE FINDINGS – NARRATIVE SUMMARY, OPEN-ENDED RESPONSES, TRACKING TOOL COMMENTS, INTERVIEW WITH PARENTS & CAREGIVERS

The major themes that emerged from the qualitative analysis were positive engagement, improvement in the feeling of safety, extension to home environment, and shifting mental health culture.

**Positive Engagement:** There was evidence to show students’ positive engagement, demonstrated by student use of resources, support of one another, and leading initiatives. This finding supports those from the previous evaluation; however, this evaluation provided further views on students’ leadership. In particular, the analysis of the Student Idea Tracking Tool showed engagement through student-initiated ideas for programming. MHCB staff demonstrated that students approached them regularly with programming ideas to address areas of concerns for all students. Eventually, these types of programs were either co-facilitated with the student-leaders or led by students themselves.
“MHCB was approached by a high school student, about putting up mental health programming for high school students. We invited the student, who happens to be [on the] school representative council, to our next wellness meeting to discuss the matter in more detail. We also encouraged her to bring her peers.” – School Coordinator

“MHCB staff was approached to support a student idea to raise awareness at the school on the issue of consent. Met with students to generate ideas for an appropriate awareness campaign.” – School Coordinator

“Students came to MHCB with [an] idea to create an online support for students while on their at home days.” – School Coordinator

Furthermore, the following quotes from students, teachers, and MHCB staff describe positive engagement through the application of MHCB resources.

We have had a lot of positive engagement with this initiative. Students responded positively to receiving the kits and indicated that they were a useful tool.” – School Coordinator

“Definitely the activity kits y’all sent out were the most helpful. It gave us students a time to step away from our worries and stress about multiple exams.” – Student

“They used it as one of their reference materials in our in-class class activity right now” – School Staff

“The well pack is our student led mental health group. Providing activities for mental health promotion and reducing stigma.” – School Coordinator

**Improvement in the Feeling of Safety:** This finding was previously established in other MHCB evaluations; however, reflections from this evaluation portrayed the feeling of physical and psychological safety not only by students but also school staff. The data reinforced that MHCB space served as a safe place for students and staff to be heard, disclose mental health concerns, be supported, and be positive.

“You’re the first person [MHCB Staff] I felt comfortable enough to come out to.” – Student

“I’ve never told anyone that I cut myself before because I never felt safe enough to.” – Student

“Can you help me get into counselling?” – Student

“Thanks for having this space for all of us to come and find our ‘zen’. I’m so glad I can come talk to you and that this room isn’t just for the students, cause sometimes I just need someone to vent to and you help me feel better!” – School Staff

“Thank you for supporting [students] and [their] families while they’re dealing with social services. It’s so important for our school to have resources like the MHCB room supporting our staff and students, especially during this difficult year.” – Principal
**Extension of Coping Skills to Home Environment:** The interviews conducted with parents and caregivers showed how students used MHCB resources in their home environment and supported the extension of the MHCB initiative to families and the community at large.

> And all of that is kind of spilled over at home as well. She has learnt so many valuable skills and she shares them with her sisters. She knows when she needs to reach out or step back and things like that.” – Parent

> “He is just a whole different person just using those things [MHCB resources]. And even if it’s just that little chart on the fridge.” - Parent

> “Now, he has learned to control his anger...and understands that there are people who cares for him, and want to help him and love him.” – Parent

> “So when this mental health program came in, I was like, ‘Oh thank God!’ (Shows a sigh of relief). It was like a gift from heaven. Not only me but my other friends and sisters said it...” – Parent

**Shifting Culture:** The qualitative evidence is beginning to point toward a shifting mental health culture within the school, attributed to the impact of MHCB activities on reducing stigma and promoting mental health discussions.

> Having the MHCB presence in our school helped because it highlights the importance of mental health in our school culture. From the conversations I have with students, mental health is slowly becoming less stigmatized in comparison to before MHCB came into our school. The focus on mental health in our culture/society also prompted these changes.” - School Staff

> “Conversations with students in regards to mental health is becoming more open and accepting. I enjoyed the conversations with staff in our book club. I also appreciate the well packs and the gifts to show appreciation for teachers and regards for their mental health.” – School Staff

> “I appreciate that the students all know that we have the program. They know there are options and resources available to them if and when a need arises. The MHCB is an understood acronym now in the building.” – School Staff
**MEASUREMENT CONCEPT – BETTER CARE**

**Evaluation Objective 2: Support Early Interventions and Facilitate Access to Treatment**

**Evaluation Question 1:** How many children are currently participating in risky behaviours? (Outcome measure)

This was assessed using the OurSCHOOL survey to show changes in children’s participation in risky behaviours.

