SCHOOL BASED MENTAL HEALTH IN THE EASTERN MEDITERRANEAN

A CULTURAL ADAPTATION OF WESTERN PSYCHOLOGY: EVALUATING THE ROLE OF COLLABORATIVE CARE IN A SCHOOL BASED MENTAL HEALTH PROGRAM IN THE EASTERN MEDITERRANEAN REGION

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Descriptive Note

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Lay Abstract

The SHINE research group are implementing a school-based mental health intervention in the Eastern Mediterranean region, alongside a facilitated collaborative learning group involving key local and global stakeholders. This study focuses on the collaborative care element of the school-based mental health program and its impact on the overall functioning of the intervention, in different country contexts. Collaborative care involves the interactions between parents, teachers, mental health professionals and researchers to ensure the sustainability of the program as well as its scalability to different country contexts. This is an exploratory qualitative study with a case study design; data has been collected with ten participants through individual and small group in-depth interviews. Interviews were transcribed, coded and then cross-compared using thematic analysis to identify overarching patterns. The primary goals of the study are to examine the role of collaboration as well as to consider some of the challenges of applying Western psychological interventions to diverse country and cultural contexts.

Abstract

Globally, children and youth are more vulnerable to experiencing mental health challenges; early intervention is key to preventing ongoing mental health difficulties into adolescence and adulthood. School-based mental health interventions have proven to be effective but require a significant amount of collaboration between teachers, parents, mental health specialists and other important stakeholders. Equally noteworthy are the significant treatment, resource and capacity gaps between high and low to middle income countries when it comes to child mental health; the SHINE research group seeks to implement a school-based mental health program in countries in the Eastern Mediterranean region. They also intend to scale-up the prevention and intervention capabilities of said countries to improve overall child mental health. This study investigated the role of collaborative care in SHINE’s program development and implementation processes, while examining the cultural and societal challenges associated with implementing a school mental health program developed primarily in high-income countries to specific non-Western contexts. Individual and small-group in-depth interviews were conducted with ten key stakeholders from the SHINE team and partner countries (specifically Iran, Jordan and Egypt). Findings identified the potential for the collaborative care approach within the SHINE school mental health program to greatly ameliorate child mental health outcomes. Additionally, participants noted the necessity for clearer stakeholder role definition and differentiation of general vs specific program elements between countries. Challenges associated with implementing the intervention in the Eastern Mediterranean region included the dominant role of the

family, challenging societal norms and stigmatization and structural barriers to applying SHINE’s specific program resources. In summary, the role of collaborative care is increasingly important to SHINE’s current efforts in improving child mental health, however, individual cultural and country characteristics should be an area of emphasis moving forward.

Keywords: school mental health, transcultural psychiatry, collaborative care, child health, implementation science

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List of Abbreviations and Symbols

CLG - Collaborative Learning Group

EMRO - Regional Office for the Eastern Mediterranean

SHINE - School Health Implementation Network in the Eastern Mediterranean Region

SMHP - School Mental Health Program

ToC - Theory of Change

WHO - World Health Organization

Declaration of Academic Achievement

The following is a declaration that the content of the research in this document has been completed by Maya Low, recognizing the valuable support of her thesis supervisor Dr. Mat Savelli and supervisory committee Dr. Anna Chiumento and Dr. Amanda Sim.

Chapter 1

Introduction

The School Health Implementation Network (SHINE) is a five-year implementation science research project based at the University of Liverpool/University of Washington that is focused on increasing mental health services and improving child and adolescent mental health in the World Health Organization's (WHO) Eastern Mediterranean Region, specifically in Egypt, Iran, Jordan and Pakistan (this study focuses exclusively on the first three as they are involved with the Collaborative Learning Groups or CLGs). The project seeks to implement a school-based mental health intervention that involves the scaling up of mental health services and treatment capacity within the school context and emphasis on a collaborative care approach to ensure that the voices of parents, children, mental health professionals and other key stakeholders are amplified (SHINE, 2020). They have since adapted their program to an online format to ensure sustainability and ongoing monitoring of progress (Alonge et. al, 2020).

The rationale for this research project has emerged through discussions with SHINE's research team and the identification of gaps within the program planning and delivery processes, specifically those relating to collaborative care. Effective collaborative care, for the purpose of this study, refers to both collaborative care as the 'unit of important people around the individual child' (within-country collaboration) as well as cross-sectoral national partnerships for regional improvements in child mental health across the region (between-country collaboration). Both applications of collaborative care can lead to more positive program outcomes for SHINE and improved

mental health outcomes for children. To clarify my relationship to SHINE, I am an independent researcher using their school-based mental health program to investigate some of the larger questions around cross-cultural mental health initiatives for children and adolescents. This qualitative study aligns with my research interests and expertise and seeks to explore collaborative care within SHINE's school mental health program and their challenges in adapting the program to unique country contexts.

By using the SHINE program as an example of a global intervention for improving child mental health, an exclusively qualitative approach will allow for a more nuanced understanding of the contextual factors regarding the applicability and expansion potential of a functional global mental health intervention. By considering the experiences of stakeholders directly involved with the program, this study addresses the ways in which the collaborative care elements of the school mental health program influence accessible mental health care for children. Further, the study explores the role of culture within the school mental health program - particularly how collaborative efforts may connect to complex challenges associated with ensuring mental health interventions are culturally and contextually appropriate.

The motivation for this research stems from a fervent belief in the importance of mental health interventions that target children and adolescents, especially within various national contexts that have not historically prioritized mental health (Rahman and Hamdani, 2020). Mental health services ought to be accessible as well as culturally sensitive. Efforts targeted at instilling resilience in children and youth, addressing mental health stigma and dismantling the perpetuation of global inequities should be priorities in

all global mental health research activities (Leiva et. al, 2020). The existing gap in mental health services for children can be attributed to broader global health issues; namely, the lack of effective mental health infrastructure and treatment capacity for children and adolescents in countries that fall within the World Health Organization's Eastern Mediterranean Region (where the SHINE program is currently being implemented) (Alonge et. al, 2020). There is an increasing, and perhaps dire, need to explore targeted, evidence-based strategies that maximize mental health benefits and early intervention techniques for children (Rahman and Hamdani, 2020). Consistent gaps in the current literature point to the need for more research around the best screening practices for common mental health issues in children and youth worldwide, as well as effective and sustainable interventions (Leiva et. al, 2020). School-based interventions are an excellent starting point for improving teacher, parent and child understanding and recognition of the importance of mental health (Gee et. al, 2020).

Research of this nature (examinations of global mental health initiatives) is also important when considering large-scale solutions for global mental health; it is necessary to consider the reasons why an intervention like SHINE's may not be effective or helpful in certain cultural contexts. Some prominent commentators within the literature raise questions about the applicability of global mental health interventions to diverse country contexts, especially as mental health itself is at its core a cultural construct (Gimba et. al, 2020). While this point is elaborated upon in Chapter 3, various religious, political and societal systems at play can all influence the ease with which an outside intervention might achieve its intended outcomes.

Findings from this study could inform future research and policy by prompting a focus on stronger and more culturally appropriate mental health services for children and adolescents within the region and beyond (such as scalable psychosocial interventions to support children and youth with severe emotional distress or trauma). It could encourage relevant NGOs, governing bodies and other key stakeholders to respond appropriately to mental health challenges in their individual countries. An additional avenue for research might examine how higher-resource countries could train non-specialized workers to respond to common psychosocial problems and increase resiliency to ensure early diagnosis and treatment in children and youth. Therefore, this research can inform both the global mental health movement and the field of transcultural psychiatry (Alonge et. al, 2020). This would have the added benefit of addressing potential mental health stigma and making quality care more accessible and culturally appropriate by empowering and encouraging local and more sustainable solutions for mental health (Alonge et. al, 2020).

The next chapter (Chapter 2) provides a comprehensive summary of SHINE and their school-based mental health program, as well as information on the way in which they situate themselves within the broader field of implementation science and research. The summary is followed by a comprehensive review of the literature regarding transcultural psychiatry, school mental health and collaborative care. Chapter 4 then describes the methodological processes of the study and provides reasoning for their selection. Chapters 5 and 6 provide an analysis of the findings, discuss the findings in relation to the primary research questions and draw conclusions.

Chapter 2

Background

2.1 SHINE

SHINE is an ongoing research project seeking to ameliorate child mental health in the WHO's Eastern Mediterranean Region through evidence-based mental health interventions in schools. The project is funded by the National Institute of Mental Health USA to the University of Liverpool in the United Kingdom and the University of Washington in the US as part of the 'Global Mental Health Research Hubs' (SHINE, 2020). The researchers work in collaboration with Dr. Khalid Saeed, the Regional Advisor for Mental Health at the World Health Organization's Eastern Mediterranean Office to address the overarching regional target of scaling up mental health programming and service delivery (Alonge et. al, 2020). Beyond that, SHINE's network is comprised of the Ministry of National Health Services, Regulations and Coordination, the Government of Pakistan, District Education Department, universities, non-governmental organizations and policy partners from EMR partner countries, with technical support from universities in the United Kingdom and United States (SHINE, 2020). To date, their implementation research has exclusively focused on Pakistan, Egypt, Iran and Jordan and has included both in person and online training for schoolteachers as part of their comprehensive programming efforts. As listed on their website, the primary desired outcomes of SHINE are:

1. Conduct implementation research on the scale up of the school mental health program (SMHP).

2. Develop a collaborative network of institutions, researchers, policy partners and community stakeholders engaged in implementing child mental health with a focus upon the SMHP.
3. Build the capacity of the network in implementation research in child mental health.

To elaborate, the SMHP is generally delivered via cascade training; mental health experts (in-country clinical psychologists, counsellors, psychiatrists etc.) train teachers and school psychologists who work in schools on the content within the comprehensive program manual developed by the WHO Eastern Mediterranean Office (EMRO) with support from technical experts in the USA and UK. The teachers or psychologists then implement it directly in a stepped-care model that uses classroom-based methods - or individual strategies for children who require more support - under the supervision of the mental health specialists within their country. The country-level specialists are provided additional support with SMHP implementation by researchers and mental health professionals from SHINE's partners in the USA and UK, who have expertise in implementation science, mixed methods research and intervention development and adaptation (2020). In response to the implementation challenge of sustainable training, the SMHP has been adapted to an Enhanced School Mental Health Program (eSMHP), which is described as "a multicomponent intervention which includes an online course to train teachers at scale with fidelity and a Chat-bot to aid the program implementation with quality in real world settings" (SHINE, 2020). The program also now includes "modules on teachers' wellbeing, addressing problems of children with learning difficulties and

readily available demonstration videos around how to identify and manage the low-intensity mental health problems of children in school settings" (SHINE, 2020). Attached to the training and ongoing implementation are a range of tools to monitor implementation and delivery, and most partner countries have collected qualitative feedback from teachers and stakeholder input from policy makers and others to guide implementation (Alonge et. al, 2020). The eSMHP is being evaluated by CLG facilitators through a cluster randomized controlled trial that compares the enhanced training program with face-to-face training. An embedded qualitative process evaluation is also exploring the positive and negative outcomes for child mental health, teacher capacity and school resources (SHINE, 2020).

Facing international health challenges requires global cooperation from a variety of stakeholders. As stated on the SHINE network, the goal of this research project is to "work alongside other global networks working to tackle priority mental health issues in different regions of the world... The aim of this collaborative network is to inform strategies for scaling-up child and adolescent mental health programmes to regional and national levels through the knowledge sharing and best-practice." SHINE's current goal is to assess the scalability of this project to other countries in the region (SHINE, 2020). Every six months, representatives from each of the partner countries meet with the team of researchers from the USA and UK for collaborative learning groups (CLGs) that are focused on support for program implementation and opportunities for research and policy influence skills development. The focus of the CLGs is to evaluate contextually driven responses to each country's implementation challenges; the groups also provide the

opportunity for shared learning (SHINE, 2020). Participants in the CLGs consist of mental health and education specialists or policymakers; they then work directly to train teachers and psychologists in their country contexts who implement the SMHP in schools, as described above.

