Developing and Implementing

School-Based Mental Health Promotion Strategies

By

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Abstract

Each year, the number of individuals impacted by mental illness worldwide continues to climb. In Canada, an estimated 15% to 30% of children and adolescents suffer from mental illness, and this percentage is expected to increase by 50% by the year 2020. Yet, on average, only 1 out of 5 children who need mental health services actually receives them. There is, thus, not merely room, but a dire, growing need for the development and implementation of strategies to address mental health issues early on and provide students with preventative resources in Canadian schools. The purpose of this investigation was to gain insight into the development and implementation of strategies for secondary schools to employ with the aim of promoting student mental health. This qualitative research study was conducted through a literature review and three semi-structured interviews with experienced educators involved in school-based mental health initiatives. Findings regarding the benefits of curricular and co-curricular integration of mental health education, professional development, and informed and responsive pedagogy, as well as the perceived barriers to strategy implementation, were uncovered and are discussed in this paper.

Key words: mental illness, mental health initiatives, mental health literacy, school-based support services
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Chapter 1: INTRODUCTION

Introduction to the Research Study

“Do you really think I’m so messed up that I need somebody else to fix me?” was the response I heard from my friend when, after hearing him speak about his depressive and suicidal thoughts almost every day for months, I suggested that he see a guidance counselor. He was likely unaware of the fact that in Canada, 1 of every 6 adolescents suffers from a diagnosable mental health disorder, or that 3.2 million teenagers are at risk of developing depression per year (Canadian Mental Health Association, 2014). Looking back at our conversation, I often think that perhaps if he had known the statistics, if he had known that he was not alone in his suffering, and if he had acquired skills that could help him manage mental illness, my friend would have reacted differently to my proposition. However, it was not merely a lack of understanding of the prevalence of mental health issues, but the stigma attached to having a mental illness, admitting the fact, and turning to someone else for support that prevented my friend from seeking professional help.

Fortunately, over the last decade, Canada has seen a dramatic increase in mental health awareness. In 2011, for instance, the Ontario government announced its release of “Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy” (Ontario Ministry of Health and Long-Term Care, 2011). As part of this cross-ministerial initiative to promote mental health awareness, the Ontario Ministry of Education developed School Mental Health ASSISST, a program designed to support student mental health and emotional well-being by providing school boards with relevant resources, tools, and implementation assistance. As 70% of adults living with mental health problems began developing symptoms during childhood
or adolescence, it is imperative that programs like these are effectively developed and implemented in order to address mental health issues early on and provide students with preventative resources (Canadian Teachers’ Federation, 2012). However, the ways in which such projects are executed by individual school boards, administrators, educators, and counselors vary, as might the effectiveness with which this is done, and, despite the increase of psychological resources in Canadian schools, on average only 1 out of 5 children who need mental health services actually receives them (Canadian Mental Health Association, 2014).

There is, thus, still not merely room, but significant need for improvement in the ways in which mental health resources are made both accessible and acceptable in Ontario schools. There remains a stigma surrounding students who have mental health problems and particularly those who seek help to overcome them. My goal is to elucidate the ways in which schools are developing and implementing strategies aimed at promoting student mental health, as well as to shed light on the perceived obstacles to their advancement and execution.

**Purpose of the Study**

This study aims to illuminate the school’s role in shaping students’ attitudes toward mental health and psycho-emotional support services. Simply providing students with faster access to school counseling services, as the Ontario government has attempted to do, may not necessarily have a dramatic impact on the number of students taking advantage of these services. That is, increasing the quantity of available resources might not directly influence how comfortable students feel about using them. If students lack knowledge about mental illness, they may not only fail to recognize the symptoms of mental illness, but they may also believe that mental illness is and should be stigmatized. Under these circumstances, they may not take
advantage of the resources to which they have access. Thus, as long as individuals remain uneducated on the topic of mental illness and using mental health resources is seen as unacceptable, the services themselves will be, in a sense, socially inaccessible.

Accordingly, I believe that there is a profound need for a deeper examination of the strategies being developed and implemented with the goal of promoting student mental health across Ontario secondary schools. Although significant research has looked at treatment options for various mental illnesses and the prevalence of mental health problems among youth, there is a lack of literature on the ways in which schools attempt to promote mental health among students, as well as the obstacles that interfere with effective development and implementation of said strategies. The current study aimed to play a part in remedying this deficiency. Its goal was to examine which strategies are being developed and implemented in Ontario secondary schools with the aim of promoting student mental health. The study’s secondary objective was to shed light on the obstacles hindering these school-based efforts to promote mental health among students. However, as there are significant differences across school boards, cities, let alone provinces, the scope of my research was limited to two independent secondary schools in Southwestern Ontario.

**Background of the Researcher and Motivating Factors**

I am currently a graduate student enrolled in the Master of Teaching program at the Ontario Institute for Studies in Education (OISE). Having a background in English, Psychology, History, and Philosophy, I have had little experience with qualitative research. My interest in mental health and mental health education can be attributed both to my personal experiences and to my academic background. Having majored in Psychology, I have long been intrigued by
topics surrounding mental health and illness. My background in English, History, and Philosophy, however, has influenced the way I view the world, leading me to critically question the information with which I am presented and attempt to interpret it from multiple perspectives. As a result, I have become interested in the theories associated with mental health and disability and the ways in which they influence stereotypes, attitudes, and policies relating to individuals who have, are perceived to have, or are associated with those who have mental health problems. Now, pursuing a career in education, I have developed a desire, and indeed a need, to study the topic of mental health more deeply so that my teaching practices may be informed and improved by current, valid, reliable, and relevant data.

In addition to my educational background, however, my engagement with mental health research has also been motivated by my personal experiences, as well as by those of my close friends. During my senior year of high school, events were occurring in my private life that left me completely overwhelmed by stress and anxiety. I slept poorly, lost my appetite, and began falling behind in my classes. For the first time in my life, I started dozing off in class, and soon I had little energy left to work on my assignments. Not once did I think of going to the school counselor. To begin with, I was unfamiliar with the symptoms of mental illness and so had difficulty recognizing the fact that I had a health problem, let alone the fact that I required professional assistance. Moreover, the guidance counselors at my school were rarely seen outside of their office, the services they provided were never thoroughly discussed, and they were rarely mentioned by students and teachers. I had little interest in telling a stranger about experiences and feelings that I had not disclosed to my closest friends. Moreover, I, like most of my friends and acquaintances as I later found out, was under the impression that counseling services were only meant for students who had severe psycho-emotional disorders or grave personal problems.
I soon learned that this was not the case. When my Chemistry marks slipped from A’s to C’s and my teacher approached me to ask what was wrong, I broke down in tears. She hugged me, took me by the hand, and led me into the guidance office, where I met the counselor whose unflinching support got me through the year.

However, although I benefitted greatly from my counseling sessions, there were moments when I felt uncomfortable, not with the counselor I was seeing, but with the fact that I was seeing her. Even my closest friends, who had always been supportive, became unusually quiet and tense when they heard that I was attending counseling sessions, as though it was somehow shameful. Accordingly, when the friend I mentioned at the start of this chapter responded the way he did to my suggestion, I was not too surprised by his reaction. I was suggesting that he see a counselor because I knew how profoundly healing a counselor’s support could be from my own experience. Yet, if even I, a girl who had been socialized to view emotionality and expressiveness as acceptable features of my identity, felt stigmatized among my closest, most compassionate friends, it is anything but shocking that a young male, who had been taught to view these character traits as weaknesses, was so reluctant to seek professional help, even when he began to entertain suicidal thoughts. I have since spoken to many friends and acquaintances about the stigma surrounding mental health and services, and several of them revealed that they had struggled with depression and anxiety, and yet did not seek help due to a lack of knowledge about the prevalence of psycho-emotional problems, as well as a fear of being stigmatized.

It still pains me to think that if schools had actively striven to equip students with knowledge and skills that could be used to avoid, manage, and overcome mental illness, and if school counselors themselves had had a stronger presence in schools, countless individuals—my
friends and I included—could have viewed the guidance office as a safe, accessible, and acceptable environment. Perhaps we would have entered that office as soon as we developed concerns about our mental health and thereby saved ourselves much grief. Perhaps we would have been educated enough in the subject to prevent the onset of psycho-social problems by taking proactive steps. Accordingly, I feel very strongly that, in addition to supplying school boards with psychological resources, the educational field must recognize the importance of starting conversations about mental health at the school level in order to reduce the prevalence of mental illness among youth and break down the stigma attached to getting help so that students feel safe accessing the resources with which they are provided. The school’s role may not be to treat mental illnesses, but it should be to actively promote the psycho-emotional well-being of its students, primarily by increasing student mental health literacy to help them prevent and cope with mental health problems throughout their lives. It is therefore my desire to learn more about the ways in which schools are trying to help students maintain their mental health by providing them with the necessary support, as well as how they could improve upon their current strategies, and what obstacles schools presently face in advancing them.

**Research Questions**

Despite the government’s growing concern for the mental well-being of school-aged Canadians, there remains a lack of specific guidelines and clear models for schools to follow when developing and implementing plans aimed at helping students avoid, manage, and overcome mental illness. Accordingly, my research was guided by the following question: what are the strategies being used at two independent schools in Southwestern Ontario with the goal of promoting mental health among students? As literature on the perceived and actual obstacles to
strategy development and implementation is highly scarce, my research was also directed by the following sub-question: what are the most significant obstacles to the development and implementation of school-based strategies aimed at promoting mental health among secondary school students?

**Benefits of the Study**

The benefits of the present study are manifold. First and foremost, as mental health issues negatively impact a large and ever-growing portion of the global population, there is an ethical and moral need to promote mental health awareness by simply keeping the conversation going. Individuals with mental illness have long been, and continue to be, stereotyped, stigmatized, and marginalized based on their mental health status. By addressing the topics of mental health and mental health promotion, the present research will be inherently valuable because it will play a part in revealing, representing, voicing, and addressing the struggles and experiences of those affected by mental illness and those attempting to reduce the number, range, and magnitude of obstacles being faced by individuals who are impacted by mental health problems.

By providing insight into the strategies being developed and executed by schools with the goal of promoting student mental health, as well as shedding light on obstacles schools face in undertaking these endeavors, the study will take part in contributing to Canada’s recent efforts to better comprehend the subject of student mental health and school-based mental health initiatives so that schools could address student needs more effectively in the future. While the findings presented in this study will add to the growing pool of resources on which educators and policy makers may draw in their advancement and application of strategies aimed at student mental health promotion, due to its case study methodology and consequent limitations, this research is,
first and foremost, simply a stepping stone in the path to fully understanding issues surrounding student mental health and the school’s role in promoting students’ psycho-emotional well-being.

