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# A collaborative, school-based wraparound support intervention for fostering children and youth's mental health

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Early mental health interventions are needed in response to a growing mental health crisis among children and youth. Schools are promising sites for early intervention because they have existing infrastructure for engaging with students. Specifically, collaborative initiatives involving community partnerships allow schools to leverage shared resources to deliver mental health support. However, more research is needed to guide the development of early interventions so that they effectively address students' mental health needs. The present study explored the role of collaborative, school mental health services in fostering children and youth's mental health, through All in for Youth, a wraparound model of support in Edmonton, Canada. Three research questions were addressed: What mental health concerns do children and youth experience? What are the factors that impact the use of collaborative school mental health services? Do collaborative school mental health services lead to perceived mental health impacts among children and youth? A multiple methods secondary analysis was conducted on school cohort data across seven elementary and junior high schools ($n$ = 2,073 students), and interview and focus group data ($n$ = 51 students, grades 2–9; $n$ = 18 parents/caregivers). The quantitative findings indicated that 42.7% of students accessed any type of mental health service across the schools, with close to equivalent service use by gender (50.2% male, 49.5% female, 0.3% genderqueer) and grade (kindergarten-grade 9; $M$ = 10%, SD = 1.9%, range = 6.3%–13%). Participants accessed mental health services in primarily individual or combined individual and group settings (72.9%) and as an informal client (75.1%). The interview and focus group findings revealed high mental health needs among students, which were exacerbated by the COVID-19 pandemic. In response to these needs, a supportive school culture, adequate school communication, and a stable and well-resourced mental health workforce promoted access to collaborative school mental health services. Finally, mental health services supported children and youth through the experience of having a supportive relationship with a safe and caring adult, an improved capacity to cope with school and life, and improved family functioning. The findings underscore the importance of developing school mental health services that take an ecological, wraparound approach to addressing students' multi-faceted mental health needs.

KEYWORDS

**mental health, wellbeing, children, youth, school-based mental health, early intervention, school-community partnership, wraparound**

## 1 Introduction

There is growing concern surrounding the mental health of children and youth (World Health Organization, 2022). In Canada, it is estimated that over one million children and youth experience a mental disorder (Smetanin et al., 2011; Georgiades et al., 2019) and suicide is the second leading cause of death among youth aged 15–19 (Statistics Canada, 2022). Rates of mental health concerns (i.e., mental disorders and poor socio-emotional wellbeing) are even greater among those who experience vulnerability due to socioeconomic disadvantage and marginalisation (Lemstra et al., 2008; Reiss, 2013; Ponnet, 2014). Furthermore, mental health concerns have been exacerbated by the COVID-19 pandemic (Gadermann et al., 2021). Social isolation and reduced support, increases in family stress, economic adversity, and increased risks for child maltreatment have all contributed to increases in mental health concerns among children and youth (Gassman-Pines et al., 2020; Gadermann et al., 2021; Abrams et al., 2022).

Despite the high prevalence and severity of mental health concerns, it is estimated that <20% of children and youth struggling with mental health receive proper treatment (Georgiades et al., 2019). This is concerning because poor mental health in childhood has the potential to affect children's immediate emotional state and functioning, and can be a risk factor for later quality of life, health, educational, occupational, and socio-economic outcomes (Case et al., 2005; Hale et al., 2015; Hale and Viner, 2018). Struggling with mental health in childhood is a risk factor for continued mental health challenges in adulthood (Fryers and Brugha, 2013; Krygsman and Vaillancourt, 2022) and later socio-economic circumstances because untreated mental health concerns can make it more difficult for children and youth to engage in school, graduate, and become employed (Case et al., 2005; Hale et al., 2015). Therefore, addressing the mental health needs of children and youth remains a significant public health challenge (World Health Organization, 2022).

Research demonstrates that schools are ideal sites for early mental health interventions because of their key role in the lives of children and youth (Hoover and Bostic, 2021). Children and youth spend the majority of their time in schools, which already have existing infrastructure in place for engaging with students (Hoover and Bostic, 2021). Additionally, the on-site provision of services reduces barriers to access that vulnerable students may otherwise face (Ali et al., 2019). Limited financial resources, transportation difficulties, and stigma are all barriers to mental health services administered outside of schools (Husky et al., 2011; Ali et al., 2019). Schools are also necessary sites for mental health supports because children and youth's unmet needs and trauma will inevitably surface at school (Anderson et al., 2015). Childhood trauma often manifests through disruptive or withdrawn behaviours, which makes it difficult for children to function and may disturb the learning of other students (Anderson et al., 2015).

In schools, mental health interventions can range in design from universal, school-wide initiatives to more targeted supports. Universal interventions are primarily aimed at prevention and the promotion of healthy socio-emotional development for all students in the school and are linked to positive impacts (e.g., improved social-emotional skills and reduced mental distress; Hoover and Bostic, 2021; Salazar de Pablo et al., 2021). However, some studies show that effects can be variable and for some students, universal interventions alone are insufficient to address mental health needs (Dray et al., 2017; Sanchez et al., 2018; van Loon et al., 2020). Accordingly, another branch of school mental health interventions includes targeted supports aimed at students with the highest levels of need in schools (Sanchez et al., 2018). Interventions can also combine universal and targeted supports through a multi-tier system of support (MTSS) approach (Scott and Eber, 2003; Hoover and Bostic, 2021). Such interventions have been identified as particularly promising as they address both prevention factors through the administration of school-wide supports, as well as targeted services for students struggling with mental health concerns (Scott and Eber, 2003; Hoover and Bostic, 2021).

Despite, the need for support, it has proven difficult to embed mental health services in schools (Atkins et al., 2017). Schools struggle with inadequate funding and resources (Atkins et al., 2017; Waddell et al., 2019). It is often the case that mental health interventions are adopted in schools over a short period of time but not sustained (Atkins et al., 2017). In response, schools have increasingly partnered with community and agency partners on the provision of supports (Atkins et al., 2017). By leveraging shared resources, services can be better tailored to local school contexts, service duplication is reduced among different community organizations, and families' access to support is streamlined through their school (Anderson-Butcher and Ashton, 2004). One such intervention is the school-community model of *wraparound* supports, which is a collaborative model that can be implemented in schools through an MTSS framework, combining both universal and targeted intervention components to better address the mental health needs of students and families (Burns and Goldman, 1999; Scott and Eber, 2003; Hill, 2020; Yu et al., 2020).

