Student, teacher, and caregiver perceptions on implementing mental health interventions in Ugandan schools

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Abstract

**Background:** The vast majority of children and adolescents in low and middle-income countries (LMICs) lack access to interventions for mental health problems. Schools provide a critical platform for evidence-based intervention delivery for young people. However, a significant need exists to understand the implementation context and strategies for delivering school mental health interventions in LMICs.

**Methods:** We conducted a focused ethnography to explore students’, teachers’, and caregivers’ perspectives on implementing evidence-based mental health interventions (EBIs) within a widespread violence prevention program in Uganda. Data collection occurred in Kampala, Uganda, using two schools that have previously implemented an evidence-based violence prevention program widely used in Ugandan schools, the Good School Toolkit (GST). Trained, local researchers facilitated four focus group discussions (FGDs) with caregivers (n = 22), four FGDs with teachers (n = 25), and in-depth interviews with primary school students (n = 12). Verbatim transcripts were analyzed using a framework analysis approach.

**Results:** Participants revealed a school culture that promotes schools’ responsibility to students beyond academics, including positive teacher–student relationships. Participants recommended an implementation process that trains teachers and students in screening and referral, peer group delivery, and is accompanied by a school-wide approach to stigma reduction and mental health literacy. Participants fundamentally agreed that teachers could be trained as intervention facilitators.
Conclusions: This study highlights the potential advantage of leveraging an existing intervention that already addresses implementation factors, such as school culture, as a fertile platform for implementing interventions for child and adolescent mental health in LMICs.

Plain language abstract: Despite the growth of implementation research for child and adolescent mental health, the study of implementation science for child and adolescent mental health in low and middle-income countries (LMICs) remains scarce. Schools provide a critical platform for evidence-based intervention delivery for young people. However, a significant need exists to understand the implementation context and strategies for delivering school mental health interventions in LMICs. This study provides rich qualitative data describing the context and influences for the successful implementation of mental health interventions in LMIC schools. We conducted interviews and focus groups with teachers, students, and caregivers to determine their perspectives on implementing evidence-based mental health interventions (EBIs) within a widespread violence prevention program in Uganda. Participants revealed a school culture promoted by the existing program that promotes schools’ responsibility to students beyond academics, including positive teacher–student relationships. Findings suggest the existing program provides fertile ground for the successful implementation of evidence-based mental health interventions in schools.

Keywords
Schools; mental health; adolescents; low and middle-income country

Introduction
An estimated 10–20% of children and adolescents worldwide experience mental health problems (Kieling et al., 2011), the majority of whom live in a low or middle-income country (LMIC). The most common mental disorders among children and adolescents are depression and anxiety (commonly referred to as internalizing disorders) (Whiteford et al., 2013). Child and adolescent internalizing disorders are associated with an increased risk of suicide, obesity, early pregnancy, substance use, decreased school performance (Fergusson & Woodward, 2002; Fröjd et al., 2008; Goodman & Whitaker, 2002; Shaffer et al., 1996), and impaired health and functioning in adulthood (Keenan-Miller et al., 2007; Weissman et al., 1999). Because the vast majority of young people with a mental disorder in LMICs do not receive care (Kieling et al., 2011), closing this so-called global mental health treatment gap requires innovative approaches in non-traditional care settings (Scorza et al., 2019).

School mental health implementation science
Schools provide an unparalleled opportunity to reach children and adolescents with mental health challenges (Fazel et al., 2014). Situated throughout urban and rural areas, schools are found in communities that typically lack other social or health service resources. Research, primarily from high income countries (HIC), demonstrates that school-based mental health services improve clinical productivity, make a notable impact on referral success and attendance, and help to reduce the stigma associated with mental health issues among children and adolescents (Hoover Stephan et al., 2007; Kang-Yi et al., 2013; Mychailyszyn et al., 2011).
There has been recent growth in the implementation science research for child and adolescent mental health (Williams & Beidas, 2019), including in schools (Lyon & Bruns, 2019). School implementation research has focused on identifying and testing strategies unique to school contexts (Cook et al., 2019), as well as multilevel factors that serve as barriers or facilitators to successful implementation (Lyon & Bruns, 2019) such as supportive school leadership, staff turnover, and available resources (Eiraldi et al., 2015; Owens et al., 2014). While many of these strategies or factors found in the predominantly U.S. implementation science literature are relevant across contexts (i.e., staff turnover and resources), many are less relevant for LMIC schools (i.e., communication among multiple school personnel types) (Wolk et al., 2019).