Finally, the present study will also provide me with direct benefits. As this major research project is a compulsory component of the Master of Teaching program, its completion will aid me in attaining a Master of Teaching degree. Moreover, the insights gleaned from this research will enable me to become a better educator by helping me develop a deeper understanding of matters pertaining to student mental health and school-based mental health initiatives.
Chapter 2: LITERATURE REVIEW

Theoretical Frameworks

The present research was conducted as a case study. Specifically, the study examined a case of the development and implementation of strategies aimed at promoting student mental health at two independent secondary schools in Southwestern Ontario, as accounted by three secondary school educators. The case studied was an instrumental case, as the intent of the case study was to understand a specific issue and a case was selected to help understand the issue. However, the study also had elements of an intrinsic case study insofar as, in addition to building a broad understanding of school-based mental health initiatives, it also examined and evaluated specific programs and strategies developed and implemented with the goal of promoting student mental health in two independent secondary schools in Southwestern Ontario.

Multiple interpretive frameworks were also used to guide and interpret the research and may have had an implicit influence on the critical assessment of existing research. First, the present study was influenced by a transformative framework (Creswell, 2007). Therefore, it was guided by the basic tenet that knowledge reflects the power and social relationships within society and so knowledge construction must be used to aid in the betterment of society (Creswell, 2007). Being guided by a transformative framework, the qualitative research in question contains an action agenda for reform that will, hopefully, alter the lives of individuals touched by mental health concerns, but particularly students struggling with, or at risk of developing, mental health issues, for the better. For, this study focused not only on the kinds of strategies being advanced and applied with the goal of promoting student mental health, but also
the ways in which these strategies could be optimized to benefit an often-stigmatized, marginalized, and alienated group of people.

Finally, this study was guided by disability theory, particularly the theory of mentalism and the social model of disability. The research was therefore influenced by the ideas that individuals with mental illness, or individuals who are perceived to have a mental illness, are marginalized, stigmatized, and excluded from society based on arbitrary, socially constructed norms that impinge on individual rights and freedoms and position people with mental health issues as incomplete or defective human beings. Disability theories are discussed in further detail in the section below.

**Theories of Disability**

Mental illness is widely regarded as a type of disability because it can interfere with an individual’s quality of life. However, there are multiple definitions of disability, as well as various ways to understand the concept of disability. Disability studies, the academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability, is concerned primarily with two distinct models of disability - the social model and the medical model (Peterson, 2005). The medical model of disability defines illness or disability as the result of a physical condition intrinsic to the individual that may reduce the individual's quality of life and disadvantage the individual in a variety of ways (Peterson, 2005). This model of disability posits that an illness or disability can be cured, or at least managed, by means of clinical diagnosis and medical intervention so that the individual may lead a “normal” life (Charlton, 2000).
The social model of disability, however, suggests that illness and disability are social constructs and posits that systemic barriers, negative attitudes and social exclusion are the factors that disable individuals (Charlton, 2000). The current social model of disability acknowledges that people can have physical and psychological variations that cause impairment or functional limitations (Charlton, 2000). However, it argues that such variations need not cause disability unless society fails to accommodate and include such individuals (Charlton, 2000). A fundamental aspect of the social model concerns equality, as the supporters of the model believe that people who are labeled as disabled are discriminated against and denied certain rights based on arbitrary, socially constructed norms and definitions (Charlton, 2000). The model thus focuses on ways in which society can be changed to be more inclusive of all individuals, regardless of differences, rather than on ways in which people defined as ill or disabled can be medically cured to meet social norms (Charlton, 2000). Indeed, the model implies that attempts to fix or cure an individual are discriminatory and prejudiced in nature, particularly when these measures are taken against the wishes of a person or without the person’s consent (Charlton, 2000).

A less popular alternative to the social and medical models of disability is the biopsychosocial model. This paradigm combines elements of the social and medical models of disability, positing that illness and disease are the products of biological, psychological, and social factors (Peterson, 2005). Despite the holistic nature of this attempt to address illness and disability, the medical and social models of disability remain the dominant paradigms in disability studies. However, the models have influenced one another and changed over time (Peterson, 2005). For instance, while the medical model used to define and discuss disability in terms of disease or impairment, the International Classification of Functioning, Disability and
Health (ICF) now frames disability in terms of levels of health and functioning, acknowledging the interaction between physical conditions, as well as personal and environmental factors (Peterson, 2005).

Discrimination and prejudice against individuals with disability is most frequently referred to as ableism, although it may also be referred to as physicalism, handicapism, or simply disability discrimination (Campbell, 2009). Theories of ableism are aligned with the social model of disability and emphasize the immorality and nonsensicalness of discriminating against people based on socially constructed norms, as suggested by Campbell’s (2009, p. 5) definition of ableism: “[ableism is a] network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical, and therefore essential and fully human.” Due to ableism’s focus on arbitrary normative standards “[d]isability is then cast as a diminished state of being human,” Campbell (2009, p.5) points out.

Mentalism or sanism, a form of prejudiced and discriminatory behaviour towards people based on perceived mental health status, functions in the same way, conceptualizing mental illness as a type of deviation from social and biological norms and thereby assigning a diminished social status to those dealing with mental health problems (Adams, Lee, & Griffin, 2007).

Recent Efforts to Conquer Mental Illness

Over the past few decades, numerous mental health initiatives have been developed across the world in an attempt to raise awareness and reduce stigma surrounding mental illness. As early as 1996, the World Psychiatric Association came out with its Open-the-Doors initiative, aimed at educating people about Schizophrenia, and Australia’s beyondblue campaign to improve the public’s understanding of depression, as well as to empower depressed individuals
to seek help, has been active for over a decade (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). With the growing number of individuals impacted by mental illness worldwide, the United Kingdom and Canada recently joined the effort to promote mental health literacy, defined as “the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems” (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2007, p. 4). Mental health literacy “encompasses knowledge and skills that address the biological, psychological and social aspects of mental health to increase the understanding of mental health and mental disorders, reduce stigma, help recognize and prevent mental disorders, and facilitate help-seeking behaviours in youth along the pathway to mental healthcare” (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013, p.110). In the last few years Canadian provinces such as Ontario have recognized the need for large scale mental health initiatives designed to promote resilience and improve attitudes toward mental illness. The Ministry of Child and Youth Services identified the increase of resilience levels among all children in the province as one of their central goals (Flett & Hewitt, 2013). The 2008 National Dialogue on Resilience in Youth provided an initial assessment of what was then known about resilience and what had to be done to cultivate resilience in Canada’s children and youth (Flett & Hewitt, 2013).

**Prevalence of Mental Illness**

Despite efforts to conquer mental illness and foster mental health in Canada and around the world, mental illness continues to have a devastating impact on the lives of countless individuals, including children and adolescents. Although estimates vary across studies and alter with time, the percentage of children and youth dealing with mental illness is suggested to be between 15% and 30%. Mental illness is defined as a condition “…characterized by alterations
in thinking, mood or behaviour (or a combination), and impaired functioning over an extended period of time” (The Public Health Agency of Canada [PHAC], 2002, p. 7). The symptoms of mental illness vary from mild to severe depending on the type of condition, the individual, the family, and the socio-economic environment (PHAC, 2002). Types of mental illness include anxiety disorders, eating disorders, mood disorders, and personality disorders (PHAC, 2002). Anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD) are all examples of mental illness (PHAC, 2002). Perhaps most disturbing is the fact that by 2020, the percentage of children and adolescents suffering from such forms of mental illness is expected to increase by 50% (Whitley, Smith, & Vaillancourt, 2013).

This increase can also have a profound negative impact on the Canadian economy, as mental health has long been identified as the biggest drain on economic productivity in the workplace, costing Canadians over CAD$14 billion a year (Schwean & Rodger, 2003). Meanwhile, in Ontario, mental health is related to school dropout at a cost of CAD$1.9 billion per year (Owens, Stevenson, Hadwin, & Norgate, 2012). Yet, despite the amount of money spent on, and lost due to, mental health issue, findings suggest that, of the adolescents suffering from mental health problems, only 36.2% have actually received treatment (Merikangas et al., 2011). Moreover, among those with severe mental illness, only 50% of the youths requiring treatment actually received it (Merikangas et al., 2011). Research has revealed that more observable forms of mental illness, such as ADHD or behavioral disorders, receive the highest levels of intervention, with 45% - 60% of the afflicted adolescents receiving treatment (Merikangas et al., 2011). Meanwhile, fewer than 1 out of 5 adolescents with an anxiety disorder, eating disorder, or substance abuse disorder receive any form of treatment (Merikangas et al., 2011). Taken with the fact that, collectively, the number of Canadian children and adolescents with identified and
unidentified mental health problems vastly outnumbers available supports in all regions of Canada and most areas of the world, these figures paint a bleak picture of the future of young Canadians, especially if the number of people requiring treatment doubles by the end of this decade (Flett & Hewitt, 2013).

If left untreated, psychological problems, even ones that do not meet diagnostic thresholds at present, may escalate into full-blown chronic mental disorders, trigger the development of other mental health issues, or even lead to suicide (Flett & Hewitt, 2013). Although rates of suicide in Canada have declined slightly since 1990, suicide remains the second leading cause of death among youth, with rising levels among girls and consistently high rates among Aboriginal adolescents (Kirmayer et al., 2007; Skinner & McFaull, 2012). Research indicates that untreated mental illness is often a causal factor, if not the sole cause, of these tragedies (Kirmayer et al., 2007; Skinner & McFaull, 2012). While the majority of people who experience difficulties with mental health do not take their own lives, of those who die from suicide, more than 90% have a diagnosable mental disorder (Washington State Coalition for Mental Health Reporting, 2014). However, few of these individuals actually receive mental health services. For instance, an analysis of the 370 adolescent suicides that took place in Ontario between the years 2000 and 2006 revealed that only 66 of the 370 adolescents who took their lives had previously received psychological treatment of any kind (Soor et al., 2012). According to Flett and Hewitt (2013), it is likely that a very substantial proportion of the remaining 82.1% of adolescents who killed themselves committed suicide without exhibiting any apparent warning signs. Flett and Hewitt (2003) have attributed this problem to the prevalence of subthreshold psychological conditions among adolescents. Although such conditions warrant
intervention, the afflicted individuals rarely receive treatment due to the lack of observable symptoms (Flett & Hewitt, 2003).