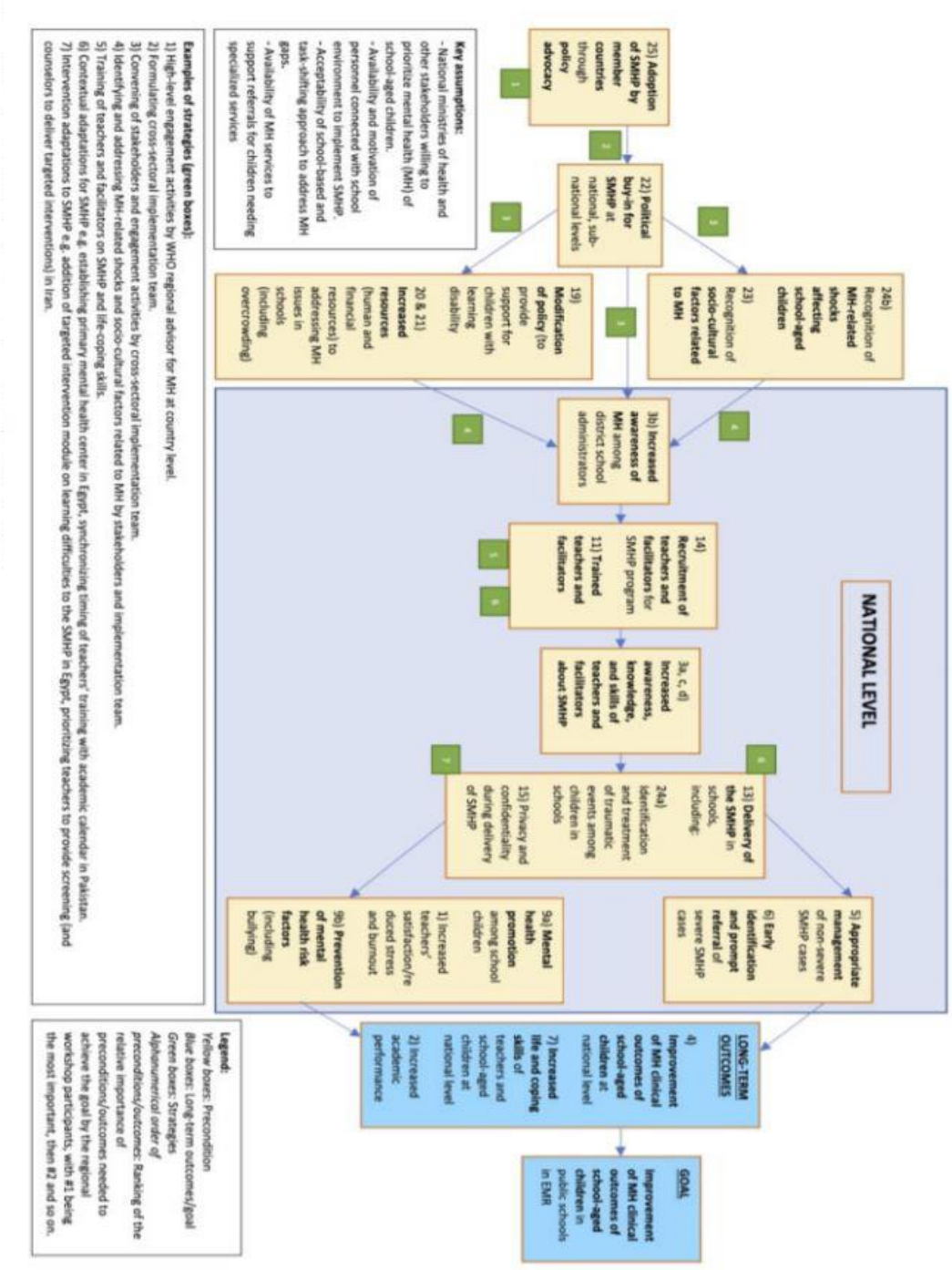
The purpose of such *intentional* collaboration is to work through the implementation tools and engage in general discussion about cross-sectoral global mental health projects. There are three key areas of emphasis in each of the CLG sessions as stated on their website: "the cultural adaptation of the program, ongoing national policy engagement and an overview of implementation science research as it applies to the school mental health program" (for stakeholders who are not familiar with this area) (2020). SHINE CLG facilitators at the University of Liverpool have already compiled some data in the form of surveys and general feedback on the effectiveness of the CLG from stakeholders in partner countries who attend the CLGs; the data has been generally positive and indicates that most countries enjoy and benefit from the opportunity to collaborate. SHINE is also interested in understanding the effectiveness of collaborating with other professionals and sharing experiences – it prompts the question of whether this form of collaboration contributes to overall program implementation effectiveness. The current CLG structure is strongly aligned with participants' identified priorities and needs. However, as implementation progresses at different rates in each country setting, the CLG model has correspondingly evolved to focus on country-specific activities, such as how to task-share between teachers and psychologists in Egypt, or how to navigate the challenging interactions with parents in Iran (SHINE, 2020).

This investigation and specific research questions have emerged from discussions with SHINE's research team and the identification of some gaps in the existing program implementation research. Topics identified include the ongoing difficulties in negotiating health and education projects with various levels of governments, as well as the challenges associated with navigating unique governmental and political systems when it comes to the technical side of mental health programming for children and adolescents. More broadly, SHINE wishes to "address the challenges of implementing school-based child mental health programs in countries under the World Health Organization's Eastern Mediterranean Region Office (EMRO)". Thus, my study seeks to explore the extent to which the collaborative care element helps to mitigate or intensify the challenges associated with implementing an evidence based SMHP to a variety of unique country contexts. An additional, broader focus that has guided the overall development of the study is how these collaborative care elements can both facilitate accessible mental health care for children and create potential barriers to the program's applicability and scalability.

2.2 Implementation Research

It is beneficial to explore the relevance of the variety of research methods concerning implementation and the ways in which they are applied to the SMHP in a variety of cultural contexts. In essence, in the context of this study, how does the SHINE consortium apply evidence-based strategies regarding school mental health to different countries for effective program implementation? This is an important area to consider

Figure 1: Regional ToC for the implementation of the SMHP in the WHO's Eastern Mediterranean Region (Alonge et. al, 2020)



as they are ultimately dependent on the functional implementation and delivery of promising health interventions for various contexts. A useful example of implementation methodology as it can be applied to health interventions is the five-step RE-AIM framework (as depicted in Figure 2 below) for it encourages global health researchers to pay more attention to key elements of program planning and development that will greatly impact the program's long-term success. To elaborate, considering factors that will support the maintenance and sustainability of a health intervention in the early stages will only promote more holistic and realistic goal and priority setting (Re-Aim, 2021).

Figure 2: RE-AIM Framework (Re-Aim, 2021)

With a five-step approach, the Re-Aim principles hope to help transform evidence-based research into practice to maximize impact and achieve the proposed health intervention. They offer specific ways to measure each principle for any given intervention and support the proactive considerations to make for effective implementation (Re-Aim, 2021). For example, should the Re-Aim framework be applied to SHINE, a program that is in the process of scaling-up across the Eastern Mediterranean, they could identify the aspects of the SMHP that are generalizable across the board from the elements that may differ across various partner countries, such as resource availability or government support for mental health. Additional considerations such as target population, sustainability efforts, institutional cooperation and delivery methods are critical aspects for program success yet not necessarily addressed in the core skeleton of the SMHP.

Owens et al (2014) discuss implementation science and provide several examples of key contextual variables that are necessary for school mental health interventions. They also outline how a focus on the elements within the implementation process can guide and support future collaborative efforts in this area. They cite school organizational factors, diversity of school-based professionals and school calendars as key implementation considerations; subsequently, they offer solutions such as professional coaching and training for school-based professionals regarding evidence-based practices, early dialogue around the sustainability of interventions in specific school conditions and ongoing integrity of evidence-based programs implemented in school contexts (Owens et. al, 2014). They conclude the study by stating that, "adaptation of evidence-based

practices in schools may be the norm, rather than the exception" and argue that contextualization within implementation science as it relates to school mental health is key for child health outcomes (Owens et. al, 2014).

Regarding the SHINE SMHP, a background on implementation research is relevant as individual country and school characteristics cannot be overlooked in program planning and implementation processes - it is equally important to distinguish the generalizable elements of the program to those that must be refined and adapted to be effective. Implementation research is a key area of focus and prioritization for most health interventions today, particularly while working across a diversity of cultures and populations.

2.2.1 Theory of Change

To provide more context as to how the SHINE SMHP evolved, it is important to understand the theory of change (ToC) methodology as it has been an integral component of all efforts to scale-up mental health services in the Eastern Mediterranean to date, whether they are associated with SHINE or with broader WHO programming and priority-setting. For the SMHP ToC has been used as a) a stakeholder engagement tool; and b) an implementation research tool. ToC in its simplest form is "a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context" (Theory of Change, 2021). When applied to an intervention such as a SMHP, it helps to fill in the gap between program implementation and the desired outcome; for example, what do individual countries need to do to ensure child mental health improves within schools as a direct result of the SHINE program?

There is an overarching focus on long-term goals and considerations of common assumptions about causes and effects of any aspect of the intervention, such as the ability of an additional 'teacher wellbeing' component to support their ability to deliver the program effectively (Theory of Change, 2021). As is the case with the SHINE program, ToC is generally a participatory process that involves all stakeholders with a common goal. However, as with any international collaboration, it is relevant to consider the external motivation that certain countries or governmental organizations have in relation to willingly devoting time to such a project (e.g., access to funding, international reputation and/or networking with other research institutions). This notion is also applicable to the interests of SHINE and the WHO and their motivation to become involved in child mental health within the Eastern Mediterranean region at this time.

A SHINE-related article discusses the ToC approach to the scaling-up of school mental health services in low resource public schools of rural Pakistan; ToC workshops were facilitated to develop relationships between key stakeholders (teachers, mental health professionals, SHINE CLG facilitators etc.) and identify mutual priorities (Hamdani et. al, 2021). Researchers found that this promoted ongoing engagement in the program planning and implementation processes as well as providing a platform for knowledge sharing about how to scale up mental health services effectively (Hamdani et. al, 2021). A similar article describes the pathways for large-scale implementation of the SMHP in the Eastern Mediterranean Region and how ToC methodology was incorporated into the development of the CLGs. An understanding of ToC helped to identify key elements of program implementation that needed to be considered both at the country-

level and for large-scale regional rollout (Alonge et. al 2020). For instance, because of a discussion surrounding the barriers to the implementation of SMHP, stakeholders in Pakistan successfully petitioned for interventions that would concentrate on the final exam period, when students across the country experience significant distress as they write exams that determine their eligibility for university. Thus, a key finding arising from ToC workshops was that the "ToC approach facilitated local ownership of the programme and stakeholders' engagement in child mental health" (Alonge et. al 2020), which reiterates the potential of ToC as an effective tool in ensuring ongoing stakeholder participation and efficient priority setting, particularly when working across a variety of settings. See Figure 1 for a detailed map of the SHINE regional ToC.

Chapter 3

Literature Review

3.1 Overview

As described in Chapter 2, this study examines the role of collaborative care within the overall functioning of the SHINE SMHP, while exploring the extent to which the collaborative care element helps to mitigate the challenges associated with implementing an evidence based SMHP a variety of unique country contexts. Despite being grounded in empirical research and program development strategies, there may be specific challenges when implementing generalized school based mental health programming into different school and healthcare systems, as well as diverse cultures and societies. For example, what happens if one school already has a team of school psychologists and another has never even considered the potential benefits of focusing on mental health within the school context? Evidently, these two schools will need targeted and individualized support to establish the program. A broader focus on how these collaborative care elements have the potential to both identify barriers to implementing a SMHP, as well as facilitate accessible mental health care for children, has also supported the development of the study research questions.

There is a clear gap in the literature pertaining to sound collaboration between various stakeholders in school mental health, especially when it comes to low to middle income countries. It is therefore not clear how to define, measure and track collaboration over time and across differing cultures. Despite the clear evidence that highlights the importance of investing in the prevention and prioritization of interventions during

childhood and adolescence (especially within various country contexts that have not historically prioritized mental health), global mental health researchers frequently cite the need for improved research around the best screening practices for common mental health issues in children and youth worldwide, as well as effective and sustainable interventions (Rahman and Hamdani, 2020). While effective mental health infrastructure is largely absent in parts of the world (particularly for children and adolescents), there is certainly a corresponding need to investigate targeted, evidence-based strategies to maximize early intervention techniques. Advocates for more grassroots approaches to school mental health suggest that a localized, bottom-up approach will result in better outcomes than simply adapting what works in high income countries (Kolbe et. al, 2015). This is relevant to this study as it brings up questions of collaboration at different levels; rather than focusing on between-country collaboration, perhaps emphasizing the importance of in-country collaboration between key stakeholders for SHINE's purposes may be beneficial.