Wraparound is an approach to service care planning that takes a collaborative, team-based approach to coordinating person-centred supports (Burns and Goldman, 1999; Bruns and Walker, 2008). Within wraparound, supports are jointly planned by a team consisting of the child and family, agency partners and service providers, and community supports based on the identified needs of the child and family (Burns and Goldman, 1999). Importantly, wraparound takes an ecological systems approach, which recognises that children and youth's wellbeing is affected by multiple contexts (e.g., their families, school environment, and communities); therefore, supports are needed across multiple domains (e.g., education, healthcare, mental health) for children to experience positive outcomes (Bronfenbrenner, 1979; Burns and Goldman, 1999). In the school context, this involves school-community partnerships with agencies and community organisations on the provision of supports (Yu et al., 2020).

Wraparound first originated as a system of care in mental health and child welfare settings to support children struggling with complex emotional and behavioural challenges (Burns and Goldman, 1999). Since then, wraparound has become a widespread approach for supporting children with complex needs and has been increasingly implemented in schools (Scott and Eber, 2003; Sather and Bruns, 2016; Yu et al., 2020). Within schools, wraparound can also be operationalized as an MTSS approach, in which students receive escalating support based on identified needs (Scott and Eber, 2003). At the primary level, universal supports are provided to all students aimed at prevention, while at the secondary and

tertiary levels, targeted supports are coordinated for children and families who are struggling the most (Scott and Eber, 2003). School wraparound programs have shown positive impacts for students struggling with complex challenges (Lee-St. John et al., 2018; Yu et al., 2020; Olson et al., 2021).

All in for Youth (AIFY) is a collaborative, school-based wraparound model of support in Edmonton, a large city in western Canada. AIFY represents a school-community partnership of 10 local organisations that came together to support the success of children and youth through the provision of school wraparound supports since 2016 (i.e., school divisions, local service agencies, not-for-profit organizations, and municipal and community partners; All in for Youth and Community-University Partnership, 2020). The program is administered in eight high-risk school communities in Edmonton, which experience significant socio-economic insecurity, such as high rates of poverty, mobility, under-resourced single-parent households, and complex home environments (All in for Youth and Community-University Partnership, 2023). To support students and families, in-school wraparound services are provided by dedicated on-site agency staff, including nutrition supports (snacks and meals), enrichment programming (mentoring and after school programming), as well as comprehensive mental health services. Mental health services are provided in schools by staff from The Family Centre, a local counselling and therapy centre in Edmonton. Mental health services include *mental health therapy*, supporting students with socio-emotional development and complex needs; *success coaching*, supporting students with school success, self-management, and socio-emotional wellbeing; and, *in-home family supports*, supporting families to foster family wellbeing (e.g., increased parenting capacity, stable at-home environments, social connectedness, and access to needed resources). Beyond these primary services, AIFY schools also have distinctive cultures of collaborative, trauma-informed, strength-based, and supportive practices, which function to promote positive child-adult engagement and create a safe school environment for students with complex needs (Ungar, 2011; All in for Youth and Community-University Partnership, 2020).

The AIFY model operates through an MTSS framework of service provision (Scott and Eber, 2003). At the primary level, all students receive universal supports, in which they are supported by school culture of supportive and trauma-informed practices and nutrition supports to foster everyday health. At the secondary and tertiary levels, targeted supports are triaged by school wraparound teams based on identified individual needs (e.g., student mental health therapy and comprehensive in-home family support). School wraparound teams consist of a core team of school administrators (principal, assistant principal) and the dedicated AIFY agency staff responsible for providing supports (e.g., mental health therapists, success coaches, in-home family support workers, out-of-school time coordinators, and mentoring facilitators). Mental health therapists hold master's or doctoral degrees in psychology or related fields and are registered psychologists, counsellors, or social workers. Success coaches and in-home family support workers have bachelor's degrees in a human services field or equivalent education. All team members work together to actively identify and respond to students who require supports based on observed student and family needs or student and family self-referral. AIFY teams meet weekly through team wraparound meetings to coordinate services to support the student and family. AIFY is informed by an ecological approach, in which school wraparound teams recognise multiple contexts that impact students' wellbeing and collaboratively coordinate accessible, school-based services to respond to their needs (Bronfenbrenner, 1979; Burns and Goldman, 1999). See All in for Youth and Community-University Partnership (2020) for more details regarding the history and structure of AIFY.

Children and youth's mental health remains a significant public health challenge and more research is needed to guide the development and implementation of early interventions so that they effectively address growing mental health needs (Dray et al., 2017; Sanchez et al., 2018; van Loon et al., 2020). Therefore, the purpose of this research study is to explore how a collaborative school-based approach to mental health services delivery serves the mental health needs of children and youth in elementary school and junior high school (kindergarten–grade 9). Three research questions guided this inquiry: (1) What mental health concerns do children and youth experience? (2) What are the factors that impact the use of collaborative school-based mental health services (enablers and barriers)? (3) Does a collaborative school-based approach to mental health services delivery lead to perceived mental health impacts among children and youth (emotionally, psychologically, and/or behaviourally)? This research inquiry is explored through the case of AIFY, a collaborative, school-based wraparound model of support in western Canada.

## 2 Materials and methods

The role of collaborative, school-based mental health services in fostering children and youth's mental health was explored using a multiple methods secondary analysis (Greene et al., 1989; Creswell and Plano Clark, 2018). Data included in the study were generated for the program evaluation of the AIFY initiative during the 2021–2022 school year. The evaluation assessed the impacts of the AIFY initiative, with an in-depth focus on the mental health of school communities, lending naturally to this secondary analysis. Due to the focus on the mental health and experiences of children and youth in elementary and junior high, data from the seven AIFY elementary and junior high schools were included in this analysis (four elementary schools, two combined elementary-junior high schools, one junior high school).

Interview and focus group data generated with students and families (children, youth, parents, and caregivers) were analysed to understand their experiences with mental health services in their schools. Additionally, quantitative school cohort data were analysed with information on students' socio-demographic characteristics and use of services across schools. Qualitative description methodology guided the analysis of the interview and focus group data (Sandelowski, 2000). Qualitative description is used to develop a comprehensive description of data in "everyday terms," and therefore, was well-suited for the development of a thorough analysis of collaborative school-based mental health services (Sandelowski, 2000, p. 1). Ethics approval was received from the University of Alberta Research Ethics Board (No. Pro00121925), as well as under the University of Alberta Faculty of

Education Cooperative-Activities Program from Edmonton Public Schools and Edmonton Catholic Schools.