Flett and Hewitt (2013) have also suggested that many psychological problems go undetected because distressed individuals often conceal their difficulties from the public. This type of behavior is particularly common among children and adolescents because of their elevated levels of self-consciousness (Flett & Hewitt, 2013). In fact, almost 1 in 10 adolescents suffers from social phobia, an anxiety disorder characterized by extreme anxiety and excessive self-consciousness in everyday social situations (Flett & Hewitt, 2013). With this condition being so widespread and only 10% of those affected receiving treatment, it is not surprising that these teenagers are reluctant to make their difficulties known to the public (Flett & Hewitt, 2013). Unwillingness to self-disclose is also prevalent among children and adolescents with elevated levels of trait self-concealment and perfectionistic self-presentation, personality traits which render it unlikely that self-disclosure will take place even in the presence of severe psychological pain known as psychache (Flett & Hewitt, 2013). Moreover, in addition to hiding symptoms of mental illness, perfectionistic youths tend to engage in displays of positive emotion in order to present themselves as happy, healthy individuals (Flett & Hewitt, 2013). This condition is typically referred to as “smiling depression” or “disguised depression” (Flett & Hewitt, 2013). This pattern of behaviour also extends beyond depression and is involved in a variety of conditions termed “secret illnesses” (Flett & Hewitt, 2013). However, individuals experiencing these conditions are reluctant to self-disclose not simply because they are self-conscious, but because they see mental illness as something shameful (Flett & Hewitt, 2013). That is, they are hindered by stigma.
Stigma & Self-Stigma among Youths

There are two types of stigma: public stigma and self-stigma (Corrigan & Watson, 2002; Hartman, Michel, Winter, Young, & Flett, 2013). Typically, the term stigma is used to refer to public stigma, which is the social process whereby individuals endorse negative stereotypes about a set of people and proceed to distance themselves from, and limit the rights of, that group (Corrigan & Watson, 2002). Self-stigma, however, refers to the internalization of public stigma and the resulting sense of shame (Hartman et al., 2013). While findings have suggested that the general public tends to lack knowledge about symptoms of various mental illnesses and symptoms among people with subthreshold levels of psychological problems are rarely apparent, most often, it is not a failure to recognize symptoms, but a sense of humiliation and self-consciousness, that prevents an individual with mental illness from seeking help, or even telling someone about their condition (Hartman et al., 2013).

Studies have revealed stigma as the most frequently cited barrier dissuading people from seeking and adhering to treatment regimens (Corrigan, 2004; Martin, Pescosolido, & Tuch, 2000; Rickwood, Deane, Wilson, & Ciarrochi, 2005). In a study of 116 families of children and adolescents with mental illness, for instance, over 35% of parents reported a barrier to mental health services and indicated that perceptions of mental health and of mental health services were seen as more of an obstacle than structural constraints such as lack of availability of providers, long waiting lists, lack of insurance or inadequate insurance coverage, inability to pay for services, transportation problems, and inconvenient services (Owens et al., 2002). Thus, despite considerable advances in the quality of, and accessibility to, a range of empirically supported services, countless individuals with mental illness never seek treatment to avoid being
stigmatized by others, in part because they already stigmatize themselves (Corrigan, 2004). In fact, in Canada, only one third of those who need mental health services actually receive them (Statistics Canada, 2013).

The negative effects of public stigma have been studied at length with findings suggesting that individuals with more serious forms of mental illness, such as schizophrenia, are often stereotyped as dangerous, unintelligent, and incapable of recovery (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Such stereotypes are thought to lead to discrimination (Crisp et al., 2000). Particularly worrisome is the fact that although not all mental illnesses are associated with the same stereotypes (for instance, a schizophrenic is likely to be perceived as being more dangerous than someone with depression), they are all linked to negative and only negative stereotypes (Corrigan et al., 2007). Studies have shown that whereas other stigmatized groups, such as African Americans, are associated with both negative and positive stereotypes, individuals with mental illness are the objects of exclusively negative stereotypes (Corrigan et al., 2007). These findings suggest that while children tend to report fewer negative and more positive attributes about stigmatized groups as they age, they may report fewer negative attributes about individuals with mental illness without showing a change in positive attributes about the group (Corrigan et al., 2007).

This implication is particularly troubling considering the fact that children as young as five have been found to endorse prejudice about people with mental illness (Corrigan et al., 2007). Findings suggest that although these children generally lack knowledge of mental illnesses and their associated stereotypes, they nonetheless already possess stigmatizing attitudes and tend to actively avoid individuals with mental illness (Wahl, 2002). These stigmatizing
attitudes often fully emerge by puberty and solidify in adulthood (Hinshaw & Stier, 2008). Fortunately, the current generation of adolescents appears to have less negative views on mental illness than their predecessors, claiming that they would not be frightened if approached by someone with a mental illness, disagreeing that people with a mental illness should be avoided, and indicating that they would be comfortable meeting someone with a mental illness (Wahl, Susin, Lax, Kaplan, & Zatina, 2012). However, a survey of middle school students also revealed that modern adolescents nonetheless endorse negative views of mental illness (Wahl et al., 2012). According to the survey, about 1 in 6 students agreed that only individuals who are weak and overly sensitive let themselves be impacted by mental illness and 1 in 4 students saw themselves as having little in common with a person with mental illness (Wahl et al., 2012). Moreover, approximately 1 in 4 teenagers said that they would find it embarrassing to have a mental illness and 1 in 3 students indicated unwillingness to work on a class project with a classmate with a mental illness (Wahl et al., 2012). For the large percentage of adolescents who suffer from mental illness and the young children who sometimes fall victim to such forms of mental illness as depression and anxiety, an environment with such a powerful undercurrent of negative views on mental illness could contribute to the development self-stigma at a very young age.

Self-stigma is a major issue among individuals dealing with mental illness. Risk factors associated with greater levels of self-stigma include younger age, lack of familiarity with mental illness, and low self-esteem (Hartman et al., 2013). Accordingly, children and adolescents are particularly vulnerable to self-stigma. In fact, about 1 in 8 Canadian high school students grapple with self-stigma (Hartman et al., 2013). The experience involves feeling a sense of shame about voicing mental health concerns and feeling self-conscious about seeking help (Hartman et al.,
2013). Although the development of self-stigma is linked to the level of public stigma to which an individual is exposed, self-stigma alone is believed to have negative effects on help-seeking and treatment engagement above and beyond the influence of public stigma (Vogel, Wade, & Hackler, 2007). That is, while the awareness and endorsement of public stigma initially plays a role in the development of self-stigma, it is self-stigma that is the more proximal and reliable indicator of a person’s willingness to seek out professional support (Vogel et al., 2007).

**School-Based Mental Health Initiatives**

As both self- and public stigma function as major barriers to help-seeking behaviour among children and adolescents, several school-based initiatives have been developed over the years to help promote mental health by combating stigma. As Hartman et al. (2013) have pointed out in their review of anti-stigma programs, there are three central approaches to breaking down stigma: protest, education, and contact. The first approach, protest, involves suppressing stigmatizing attitudes (Hartman et al., 2013). Schools can achieve this by reprimanding students who demonstrate prejudice towards people with mental illness, as well as simply pointing out the injustice of prejudice and discrimination and asking students to suppress stigmatizing attitudes (Hartman et al., 2013). While such reactive strategies can help reduce stigma in some contexts, they have generally been found to be ineffective (Hartman et al., 2013). Moreover, research suggests that the protest approach to stigma reduction can produce a “rebound” effect, causing an increase in prejudice against a given group (Corrigan et al., 2012). The two alternative approaches to combatting stigma, education and contact, are discussed in the next section.
Mental Health Education & Stigma Reduction

More successful approaches to the dissolution of stigma include education and contact (Hartman et al., 2013). The education approach entails using factual information to challenge or disprove myths concerning mental illness (Hartman et al., 2013). Findings indicate that people who have more accurate knowledge of mental illness are generally less likely to stigmatize individuals with psychological problems (Faulkner, Irving, Paglia-Boak, & Adlaf, 2010). Studies such as those conducted by Pinfold and colleagues (2003; 2005), have suggested that even short video- and leaflet-based educational workshops are capable of producing a small, but significant effect on students’ attitudes toward mental illness. Contact, however, has been found to be the most effective proactive approach to the dissipation of stigma (Couture & Penn, 2003). This strategy involves dispelling negative and inaccurate beliefs about mental illness by means of direct exposure to and interaction with people who have had mental health issues and have sought professional help for their problems. This method is most effective when it involves mental health service recipients sharing with others their personal experience about their illness (Corrigan & O'Shaughnessy, 2007). Pinfold and colleagues’ (2003; 2005) national and international studies of brief school-based educational workshops have shown that the inclusion of contact in such workshops has been found to increase the effectiveness of mental health education, to better foster mental health literacy, and to bring about more lasting positive changes to beliefs about mental health.

Indeed, even students appear to understand the value of contact intuitively, as the student participants in Pinfold and colleagues’ (2003; 2005) educational workshops actually suggested that future sessions feature speakers who have personally experienced mental illness. Notably,
however, some studies have found that, while contact was more effective than education at reducing prejudice among adults, the reverse pattern was found among adolescents (Corrigan et al., 2012). Corrigan et al. (2012) suggested that the difference may have emerged due to the fact that adolescents’ beliefs about mental illness are not as firmly developed as those of adults and, as a result, adolescents are more likely to be responsive to education. Compared with adults, adolescents show more variance in response to stigma measures and hence have more room for change (Corrigan et al., 2012). Still, preliminary research suggests that educational programs that incorporate contact show promise not merely in reducing prejudice toward individuals with mental illness, but in increasing a youth’s willingness to seek help (Rickwood et al., 2004).

However, like protest, both education and contact can have adverse effects on stigmatizing attitudes (Corrigan & Shapiro, 2010). For instance, it has been found that when educational programs present mental illness as a brain disorder, they have both negative and positive effects on stigmatizing attitudes. As intended, such forms of education lead to a reduction in stigma related to onset responsibility (Corrigan & Shapiro, 2010). That is, after exposure to such educational presentations, students are less likely to believe that people with mental illness are to blame for contracting the condition (Corrigan & Shapiro, 2010). Yet, these types of presentations were also found to make the students more likely to believe that individuals with mental illness are unresponsive to treatment and unable to overcome their difficulties because the condition is hardwired in their system (Corrigan & Shapiro, 2010).

Similarly, contact can, research suggests, have unintended negative consequences. For example, mental health service providers are more likely to endorse stereotypes regarding individuals with mental illness being dangerous and irresponsible than the general public.
(Corrigan & Shapiro, 2010). As found by Corrigan and Shapiro (2010), in order for contact to be an effective form of stigma reduction, it must occur between people of relatively equal status, who possess common interests and goals. The individuals involved should also be engaged in a rewarding activity and the person who has had or is currently dealing with mental health problems must moderately disprove stereotypes associated with the mentally ill (Corrigan & Shapiro, 2010). People whose behaviour matches stereotypes simply strengthen stigmatizing attitudes, while those whose actions radically challenge stereotypes tend to be dismissed as rare exceptions to the rule and so fail to reduce stereotype endorsement (Corrigan & Shapiro, 2010). However, mental health service providers typically interact with individuals of a different status. Mental health professionals and their patients also tend to have differing interests and goals. Moreover, the activities in which they engage often fail to be rewarding and the patients often act in accordance with stereotypes (Corrigan & Shapiro, 2010).

