Saskatchewan Health Authority

Mental Health Capacity Building

2022-2023 Annual Report

2024

Research Department
Academics & Learning

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Executive Summary

Background

Youth mental health issues affect approximately 1 in 7 individuals aged 10-19 globally, according to the World Health Organization (World Health Organization, 2021). The COVID-19 pandemic exacerbated these concerns, with surveys in Saskatchewan showing high rates of anxiety, depression, and emotional dysregulation among young people, persisting even a year later (Muhajarine, Hinz, et al., 2022).

The current report summarizes outcomes from the Mental Health Capacity Building (MHCB) project for the 2022-2023 academic year. MHCB integrates coordinators and promoters into school communities to facilitate development and implementation of homegrown initiatives to support mental health prevention and promotion. MHCB is rooted in the evidence-informed Comprehensive School Community Health (CSCH) framework, consisting of four components: (1) family and community engagement, (2) high quality teaching and learning, (3) healthy physical and social environments, and (4) effective policy. The Core Indicators Model (CIM)—created by the Joint Consortium of School Health (JCSH), provides an evidence-based framework for assessing CSCH using three categories (i.e., environmental, health, and educational, the latter being sub-divided into personal growth and academic indicators), each assessed according to three domains (i.e., affective/social-emotional, behavioural, and cognitive). This results in 12 core indicators, 10 of which are relevant to MHCB.

On February 27, 2019, the Government of Saskatchewan launched the MHCB program as a pilot project in five Saskatchewan schools in the K-12 system (Government of Saskatchewan, 2019). Co-led by the Ministry of Health, Ministry of Education, and Saskatchewan Health Authority (SHA), MHCB addresses a recommendation in the province's 2014 *Mental Health and Addictions Action Plan* (Stockdale Winder, 2014) to increase awareness of child and youth mental health and addiction issues and to help them develop lifelong skills to support their emotional and social health. Focused on primary and secondary mental health prevention and promotion, MHCB aims to enhance schools' self-efficacy in sustaining mental health initiatives independently (Government of Saskatchewan, 2019). The program was expanded to include an additional five schools for the 2022-2023 school year, with further expansion planned for 2024-2025 as part of the province's updated *Action Plan for Mental Health and Addictions 2023-2028* (Government of Saskatchewan, 2022, 2023a, 2023c).

Objectives

Findings from 10 participating schools during the 2022-2023 academic year indicate the project's potential for enhancing protective factors and reducing mental health risks. Five objectives were outlined:

1. Utilize the CSCH framework to address mental health promotion in a planned, integrated, and holistic way.
2. Use evidence-based and innovative programming to enhance mental health and well-being in students and families by: (a) building and strengthening awareness, knowledge, skills, and confidence, and (b) creating a school culture that fosters a sense of belonging and safety.
3. Build capacity of school staff through professional development that supports mental health literacy, the reduction of stigma, and curricular connections.
4. Support early intervention and facilitate access to supports for students and families who are experiencing, or are at risk of experiencing, mental health concerns.
5. Develop a network of participating MHCB Schools to support program implementation and delivery.

Methods

A mixed-methods study design was used. Teachers and non-teaching staff at MHCB schools were invited to complete an online survey. Program metric data and narrative reflections were provided by MHCB coordinators. Aggregate-level results were also obtained from a standardized self-report survey regarding students' health and well-being (OurSCHOOL), which is administered annually by a third-party service provider (The Learning Bar). Only OurSCHOOL data from Cohort 1 schools was used for this analysis, as Cohort 2 schools were just beginning MHCB when the survey was administered. Approval for this study was granted by the Saskatchewan Health Authority Research Ethics Board (REB-18-89).

Results

A total of 287 individuals completed the staff survey (i.e., 187 teaching staff, 87 non-teaching staff, 1 not reported). School-level response rates for teaching staff ranged from 34% to 81% (M = 59%), while non-teaching staff response rates ranged from 18% to 62% (M = 37%). The overall response rate across schools was 48%.

The majority (94%) of the respondents were aware of the MHCB project. Of these, 80% attended at least one MHCB activity and 65% engaged directly with the MHCB team. Nearly two-thirds of participants who were aware of MHCB agreed or strongly agreed that the program is helping to create a school community environment that supports positive mental health and well-being.

Inclusive School Environment

Feedback from staff at MHCB schools was positive, with at least three-quarters of respondents noting its role in fostering a school community environment that is open, welcoming, and encourages participation; improving safety (e.g., physical, psychological, social); and addressing matters of equity, diversity, and inclusion. Qualitative feedback from school staff and MHCB coordinators supports these findings. Numerous respondents provided comments about Wellness Rooms within the schools, with the majority finding these to be helpful resources for students, providing a place to decompress. Satisfaction with MHCB program staff was school-dependent. Several comments described the reduction of stigma around mental health and well-being and how MHCB supported normalizing discussions of mental health in the school community environment. However, OurSCHOOL data showed only modest improvements in sense of belonging (2%) and bullying, exclusion, and harassment (1%) and lower scores for feeling safe in school (-3%) and bullying and exclusion (without the element of harassment; -7%) as compared to the previous year.

Sustainable Adult Engagement and Partnerships

Despite positive experiences such as community collaboration and impactful guest lectures, survey results revealed comparatively low scores for sustainable engagement, with fewer than two-thirds of respondents acknowledging partnerships with external organizations or improved staff involvement with mental health and well-being initiatives. Nonetheless, there are ongoing efforts to enhance support for mental health initiatives within school communities, including initiatives led by MHCB coordinators advocating for mental health and outreach to parents and the broader community.

Understanding of Comprehensive School Health

School staff indicated that their engagement in MHCB would benefit from increased communication among MHCB staff, school staff, and administration. Approximately three-quarters of respondents felt supported in their work with MHCB by school administration, with two-thirds feeling supported by their School Division.

Mental Health and Well-Being

The majority of staff survey respondents (range: 70-75%) noted improvements in their knowledge to support protective factors and reduce risk factors that threaten mental health and well-being, and feeling encouraged to learn more about student mental health and well-being, as well as their own. Feedback from staff indicated that the program has potential to support mental health prevention and promotion, but that there is more work that can be done to help students adapt healthy coping mechanisms. While self-esteem scores were lower in MHCB schools compared to provincial norms, scores pertaining to anxiety, depression, and positive relationships were similar.

Health and Health Behaviours

Survey findings indicated enhanced confidence in modeling positive mental health behaviours (65%) and improved mental health knowledge (74%) among respondents. MHCB schools demonstrated lower rates of inhalant and drug use compared to provincial trends: Cohort 1 schools showing notable reductions in marijuana (decrease of 4 percentage points) and alcohol use (decrease of 8 percentage points) compared to when MHCB was initiated at their schools, despite provincial norms remaining consistent. Open-ended feedback was positive, with survey respondents highlighting that students were taking more initiative in using coping strategies and that the mental health-related knowledge and skills being developed were helpful to staff in their own lives as well.

Health Literacy

Presentations—both by MHCB staff and guest presenters—were frequently cited by survey respondents as being beneficial in raising awareness and imparting important mental health-related knowledge and skills. Efforts to reduce stigma around mental health were noted, although some variability existed in staff scores regarding health literacy improvements. Nonetheless, there was widespread recognition of available resources and professional development opportunities supporting mental health and well-being. In their open-ended feedback, several survey respondents indicated that having open discussions about mental health was important in reducing stigma. Respondents felt less well versed in how to connect students and families to appropriate mental health services in instances when promotion and prevention were not enough.

Identity Development

Identity development was not assessed via the staff survey. MHCB students completing the OurSCHOOL survey exhibited comparable scores for sense of purpose and life satisfaction as compared to the provincial norm, although scores for pursuit of enjoyment were 5% lower in MHCB schools than across the province.

Youth Engagement

Youth engagement in identifying, planning, and leading positive mental health and well-being initiatives was high, with 75% of school staff respondents agreeing or strongly agreeing with this statement. One area in which students should continue to be supported is in helping them to take the skills that they learn via MHCB programming and applying them within other settings both inside and outside of school.

Academic Motivation

OurSCHOOL data showed similar scores in MHCB and non-MHCB schools regarding the amount of value students placed on school outcomes, as well as their interest and motivation. Goal orientation was lower (55%) for students in MHCB schools compared to provincial norms (59%).

Academic Participation

OurSCHOOL data showed similar scores between MHCB and non-MHCB students for positive behaviour at school. Students at MHCB schools, however, had lower scores for effort, positive homework behaviours, and planning to finish high school, as well as higher truancy.

Discussion

Staff survey results and MHCB Coordinator narrative reflections indicated that the four indicators on which MHCB has had the strongest positive impact are: inclusive school environment, mental health and well-being (staff's and students'), health literacy (i.e., knowledge about mental health and well-being), and youth engagement. There are opportunities for growth in parent/caregiver and community engagement, helping staff translate knowledge into practice (e.g., school staff applying MHCB learning in other scenarios, confidence in modelling and practicing positive mental health and well-being strategies), as well as School Division support.

The MHCB program has important implications for mental health prevention and promotion among the province's youth; however, some limitations in the current evaluation are noted. OurSCHOOL data were restricted to Cohort 1 schools only, as due to the timing of data collection, Cohort 2 completed the survey when the initiative was just commencing at their schools. As mental health initiatives take time to yield results, tracking student progress longitudinally is crucial, yet there is currently no mechanism for doing so. Additionally, OurSCHOOL data may not capture the full scope of impact, highlighting the need for additional data sources—such as interviews with students, parents, and staff—to gather more comprehensive feedback.

Conclusion

MHCB received consistent praise as a vital support for students' mental health and well-being, with school staff highlighting its positive impact, particularly in raising awareness and reducing stigma. Staff engagement varied among schools; however, a desire for increased parental and community engagement was expressed overall. While staff reported improved mental health-related knowledge, translating it into providing effective support for students was challenging. Despite positive staff feedback, OurSCHOOL survey outcomes did not show significant improvements in mental health and well-being measures and should be interpreted cautiously. Nonetheless, with the Ministry of Health's plan to expand the program to a third cohort of schools in the upcoming year, this evaluation's findings will guide future implementation efforts.

Background

The mental health challenges that youth experience are well documented and have been flagged as a global concern. The World Health Organization (WHO) notes that it is estimated that 1 in 7 young people aged 10-19 experience at least one mental health condition (World Health Organization, 2021). The COVID-19 pandemic amplified these concerns: A survey of 510 youth–parent/caregiver dyads in Saskatchewan conducted in the spring and summer of 2021 revealed that even when focusing on just the week prior to completing the survey, youth screened positive for medium to high severity for symptoms of anxiety (10%) and depression (9.3%) at a rate of approximately 1 in 10, with nearly one quarter (24%) experiencing symptoms of emotional dysregulation such as difficulty controlling one's feelings and how they act upon those feelings (Muhajarine, Adeyinka, et al., 2022). In a similar survey conducted one year later with 563 youth–parent/caregiver dyads, when asked to reflect back on the previous two weeks, high rates of depression (23%) and anxiety (38%) remained a concern (Muhajarine, Hinz, et al., 2022).

Several models of mental health have been posited (e.g., Canadian Mental Health Association, n.d.; Centre for Addiction and Mental Health, n.d.; Government of Canada, n.d.), which often share three common themes:

1. Mental health is multi-faceted,
2. Mental health is not an either/or concept but rather, it exists along a continuum, and
3. The relationship between mental illness and mental well-being is complex—it is possible for someone to have been diagnosed with a mental health condition yet still experience positive mental well-being.

This report provides the results of a program evaluation of a provincial initiative designed to support the mental health and well-being of Saskatchewan youth. The Mental Health Capacity Building (MHCB) project is a school-based mental health promotion and prevention initiative dedicated to enhancing protective factors and reducing risk factors associated with mental health and well-being. In so doing, MHCB supports a school community environment that promotes and sustains positive mental health and well-being for everyone. This is accomplished by embedding MHCB coordinators and mental health promoters within selected schools in order to work directly with students, staff, and other members of the school community. These findings primarily pertain to all 10 of the schools that participated in the project during the 2022-2023 school year, although some comparisons are made to data collected at the end of the 2019-2022 school year, which marked the launch of the program at an initial five pilot test sites.

Mental Health Capacity Building (MHCB) in Saskatchewan Schools

On February 27, 2019, the Government of Saskatchewan issued a media release announcing the launch of a Mental Health Capacity Building (MHCB) program, to be pilot tested at five schools in the Kindergarten to Grade 12 system (K-12) throughout the province (Government of Saskatchewan, 2019). The MHCB program—modelled after a similar initiative in Alberta (Alberta Health Services, n.d.)—aims to support youth mental health by embedding an MHCB Coordinator and Facilitator at each school in order to work directly with students, staff, and other members of the school community to engage in mental health promotion and prevention activities. MHCB is a joint effort led by the Saskatchewan Health Authority (SHA) and supported by the Ministry of Education and Ministry of Health (Government of Saskatchewan, 2019). The MHCB program was created to address one of the recommendations in the province's 10 year Mental Health and Addictions Action Plan, which was to "increase awareness of mental health and addictions issues in children and youth

through schools, including development of skills for lifelong emotional and social health" (Stockdale Winder, 2014, p. 13).

The Mental Health Capacity Building (MHCB) program supports positive mental health and well-being by enhancing protective factors and reducing preventable risk factors for mental illness. This is accomplished by creating a school community that promotes and sustains positive mental health and well-being for everyone. The MHCB program builds capacity for students, families, caregivers, staff, and communities to work together towards a healthy school environment.

On August 22, 2022, the Government of Saskatchewan announced an additional investment into the MHCB program and that it was being expanded to include an additional five K-12 schools for the 2022-2023 school year (Government of Saskatchewan, 2022). On October 6, 2023, it was announced that as part of its new *Action Plan for Mental Health and Addictions 2023-2028* (Government of Saskatchewan, 2023a), MHCB will be further expanded to include an additional five schools in the 2024-2025 school year and to all 27 school divisions by 2028 (Government of Saskatchewan, 2023c).

Comprehensive School Community Health (CSCH)

MHCB programming was designed using the principles of Comprehensive School Community Health (CSCH). The CSCH framework is an evidence-informed, holistic approach to supporting students' success and well-being (Murray et al., 2007; Veugelers & Schwartz, 2010). Noting that there are some terminology differences from province to province, at its core, the framework consists of four integrated components (Pan-Canadian Joint Consortium for School Health, n.d.):

1. **Family and Community Engagement.** This component of the CSCH model emphasizes the importance of moving beyond a student–teacher view of student success, instead emphasizing that students and teachers are part of a larger ecosystem including non-teaching staff, peers, parents/caregivers, family, community leaders, cultural and social organizations, and members of the broader community. Including a focus on community shines a spotlight on ways that the unique characteristics of individual communities play a role in students' experiences both in and out of school.
2. **High-Quality Teaching and Learning.** Providing students with a robust education grounded in evidence-informed curricula is key to facilitating student success. Educational materials and instructional practices should be culturally responsive and appropriate to the developmental needs of students, motivating students towards increasing self-efficacy.
3. **Healthy Physical and Social Environments.** Student health is an essential component in facilitating student achievement. The CSCH model takes a holistic view of student wellness, encouraging practices that support the physical, mental, and social well-being of students. This includes supporting students in ways such as encouraging healthy eating and physical activity, mental health prevention and promotion activities, and helping students make positive contributions to their communities.
4. **Effective Policy.** An important aspect of a taking a comprehensive approach to school–community health is creating, revisiting, and maintaining policies and practices that clearly delineate roles, responsibilities, and objectives. Programs designed to support student wellness and achievement should be evaluated regularly to ensure that they are achieving their stated objectives and to engage in ongoing quality improvement.