**RESULTS – TABLE 5 – RISKY BEHAVIOURS IMPACTING PHYSICAL HEALTH**

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</thead>
<tbody>
<tr>
<td>% of students that have ever drunk alcohol</td>
<td>31%</td>
<td>27%</td>
<td>13%</td>
<td>SIMILAR Can Norm</td>
<td>SIMILAR Can Norm (27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SIMILAR Prov Norm</td>
<td>BELOW Prov Norm (29%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>ABOVE Replica pop (23%)</td>
</tr>
<tr>
<td>% students that use marijuana</td>
<td>15%</td>
<td>12%</td>
<td>20%</td>
<td>SIMILAR Can Norm</td>
<td>BELOW Can Norm (13%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (11%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>SIMILAR Replica pop (12%)</td>
</tr>
<tr>
<td>% students that have sniffed glue or other inhalants</td>
<td>9%</td>
<td>8%</td>
<td>11%</td>
<td>ABOVE Can Norm</td>
<td>ABOVE Can Norm (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>ABOVE Replica pop (6%)</td>
</tr>
<tr>
<td>% students that have used ecstasy, crystal meth, heroin or cocaine</td>
<td>12%</td>
<td>10%</td>
<td>17%</td>
<td>ABOVE Can Norm</td>
<td>SIMILAR Can Norm (9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>ABOVE Replica pop (8%)</td>
</tr>
<tr>
<td>% students that have used steroid pills or shots</td>
<td>6%</td>
<td>4%</td>
<td>33%</td>
<td>ABOVE Can Norm</td>
<td>BELOW Can Norm (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Prov Norm</td>
<td>ABOVE Prov Norm (3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ABOVE Replica pop</td>
<td>SIMILAR Replica pop (4%)</td>
</tr>
</tbody>
</table>

From table 5 above, a slight decrease in the proportion of children with risky behaviours can be noted across all the measures when comparing the two reporting periods; however, most of the measures were slightly above the normative data (i.e., proportion of children with risky behaviours across the MHCB schools are above the reference populations). The total proportion of students who have drunk alcohol was distinctly higher than the other measures, and this reflects the need for more targeted educational awareness.

**Evaluation Question 2:** Do children receive the necessary interventions and have access to the treatment services they need? (Process measure)

This would be assessed by showing that the MHCB schools were successfully connecting children in need of services, if there were positive changes in these two areas:

a. The number of incoming referrals made to MHCB staff either from within or external to the school setting
b. The number of outgoing referrals made by MHCB staff to other services or providers
RESULTS: TRACKING TOOL - NUMBER OF INCOMING REFERRALS MADE

In total, there were 1382 incoming referrals made to the MHCB team through the two reporting periods (n=809 in 2019/20 & n=573 in 2020/21). The peak of incoming referrals was before the COVID-19 lock down (December 2019 to February 2020), which was mostly due to increasing self-referrals from grades 7-9. In February 2020, out of the 217 total referrals, 169 were for grades 7-9 and 58% of those were self-referrals. It should be noted that grades 7-9 were not the highest program audiences in 2019/20. As shown earlier in Figure 3, the highest audiences were reported for programs delivered to the whole school, followed by grades 10-12, and then grades 7-9.

For the 2020/21 period, incoming referrals (as shown in Figure 6 below) seemed to be gradually spreading across other grades including PreK-6 and grades 10-12, while grades 7-9 were steadily decreasing.

In 2019/20, out of the total referrals, 0.6% were for PreK-6, 19% for grades 10-12, and 80% for grades 7-9. Comparatively, in 2020/21, 14% were PreK-6, 40% were grades 10-12, and 46% grades 7-9. This could be attributed to programs being delivered to a broader and mixed groups of audiences.

As it was previously established, program delivery increased for PreK-6 in the associate schools, therefore, increasing referrals for this age group could have resulted from the increasing awareness in the associate schools. The sharp rise in September 2020 for grades 10-12 was largely due to referrals from one school, where 96% of those referrals were made by teachers. However, this was in contrast to the other months during the 2020/21 period, where grade 10-12 referrals were spread across all the MHCB schools. Despite this increasing awareness for different grades, total referrals made by teachers increased from 650 in 2019/20 to 749 in 2020/21, while self-referrals drastically decreased from 372 in 2019/20 to 65 in 2020/21.

Overall, Figure 6 shows an overall decrease in the average number of incoming referrals from 2019/20 (n=67/month) to 2020/21 (n=48/month). Given that a deceased average for referrals was shown for 2020/21, and the total self-referrals also recorded a sharp drop, the role of reduced student attendance in schools due to COVID-19 cannot be underplayed as a contributing factor.
RESULTS: TRACKING TOOL - NUMBER OF OUTGOING REFERRALS

In total, there were 282 outgoing referrals made by MHCB teams during the two reporting periods (n=90 in 2019/20 & n=192 in 2020/21). The chart below (Figure 7) highlights a steady increase in the number of outgoing referrals except during COVID-19 lockdown, summer breaks, and Christmas breaks when there were observably sharp drops in outgoing referral rates.