With notable exceptions (Dorsey et al., 2019; Huang et al., 2017; Murray et al., 2014), the application of implementation science for child and adolescent mental health in LMICs remains scarce. A growing body of evidence demonstrates the effectiveness school-based mental health interventions in LMICs (Fazel et al., 2014), but much more research is needed on implementing effective interventions. One barrier to school mental health implementation is the shortage of trained mental health professionals. In many low-resource schools, particularly in LMICs, community-based mental health providers are not available, leaving non-mental health school personnel with the responsibility of supporting students to the best of their ability (Eiraldi et al., 2015). School organizational culture and climate may serve as an additional barrier. Domitrovich et al. (2008) explain school culture as “the way things are routinely done in an organization, and reflects the norms, values, and shared beliefs or assumptions of the membership” (p. 15). School culture relates to, in part, how a school community perceives its mission, for example, the favorability of non-academic student support. Additionally, school climate (both molar and strategic) may also impact mental health implementation in schools. Under adverse molar climate conditions, school faculty and staff may generally feel undervalued, unsupported, and exhausted. These conditions may compromise the emotional health of students, weaken relationships between teachers and parents, and decrease capacity to implement effective interventions (Thapa et al., 2013). Strategic school climate relates more specifically to a shared perception that the school supports personnel for implementing research-based practices (Lyon et al., 2018; Williams et al., 2018). The strategic climate is thought to have a more direct relationship with the use of the evidence-based practice, but is dependent on a positive molar climate.

Child and adolescent mental health in Uganda

Those under the age of 18 constitute almost 60% of Uganda’s population. Prevalence data on child and adolescent internalizing disorders in Uganda, albeit limited, reveal high rates of depression and anxiety. Kinyanda et al. (2013) found the point prevalence of depressive disorder syndromes among early adolescents (ages 10–13) from four poor, rural districts to be 11.1%. In a cross-sectional study of 1587 children/adolescents, ages 3–19, Abbo et al. (2013) found anxiety disorders in close to 20% of the sample. While several studies have demonstrated the effectiveness of mental health interventions for young people in Uganda (Bolton et al., 2007; Ssewamala et al., 2012), there is a lack of resources and trained practitioners to deliver effective interventions (Kieling et al., 2011; Kigozi et al., 2010; Ssebunnya et al., 2011).
Good School Toolkit

Developed for schools in Uganda, the Good School Toolkit (GST) is an evidence-based, universal program focused on changing the operational culture of schools to prevent school violence against children (http://raisingvoices.org/good-school/). In particular, GST focuses on changing the knowledge, attitude, values, and behavior that all stakeholders manifest at their school, including culturally accepted practices such as corporal punishment by teachers (Devries et al., 2013; Naker, 2011). To date, GST has been implemented in over 750 primary schools in more than five districts in Uganda, piloted in secondary schools, and adapted for use in other African countries.

Research question

The current study explores perspectives from multiple key stakeholders, a unique asset of qualitative research particularly relevant for implementation science (Southam-Gerow & Dorsey, 2014), on the potential implementation of group-based mental health interventions for internalizing disorders added to the GST. Findings will inform the implementation of prevention and treatment of internalizing disorders through the GST.

Methods

The study employed a focused ethnography methodology to understand the perceptions of students, caregivers, and teachers on the potential implementation of mental health in Ugandan schools (Knoblauch, 2005). This applied qualitative methodology allows the researcher to focus on a discrete community that holds specific knowledge and experiences to understand the complexities of a given issue from participants’ perspectives while applying an outsider’s framework (Venzon Cruz & Higginbottom, 2013). Focused ethnographies have demonstrated usefulness in the study of mental health services and implementation (Kitchen et al., 2017; Park et al., 2015).