It is noted that after the current annual review cycle had commenced, a revised CSCH framework was released by the Ministry of Health; however, the wording used throughout this report is from the model that was in use at the time when the data were collected (Government of Saskatchewan, 2023b).

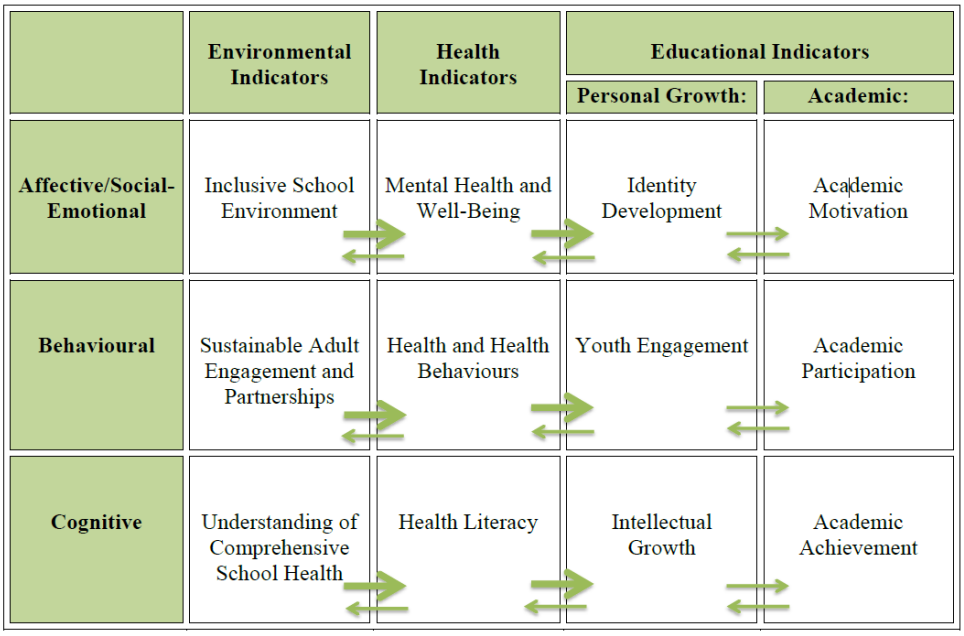
In Saskatchewan, the Ministries of Education and Health and the Saskatchewan Health Authority are committed to promoting the CSCH approach to help guide and coordinate actions to encourage strong family, school, and community partnerships; integration of services; and policy development and implementation to support overall student wellbeing and achievement.

Core Indicators Model (CIM)

The Core Indicators Model (CIM) was created by the Joint Consortium of School Health (JCSH) which is made up of Representatives of the Education and Health ministries of 12 provinces and territories, along with the Public Health Agency of Canada. The JCSH members work together to enhance Canadian students' Kindergarten to Grade 12 public school experience, using a Comprehensive School Health approach. The CIM provides an evidence-based framework by which to assess the impact of initiatives designed to support a CSH/CSCH approach.

Three categories of indicators are identified—environmental, health, and educational—with the latter sub-divided into personal growth and academic indicators. Taken together, these intersecting indicator categories and learning domains suggest 12 key indicators upon which CSCH initiatives may be assessed (Figure 1).

Figure 1. Core Indicators Model (CIM).



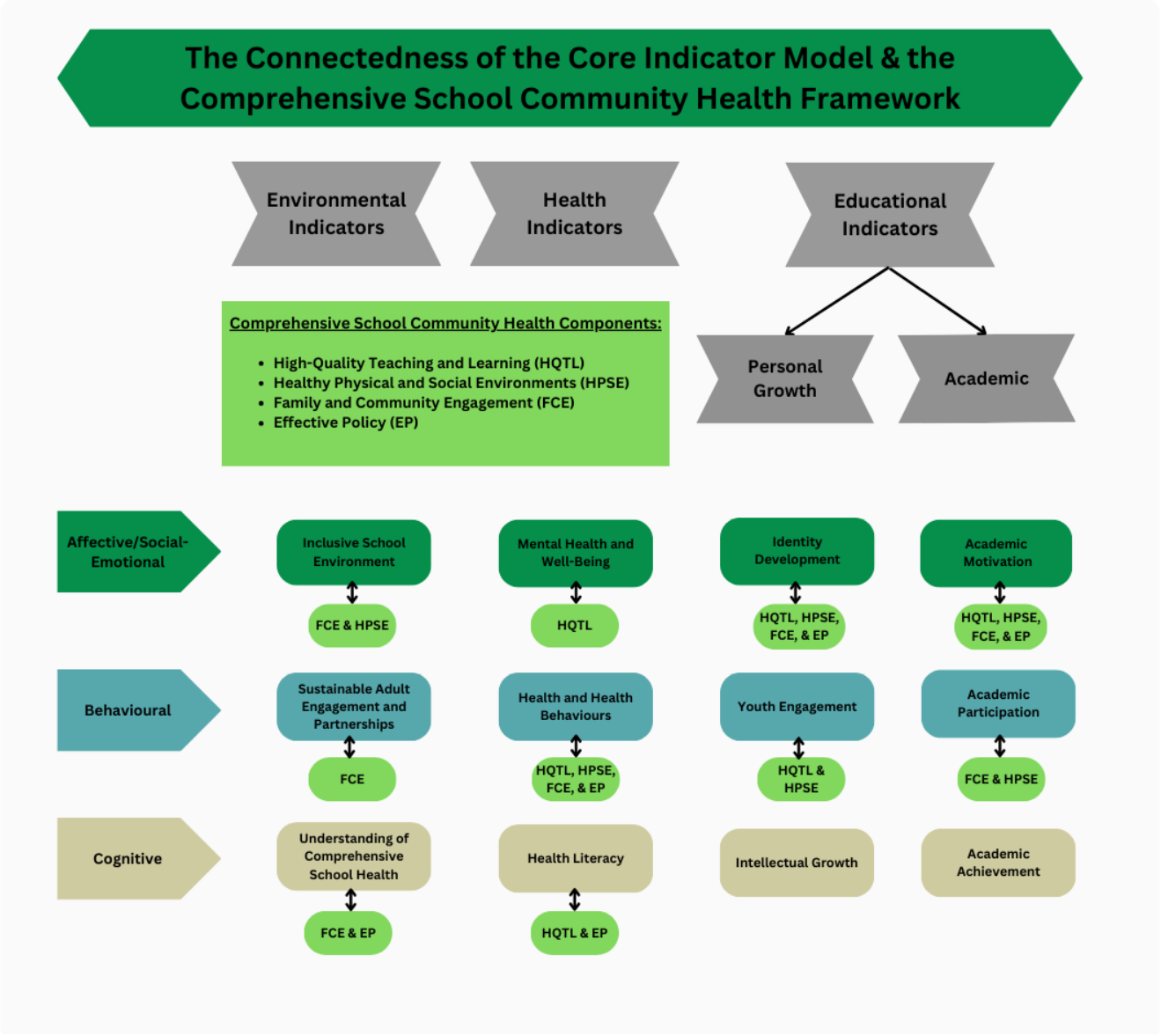
Source: Freeman et al. (2016).

Environmental indicators focus on the school setting and how it is situated within the broader community. Health indictors pertain to physical and mental health, as well as understanding and familiarity with health-

related concepts. Personal growth educational indicators relate to the students' inner states of identity development, engagement, and intellectual growth, whereas the corresponding academic educational indicators reflect the more outwardly observable results of these inner states.

Cross-cutting each of these indicators are three learning domains: affective/social-emotional (how they feel), behavioural (how they act), and cognitive (what they know). Figure 2 shows how each of the core indicators relates to the four parts of the CSCH framework. **The indicators that are directly relevant to the MHCB project will be described within the corresponding areas of the Results section of this report.**

Figure 2. Relationship between components of the Core Indicator Model and Comprehensive School Community Health framework. .



Evaluation Plan

A plan for the evaluation of the MHCB project for the 2022-2023 school year was developed by the MHCB Provincial Team, consisting of representatives from SHA, the Ministry of Health, and the Ministry of Education. The plan was initially designed to align with the Ministry of Health's principles of better health, better care, better value, and better teams (Government of Saskatchewan, n.d.), as had been done in the past.

However, the Provincial Team determined during the 2023-2024 school year that the Core Indicators Model would be a more appropriate framework for evaluating the MHCB program. Therefore, results of this evaluation are organized according to the CIM.

The evaluation questions posed at the outset of the 2022-2023 school year (Box 1)—which were originally designed to align with the categories of better health, better care, better value, and better teams—are also addressed in the Discussion section of this report.

Box 1: Evaluation Questions

Process Measures

- Are children receiving the knowledge/skills they need for optimal mental well-being?
- Do children receive the necessary interventions and have access to the treatment services they need?
- Do the school staff feel they have the necessary skills to promote positive mental health behaviours?

Outcome Measures

- Are children obtaining outcomes associated with positive mental health?
- Does the MHCB program create a culture of connectedness, psychological and physical safety?
- How many children are currently participating in risky behaviours?
- Do the MHCB staff provide appropriate information and resources for staff?
- Are MHCB staff successful in creating awareness of the MHCB initiative as a resource within the community?

Program Objectives

Five objectives were identified for the MHCB program:

1. Utilize CSCH framework to address mental health promotion in a planned, integrated, and holistic way.
2. Use evidence-based and innovative programming to enhance mental health and well-being in students and families by:
    a. building and strengthening awareness, knowledge, skills and confidence (e.g., self-regulation and interpersonal skills); and,
    b. creating a school culture that fosters a sense of belonging and safety.
3. Build capacity of school staff through professional development that supports mental health literacy, the reduction of stigma, and curricular connections.
4. Support early interventions and facilitate access to supports for students and families who are experiencing, or are at risk of experiencing, mental health concerns.
5. Develop a network of participating MHCB Schools to support program implementation and delivery.

Methods

A concurrent mixed-methods design was used for data collection and analysis. Data consisted of self-report measures collected from school staff and MHCB coordinators, as well as a standardized self-report survey about students' health and well-being (OurSCHOOL), which is collected annually and administered by a third-party service provider (The Learning Bar). This study was approved by the Saskatchewan Health Authority Research Ethics Board (REB-18-89).

MHCB Schools

At its inception during the 2019-2020 school year, the MHCB pilot initiative included five schools ("Cohort 1"), four of which were high schools, with the remaining school consisting of Kindergarten to Grade 12 students (Table 1). MHCB was introduced at an additional five schools ("Cohort 2") at the beginning of the 2022-2023 school year. Cohort 2 consists of three high schools and two elementary schools (Pre-Kindergarten to Grade 8).

Table 1. Mental Health Capacity Building Schools, by Cohort (Introduced in 2019-20 vs. 2022-23).

Mental Health Capacity Building Schools

	Name of School	City	Grade Range	School Division
Cohort 1 Schools (MHCB introduced in 2019-20)	Dr. Martin LeBoldus Catholic High School	Regina	9 to 12	Regina Roman Catholic
	North Battleford Comprehensive High School	North Battleford	7 to 12	Living Sky
	John Paul II Collegiate		8 to 12	Light of Christ Roman Catholic
	Greenall High School	Balgonie	9 to 12	Prairie Valley
	Hector Thiboutot School	Sandy Bay	K to 12	Northern Lights
Cohort 2 Schools (MHCB introduced in 2022-23)	Churchill Community High School	La Ronge	7 to 12	Northern Lights
	Prince Albert Collegiate Institute	Prince Albert	9 to 12	Saskatchewan Rivers
	St. John Community School		Pre-K to 8	Prince Albert Roman Catholic
	Weyburn Comprehensive High School	Weyburn	7 to 12	South East Cornerstone
	Dr. Brass Elementary School	Yorkton	Pre-K to 8	Good Spirit

Data Sources and Procedures

Data were derived from four sources: (1) a staff survey administered at the end of the 2022-2023 school year, (2) annual OurSCHOOL survey data collected from students at the beginning of the 2022-2023 school year, (3) an MHCB Coordinator monthly tracking tool that provided primarily quantitative data, and (4) an MHCB Coordinator narrative tool that was completed the end of the 2022-2023 school year (Table 2). The staff survey and the OurSCHOOL survey were the primary sources of data for each of the core indictors; exceptions are noted in each sub-section, as applicable. The MHCB Coordinator monthly tracking tool was the primary source of data for program metrics. The MHCB Coordinator narrative tool provided additional context throughout.

Table 2. Overview of Data Sources.

Data Sources for Annual Report	Quantitative	Qualitative
Staff survey	✓	✓
OurSCHOOL survey	✓	N/A
MHCB Coordinator monthly tracking tool	✓	minimal
MHCB Coordinator narrative tool	minimal	✓

Staff Survey

The annual staff survey administered as part of the MHCB program evaluation underwent major revisions for the 2022-2023 school year. This was done for several reasons. First, changes to the survey questions have resulted in better alignment with the CIM and key indicators. Previously, the approach taken in the evaluation framework and the organization of program evaluation results aligned with the Ministry of Health's principles of "better health, better care, better value, and better teams" (Government of Saskatchewan, n.d.). Revisions to the staff survey were also undertaken in order to better reflect the project's mandate of mental health promotion and prevention (e.g., removal of items pertaining to resources for responding to mental health emergencies). Finally, several questions on the original survey were designed using dichotomous outcomes (yes/no), which lacks nuance when assessing the feedback about the MHCB program.

A new online survey for school staff that was consistent with the CIM was developed by the members of the MHCB provincial project team. The survey was hosted in REDCap. Superintendents were provided with the survey link and a cover email for distribution. Surveys were completed between May 23 and June 19, 2023. Superintendents were requested to distribute a reminder email partway through the data collection period. Assuming the survey was forwarded to all staff as requested, the survey is expected to have been distributed to 330 teaching staff and 266 non-teaching staff (N = 596).

School staff were asked to complete a series of demographic questions, questions about their awareness of—and involvement with—MHCB. Staff were also presented with 22 Likert items ranging from 1 = strongly disagree to 5 = strongly agree. Survey items were designed to address the two parts of the CIM—school community environment, and health and well-being—that were most applicable to the objectives of the MHCB program. Thus, ten survey items pertained to the school community environment, 11 items addressed health and well-being, and one item allowed participants to make a global assessment of MHCB. Open-ended feedback was also collected about the nature of participants' engagement with MHCB, positive experiences

with MHCB, suggestions for improvement, the impact of MHCB on the school community environment and on health and well-being, as well as space for general comments.

In addition to providing summative feedback about staffs' experiences of MHCB over the past year, the survey also provides valuable formative information. Survey responses, particularly when filtered at the individual school level, can be used by the MHCB program delivery team for school planning and to identify process improvements for the coming year.