In 2019/20, out of the 90 referrals, 86% were referred to school-based supports; however, this changed dramatically in 2020/21, where only 34% out of the 192 referrals were made to supports within the school settings. It is unclear whether this was a result of an extended COVID-19 lockdown or effects of re-opening protocols such as cohorting, alternating school days and remote learning. Nevertheless, the tracking tool showed that the referrals made to external agencies (66%) in 2020/21 were spread across online and in-person services such as Kid’s Help Phone, Trans Life Line, Mental Health and Addictions Agencies, Ministry of Social Sciences, Food Bank, Child and Youth Services, Family Services, Health Centre, etc.

Although all schools utilized the referral process for students in need of more therapeutic services, one school accounted for 83% of the total outgoing referrals for the 2020/21 reporting period.

Overall, the average number of outgoing referrals per month increased by 100% from 8 referrals per month in 2019/20 reporting period to 16 referrals per month in 2020/21 reporting period, when schools re-opened following COVID-19 lockdown.

![Figure 7 - Monthly Trend: Outgoing Referrals June 2019 - May 2021](image_url)
QUALITATIVE FINDINGS – NARRATIVE SUMMARY

Besides the consistent emphasis on MHCB space as a school environment for supportive mental health discussions, the narrative summary highlighted the role of MHCB staff in bridging the gap of care for students in need of referrals. In particular, they demonstrated the intention to improve their relationships with new and existing supports. For example, some School Coordinators described their commitment to existing relationships with the student support team, while building new relationships with community organizations.

“That is why it is important for us to focus on building that relationship with other organizations within the community, so we can connect those who seek tier two supports with the proper organization or person(s).” – School Coordinator

“We have created a better working relationship with our student supports within the school and have committed to a grief camp, healing circles, and restorative programs.” – School Coordinator

“It [referrals from MHCB] allows a specialist to support students in the proper manner rather than inconsistent responses from teachers/staff.” – School Coordinator
MEASUREMENT CONCEPT – BETTER VALUE

Evaluation Objective 3: Build Capacity in School staff to deliver wellness programming

Evaluation Question 1: Do the MHCB staff provide appropriate information and resources for staff? (Outcome measure)

This was assessed using the School Staff Satisfaction Survey to show whether MHCB staff could create a positive experience for school staff by investigating the changes in:

a. Proportion of school staff using MHCB programming and their level of satisfaction
b. Proportion of school staff reporting a change in their confidence in discussing mental health issues with students

DATA NOTES: School Staff Satisfaction Survey

The cross-sectional data from 2020 and 2021 surveys were collected with no evidence that the same staff participated each year. Therefore caution should be taken in interpreting the % changes highlighted in Table 6 – 11.

The % changes are hereby provided for a general overview based on direct comparisons between the proportions of respondents to each survey.

RESULTS - SCHOOL STAFF UTILISATION AND SATISFACTION WITH MHCB PROGRAM

- A total of 135 participants responded to the School Staff Satisfaction Survey, which was an 18% decrease from the 2020 survey. Teaching staff represented the majority of respondents with 76%, while non-teaching staff were 24%. The ratio of teaching versus non-teaching staff was similar to those of the 2020 survey.
- From Table 6 below, there was a high proportion of school staff (98%) who were aware of the MHCB initiative; although, this was a 2% decrease in comparison to the 2020 survey, presumably due to new staff members, as the change was substantially low.
- There were 66% of school staff who had attended an MHCB program, while those who had direct programming in their classroom were 49%. These were observably lower than the proportions recorded for the 2020 survey, possibly due to COVID-19 restrictions; however, this highlights the continued need for teacher engagement and classroom integration.
- In contrast, about 62% of respondents (a 7% increase from 2020 survey), had at one point referred students to the MHCB team. This supports the evidence shown under ‘Better Care’ that teachers initiated a large proportion of student referrals made to MHCB staff.
Table 6 - Changes over Time in School Staff Participation (% positive responses)

<table>
<thead>
<tr>
<th>Measure</th>
<th>MAY 2020</th>
<th>MAY 2021</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWARENESS</td>
<td>100%</td>
<td>98%</td>
<td>2%</td>
</tr>
<tr>
<td>ATTENDED</td>
<td>74%</td>
<td>66%</td>
<td>11%</td>
</tr>
<tr>
<td>DIRECT PROGRAMMING</td>
<td>52%</td>
<td>49%</td>
<td>6%</td>
</tr>
<tr>
<td>REFERRED</td>
<td>58%</td>
<td>62%</td>
<td>7%</td>
</tr>
</tbody>
</table>

- Similar to the 2020 survey, Table 7 shows about 71% of all staff respondents were somewhat satisfied or very satisfied with the MHCB initiative at their school. In addition, 70% would recommend MHCB initiative to other schools.
- In terms of COVID-19, school staff were asked this year to rate access to MHCB resources since the pandemic, and 78% (Table 8) of the respondents rated access to resources as good, very good or excellent.