## 2.1 Interview and focus group data generation and analysis

Interview and focus group data were generated between April and June 2022. Overall, data from $n = 69$ individual student and parent and caregiver participants were analyzed. A total of 51 individual students were engaged through semi-structured focus groups and one-on-one interviews across seven schools, with some students participating in both focus groups and interviews ($n = 4$). Focus groups took place at all seven schools ($n = 8$ focus groups, ∼six students per group, $n = 45$ students; grades 2–9). Two focus groups took place at one of the combined elementary/junior high schools for both an elementary and a junior high group, whereas an integrated elementary and junior high focus group took place at the other elementary/junior high school. Interviews were conducted with junior high students ($n = 10$ students; grades 7–9) at the combined elementary/junior high schools and the junior high school. All focus group and interview sessions took place in person at school sites.

Parents and caregivers were engaged through semi-structured one-on-one interviews ($n = 18$). These interviews took place with parents, and/or individuals who were considered the primary caregiver in their child's life (e.g., grandparents, stepparents, aunts, uncles; parents and caregivers are here forth referred to as "caregivers"). Most caregivers were interviewed over the phone ($n = 14$), a few chose to do it in person at school sites ($n = 3$), and one was done over the video communication platform Google Meets.

Students and families were recruited to participate in interviews and focus groups through a purposeful sampling method; in which participants were invited to participate based on their experiences with, and ability to speak to AIFY services, as well as a convenience sample, based on students and families being available and interested in taking part in research activities (Mertens, 2020). This recruitment process was facilitated by agency staff and school administrators who have relationships with students and families. AIFY agency staff and school administrators invited potential participants that they worked with and/or they believed could speak to supports to share their perspectives in the research activities. These partners played a critical role in bridging connections between the research team and families; however, all participants were made aware that their participation was voluntary and would not affect their existing relationships or the services they received from their school. Interviews and focus groups were conducted by four members of the AIFY research team (including an evaluation lead, research assistant, the lead author, and the third author). In some cases, school administrators co-facilitated student focus groups with the research team ($n = 4$ focus groups) to bridge relationships between the students and research team and build staff capacity for research.

Interviews and focus groups were semi-structured, allowing facilitators to have flexibility to diverge from the interview guide explore participants' remarks (Gill et al., 2008). Participants were asked about their mental health and wellbeing and their experiences in using school-based mental health services. Participants were also asked about the lasting effects of the COVID-19 pandemic. This is because data were collected during 2021–2022 school year, following the return to in-person instruction after the pandemic. Previously, in-person classes in Alberta were cancelled in response to the outbreak of COVID-19 in March 2020. In the following 2020–2021 school year, students and families were given the option for remote or in-person learning, and by the 2021–2022 school year, in-person instruction resumed. Therefore, students and families were asked about their transition back to in-person learning and their mental health experiences. Overall, the interview and focus group data addressed all the guiding research questions on (1) what types of mental health concerns children and youth are experiencing, (2) the factors that impact mental health service use, and (3) the perceived mental health impacts of the collaborative school-based mental health services. Participants completed written consent (from caregivers of participating children and caregiver interview participants) and verbal consent from student participants in the form of assent. Sessions were audio-recorded and transcribed with the support of the transcription service Otter.ai (2023).

Reflexive thematic analysis was used for the analysis of interviews and focus groups (Braun and Clarke, 2006). Reflexive thematic analysis is an analytic approach that recognises the active role of the researcher in developing findings, and values the researcher's reflexive engagement with data as a strength and source for knowledge (Braun and Clarke, 2006). Analysis was implemented according to Braun and Clarke's (2006) multi-phase process of immersing yourself in the data, generating codes, developing themes, reviewing themes, defining themes, and writing out findings. Additionally, the analysis was conducted across two broad stages. First, data were analysed separately by groups of students and caregivers for each school and assessed for divergence and convergence. Next, student and caregiver data were integrated together. An inductive approach was taken, in which observations were primarily data-driven, as opposed to being guided by pre-existing conceptualizations (Braun and Clarke, 2006). Themes were peer-reviewed to promote critical thinking and the richness of interpretation (Braun and Clarke, 2019). An audit trail was also maintained of key decisions throughout the research process to enhance the trustworthiness of the research (Lincoln and Guba, 1985).

## 2.2 School cohort data collection and analysis

School cohort data were provided between November and December 2022 for the seven AIFY schools. These data provide information on individual students' socio-demographic characteristics and their use of mental health services, in each school during the 2021–2022 year. These data are completed by the school administrators and AIFY agency staff at schools who know each student and the services they accessed during the year.

Students' school level (elementary, junior high) and gender (female, male, gender non-binary or gender queer) were reported. Population sub-group status was also reported based on whether

students self-identified as Indigenous (First Nations, Métis, Inuit), refugee, English language learners (ELL) or had identified specialised learning needs (i.e., emotional, behavioural, cognitive, learning, speech, hearing, vision, physical, or medical needs that require specialised programming). Additionally, the use of mental health services was reported for each student. This was categorised by type of service, including by mental health therapy, success coaching, and/or in-home family supports. It was also categorised by type of client, including whether students received support as a formal client over the long-term or as an informal client on a short-term basis. Finally, mental health services were also organised by type of delivery, including whether students received support in individual sessions or in group settings. All services were offered in person at school sites.

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

## 2.3 Mental health service use across schools

Across seven schools, 2,073 students were enrolled during the 2021–2022 school year. Of this, 885 students and their families accessed any type of school mental health service, representing 42.7% of enrollment. This includes the use of any mental health service offered at school (mental health therapy, success coaching, in-home family supports) on a short-term or long-term basis, and in an individual or group setting. To break this down further, service use was also calculated for mental health services, excluding the use of in-home family support as the only service accessed (i.e., excluding cases where students and families only used an in-home family support worker, and did not also access mental health therapy and success coaching). Engagement with in-home family support typically has a more general focus on overall family wellbeing, with some exceptions; therefore, this calculation allows for a more targeted measure of children and youth's use of mental health services. With this adjustment, the level of service use remained high, with 795 individual students who used mental health services, representing 38.4% of enrolment.

### 2.3.1 Student socio-demographic characteristics

Among students who accessed services, 50.2% were male, 49.5% were female, and 0.3% were gender non-binary or genderqueer. This reveals a nearly equivalent distribution of service use by male and female students, with a lower proportion of identified genderqueer students using services. Additionally, there was equivalent service use by elementary and junior high students, with a similar proportion of students accessing services across all 10 grade levels (kindergarten–grade 9; $M = 10\%$, SD $= 1.9\%$, range $= 6.3\% - 13\%$). Among population sub-groups, almost a quarter (24.5%) of service users were self-identified Indigenous persons and close to one-tenth (9.5%) of service users had refugee status. Furthermore, 30.1% of students who accessed services were ELL and 18.7% had specialised learning needs.