Throughout this report, the term "school staff" is used to refer to responses from all types of school employees (e.g., teachers, counsellors, support staff, administrators). Data are suppressed where cell counts are < 6, in order to protect respondents' anonymity. Quotes from open-ended responses are included throughout this report. Identifying details have been anonymized. Such changes are identified within square brackets. Additionally, minor changes to grammar and punctuation have been made in some instances to improve readability. These corrections are not marked.

MHCB Coordinator Reports

Feedback from MHCB coordinators was collected using REDCap. The **monthly reporting tool** completed by MHCB coordinators consisted primarily of qualitative program activity and engagement statistics. The **narrative summary report** completed at the end of the school year collected a series of open-ended items prompting coordinators to reflect on the successes, challenges, and impact of MHCB over the past year, as well as to share their suggestions for strengthening the program.

OurSCHOOL Data

Near the beginning of each school year, students and staff at Saskatchewan K-12 schools are asked to complete the OurSCHOOL online survey. In Saskatchewan, schools have the option of repeating this survey at the end of the school year; however, as only one MHCB school did so, only start of year results have been used in this report.

The OurSCHOOL survey is created, hosted, and analyzed by a third-party vendor (The Learning Bar) and is implemented in numerous schools throughout Canada. Survey questions are categorized into several composite outcome scores that provide data on student mental and physical health and well-being, academic outcomes, social experiences within the school community environment (including bullying), The OurSCHOOL platform allows authorized users to generate charts showing the results for their individual school and/or School Division, depending upon the user's permissions. A category consisting solely of MHCB schools was created to facilitate ongoing MHCB evaluation efforts.

A limitation of the OurSCHOOL reference school data is separated into "elementary school" and "middle–high school." Thus, Hector Thiboutot School (K-12) includes grades that are not captured within the matched cohort. The decision was made to include Hector Thiboutot school within the cluster of the other Cohort 1 schools despite this limitation, as: (a) the same limitation would arise if these data were matched to an elementary school reference sample instead, and (b) ethical and privacy considerations precluded presenting the results from a single school in this manner.

Only OurSCHOOL data from Cohort 1 is presented in this report. The OurSCHOOL survey is administered at the beginning of the school year. Cohort 2 schools were only beginning their implementation of the MHCB project at the time of data collection in Fall of 2022 and thus historical comparisons to the schools' data from previous

years would not be informative. However, Fall 2022 data will, serve as a useful baseline measure for Cohort 2 outcomes in future reports.

Data Analysis

Results from the staff survey, MHCB Coordinator monthly reporting tool, and MHCB Coordinator narrative summary report are presented as an aggregate of all 10 MHCB schools. Data analyses were conducted by a Research Scientist with SHA. Members of the Provincial Team were actively involved in interpreting the findings, providing feedback, and contributing to the proposed future directions for the evaluation plan and MHCB program.

Quantitative Data

Descriptive statistics for the staff survey were produced in R version 4.1.3 (R Core Team, 2022) using RStudio 2021.09.2 Build 382 (R Studio Team, 2022). Where missing data was present on the staff survey (e.g., a participant skipped or declined to answer a question) the valid percentage is reported. Valid percentage is calculated using as the denominator the number of responses to whom a question or item was applicable, not the total number of participants.

All figures presenting mean scores from the school staff survey include error bars, which represent the standard deviation of responses for that item. Due to the major revision to the staff survey that was undertaken for the 2022-2023 school year, there are no comparisons of staff survey data with results collected during previous years. Results from Cohort 1 and Cohort 2 schools are presented in aggregate, as comparisons between cohorts showed only slight, non-statistically significant differences.

Monthly coordinator report descriptive statistics were summarized using pivot tables in Microsoft Excel. The Learning Bar provides users with an overview of the questions used, and data transformations applied, to produce composite outcome measures; however, as this is proprietary information, details cannot be shared in this report. Outcomes for Cohort 1 schools are compared with provincial norms for middle–high schools. For items marked with an asterisk (*) in the charts, a higher score indicates a less favourable outcome. For all other items, a higher score is the preferable outcome.

Qualitative Data

Coordinator narrative summary reports and open-ended data from the monthly reporting tool and staff survey were analyzed in NVivo 12 Plus (QSR International, 2018). Given that a theoretical framework for presenting the results of the evaluation (the Core Indicator Model) had already been agreed to by the provincial team, an inductive/deductive hybrid thematic analysis approach was used (Proudfoot, 2023). This approach to data analysis allows for data to be coded into categories “from the ground up” while doing so within the context of an overarching theoretical framework. The data largely could be conceptually aligned to individual indicators in the CIM. However, given that all qualitative data were collected via written responses, which typically yields less in-depth data than interviews or focus groups, the qualitative findings are only broken down into the two relevant main domains within the CIM (school community environment and health and well-being; school staff and MHCB coordinators were not asked to comment on potential implications of the program on academic growth and performance, as such outcomes are secondary to the program’s objectives).

Results

Results of this program evaluation are organized according to the CIM. Results from the Likert items on the staff survey and relevant portions of the OurSCHOOL survey data are presented within each indicator.

Overview of Survey Responses

A total of 287 people completed the staff survey, including 187 teaching staff, 87 non-teaching staff (*n* = 1 unreported). The response rate for teaching staff ranged from 34% to 81% (*M* = 59%) and the non-teaching staff response rate ranged from 18% to 62% (*M* = 37%). The overall response rate was 48%, ranging from 31% to 69% across schools. When considering feedback on MHCB as a whole (i.e., not conducting sub-analyses comparing responses by school or role), this response rate is sufficient to assume with a 95% confidence interval that responses are accurate within a 5% margin of error. Approximately two-thirds of respondents were teachers and approximately half of the respondents had been at their school for more than five years (Table 2).

Table 2. Demographics of Staff Survey Responses.

Responses	**n = 287**
Role	
Teacher	195 (67.9%)
Administrator	16 (5.6%)
Educational Assistant	33 (11.5%)
School Counsellor	10 (3.5%)
Other school staff	32 (11.1%)
Unknown	1 (0.3%)
Years at School	
Less than 1 year	41 (14.3%)
1 to 2 years	39 (13.6%)
3 to 5 years	54 (18.8%)
More than 5 years	149 (51.9%)
Unknown	4 (1.4%)

A total of 271 (94%) indicated that they were aware of the MHCB project at their school. Of these 271 individuals, 218 (80%) reported that they had attended at least one MHCB activity, event, or program and 177 (65%) indicated that they had been supported by, or otherwise directly engaged with, the MHCB team at their school. There was a relatively even distribution of individuals who had been engaged with the program for less than 1 year, 1-2 years, and 3 years or more (Table 3). On a scale of 1 (strongly disagree) to 5 (strongly agree), of the participants who were aware of the MHCB program, 74% agreed or strongly agreed with the statement, “overall, I believe that the MHCB initiative is helping to create a school community environment that supports positive mental health and well-being” (*M* = 3.9, *SD* = 1.1).

Table 3. Survey Respondents' Years of Engagement with the MHCB Project.

Years Engaged with MHCB	Cohort 1 n = 97	Cohort 2 n = 79
Less than 1 year	13 (13.4%)	43 (54.4%)
1 year	11 (11.3%)	35 (44.3%)
2 years	16 (16.5%)	[a]
3 years	20 (20.6%)	[a]
More than 3 years	37 (38.1%)	[a]

[a]Cells <6 are suppressed to preserve anonymity

Program Metrics

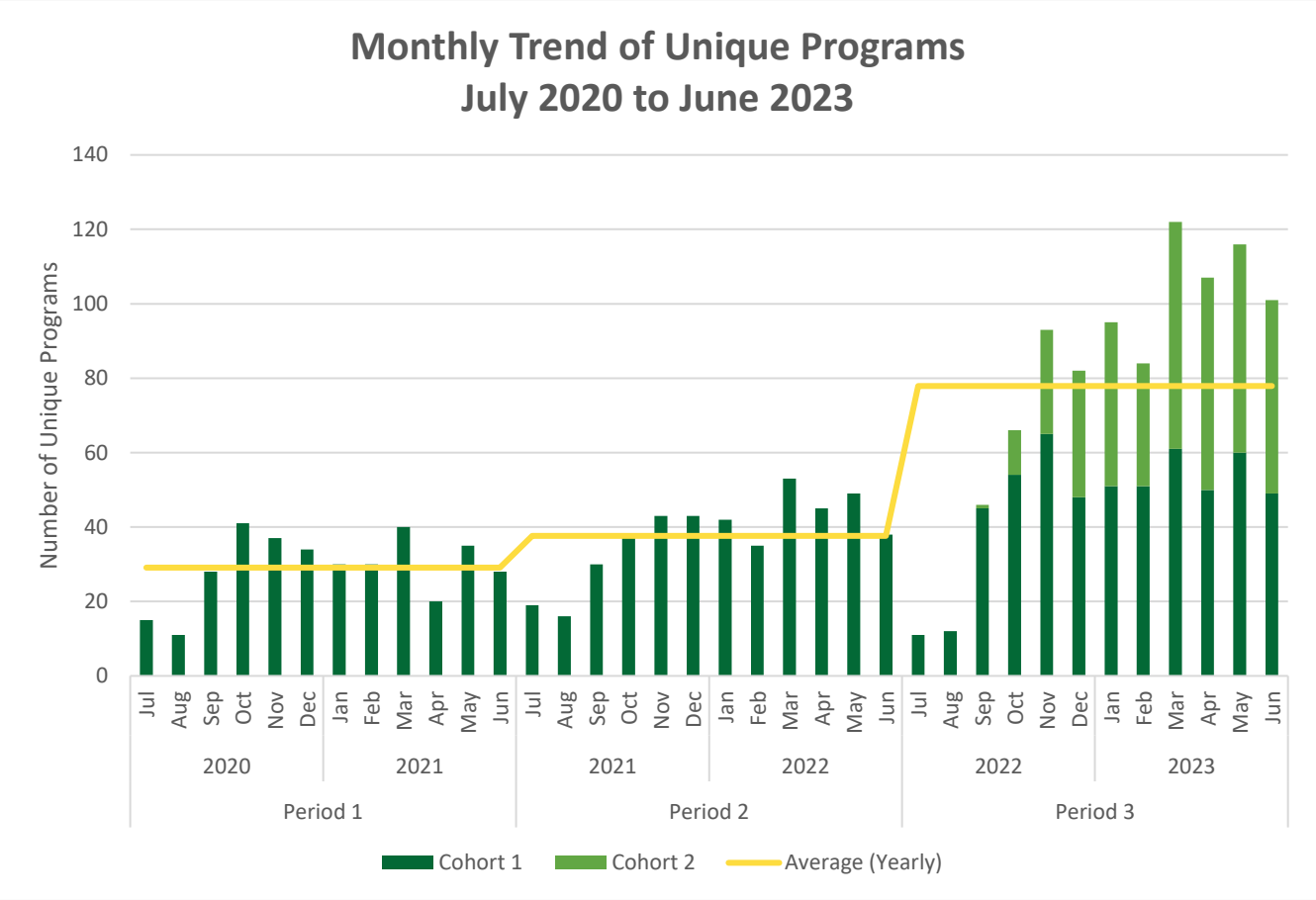
Each month, MHCB Coordinators entered data about their activities into a monthly tracking tool hosted in REDCap. These data served a dual purpose: (1) to provide program metrics for the evaluation report, and (2) to inform the MCHB Program Lead about the work being undertaken at each school for review and discussion during regular one-on-one and group meetings with MHCB Coordinators.

Average monthly unique programs and average monthly program occurrences were computed by calculating the mean score for the period of July through June for each academic year. "Unique programs" are defined as distinct programmatic offerings (e.g., Mindful Schools curriculum; stress, coping, and resiliency training; inclusion, diversity, and equity action building; Mental Health Mosaic, parent/community night). "Program occurrences" refer to the total number of activities offered, as many of the programs offered consisted of multiple sessions (e.g., in-class presentations to different classrooms on the same topic, training that was offered over the course of multiple days or weeks).

As was the case in previous years, monthly offerings of unique programs and program occurrences were lower during the summer months. With the number of MHCB schools having doubled from five schools to 10 in the 2022-2023 school year, there was a sharp increase both in the average number of unique programs and the total number of program occurrences each month when compared to data from previous years.

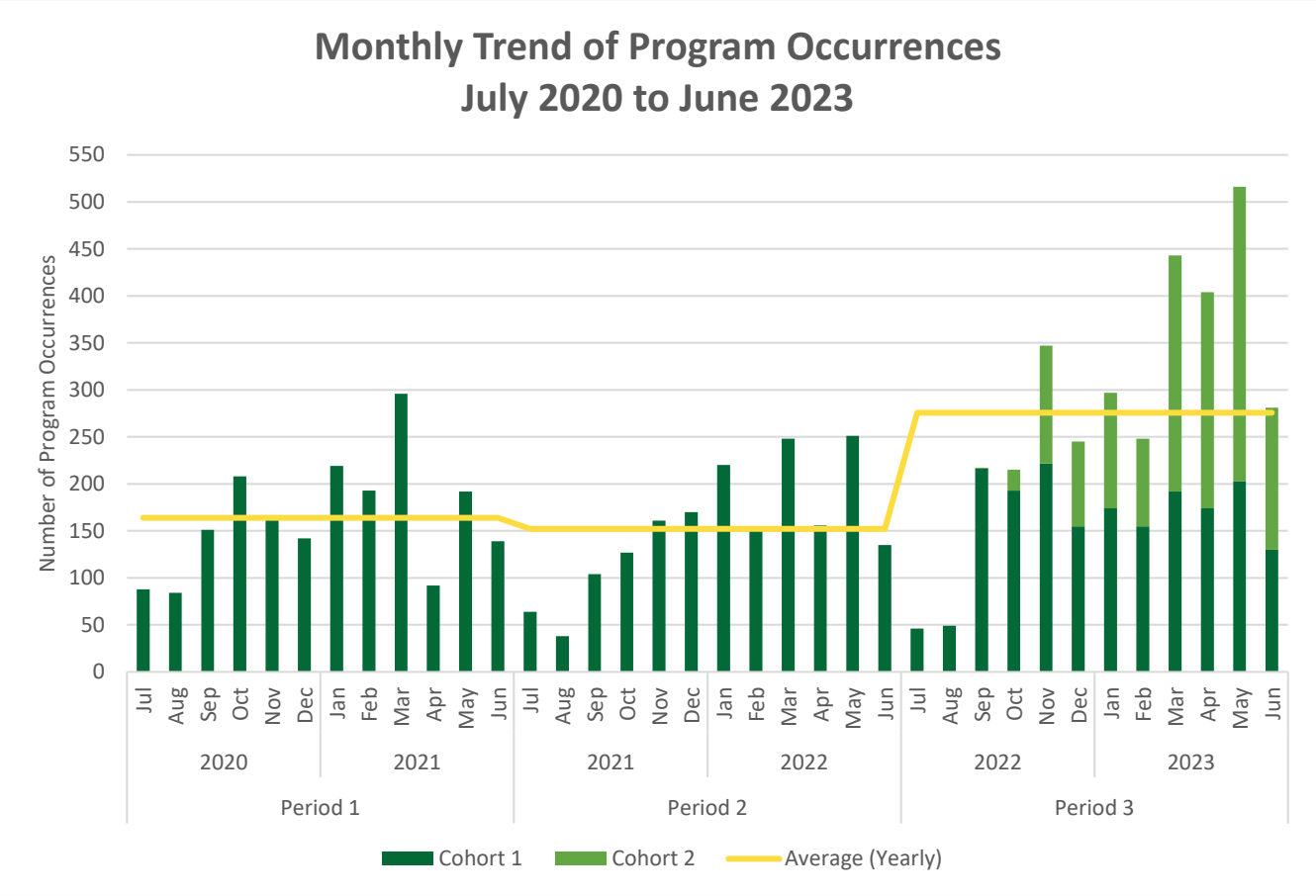
The monthly unique programs offered during the 2022-2023 school year more than doubled, from an average of 37.6 unique programs per month in 2021-2022 to an average of 77.9 unique programs per month in 2022-2023 (Figure 3). The number of unique programs offered at Cohort 2 schools increased steadily from September 2022 to January 2023, with a slight decrease in February. However, in March, both cohorts offered the same number of unique programs (n = 61) and remained comparable with one another for the remainder of the school year. This suggests that on average, it takes approximately six months from the start of the new school year for new MHCB schools to complete the onboarding process and begin operating at full capacity.