Table 7 - Changes over Time in School Staff Satisfaction (% very/ somewhat)

<table>
<thead>
<tr>
<th>Measure</th>
<th>MAY 2020</th>
<th>MAY 2021</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL SATISFACTION</td>
<td>69%</td>
<td>71%</td>
<td>3%</td>
</tr>
<tr>
<td>WOULD RECOMMEND</td>
<td>75%</td>
<td>70%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Table 8 – Access to Resources since COVID-19 Pandemic (% good/very good/ excellent)

<table>
<thead>
<tr>
<th>Measure</th>
<th>MAY 2020</th>
<th>MAY 2021</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS TO MHCB RESOURCES</td>
<td>N/A</td>
<td>78%</td>
<td>No change</td>
</tr>
</tbody>
</table>
RESULTS - SCHOOL STAFF CONFIDENCE IN DISCUSSING MENTAL HEALTH ISSUES WITH STUDENTS

- Given that school staff had some degree of inherent confidence, they were asked if MHCB support/resources has resulted in changes in their confidence interacting with students concerning mental health issues and their responses are as follows:
  - In total 45% of respondents indicated that their confidence had not changed
  - 50% (Table 9) indicated they felt more confident (11% increase from 2020 survey)
  - 5% indicated they were still somewhat unconfident, which was lower than the 8% from the 2020 survey

Table 9 - Changes over Time in School Staff Confidence (% higher confidence)

<table>
<thead>
<tr>
<th>Measure</th>
<th>MAY 2020</th>
<th>MAY 2021</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL CONFIDENCE</td>
<td>45%</td>
<td>50%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Evaluation Question 2: Do the school staff demonstrate they have the necessary skills to promote positive mental health behaviours? (Process measure)

This was assessed using the Monthly Tracking Tool to show if MHCB has been successful in inspiring teachers to integrate mental health opportunities into their teaching via:

- change in the number of mental health programs delivered by non-MHCB staff
- change in the number of mental health programs co-facilitated by MHCB staff and school staff

As previously established, there were more total program occurrences in the 2020/21 reporting period:

- Out of the total program occurrences, MHCB staff directly accounted for 75% of the program delivery, which was similar to 74% in the 2019/20 period.
- Program delivery by non-MHCB staff (i.e., teachers, parents or students), remained unchanged at 3% of total program delivery.
- As shown in Figure 8 below, on a monthly basis, the average number of co-facilitated programs showed an 86% increase from 14 per month in 2019/20 period to 26 per month in 2020/21 period, and the average for non-MHCB staff (i.e., teachers, parents, or students) only increased from 3 to 4 per month, while those delivered by external presenters decreased from an average of 6 to 1 per month. In reflection, this may highlight the ‘you do’ challenge, because co-facilitation showed a significant increase while independent delivery by teachers, parents, or students was close to a relatively unchanged data. In addition, the observed decrease in external presenters likely reflects reduced in-person engagement due to COVID-19, leading to fewer invited guest presenters.
QUALITATIVE FINDINGS – NARRATIVE SUMMARY AND OPEN-ENDED SURVEY RESPONSES

From the open-ended responses in the Staff Survey, teacher satisfaction with MHCB resources and programming was emphasized. Importantly, the data reflected the impact of MHCB on staff’s wellness by describing how MHCB provides a platform that encourages openness and allows staff in need of care to reach out.

“As a teacher I feel like someone cares more about my mental health and well-being since the MHCB has started. I really appreciate the little things they do to let us know we are loved and supported.” – School Staff

“The wellness promoter has absolutely been an amazing resource for staff as well as our students! We appreciate the work that she is doing very much!” – School Staff

“The MHCB team has also been there in a similar capacity for staff, giving us some tools that relieve the pressure a bit. Every school would benefit from this initiative.” – School Staff

The findings also supported those of previous evaluations in terms of evidence supporting positive teacher engagement in the delivery of mental health programs.
“I have been fortunate to collaborate with the MHCB program on several occasions at various levels of school support. I hope to add to our collaborations in the years to come!” – School Staff

“Great job! Reaching out to teachers to have students participate in events such as the awareness bench has student think critically about mental health and brings awareness to MHCB initiatives.” – School Staff

“Relationships built with staff who are now partnering with MHCB and supporting our programs.” – School Coordinator

“Thank you for coming into my classroom to engage my students in conversations about relationships, body image, and mental wellness.” – School Staff

Similar to the previous evaluations, only a few teachers provided comments that supported improved confidence in interacting with students or facilitating mental health discussion and programming. This supports the quantitative data (Table 9 above) showing that only half of staff survey respondents reported improved confidence since MHCB involvement in the schools, as well as the high rates of teachers who have neither attended nor had direct MHCB programming in their classrooms.