Three areas were selected for this literature review that encompass the research topics and questions described above: transcultural psychiatry, school-based mental health programs and collaborative care models. These topics are interconnected and relate to the broader purpose of this study and they allow for an exploration of what currently exists within the research landscape. Each topic builds off one another; the background on transcultural psychiatry provides examples of implementing psychological interventions developed largely in Western, high-income contexts in diverse cultural and low to middle income contexts. This connects to school mental health; the second section explores what

the evidence suggests about the school context as an environment to target child mental health prevention, promotion and intervention. Finally, an investigation of the research on collaborative care within the context of both transcultural psychiatry and school mental health addresses both primary research questions of the study.

The organizational structure of the review is thematic; in essence, relevant articles are categorized according to thematic association. The scope of the review is broad, but it focuses on specific aspects of the topic that relate overarching research questions. Selected articles are a combination of both evidence-based scoping literature and specific examples of relevant studies. The criteria used for selecting articles were as follows: peer-reviewed journal articles, written in English and from the past twenty years (2001-2021). Keywords used when conducting searches in various databases included "school mental health", "implementation research", "collaborative care", "transcultural psychiatry" "global child mental health" and "school interventions".

3.2 Transcultural Psychiatry

Overarching findings from the transcultural psychiatry literature as it applies to school mental health point to the indisputable reality that global mental health is yet another area within global health wherein issues around inequality and poverty cannot be overlooked. Further, the important role of religion and culture is critical to consider in the planning and implementation processes of any mental health intervention. The topic is divided into three sub-themes to improve the depth and breadth of the analysis.

3.2.1 Global Mental Health

When comparing high income countries to low to middle income countries (also referred to in this review as the Global North and Global South) there are undeniable inequities when it comes to access to health care, treatment capacity, resources and service provision. Disparities in health on the international level can be attributed to a combination of historical, political and social elements that are deeply entrenched in ongoing global processes (Rahman and Hamdani, 2020). The Global South bears as much of three quarters of the burden of global mental health issues worldwide, which can be attributed to their relative poverty regarding resources and capacity for mental health (Rahman and Hamdani, 2020). Mental health is not usually prioritized in the Global South alongside the other challenges; namely, political instability, civil conflict, hunger, poverty and access to education, therefore, it is appropriate to assume that populations facing ongoing global health challenges may also have poor mental health (Gimba et. al, 2020 and Rahman and Hamdani, 2020). One researcher suggesting that the way in which we think about global mental health requires significant reframing says that "exclusive attention to mental disorders identified by psychiatric nosologies may shift attention from social structural determinants of health that are among the root causes of global health disparities" (Kirmayer and Pederson, 2014). They progress to offer a solution: " community-based practice and ongoing research… greater equity and social justice in access to effective, socially relevant, culturally safe and appropriate mental health care on a global scale" (Kirmayer and Pederson, 2014). More targeted global mental health research suggests that children and adolescents are particularly vulnerable

to the negative repercussions of this reality and there is an increasingly pressing need to explore targeted, evidence-based strategies that maximize mental health benefits and early intervention techniques and focus on sustainable investments in this area by key stakeholders (Leiva et al., 2020). There is significant proof to suggest that mental disorders later in life can be mitigated or entirely avoided by early identification and treatment in childhood. For example, several researchers point to the "evidence base on the burden of child mental disorders and their long-term consequences… and the proven effectiveness of a range of pharmacological and psychosocial interventions for these disorders, [yet] the vast majority of children in low to middle income countries do not have access to these interventions" (Patel et. al, 2013). There is a need to capitalize on existing research, human capacity and innovative technology to detect and treat the most common child mental health disorders (Patel et. al, 2013).

To elaborate on the disparities within and between countries, the lack of mental health care within primary care services in low and middle income countries is largely due to the lack of human capacity; that is, the lack of qualified mental health specialists and registered professionals within those countries (Mendenhall et. al, 2014). A group of researchers proposed the notion of replicating a 'task-sharing' solution, whereby non-specialized workers were trained by specialized workers to take on some of the necessary tasks in primary care settings, to improve mental health service provision on a grander scale (Mendenhall et. al, 2014). They interviewed stakeholders from Ethiopia, India, Nepal, South Africa and Uganda to assess the accessibility and feasibility of task-sharing for mental health. They found that the task-sharing model has potential if there is ongoing

training and support and adequate resources and compensation (Mendenhall et. al, 2014). The study therefore provides some insight into the potential benefits in focusing on collaboration between stakeholders for mental health. While it may seem at first glance that an intervention is not feasible due to a lack of individuals who specialize in mental health, it may become more realistic when considering the role of all impacted individuals and groups and how together they may support and guide the intervention in question.

An article written by some of SHINE's CLG facilitators argues for improved implementation science for the scaling up of mental health services in the Eastern Mediterranean region (Rahman and Hamdani, 2020). They describe the complex history of war, conflict and political instability within the region and how this can be directly correlated with the increase in burden of mental disorders - particularly for children and adolescents (Rahman and Hamdani, 2020). They further explain the limited evidence to support the implementation of a Western psychological intervention in this region and advocate for more research on the scaling-up of mental health services so that they are increasingly culturally sensitive and more likely to have an impact on national policy (Rahman and Hamdani, 2020).

SHINE exemplifies the potential of some of these characteristics (effective partnerships and task-shifting), yet they also call for more research in the field to support their intervention and others. By utilizing the CLGs as an opportunity for researchers from the USA and UK to share their knowledge around effective SMHPs with in-country professionals, translating this information to teachers, parents and children and the

appropriate division of tasks in the individual country context becomes more easily facilitated (SHINE, 2020).

3.2.2 Religion

Culture in and of itself is a broad term; it consists of the "social behavior and norms found in human societies, as well as the knowledge, beliefs and habits of these societies" (Rothman, 2014). One aspect of culture that is frequently addressed in the global mental health literature is the role of religion in the identification and treatment of mental disorders. The role that religion plays has been a matter of debate in the field of transcultural psychiatry for decades and there are various opinions on whether religion is overwhelmingly 'good' (a source of community and social support) or 'bad' (indicative of individual mental or emotional weakness) for mental health (Lewis, 2001). This is relevant both for high income and low to middle income countries and is applicable to both the general population and those more marginalized or vulnerable.

To illustrate, in the handbook of religion and mental health, Levin and Chatters argue that "one of the central issues concerning the role of religion in human affairs has been its relationship to constructs such as mental health, emotional well-being, and adjustment" (1998). There is much debate and dialogue around the impact of religious involvement on psychiatric outcomes and whether this should be of importance to clinical professionals and researchers (Levin and Chatters, 1998). Exploring individual belief systems may support researchers in better understanding the intersection of mental health and religion for a specific set of individuals (such as children or adolescents). One study concluded that the complex and inconsistent conclusions regarding the importance of

religion in mental health diagnosis and treatment simply allude to the significant weight of religious beliefs and identity in relation to mental health and that the subsequent effects depend on the perceptions and conceptualizations of mental health for any given context (Lewis, 2001). Other individuals are adamant that religion and spirituality *must* be included in mental health research and psychiatric care and suggest that it could vary between different faith groups; there is conflicting evidence to suggest that high religiosity is generally good or bad for one's overall mental wellbeing (Dein, 2018). Overwhelmingly, much of the prominent literature concludes that "both clinical work and research need to be more sensitive to cultural and theological issues" (Dein, 2018). From this, it could be inferred that religious norms have different implications depending on the variety of contextual factors, such as unique histories with mental health, specific belief systems and differing conceptualizations of 'mental health'.

On another note, researchers Bassett and Baker examine the concept of 'normative uncertainty' in psychiatric practice in what they label 'multicultural clinical interactions' and allude to the need to consider religion in health care (2015). Their work draws from broader theories within the same research landscape, such as cultural relativism, absolutism and universalism. They suggest that the dilemma that arises for professionals when trying to distinguish religious experiences from psychological symptoms can be problematic in practice. Decontextualizing culture may lead to negative outcomes for both the practitioner and the service user, yet it is difficult to equate symptoms with either 'religious beliefs' or 'psychological symptoms' in any given clinical interaction (Bassett and Baker, 2015). Specifically, they state that "issues that arise from dilemmas

surrounding the question of 'culture' or 'psychopathology' are intimately tied to wider cultural ideas about what is considered 'normal'". For example, religious rituals that take place daily (or hourly, in some cases) may be perceived as obsessive or compulsive in a different cultural context where the ritual does not hold the same meaning (Bassett and Baker, 2015).

One of their studies illustrated this concept again by speaking specifically to the lack of religion-specific knowledge in general nurse training. For those that do receive training on culture and religion, there is still a significant gap in understanding regarding how to apply this knowledge within various health care systems (Bassett et. al, 2015). Their study highlights the potential practice implications resulting from the risk of misinterpretation of beliefs and experiences – especially in different country contexts. Proposed solutions included "using different models of belief systems and approaching the issue in nurse education" (Bassett et. al, 2015).

From a global perspective, it is impossible to ignore the role of religion in health care in countries in which religious beliefs are deeply tied to political and social norms. Whether implementing a mental health intervention, measuring the incidences of mental illness, or attempting to effectively support a population, it seems as though a consideration of religion as a critical component of all mental health care and service provision activities, whether it be at the local, national, or international level, will be beneficial for the target population. Again, the literature suggests that the acknowledgement of culture will help decrease the "religiosity gap" between clinical professionals and service users, with overall improved outcomes for multicultural clinical

interactions alongside higher levels of confidence amongst professionals (Bassett et. al, 2015 and Dein, 2018).

3.2.3 Culture and Evidence Based Practice

Another prominent theme within the literature on cultural psychiatry is the potential limitations of the biomedical model for identifying the origins of mental illness. While culture is often seen as a variable independent of mental illness rather than a potential dependent variable, it may be valuable to highlight the interconnectedness of culture and mental illness (Sam and Moreira, 2012). It is necessary to re-evaluate what one means by 'culture' and consider how perceptions of mental illness and mental health can greatly differ based on the individual or group in question. Cultural differences could, in theory, prevent or cause a mental illness, as well as hinder or promote one's recovery and treatment - it all depends on individual contextual factors and subsequent risks and benefits (Sam and Moreira, 2012). Determining what is indicative of good or bad mental health (especially regarding symptoms and diagnoses) is also strongly informed by culture. A connection can also be drawn between one's individual wellbeing and their personal attitude and understanding of their individual cultural context.

Whether collaborative learning is relevant in the dialogue around culture and mental health when looking at individual mental health across multicultural populations is another sparse area in the literature. Ward et al discuss the differences between multiculturalism in the traditional, superficial sense and what they label 'normative multiculturalism', which addresses the differences between majority and minority groups within any given culture (2018). For example, multiculturalism in the Global North

usually refers to the approach of a government to acknowledge and respect cultural differences within their societies; in the Global South, normative multiculturalism may allude to the differences between socioeconomic status, religious sect, immediate environment etc. Does this necessitate a closer examination of intercultural dynamics within countries in relation to mental health outcomes? A multicultural context may vary based on the country in question and can oftentimes exacerbate differences between groups. Thus, understandings of multiculturalism on the country-level (political and societal) should be an area of consideration when attempting international interventions for mental health (Ward et.al, 2018).

To speak directly to child mental health, Canino and Alegria distinguished universalist views (i.e., the belief that mental health problems are universal in nature and related to non-culturally specific issues - such as genetic predisposition or brain-based somatic issues) from relativist views (i.e., the perspective that mental health problems are effectively cultural constructs whose meaning and experience are culturally dependent) (2008). They identified a need to test specific criteria for mental illness for cross-cultural validity and fill in the research gap regarding how ethnicity and culture may impact assessment and treatment. While their results point to a need to differentiate between specific mental health diagnoses, mental health professionals should be aware of the unique risks and protective factors between different cultural groups (Canino and Alegria, 2008).

Similar examples include an examination of whether a Western mental health promotion program worked to improve the mental health of Iranian adolescents; the

results were inconclusive as it was difficult to measure the success rate in a non-western cultural context (Heizomi et. al, 2020). Cross-cultural intervention may require an adaptation of the monitoring and evaluation system, in addition the modification of the intervention itself. A final study looked at an evidence-based family advocacy training program and whether it was functional for a culturally diverse target population. Again, the results were inconclusive, but the researchers stated a clear need for the holistic integration of cultural norms, beliefs, values into evidence-based mental health practice (Briggs, 2009). This was highlighted once again: "the root of the issue is whether evidence-based treatments developed within a particular linguistic and cultural context are appropriate for ethnocultural groups that do not share the same language, cultural values, or both" (Jiménez-Chafey et. al, 2003). While some individuals advocate for universality and overall cultural compatibility in diagnosis and treatment, others insist that there are tools and resources that one can use to adapt any given mental health intervention to be more effective (and beneficial) for different ethnocultural children and youth (Bassett and Baker, 2015 and Jiménez-Chafey et. al, 2003). It would be appropriate for future research and program development to carefully consider their target population and whether the intervention in question will ever be scaled-up across a region or country, as is the case for many global mental health programming efforts.