Figure 3. Number of unique programs offered each month at MHCB schools since program inception.



Similarly, there was a marked increase in the total number of program occurrences each month during the 2022-2023 school year compared to previous years, with average monthly program occurrences increasing from an average of 152.2 program offerings per month in 2021-2022 to an average of 275.7 program offerings per month in 2022-2023. Program occurrences remained relatively consistent at Cohort 1 schools during the months of September through May, ranging from 155 to 222 (Figure 4). The most notable changes in monthly program offerings within Cohort 2 schools took place from October (*n* = 22) to November of 2022 (*n* = 125), suggesting that new MHCB schools may anticipate that program implementation will gradually ramp up during the first three months of the school year. This information may help coordinators and school staff to plan for implementation of MHCB at additional schools in the future.

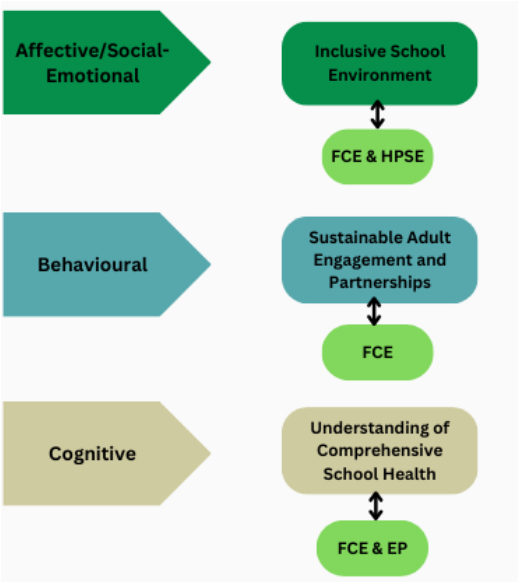
Figure 4. Total number of program occurrences per month at MHCB schools since program inception.



Environmental Indicators

Environmental indicators within the CIM address the importance of the following roles as part of the CSCH framework:

- an **inclusive school environment** (affective/social–emotional domain),
- **sustainable adult engagement and partnerships** (behavioural domain), and
- **understanding of comprehensive school health** (cognitive domain).



Inclusive School Environment

An **inclusive school environment** involves:

- ✓ Family and Community Engagement
- ✓ Healthy Physical and Social Environments

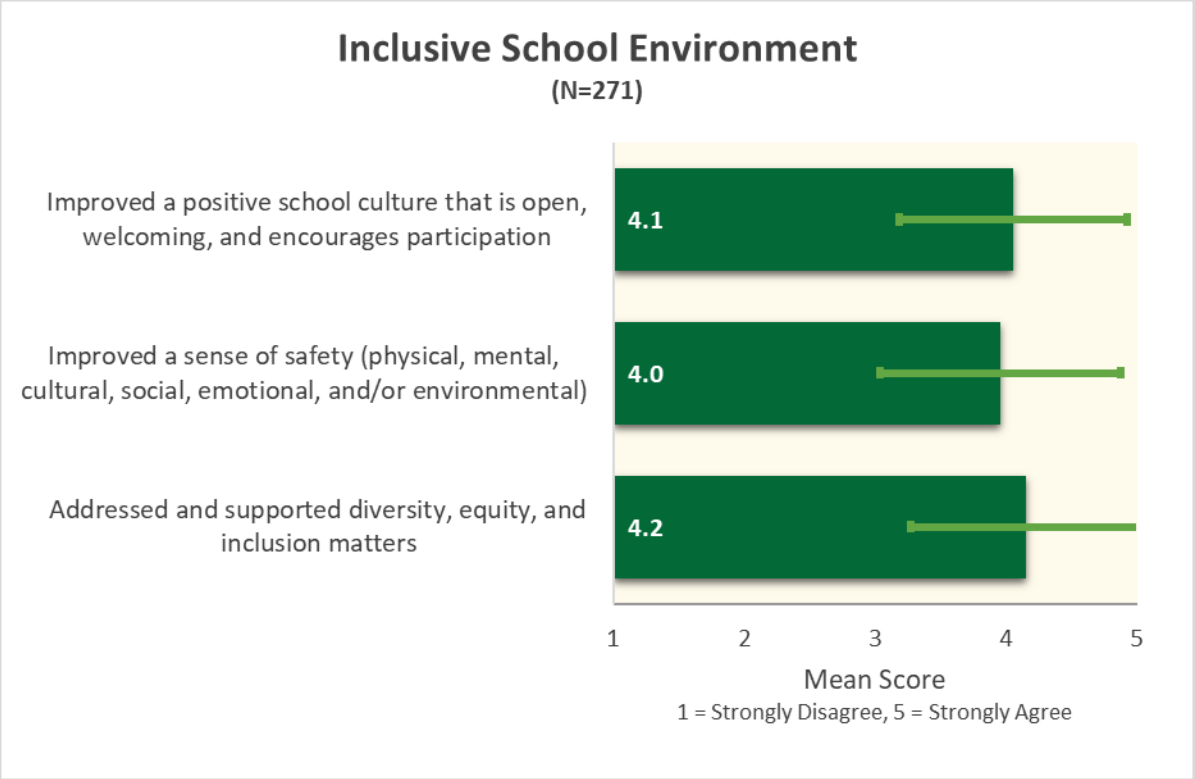
An inclusive school environment is one in which everyone feels welcome and is supported to fully participate in school community environment (Freeman et al., 2016).The degree of inclusivity in the school environment can be measured by considering factors such as how safe students feel in their environment (e.g., physically, psychosocially, culturally) holistic approach and how positive and accepting the school environment is overall.

Most respondents to the school staff survey had positive things to say about the presence of MHCB within the school community environment and the importance of this initiative, with several voicing their support for this program to continue; for example:

- *They have really brought the school together and have brought some great ideas and programs to the school that the students are truly engaged in.*
- *Hope to see the engagement of the MHCB continue as it is a big support for our students and families in our school*
- *Overall, I think this is much needed in our schools as our resources become less and less, but the need for mental help/issues becomes higher. Such a great way for students to get help and education when needed.*
- *It has allowed classroom teachers to have a safe space to send students who are experiencing mental health needs or crisis. It allows teachers to stay in the classroom and support all the other students. This program reminds all school personnel and students to prioritize mental health. It is an investment in long term benefits for students and staff and will support the economy with preventative strategies rather than reactive strategies.*

The cluster of three school staff survey items that pertained to an inclusive school environment collectively had the highest average scores compared to all other indicators. For each item, at least 75% agreed or strongly agreed that the MHCB program fostered a school community environment that is open, welcoming, and encourages participation; improved safety (e.g., physical, psychological, social); and addressed matters of equity, diversity, and inclusion (Figure 5).

Figure 5. School staff survey results for questions about an inclusive school environment.



Several positive comments were received about the classroom presentations and guest speakers who were brought in to speak to the students on a variety of topics. One specific resource that was mentioned frequently in the open-ended comments was the existence of Wellness Rooms at several schools. Many school staff thought that these rooms were helpful for students needing support; for example:

- *We have had a couple of students who have needed to go to our 'POP' room to calm down and work through their anxiety. Then they are able to return to class and be successful at completing their day.*
- *POP room provides a great space for youth and staff to feel supported and connected.*
- *The students know the POP room is always a place of welcoming vibes.*
- *The students' use of the Wellness room has been very positive. The students feel safe and welcome.*
- *The MHCB room was always full of students that required a safe, quiet space that supported the issues they were going through. A large percentage of students will miss this room.*

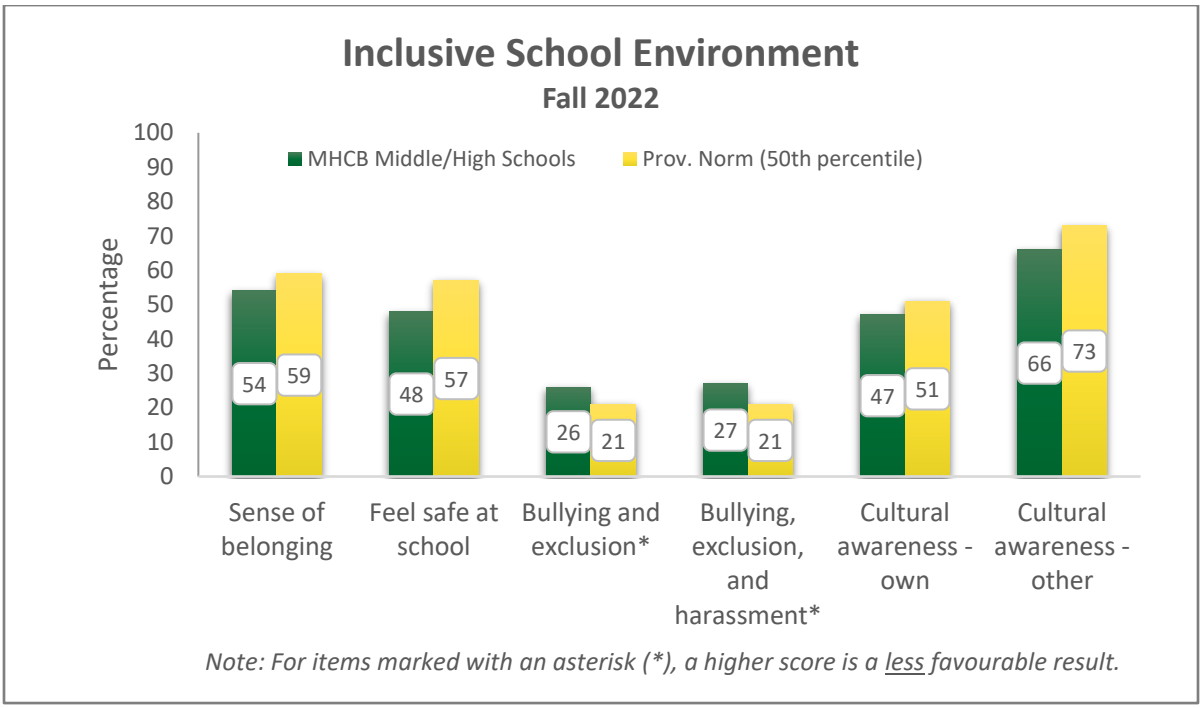
Nevertheless, two respondents raised concerns that students appear use this resource inappropriately and that their existence is detrimental to the school community environment overall, as it served as a "hangout room" or a place where students could go to "ditch class."

There was noticeable division amongst respondents regarding their feelings about the effectiveness of the MHCB staff (coordinators and promoters) assigned to their schools. The tone of such comments was, for the most part, school-dependent. Some staff felt that the MHCB coordinators and promoters were a vital part of the school community and singled them out for praise in their written survey comments and participants indicated satisfaction with the presence and engagement of MHCB staff at the majority of schools.

At the start of the 2022-2023 school year, Cohort 1 MHCB schools had less favourable scores overall, as compared to provincial norms, on all of six OurSCHOOL measures that represented an inclusive school environment. It should be noted, however, that one of the criteria for selection to participate in the pilot was demonstration of need for the program at the school.

When examining Cohort 1 schools' data from that of the previous year, there were modest improvements in sense of belonging (2%) and in bullying, exclusion, and harassment (1%). However, scores for feeling safe in school (-3%) and bullying and exclusion (without the added element of harassment; -7%) were actually lower than during the previous year (Figure 6).

Figure 6. Comparison of MHCB schools and provincial norms on categories relevant to an inclusive school environment for the 2022-2023 school year.



Sustainable Adult Engagement and Partnerships

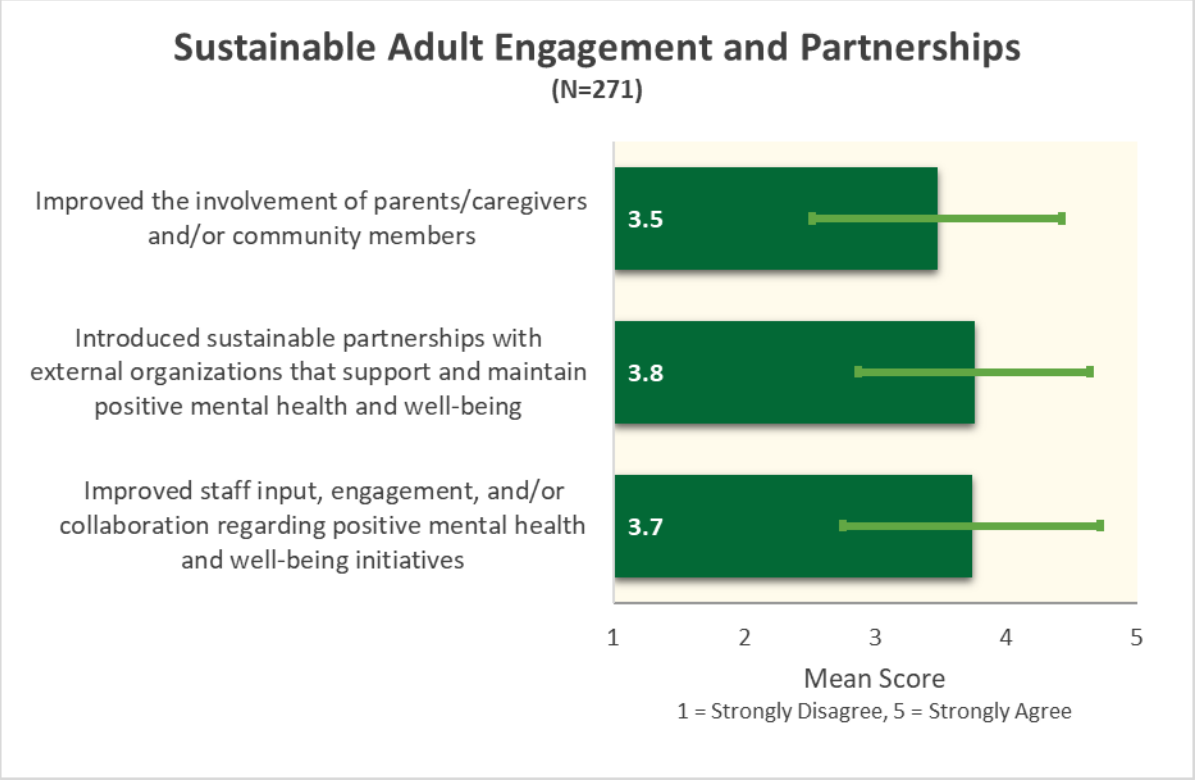
Sustainable adult engagement and partnerships involve:

- ✓ Family and Community Engagement

Sustainable adult engagement and partnerships are marked by the collaborative efforts of school staff, parents/guardians, and the community in implementing and living the values of a CSCH approach (Freeman et al., 2016). Sustainability can be measured by considering factors such as involvement of parents, families, and the broader community within the school community environment, strengthening partnerships between school staff and community organizations and leaders, and ongoing professional development amongst school staff.