### 2.3.2 Structure and delivery of mental health services

Most students accessed services in individual settings or a combination of individual and group settings (72.9%), with around a quarter of students accessing support in only group settings (27.1%). In terms of client type, most students accessed supports at informal client, only (75.1%), while the remaining accessed support as a formal client or both a formal and informal client (24.9%). Additionally, of service users, 42.2% used two or more of any type of mental health service during the year. A typical combination of multiple service use was individual work with a mental health staff, as well as taking part in group sessions.

# 3 Results

Based on interview and focus group discussions with students and caregivers, themes are presented that address the three research questions on the mental health concerns that children and youth experience, the factors that impact the use of collaborative school-based mental health services, and the impact of mental health services. Participant quotes are incorporated in the findings, with student participants identified by their level of school (elementary or junior high, written as "JH") and the type of data generation activity they participated in (interview or focus group, written as "FG"). Caregiver participants are identified by the level of school applicable to their child.

## 3.1 Mental health concerns experienced by children and youth

Two themes (*Coping with Multi-Faceted Needs and Experiences, Impact of the COVID Pandemic on Wellbeing*) and two subthemes (*Coping at School, Navigating Social Relationships*) were developed that respond to the first research question: What mental health concerns do children and youth experience?

### 3.1.1 Coping with multi-faceted needs and experiences

Students and caregivers made it clear that childhood and adolescence is often a difficult and overwhelming period of development. As described by one student, "You will face everything you are going through... because it's your teenager-age, right?" and gave the examples of "drama, relationships, growth, mental health, parents, everything" (JH Interview Student). Students spoke about struggling with mental health (depression, anxiety), family and peer dynamics (relationships, transitions, bullying), and learning difficulties (focus, academic pressures). With these challenges, students shared that they often did not feel well-equipped to process their emotions and cope with situations. For example, one student commented, "People are hiding their

feelings. They're actually emotions and just covering it up" (JH FG Student). Processing emotions and coping was described to be particularly difficult when children and youth did not feel like they had a safe space or support to do so, with one student explaining, "Some people at home they get in trouble for having feelings. And so, they just shut it out" (JH FG Student).

Unfortunately, experiencing environments that are unstable or unsafe is not uncommon. On top of daily challenges, students and caregivers shared about the experience of complex circumstances, such as unmet needs (housing, food insecurity), complex transitions (refugee status, family separation or loss), and exposure to maltreatment (abuse, neglect, substance misuse). Participants appreciated that such experiences are difficult for children and youth. For example, one caregiver described the challenge of economic insecurity and not getting coverage for his child's medication for a period, "I didn't have the medication covered. So, he [child] was not on his meds. So, he was kind of really, you know, not all there" (Elementary Caregiver). Another caregiver escaped violence with her children and shared that she and her children all, "coped with suicidal thoughts" while living in her car (Elementary/JH Caregiver).

Consequently, participants emphasised that children and youth need mental health support to help them process emotions and cope with complex experiences. Without this, participants emphasised that it could lead to suffering over the long-term and mental health concerns may become worse. One student explained, "If you're going to hide your emotions, you're going to sit there and suffer and suffer more until it comes to the point where you're going to have an emotional breakdown" (JH FG Student). Therefore, mental health supports are needed to help process "things you've been holding in" (Elementary FG Student).

### 3.1.2 Impact of the COVID pandemic on wellbeing

The challenge children and youth experienced with coping was described to be aggravated by the COVID-19 pandemic. It was made clear by participants that the pandemic had far reaching and ongoing effects in their lives, which made *Coping at School* and *Navigating Peer Relationships* more difficult.

#### 3.1.2.1 Coping at school

Students recounted their experiences with online schooling and explained that it was often difficult due to barriers in resources and limited access to learning support, as described by one student, "You aren't getting as much help as when you are in person" (Combined FG Student). Many students also struggled with the disruption to their routine and found it difficult to self-motivate. One student shared, "I feel like just online was kind of bad…I had kind of even made a choice, which isn't right, to like sleep instead" (Combined FG Student).

The transition back to in-person school was also challenging for many families. Participants explained that after online learning, many children and youth were not well-equipped with the coping skills needed for in-person school. For some students, it was difficult to return to a routine. One caregiver described this challenge for her child, "the pandemic helped her stay home more. And then the more she stayed home, the harder it is for me to get her to go" (Elementary Caregiver). For other students, it was challenging to keep up with increased academic expectations. One student explained, "I've usually barely gotten C's. But then when COVID hit, all I got was C's" (JH FG Student). Additionally, other students felt stressed and ill-prepared for in-person school, as described by one student:

> I feel like a lot of people…haven't been able to find, like, strategies to cope with stress. And then like, for me, when I came back to school…like, restrictions are getting loose, and teachers are obviously going to expect more. I have been really like, kind of sensitive to things. Like a lot. And I think it's because I haven't really had like encounters with like those things. And I haven't been able to find a way to like kind of help me cope with it. (JH FG Student)

Therefore, participants stressed that supports are needed to help equip children and youth with the socio-emotional and self-regulation skills to succeed in school following the pandemic.

#### 3.1.2.2 Navigating social relationships

Students also described struggling with social relationships after prolonged isolation and online school during the pandemic. Participants often said that online schooling was a difficult experience, "I died with no socialization" (JH FG Student). Another student shared, "I think every friendship has gone like further apart" (JH FG Student). This is challenging from a developmental perspective, as described by one caregiver, "Because socialisation for young children is of utmost importance, so that they'll know how to be civilised and the proper citizens of the community" (Elementary Caregiver).

After returning to school, some students expressed relief or gratitude at being able to socialise with friends again, "I guess coming out of COVID, it makes me glad that like, I can actually go out and hang out with people" (JH FG Student). However, many students described feeling overwhelmed and struggling to navigate social relationships. One student stated, "It's scary, it's really scary coming back" (JH FG Student). Another student commented, "I used to be completely fine being in big spaces with a lot of people. But now I just I can't do that. Like even coming to school, sometimes it's really hard" (JH FG Student). Another student explained:

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

Therefore, participants made it clear that navigating peer relationships was more difficult following the pandemic and that mental health support is needed for children and youth to develop skills and tools to navigate this.

## 3.2 Factors that impact mental health service use

Three themes (*School Culture of Support*, *School Communication*, *Stable and Well-Resourced Staff*) and two

subthemes (*Staff Resources*, *Staff Stability*) address the second research question: What are the factors that impact the use of collaborative school-based mental health services?