In employing education and contact with the aim of promoting student mental health, schools may also be risking aggravating or spreading not only stigma, but mental illness itself, as suggested by recent studies on mental health and contagion (Fowler and Christakis, 2008; Rosenquist, Fowler, & Christakis, 2011). Studies conducted by Fowler and Christakis (2008), and Rosenquist et al., (2011) found that changes over time in depression and happiness are strongly correlated within social networks. Furthermore, self-destructive behaviours, like suicide, have also been found to be contagious in nature, as research has repeatedly found that media coverage of suicide can lead to imitative behaviour (Gould, Jamieson, & Romer, 2003; Pirkis, Burgess, Francis, Blood, & Jolley, 2006). Findings supporting this link between media and imitative suicide have instigated the development of media guidelines that include avoiding sensationalism and glorification of suicide, as well as abstaining from disclosure of the methods
used to commit the act (Pirkis, et al., 2006). The research suggests that simply by raising topics pertaining to mental illness and encouraging conversation among students and staff, school-based health initiatives may put students at risk of the kind of contagion effects found in recent research on mental health, even if they adhere to untested guidelines like those set for the media when delivering content on mental health.

**Gaps in the Research**

While the growing awareness of mental health issues has increased interest in mental health education and school-based anti-stigma programs, research into school-based mental health education is still in its infancy. In addition to there being a lack of studies on school-based strategies aimed at increasing students’ mental health literacy, or promoting student mental health more generally, the findings obtained on the topic thus far present a troublingly equivocal account of the effectiveness of school-based mental health initiatives. Current literature suggests that findings concerning the effectiveness of school-based strategies aimed at promoting student mental health lack validity and reliability, and so cannot be used to generate empirically sound models for strategy development and implementation. For instance, in a review of 27 articles, including 5 randomized controlled trials (RCTs), 13 quasi-experimental studies, and 9 controlled-before-and-after studies, Wei et al. (2013) found that although most of the reviewed studies asserted that school-based mental health literacy programs improve knowledge, attitudes, and help-seeking behaviour, most studies revealed a risk of bias. Employing a modified version of the Risk of Bias (ROB) assessment tool, Wei et al. (2013) assessed potential bias based on the following criteria: selection bias (e.g. randomized sequence generation and allocation concealment), attrition bias (loss to follow-up), confounding (definition and control of important
School-based mental health promotion, confounders, outcome measurement (valid and reliable measurement of outcome) and reporting bias (selective reporting or underreport of unexpected results). Of the research reviewed, 17 studies met criteria for high risk of bias, 10 studies for moderate risk of bias, and no studies for low risk of bias (Wei et al., 2013). In their review of the literature, Wei and colleagues (2013) revealed that they were unable to use meta-analysis to synthesize study results and evaluate levels of confidence for any of the outcomes of interest due to methodological errors within most the studies being reviewed. Methodological issues included excessive variability across studies in types of design, measurements used, measurement timing, types of intention, intervention duration, and participants’ age, and made meaningful cross-study comparisons unattainable (Wei et al., 2013).

Additionally, research has shed little light on the specific strategies that contribute to effective school-based mental health promotion, focusing simply on evidence of overall impact, rather than the comparative effectiveness of individual methods. Furthermore, as Wei et al. (2013) have pointed out, there is not only a shortage of valid and reliable research on school-based mental health promotion, but also a scarcity of relevant, effective, systematic reviews of the available research. Most reviews have focused on prevention strategies concerned with symptomatic youth or promotional activities addressing self-concept, self-esteem or social and coping skills (Wei et al., 2013). While some of these reviews have touched on findings regarding mental health education in schools, until 2013, none had concentrated solely on mental health literacy (Wei et al., 2013). Of course, the shortage of reviews of research in school-based mental health education is also reflective of the scarcity of such research. Indeed, as researchers such as Lindley (2012, p. 78) have pointed out, “there has been a tendency to overlook the importance of the pedagogical structure of anti-stigma education,” and while educators and mental health
professionals may share the objective of integrating mental health literacy and education, research has made little progress in helping to establish a consensus on the most effective way of incorporating mental health education into the school curriculum. The aim of the present study was to help bridge this gap in the literature and examine specific strategies being developed and implemented with the goal of promoting student mental health, including strategies aimed at increasing mental health literacy.
Chapter 3: METHODOLOGY

Research Design and Rationale

Employing qualitative methodology, this research study examined the strategies being developed and implemented at two independent secondary schools in Southwestern Ontario with the goal of promoting student mental health, as accounted by three educators. The intent of the current case study was to illuminate the ways in which schools are trying to promote student mental health, as well as to offer insight into the obstacles standing in the way of these efforts. Conclusions made regarding the research topic and questions were based on data collected from face-to-face interviews with three educators from two independent secondary schools in Southwestern Ontario, as well as existing literature on mental health and school-based mental health initiatives. Data obtained from the interviews was transcribed, analyzed, and coded in an effort to expose common themes proposed in the literature, as well as to gain a better understanding of school-based mental health programs in secondary schools in Southwestern Ontario more specifically.

Procedure

The literature review was conducted prior to the primary data collection process so that it could not only provide me with a foundational understanding of issues surrounding mental health among adolescents and the efforts being made to promote mental health in schools, but also to inform the questions employed during the interviews, as well as the data analysis. However, the literature review was edited retrospectively during the process of data analysis, with select references being eliminated due to irrelevance and new citations being added due to their newly
acquired significance. Sources consulted and referenced include qualitative and quantitative academic literature, in addition to government documents and websites, as well as mainstream media publications pertaining to topics of mental illness among Canadians, mental illness among adolescents, mental health literacy among adolescents, and school-based efforts to promote mental health and mental health literacy.

The primary means of collecting data for the present study was semi-structured interviews (see Appendix B) with three consenting participants, identified using the pseudonyms Samantha, Elizabeth, and Karen. Samantha is a Physical Education instructor and department head with nearly 20 years of formal teaching experience. Elizabeth is a guidance counselor and Physical Education instructor, who has also had experience working as a life coach. Samantha and Elizabeth were working at the same independent school in Southwestern Ontario when the interviews were conducted. This school will henceforth be referenced under the pseudonym Devane Academy. Karen is a guidance counselor and Careers teacher at another independent school in Southwestern Ontario, which will henceforth be referenced under the pseudonym Applewood Collegiate. She was involved in academic and university admissions counselling, as well as overseeing a professional development program on Mindfulness for school staff. All three participants are teachers at the intermediate/secondary level. I chose these participants in part because I had had minimal contact with them prior to the recruitment stage of the study. I believed that the familiarity would allow the participants to feel comfortable enough with me to provide honest and detailed responses. However, as the degree of familiarity was very limited, the participants would not feel close enough to me to want to answer my questions simply to please me or to help me acquire the responses I might want to hear. I also selected these educators to be my participants because I knew that each of them was interested and literate in
issues surrounding mental health, including mental health challenges prominent among adolescents. I was also aware that all three individuals were devoted to promoting mental health in their schools, and were directly involved in school-based mental health initiatives. Accordingly, I felt that these educators could offer valuable insights into the mental health climate at their schools, as well as rich descriptions of the specific strategies being used by them and their colleagues with the goal of promoting mental health among secondary students.

Indeed, the very purpose of the interviews was to gather information about the place of mental health promotion in secondary schools. Specifically, the intent of the study was to uncover the strategies being developed and implemented with the aim of promoting student mental health. The interviews were also intended to elicit information that would allow for an assessment of the effectiveness of these strategies by revealing how they have impacted mental health and mental health literacy, as well as stigmatizing and help-seeking attitudes among students.

The interviews were guided by a set of 22 closed- and open-ended questions regarding mental health and school-based mental health education. I chose to conduct semi-structured interviews so that I could ask all participants the same core set of questions (listed in Appendix B), while retaining the freedom to reword my inquiries or generate new questions based on individual responses in order to make certain that the information being exchanged was clearly understood by both parties. I believed that the method of asking all participants the same basic set of questions would elicit responses that focused enough to address my research question and to reveal common themes. The participants were interviewed individually and interviews were conducted face-to-face in a location selected by the participants. The interviews were audio-recorded and relevant notes were taken during and after each interview. The interviews were
transcribed, analyzed, and coded for common themes and patterns that were compared to those presented in the existing literature on mental health initiatives, particularly school-based programs. The findings from the data analysis will be examined and discussed in chapters 4 and 5.

Data Analysis

Once the data was collected, interview recordings were transcribed in Standard English. Filler words, such as “um, er, ah, mmm,” were removed, unless they were uttered in direct response to an interview question (i.e. “mhmm” to indicate agreement or affirmation). All data was analyzed to make sense of the gathered information. QRT Miner 4, software used for coding, was employed to identify themes in the acquired data by means of colour-coding and labeling. The data was analyzed for common themes relating to the research question and sub-questions and was then organized according to these themes. Existing literature was used to help interpret the collected data and emergent themes.

Ethical Review Procedures

Ethical considerations remained at the forefront of my mind throughout the research process. The interview participants recruited for this study were given letters of informed consent prior to engaging in the interview process to review the study conditions and guidelines (see Appendix A). Before agreeing to the study’s terms and signing the consent form, participants were provided with the opportunity to have their questions and concerns addressed in person. The participants were reminded before the study that they could withdraw from the study at any time, refrain from answering any questions, as well as have their answers omitted or altered by
contacting the researcher. All procedures were conducted as specified in the consent forms that were signed by the research participants.

All personal information such as names and institutions, or other pieces of information that could compromise the anonymity of the participants were omitted or altered before publication and participants were made aware of this condition and their right to complete confidentiality. Lastly, prior to beginning the interview process, participants were warned that, due to the nature of the research topic, they did face the risk of experiencing a degree of emotional or psychological discomfort, but that there were no other foreseeable risks to taking part in the study.

Limitations

One of the primary limitations of the study was the potential for my personal experiences with mental illness to influence my data collection and analysis, and hamper my ability to maintain objectivity. However, my personal background also helped me understand the issues that could be raised in the interviews and the data that was collected during the study, as it had provided me with some insight into the effectiveness of particular strategies used with the aim of promoting mental health in schools.