Research setting

The study occurred in two government-run primary schools in Kampala, the capital city of Uganda. Similar to other LMIC, Ugandan students are often still required to pay school fees in order to attend government-sponsored schools. Like most primary schools in Uganda, the study schools include levels Primary 1 through Primary 7 (approximately the same as U.S. elementary grades kindergarten through sixth). Enrollment at the time of data collection were ~400 and 600 students, with 20 and 24 teachers per school. Schools were located in a low-income, densely populated parish. The language of instruction in the schools is English, however, the primary language spoken among community members is Luganda. Due to an influx of migrants from across Uganda, some participants primarily spoke a third language. Both schools had previously implemented the GST.

Data collection and participants

Primary schools were purposively selected for the focused ethnography based on their prior use of the GST, being non-residential (i.e., having non-boarding students), and serving low-income communities. Head teachers (equivalent to school principals) were first sent an invitation letter and asked if their school would be interested in participating. Both
schools initially approached agreed to participate and head teachers assisted in identifying potential participants. Head teachers then approached teachers and caregivers via phone or face-to-face to request their attendance at an in-person, school-based information session led by researchers. Perspectives from multiple respondent groups of the selected GST school communities were sought: caregivers, teachers, and students. Individuals were selected based on the following criterion: student currently enrolled in class levels Primary 5 through Primary 7 (approximate to U.S. grades fourth through sixth), currently working at the school (teachers), or having a child who attends the school (caregivers); providing informed consent (teachers and caregivers) and providing assent (students); and gender (for students and caregivers). All adults were 18 years of age or older, and most students who completed in-depth interviews were between 10 and 14, with one student being 18 years of age. During the informed consent process, the interviewers introduced themselves to the participants, informed them about the purpose and content of the study to improve school-based mental health services, and informed them of their right to end study participation at any time. No one declined to participate or withdrew from the study.

In February 2018, we conducted 8 focus group discussions (FGDs) with caregivers and teachers (4 FGDs per respondent group), and 12 in-depth interviews (IDIs) with boy and girl students (6 per respondent group), engaging a total of 25 teachers, 22 caregivers, and 12 students. All data collection occurred in private spaces in Ugandan primary schools. Two female, bachelor’s level Ugandan research consultants facilitated all discussions and interviews. The interviewers had prior extensive experience in qualitative health research with adolescents, and received additional training on mental health research. Another trained Ugandan research consultant attended each FGD to document any logistical challenges, non-verbal cues, and main impressions. All interviews and most FGDs were in Luganda. Teachers in one FGD preferred to speak in English, the primary language of instruction in Ugandan schools. FGDs included an average of six participants and lasted between one and two hours. IDIs with students were conducted one-on-one and lasted 45 to 60 min and included developmentally appropriate engagement strategies. FGD and IDI guides, both pilot tested with relevant groups prior to the study, included questions on perceived characteristics and causes of internalizing child mental health difficulties, perceived characteristics and causes of positive child mental health, existing strategies within the school to address child mental health difficulties, and perceptions around the implementation of groups to address child internalizing symptoms. IDI guides also included questions on personal experiences of mental health difficulties.

Data preparation and analysis

The study received approval from the Institutional Review Boards of the University of Alabama (17-06-281) and the Ugandan National Council of Science and Technology (SS 4521). All FGDs and IDIs were audio recorded (with prior consent) and fully transcribed

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1 Prior to specific questions on groups, participants were presented with the following script: “I’d like you to imagine that we were going to offer a new group that would help some of the students experiencing things such as having pressure, thinking too much, deep sorrow, swinging heart, or similar things [culturally-specific internalizing terminology]. This group of about eight students would meet once a week. The group of students would share their feelings and difficulties. The groups would also offer support to students and ideas about how to feel better.” Subsequent questions about the hypothetical groups included: “Would these groups be helpful? Could these groups take place at school? Who would be good people to lead the groups?”
and translated. Verbatim transcripts were uploaded into Atlas.ti 8.0 (2016). We used a five-step framework analysis approach to analyze the data, including: familiarization, developing a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 2002). We first familiarized ourselves with the data through reading, organizing and initial memoing. Using a hybrid inductive/deductive approach, we developed an a-priori codebook (based on common domains from the school implementation science literature: inner “school” setting, outer “school setting, individual provider characteristics, and intervention-level aspects (Lyon & Bruns, 2019), which was subsequently revised to accommodate emergent codes. Transcripts were coded line-by-line by a graduate research assistant fluent in English and Luganda and simultaneously organized into frameworks corresponding with the core research questions. During mapping and interpretation, we summarized coded data based on broader thematic levels, developing additional matrices and conceptual models to describe key findings. Several steps were taken to increase analytic rigor and credibility. First, a research assistant bi-lingual in English and Luganda participated in coding and analysis, returning to original Luganda transcripts when necessary to improve linguistic or contextual interpretation. Second, detailed memoing created an audit trail of analysis decisions and promote flexibility during data analysis and interpretation. Finally we held a validation workshop with the local research team and experts in school-based programming, as well as sought feedback through meetings with a local advisory group of mental health experts.