“Most importantly, your programming gives me a way to open up more conversations with students about their mental health and what they need from me in the classroom to help support their growth.” – School Staff

“Thank you so much for that great presentation yesterday. It was so clear! Students like the hand-outs. They used it as one of their reference materials in our in-class class activity right now.” – School Staff

In conclusion, the analysis of the qualitative data supports positive teacher engagement and demonstrates a slight improvement of teacher confidence in interacting with students on mental health. In addition, the findings support the quantitative evidence pointing towards an overall teacher satisfaction with the programming and resources; however, with some notable dissatisfactions which will be discussed further under Better Teams.
MEASUREMENT CONCEPT – BETTER TEAMS

Evaluation Objective 4: Establish the MHCB initiative as a resource within the mental health and addiction continuum of care

**Evaluation Question 1:** Are MHCB staff successful in creating awareness of the MHCB initiative as a resource within the community? (Process/Outcome)

This was assessed using both the Staff Satisfaction Survey (outcome measure) and the qualitative data from Narrative Tool and Meetings/Outreach Tracking tool (process measure).

The staff satisfaction survey should show that:

- School staff indicate a change in perceived barriers to positive mental health and resources available for mental health emergencies.

The narrative summary, open-ended responses, and meetings tracking should show that:

- MHCB staff provide evidence of looking for means to build upon and improve current service provision within their community by:
  - identifying partnerships
  - identifying program impacts and strengths
  - identifying emerging ongoing trends
  - collecting quotes and impact stories
  - identifying program challenges

**RESULTS - CHANGE IN PERCEIVED BARRIERS TO POSITIVE MENTAL HEALTH AND RESOURCES AVAILABLE FOR MENTAL HEALTH EMERGENCIES**

School staff were asked about specific perceived barriers to positive mental health, and whether MHCB had helped to overcome this barrier.

Results from the School Staff Satisfaction Survey showed that there were improvements for all the perceived barriers to mental health (as highlighted in Table 10 below). This was shown by the lower levels of school staff who believed that the perceived barriers still existed. For example:

- In 2020, 22% of respondents reported that student mental health is still a low priority in the schools, compared to 18% in 2021, and 71% of these respondents believed this positive change was due to MHCB support.
- In terms of mental health stigma by students, 66% reported it as a barrier in 2020, relative to 53% in 2021 which was remarkably lower, and 71% of these respondents believed the positive change was due to MHCB support.
• However, a large proportion of respondents (86% in 2020 & 83% in 2021) still perceive that language and cultural barriers are existing challenges to positive mental health within the schools. This shows an area that needs to be addressed to promote cultural responsiveness and reduce language barriers that may impede mental health promotion efforts.

Table 10 - Changes in Perceived Barriers to Positive Mental Health (% Yes)

<table>
<thead>
<tr>
<th>Barrier</th>
<th>(2020)</th>
<th>(2021)</th>
<th>% Change</th>
<th>Due to MHCB support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low priority given to student mental health versus other initiatives in the school</td>
<td>22%</td>
<td>18%</td>
<td>18%</td>
<td>71%</td>
</tr>
<tr>
<td>Lack of adequate staff training to learn about student mental health</td>
<td>51%</td>
<td>49%</td>
<td>4%</td>
<td>80%</td>
</tr>
<tr>
<td>Stigma (negative attitudes or unfair treatment) by school staff</td>
<td>38%</td>
<td>33%</td>
<td>13%</td>
<td>64%</td>
</tr>
<tr>
<td>Stigma (negative attitudes or unfair treatment) by students</td>
<td>66%</td>
<td>53%</td>
<td>20%</td>
<td>71%</td>
</tr>
<tr>
<td>Language and cultural barriers arising from an ethnically and racially diverse student population</td>
<td>86%</td>
<td>83%</td>
<td>4%</td>
<td>55%</td>
</tr>
<tr>
<td>Lack of contact between the school and families</td>
<td>47%</td>
<td>44%</td>
<td>6%</td>
<td>69%</td>
</tr>
</tbody>
</table>

School staff also reported the extent to which they felt the following resources have been made available for mental health emergencies since MHCB involvement in the schools. The following observations can be drawn from Table 11 below, by looking at the proportions of respondents to each measure in 2020 and 2021 surveys.