Additionally, time and resource constraints allowed for only three interviewees to be involved in the case study: three intermediate/secondary educators from two independent schools in Southwestern Ontario. While the inclusion of representatives of two different independent schools allowed for a comparative analysis of the strategies being employed to promote mental health among students, the small number of study participants limited the scope and depth of the comparison, and overall analysis of the data collected. The small number of participants also
rendered the findings less generalizable, especially due to the fact that independent schools, which are obligated to adhere to more flexible curricular guidelines than public schools, were represented. Also, as with many previous studies, variability in the strategies being implemented made it difficult to identify common themes or to adequately evaluate the effectiveness of individual educational or integrative methods. Moreover, as only teachers and guidance counselors were interviewed for this study, the data obtained excludes the perspectives of administrators, parents, and, perhaps most importantly, students. Accordingly, it was impossible to adequately evaluate the effectiveness of the strategies being studied, as well as the frequency and consistency with which they were implemented by individual teachers, as any conclusions on these matters could only be based on subjective observations and anecdotal evidence that has not been and cannot be quantified. Additionally, due to the study’s qualitative nature and lack of quantitative measures, the effectiveness and impact of the mental health education strategies to be examined could not be measured directly. Consequently, the validity and reliability of the measures and data was difficult to assess. Thus, the current study can provide only a partial understanding of the research topic. Further research will need to be conducted to supplement the findings.
Chapter 4: FINDINGS

The findings discussed in this chapter were obtained from three semi-structured interviews with secondary educators in order to answer the research question, what strategies are being developed and implemented at two independent secondary schools in Southwestern Ontario with the goal of promoting student mental health? Accordingly, the acquired findings pertain to the development and implementation of strategies aimed at promoting mental health among students at Devane Academy, where Samantha and Elizabeth teach, and Applewood Collegiate, where Karen teaches. The findings also shed light on the role of the educator in relation to implementation of strategies aimed to promote mental health among students, as well as the perceived obstacles to successfully implementing these strategies. Several themes emerged during the interview and these themes have been organized into two categories: Strategies Aimed at Promoting Student Mental Health and Obstacles to Strategy Implementation.

Strategies Aimed at Promoting Student Mental Health

Curricular Integration of Mental Health Education

While all three interviewees pointed out that mental health education was not sufficiently integrated into the curricula at their respective schools, both Devane and Applewood have made attempts to make mental health education a component of the school curriculum. At Devane Academy, Student Services and the Physical Education department have collaborated in developing study units on mental health and incorporating them into the Phys. Ed. curriculum at each grade level. Since Phys. Ed. is a mandatory course for all grades at Devane Academy, these units are taught to all students. As Samantha explained, each unit has been designed to address aspects of well-being and to foster the development of coping skills:
[. . .] we really do a focus on thoughts, emotions, and reactions, and how they all go together. So, you know, if you don't make the team, what are your thoughts around that, how are you feeling with that? And then what are the actions that come out because of that, when you probably close yourself off to people? Maybe you don't like the teacher because they didn't choose you. Well, let's just change the thought around it, and let's see if we can take it in another direction, and maybe that'll actually get you to work on some skills, and maybe go for it again, or try something else. So, just that cycle of thoughts–feelings–actions, and then resiliency, and then what mental health is.”

Each grade focuses on a different component of mental health education. In grade 9, the teachers employ curriculum resources developed by the Centre for Addiction and Mental Health (CAMH) to educate students about various forms of mental illness, including symptomatology and treatment, as well as strategies for supporting oneself and others. The topic of stigma is also addressed at this point. In grade 10, the focus shifts to fear of failure and the pressure of competition. Students are provided with a foundational understanding of neuroplasticity and the ways in which positive and negative thoughts affect brain circuitry. Students are then required to apply this theoretical knowledge to their lives in a practical way by creating stress management plans to help them develop the skills and resources that could help them cope with current and future stressors. The content covered in grade 11 continues to focus on strategies for managing stress and maintaining mental health with a particular focus on life after graduation. As part of the grade 10 unit, students must complete a personal health assignment, which requires them to synthesize the skills and knowledge acquire in previous years in developing a more extensive, detailed plan to help them build and sustain resilience. Mindfulness training is also incorporated into this unit. Additionally, Samantha and her colleagues in the Phys. Ed. department have
integrated yoga units into the curriculum and, as yoga has been found to help foster mindfulness and positive mental health, Samantha expressed that she regards this too as a component of mental health education.

In addition to being guided through mental health units by their Phys. Ed. teachers, students at Devane also receive visits from Elizabeth and other representatives of Student Services during which students take part in interactive workshops. Elizabeth explained the collaboration between Student Services and the Phys. Ed. department as follows:

[W]e don't really have Guidance curriculum, but we're kind of making our own […] So, for Phys. Ed., we would focus on all things from, like, abusing alcohol and drugs—which can come from a mental illness, right?–to different forms of anxiety, to eating disorders, to, you know, depression is a huge one, suicide, you know […] And then in our Guidance workshops, you know, we would kind of hone in on different things we felt were really important, which would be–stress would be a big one for us, anxiety because we see a lot of that in our office, you know, and depression–but really we approach it from a different angle about how can you become resilient, and how can you recognize when you're feeling a certain way, and what are the things you can do to overcome it or to get help, and we kind of approach it from that angle, and building up one's own self-esteem, and, you know, a support network.

Students are provided with five to six Guidance workshops each year as part of the Health and Phys. Ed. curriculum. Elizabeth stressed that rather than lectures, her visits to Phys. Ed. classrooms have always been interactive workshops: “It's really about conversations, and talking to one another, and getting up […] It's more about getting their feedback, and having peer groups run peer groups, and watching videos, and interactive activities.”
Devane Academy has also integrated mental health literacy into the Experiential Education portion of the school curriculum. Samantha and Elizabeth have been collaborating with the leader of a well-known experiential learning program to provide students with camp experiences that focus on leadership, as well as mental health and wellness. At a small additional charge of approximately $30, the students spend about three days at a camp, where they take part in a variety of workshops, some of which deal specifically with stress management, wellness, and mental health. These annual trips takes place at each grade level, and, despite the extra cost, they are regarded as a curricular, rather than an extra-curricular or a co-curricular, component of the students’ learning experience at the school.

Like Devane, Applewood has also made mental health education a part of the school curriculum across grades. However, unlike Devane, Applewood has developed a stand-alone Guidance curriculum that is not integrated into any specific subjects. As Karen explained, the Guidance curriculum is the equivalent of a half-credit course than is broken up over four years. It is similar in focus and scope to the mental health units and Guidance workshops provided at Devane. The grade 9 curriculum is concerned with educating about, and fostering, healthy habits pertaining to sleep, hydration, and mindfulness, as well as clarifying the role of the Guidance department in the school. In grade 10, a social worker aids the Guidance department in helping students better understand anxiety and such coping strategies as journaling and mindful meditation. In the higher grades, previously addressed issues and topics are revisited and covered in greater depth, and students are provided with more opportunities to discuss their questions or concerns in either a group or a one-on-one setting. Each grade is also faced with an overarching question. So, as students advance from grade to grade, they are forced to consider, “Who am I, where am I going, and how am I going to get there?” As a guidance counsellor, Karen played an
active role in developing and implementing the curriculum, and explains that she feels that the structure and span of the program is advantageous because it allows for a “learning spectrum.”

Co-Curricular Integration of Mental Health Education

At both Devane and Applewood, students and staff have developed and implemented strategies aimed at promoting mental health among students by means of co-curricular activities and events. Samantha and some of her students started a club focused on promoting student wellness. The club members organize a range of events with the goal of either educating students about mental health topics or improving students’ mental health. For instance, they once ran an optional informational session for students about issues related to stress and anxiety during the lunch period. They also organized multiple free, healthy community meals for students to promote healthy eating and foster a sense of interconnectedness. In addition, the clubs members also do such things as post positive messages around the school, and provide care packages with encouraging notes and healthy treats for all students during exam time to help reduce stress and foster positive thoughts and feelings. The school’s Gay-Straight Alliance club also ran workshops for peers, focusing on the relationship between language, prejudice, discrimination, and mental health in relation to the LGBTQ community. At Applewood, a group of students formed a club to discuss the definition of success and its relationship to student culture. The club members are focused on identifying their school culture’s merits and issues, and generating ideas about ways in which the school could change to improve student well-being.

Beyond clubs, Devane Academy has also become involved in large-scale initiatives, like International Day of Pink and Canada’s Bell Let’s Talk Day. The Day of Pink is a Canadian anti-bullying event dedicated to putting an end to bullying, discrimination, transphobia, and
transmisogyny (Day of Pink, 2015). While the initiative is not focused specifically on mental health, it is nonetheless connected to issues surrounding mental health, stigma, and overall well-being. In recent years, topics pertaining to the Day of Pink have been addressed at Devane’s assemblies. At one such assembly, Elizabeth actually came out as gay in an effort to normalize and model openness to speaking about identity and personal struggles, as well as to promote a party being held in honour of the Day of Pink.

On Bell Let’s Talk Day, Devane staff attempted to take part in the promoting mental health literacy, contributing to the national conversation on mental well-being, as well as to encourage students to be more open about their mental health struggles and seek help when necessary by holding a panel session wherein a small number of staff members spoke about their experiences with mental illness. 60 students and staff members attended the optional event.

Driven by similar goals, Karen led a mental health initiative at Applewood, as part of which she and her colleagues in Student Services held open drop-ins for students who wanted to discuss issues pertaining to mental health. Several students took advantage of the opportunity in order to share and inquire about mental health obstacles faced by them and those close to them.

Professional Development

All three interviewees agreed that schools have a moral responsibility to educate students about issues pertaining to mental health, and that teachers must play a role in the process. Accordingly, each interview stressed the necessity and significance of professional development, explaining that educators must be taught about mental health before they could teach about mental health. Karen described her stance on professional development in the area of mental health promotion in the following way:
From the teacher’s side, as an educator, I think that when a teacher is being trained as you are in the process of being trained to be a teacher, I think there needs to be more focus and attention on better understanding how mental health looks—first of all, what does it look like in the classroom? And what do you do about it? Because guidance counselors are understaffed across schools. We are not medical professionals, we, like teachers, have similar training—yes, a little bit different, but we’re still not counselors either. So, we have to come together and get more professional development, and I think it needs to start on the university side, and then work its way into schools.

Elizabeth expressed similar views on the matter, explaining that, as the students’ “parents away from home,” teachers have the duty “not just to teach them, but to keep them emotionally safe,” which makes them “100% [...] morally responsible” for developing and implementing strategies aimed at promoting student mental health.

Although all interviewees stated that there is room for more professional development opportunities at their respective schools, they also asserted that matters of student mental health have been receiving more attention in the sphere of professional development at both schools, and have been frequently brought up at staff meetings. At Devane Academy, Elizabeth and her colleague, a social worker from Student Services, led a workshop on solution-focused therapy that teachers could use to support students who appear, or claim to be, struggling with mental health issues. During the workshop, Elizabeth and her colleague explained how they had been using a solution-focused approach to help students work through their mental health difficulties, and offered attending teachers suggestions as to how they could employ solution-focused strategies to help themselves and their students manage stress and anxiety, even providing multiple simulations. The workshop was, however, one of several options for teachers on a
single PD day at the school. However, other workshops pertaining to issues in mental health, such as an expert-led workshop on bullying, were also offered as professional development options on PD days throughout the year. Elizabeth also revealed that at different points during the year, experts were also brought in to educate staff about teenage brain development, which she believed was relevant to mental health as well.