Staff survey items for this indicator had the lowest cumulative average score compared to all indicators (Figure 7). Less than two-thirds of respondents agreed or strongly agreed that the MHCB program had introduced sustainable partnerships with external organizations (61%) or improved staff input, engagement, and/or collaboration to support mental health and well-being initiatives (63%). Less than half agreed or strongly agreed that the MHCB program had improved the parent, caregiver, or community involvement within the school community environment.

Figure 7. School staff survey results for questions about sustainable adult engagement and partnerships.



One participant indicated in their written feedback that they were unsure of the types and level of engagement between the MHCB team and external partners:

- *As a teacher, I have no idea their involvement in external partnerships, division or admin support.*

When asked to comment about positive experiences and/or successes of the program, several participants noted family and community engagement as examples:

- *Community collaboration with various organizations that strive to reach the common goal for a healthy community.*
- *The MHCB workers are so great at supporting the whole community- staff, students and families. I can see the investment of funds, time and staffing has made HUGE impacts that will have lifelong positive influence.*

Numerous participants mentioned that guest lectures in their class—both by MHCB team staff and external presenters—were positively received. Some respondents also indicated that the school community environment would benefit from increased engagement with parents, caregivers and the broader community, suggestions, for example:

- *A component to bring awareness to the parent and caregivers would be a benefit to all involved.*
- *Parents need to take a bigger part in this initiative.*
- *We would also love to see some family/community engagement in the evenings—drop in sessions about how caregivers can help promote mental health and wellbeing, have difficult discussions around their children's mental health and substance use, connect caregivers to outside resources, etc.*

Positive feedback was received when events were hosted outside of school hours in order to accommodate the inclusion of parents and other members of the community:

- *The parent nights that they put on and offered support were information and helpful for parents. Also, the education and resource booths put up at parent teacher interviews were also of benefit to students, parents and teachers.*

The Wellness Carnival was cited as a specific example of a successful initiative for bringing together students, teachers, parents, and community members in support of mental health and well-being:

- *The Wellness Carnival was very well attended by both parents and students. Every year, more community partners participate in various events hosted by MHCB.*
- *Our mental wellness carnival drew hundreds of students, parents and community members to learn about mental health and positive initiatives in the school.*

There were no OurSCHOOL categories related to this indicator.

Understanding of Comprehensive School Health

Understanding of comprehensive school health involves:

- ✓ Family and Community Engagement
- ✓ Effective Policy

Having a strong understanding of comprehensive school health means that individuals representing a variety of roles within the school community environment (e.g., students, staff, parents/guardians, community members) are aware of policies that support CSCH and programs (such as MHCB) that have been implemented that support a CSCH approach (Freeman et al., 2016). The extent to which members of the school community environment understand comprehensive school and community health can be measured by considering the degree to which students, school staff, parents/guardians, health partners, and community members are aware of—and understand—the policies, programs, and initiatives supporting CSCH within the school community environment.

This indicator was addressed indirectly within the school staff survey by asking respondents about how well supported they felt in implementing the MHCB program. Perceived support from school administration and the School Division may suggest the extent to which school staff felt that program policies and the supports that are available to them were communicated.

When asked to provide any ideas they may have to improve the MHCB initiative within their school community, a few participants noted communication and collaboration with the School Divisions/administration as areas that could be improved:

- *The communication between admin and MCHB as well as bringing families in.*
- *Transparency is needed, regular reports to the admin and staff re: what [MHCB staff are] doing.*
- *I believe that they are working to support teachers and students but not always are the recommendations given to admin accepted by admin.*

On the staff survey, two-thirds of staff agreed or strongly agreed that they had been supported by the School Division and 76% agreed or strongly agreed that they had been supported by their school administration (Figure 8).

One participant noted a particular benefit of having MHCB coordinators in the school:

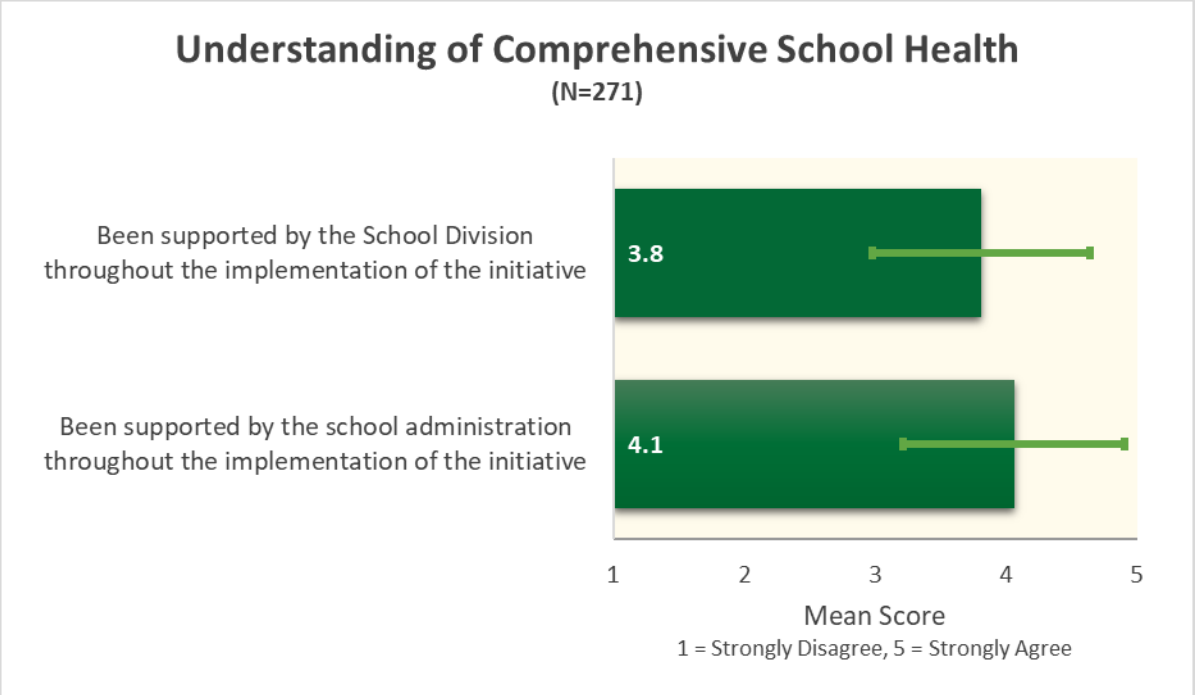
- *The extra effort to meet with teachers and take mental health concerns to admin is helpful - it provides anonymity.*

Another participant made note of efforts within their Division to support mental health and well-being within their school community environments:

- *Centrally, we are going to align the Superintendent of School Operations role and the Superintendent that has Mental Health in their portfolio to better support the school-based team.*

There were no OurSCHOOL categories related to this indicator.

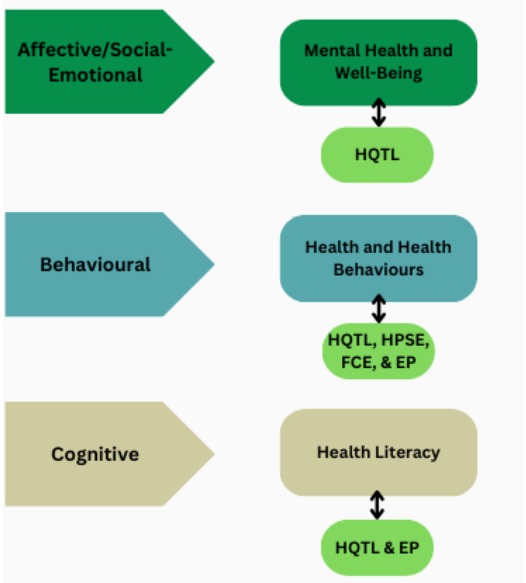
Figure 8. School staff survey results for questions about understanding of comprehensive school health.



Health Indicators

Health indicators within the CIM address the importance of the following roles as part of the CSCH framework:

- **mental health and well-being** (affective/social–emotional domain),
- **health and health behaviours** (behavioural domain), and
- **health literacy** (cognitive domain).



Mental Health and Well-Being

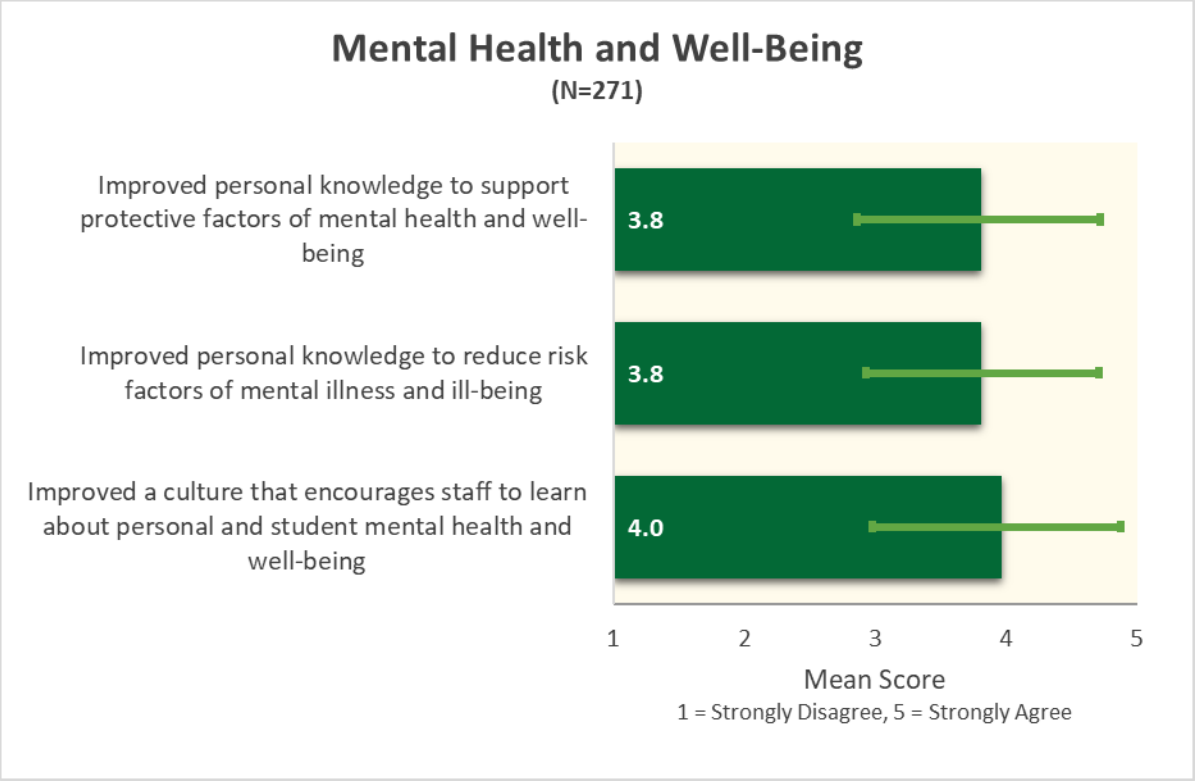
Mental health and well-being involves:

- ✓ High Quality Teaching and Learning

The CIM framework adopts the World Health Organization's definition of mental health, which characterizes mental health as a state of well-being in which individuals are able to enjoy life to its full potential (Freeman et al., 2016; World Health Organization, 2022). Mental health and well-being can be measured by considering factors such as depression, anxiety, stress, resiliency, and the health of social relationships.

Most staff survey respondents (70-75%) agreed or strongly agreed with survey items pertaining to improvements in mental health and well-being (Figure 9).

Figure 9. School staff survey results for questions about mental health and well-being.



These findings illustrate increased knowledge to support protective factors and reduce risk factors for mental health and well-being, as well as an improved culture that encourages staff to learn about personal and student mental health and well-being.

Speaking about their experience at a school which just implemented the MHCB program in the 2022-2023 school year, one survey respondent from a Cohort 2 school explained:

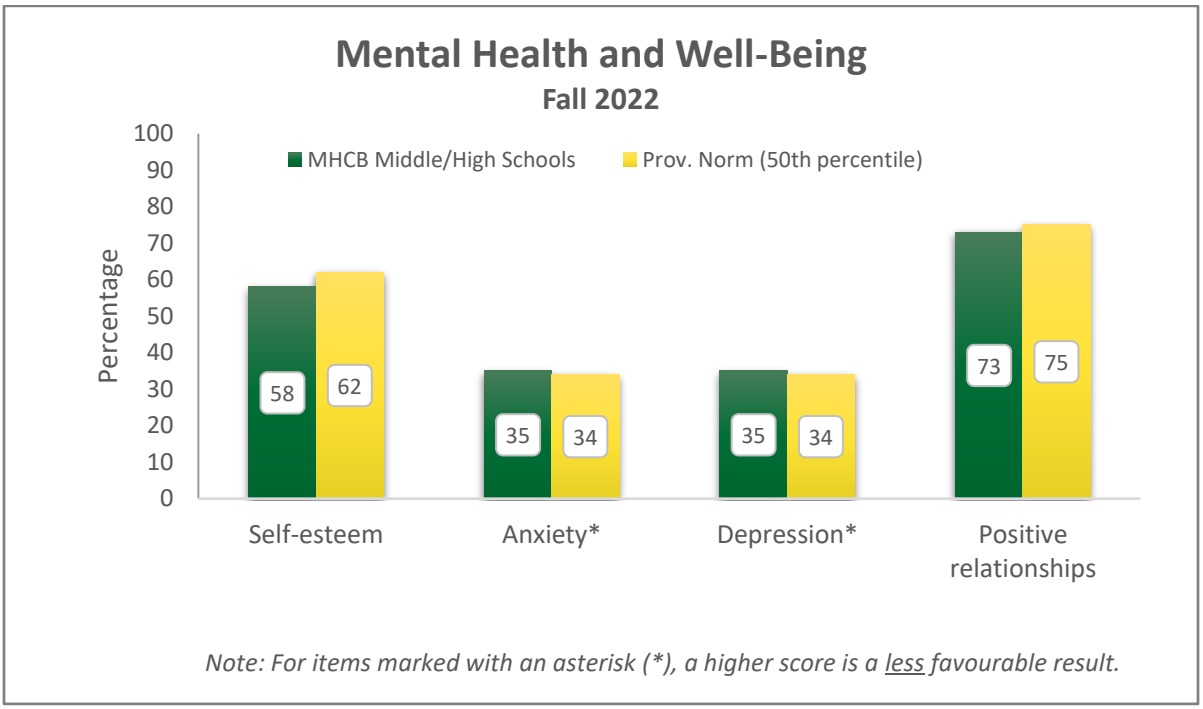
- *[This school] is a high-need school when it comes to student wellbeing and mental health concerns. The impact and need for this MHCB initiative and team cannot be overstated. Progress may have been slow at first, but much growth has been witnessed with each new month, as the processes have become more embedded in school routines.*

Two participants suggested that while MHCB was helping to raise awareness of mental health and well-being, there was still work to be done to build capacity to support mental health and well-being in their school:

- *I believe that the MHCB initiative could be extremely beneficial for our school. However, we have had it for a few years and only 'fluffy' cute things have been done. While it does bring awareness and participation, I think that it's missing the point. I don't believe our school's population is building any capacity to deal with their mental health.*
- *Understanding mental health issues is important. However, we need to teach students (and staff) that merely recognizing these issues does not move the needle forward. We need to find strategies to encourage our school population to exist beyond these seemingly paralyzing feelings and move forward through the hardships of life, stress, anxiety, and the feelings of hopelessness.*

Compared to provincial norms, other than self-esteem (which was slightly lower in students at MHCB schools at the beginning of the school year) scores on OurSCHOOL measures relevant to the mental health and well-being indicator were otherwise comparable. (Figure 10).