3.3 School-Based Mental Health Programs

The school context has frequently been referred to in the literature as a critical environment for mental health promotion, prevention and intervention for children and adolescents. Sub-themes within the review of this literature include the characteristics that

make up an effective school-based mental health intervention, how these elements translate to various country contexts and the role of collaboration within school mental health activities.

3.3.1 Effective School Mental Health

A review conducted in the UK examining the factors related to the successful implementation of mental health programs for adolescents found that the planning processes can be quite challenging, given the varying levels of acceptability and practicality of different interventions (Gee et. al, 2020). While early interventions in schools show significant promise for the prevention and treatment of mental illness, the authors suggest that the focus moving forward should be on developing a school culture of mental wellbeing and improving the resources and training available to key stakeholders (Gee et. al, 2020). This article prompted a further discussion of what exactly constitutes school mental health and how CLG facilitators can be effective in achieving intended outcomes.

Cavioni et. al examine a variety of country contexts and assert that certain skills and behaviours should be targeted within schools, as should an emphasis on teacher mental health; in essence, they argue that a more holistic approach will elicit the most positive outcomes (2020). They also advocate for mental health programs to not be viewed in isolation from the overall organizational approach of the school and conclude that the involvement of community, family and policymakers in all school mental health activities will also greatly influence program success (Cavioni et. al, 2020). On a similar note, the specific characteristics that make up effective school mental health programs

have been investigated by a variety of researchers. For example, elements such as better planning, cultural awareness, levels of adaptability, familiarity with the intervention and acknowledgement of program strengths and weaknesses can all be pinpointed as crucial to overall program functioning (Leiva et. al, 2020). Addressing these critical program elements can lead to more successful teams and ensure actual outcomes meet expected outcomes (Leiva et. al, 2020). On the flip side, treatment engagement is frequently cited as a challenge in school mental health (especially when working in different cultural contexts) and various evidence-based engagement strategies regarding specific challenges can help support mental health professionals in increasing the participation of teachers, parents and children (Becker et. al, 2020).

Another recurrent challenge is training teachers on how to best identify common mental health disorders so that early identification can be facilitated. Differentiating between internalizing (i.e., depression, anxiety) and externalizing disorders (i.e., ADHD, conduct disorder) is of utmost importance, yet require the teacher to be extremely effective in their role in early identification (Park et. al, 2019). While the studies described here did not directly consider the role of culture within common program factors of success, it would be interesting to consider how additional cultural barriers could make this process even more challenging for teachers and mental health professionals - how can this issue be addressed when contemplating the engagement of stakeholders in mental health programming efforts?

3.3.2 School Mental Health in Low- and Middle-Income Countries

For this study, it was also important to explore the current research landscape regarding school mental health in various countries in the Global South. Overall, there are significant gaps in the research of culture and country specific school mental health interventions for non-Western countries and much of the research points towards a need for future analysis of school mental health in these regions of the world. For example, one literature review found that modules of school mental health programs in low and middle income countries are almost exclusively designed according to Western countries' curriculum and therefore are not comprehensive nor culturally sensitive (Gimba et. al, 2020). The same researchers found that none of the key program elements, targets, or considerations of these interventions were created from scratch; rather, they were in fact entirely adaptations of Western interventions. While they acknowledged the universality of some modules, they highlighted the dire need for more culturally relevant school mental health programs, with inclusion of parents, teachers and children at the forefront of change (Gimba et. al, 2020). Gimba et. al suggest that CLG facilitators should perhaps proactively anticipate more challenges rather than assuming that what works in one context will be easily replicable in all contexts (2020).

To use Pakistan as a case study for the scaling up of school mental health within a country that has not traditionally prioritized mental health for children and adolescents, SHINE developers used the theory of change approach (as introduced in Chapter 2) for sustainable collaboration and mutual goal setting between key stakeholders (Hamdani et. al, 2021). Through a large-scale qualitative investigation, they found that while different

stakeholders may have different priorities, identified barriers and suggested solutions, children should ultimately remain the key voice in all program development and implementation activities as to centralize the primary goals of the project from the initial planning stages. According to this study, ongoing collaborative workshops with children, parents and child health specialists were particularly beneficial in this realm, as they supported team building and stakeholder engagement and centered the voice of the child (Hamdani et. al, 2021).

A more recent examination of the impact of the COVID-19 pandemic on the mental health of children and youth in Pakistan found that the pandemic presented challenges for children already accessing mental health services, such as the shift to a virtual environment and overall change in routine. Professionals argue that the school environment is key moving forward from the pandemic; however, prioritizing schools in different country contexts may be difficult due to limited resources and human capacity (Mian and Chachar, 2020). Mian and Chachar allude to the exacerbated global inequalities because of the pandemic; while this is easily visible at the economic and political level, it will also have a trickle-down effect to social and health policy (2020). Given the seemingly widespread underrepresentation of mental health policy and programming within certain regions of the world, it will take significant advocacy and research efforts to promote the necessity to invest in child mental health post-pandemic.

3.3.3 Collaboration in School Mental Health

Finally, the most prominent theme within the literature about school mental health was the critical role of collaboration. This will serve as an introduction to

section 3.4, in which the research surrounding collaborative care models will be reviewed in depth. A limitation of much of this research is that it is primarily from an American lens and thus the applicability to different regions or countries may be challenging.

Since schools are evidently an essential component of child mental health care, many researchers look towards the future of school mental health and identify where there are opportunities to strengthen the system as it currently exists. Hoover and Bostic (2021) assert that there is a significant amount of evidence to support the benefits of having multiple stakeholders work towards a common goal and argue that a policy shift towards an increasingly integrated and coordinated approach is necessary. Indeed, the authors state that the mental health system needs to be integrated into the education system while still aligning with the health and political structures of the country in question (Hoover and Bostic, 2021). One study from the United States implemented a national and systemic learning collaborative for school mental health that holds many parallels with SHINE's work in the Eastern Mediterranean region. Results showed that it helped implementation in individual school districts and pursued ongoing improvement within mental health service delivery and treatment capacity (Connors et. al, 2020). This type of study shows promise for the potential of scaling-up mental health services within a region or group of countries with similar political, social and cultural attitudes towards mental health. According to Becker et al, there is also potential for improved treatment engagement through effective coordinated knowledge systems and treatment plans; this was found through a comprehensive assessment of the acceptability and feasibility of

various mental health professionals and demonstrates the efficacy of collaboration when used correctly (2019).

A final article (Marsh and Mathur, 2020) assessed the role of school based mental health professionals within multi-tiered support systems; the authors essentially examined collaboration in practice. The authors confirmed that the goal of mental health professionals should be to help teachers identify, refer and intervene early for students at risk to ultimately improve the overall effectiveness of the intervention (Marsh and Mathur, 2020). One can infer from this research that it is not only important to have a variety of key actors involved, but it is equally necessary to clearly identify the roles of all actors to reach optimal program functioning at all stages.

3.4 Collaborative Care Models

The final section of this review examines the literature regarding collaborative care models in general and uses applications of this research that relate to the primary research questions of this study. First, an examination of the evidence around collaborative care models for mental health is discussed, followed by a discussion around why they work well for children and adolescents in the school context.

3.4.1 Evidence for Collaborative Care

For perspective, it is helpful gain a broader perspective on the notion of collaborative care within international research programs and partnerships; this is a critical aspect of all global health or global mental health activities. Kalbarczyk et. al (2020) explored a specific academic research team spanning eight countries around the world and identified twelve evaluation criteria for effective and authentic partnering

across countries. Their results demonstrate that not only do international partnerships come with a unique set of considerations and variables, but they require comprehensive communication skills, expectation setting, capacity building and institutional support from the initiation of the partnership (Kalbarczyk et. al, 2020). While this example focuses strictly on research partnerships, one can infer those similar elements are important when applied to the practical implementation of a program in a diverse group of countries.

Regarding mental health, a variety of collaborative care models are discussed in the literature for unique target populations. While its efficacy has been widely accepted for primary care, American researchers found that there was adequate evidence for policy change and concrete attempts to scale up collaboration efforts to many different health centers working to support the mental health of American war veterans (Bauer et. al, 2019). There is more research to be done on implementation and how professionals can engage in effective partnerships; however, the applicability of collaborative efforts to chronic mental health conditions is noteworthy.

Indeed, Sanchez et. al bridged the gap between evidence-based science to real world application by exploring how to broadly implement a collaborative care model to treat anxiety and depression in primary care settings (2014). They identified four main themes - organizational change, processes, communication and barriers - that impact the implementation of the collaborative model and concluded that organizational setbacks can greatly impact patient outcomes in both the short and long run. Thus, according to

Sanchez et. al, collaboration is extremely relevant when it comes to mental health and should be directly connected to patient outcomes (2014).

Finally, an example from Iran discusses the lack of community mental health services to serve the needs of the adult Iranian population. The implementation research was evidence based and took on a collaborative care approach; they found that the main challenges were obtaining the appropriate funding and skilled personnel (Sharifi et. al, 2021). In the case of Iran (and many countries within the Eastern Mediterranean region), the research insists that mental health needs to be incorporated into their national health care system to fill the treatment gap; this fact brings up questions around the unique challenges that come with collaboration in different countries when the political, social, legal, health and education systems may or may not have a history of effective partnerships (Sharifi et. al, 2021).

3.4.2 Collaborative Care for Child Mental Health

To further pursue the case of Iran, given their recent expansion of the collaborative care model for adults to include mental health, several researchers embarked on a qualitative research study to see if this model could also include children and adolescents. The research highlighted the need to clearly define the role of general practitioners; they should be differentiated from psychiatrists, require more overall training and better facilitate child and youth participation in all SMHP activities (Zarafshan et. al, 2019). This would suggest that it is of utmost importance when working with children to be proactive regarding elements such as legal and ethical obligations and parental involvement and consider them early on in program implementation processes.

Therefore, while there is certainly potential for collaborative care as a biomedical model applied to child mental health (in low and middle income countries especially), child mental health is more complex than the well-established collaborative networks for adult mental health due to limited services and trained practitioners (Sharifi et. al, 2019). Sharifi et. al go on to cite two-generational aspects of care, high degrees of comorbidity and variations in presentation across developmental stages as important aspects to consider before scaling up collaboration efforts to include children (2019).

So, what makes a collaborative care model effective for children? Yonek et. al (2020) sought to identify the key aspects of integrated care models for adolescents for future research efforts (which hold many similarities to the collaborative care model)and found that population-based care, measurement-based care and the delivery of evidence-based mental health services in pediatric primary care are the most important model components in effective programs. Once again, they placed significant emphasis on the necessity of adapting any program implementation process to different country contexts.

Finally, one of the most common themes within the literature was the reference to the 'whole school, whole community, whole child' approach. This framework seeks to "promote greater alignment between health and educational outcomes" (Lewallen et. al, 2015). It focuses on collaboration between the health and education sectors and necessitates several critical facilitative factors, such as greater community involvement and inclusive and progressive policies for holistic child health and educational attainment (Lewallen et. al, 2015). While this approach makes sense theoretically, in practice, researchers found that the "need to purposefully strengthen, expand and interconnect

national, state and local collaborative partnerships and support infrastructures that concomitantly can improve both education and health" (Kolbe et. al, 2015). Baldwin and Ventresca looked at different school districts in America and provided proof to suggest that the approach works, as concluded through analysis of the evidence of improvement over time for holistic district wellness strategies (2020). From this, it could be inferred that all of the sectors involved require a certain level of flexibility and willingness to change the current system to adopt a truly collaborative approach. A clear limitation of the research lies in the fact that it has been done exclusively in the American context; however, it could still be a useful tool in applying prioritization and monitoring skills to measurably improve child mental health in different contexts.

3.5 Conclusions

In summary, this review examined the current literature associated with the research topic and questions. Three connected thematic areas were selected, specifically, transcultural psychiatry, school-based mental health programs and collaborative care models. The purpose of the thematic organization was to examine how different disciplines and research areas are interconnected regarding collaboration for school mental health in different cultural contexts. Several key conclusions about common assumptions, patterns and gaps within the current literature can be made following the review process and will be described below.