• About 43% of respondents in the 2021 survey reported that staff have been trained on how to deal with students’ mental health emergencies, and 35% reported that people responsible for mental health emergencies have been clearly defined.

• Furthermore, only 34% of staff were aware of follow-up services internal to school, while 29% were aware of follow-up services external to school, since MHCB involvement. In reflection, this slightly contradicts the findings from ‘Better Care’, which was reported by MHCB staff in the Monthly Tracking Tool, where a significant proportion of incoming referrals to MHCB teams were from teachers. It should be noted that the Monthly Tracking Tool captures referral rates from teachers who either had awareness or engagement with the MHCB initiative, while the Staff Satisfaction Survey was administered cross-sectionally to the school staff including those without any prior MHCB engagement. Even though regular referrals by engaged teachers would be deemed positive, it does not account for the total level of awareness among school staff.

• Given that all the measures in Table 11 below showed respondents fewer than 50%, more awareness and collaborations with school staff may be needed to better understand the available resources for students’ mental health emergencies.
Table 11 - Changes in Resources Available (% Partially/ Fully in Place)

<table>
<thead>
<tr>
<th></th>
<th>In place since MHCB (2020)</th>
<th>In place since MHCB (2021)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>The people responsible for specific tasks or duties in a mental health emergency are clearly defined</td>
<td>37%</td>
<td>35%</td>
<td>5%</td>
</tr>
<tr>
<td>School staff have been trained how to respond appropriately to students who experience mental health emergencies</td>
<td>38%</td>
<td>43%</td>
<td>13%</td>
</tr>
<tr>
<td>There are follow-up services (internal to the school) available for students who experience mental health emergencies</td>
<td>39%</td>
<td>34%</td>
<td>13%</td>
</tr>
<tr>
<td>There are follow-up services (external to the school) available for students who experience mental health emergencies</td>
<td>38%</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>Information about mental health emergencies is shared with families in the event a mental health emergency occurs</td>
<td>38%</td>
<td>32%</td>
<td>16%</td>
</tr>
<tr>
<td>Procedures are in place to follow-up with families after a mental health emergency occurs</td>
<td>40%</td>
<td>33%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**RESULTS - MHCB STAFF SHOW EVIDENCE OF IMPROVING CURRENT SERVICE PROVISION WITHIN THEIR COMMUNITY**

The qualitative data gathered from the MHCB staff showed that they enhanced, innovated and developed the breadth of their service provision under the following themes.

**EXPANDING REMOTE PROGRAM DELIVERY FOR WIDER REACH OF SERVICE PROVISION**

The MHCB staff were asked about their innovations over the last six months and a common theme was the use of technology for remote delivery of programming. They explained that remote delivery has improved the ability to stay connected with stakeholders. Some of the benefits highlighted with this approach include:

- Staying connected with stakeholders using google classrooms, school websites, etc.
- Having a larger platform for mental health promotion, particularly via social media channels such as Facebook, YouTube, Instagram, and TIK TOK
- Leveraging the use of technology for sharing of information via newsletters, emails, etc.
- Inspiring innovative training opportunities for MHCB staff
BUILDING PARTNERSHIPS FOR SUCCESSFUL SERVICE PROVISION

The MCHB staff showed the range of partnerships being created to deliver successful programming. Through the data from the Meetings/Community Outreach tracking, the range of MHCB networking are thematically categorized as follows:

- School Administration (i.e., School Division, Associate Elementary Schools, Superintendents, Principals)
- Saskatchewan Health Authority (i.e., Population Health Department, Research Department, Nutritionist, Dental Hygienist)
- Government of Saskatchewan (i.e., Ministry of Health, Ministry of Education, Ministry of Social Sciences)
- MCHB Team (i.e., internal MCHB hub, Alberta MCHB team)
- School Staff (i.e., teaching staff, non-teaching staff)
- Student Support Staff (i.e., school social workers, school addictions workers, school counsellors)
- Student-Led Associations (i.e., student leadership groups, Gender-Sexuality Alliance [GSA])
- School Associations (i.e., School Community Council, Student Services, Settlement Workers in Schools)
- Community-Based Organizations (i.e., Canadian Red Cross, Canadian Mental Health Association, RCMP, Jumpstart)
- Indigenous Groups (i.e., Peter Ballantyne Cree Nation, Indigenous resource worker, Reconciliation Committee, Elder’s meeting)
- Service Agencies (i.e., Cree Nation Child and Family Services, Child and Youth Services, Victim Services, Catholic Family Services, Sexual Health Centre)
- Community Guest Presenters (i.e., expression art therapist, yoga instructor, health and wellness coach, author and consultant Ron Nash)

PROGRAM CHALLENGES AND GAPS FOR IMPROVEMENT

There were certain challenges identified concerning the delivery and effectiveness of the MHCB initiative within schools. These are by no means the only challenges identified; however, they emerged as the commonly reflected ones. They are thematically broken down into challenges identified by school staff and MHCB staff.