Results

Teachers’ role in student mental health

Nearly all teachers, parents, and students from GST schools stated views that schools should have a role in addressing students’ mental health. Many teachers described feeling a responsibility for the overall wellbeing and general development of students beyond their academic education. One teacher remarked,

Teachers have a role to play in mental health of children, since we are the people who are staying with the children and we are the people handling them in classes, we really need to understand them, so that we shall be able to help them as individuals not taking them as a whole class, because they have different abilities.

(Female teacher)

Each participant group specifically suggested that teachers should take responsibility to talk with students who are having emotional difficulties. According to a male student, “when the teachers see that the students are not happy in class, they [should] call them and ask them what is the thing that is wrong, what is happening.” Teachers also described the need to pull students aside that appear to be having difficulties and to “counsel,” “encourage,” and/or “praise” them. Several teachers even described their role as a teacher to “show love” to their students.

School environment and relationships

Participant perspectives also reflected GST concepts on the need for a positive school environment and the value of safe relationships between students and teachers. For example,
teachers commented on the mental health consequences of a school environment in which students are fearful of their teachers.

At school, [when a] teacher is walking with a stick everywhere, so that child can never have that kind of good mental health. And another thing that can also make a child have good mental health, let me maybe bring it at school, is for a good school environment…

(Female teacher)

According to another teacher, part of a good school environment is,

…where a child is listened to, whenever a child has a problem, there must be someone to listen even if you cannot act, but just giving a child time makes that child have [better] feelings and will be free with whatever problem will not keep any challenge the child has, he will be able to always to speak out whenever he has a problem.

(Female teacher)

Teachers also described the way that their positive interactions with children can improve their ability to learn and make their role as educators easier.

I think teachers have a big role towards the modeling of the mental health of children, if they do not do so then their work will also be difficult. We have to do it, in order to simplify our work of teaching.

(Female teacher)

Each participant group was asked what schools could do to help children with mental health difficulties. The most commonly suggested solution was counseling sessions for those students experiencing mental health challenges. Students, teachers, and caregivers unanimously mentioned counseling as being an appropriate school-based intervention. Although participants did not specifically identify a provider when discussing “counseling”, participants were later explicitly asked about recommended providers of group-based mental health interventions.

Parents viewed the schools’ ability to support students with mental health difficulties dependent upon the quality of the student-teacher relationship.

There is support here at school but it also depends on the kind of relationship that the teacher has with that student who is experiencing difficulty. If the child has received support and he is friends with the teacher, the student talks to the teacher and that teacher helps the student to overcome the problem.

(Male caregiver)

An additional suggestion on how to best help students experiencing poor mental health included engaging parents within the community. Participants, especially caregivers and students, expressed the need for teachers, students, and parents to come together to speak with a student, as described by one mother below.
I am suggesting the child, parent, and teacher are supposed to come together. This child will open up if they all meet together and they ask her what is wrong with her, what is stopping her from being happy.

(Female caregiver)

However, teachers and parents described significant challenges due to a lack of knowledge and/or ability to effectively help students with mental health difficulties. Teachers expressed that, despite their best intentions and tactics, they feel an overwhelming inadequacy when trying to help students overcome symptoms of sadness and/or isolation. Teachers believe they can recognize when something is wrong with a child, yet they often feel powerless to help students who suffer the most. The following quote is from a teacher who tries to help her students with the techniques she knows:

However much I could try to make [students] feel happy and in place, they could never. I said “Oh My God, what do I do?” Do we dance together? Come we dance, so when they came we danced, they smiled, so the others said “Ehhh, I think that is good.” But the following day they still went back to their moods. Now I said that, now this time I think we need to pray for them, maybe there is something behind all this.