### 3.2.1 School culture of support

Students and caregivers made it clear that school culture plays a significant role in access to mental health services. AIFY schools have distinctive cultures of collaborative, trauma-informed, strength-based and supportive practices, which is reflected in how participants described their schools. For example, one student described school as a "very kind, caring environment," where students are, "getting the support we need" (JH Interview Student). Another student stated that adults in the school are, "just really there to help" (JH Interview Student).

Within this supportive school culture, students and caregivers described feeling comfortable to reach out to staff in the school for support. For example, one student commented, "Pretty much anyone in school you can really talk to" (Elementary FG Student). A caregiver shared, "I can literally phone and tell them anything" (Elementary Caregiver). In turn, staff were described to be receptive to, and understanding of, children and youth's mental health needs. For example, one caregiver explained that teachers were understanding of her, "kids' limitations" when they were leaving an unsafe home situation (Elementary/JH Caregiver). Furthermore, staff were described to facilitate students' access to mental health supports. For example, students talked about being able to excuse themselves from class to seek support from mental health staff, without receiving objections from their teacher. One student commented on this, "[Mental health room] is like a place where you could go and calm down and take a break. And ask teachers and they're always supportive for you" (Elementary FG Student).

This supportive culture was also emphasised to be meaningful when participants spoke about negative experiences at non-AIFY schools. For example, a caregiver shared that other schools were not understanding of her children's complex needs, explaining that her children were, "not only bullied by their peers, but by the staff members there...I had to fight for everything...And then in the end, it was worth nothing because they pretty much destroyed my kids' self-worth and self-confidence" (Elementary Caregiver). However, at her current school, "Everything has been positive...I have never experienced anything like this before." Consequently, this supportive culture was described as special and was able to facilitate students' access to mental health supports because students and caregivers were made to feel comfortable to reach out to staff in school buildings, who were receptive to their needs and able to connect them with care. As described by a caregiver, "I feel secure and safer that someone is out there who's, who's able to give me a value and respect and care for me, right? Like, if I need something like I know who to ask" (Elementary Caregiver).

### 3.2.2 School communication

Students and caregivers also discussed the importance of school communication when it comes to accessing mental health services. It was emphasised that when there is clear communication from the school about what mental health services are available and how to access mental health services, families are better able to reach out for support when they need it. For example, one student stated, "I knew where to go," when asked about how he first accessed mental health support (JH Interview Student). Another student shared that they knew about supports because mental health staff actively visited classrooms and connected with students, "[Mental health staff] came in [class] like almost every second Friday" (Elementary FG Student). However, when participants did not receive clear communication from the school about available supports, this mitigated their access, as described by a caregiver:

> We didn't even know that these programs existed until we had a family issue occur...I think if we had known about it sooner, it would have helped to know that there was support there. To a point I even let some of the other parents they know who are having issues with stuff. I let them know, like, "Hey, did you guys know if there was free program in the school?" And none of them had any idea that it was even there. (JH Caregiver)

Furthermore, participants suggested that school communication is needed not only on what services are available, but also how to access services. Within the AIFY model, wraparound teams actively work to identify students and families who might benefit from support. Alternatively, students and caregivers who are struggling can also self-refer themselves for these supports, and do not need to wait to be identified by the school. However, as described by one student, it is not always well-understood by students that they can refer themselves for supports, "Especially some of the younger kids, they don't know when it's okay to go to ask for help" (JH FG Student). The student went on to explain, "With younger grades...make sure to talk more about [mental health supports]...Like [tell them], 'it's okay to come'...Even if you don't get in trouble. Like if you need to talk to somebody." Therefore, clear school communication was key to promote children and youth's access to mental health services.

### 3.2.3 Stable and well-resourced staff

Finally, students and caregivers also spoke about the importance of mental health staffing when it comes to accessing mental health services. Participants explained that adequate *Staff Resources* and *Staff Stability* is needed to enable access to mental health services.

#### 3.2.3.1 Staff resources

Many students talked about mental health staff capacity at their schools. Most schools ($n = 5$) had three part-time mental health staff (mental health therapist, success coach, in-home family support worker), while some schools ($n = 2$) had only two staff due to funding constraints. It was made clear by students, in schools with either two or three staff, that the demand for support frequently exceeded available staff. One student explained, "We definitely need another counselor. Because like they're always just so busy. So you don't get to see them that much" (Elementary FG Student). Another student discussed the challenge of needing someone to talk to but not having any staff available that day:

> I think maybe we should get another counselor because I know for me because there's some times in my life where I need someone to talk but I felt like the counselor here was really busy...So I feel like maybe with another counselor it'll free up

> the space…And also it'll be another person to talk to you in case you need it the most, and I think maybe like it'll be easier for families to talk to feel more open, and because it'll be much quicker until the next time. (Elementary FG Student)

As illustrated by the above student, a lack of available mental health staff means that students may not be able to see mental health staff on days when they feel that they need someone to talk with. They may also experience longer wait-times between appointments, all of which are added barriers to receiving needed support, building trusting relationships with mental health staff, and making progress in therapy. Therefore, participants indicated that more mental health staff is required to meet the high volume of student needs.

#### 3.2.3.2 Staff stability

Students and caregivers also spoke about the stability of mental health staff. In some cases, participants had long standing relationships with staff. Alternatively, some schools experienced high turnover among staff, which was a barrier to service access. When there is staff turnover, participants temporarily lost access to support, as described by one caregiver, "There was a little bit of time where she [child] didn't have a counselor. And I have to say, I really noticed that. She came home and she would tell me, 'I flat out notice this mummy"' (Elementary Caregiver). Furthermore, due to the importance of these caring relationships, participants may experience stress when mental health staff leave. For example, one caregiver who learned that the mental health staff supporting her child was leaving said, "We were talking about how my how [child] is going to, you know, not take that news very well" (Elementary Caregiver).

Similarly, caregivers may also feel the change when mental health staff leave. One caregiver commented, "I'm probably more sad [when] she'll [mental health staff] won't be around. Cuz she's really been supportive to me too" (Elementary Caregiver). For some participants, this change may cause significant distress. One caregiver shared, "I feel cheated" when the mental health staff working with her family "disappeared" (Elementary/JH Caregiver). It may also be difficult for some participants to become comfortable with a new mental health staff. The same caregiver explained that it was "harder…to trust" a new staff who was male, after her family experienced abuse at the hands of a male family member. Therefore, participants indicated that turnover among mental health staff can be challenging, and that access to mental health services is best supported when schools have a stable mental health workforce.