Figure 10. Comparison of MHCB schools and provincial norms on categories relevant to mental health and well-being for the 2022-2023 school year.



Health and Health Behaviours

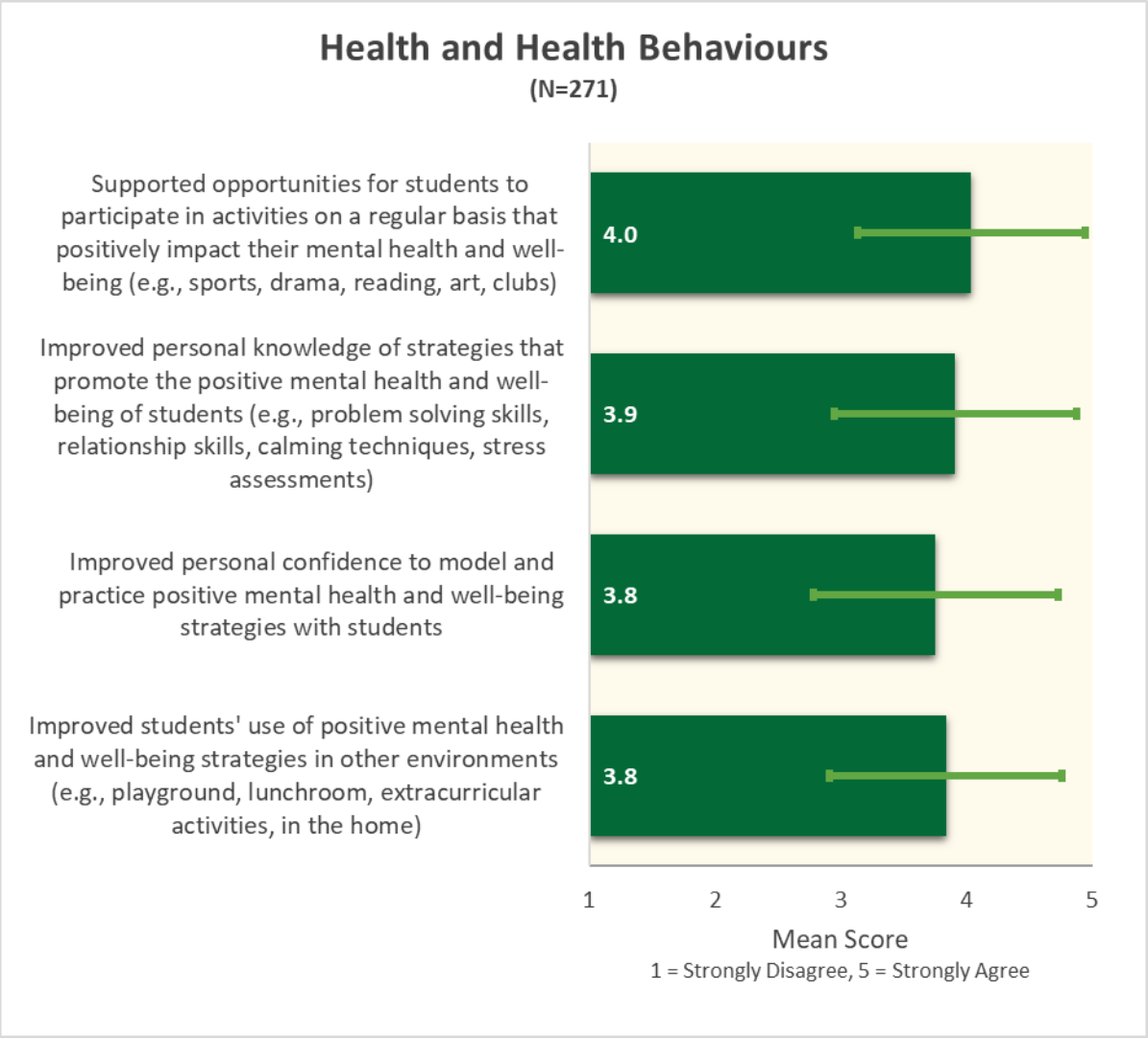
Health and health behaviours involve:

- ✓ High Quality Teaching and Learning
- ✓ Healthy Physical and Social Environments
- ✓ Family and Community Engagement
- ✓ Effective Policy

Health and health behaviours are characterized by the state of one's physical health and the actions that one takes to take care of their health (Freeman et al., 2016). The state of health and health behaviours among students and school staff can be measured by considering factors such as physical activity, eating habits, body image, sleep, and substance use.

Staff survey respondents perceived an improvement in personal and student health and health behaviours (Figure 11).

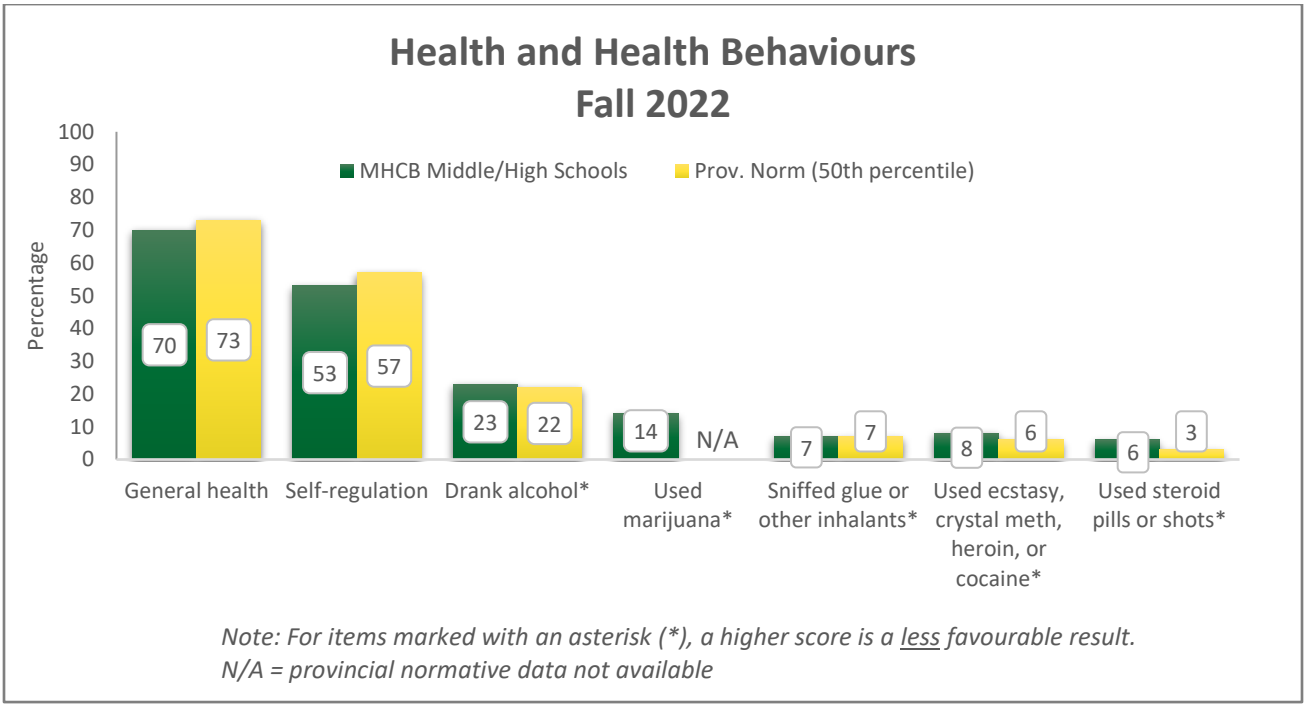
Figure 11. School staff survey results for questions about health and health behaviours.



Approximately two-thirds (65%) of respondents indicated that their confidence to model positive mental health and well-being strategies to students, and students' use of these strategies had improved. Roughly three-quarters (74%) felt their personal knowledge of such strategies had improved and that students were regularly supported to engage in activities that would have a positive impact on their mental health and well-being.

Within the OurSCHOOL data, students at MHCB schools were roughly on par with the provincial norm on most of the measures associated with health and health behaviours, although the use of inhalants and "hard" drugs was lower at MHCB schools (Figure 12). While there was no change in provincial norms for various types of substance use Fall 2019 to Fall 2022, there were noticeable improvements in the MHCB Cohort 1 schools, particularly with respect to the use of marijuana (-4%) and the use of alcohol (-8%).

Figure 12. Comparison of MHCB schools and provincial norms on categories relevant to health and health behaviours for the 2022-2023 school year.



Note: For items marked with an asterisk (*), a higher score is a less favourable result.
N/A = provincial normative data not available

Several respondents noted that both they and their students had acquired behaviours to support their mental health as a result of the MHCB program; for example:

- *[The MHCB staff] have been the strongest factor in improving our staff's morale this year, in my opinion.*
- *I have used these techniques both in and out of the school. They are life-long lessons that I have taken home with me.*
- *I noticed that students are using the regulation tools on their own, and they are using them responsibly. I noticed an overall improvement in behaviours in our school since last year—we still have work to do, but we really made strides.*
- *Students who engage with MHCB are noticeably more regulated than others, which is a big deal post-COVID [pandemic].*

Health Literacy

Health literacy involves:

- ✓ High Quality Teaching and Learning
- ✓ Effective Policy

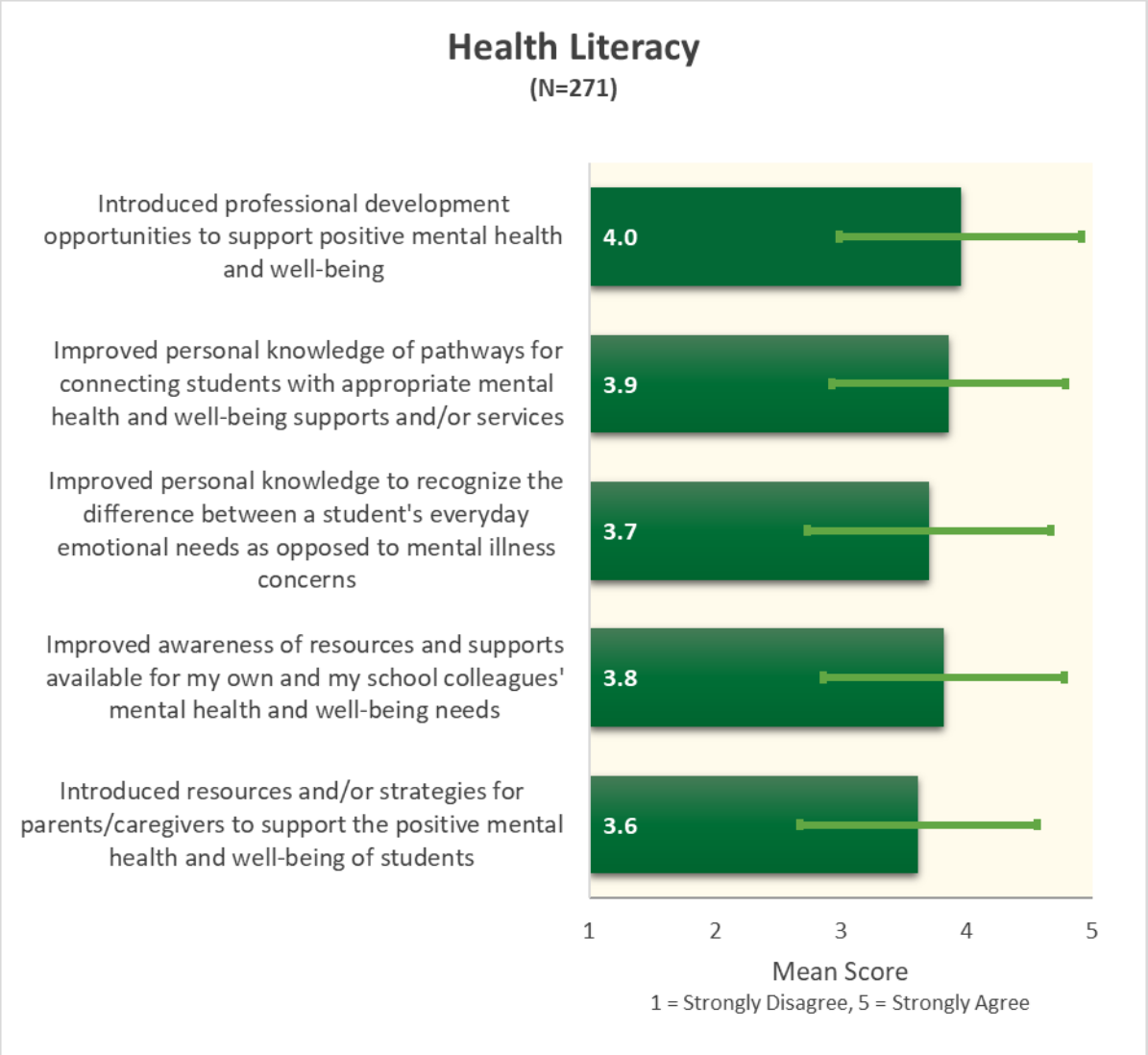
Health literacy pertains not only to one's understanding of health-related information (including mental health), but also their ability to seek out this information, critically evaluate this information, and communicate this information to others (Freeman et al., 2016). The health literacy of the school community environment should consider the abilities of all members of the school community environment (e.g., students, school staff, parents/guardians, community members) to seek out, understand, evaluate, and communicate health information.