First, there are several limitations of the current research landscape; this encompasses problem areas within the existing research as well as areas to address in guiding future areas of study. There is a clear discrepancy between research conducted in

the Global North and the Global South - the latter has little to no contribution regarding mental health research as a whole nor to research specific to child mental health in schools. Further, most current interventions and developments in low to middle income countries are merely adaptations of research that has proved to be effective in the West; this fact relies upon problematic assumptions relating to universality that may limit the ability of certain countries to improve the health of any given target population. Likewise, researchers have expressed difficulties in adapting evidence-based mental health interventions across cultures and many acknowledge the need for more cultural awareness and acknowledgement within research and implementation activities. The Global South is also resource-poor in terms of professionals, policies and funding for mental health, which should be a key consideration in the feasibility and sustainability of future research activities. Finally, not only was most of the research around child mental health from a Western lens, but the research surrounding collaborative care was almost exclusively from America. More investigation into the applicability of these studies to different countries is necessary moving forward.

Other patterns within the literature include the widely accepted opinion that school is a very important context for child mental health prevention and intervention. Additionally, the evidence points towards a lot of potential for collaborative care within schools to be very effective to improve child mental health if all key elements are met before, during and after the implementation processes. The final recurring theme within the selected articles was the importance of clearly identifying all stakeholder roles and contributions in collaborative efforts.

To situate this literature review within this study, there are several ways in which the research aligns with the findings. SHINE is an example of collaborative care in action and their approach to scaling up their SMHP in the Eastern Mediterranean region is grounded in their emphasis on authentic partnering and mutual knowledge sharing between stakeholders. As the research suggests, even in SHINE's case, individual country characteristics should be considered early in the program development and planning stages. More details and discussion around the findings of the study can be found in Chapter 5. However, given the lack of research on the role of collaborative care within cross-country, large-scale mental health programming, this study certainly seeks to fill a gap within the existing knowledge base and address how effective collaboration - referring to both collaborative care for important people around the child as well as cross-sectoral national collaboration for child mental health - can lead to more positive program outcomes and mental health outcomes for children. Future research could investigate how to better incorporate country and cultural variables proactively, as well as how partnerships differ based on the specific intervention and context in which it is being implemented.

Chapter 4

Methodology

4.1 Study Design

Following my initial communication with the SHINE research group which established their interest and willingness to participate in the study, the research question for the thesis was formulated collaboratively between myself and the SHINE team. The research question is two-fold and is as follows:

1. What is the role of collaborative care as it applies to: a) the school mental health program implementation in the partner countries and b) interactions between stakeholders in different countries (i.e., the collaborative learning groups) and how does it contribute to the overall functionality of the program?
2. What are the challenges associated with implementing a mental health intervention based on evidence from Western models within unique cultural and country contexts?

Once the research questions were successfully identified, details regarding the study design began to emerge from ongoing discussions with the SHINE team. Stakeholders unanimously agreed that a small-scale, exploratory qualitative study that makes use of both in-depth and small group interviews as means of data collection was the most appropriate approach. Indeed, this choice makes sense when considering the type of data required to answer the research questions which are largely based on an individual's personal experiences with the school mental health program as well as additional opinions and beliefs. Qualitative interviews also align well with the study's

focus on exploring the impact of a collaborative care model on various cultural adaptations of a school-based child mental health intervention; there is certainly a need for a more nuanced approach and a clear understanding of context when working across cultures. With the intention of exploring complex questions in an in-depth way, qualitative interviewing allows for an element of therapeutic rapport and trust which typically facilitates richer discussion (Rossetto, 2014). Finally, this data collection method allows for heightened explanatory power and contextual understanding to the results given the high level of authority and involvement of the participants within the school mental health program in their unique country contexts (Knapik, 2006). The interview guide can be found in Appendix A.

All activities have been conducted in a way in which highlights the qualitative elements within mental health policy and mental health program implementation as it relates to overall child mental health in the school context. The primary intended outcome of the study was to gauge the impact of a collaborative care model on learning and support processes within the school mental health intervention. The goal was to examine the role of specific mechanisms within the collaborative element and note whether interactions between stakeholders contribute to the overall functionality of the school mental health program. The secondary outcome of this study was to use the experiences of the CLG facilitators to investigate how the collaborative care model plays a role in the development, implementation, monitoring and evaluation efforts of a mental health intervention to unique cultural and country contexts, with an overarching goal of understanding the experiences of those involved.

4.2 Recruitment and Data Collection

The target populations for this study were the key stakeholders involved in the creation and delivery processes of the school mental health program in three of the SHINE partner countries (specifically Egypt, Iran and Jordan), as well as individuals involved in the overall school mental health program development and collaborative learning group facilitation. Participants included researchers and CLG facilitators from the SHINE team, as well as mental health specialists, medical professionals and health policy specialists from the SHINE partner countries.

The recruitment and data collection process involved three distinct steps:

1. Recruiting study participants and obtaining verbal consent for the study.
2. Conducting in-depth individual and small group interviews with study participants, using targeted questions to answer the research questions.
3. Interpreting results by thematically analysing all interview data.

The study has a total of ten participants who come from a variety of professional and academic backgrounds. There were two representatives from Egypt, two from Iran, one from Jordan and three SHINE CLG facilitators. The sample size was determined based on a non-probability purposive sampling approach, specifically a combination of convenience and snowball sampling. Participants were selected in part based on their availability and willingness to participate in the study. The SHINE research team also provided significant support in suggesting qualified and consenting individuals from individual countries. One restriction to participation was that all individuals needed to have a working level of English to engage in the interview with the primary researcher.

All participants were selected from SHINE's database of people who had already consented to future contact for research purposes; thus, no other recruitment efforts were necessary given the specificity of the research questions to this school mental health program.

Due to the modality of the study (online), verbal consent of study participants was obtained rather than written consent. This option helped facilitate easeful communication across cultures; it also ensured that all parties were clear on the study intentions and goals. The verbal consent was captured in a short audio file recording kept separate from the main recording of all interviews in order to maintain participant anonymity. On a similar note, the conduct of this study was monitored by obtaining ethics approval from the HiREB, in alignment with anticipated deadlines, consistent and ongoing discussion and approval of all study activities by the academic supervisory committee at McMaster University and continuing discussion and collaboration with the SHINE research group and relevant contributors. The consent form given to all study participants can be found in Appendix B. The letter of approval from HiREB can be found in Appendix C.

The interview data was stored on an encrypted, password protected USB key that was only accessible to the primary investigator. To the best of the researcher's ability, all identifiable information within interviews was removed during transcription. The study data will be kept until the end of 2021, after which the raw audio and written data will be permanently deleted. An executive summary of the primary findings and implications will be shared with the SHINE research group for their ongoing programming and research efforts.

4.3 Data Analysis

Once the interviews were completed and transcribed, with all identifiable information removed, the interview data was organized and analyzed with the goals of uncovering the overarching themes present in the data and interpreting the meaning of the combined in-depth individual and small group interviews. Both generalizability of the role of collaborative care within the school mental health program as well as differences between individual country contexts were prioritized in the data analysis to align with the two primary research questions of the study.

Moreover, the selection of thematic analysis as a primary analytical approach was due to its focus on inductive reasoning and space to create conceptualizations from the data prompted (Strauss and Corbin, 1997). To elaborate, the goal was to discover emerging patterns within the data to offer an explanation about the role of collaborative care in SHINE as well as insight into the difficulties in implementing a school mental health intervention in unique cultural contexts. Thematic analysis was selected for this study due to its practical applicability to the analysis of qualitative interview data; it also provided the space to integrate theoretical perspectives with contemporary research to draw meaningful conclusions (Javadi et. al, 2016). The approach to thematic analysis for this study was adapted from a six-phase process from the University of Auckland School of Psychology and is summarized in the following table:

Table 1: Thematic Analysis (adapted from the University of Auckland School of Psychology, 2019)

Phase in Analysis	**Specific Procedures**	**Intended Outcomes**
Familiarization with the data	- Listen to the interview recordings - Read through the interview transcriptions	- Become familiar with the different interviews and overarching topics and themes within the dialogue
Coding Data	- Identify and label important sections in the interview data - Organize labelled sections	- Begin to collect key pieces of data that are relevant to one or both of the research questions - Separate the useful data from the non-useful
Generate Initial Themes	- Compare the labelled sections of data - Identify any patterns or initial thematic areas within labelled sections	- Begin to assess data for potential meaning in relation to research questions

Review Themes	- Check themes against initial dataset to ensure relevancy - Discard non-relevant themes - Name themes to distinguish them from one another	- Refine initial themes, determine the focus and scope of each theme - Clearly connect themes from data to research questions
Write-Up	- Write-up of the themes and data analysis processes - Draw conclusions about research questions - See Chapter 5 (Findings and Discussion)	- Connect data analysis to overarching research questions, literature review and study purpose - Frame findings in wider scope of research area

4.4 Reflection

There were several challenges regarding the overall methodological procedures of this study that can be identified as lessons learned and could help guide future research efforts in this area. For instance, conducting research both virtually (via Zoom) and internationally (across several distinct cultures and time zones) comes with a particular set of barriers that would not occur should the research have been conducted in a local, in-person environment.

Further, it seems apparent that when it comes to qualitative research, effective communication is key and consists of several critical elements; namely, transparency, balance and mutual respect (Knapik, 2006). These are difficult elements to uphold in-person; in the context of a virtual interview, these elements must be intentionally addressed, implemented and monitored to ensure optimal functioning. Technical difficulties associated with online platforms might require an unusual amount of valuable time. The virtual context wherein the recruitment and data collection processes occurred also made it difficult to communicate with and schedule interviews with study participants due to different time zones and competing priorities of all parties. This could be somewhat resolved in the future by relying on an additional method of communication (text messaging or phone calls) to communicate with participants throughout the recruitment and data collection phase.

When participating in interviews across cultures, the interviewer and interviewee may have different expectations or goals for both the interview and the research that aligns with their own life experiences and expectations. This can have a significant

impact on interview dynamics and overall functioning. As a researcher, one can always practice cultural humility, but this is especially important in international research. Engaging in ongoing self-reflection and being aware of different cultural perspectives and opinions can lead to an effective and positive learning experience for all parties. The study had a relatively small sample size, largely due to the language barrier between the primary researcher and the target population. Future research could accommodate this in study planning by arranging a translator for the interviews or considering alternate forms of data collection.

Chapter 5

Findings and Discussion

This chapter explores the key themes extracted from the data analysis process while discussing what these findings mean in the context of the study and the wider field of research. To reiterate, this study evolved from the recognition of an increasing need to explore targeted, evidence-based strategies that aim to maximize mental health benefits using early intervention techniques for children. The literature suggests that school-based interventions are an excellent starting point for improved teacher, parent and child understanding and can foreshadow the acknowledgement of the importance of mental health across diverse populations (Leiva et. al, 2020). Using the SHINE SMHP as an example of an intervention already being implemented, it is relevant to explore the processes of advancing their efforts across multiple countries (in this case, within the WHO's Eastern Mediterranean region). Once again, the research questions are:

1. What is the role of collaborative care as it applies to: a) the school mental health program implementation in the partner countries and b) interactions between stakeholders in different countries (i.e., the collaborative learning groups) and how does it contribute to the overall functionality of the program?

2. What are the challenges associated with implementing a mental health intervention based on evidence from Western models within unique cultural and country contexts?

This chapter is divided into two sections; the first section labels and describes the key thematic areas that emerged from interviews with key stakeholders from the target

countries. The second section investigates further the various interpretations and implications of the identified themes and looks towards potential future research. All research instruments (i.e., interview guide, consent form) can be found in the Appendices.

Observations throughout this study, based on the series of in-depth individual and small group qualitative interviews, suggest that: a) the SHINE program needs to be more proactive in identifying country-specific elements for optimal collaboration and program sustainability because the role of collaborative care as it relates to the unit around the child is critical between stakeholders *within* any given country context (the SMHP), and b) the collaborative learning groups are beneficial for research purposes, but not necessarily for implementation purposes; essentially, the importance of collaboration *between* countries is unclear (the goal of the SHINE CLGs). The findings also indicated that the role of individual country variables should be addressed early on in program planning and delivery to mitigate any potential challenges associated with cultural or societal factors. Regarding the second question, the evidence suggests that a) parents should play a more active role in the collaborative process, b) the significant influence of mental health stigma in rural areas should be accounted for and c) there is skepticism around interventions developed out of the country of implementation and further research ought to explore how this reluctance might be proactively addressed.