Additionally, Devane’s administrative team frequently notifies all staff members of professional development opportunities related to mental health promotion outside of the school. Moreover, while attendance is not mandatory, the cost of participation is covered for all willing staff members. Samantha, for instance, had the opportunity to travel across the country for a conference regarding mental health education, and the school covered the cost of the flight and hotel. Staff members have also been encouraged to take part in a two-day conference on Mental Health First Aid, and the individuals who did attend, like Elizabeth, were then asked by administration to present their newly acquired knowledge to the rest of the staff.

At Applewood Collegiate, Karen led professional development sessions on mindfulness, helping teachers develop strategies that could be implemented in the classroom in an effort to “address mental health in a way that is helpful, that is not fear-based, and is not blurring the line between a treatment facility and [a school].” A psychiatrist was also invited to provide regular professional development sessions to staff in Student Services. Another psychiatrist was invited to run a professional development workshop specifically for teachers that focused on cognitive development among teenagers, as well as trends observed across the adolescent population in the city. The growing interest in mental health also motivated multiple teachers at Karen’s school to take Guidance Part I, an Additional Qualifications course concerned with basic guidance, interpersonal, and counselling skills that can be implemented in the classroom. As with Devane,
most of the professional development events at Applewood have been optional and held outside of the school. Accordingly, Karen admitted that, although she could not provide me with the number of attendees, she recalled that the attendance rate at Applewood’s mental health professional development sessions was rather low.

**Teacher Vigilance and Accommodation**

Samantha, Elizabeth, and Karen each voiced the belief that individual teachers can play a crucial role in promoting mental health among students and so they each try to interact with students – in and out of the classroom – in a way that is informed by their knowledge of issues surrounding mental health and is responsive to students’ perceived or actual mental health needs. All three participants placed particular emphasis on the importance of practicing vigilance and in order to remain aware of students’ past, present, and potential mental health experiences and be able to provide accommodations when appropriate to help students achieve success. Karen discussed the significance of vigilance and accommodation as follows:

So, I really do try and look at students, even when I'm teaching in a class. I really try and look at them as best as I can as individuals, and when something happens, you know, even from my classroom management standpoint—and I have a thought in my mind of one thing last year—really try and see the child for who they are, and what they're working through, and modify maybe my approach to best allow the student who is struggling, or you know—who also is even successful—just really modify my approach to how I give feedback, to how I classroom manage, to give students an opportunity to do their very best, and not be hindered by—you know, either overly burdened because they're told so much they're successful, and that can become an overburden—or, you know, students who
might be underachieving because they have more in their life—recognize that when you're teaching a student, they come into your classroom not just with backpack of books, that they have a history and a story, and I think the more teachers can think about that—and I know it's busy, and I know it's a lot, but look out at your students before you teach, and think, every child there has a story and a lot of it you might not know. It might change the way—how you interact with your students, even the ones that you find challenging.

For Karen, as for Samantha and Elizabeth, remaining mindful of possible mental health concerns when making sense of students’ behaviour is a crucial aspect of good teaching because it allows her to identify and create opportunities to support student success. Karen went further to point out that often even classroom management issues may stem from students’ experiences with mental illness, and appropriate responses to such issues may take a variety of forms. Rather than simple having “a bad attitude” and intentionally frustrating the teacher, a student may simply be struggling with diagnosed or undiagnosed mental health difficulties that are hindering their ability to succeed in the classroom. Accordingly, Karen presented modification of feedback or classroom management techniques as viable examples of accommodation. Karen, Samantha, and Elizabeth also gave such examples of accommodation as allowing a student to listen to music or go for a walk during class to calm down, providing students with stress balls to reduce anxiety, letting a student break away from a group to work alone, or incorporating mindfulness exercises into the class session.

De-emphasizing the importance of marks was also cited by participants as a valuable example of a supportive, accommodative response to student mental health needs. Samantha recalled repeatedly witnessing students at Devane Academy, where the academic environment is highly competitive, struggling to deal with the stress of competition and high academic
expectations, often breaking down in tears. Perceiving a causal link between the academic standards of the school and student mental health problems, Devane recently made a school-wide accommodation in response to perceived student needs by implementing a new grading scale. The new system employs levels rather than percentages. According to Samantha, staff members hope that the new scale will help reduce stress and anxiety caused by they regard as an unhealthy focus on marks.

In addition to simply observing students, and accommodating them based on inferences about their mental health needs, Karen, Samantha, and Elizabeth also stressed the significance of actually speaking to students. Each participant advocated for the facilitation of check-ins as a tool for monitoring and identifying students’ mental health issues in order to provide the most appropriate accommodations. While Karen and Samantha conduct their check-ins rather casually by simply encouraging students to come to them if they would like to talk through a problem and initiate conversations with students in whom they perceive signs of sadness, frustration, or distress, Elizabeth conducts her check-ins more formally and systematically. In Elizabeth’s class, students sit in a circle at the start of the lesson and take a moment to report on their emotional well-being, using a number scale to quantify their stress levels, after which the students spend a few moments discussing possible strategies for managing their stress and improving their well-being by the end of the day.

As Samantha explained, checking in with students involves more than monitoring and identifying mental health problems:

[T]eachers have got to model what they want to teach, what they want kids to learn, and kindness is a big part of it. Our kids need to learn how to be kind. It's impossible for a teacher to have that many hats on, and to–to fill that role in a classroom setting. But I do
think, as a teacher, you do need to—I always call it having kids on your radar. And I think every kid needs to be on your radar, and if there's anybody you feel like you haven't been aware of, check in. Making that one-on-one happen in your class—people say it's impossible, but it's not, because it can be quick. It's just eye contact, it's mentioning their name, it's giving some positive feedback. But it can tell you so much from a look, just looking at their eyes or their body language.

For Samantha, actively and consistently checking in with students not only helps her respond to students’ perceived and actual mental health needs more quickly and thoughtfully, but also allows her to model the kind of compassion with which she feels students must learn to treat one another, as well as themselves. Samantha also spoke of the Devane’s tentative plan to create an opportunity for whole-grade check-ins for students that would help all faculty members become more aware of the stressors having the greatest influence on each grade, whether it be sleep deprivation or an important exam, so that they could respond accordingly (e.g. by reducing the workload).

**Obstacles to Strategy Implementation**

**Stigma and Ignorance among Staff**

While the interviewees all asserted that the staff at their respective schools were overall supportive of the school’s implementation of strategies with the goal of promoting student mental health, stigmatizing attitudes and poor mental health literacy among staff nonetheless hampered each school’s efforts to implement said strategies. Samantha actually expressed her belief that stigma and ignorance among staff have been the biggest obstacle to implementing strategies intended to promote student mental health, stating, “I don't think enough people are
comfortable with it. I think there's too much stigma with adults because that's the generation where it's been.” She reported that several of her colleagues, even in the Health and Phys. Ed. department, the department collaborating most closely with Guidance and the only department required to explicitly provide mental health education as part of the curriculum, “don’t believe in this what they call ‘fluff’— they used to call [mental health] ‘fluff’ all the time.” Samantha went further to explain that this ignorance of and disregard for matters concerning mental health serves as an obstacle to the implementation of strategies intended to promote student mental health:

And we got a classic case of that with a teacher in our group who didn't feel like it was something he had to really learn much about, and could just do a textbook thing. And he started a dialogue [about mental health] and didn't have the information. And actually, it ended up with a student writing the VP a note saying that this was an awful lesson, and “my questions were just tossed aside as if they had no importance.”

Samantha expressed concern over the effect that such poor implementation of strategies intended to support and promote student mental health could actually have detrimental effects on the student mental health, as, in cases like the one mentioned, students with questions or concerns regarding matters of mental health may feel stigmatized or ignored.

Karen voiced similar worries over potentially harmful effects of strategies implemented improperly due to ignorance and/or stigma among staff: “[I]f it's poorly taught, then, you know, would there be more stigma? Because, you know, you're using more language out there, and would people start to actually be called things that, you know, are hurtful?” Accordingly, Karen suggested that “a challenge could be that it needs to be taught well,” and yet, she contended, because the topic is still sensitive and there is much stigma attached to it, teachers with little
relevant knowledge may not teach well due to ignorance and/or discomfort. Elizabeth, in turn, pointed out that the negative, ignorant attitude towards mental health issues held by some of her and Samantha’s colleagues has impeded her efforts to teach students about mental health issues at all:

So, you know, you can only ever go to certain teachers, who say you can have a class, which means we're not getting those teachers on board, you know. I think every teacher who is not informed about mental health, or who thinks there's a stigma with it, gets in the way of our progress. Sure, it can be an obstacle [. . .] There's definitely, like, a pushback sometimes, trying to say, "Hello, we have to go into classes, we've been mandated–admin has said each grade has X amount of classes, and you need to–"and they tell teachers, you know, "Guidance may choose your class to go into, please try and accommodate," and then you may get some resistance for sure [. . .]

Elizabeth and her colleagues from Student Services have, therefore, often been unable to successfully deliver the school’s new guidance curriculum. Thus, negative attitudes toward strategies aimed at promoting mental health held by members of school staff serve as a major barrier to the implementation of such strategies, as, in Elizabeth’s case, they actually prevent students from receiving the mental health curriculum.

However, Karen and Samantha suggested that certain educators may be resistant to taking part in mental health initiatives out of fear. In Karen and Samantha’s understanding, ignorance among staff often generates not only insensitivity, but also fearfulness when it comes to either providing mental health education or responding to students’ difficulties with mental health. As Karen pointed out, teachers low in mental health literacy are often unsure as to which course of action would be most appropriate in situations concerning student mental health, and
fear making a mistake when implementing a given strategy: “And I think, you know, it's often hard for teachers when they don't know what's mental illness. We get a lot of students just sent down to the Guidance department, right? [But] you can deal with it in the classroom.” During the interview, Karen said that, in most cases, she does not think teachers who refrain from implementing strategies aimed at promoting student mental health do students any harm. However, she also expressed her belief that, in abstaining from strategy implementation, such educators hamper the school’s ability to progress in their efforts to promote student mental health.

**Inadequate Resources & Direction**

Each interviewee expressed frustration over a perceived lack of direction and inadequate resources. The interviewees felt that they were not provided with enough direction from school administration, but at the same time defended members of administration, stating that these individuals were in turn receiving inadequate direction and resources from the Ministry of Education. Samantha was particularly preoccupied with the issue of inadequate direction and resources:

The last edition [of the Phys. Ed. curriculum] was 1999. They tried to roll something out about 10 years ago, but there was public outcry around the Sex Ed. curriculum. So, they still haven't rolled out anything new. They rolled out the K-8 curriculum that had–it had mental health spoken in there, but it wasn't necessarily a unit. It was “emotional health should be tied into everything,” so it's really vague terminology and there's nothing there concretely, “this is what you do with it; this is how you teach it” and all the rest. So, still waiting this many years later for a renewed curriculum there. It hasn't come out and so much has changed. And, really, a lot of Health and Phys. Ed. teachers are just like
probably doing their own thing because you can't rely on the old curriculum. So, I
developed the mental health units for [...] Devane Academy. But in other schools, there's
only one pause on a mental health unit in grade 11 that was developed. But grade 11 is
too late, and one unit, which isn't—it isn't expansive in any way—Isn't really enough.