(Female teacher)

Later she continued describing the seemingly depressed state these students return to despite her efforts to help them feel better through prayer or dance:

They would never want to talk. Somebody comes, sits, you teach, after trying to do the work, they would put the head on the desk and [be] very gloomy and very not friendly at all. Even when others go for break, they want to sit alone, and you just see somebody sorrowful.

(Female teacher)

School policies and practices

All participant groups—teachers, caregivers, and students—described school-wide policies and practices as important components to attaining a positive school environment and supporting students with mental health difficulties. Participants discussed the ways that stressful academic practices and students’ financial worries contributed to experiences of mental health difficulties. In particular, the shaming of students whose parents default on school fees was mentioned by students as contributing to feelings of anxiety, trauma, and depression. One girl recommended schools do more to accommodate families’ financial burdens and the stress it places on students.

Yes [schools] can do something to teach [students] well and provide students with everything that they need in their studies. [Schools should be] providing for them because our parents are different. Some [parents] know how to provide for their children, whereas others do not know. If the parent says that “when I do get money I am going to bring it,” then the teacher doesn’t have to torture that child by sending her out of class all the time. Though she or he does not know that, when you send her out it is hurting and traumatizing this child.
Teachers explained additional practices they believed would promote positive mental health among students and improve teacher–student relationships, such as giving students more time to finish assignments and more down-time during the school day to time to relax, play, or sing.

Views on peer group delivery

All participants were asked their views on implementing psychotherapy peer groups in schools for students with mental health difficulties; virtually all participants responded favorably. The mode of peer group delivery received particularly positive feedback. Many interviewed believed that a potentially strong advantage of group work was the potential for students to connect and help other students who have experienced similar issues. One teacher described the potential benefit of group-based mental health intervention:

For the groups, when they come together and they talk about the problems, first of all, they will know that they are not alone. There are other people who have the same problem and then they will also learn how they can be able to handle that problem. [They will] learn from the other friends. When this one happens, what do you do? They can also learn how to cope with their problem, from their friends.

Students also responded positively to a peer group format. One female student, reporting a history of depressive symptoms and stress as a result of her parents’ divorce and inability to pay school fees, described the potential value of joining a group. In explaining what would motivate her to join such a group, she described how she would like to help other students in similar situations.

Because I want to help my fellow young children because the situations we are passing through is not permanent. It’s not forever. We shall grow up and just remember the past situations. And if you join that group you can be able to help others in their groups. Some in such a group you can grow up and help others who are young and you help them to understand that they are not alone. The condition is temporary. I also passed through the same situations and I know you will also pass through it and you will overcome it.

Another student further described the benefits of being in a peer group:

“Because if a child gets to learn about something from a fellow child, without being forced, the child feels like he or she is not mandated to do it… the way parents do it. When she or he gets to hear about this from a fellow child she or he understands faster and puts it into practice.”
Respondents were also asked who should identify those children experiencing mental health difficulties for participating in groups. All research participants (females, males, caregivers, and teachers) suggested teachers as being the most appropriate persons to identify children with mental health difficulties. However, it was suggested in order for teachers to effectively identify students with mental health needs, they need to have a positive relationship and good communication with their students (concepts of a “good teacher” emphasized in the GST):

So, sometimes it is a bit easier to know the mental health through participation of the children, how they are participating but also, on the other hand, it has something to do with the relationship— with the way the teacher is handling the students. Openness is created by the good teacher. The good teacher will always stimulate learners [students] even to forget some other stuff that maybe affecting them in their daily lives.

(Male teacher)

One student suggested peer identification as an effective way to identify students with mental health difficulties. To support identification and intervention delivery, some teacher and student participants discussed the need to ‘sensitize’ the school community on issues affecting students’ mental health, and the importance of discovering ways to promote positive mental health. Such sensitizations mirror current trainings and school-wide promotional materials included in the GST on topics such as positive discipline. One teacher suggested the following:

I am of the view that if all the stakeholders in the school could be sensitized—what do I mean by the stakeholders? The parents, the children themselves, the teachers and the people who manage school—about how children can be handled. I think it can help the children to have a good mental health.