## 3.3 Impacts of mental health services

Three themes (*Supported by a Safe and Caring Adult*, *Improved Capacity for Coping in School and Life*, *Improved Family Functioning*) and five subthemes (*Improved Coping with Life*, *Improved Coping with School*, *Healthy Action*, *Family Relationships*, *Family Wellbeing*) address the third research question: Does a collaborative school-based approach to mental health services delivery lead to perceived mental health impacts among children and youth?

### 3.3.1 Supported by a safe and caring adult

Students consistently said that their mental health staff was their safe and caring person that they could go to when needed. Students felt like they could confide in mental health staff, share their thoughts and emotions, and be received without judgement or consequence. For example, one student stated that her mental health staff is, "the one person that I would choose to talk to about anything" (JH Interview Student). Another student remarked, "it makes you feel safe" (Elementary FG Student). Students also saw mental health staff as someone they trusted to provide them with helpful guidance, "you can tell her [mental health staff] anything and then she'll give you really good advice" (JH Interview Student).

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

### 3.3.2 Improved capacity for coping in school and life

Students and caregivers also explained that children and youth's coping skills improved with mental health support, including *Improved Coping with Life* and *Improved Coping with School*, as well as being better able to take *Healthy Action*.

#### 3.3.2.1 Improved coping with life

Students spoke of feeling better equipped to deal with life's challenges, having received mental health support. This ranged from navigating everyday experiences to coping with complex and challenging life circumstances, "you can process what's going on in your life" (JH Interview Student). Another student shared, "I'm able to express myself more. I'm able to release a lot of things" (JH Interview Student). Specifically, participants described developing skills and tools to navigate different challenges. For example, one student who struggled with anxiety said the mental health staff, "taught me some strategies, on ways to not be so anxious all the time" (JH Interview Student). Participants observed noticeable improvements with support. Another student who also struggled with anxiety shared, "I used to have really bad anxiety attacks. But now it doesn't bug me anymore" (JH Interview Student). A caregiver shared that her child is "a lot more comfortable in her own skin, and willing to be more open and talk about things" (Elementary/JH Caregiver). Another caregiver shared:

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

Furthermore, many students expressed concern that they would not be able to cope as well without mental health support. One student explained that without mental health staff, "I'd be so overwhelmed because there's so much so many things going on" (JH Interview Student). Another student shared, "Maybe I'd be a little bit more depressed, or I'd be a little bit more anxious... but now I have actually a way to process my emotions and someone to go to if I ever have a problem" (JH Interview Student). Another caregiver expressed concern that, without support, her child would struggle even more with self-management and disruptive behaviours, "It would be total disrespect" (Elementary Caregiver). Therefore, students and caregivers expressed that it was meaningful and impactful for students to be able to unpack emotions and experiences in a safe space and learn coping tools for navigating life.

#### 3.3.2.2 Improved coping with school

With mental health staff, students also said that they were better able to cope in school. Specifically, when students were able to share and process their emotions with mental health staff, they were better able to focus on class. One student explained this, "When I express my feelings to them it makes me, I guess, focus more on school because I don't have to worry" (JH Interview Student). Another student remarked, "It would make me concentrate more on my work... Because you're calmer... your academic reflexes are higher" (Elementary FG Student). This is meaningful because, as explained by a student, it is difficult to concentrate in class when experiencing emotional distress, "for kids who are going through like really tough times, at times, maybe they can't learn at the moment and it's just nice to go there [to see mental health staff]" (Elementary FG Student). Another student remarked, "When you're like having a really hard time, and like, you can't really work... it's just nice to get off your chest... And then you go back to class and you feel like you can actually do work" (Elementary FG Student). Additionally, students also described receiving guidance from mental health staff in setting goals and developing skills and tools for managing classes, "They have like really good strategies that they use for each individual student. That depends on like, what you're going through" (JH FG Student). Another student shared the impact of this support, explaining that it was, "difficult for me to like focus on one thing... And now I can like pay attention" (JH Interview Student). Therefore, participants made it clear that mental health supports were critical in helping them to both process their emotions and develop coping strategies to foster their engagement and success in school.

#### 3.3.2.3 Healthy action

With mental health support, students also discussed feeling better supported and equipped to take action that fostered their health and safety. By talking to a trusted mental health staff, students had the opportunity to share challenges in their life for which they needed support. For example, one caregiver explained that her child, "opened up" with mental health staff and was able to, "talk about... addiction, like things that he needs to work on" (Elementary/JH Caregiver). Mental health staff were then able to help students make plans and decisions to support their health and safety. For some students, this was guidance on how to protect their wellbeing and set boundaries amidst external pressures, such as the role modelling of substance use or unhealthy relationships. For others, this involved making safety plans when children are experiencing significant emotional distress or suicidality. One caregiver commented on this support for her child, "At one point she [child] was... considering self-harm," and without support from mental health staff, "maybe like things would have gone downhill instead of getting better" (Elementary Caregiver). Similarly, a student shared that mental health staff prevented him from, "going down a bad road," by "trying to talk me out of doing a lot of things" (JH Interview Student). The student explained that without this support, "I don't think I'd probably be here right now." Mental health supports were, therefore, critical for helping children and youth to take healthy action and make safe decisions, often amongst complex circumstances.

### 3.3.3 Improved family functioning

Finally, students and caregivers also explained that their family functioning improved with mental health support, including improved *Family Relationships* and *Family Wellbeing*.

#### 3.3.3.1 Family relationships

Students shared that mental health supports helped them to navigate family relationships and dynamics, such as changes in family structure, complex relationships, or conflict. For example, a caregiver shared that mental health staff helped with tension between her child and his stepparent, explaining, "There's definitely a wedge between them," but support, "has made things smoother and more tolerable. And we can figure out where we're going... and how can we get there" (JH Caregiver). A student also explained that the mental health staff helped to facilitate conversations with his family about sensitive topics, "She was able to let my parents know what was going on. And I was able to talk to them about it with her in the room, so I was in a safe place" (JH Interview Student). Another caregiver shared how mental health staff helped their family meditate conflict, "[Mental health therapist's] very skillful at handling difficult situations, and difficult personalities" (Elementary Caregiver).