A common theme in the school staff survey responses related to reducing stigma about mental health and well-being. In particular, several respondents mentioned improvements in overall mental health awareness and understanding, as well as normalizing conversations about mental health. The resources to educate members of the school community were seen as being a crucial aspect of this support; for example:

- *I love how they have brought language, awareness and normalcy to mental health conversations and strategies.*
- *We are far more educated and understanding because of their initiatives.*
- *MHCB has positively influenced and affected the school community. We are far more educated and understanding because of their initiatives.*
- *I strongly believe that the MHCB is a terrific and must needed addition to our school. Both staff and students benefit from the resources and the education that is provided. I hope that these are placed in the elementary schools as well. I believe that the younger we are taught how to evaluate, accept and work through events and feelings the better we are.*

There was some variation in staff survey scores on items pertaining to health literacy (Figure 13). Half (51%) of respondents felt that the MHCB program improved their personal knowledge of pathways for connecting students with appropriate mental health and well-being supports and/or services. Similarly, 55% of respondents indicated that the MHCB program had introduced resources and/or strategies for parents and caregivers to support the positive mental health and well-being of students.

Figure 13. School staff survey results for questions about health literacy.



Less than two-thirds of respondents (61%) agreed or strongly agreed that their personal ability to recognize the difference between students' everyday emotional needs vs. mental health concerns had improved. Respondents felt more positively about improvements about their awareness of available resources and supports for their own and their colleagues' mental health and well-being needs (71%). Nearly three-quarters (74%) of respondents indicated that the MHCB program had introduced professional development opportunities into their school community environments that supported positive mental health and well-being.

There were no OurSCHOOL categories related to this indicator.

Educational Indicators

None of the qualitative data collected related to the impact of MHCB on educational indicators. One question on the school staff survey pertained to educational indicators. Categories of responses from the OurSCHOOL survey that represent educational indicators are also reported.

Identity Development

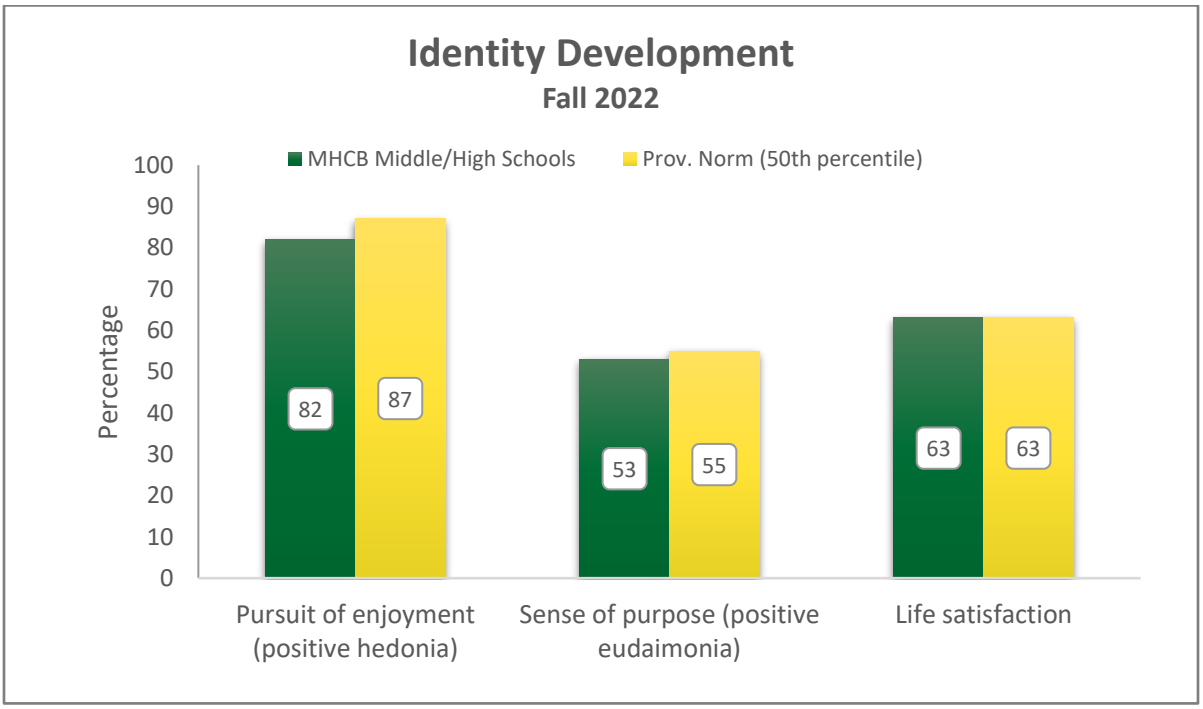
Identity development involves:

- ✓ High Quality Teaching and Learning
- ✓ Healthy Physical and Social Environments
- ✓ Family and Community Engagement
- ✓ Effective Policy

Identity development is one aspect of the formation of an individual's unique personality, which tends to be relatively persistent after adolescence, although some changes may be noted over time (Bleidorn et al., 2022; Freeman et al., 2016). Identity development can be measured by considering factors such as the individual's worldview, resilience, and one's overall sense of self.

Students at MHCB schools had slightly lower scores for a composite measure of positive hedonia (i.e., the pursuit of enjoyment), but had comparable scores to the provincial norm for positive eudaimonia (i.e., sense of purpose) and life satisfaction (Figure 14).

Figure 14. Comparison of MHCB schools and provincial norms on categories relevant to identity development for the 2022-2023 school year.



Youth Engagement

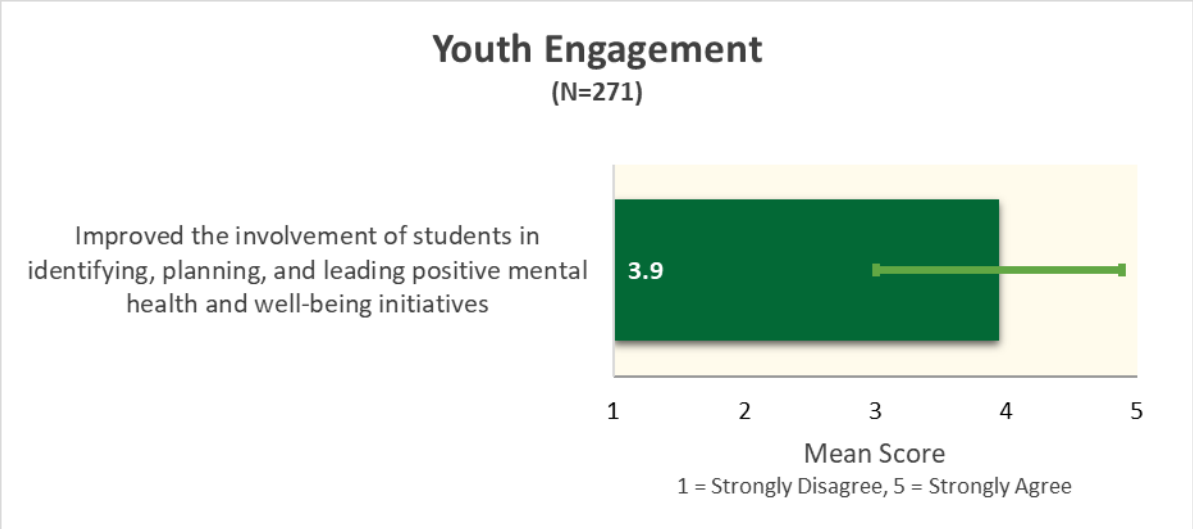
Youth engagement involves:

- ✓ High Quality Teaching and Learning
- ✓ Healthy Physical and Social Environments

Youth engagement is considers how meaningfully engaged a young person is in an activity, as well as the degree to which they sustain this level of involvement (Freeman et al., 2016). Youth engagement may be measured by considering a number of factors, such as the number of extra-curricular activities they participate in, the type or level of involvement they have (e.g., holding leadership position), and the quality of their participation (e.g., frequency of attendance, how actively they participate in the activities).

One question on the school staff survey asked respondents to rate the impact of MHCB on youth engagement in the school community environment (Figure 15). Three-quarters of respondents agreed or strongly agreed that the MHCB program improved the involvement of students in identifying, planning, and leading positive mental health and well-being initiatives.

Figure 15. School staff survey results for questions about youth engagement.



There were no OurSCHOOL categories related to this indicator.

Academic Motivation

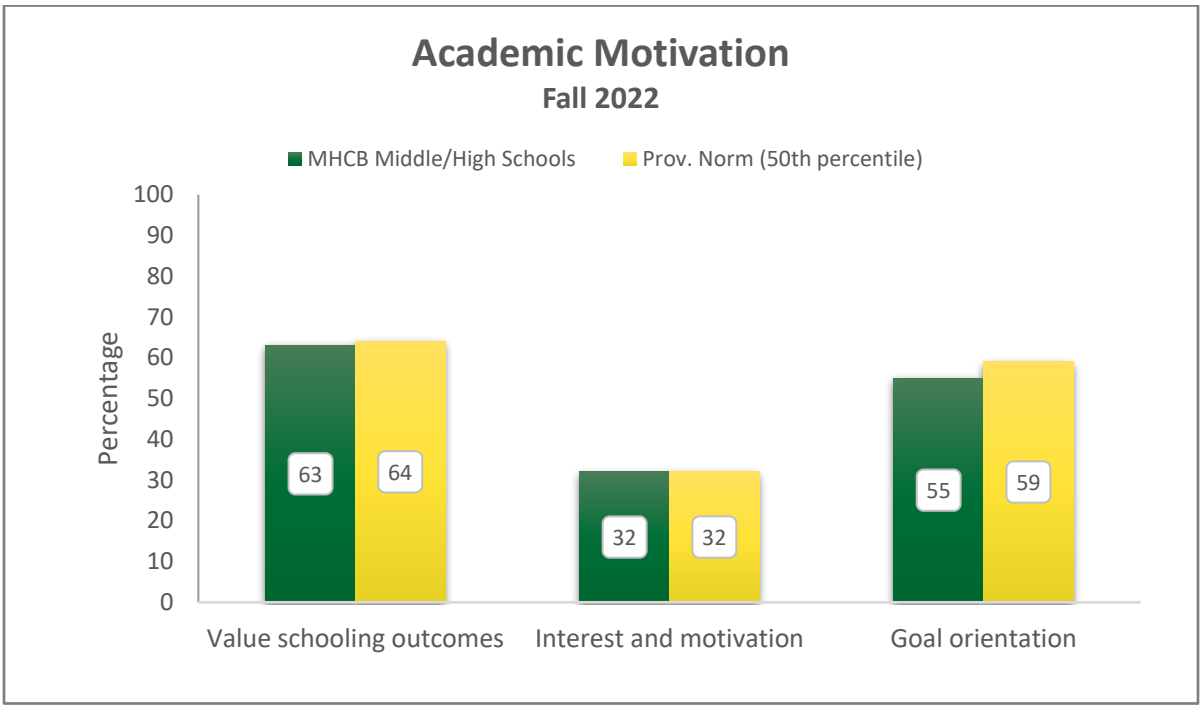
Academic motivation involves:

- ✓ High Quality Teaching and Learning
- ✓ Healthy Physical and Social Environments
- ✓ Family and Community Engagement
- ✓ Effective Policy

Academic motivation refers to a student's internal drive to succeed in their studies (Freeman et al., 2016). The degree of one's academic motivation can be assessed by considering intrinsic factors such as self-efficacy, ability to regulate their engagement in academic activities, how much they value their education.

Three categories of results from the OurSCHOOL survey are relevant to the academic motivation indicator (Figure 16). Students at Cohort 1 schools had scores lower than the norm for goal orientation (-4%); however, scores were on par for interest and motivation, and close to even for valuing school outcomes (-1%).

Figure 16. Comparison of MHCB schools and provincial norms on categories relevant to academic motivation for the 2022-2023 school year.



Academic Participation

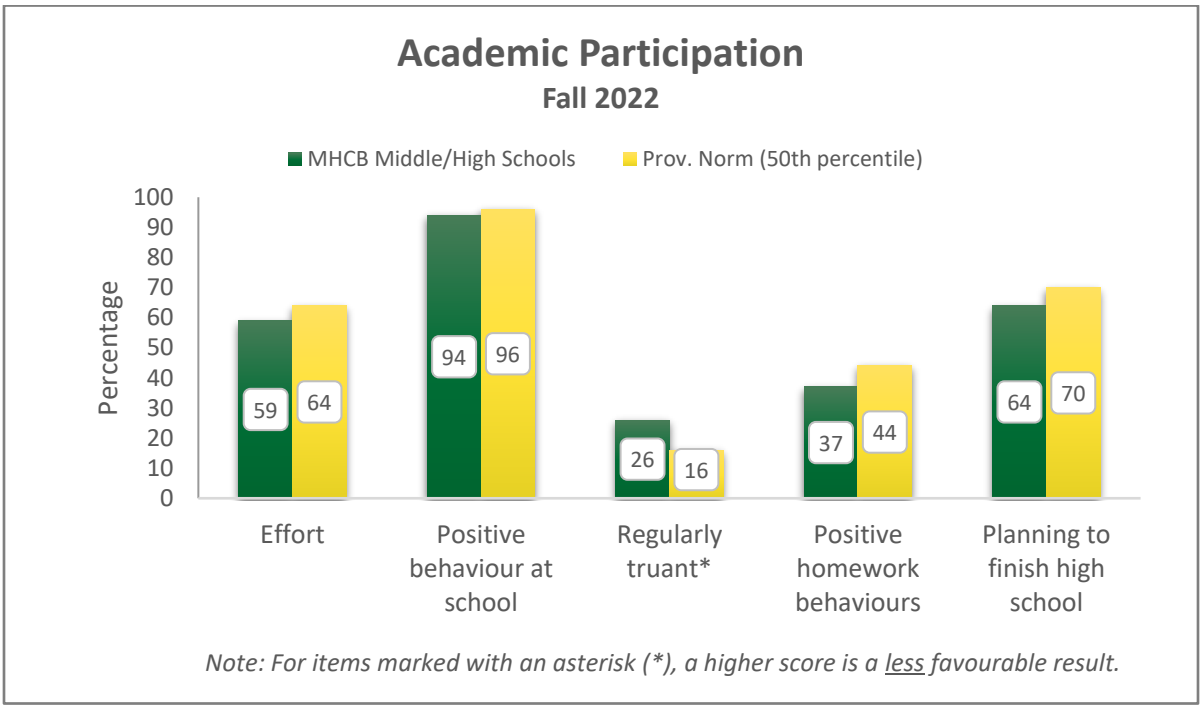
Academic participation involves:

- ✓ Family and Community Engagement
- ✓ Healthy Physical and Social Environments

Academic participation refers to a student's active engagement in their own education (Freeman et al., 2016). This may be assessed using externally observable measures such as attendance, disciplinary actions, academic retention, and participation during class.

Five categories of results from the OurSCHOOL survey are relevant to the academic participation indicator: effort, positive behaviour at school, regularly truant, positive homework behaviours, and planning to finish high school (Figure 17). Students at MHCB Cohort 1 schools performed less favourably then the provincial norm on all five indicators, with differences ranging from 10% (regularly truant) to 2% (positive behaviour at school).