(Female teacher)

A few participants also expressed some concerns about a hypothetical group intervention. The primary concerns expressed by students and teachers centered on issues of confidentiality between both fellow students and with adults. In order to help encourage disclosure and participation, and affirm safety in disclosure, one teacher recommended the number of participants in each group be kept low:

Small numbers can remove that fear, at times there are some students who fear to come up with their difficulties when they are within a very big congregation. But, if they are few under somebody they can come up and tell what their difficulties are.

(Male teacher)

Participants suggested the groups could be called “clubs” in order to normalize participation and to mirror other extracurricular groups at the school, such as dance or sports clubs.
Characteristics of group facilitators

Each participant was asked who they thought would make good group facilitators. The most commonly suggested response was teachers, mentioned by students, teachers, and caregivers. Ideally, these teachers would be ones that already have a good relationship with the students and are already in a school role of guiding children on issues outside of academics. Every student interviewed recommended teachers as potential facilitators. However, one female student expressed a concern that group participants may fear to disclose or to open up in presence of an adult in authority. The second most frequently mentioned potential facilitators were the students themselves. According to one father:

If [children] are in a group of the same age bracket, children at times learn better than when they are with their parents. They can share things freely and help each other more freely than when they are with their parents and teachers.

(Male caregiver)

While most respondents did not suggest caregivers as potential facilitators, they did indicate that they should be generally involved and at least informed/aware of the purpose of the group.

Discussion

This study contributes to the emerging literature from LMICs on child and adolescent mental health implementation science. Particularly lacking from the field are qualitative studies that explore multiple perspectives from potential constituents, facilitators, and other key stakeholders on mental health interventions. A focused ethnography with students, teachers, and caregivers from two schools in Kampala, Uganda revealed important viewpoints to inform the development of an implementation strategy to address student mental health in primary schools. This study explored the potential for implementing group-based interventions for internalizing symptoms within an existing school-based intervention (GST), including what aspects of the school the GST already addresses or could be utilized to create a school environment primed for successful implementation. Findings relate to (1) Teachers’ role in student mental health; (2) School environment and relationships; (3) School policies and practices; (4) Views on peer group delivery; (5) Sensitizing, identifying, and ensuring confidentiality; and (6) Characteristics of group facilitators. This study highlights the opportunity to leverage a popular, school-based program already targeting theoretically based implementation elements in the successful uptake of school-based interventions for internalizing disorders.

Nearly all teachers, parents, and children expressed that schools have a role in addressing students’ mental health. Personal attitudes favorable toward evidence-based mental health interventions is an important aspect in developing a setting that is primed for successful implementation in community settings, including under-resourced schools (Eiraldi et al., 2015). The literature on implementation climate (e.g., Williams et al. (2018) suggests that these attitudes may serve as motivators in the successful uptake and delivery of mental health interventions (Williams & Beidas, 2019). Favorable views of a group-based interventions by both teachers and the head teachers (who serve a similar function to
principals in Ugandan schools) may also contribute to successful school mental health implementation (Forman et al., 2009).

Teachers expressed an understanding of the potential impediment mental health problems can have on students’ academic achievement. These findings are notable, indicating a shared norm by teachers, students, and caregivers that schools have a role beyond that of academics and suggests members of the school community will be more open to being trained in delivering, or at least supporting, mental health programming in schools. Prior studies suggest that one of the most common barriers to the successful implementation of evidence-based mental health intervention is “competing priorities within school,” such as academic instruction or testing (Eiraldi et al., 2015). A recent school-based mental health intervention study in Kenya found, for example, that teachers prioritized exam preparation over other non-academic activities which served as a barrier to intervention attendance (Meza et al., 2020). Notably, the current study found that teachers and students in the GST schools identified how school policy and practices are related to student mental health, such as the need to give students breaks from academics throughout the day. Thus, Ugandan schools implementing GST may be uniquely primed to overcome barriers of implementing mental health interventions in schools.

Findings related to the importance of safe and supportive relationships within the school are consistent with research linking molar school climate with students’ emotional health and wellbeing. Students have better academic performance, behavior, and emotional health in the context of a positive school climate in which students feel safe and supported by teachers and their peers. Parents’ views on the importance of teamwork between students, parents, and teachers also resonates with research demonstrating the importance of a climate characterized by healthy school-family partnerships (Thapa et al., 2013).