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

#### 3.3.3.2 Family wellbeing

Students and caregivers also described receiving supports which supported their families' overall wellbeing and access to needed resources. The wraparound approach of the AIFY model and the role of the in-home family support worker means that mental health supports often overlaps with other wellbeing-related supports, which are needed to promote stable home environments for children and youth. Therefore, students and caregivers discussed receiving support in accessing critical resources and navigating external systems to foster their family wellbeing. For example, one caregiver shared, "I got support for my clothes, my child's school stuff, books, stationery" (Elementary Caregiver). Another caregiver shared that the mental health staff, "helped with clothing and food. Like going to the food bank" (Elementary Caregiver). Another caregiver received support to apply for "disability tax credit" to support his child with a disability (Elementary Caregiver). Another caregiver, who is a newcomer, received support for immigration, "My work permit is expiring... If my child and I don't have a permit, he can't go to school, and I can't work... But and the school has tried to help me in the immigration, like, make a good support letters" (Elementary Caregiver).

When the whole family receives support, caregivers are able to foster a more stable environment to promote children and youth's wellbeing. For example, one caregiver shared that this support, "just helped me to be a stronger parent" (JH Caregiver). Another caregiver shared, "Without them, I wouldn't be as good of a parent... [It] makes me like teary eyed because it's very, very helpful... I'm a single parent and with their help it's made me stronger as a single parent" (Elementary/JH Caregiver). Therefore, students and caregivers made it clear that mental health supports that extend to the home helped to promote overall family wellbeing and stable home environments for children and youth.

## 4 Discussion

Responding to the mental health needs among children and youth remains a critical public health challenge and research is needed to guide the development of early interventions so that they effectively address the mental health needs of children and youth (Dray et al., 2017; Sanchez et al., 2018; Georgiades et al., 2019; van Loon et al., 2020). Therefore, the present study explored the role of collaborative, school-based mental health services in fostering children and youth's mental health, as implemented through the AIFY program.

### 4.1 Use of mental health services

The findings reveal a high use of mental health services across seven schools. Overall, a little under half the student population (42.7%) used any mental health service. The level of service use remained high after calculating students' use of mental health services excluding in-home family support as the only service accessed (38.4%). These data indicate that there is a high demand for mental health services and uptake of services when they are available in schools, which builds on existing literature documenting significant mental health concerns among children and youth (Smetanin et al., 2011; Georgiades et al., 2019).

Among students who accessed mental health services, rates of service use were equivalent between female and male students (50.2% male, 49.5% female, 0.3% genderqueer). This is interesting to note because gender differences are often seen in mental health service use, with less use among male clients, typically attributed to greater perceived stigma (Chandra and Minkovitz, 2006; Pattyn et al., 2015). Equivalent mental health service use was also seen among elementary and junior high students (kindergarten–grade 9; $M = 10\%$, SD $= 1.9\%$, range $= 6.3\%-13\%$). As younger children are typically less equipped to advocate for their mental health, this likely meant that staff identified younger students who they believed needed additional supports.

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

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

### 4.2 Mental health concerns

The findings also shed light on the mental health concerns experienced by children and youth. Participants shared that many children and youth experience complex mental health concerns. This included feeling overwhelmed with personal, school, or family challenges; facing complex circumstances, such as poverty, unsafe homes, or child maltreatment; and experiencing anxiety, depression, trauma, or feelings of suffering. These findings build on previous literature which outlines the burden of unmet mental health needs on children and youth and the need for early mental health supports (Smetanin et al., 2011; Georgiades et al., 2019). Participants also expressed concern for children and youth's long-term outcomes if mental health concerns are left unsupported.

These concerns are validated by literature, which finds that untreated mental health concerns are associated with increased risks for distress, impaired functioning, and long-term health and socio-economic risks in adulthood (Shonkoff et al., 2009, 2012; Hale et al., 2015).

Furthermore, participants explained that the pandemic made their experiences in school and life more difficult and compounded the need for mental health supports. Participants described challenges during the pandemic with online schooling, such as barriers to online platforms, disruption to their routines, and reduced access to social support. Recent literature has affirmed these challenges, with effects being the most pronounced for families facing social vulnerability and economic disadvantage (Bonal and González, 2020; Engzell et al., 2021; Whitley et al., 2021). Participants also said that the transition back to in-person instruction was difficult after prolonged online learning and cited concerns such as diminished regulation and coping skills, increased school pressure, academic learning gaps, and social anxiety. Emerging research also shows evidence for learning gaps and losses, particularly among socially vulnerable children and youth (Bonal and González, 2020; Engzell et al., 2021; Whitley et al., 2021).

Consequently, the study findings underscore the critical need for early supports to meet the mental health of children and youth in order to relieve emotional distress, and promote functioning in school and life, healthy development, and long-term health outcomes, with increased needs following the pandemic. Additionally, due to the complex interplay between mental health and adverse environmental factors (e.g., unmet needs, abuse), findings also emphasise the value of wraparound interventions, which take an ecological approach and consider children and youth's mental health needs in relation to the different contexts that affect them, such as family wellbeing, home stabilization, and access to critical resources (Burns and Goldman, 1999; Bruns and Walker, 2008).

## 4.3 Enablers and barriers to support

Several factors were identified in the study which make school-based mental health services more accessible for children and youth. First, a supportive school culture was indicated to foster safe and positive child-adult relationships, in which children and youth can feel comfortable to share their mental health concerns with staff, and in turn, be connected to mental health support. This finding aligns with existing literature, which demonstrates the benefit of trauma-informed care and positive child-adult relationships in schools for students' functioning and wellbeing (Shonkoff et al., 2012; Anderson et al., 2015), and their access to mental health support (Mariu et al., 2012; Halladay et al., 2020).

As shared by participants, it is often the case that children are exposed to significant adversity in their lives (Giano et al., 2020). In response to trauma, children may experience emotional dysfunction and cope in maladaptive ways (e.g., disruptive or withdrawn conduct; Shonkoff et al., 2012; Anderson et al., 2015). Research demonstrates that when schools implement trauma-informed care, this functions to foster a safe, predictable, and supportive environment for all children, promoting student resilience and positive child-adult relationships (Shonkoff et al., 2012; Anderson et al., 2015; Brunzell et al., 2015). Participants in the study noticed the supportive culture cultivated by their school and described feeling safe to reach out to school staff for support, who they said were receptive to their mental health needs. This builds on previous literature noting the connection between supportive school relationships and help-seeking behaviours (Mariu et al., 2012; Halladay et al., 2020). Specifically, a recent study conducted with 31,120 students from 248 schools in Ontario found that students reported a greater intention of seeking mental health support when they perceived their teacher to be responsive to their emotional needs and felt that they had a quality relationship with their teacher (Halladay et al., 2020). Consequently, study findings underscore the importance of robust and ongoing school training in trauma-informed care and supportive practises to foster and maintain a school culture of support (Ko et al., 2008; Anderson et al., 2015) and promote help-seeking behaviours (Mariu et al., 2012; Halladay et al., 2020).