5.1 Findings

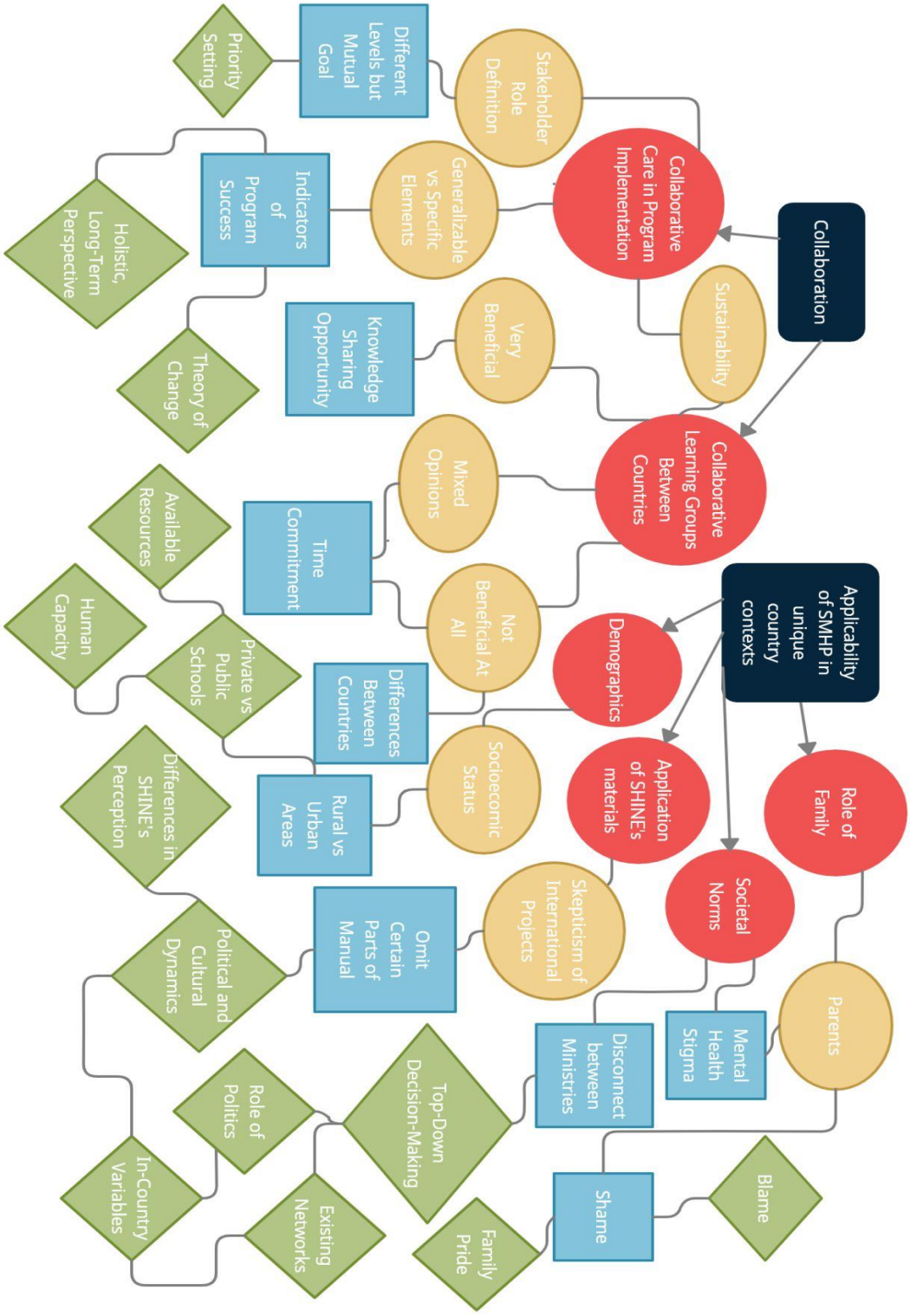
As outlined in Chapter 4, thematic analysis was the specific methodological approach that was used for analyzing the data. Keeping in mind the objectives of a) identifying emerging patterns within the data to offer an explanation about the role of

collaborative care in SHINE and b) offering insight into the difficulties in implementing a Western school mental health intervention in unique cultural contexts, the chosen method of analysis allows for a systemic, yet nuanced approach.

Corresponding to the two research questions, thematic areas were separated into two categories and summarized in a comprehensive concept map below (Figure 3). A concept map is a useful tool for thematic analysis because it allows for a broad overview of the most important pieces of data while having a visual representation of how these critical aspects relate back to the research questions. In this case, it also allows for connections to be drawn between the two research questions and demonstrates how research around collaboration is applicable to both areas. It also significantly contributes to the ease with which the most relevant parts of the interviews could be highlighted appropriately. A visual depiction of the study findings is also representative of the complex and nuanced themes that study participants brought forth in the interviews; finally, it is also a more accessible way to share primary themes with those not directly involved with the research activities.

The concept map is intended to be a presentation of the findings; further discussion about what these findings mean in the context of the study and how they relate to the research questions will be discussed in the following section. However, in reference to the first research question, it is important to highlight the distinction between collaboration *within* the implementation of the intervention and the collaboration *between* the different countries involved with SHINE's SMHP. As depicted in the concept map,

Figure 3: Concept Map



key themes relating to one or both definitions of collaboration are: improved stakeholder role definition, clear identification of generalizable vs country-specific factors, a focus on sustainability and mixed reviews on the usefulness of the SHINE CLGs. Sub-themes involved challenges in priority-setting (i.e., when different stakeholders have different agendas), how to measure progress (largely dependent on whether one is looking at the SMHP from a micro, short-term perspective or a macro view of the program (how well does it address the larger goals of the WHO Eastern Mediterranean Office for child mental health?) and the amount of resources and capacities each country has for collaborating with other countries (e.g., time commitment, relatability of lessons learnt).

For the second research question, patterns within the data include the essential role of the family unit, demographic variables, societal norms and the various applications of SHINE's program materials. Sub-themes include the widespread stigma of mental health (how feelings of shame and blame are often associated with child mental health challenges), the impact of variables within countries that increase one's vulnerability (i.e., low socioeconomic status, living in a rural area)and the larger political and social sphere that may hinder the ability of an international SMHP to be effectively implemented. For example, there is an underlying skepticism towards interventions developed based on evidence from outside of the region that exists in many Eastern Mediterranean countries, which can be attributed to historical and contextual factors, such as political instability and social conflict.

5.2 Discussion of Findings

This section discusses the various interpretations of the findings: what do the results mean in the context of the study? It also considers the various implications of the results and attempts to explain their importance for current and future research. Limitations of the methodology, findings and recommendations for practical action are also explored in this section.

5.2.1 Interpretations and Implications

To begin, it is essential to consider the two ways in which the term 'collaborative care' is used in the context of this study. First, opinions of key stakeholders are mixed regarding whether the influence of inter-country dialogue improved overall functioning of SHINE CLGs. Across all countries, CLG participants questioned the degree to which they can contribute to the meetings when all countries were in unique phases of program implementation: "during the CLGs [we] did not understand their experiences very well". It is important to remember that for CLG facilitators, the purpose of the CLGs is to "bring all the stakeholders from the different countries involved together with the facilitators and develop a community to provide a supportive learning setting where [we're] supporting each other, facilitating those discussions and identifying common challenges and approaches" (SHINE, 2020). One CLG participant highlighted the advantages of discussing the program with other countries and said that the CLGs helped their team to fill in knowledge gaps, particularly around implementation research methods and the theory of change (as discussed in Chapter 2). One participant said "the implementation research and using qualitative methodology was new for us and it was

very interesting for us to learn". They also described the opportunity to learn from the challenges and successes faced by other countries as very beneficial: "it is good to have these kinds of tools to make us understand what does and does not work".

Considering the evidence to suggest the efficacy of certain approaches for school mental health while balancing varying levels of mental health awareness between countries, the CLGs provided a platform on which education and skill development regarding implementation science and mental health promotion could be prioritized. Another CLG participant said that the CLGs were indeed helpful, with the only barrier to engagement being the time commitment for professionals with busy schedules: "the only challenge is the time required to participate". An entirely opposing position was that of a participant who did not see benefit in the CLGs when all countries had such unique characteristics and needs: "it may have well been an isolated program in our country and it would have had the same effect". It is worthwhile to note that the SMHP is an activity most stakeholders were taking on in addition to their established roles and duties; thus, meeting with a variety of professionals in different countries where program timelines and objectives differ greatly may not be the best use of available resources and capacity.

These mixed results regarding the CLGs give insight into the challenges of implementing the SMHP in different countries; there are inevitably going to be different priorities, schedules and agendas that may hinder the ability of the CLGs to achieve their desired outcomes, which is to ultimately improve the SMHP planning and implementation processes. Perhaps further incentives for participating countries may be required to ensure proper engagement and outcomes, such as an opportunity to bring

individual questions or concerns to the SHINE research group or offer additional program materials.

While comparing different countries is useful from a theoretical or analytical point of view - for instance, from the SHINE team's perspective, it is quite appropriate to analyze the strengths and weaknesses of the program as 'one' - it is important to consider whether these meetings do indeed contribute to the activities of the SMHP on the ground. A researcher from SHINE said that the CLGs are "really bringing this to life by working on the ground, with people who are implementing this intervention, to see the bottlenecks, the challenges and the potential solutions... having this group has been certainly very helpful in terms of the implementation process". While it may be beneficial to the implementation process in SHINE's view, one interviewee stated that "the only positive point [of the CLGs] was that [SHINE] was following up on us... we don't have any real connection with the group... we don't get any money or major bureaucratic support" (CLG participant). Another stakeholder cited the "amount of time it takes for my colleagues to prepare materials or take part in the meetings" (CLG participant) as another setback. There are various levels within the SMHP; for example, the theoretical level whereby the program is shaped and reviewed and the level of its practical application in a variety of contexts. Thus, to attribute the benefits of the CLG to actual program implementation does not seem applicable given the interview data; rather, the CLG is most likely helpful in macro-level country comparisons and generalizations about program strengths and weaknesses.

The second application of collaborative care is how it relates to the actual implementation of the intervention. This definition of collaborative care can be described as consisting of different stakeholders at different levels with the same goal - in the case of the SMHP, it is the "unit surrounding the child seeking to improve their overall mental health outcomes" (CLG facilitator). Several interesting patterns emerged from the findings, including the need to clearly define the roles of all individuals and groups involved and determine indicators of success early on.

For example, an interviewee explained the variety of "mature networks within the countries that represent what historical collaboration has taken place in those countries... this actually shapes how much the program is able to benefit" (CLG facilitator). It is critical to consider the historical nature of interactions within networks of professionals to determine which stakeholder might deliver the intervention most effectively; whether this choice is sustainable given the resources available also indicates that there is an optimal level of engagement from all stakeholders. One study participant said that collaborative care "requires people to potentially be involved in things that may sit outside of their core role" (CLG facilitator); therefore, professionals may need to make adaptations to their current work to align with the overarching goal of making the discussion around child mental health and wellbeing more accessible in their context. Moreover, a consideration of the various objectives and priorities amongst stakeholders should be discussed to ensure those most invested in the SMHP are able to have a more prominent role in program implementation than those with competing obligations.

CLG facilitators also discussed the difficulty of fine tuning monitoring and evaluation tools when the indicators of success varied so greatly between countries: “the countries are at very different levels in terms of what has existed, where they've come from and how far they've come in terms of their actual ability to bring these stakeholders together and actually have them implement the program” (CLG facilitator); this suggests that proactively identifying country-specific goals and indicators of success are necessary for effective monitoring and evaluation efforts. For example, “in Jordan, until now we don't have any proper healthy mental health program running inside the schools… due to many different reasons” (CLG participant) whereas in Egypt, “the Ministry of Education believes that yes, something has to be done for the mental health of the students” (CLG participant). This can be connected to the benefits of using the theory of change and adopting an overall more holistic, long-term perspective early on; this will hold significant weight for SMHP implementation as it progresses. At a certain stage, the focus will inevitably shift from planning and development to sustainability and the role of collaboration takes on a different yet equally fundamental meaning. The themes identified here suggest that it is essential to incorporate these considerations as a proactive measure rather than later in the program timeline.

Next, we will move on to the second research question. The focus here is targeted interview questions around cultural dynamics and mental health stigma and an exploration of the potential challenges in replicating a program such as the SMHP across a diverse group of cultures and countries. The most prominent theme that emerged was the role of the family and the corresponding societal norms that inevitably interact with

any child and adolescent mental health-oriented activity. The family did not have a large role within the dialogue between CLG facilitators in describing collaborative care within the SHINE SMHP; stakeholders within the collaborative care network primarily included professionals (i.e., researchers, psychologists, teachers, mental health workers).