Teachers were the most commonly referenced group to serve as facilitators of group-based mental health interventions in schools. Teachers have effectively led other school-based mental health promotion interventions in LMICs (Barry et al., 2013); however, more research is needed on the delivery of prevention and treatment interventions (Fazel et al., 2014). The idea of task shifting, using schoolteachers or other non-mental health professionals to fulfill more than one role in the school community, has the potential to enhance the scale-up of evidence-based mental health interventions (Owens et al., 2014). Recent evidence indicates the feasibility of training Ugandan early childhood teachers in evidence-based practices around child social and emotional wellbeing (Huang et al., 2017). Additionally, a study on the delivery of TF-CBT by teachers in Kenyan primary schools demonstrated teacher acceptability, feasibility, and appropriateness (Dorsey et al., 2019). Still, questions remain about the implementation of teacher-led interventions in low-resource schools, especially for internalizing disorders, including teacher selection, the timing and dosage of training and supervision, and sustainment (Owens et al., 2014).

The influence of the GST goals and activities were evident from participant responses. For example, the GST focuses on improving relationships in schools, between teachers and students, and between the students themselves. With a focus on preventing teacher violence against students, the GST may serve as an important step in creating an environment...
where teachers value and respect students and where students feel safe and comfortable opening-up to teachers. The GST also focuses on student empowerment and helping all schools to understand the power that children have in making decisions, leadership roles in their schools, and taking action in their own lives. It is possible that the findings identifying the students’ potential to be facilitators reflect the emphasis of the GST on student empowerment. Allowing students to have a voice in decisions made within the school is consistent with a positive school culture in which students feel safe and cared for, beyond their academic success. Schools that successfully implement mental health programs may be those that have a positive organizational culture and climate (Eiraldi et al., 2015; Williams & Beidas, 2019). Similarly, the GST emphasizes positive relationships between teachers and students, effective teaching techniques, and positive operation of the school, factors also may impact successful implementation of mental health interventions (Eiraldi et al., 2015; Forman et al., 2009; Huang et al., 2014; Williams & Beidas, 2019).

A study on implementing mental health programming in Uganda found schools with a more open communication climate had greater teacher engagement (Huang et al., 2015). Other mental health implementation studies indicate that intervention implementers’ (usually teachers) respect for students was one of the key determining factors, as well as good teaching skills (Forman et al., 2009). These contextual factors (culture, climate, relationships, etc.) are key areas addressed within the GST and, as reflected in the qualitative findings, may provide an effective and unique opportunity to implement and scale-up evidence-based mental health interventions in Ugandan schools.

Like all research, this study has several limitations that should be noted. As qualitative research is not intended to be representative, the findings of this study are reflective only of study participants and are meant to contribute to a more in-depth understanding for the development of implementation. Studies conducted in different types of schools (i.e., private) or locations (i.e., rural) may result in different conclusions and findings are not necessarily generalizable to other settings. The given study intentionally focused on GST schools; similar research in non-GST schools may yield different results. Further, questions focused on internalizing symptoms relating to child depression or anxiety and likely impacted respondents’ views. Head teachers assisted with recruitment, which may have contributed to potential selection bias. All interviews were conducted in English, the language of school instruction, or Luganda, the primary local language in the region of Uganda where the study took place. However, one focus group discussion with caregivers included some respondents for whom neither Luganda nor English is their native language and required real-time translation, potentially limiting full understanding.

Future research should explore multiple stakeholders’ reflections on the outer school setting and aspects of the intervention that may impact the implementation of mental health interventions. Aspects of the outer setting may include knowledge or views on child and adolescent mental health or education policy, as it applies to school-based mental health interventions (Owens et al., 2014). Social norms and stigma around child and adolescent mental health and mental health programming are also important areas of future study. Finally, research investigating participant views on aspects of particular interventions for internalizing symptoms is warranted.
Conclusions

Results from this exploratory study support the potential for school-based delivery of mental health interventions in Uganda. Teacher, student, and caregiver participants largely agreed that schools and teachers have a role to play in addressing child mental health, and that a positive school environment with supportive relationships and practices are tied to mental health. Participants also responded favorably to the delivery of interventions for internalizing disorders via peer group format with teachers as potential facilitators. In particular, this study finds that schools which have previously adopted the GST may be well-primed for successful implementation of mental health interventions.

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