Samantha admitted that she has a sense of direction and preparedness when it comes to
developing and implementing strategies intended to promote student mental health primarily due
to her personal experiences with mental health issues, rather than support from the school, the
board, or the Ministry of Education. Similarly, Karen said she feels she derives her sense of
direction and preparedness from her work and expertise as a guidance counsellor, rather than
from institutional support, and said that she did consider this an issue: “But I do think that more
general support, I'm hearing on the public side, is absolutely required, and on the independent
school side as well.” While Samantha and Karen both stated that she had gotten the sense over
the past few years that student mental health is moving up the priority list in the field of
Education, but that this shift in priorities is insufficient. Of the shift, Samantha said the
following:

[Mental health] certainly is [a priority] in the public school board because you can see it
as a mandate. But I still believe it's just—it's been put out there, so it's a buzz word right
now. But there's nothing to support it enough yet, so people don't know actually how to
do it. You know, yeah, it's a priority, but what do we do with that priority?

Samantha asserted that one of the main reasons schools are struggling to even start developing
strategies aimed at promoting student mental health is the absence of an appropriate foundation
upon which to build mental health initiatives and programs. She suggested that as a result of
lacking adequate curricular resources, many schools lack the culture necessary for mental health initiatives and curricula to take hold and flourish.

However, while all three interviewees expressed concern over inadequate support from the school, ministry, and government, they spoke more of inadequate direction rather than a lack of resources being an obstacle to implementing strategies with the goal of promoting student mental health. Samantha and Elizabeth said that they felt burdened by the recent and sudden increase in information being presented to them and the lack of information regarding how exactly the information should be used. Samantha said that “there’s almost too much coming in, now,” and that the ministry should now focus on streamlining and formalizing specific strategies intended to promote student mental health:

So many situations now that have stemmed from kids suffering from mental health issues, and mental illnesses, or just fears and insecurities. Just so many issues have come up. So, I think we need to be told—we need to be told how to do this. But I think it's still a big mystery. No one has figured that out yet. And it's because it's so complex and involves so much.

In response to the question, “do you feel that, overall, public schools adequately address mental health issues and equip students with the skills to avoid, manage, and overcome mental illness,” Karen replied: “And that again is largely dependent on the board you're in, the administration you have, the guidance department you have, the population of students. So, I think it's too varied. I think it needs to be more streamlined across the country.” Karen also complained about the lack of formalized protocol for teachers with regards to responding to students’ mental health questions and concerns raised in the classroom. The consensus among the interviewees thus was that the lack of focused, streamlined curricular document and formalized, specific
implementation directions from the ministry serve as an obstacle to the development and implementation of strategies aimed to promote mental health among students.

**Structural Constraints**

Structural constraints faced by teachers were cited by all interviewees as obstacles to the implementation of strategies aimed at promoting student mental health. Factors such as lack of time, rigid and expansive curricula, large class sizes, and surplus of teacher obligations were mentioned. Samantha explained the significance of structural limitations in the following way:

> That's the difficult thing with teaching it. It's that you're really tied to a tight curriculum, tight timeline, and I always feel class dynamic is one of the biggest things that– classes of 28 to 30 kids–it's too big, too big to really touch on issues that really need some deep conversations and to have everybody be fully engaged and to be fully listening–to have that empathetic quality too coming in [. . .] So, absolutely, it's critical, but I don't think the nature of how we teach and the structure of it is really the best model of delivery for this. And that's always a key issue.

Karen also admitted that, while she believed that mental health promotion should be a focus for all staff members, she could understand that the addition of new teacher responsibilities might be “daunting” for many, including herself: “You know, you're looking to teach the curriculum, you're planning, you're marking, you're doing classroom management, your days are full, the speed in schools are fast. It feels like maybe an add-on.” Elizabeth also stressed that this attitude was likely to be particularly common at highly academically-oriented, competitive, fast-paced schools like Devane, where teachers were sometimes reluctant to let her take class time to teach the guidance curriculum because they felt they and their students could not afford to surrender
time that could be used to teach academic material and prepare students for assignments and exams.

The implications of these findings, as well as their relationship to existing literature on mental health and school-based initiatives, will be discussed in further detail in the following chapter.
Chapter 5: ANALYSIS AND DISCUSSION

Introduction

I began my research after having had personal struggles with mental health, and having observed those of my friends, colleagues, and students. Having suffered firsthand from the stigma attached to mental illness and help-seeking in a school wherein mental health literacy received almost no attention from staff or students, and wherein few school-wide, systematic efforts were made to promote student mental health, I wanted to conduct a study that would help educators like myself learn more about school-based mental health initiatives. In light of the fact that the number of Canadian youth with mental health issues already significantly outnumbers available supports in all regions of Canada, and that the number of people requiring treatment is expected to grow by 50% within the next 5 years (Flett & Hewitt, 2013), I believe that the government and educational sector have the moral obligation to take all feasible measures to ensure that students are actively provided with knowledge and skills to avoid, manage, and vanquish mental health difficulties. Accordingly, the purpose of this study was to determine what strategies are being implemented at secondary schools in Southwestern Ontario with the aim of promoting student mental health, as well as to identify what educators view to be the most significant obstacles to the successful implementation of these strategies. In discussing the findings of this study, this chapter will look at the ways in which the acquired data relates to current literature on adolescent mental health, mental health initiatives, and school-based mental health promotion strategies. The chapter will also discuss the implications and limitations of this research, as well as offer recommendations for further study.
Findings in Relation to Current Literature

*Addressing Mental Health in Terms of Disability, Ability, and Stigma*

Although specific theoretical frameworks are not always explicitly cited, or even consciously acknowledged, by individuals involved in the development, implementation, or analysis of strategies aimed at promoting mental health among a given population, any kind of engagement with the topic of mental health is invariably shaped by the individual’s underlying assumptions about the concept of ability and disability. In the case of Karen, Samantha, and Elizabeth, their understanding of, and involvement with, the strategies being used at their respective schools with the goal of promoting student mental health have been influenced by their conceptions of mental health and mental illness. These educators’ responses to the interview questions suggested that the purpose of the strategies being implemented at their schools was not to promote mental health by fixing students, but to accommodate students’ needs by modifying social and academic expectations, and providing them with additional resources to meet existing expectations. Their words thus pointed to an underlying assumption that mental illness often becomes a disability because of the social norms with which an individual is faced, and that the need may be to adjust the norms to enable these individuals to succeed, rather than alter the individuals to make them fit the norms.

For instance, although she did use the term “mental disabilities” during the interview, when I asked Elizabeth to share her own definition of mental illness with me, she responded, “You know, I've never really thought about what my definition of mental illness is because I try really hard not to try to think of it as disabilities, and things that are negative and wrong.” Elizabeth does not--or at least consciously tries not to--frame mental illness as inherently
disabling. Accordingly, Elizabeth indicated that one of her goals in developing and implementing strategies aimed at promoting student mental health is to normalize having, and speaking about, mental health issues because social stigma itself is disabling. Indeed, research has suggested that social stigma can aggravate mental health issues, and that a sense of humiliation and self-consciousness, rather than a failure to recognize symptoms of mental illness, most often prevents an individual with mental illness from seeking help, or even telling someone about their mental health challenges, potentially exacerbating the condition even further (Hartman et al., 2013). Stigmatizing attitudes and negative stereotypes of individuals with mental health concerns are, in turn, thought to lead to discrimination (Crisp et al., 2000). For instance, as referenced earlier, a study by Wahl et al. (2012) found that, while 1 in 4 teenagers said that they would find it embarrassing to have a mental illness, 1 in 3 students indicated unwillingness to work on a class project with a classmate with a mental illness. If a student became unable to take an active part in social and academic activities because of their perceived or real mental health status, as in this scenario, the social stigma and resulting discrimination experienced by the student would indeed have played a role in disabling them.

However, although Karen, Samantha, and Elizabeth did focus on the social aspect of disability, they also revealed their belief that there is often a biological or medical component to mental health issues, and that, depending on their location on the spectrum of mental health, certain individuals do require medical and psychiatric intervention to address more severe problems. As Karen phrased it, “[…] you might have a genetic predisposition to mental illness, and your environment can incrementally impact how that mental illness plays out in your life.” In some cases, the disability faced by a student with mental health issues can be diminished or reduced through the use of accommodations like a modified curriculum. However, as Karen
pointed out, in certain cases, the degree of necessary accommodation may simply be too great to grant without compromising the integrity of a school’s established system of values and norms.

This mindset, which is also shared by Karen and Samantha, aligns with the biopsychosocial model of disability, which combines elements of the social and medical models of disability, asserting that illness and disease are the products of biological, psychological, and social factors (Peterson, 2005). The model suggests that mental illness functions as a disability as the result of a complex interplay between biological predispositions and deviations, as well as social systems and psychological factors. The holistic nature of the strategies being implemented at their schools with the goal of promoting student mental health appears to be in accord with this paradigm, as well. Devane’s Phys. Ed. mental health units, and the Guidance curricula employed at both schools, teach students about the biological and psychological basis of mental illness, while, in collaboration with co-curricular events, also addressing and attempting to alter social norms. The participants’ engagement in vigilance and accommodation also demonstrate a commitment to adapting social norms and reducing stigma in an effort to diminish disability.

In their involvement with the school-based strategies, Karen, Samantha, and Elizabeth are therefore guided by attitudes and beliefs that oppose ableism, defined in the literature as a “network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical, and therefore essential and fully human” (Campbell, 2009, p. 5). By focusing on arbitrary normative standards, ableism casts disability “as a diminished state of being human,” Campbell (2009, p. 5) points out. By grounding the development and implementation of strategies aimed at promoting student mental health in the idea that everyone exists on a “spectrum in mental health,” as Karen put it— that is, that everyone is susceptible to mental health difficulties and everyone needs to devote attention
to their mental well-being—Devane and Applewood are actually engaged in counteracting ableism, mentalism, and sanism. While theories of disability may not have explicitly guided the employment of the strategies, they must nonetheless be viewed as being in dialogue with one another.

_Mental Health Literacy in Schools_

The strategies being implemented at Devane and Applewood with the aim of promoting student mental health—curricular and co-curricular integration of mental health education, professional development, and teacher vigilance and accommodation—overall align with recent findings suggesting that mental health initiatives more effectively reduce stigma by focusing on education and contact, rather than protest (Hartman et al., 2013). Research has revealed that the protest approach to promoting mental health, which involves reducing stigma by taking punitive measures against those who engage in discriminatory behaviour, can actually precipitate an increase in prejudice against the stigmatized group (Corrigan et al., 2012). Providing people with factual information that challenges or disproves myths concerning mental illness has been found to decrease stigmatizing attitudes more effectively (Faulkner et al., 2010; Hartman et al., 2013). Devane and Applewood’s development and implementation of integrated and stand-alone curricula on mental health focus specifically on providing students with such knowledge. Devane’s Guidance curriculum and Phys. Ed. mental health units devote particular attention to teaching students about the biological and psychological aspect of mental health.