Despite this, almost all interviewees cited parents as the most difficult stakeholder to collaborate with: "the part of the collaboration that was much more difficult than the collaboration with teachers was collaboration with the parents... it was the challenge of the stigma, they didn't believe that their kids have any kind of problems" and "it [is] much more difficult to collaborate with parents" and "there is a stigma problem with the parents" (CLG participants). It appears one of the biggest barriers to effective collaborative care within the SHINE SMHP is the lack of parental voice; their input, opinions and levels of understanding are critical as they are the ones who ultimately make decisions for their children.

Several study participants offered solutions for improved parental involvement at all stages of the program; usually these ideas involved more training for parents and improved trust and rapport between parents and mental health professionals. For example, one participant noted that "we need to change the program and have more focus on providing training not to teachers but to parents" and "we want to add the training of the parents... we realize that we cannot do this without all these partners doing all their efforts to implement school mental health" and "we want to work on the awareness of our parents" (CLG participants). To tie this clear emphasis on parental involvement to the broader themes of family and society, the interviews introduced the notion that mental

health stigma within Iran, Egypt and Jordan often results in parents shaming their children for struggling with mental health or blaming themselves for their child's mental state. One CLG participant said: "parents think a girl will not get married if people think that she has mental issues... it will impact the whole family's future... some of the villagers, if they see that they have a mental problem with their daughter they just keep them in the house". This is relevant because a SMHP that originates from a population more focused on mental health awareness and promotion may not account for the strength of the shame and blame that can exist within the family unit around mental health and could be attributed to historical, cultural, religious, or societal factors.

Similar patterns of gendered decision-making and family pride were exemplified when a participant described how the visibility of a mental disorder impacts the societal response of parents: "they cannot tolerate any agitation or behavior problems, but they can tolerate internalizing conditions like depression and anxiety... my sense is that they are more comfortable with treating externalizing problems" (CLG participant). This specific comment could be very important for future program development, for it suggests that a more detailed examination of specific mental health challenges and cultural variables may be required for improved outcomes. Again, it is necessary to gain perspective on the larger unit around the child to see the ways in which child mental health is perceived and managed. The parental and familial roles are the core of decision-making around child mental health and are also the most likely to uphold traditional value systems and norms around mental health.

The reality of mental health stigma within Iran, Jordan and Egypt was emphasized in certain sects of the population; for example, those who lived in rural areas or were of a lower socioeconomic status were more likely to experience the negative repercussions of stigma. An interviewee stated: "the parents - especially in the countryside, not in the city - don't accept this and they refuse to hear that their daughters have mental issues and can be sorted out" (CLG participant). A similar comment alluding to the differences in understanding of mental health was that "since the program was conducted in the capital city, the broad knowledge of people - even in the poorer areas of the city - is much better than the remote areas of the country" (CLG participant). Another said that "the majority of the parents that we worked with at public schools, with low socioeconomic level families, thinks that the school is entirely responsible for mental health" (CLG participant). Several interviewees also reiterated this difference in levels of acceptance between private and public schools; public schools simply lack the physical resources and mental health specialists for a SMHP to come close to achieving intended results: "in public schools we don't have specialized people and faculty to work with such [mental health] cases" (CLG participant). Thus, a reasonable inference is that there are not only implementation challenges between countries, but also within countries when it comes to issues of poverty and inequality and in terms of access to knowledge and resources; stakeholders who understand the cultural and country dynamics will be the most likely to be able to include this consideration in broader SMHP developments.

Finally, the unique characteristics of specific countries were again highlighted when considering the distinct difficulties that they experienced when trying to implement

the materials from SHINE. The broader political system of a country "impacts the way of delivering the information and the extent to which the information can be accepted... this is something that is representative of cultural and religious backgrounds which is different from country to country" (CLG participant). A similar comment was that "we had problems because the priorities of the Ministry of Education could be changing... they had problems with providing money and funds to cover the costs of the program" (CLG participant). The same study participant went on to explain that program success ultimately has a lot to do with the individual political, health, or education authorities and whether they are personally invested in mental health; thus, if such authorities change before or during the implementation process, it will greatly impact program functioning. For instance, "it depends on who is the head of the project in the Ministry of Health… with somebody who puts [in] effort and perseverance, it would [move] forward" (CLG participant). This is largely indicative of top-down structures of decision-making and the intersections between the political, economic and cultural spheres.

For example, mental health is not viewed in isolation from all other aspects of policy: "it is a mixture of the culture and the political atmosphere...we have so many things to think about other than the ones mentioned in the SHINE program" (CLG participant). This statement points to the interconnectedness of social issues with religion and politics and the ways in which they can potentially be stacked against one another, especially when resources are scarce. Collaboration between the various ministries within the government is difficult (usually the education ministry and the health ministry): "authorities in those two bodies have to cooperate and collaborate to have common

ground", and their differing priorities and opinions have a large influence on the level of funding and support received for mental health. An interviewee described this phenomenon by saying: "when you want to work between ministries, it is usually a problem because it's hard to get a mutual perspective for targets" and "the Ministry of Health gave us a hard time" (CLG participant). One can see how the implementation and subsequent functionality of the SMHP are largely dependent on unique country variables, yet a common theme is the difficulties associated with cross-ministry coordination, therefore this should perhaps be emphasized more proactively in the collaborative process.

On a similar note, there was a pattern within the interview dialogue of participants referring to the challenges associated with implementing SHINE's specific materials and resources. In all countries, sections of SHINE's manual that described topics such as suicide or sexual development were omitted due to political barriers and religious norms. One interviewee said that "in Egypt, they refused to talk [about] this issue and they asked [that] we don't put it in our manual" and another said, "they did not want us to mention this in their curriculum". This is again an evident discrepancy between Western and non-Western country dynamics in terms of what is deemed important or appropriate for child mental health; these differences should be addressed early in the program planning stages.

On a larger scale, one interviewee discussed the bigger barriers faced when working with an international research project like SHINE because of internal skepticism; they said that about half of what SHINE gives them they simply cannot apply due to the concerns surrounding international intervention of any sort (anything not originating from

the country in question). While these concerns usually involve economic or political matters, there is a certain stigma around any sort of external initiative that may threaten the stability or norms of any given country; this underlying fear is extended to programs such as the SHINE SMHP. These barriers may be relevant because the program is focused on children: "it's okay if you have *business* with the international world, but when it comes to culture and children's development it has to be something local" (CLG participant). While interpretations of child mental health may differ, the understanding that children are a vulnerable population and should be protected seems to be a common thread both inside and outside of a country. Another CLG participant described the reality in their country: "we also believe that for the development of children and adolescents we should only rely on ourselves... even if its a mental health issue, we should rely on local mental health programs". This could certainly prompt a further examination of boundaries and acceptability for external child mental health programs in specific countries. It could also suggest that there is a discrepancy between what the SHINE research team thinks is happening and what is happening on the ground (perhaps local initiative and authority will always trump international intervention), despite the efforts of all the professional partners trying their best to promote school mental health.

To place the findings in the context of the literature, this study aligns with the common theme of noting the importance of including all potential stakeholders and acknowledging their inevitable influence on school mental health activities. The study also demonstrated the potential of the school context to be extremely critical to child and adolescent mental health; this holds many parallels with the current research landscape.

Finally, the comments from study participants suggest that there is a need for the research on a specific intervention to take place in the context in which it intends to be implemented (i.e., SHINE's materials and programming are predominantly created outside of the Eastern Mediterranean region and an in-country approach to research and program development could perhaps mitigate some of the challenges). Not only will this make the intervention more responsive to contextual factors, but it will allow for a more realistic picture of dispensable resources and capacity within any given country and how to allocate them effectively.

It is also worthwhile to situate these results in the context of the Re-Aim framework, which was introduced in Chapter 2. Re-Aim is a framework within the field of implementation science used to help guide the transition from evidence-based research into practice. The five steps help researchers to identify the ways in which they can proactively consider key variables to ensure program implementation is successful and sustainable (Re-Aim, 2021). Regarding the SHINE SMHP, the Re-Aim framework could consider factors that are critical for program success yet not necessarily addressed in the core skeleton of the SMHP (such as resource availability, government support for mental health, institutional cooperation, program delivery methods etc.). The five principles that Re-Aim highlights are: reach, effectiveness, adoption, maintenance and implementation (Re-Aim, 2021). As the results indicated, there were some challenges in *reaching* the target population (children) due to a lack of parental involvement and understanding, as well as some difficulty in *adopting* the SMHP as is due to institutional barriers and inconsistencies. There was also ambiguity about the *effectiveness* of the CLGs due to

mixed participant reviews and lack of clarity as it relates to the impact of collaboration between countries on child mental health. *Implementation* varied based on individual country characteristics and timelines. Finally, how to best *maintain* the structure of the SMHP in each individual country should be a focus of both within-country and between-country collaborative efforts, as SHINE itself is operating on a time-limited funded grant.

In summary, there are a few practical implications of this study as they relate to the SHINE CLG. Some CLG participants feel as though these facilitated interactions are not providing adequate support to their implementation of the SMHP. Thus, SHINE should identify the specific elements of the CLG that people feel are lacking (for example, money, technical research support, implementation support etc.) to ensure the activities are aligned with what the CLG participants deem important. SHINE should also articulate their limits of what they can provide, for instance, they are not able to address issues in cross-ministry collaborations within a specific country. They should readdress the time and resources commitment of CLG participants to ensure it is appropriate for their current capacities. Finally, the implications relevant to the SMHP are the necessity to incorporate targeted parental involvement for the intervention (moving beyond school-based mental health to a true collaborative care model) and future specific research about the contextual adaptation of similar interventions.

5.2.2 Limitations and Recommendations

While the above findings hold significant depth and breadth, there are still some limitations of these identified thematic areas that leave certain questions unanswered. For example, from these interviews, it appears as though the primary issue

with the current organization of the CLGs is that different countries are experiencing different levels of progress with program development and implementation, which could result in some countries feeling like they are falling short in comparison. This study did not go into detail about specific positive and negative elements of the CLGs and a more thorough examination of participant's attitudes could be beneficial for overall collaboration and engagement.

Similarly, a prominent theme was the lack of parental involvement in the entire SMHP development and implementation process. While this could be due to a variety of factors, a limitation of this study is that it does not include the voices of any parents with children in the SMHP. One interviewee stated that: "parental engagement in a school setting varies hugely and that seems to be a product of how education is viewed and how schools are viewed… there is a perception around the different roles that there are when it comes to addressing emotional and mental well-being and whose responsibility that is" (CLG participant). Larger questions of role definition, task-sharing and responsibility arose and should be addressed in more depth in future country-specific research.

Another limitation of the findings of this study is that they do not explore questions of program sustainability or scaling up on national or international levels in much depth. The SHINE SMHP itself is running on a time-limited funded grant and it is indeed important to consider the primary program strengths and weaknesses to better understand the longevity of the current situation. Also, while collaboration has, in many ways, facilitated the adaptation of the SMHP to unique settings through internal learning and maturity of existing networks - a more targeted interview question to this point could

support a more nuanced discussion and future strategy development. For instance, what are the elements of collaboration that work well and what are the ones that need improvement? Finally, as identified in Chapter 4, limitations of the study include the challenges conducting interviews in an international and virtual context as well as a small sample size due to language barriers.

There are a few additional recommendations that can be made when considering future practical development or scientific research. SHINE CLG facilitators alluded to the future of the SMHP by describing a multidisciplinary 'community of practice' in which there are resources and facilities for countries to utilize for their own in-country adaptation of the program. A more informal approach to CLGs could be more efficient and applicable to all parties yet still encourage collaborative learning and knowledge-sharing opportunities, such as accessible online learning platforms and/or forums to discuss SMHP progress. Likewise, while the SMHP is still at a stage in which there is a significant amount of bidirectional learning between SHINE and individual countries, it would be beneficial to examine the areas within the program where SHINE provides the most guidance to see whether countries may be able to continue the program without SHINE in years to come. Lastly, more detailed research regarding the similarities and differences between individual countries and specific country dynamics could help mitigate some of the challenges associated with implementing the SMHP to such diverse country contexts.