SCHOOL STAFF: Two themes emerged as challenges from the open-ended responses of the School Staff Satisfaction Survey.
Concerns with program mandate and suitability – Despite the level of teacher satisfaction previously explained, some school staff believed that some programming are not as mental health-specific as expected.

“In general, I am unfamiliar with the duties of the MHCB and feel a disconnect from the program.” – School Staff

“I see some activities but I am unaware of many, and I don’t feel that the program is specific enough to mental health at times, nor is it being utilized as efficiently as it could be” – School Staff

“The individuals who are in the school are kind individuals however, I am not sure there is a clear direction or mandate of what the MHCB is.” – School Staff

Dissatisfaction with expected commitment from teachers – A few of the teachers that completed the satisfaction survey reflected on their disapproval with what is expected of them through their engagement in the initiative. In reflection, this provides caution that teacher engagement may be disrupted due to miscommunication of their expected commitments and their busy schedules. One of the foundational approaches of MHCB initiative is to promote the “I do, we do, you do system”, whereby teachers witness MHCB staff’s delivery in their classrooms, and then move to co-facilitation, before ultimately having some level of independent delivery. Given that some teachers showed dissatisfaction with their expected commitments, providing regular orientations to school staff may be warranted for a clearer communication of expectations.

“I am also disappointed in how much they are asking teachers to do now. I am all for getting involved but they are now asking teachers to do leading instead of participation. One teacher leads the [mental health program] on top of their full time teaching job.” – School Staff

MHCB STAFF: Furthermore, the challenges identified in the narrative summary, which was completed by MHCB staff, are categorized below:

Teacher commitment: The MHCB staff reflected that getting as many teachers engaged can be challenging particularly because of the busy schedule of the teachers. The MHCB staff suggested possible solutions as more collaborative work with the school leadership and the provincial team.

“There are a few areas where some staff are not on board. It make it difficult at times but we try to focus on our champions.” – School Coordinator

“Classroom time is precious.” – School Coordinator

“...lack of staff participation” – School Coordinator
**Mandate Fidelity:** The MHCB staff explained that due to staff misunderstanding, they occasionally find themselves clarifying their position, type of support, and mandate within the schools. They suggested a possible solution as continuing to build relationships.

“...We are still often seen as outsiders not part of the school.” – School Coordinator

“One of the barriers we continue to deal with especially now with the current times is getting the public to understand that we are not a [one-on-one] intervention program.” - School Coordinator

**OBSERVED TRENDS**

MHCB staff were asked to discuss the ongoing trends within the last 6 months, and the themes from the positive trends and negative trends, as described by the School Coordinators are explained below:

**POSITIVE TRENDS**

**Reduced stigma:** The reflections from the MHCB staff and the feedback comments from school staff showed that the stigma surrounding mental health has gradually reduced within the schools, particularly due to openness to discuss mental health and increased awareness. This supports the evidence of a shifting mental health culture within the schools.

“More open discussion regarding mental health and the need for mental health resources that are sustainable.” – School Coordinator

“The pandemic has prompted an increase in awareness about mental health and reduced the stigma around discussions about mental health.” - School Coordinator

“The stigma surrounding the word ‘mental health’ is more openly talked about” – School Coordinator

“Since the MHCB has been put at our school, the discussions around Mental Health are greatly improved. I am very grateful that they are a part of our school.” – School Staff

**Improved technological skills:** Due to the transition to remote delivery, MHCB staff reported that they have been learning and improving their technological skills.

“...engaging with students through technology that would not attend in person.” – School Coordinator

“Technology skills have improved” – School Coordinator
NEGATIVE TRENDS

Observed increase in negative mental health outcomes: This trend was described by some of the School Coordinators. They reported that the COVID-19 adjustments within the school system such as cohorting, alternate school days, and online transitions, may have played a role in this trend. In reflection, caution should be taken in interpreting this observational data, as several other social and environment factors such as family circumstances, economic status, stress, stigma, and trauma, among others, may be responsible for this negative trend.

“Stress among both students and staff has increased substantially.” – School Coordinator

“Self-reported rates of depression and suicide attempts have increased.” – School Coordinator

“Added pressure with the Block System (time constraints, quicker pace, etc.) making staff frustration increase in stress and anxiety.” – School Coordinator

This observational finding supports the OurSCHOOL outcome measures on emotional health and risky behaviours, where the total percent of students without positive self-esteem and those with anxiety, depression, and alcohol use were relatively over 30%.