Students and caregivers also emphasised that clear communication from the school about what mental health services are available further enabled their access to mental health services, and without this, students and families are often unaware of the supports available. A lack of knowledge about available mental health supports has been confirmed in literature to be a barrier to receiving mental health support (Statistics Canada, 2019; Zifkin et al., 2021). For example, a study in 2018 found that 78.2% of Canadians with unmet mental health needs reported barriers to receiving mental health support, including not knowing where to go for support (Statistics Canada, 2019). Additionally, as indicated by participants, it may not be obvious to families that school can be a place that they can turn to for support. This is because the traditional role of school has been to provide academic instruction, rather than support the development of the whole child (Yu et al., 2020), which furthers the need for clear communication.

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

Sufficient funding and resources for mental health staff was another critical factor identified as important for access to mental health supports. School-community models, such as the AIFY model, have been noted in the literature as cost effective strategies for delivering mental health services because they involve leveraging shared resources between schools and community partners (Anderson-Butcher and Ashton, 2004; Atkins et al.,

2017). That being said, study participants continued to experience resource constraints as a barrier to accessing support because mental health staff had a limited capacity for taking on additional clients and experienced burnout and staff turnover. Therefore, greater funding needs to be invested in early intervention programs so that they are better equipped to support children and youth's mental health (Waddell et al., 2019). This call for investment has been echoed by research and advocacy groups across Canada (People for Education, 2019; Waddell et al., 2019; Canadian Psychological Association, 2022).

## 4.4 Impacts of mental health support

Finally, the study findings also provided insights into the impacts that school-based mental health supports have on the lives of children and youth. Participants explained that mental health staff were safe and caring persons in the lives of children. This is significant because positive child-adult relationships are key for healthy child development and can function as a protective factor that promotes resilience (Armstrong et al., 2005; Bernat and Resnick, 2006). Positive child-adult relationships are also shown to protect against poor mental health outcomes and risky behaviours, such as emotional distress, bullying, and substance misuse (Bernat and Resnick, 2006; Brown and Shillington, 2017; Steiner et al., 2019). As such, the experience of a safe and caring relationship with mental health staff may benefit students alone (Bernat and Resnick, 2006), regardless of the tools they acquire through mental health sessions.

Additionally, after receiving mental health support, children and youth described feeling better equipped to process their emotions, cope in school and life, and take action that fostered their health and safety (e.g., make safe decisions and set boundaries). Similar findings have been proposed by previous literature exploring the effects of school mental health interventions (Fazel et al., 2014; García-Carrión et al., 2019; Hoover and Bostic, 2021). This is also significant because developing healthy coping skills may have meaningful short-term and long-term effects (Case et al., 2005; Belfield and Levin, 2007; Hale et al., 2015). By developing coping strategies early, children and youth may be better equipped with the self-management tools needed to cope with later life circumstances and to manage mental health concerns before they manifest in more serious ways (Belfield and Levin, 2007). Additionally, through improved engagement in school, students may also be better positioned to succeed academically and graduate, which are linked to later positive health and socio-economic outcomes (Case et al., 2005; Belfield and Levin, 2007; Hale et al., 2015).

This study also found that the mental health supports helped to improve overall family functioning, including family relationships and access to needed resources (food, clothing, shelter, navigating external supports). Participants indicated that a whole-family engagement approach to mental health support was meaningful for promoting child and youth's wellbeing because children and youth are best able to achieve mental health and wellbeing in home environments that are stable and secure (Armstrong et al., 2005; Bernat and Resnick, 2006). Therefore, these findings reaffirm the value of the wraparound approach in fostering children and youth's mental health, which takes an ecological approach and considers family and environmental contexts in the provision of support (Burns and Goldman, 1999; Bruns and Walker, 2008). This is also reinforced by growing body of literature on ecological approaches to mental health interventions (Cappella et al., 2008; Atkins et al., 2017; García-Carrión et al., 2019). For example, a recent systematic review found that school interventions focusing on interactions with school and family and community contexts were associated with improved social skills and personal wellbeing among children and youth (García-Carrión et al., 2019).

## 4.5 Limitations

This study has strengths and limitations. First, this study was completed as a secondary analysis, which had its limitations, such as distance from the original research purpose and data. However, in this case, the original program evaluation was centred on the mental health of school communities, lending naturally to this secondary analysis. Additionally, the lead author was involved in the primary data generation, which allowed for a rich understanding of the context of the AIFY program. Second, although the study sample was large and diverse, it is situated in the context of the AIFY school-community wraparound program. Therefore, contextual factors need to be considered when applying findings to other settings. Programs should be adapted according to their local context, as this allows programs to build on the strengths and experiences of local partners (Bruns and Walker, 2008). A forthcoming manuscript is being prepared with in-depth details on the AIFY model of support, which will support the process of extracting findings to other programs. Finally, it would be beneficial to include the perspectives of school and agency staff on school-based mental health services; therefore, another manuscript is being prepared from the school perspective.

# 5 Conclusion

Overall, the study findings demonstrate that school-based mental health services which recruit school-community partnerships on the delivery of services and take an ecological, wraparound approach meaningfully meet the mental health needs of children and youth. This adds to the evidence base on effective early mental health interventions to support of children and youth (Fazel et al., 2014; García-Carrión et al., 2019; Hoover and Bostic, 2021). Additionally, this study identifies several factors which make collaborative, school-based mental health services more accessible, including a school culture of support, clear school communication, and a stable and well-resourced mental health staff. To support these factors, schools need to adopt training and practises that foster a supportive culture and communication, and funding is needed to support a stable mental health workforce. Finally, an increased investment of sustainable funding is needed to support collaborative, school-based models of mental health support in order to support children and youth in reaching their full potential (People for Education, 2019; Waddell et al., 2019; Canadian Psychological Association, 2022).

## Data availability statement

The data analysed in this study is subject to the following licenses/restrictions. The data are restricted due to confidentiality agreements. Requests to access these datasets should be directed to JH, jbhaight@ualberta.ca.

## Ethics statement

The studies involving humans were approved by the University of Alberta Research Ethics Board (No. Pro00121925), as well as the University of Alberta Faculty of Education Cooperative-Activities Program by Edmonton Public Schools and Edmonton Catholic Schools. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation in this study was provided by the participants' legal guardians/next of kin.

## Author contributions

JH: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing—original draft, Writing—review & editing. RG: Supervision, Writing—review & editing. JD: Supervision, Writing—review & editing.

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## Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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