Figure 17. Comparison of MHCB schools and provincial norms on categories relevant to academic participation for the 2022-2023 school year.



Intellectual Growth

Intellectual growth pertains to a student's ability to continuously develop their ability to think critically about information and experiences. Intellectual growth may be assessed by considering outcome measures that capture critical and creative thinking, communication skills, and awareness of their own thought processes.

There was no school staff survey data or outcome data on the OurSCHOOL survey relevant to a potential impact of MHCB on intellectual growth to report, as this indicator was outside the scope of the program objectives.

Academic Achievement

Academic achievement is characterized by the degree to which students have achieved their own educational goals (Freeman et al., 2016). The degree of one's academic participation can be assessed by considering external outcome measures of academic success, such as scores on standardized tests, Grade Point Average, qualitative feedback on report cards, and achievement awards.

There was no school staff survey data or outcome data on the OurSCHOOL survey relevant to a potential impact of MHCB on academic achievement to report, as this indicator was outside the scope of the program objectives.

Discussion

The tone of the qualitative feedback received from school staff at MHCB schools and from the MHCB coordinators themselves was positive. This was reiterated in the quantitative data collected via the staff survey.

As indicated via the figures and quotes included throughout the Results section of this report, both the qualitative and quantitative data indicated that the MHCB program as a whole is valued and efforts are largely well-received by staff, students, families, and the community. Aligning with Program Objective #2, responses to the staff survey indicated that MHCB has had a positive impact on creating an inclusive school environment, improving staff and students' mental health and well-being, improving knowledge about mental health and well-being, and fostering active engagement of students in MHCB programming development and delivery. MHCB schools showed less favourable scores than provincial norms on measures of an inclusive school environment on the OurSCHOOL survey, although this may be an indication that the schools selected for inclusion in MHCB were in greater need than average; indeed, one of the selection criteria for schools was demonstration of need.

On the staff survey, the areas identified as most needing improvement fit into two categories:

- **Parent/caregiver and community engagement**. School staff felt that more work needed to be done to engage parents/caregivers and external organizations in MHCB programming, and to provide resources to support parents/caregivers in supporting their children's mental health.
- **Translating knowledge into practice.** School staff identified that there was room for improvement in students' use of the strategies they learn in MHCB within other environments (e.g., playground, lunchroom, extracurricular activities, home), staff confidence in modelling and practicing positive mental health and well-being strategies, and being able to differentiate students' everyday emotional needs from mental illness concerns.

Additionally, school staff felt less supported by their School Division (66%) than by their school administration (76%) in implementing MHCB in their schools. These findings suggest that there is room to further support MHCB schools in meeting Program Objective #3, which involves building capacity within school community environments to support mental health literacy, reduction of stigma, and connecting MHCB initiatives to curriculum.

These provide opportunities to focus on ways of enhancing engagement beyond staff and students in the coming year, as well as to identify ways of increasing staff confidence in their ability to support the mental health of their students, themselves, and their colleagues. This may include developing strategies for identifying opportunities to take skills and knowledge learned in one setting may be applied to other situations.

Program Objectives

Five program objectives were articulated at the start of the 2022-2023 school year. The findings are contextualized and further discussed within the context of these specific objectives. Although the framework for evaluating the MHCB program shifted from a focus on the principles of better health, better care, better value, and better teams to the Core Indicator Model, the evaluation findings are related back to each of the original evaluation questions below. Outcomes related to the evaluation questions are addressed within the program objective with which each is most closely aligned.

Objective #1

Utilize CSCH framework to address mental health promotion in a planned, integrated, and holistic way.

Presentations—both by MHCB staff and guest presenters—were frequently cited by survey respondents as being beneficial. Other activities were more interactive. While some presentations and activities focused on specific mental health and well-being topics or skills, frequently there was integration of different aspects well-being (e.g., yoga as a practice supporting physical, mental, and spiritual health) and addressed more than one indicator (e.g., the wellness carnival addressed multiple core indicators across all three functional domains).

Evaluation Question #8: Are MHCB staff successful in creating awareness of the MHCB initiative as a resource within the community?

Of the 287 individuals who responded to the staff survey, 94% indicated that they were aware of the MHCB project at their school. MHCB coordinators engaged in numerous outreach and promotion activities, including connecting with external organizations and sharing information about MHCB program offerings on social media sites. Survey items pertaining to the “sustainable adult engagement and partnerships” indicator received the lowest collective scores on the staff survey, however. In particular, less than half of respondents felt that there had been improved involvement of parents/caregivers and/or community members as a result of the MHCB program. This was supported by qualitative feedback suggesting a focus on increasing parent/caregiver engagement in particular.

Objective #2

Use evidence-based and innovative programming to enhance mental health and well-being in students and families by: (a) building and strengthening awareness, knowledge, skills and confidence (e.g., self-regulation and interpersonal skills); and, (b) creating a school culture that fosters a sense of belonging and safety.

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

As expected, the monthly average number of unique programs and total program occurrences has increased substantially with the addition of five new MHCB schools in the 2022-2023 school year. Feedback received from school staff on open-ended survey items suggested that there has been a noticeable increase in students' knowledge and understanding of mental health and well-being. Youth engagement in identifying, planning, and leading positive mental health and well-being initiatives was high, with 75% of school staff survey respondents agreeing or strongly agreeing with this statement. One area in which students should continue to be supported is in helping them to take the skills that they learn via MHCB programming and applying them within other settings both inside and outside of school.

Evaluation Question #4: Are children obtaining outcomes associated with positive mental health?

Mental health and well-being outcomes were assessed via the OurSCHOOL survey, which for the most part showed declines in mental health and well-being outcomes within MHCB schools compared to a matched cohort. However, the use of OurSCHOOL survey data to extrapolate gains or losses in mental health and well-being amongst students who *actually participated* in the MHCB program for some duration, as compared to the matched cohort, has some notable limitations, as described earlier in the Discussion section of this report. Qualitative feedback from school staff and MHCB coordinators paints a different picture, with several individuals recounting the benefits that they have witnessed with respect to their students' mental health and well-being.

Evaluation Question #5: Does the MHCB program create a culture of connectedness, psychological, and physical safety?

The cluster of school staff survey items pertaining to an inclusive school environment had the highest cumulative mean score compared to all other indicators, with 75-78% of respondents agreeing or strongly agreeing with each of these items. Qualitative feedback from school staff and MHCB coordinators supports these findings. Several comments described the reduction of stigma around mental health and well-being and how MHCB supported normalizing discussing mental health in the school community environment.

Objective #3

Build capacity of school staff through professional development that supports mental health literacy, the reduction of stigma, and curricular connections.

Evaluation Question #3: Do the school staff feel they have the necessary skills to promote positive mental health behaviours?

Quantitative and qualitative feedback from school staff indicated that most respondents felt that their knowledge about—and ability to promote—positive mental health behaviours had improved as a result of the MHCB program. More than 7 out of 10 respondents felt that their knowledge of how to support protective factors of mental health and mental well-being, and their knowledge of how to reduce risk factors of mental illness and ill-being, had improved. Nearly three-quarters of respondents also felt that their personal knowledge of strategies that promote the positive mental health and well-being of students had improved. There is room for further growth in supporting staff in feeling confident in translating this knowledge into practice, however, as 65% of respondents felt that their personal confidence to model and practice mental health and well-being strategies to students had improved.

Evaluation Question #7: Do the MHCB staff provide appropriate information and resources for staff?

MHCB Coordinators are tasked with implementing evidence-based approaches and finding and/or developing evidence-informed resources to support MHCB initiatives within schools. The school staff survey did not include any items that assessed the perceived appropriateness of the resources that were provided to them. However, 74% of respondents reported that they agreed or strongly agreed that the MHCB program had introduced professional development opportunities to support positive mental health and well-being. Additionally, perceived appropriateness of information and resources may be extrapolated from survey items pertaining to the extent to which respondents felt that their knowledge about mental health and well-being had improved, as reported for Evaluation Question #3 above. Several survey respondents also indicated in the open-ended survey comments that they found the information and resources provided to be helpful.

Objective #4

Support early interventions and facilitate access to supports for students and families who are experiencing, or are at risk of experiencing, mental health concerns. This includes creating awareness of the school and community's Pathways to Care.

Evaluation Question #2: Do children receive the necessary interventions and have access to the treatment services they need?

In light of the focus of the MHCB program being on mental health prevention and promotion, the provincial team identified that this evaluation question drifted from the mandate of the program. As a result, intervention and access to treatment services was not a focus of this evaluation report. One item on the school staff survey that does relate to this evaluation question, however, measured the extent to which staff felt that their personal knowledge of pathways for connecting students with appropriate mental health and well-being supports and/or services had improved as a result of the MHCB program, with 51% of respondents agreeing or

strongly agreeing that this was the case. This underscores the importance of ensuring that students, families, and school staff be aware of—and supported in connecting with—various pathways to care.

Evaluation Question #6: How many children are currently participating in risky behaviours?

Students at MHCB schools were roughly on par with the provincial norm on most of measures of risky behaviours (i.e., alcohol and drug use), although the use of inhalants and hard drugs was lower at MHCB schools. These are two areas where improvements were also noted when comparing OurSCHOOL data from MHCB Cohort 1 schools in Fall 2022 with their Fall 2021 data. What is particularly noteworthy is the improvement noted in substance use within MHCB Cohort 1 schools over a longer period of time (Cohort 2 schools could not be assessed, as the most recent OurSCHOOL survey was administered at the start of their implementation of MHCB). Although the provincial norms for various types of substance use remained steady from Fall 2019 to Fall 2022, there were noticeable improvements in the MHCB Cohort 1 schools. During this time, use of inhalants decreased by 2%; use of ecstasy, meth, heroin, and/or cocaine, as well as use of marijuana decreased by 4% each; and use of alcohol decreased by 8%.

Objective #5

Develop a network of participating MHCB Schools to support program implementation and delivery.

None of the eight evaluation questions addressed this objective; however, this can be assessed using program administration information. By design, the approaches taken within each school community environment are custom tailored to the needs of those communities. Nevertheless, there were core programming elements within each school. Monthly MHCB coordinator meetings, led by the program coordinator, ensured continuity in program implementation across the 10 participating schools and allowed for coordinators to exchange ideas, share success stories, and brainstorm solutions to challenging situations.

Conclusions

The MHCB program was consistently described as an important and highly beneficial program to support students' mental health and well-being. Open-ended comments from school staff in particular demonstrated the impact of the program within their schools. In particular, the program excelled in increasing mental health awareness, reducing stigma, educating staff and students about mental health and well-being, and providing timely supports to students in the moment (e.g., wellness rooms). The degree to which staff felt engaged with the program—as evidenced by their survey responses—differed by school, with a pattern emerging of feeling highly engaged and supported by MHCB coordinators and promoters at some schools and less so at others. Engagement of the broader school community—including parents/caregivers and community organizations—was consistently identified as an area in need of further development. Additionally, while most staff felt that their knowledge of mental health and well-being had improved, this did not always translate into their confidence or perceived ability to implement this knowledge to support students' mental health and well-being.

The positive feedback obtained from school staff did not translate to improvements on outcomes associated with mental health and well-being on the OurSCHOOL survey; however, as described in the Discussion section, there are several potential reasons for this that are unrelated to the effectiveness of the MHCB program itself.

Thus, the OurSCHOOL data should be interpreted with this caveat in mind when considering the overall impact of the MHCB program. This also presents a potential opportunity to more proactively use data from the OurSCHOOL survey for the purposes of planning and identifying opportunities for further student engagement.

Limitations

In addition to the challenges of using the OurSCHOOL findings to draw conclusions about the effectiveness of the MHCB program, it should also be noted that the use of OurSCHOOL data was limited to Cohort 1 schools only. This is because the OurSCHOOL survey was only required in Saskatchewan K-12 schools at the start of the school year. Thus, the OurSCHOOL data from Cohort 2 schools was collected just as the program was getting underway at the schools. This data could be used as a baseline for future evaluations; although the previously noted limitations in applying these findings to the evaluation of the program would still be present.

Some of the students included in the OurSCHOOL survey would have had limited or no exposure to MHCB at the time of the survey. As the most recent OurSCHOOL survey was administered at the start of the 2022-2023 school year, a student just entering into a Cohort 1 school (e.g., beginning high school) would have had no exposure to the MHCB program, even though they are counted as a student attending an MHCB school.

Related to the point above, mental health prevention and promotion activities take time to show results. As the same students are not tracked longitudinally, the utility of OurSCHOOL data in assessing the impact of the MHCB program may be limited overall. There is no available data to track how the students who were in MHCB schools fared post-graduation/termination of their participation in the K-12 education system.

Another limitation of this evaluation that should be noted is that the OurSCHOOL survey was the only source of students' responses. In 2020, 15 interviews were conducted with a sample of student leader–parent dyads, school staff, and MHCB coordinators (Hassan, 2021). Although the sample size for the above qualitative study was small, interviews nevertheless generate richer and more in-depth descriptions about the impact of a program than can generally be collected via written responses on open-ended survey items. It may be worth considering alternative approaches to collecting more in-depth feedback in future evaluations, particularly from students and parents.

Implications and Future Directions

In light of the recent announcement by the Ministry of Health that the program will be expanded again to include a third cohort of schools in the 2024-2025 school year (Government of Saskatchewan, 2023c), the results of this evaluation will be important to consider when planning the implementation of the program at the new schools, with an eye to proactively addressing the areas in greatest need of further development, as reported in this evaluation.

Individualized evaluation results will also be provided to individual schools in a shorter report format. This will facilitate discussions about the unique strengths and challenges with the program in the individual school community environments. It is hoped that this feedback will be considered and used to support program improvements going forward.

The staff survey was redesigned for the 2022-2023 school year evaluation to align with the Core Indicator Model. Similarly, for the 2023-2024 school year, the MHCB monthly tracking tool and narrative summary have been streamlined into a single report tool, focusing on the outcome measures that are most relevant and

informative within the context of this model. Integration of narrative elements within this new combined monthly reporting tool will also facilitate more timely discussions about the successes and challenges experienced within individual school community environments, with an aim to address challenges as they arise.

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We acknowledge Saskatchewan as the traditional territory of First Nations and Métis people, which includes Treaties 2, 4, 5, 6, 8, and 10. We acknowledge the pain, loss, and dislocation caused by the residential school system on individuals, families, communities and nations. We commit to fostering and maintaining respectful relations with all First Nations and Métis people, and to acknowledging the traditional worldviews, knowledge and practices of First Nations and Métis people for health and wellbeing.

We identify an opportunity to address some of the Truth and Reconciliation Commission (TRC) of Canada's *Calls to Action* (Truth and Reconciliation Commission of Canada, 2015) pertaining to education and health via the work of the Mental Health Capacity Building Program. These include, in particular TRC Call to Action #18 ("…to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools…") and TRC Call to Action #63 (iii) and (iv) by "building student capacity for intercultural understanding, empathy, and mutual respect" and "identifying teacher-training needs relating to the above." This program has the opportunity to contribute to larger efforts to address TRC Call to Action #19 (closing gaps pertaining to suicide, mental health, and addictions).