Chapter 6

Conclusions

The purpose of this research was to analyze the function of collaborative care within the SHINE CLG as well as to examine whether a mental health intervention like the SMHP can be easily transferred to a variety of settings. Based on a series of in-depth individual and small group qualitative interviews, it seems that the role of collaborative care is most important between stakeholders within any given country and that the significance or benefit of collaboration between countries is still unknown. The main arguments emerging from this study are that a) the SHINE program needs to be more proactive in identifying country-specific variables for optimal collaboration and program sustainability and b) the CLGs are beneficial for research purposes, but not necessarily implementation purposes. The findings also indicate that the role of individual country variables should be addressed early on in program planning and implementation to mitigate any potential challenges associated with cultural or societal barriers. In addition, the data suggest that a) parents should play a more active role in the collaborative process, b) the significant influence of mental health stigma in rural areas should be accounted for and c) there is skepticism around international intervention and further research should explore ways in which this hesitancy can be mitigated proactively.

SHINE works in collaboration with the World Health Organization's Eastern Mediterranean Office to address the overall lack of mental health infrastructure in the region as well as the overwhelming treatment gap between high income and low to middle income countries for mental health, especially for children and youth. Traditional

quantitative research methods for investigating various areas of health present several challenges when the focal point is mental health; while the SHINE SMHP addresses the intersection between evidence-based practice and realities on the ground by encouraging collaborative learning and ground-up decision-making, this study intended to take it one step further by examining the cultural nuances and societal norms that may support or impede the ability of the SMHP to be as effective as possible in the local contexts.

Thus, a qualitative lens was adopted and a focus on the experiences of those directly involved in program implementation was a reference point for the entirety of the study. This approach did extract very detailed and complex interview data; however, in reflection, it would have been fruitful to also hear from the parents, teachers and children who are the immediate program beneficiaries. The inclusion of those directly affected could have provided a more complete understanding regarding both research questions; for example, it might have supported the investigation of interactions between various stakeholders and to what degree (if any) their personal beliefs impact their level of engagement or participation with program implementers and the program itself.

Given the nature of the research questions, the complexity of the findings is not surprising. In fact, the breadth of the study allows for considerations of more specific future research questions and insights. For example, how might different aspects of collaboration (i.e., communication, monitoring and evaluation, task-sharing, teamwork) have different impacts on both CLG and SMHP functioning? How does religion directly interact with mental health and how might this be proactively addressed in programming efforts? Does the SMHP need to be refined to target specific mental health challenges

among children? As one can imagine, there are many avenues of research related to one or both primary research questions and this study certainly allowed for insights to emerge through discussions with a variety of professionals, researchers and policy specialists.

Now, it is important to acknowledge that this research project would not have been possible without a successful collaboration between myself and SHINE. Collaboration is at the forefront of all academic, policy and health issues and bringing stakeholders with a mutual goal together will ultimately result in the most positive outcomes. A review of the current literature indicates a gap in meaningful collaboration when implementing a mental health intervention across cultures; therefore, this study sought to shed light on the need to address child mental health in countries that have not historically prioritized early intervention for mental health in their social, political, or cultural spheres. This study affirms the importance of prioritizing collaboration and addressing the role of culture early on; hopefully, it will be one of many contributions to the promotion of working towards improved mental health outcomes for children around the globe.

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Appendices

Appendix A: Interview Guide

Faculty of Health Sciences
Global Health Office
McMaster University
1280 Main St. West MDCL 3500

Interview Guide

Facilitator
Maya Low - lowm8@mcmaster.ca

Intended Outcomes

1. Gage the impact of the collaborative care model on the development of the school mental health program in different country contexts.
2. Examine the role of specific mechanisms within the collaborative care element and note whether interactions between stakeholders in different countries (i.e., the collaborative learning groups) are contributing to the functionality of the program.
3. Investigate whether the collaborative care model helps mitigate the challenges associated with implementing a Western mental health intervention to a unique cultural and country context.
4. Understand the experiences of those involved in program implementation.

Structure
Welcome, Logistics, and Consent

- Welcome and thank you for volunteering to take part in this interview. You have been asked to participate as your personal insight is extremely beneficial. I realize that this is probably a very busy time of year - I appreciate your time.
- Introduce myself, the study, and its purpose. Read intended outcomes, re-send consent form.
- This discussion is designed to assess your current thoughts and feelings about the collaborative care element of the school mental health program. Our conversation will not take more than thirty to forty minutes.
- Start recording - Obtain verbal consent to collect data.
- Anonymity: Despite being taped, I would like to assure you that the discussion will be de-identified. The tapes will be kept safely on an encrypted, password-protected USB key until they are transcribed verbatim, and then they will be destroyed. The transcribed notes of the interview will contain no information that would allow you to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however, please try your best to answer.

Logistics and Ground Rules

- There are no right or wrong answers.
- You do not have to speak in any order.
- When you do have something to say, please do so.
- You do not have to agree with the views of other people.
- Does anyone have any questions?

Questions

Opening

- Could you tell me more about your role and background with the school mental health program?
- How have interactions between key stakeholders - i.e., parents, teachers, the school, and the government - been for you within the school based mental health program?
- Have you identified any specific problems or people that will be especially challenging?
- What is your definition of the collaborative care element within a school-based mental health program? (not necessarily SHINE) What is your understanding of its purpose?

Middle

- What has been the easiest and the most challenging aspect of collaborating with various stakeholders?
- Have there been any challenges in adapting the program to Iran specifically? If so, what are the biggest barriers in implementing the program?
- How is mental health usually presented in the culture/society in which the program is being implemented?
- Has the school-based mental health program been widely accepted with parents and other stakeholders as an approach for addressing mental health problems?
- Does the collaborative care element take up a lot of time? If so, does it take away from the actual implementation at all?
- Do you think a collaborative care model has shaped the development of the SHINE school mental health program in any way? If yes, has this been beneficial for the program and its intended outcomes? Why or why not?
- Is collaborative care within the individual countries part of the ongoing monitoring and evaluation efforts of the program?
- Are the collaborative learning groups contributing to the overall functionality of the program? Why or why not? What are the strengths and weaknesses of having these events?
- What is the added impact of COVID-19?

Concluding

- Is there anything else you would like to contribute to our conversation that I have not yet asked?

Conclusions and Reminders

Thank you for participating. This has been a very successful discussion and your opinions will be an asset to the study. I hope you have found the discussion interesting; If there is anything you are unhappy with, please contact me later. I would like to remind you that any comments featuring in this report will be anonymous.

Appendix B: Consent Form

LETTER OF INFORMATION / CONSENT

Cultural Adaptations of Western Psychology:
Evaluating the Role of Collaborative Care in a School-Based Mental Health Program in the Eastern Mediterranean Region

Investigators

Local Principal Investigator:
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Purpose of the Study and Research
My thesis project falls under the thematic areas of global mental health and transcultural psychiatry. The SHINE research group is a five-year project initiated by the Co-PI's Atif Rahman (University of Liverpool) and Lawrence Wissow (University of Washington) and seeks to implement a school-based mental health intervention in the Eastern Mediterranean Region. Part of this work involves facilitating collaborative learning groups with key stakeholders from each of the target countries. My research seeks to explore the collaborative care element of the school mental health program, which involves the interactions between parents, teachers, mental health workers, and researchers within participating countries. Analyzing the effectiveness of collaboration is important to ensure the long-term sustainability of the program as well as its scalability to different cultural contexts. Data will be collected through qualitative research methodologies with a variety of individuals involved in the program development, implementation and delivery.

You are invited to take part in this study on the role of collaborative care within the school-based mental health program. I hope to examine the benefits and challenges associated with collaborative care and learn more about the applicability of Western psychotherapy to different cultural contexts.

Procedures Involved in the Research
1. Recruit study participants and obtain verbal consent for the study.
2. Conduct in-depth individual and small group interviews with study participants, using targeted questions to answer the research questions.
3. Interpret results by combining all interview data.

All interview sessions will begin with introductions, objectives, verbal consent, and ground rules. The middle part of the sessions will focus on open-ended discussion questions. The sessions will conclude with a summary and opportunity for additional questions or comments.

For both the focus group and interview portions of the study, auditory data will be recorded to be transcribed and analyzed following the session with your permission. The interviews will be about half an hour to forty-five minutes. All sessions will be held via Zoom using an institutional Zoom account from McMaster University.

Potential Harms, Risks, or Discomforts
The risks to you are minimal as all data will be collected remotely and participants' privacy and confidentiality will be prioritized. Questions will be sensitive to different cultural contexts as to ensure minimal risk of emotional or psychological distress when speaking of child mental health. Sensitive questioning will be ensured by ongoing researcher reflexivity, acknowledging power imbalances and positionality, and adaptability to the individual conversation and context.

The risks will be minimized and managed by establishing initial rapport and trust with study participants and ensuring confidentiality in both the survey and interview process. This will be done by creating a comfortable environment, appropriate body language, and authentic questioning. Also, all research activities will go through the in-country teams of mental health professionals who can follow up with participants, as necessary. If you choose to take part in this study, you will be told about any new information which might affect your willingness to continue to participate in this research. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable, and you can stop to take a break or withdraw up to two weeks after the interview takes place.

Potential Benefits
The SHINE network has already contributed greatly to the field of global child mental health. The WHO EMRO is an official project partner and is leading to potential significant benefits of learning at a regional level. Specific future uses of the data collected in this study could focus on stronger collaborative care elements and more culturally appropriate mental health services for children in the region and beyond, such as focused and scalable psychosocial interventions to support children and youth with severe emotional distress or trauma.

Confidentiality
Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified within the data analysis processes. However, please note that while specific identifiers will be removed, people may be identified by the stories they tell, so please bear that in mind when responding. Direct quotes may also be used in the thesis write-up, but they will be de-identified.

The data will be stored on an encrypted, password protected USB key that is only accessible to me. To the best of my ability, all identifiable information within interviews will be removed. Any email communication with participants to arrange interview times will be deleted once the meeting time has been set. The data will be anonymized immediately after the data collection period and will be kept until the end of 2021. After this, the raw data will be permanently deleted, and an executive summary of the primary findings and implications will be shared with the SHINE research group for their ongoing programming and research efforts.

Regarding privacy information related to the use of Zoom, this study will use Zoom to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available here https://zoom.us/privacy. While the Hamilton Integrated Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers. If you are concerned about this, I would be happy to make alternative arrangements for you to participate, perhaps via telephone. Please reach out if you have any concerns.

Participation and Withdrawal
Your participation in this study is voluntary. If you decide to be part of the study, you can decide to withdraw up to two weeks after the interview takes place – even after giving verbal consent or part-way through the interview. If you decide to withdraw, there will be no consequences to you and all research data collected with potential identifiers will be removed. If you do not want to answer some of the questions you do not have to, but you can still be in the study, and your decision whether to be part of the study will not affect your role within the SHINE research group.

Information about the Study Results
I expect to have this study completed by approximately July 2021. If you would like a summary of the results, please let me know how you would like it sent to you.

Questions about the Study
If you have questions or need more information about the study itself, please contact me at: lowm8@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about the study being conducted by Maya Low of McMaster University and am aware of how to contact the researcher to ask questions about my involvement in this study and to receive additional details I requested.
I understand that I will be asked for my verbal consent at the beginning of the study in lieu of written consent. if I agree to participate in this study, I may withdraw from the study at any time.

Appendix C: Letter of Approval from HiREB

HiREB
Hamilton Integrated Research Ethics Board

Project Number: 13137

Project Title: Cultural Adaptations of Western Psychology: Evaluating the Effectiveness of a Collaborative Care Model in a School-Based Mental Health Program in the Eastern Mediterranean Region

Student Principal Investigator:

Local Principal Investigator: Dr Mat Savelli

We have completed our review of your study and are please to issue our final approval. You may now begin your study.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Protocol	Apr-12-2021	2
Email Script	Apr-27-2021	1
Interview Guide	Apr-27-2021	3
Consent	Apr-27-2021	3
Role Clarification 1	May-22-2021	1
Role Clarification 2	May-22-2021	1
Study Key	May-22-2021	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
Summary of Changes	Apr-27-2021	1
tcps2-eptc2-certificate	Apr-28-2021	1
Summary of Changes 2	May-22-2021	1

In light of the current COVID-19 pandemic, while this study has been reviewed by HiREB and given final approval status, the actual conduct of the research needs to be performed in accordance with institutional restrictions with respect to Coronavirus (which may mean new subjects cannot be actively enrolled and most research staff will be limited with respect to access to other data sources for the time being).

Any changes to this study must be submitted with an Amendment Request Form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study please submit a **Study Completion Form**.

If you require more time to complete your study, you must request an extension in writing before this approval expires. Please submit an **Annual Review Form** with your request.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE.

Good luck with your research.

Kristina Trim, PhD, RSW
Chair, HiREB Student Research Committee
McMaster University

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; for studies conducted at St. Joseph's Healthcare Hamilton, HIREB complies with the Health Ethics Guide of the Catholic Alliance of Canada