Decreased attendance and in-person engagement: Due to transition to remote learning, reduced opportunity for in-person engagement in classrooms and MHCB spaces, and loss of extra-curricular activities has resulted in decreased attendance and resulting opportunities to engage with students who may be susceptible to feeling isolated. Even though reduced school attendance was noted, there was a favourable impact for one-on-one interaction with students within the MHCB spaces.

“A drop in school attendance has been very noticeable.” – School Coordinator

“Students are feeling disconnected from the school, friends, extra-curr., etc.” – School Coordinator
POSITIVE AND NEGATIVE IMPACTS OF COVID-19 ON PROGRAM DELIVERY

The School Coordinators also reflected on positive and negative impacts of COVID-19 on MHCB programming. These are categorized below:

<table>
<thead>
<tr>
<th>Positive Impacts (Themes)</th>
<th>Quotes from School Coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. More one-on-one interactions and referrals</td>
<td>“The amount of students permitted in the mental health room is significantly lowered. This has made space for more one-on-one interactions and referrals to mental health resources.” “Smaller groups in a classroom really give educators the opportunity to connect at a different level.”</td>
</tr>
<tr>
<td>2. Staying connected with students</td>
<td>“Moving to an online platform has its pros and cons and it allows for us to stay connected.” “Knowing that we can still have engagement virtually and connect with students who are poor attenders.”</td>
</tr>
<tr>
<td>3. Reaching wider audience</td>
<td>“Positive impacts include an increase and diversity in the audience we are reaching.” “Increased visibility and understanding of the program. Larger platform for mental health promotion.”</td>
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<tr>
<td>4. Increased creativity and flexibility</td>
<td>“The need to be flexible, adapt to circumstances, be willing to learn new skills and platforms to deliver programming and supports.” “New ways to deliver programs that will continue past the pandemic.”</td>
</tr>
<tr>
<td>5. Leveraging social media platform</td>
<td>“Rely more on technology and social media for information sharing.” “We try to engage staff and students as much as possible over these platforms.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Impacts (Themes)</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Affecting social engagement with programming</td>
<td>“Decreased student and staff engagement with programming.” “However, I think our biggest obstacle in regard to online learning, is how you are pretty much socializing at a distance. That has a major impact on our students and it takes away the social aspects that many programs we run tend to focus on.”</td>
</tr>
<tr>
<td>2. Reduced unique programs</td>
<td>“We have had to reduce the type of programs that we offer due to pandemic protocols.” “It is hard to do these programs when attendance is low.”</td>
</tr>
<tr>
<td>3. Concerns with effectiveness</td>
<td>“…although we are connecting with our students with the online resources, I feel that we are still very limited in its effectiveness to ensure the kids are engaging in the material and learning from it.”</td>
</tr>
</tbody>
</table>
Conclusion

The purpose of this evaluation was to show the impact of the MHCB initiative in Saskatchewan schools and communities by showing changes in process and outcome measures across two reporting periods, and highlighting the impact of COVID-19 on programming. So far, the MHCB initiative has shown some positive impacts across a considerable amount of the targeted measures in this evaluation.

The Monthly Tracking Tool showed increased total occurrences of programmed events despite reduced unique types of programs due to COVID-19. The School Staff Satisfaction Survey showed an overall teacher satisfaction as well as a slight improvement in teacher confidence. The Student Ideas Tracking supported evidence of students’ positive engagement including taking the lead on initiatives. The Meetings/Community Outreach Tool provided a vast range of partnerships that MHCB staff engage with to promote the initiative as a resource within the mental health and addiction continuum of care. The OurSCHOOL Survey showed improvement in students’ sense of belonging, positive relationships, and feelings of safety. Themes from the qualitative analysis supported and extended understandings of the targeted measures.

The success of the MHCB initiative is based on observations of all schools combined, but recognition is required of differences that exist between schools in the pilot. This evaluation showed evidence of reduced stigma from students. In addition, this evaluation provided evidence of a shifting mental health culture supported by views from school staff themselves. However, more time may still be required to fully establish and sustain a school-wide mental health culture, given the few years of implementation and pivoting with COVID-19.

Despite the positive impacts, some challenges still exist such as mandate clarity, and teacher/school staff commitment and role in sustaining mental health culture through their classroom/school operations. These existing challenges were highlighted in this report from the perspectives of school staff and MHCB staff separately. Finally, COVID-19 may have negatively impacted interaction and engagement; however, some positive impacts such as expansion of promotional activities and reaching of broader audiences, were highlighted.
Acknowledgments

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I would like to acknowledge all schools that participated in this initiative, the students, school staff, families, and community partners. Acknowledgement also goes to the dedicated work of the MHCB staff, who are pragmatically committed to producing a significant change in mental health within their respective schools and communities. Finally, acknowledgement goes to the MHCB provincial working group as well as the advisory committee for their feedback and support in contextualizing the report.

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