Samantha, Karen, and Elizabeth’s claims that the implementation of curricular and co-curricular integration of mental health literacy have contributed to reducing stigma among students at their schools are consistent with findings obtained in previous studies on school-
based mental health programs, such as those conducted by Pinfold and colleagues (2003; 2005). Indeed, Pinfold and colleagues’ (2003; 2005) discovery that even short video- and leaflet-based educational workshops are capable of producing a significant effect on students’ attitudes toward mental illness suggests that Devane and Applewood’s more holistic, systematic, and sustained strategies of increasing student mental health literacy could be highly effective in promoting student mental health.

Similarly, the decrease in stigma and increase in help-seeking among students and staff observed by Samantha and Elizabeth, and perceived to be the result of staff members publicly sharing their personal struggles with stigma and mental health issues, also align with existing literature on the relationship between contact and stigmatizing attitudes (Corrigan & O’Shaughnessy, 2007; Couture & Penn, 2003; Rickwood et al., 2004). Previous research has found contact with individuals who have had mental health difficulties, especially those who have received mental health services, to be the most effective proactive strategy for dissipating stigma attached to mental health (Corrigan & O’Shaughnessy, 2007; Couture & Penn, 2003). The inclusion of contact in school-based mental health initiatives indeed appears to be a promising strategy for the promotion of student mental health, as Elizabeth and Samantha’s observations suggest. National and international studies of brief school-based educational workshops have shown that the inclusion of contact in mental health workshops has been found to increase the effectiveness of mental health education, to better foster mental health literacy, and to bring about more lasting positive changes to beliefs about mental health (Pinfold et al., 2003; Pinfold et al., 2005). Furthermore, both Devane and Applewood’s prioritization of education over contact in strategies aimed at students, as well as professional development events for staff, is supported by existing research (Corrigan et al., 2012). For, recent findings
suggest that, while contact tends to be more effective than education at reducing stigmatizing attitudes among adults, the reverse pattern tends to emerge among adolescents, presumably due to the fact that adolescents’ beliefs about mental illness are not as firmly developed as those of adults and, as a result, adolescents are more likely to be responsive to education (Corrigan et al., 2012). That said, due to the limitations of this study, the anecdotal data provided by the participants cannot be used to establish causality or draw valid, reliable, and generalizable conclusions regarding school-based mental health strategies aimed at promoting student mental health. The limitations of the study, as well as the perceived effectiveness of the identified strategies, will be discussed in further detail later in the chapter.

Obstacles to Promoting Student Mental Health

In addition to identifying and examining some of the strategies being employed in secondary schools in Southwestern Ontario with the goal of promoting student mental health, I sought to learn about what educators view as obstacles to the successful implementation of these strategies. Research on student mental health and school-based mental health initiatives has tended to focus on the role of mental health as a barrier to student learning and well-being and on school-based mental health initiatives as a tool for dismantling this obstacle, rather than on the hurdles faced by educators involved in developing and implementing school-based mental health programs (Lean & Colucci, 2010). The data collected from my interviews with Karen, Samantha, and Elizabeth sheds light on the latter, particularly in their citation of stigma and ignorance among staff as an obstacle to strategy implementation. Although some research has examined teachers’ perceptions of students’ mental health needs and the role of the teacher in addressing them (Kamphaus et al., 2011), as well as stigma among students (Wahl et al., 2012), there is a
glaring absence of literature on stigmatizing attitudes held by educators toward individuals with mental health concerns, and mental health services. However, Samantha went so far as to say that ignorance and stigma among staff have served as the most significant barrier to implementation of school-based strategies aimed at promoting student mental health. As she pointed out, there are educators who regard such strategies as “fluff,” and do not view the mental health of all students as a priority. Indeed, Elizabeth mentioned that, even though her school’s administration team informed all staff members that Guidance-run mental health workshops were now a formal, compulsory component of the curriculum for all students, several teachers did not allow Elizabeth and her colleagues to run the workshop in their classroom. On another occasion, as Samantha explained, a teacher who was uneducated in matters regarding mental health, and held a stigmatizing attitude toward mental illness, delivered the new curriculum in such an insensitive way that a student complained to the vice principal about how ignored and disrespected he had felt during the lesson.

However, as Samantha and Karen pointed out, although ignorance among staff can create a barrier to the implementing strategies aimed at promoting student health by contributing to the development of stigma, a lack of mental health literacy among educators can also generate fear of unintentionally harming a student by teaching the material poorly. Karen explained that teachers may choose to avoid involvement in mental health initiatives because their lack of knowledge in matters of mental health causes them to doubt their ability to successfully implement strategies aimed at promoting student mental health. Recent research by Kamphaus et al. (2011) obtained similar findings, revealing that teachers frequently cited lack of knowledge and preparation as a significant barrier to meeting students’ mental health needs. This barrier to
strategy implementation is connected to another obstacle mentioned by all three participants: inadequate resources and direction.

Despite a growing concern for the mental well-being of youth in the educational sector and the rapidly expanding body of literature on school-based mental health initiatives, in alignment with Wei et al.’s (2013) findings, all three participants spoke of a lack of specific guidelines and clear models for schools to follow when developing and executing plans aimed at promoting student mental health. While the participants stated that they were being provided with copious amounts of relevant information, they had difficulty establishing criteria through which to filter incoming resources. Thus, the participants mentioned feeling overwhelmed by the abundance of resources being made available by various government and educational organizations. Ultimately, it seems, in light of the want of clear implementation guidelines and models, educators’ efforts to develop their mental health literacy may actually be undermined by the wealth and diversity of the information at their disposal. These findings align with those of researchers like Lindley (2012), who has asserted that “there has been a tendency to overlook the importance of the pedagogical structure of anti-stigma education” (p. 78). Of course, the issue that arises out of these circumstances is that schools are developing and implementing poorly-guided strategies aimed at promoting student mental health only to serve as sources of data that is too confounded to provide researchers and policy makers with the means to develop the clear implementation guidelines that these schools require.

**Implications for Pedagogical Practice**

While the data I collected can be used neither to draw any definitive conclusions regarding the most effective strategies for promoting student mental health, nor to develop clear
and empirically supported guidelines for implementation, it nonetheless revealed a variety of possible strategies educators can use with the goal of promoting student mental health. Moreover, my participants offered an abundance of anecdotal examples to illustrate the apparent success of these strategies that largely aligns with existing literature on mental health and methods for fostering mental well-being. My findings, therefore, suggest that students and staff may benefit from curricular and co-curricular integration of mental health education through the development and implementation of workshops, displays, panel discussions, assembly presentations, and assignments focusing on topics pertaining to mental health. Current literature on the subject suggests that schools are more likely to be successful in promoting student mental health through the use of strategies that provide students with factual information on mental health topics that dispel common misconceptions, as well as with contact with individuals who have struggled with mental health, rather than reprimanding students who demonstrate prejudice or merely pointing out the injustice of prejudice and discrimination against people with mental illness (Hartman et al., 2013).

Notably, data obtained by the present study implicates stigma and ignorance among educators, a poorly researched subject, as a potential, and significant, obstacle to successfully implementing strategies aimed at promoting student mental health. Consistent with current research on mental health literacy among teachers, Samantha, Karen, and Elizabeth reported a lack of relevant knowledge and preparedness as a potential barrier to implementing school-based health initiatives and addressing students’ mental health needs (Kamphaus et al., 2011). The anecdotes shared by my participants suggest that engaging staff members in professional development activities focused on mental health literacy may effectively contribute to overcoming this implementation hurdle. However, Karen and Samantha both stressed the need
for delivering mental health education not only to professionals in the field, but also to pre-service teachers. Karen summed up her view on the matter as follows:

From the teacher’s side, as an educator, I think that when a teacher is being trained as you are in the process of being trained to be a teacher, I think there needs to be more focus and attention on better understanding how mental health looks-- first of all, what does it look like in the classroom? And what do you do about it? Because guidance counselors are understaffed across schools, we are not medical professionals, we, like teachers, have similar training--yes, a little bit different, but we're still not counselors either. So, we have to come together and get more professional development, and I think it needs to start on the university side, and then work its way into schools.

As Karen and Samantha implied, a bigger focus on mental health literacy in teacher education and professional development would likely contribute to reducing stigmatizing attitudes among educators, as well as fear of incorrectly implementing strategies aimed at promoting student mental health or simply broaching the topic, thereby diminishing a perceived obstacle to the execution of such strategies.

In alignment with current research, the present study also suggests that, in addition to more mental health training, educators are in need of more detailed, streamlined, and reliable models of strategy development and implementation. While Samantha expressed enthusiasm over Devane’s recent efforts to streamline the strategies being developed and implemented with the goal of promoting student mental health, Karen repeatedly asserted that Canadian schools require more particular and consistent direction:

And are schools approaching [student mental health] in different ways? They are. And that again is largely dependent on the board you're in, the administration you have, the
Guidance department you have, the population of students. So, I think it's too varied. I think it needs to be more streamlined across the country.

Similarly, Samantha explained that “[…] even the people, who are on board, and want to do this—they still need some direction and streamlining!” Like Karen and Elizabeth, she noted, “I just think, in coming from so many different areas, like I said, we've got to find that common thread that's going to allow us to go somewhere else with it—the next step.” Karen and Elizabeth suggested that the “next step” requires more support from the government, and the Ministry of Education’s help in formalizing school-based mental health initiatives across Canada.

According to Samantha, one the primary needs for streamlining and greater direction has to do with educators’ struggles with addressing student mental health needs in a cohesive and sustained way, particularly by providing “follow-up.” “And if you do it as a one-off, which would basically a 5-day lesson, you better have follow-up, you better have something else going on, because it just gets lost. It gets lost in the momentum of everything else going on. And then it loses its function.” Moreover, data obtained from interviews with Karen, Samantha, and Elizabeth suggests that there is a need for models of mental health promotion strategies that provide guidelines for scaffolded strategy implementation that address explicit strategies aimed at promoting student mental health, such as curricular and co-curricular mental health integration, as well as implicit strategies to be used in laying the necessary cultural foundation. Recalling the changes she had witnessed in the social culture at Devane Academy, Samantha explained this need in the following way:

[…] just to come into a school when you haven't done anything like that and throw in mental health, you haven't created the culture. You haven't created the foundation to let it grow. And that's—that's a danger! And I think that's why a lot of schools—I think that's
why a lot of schools struggle to even know how to start this. If you’ve got nothing else to allow it to settle in and grow, then it's very hard.

Accordingly, Samantha, like Elizabeth and Karen, has suggested that fostering compassion, kindness, and community through vigilance and accommodation is absolutely necessary for the sustained and effective promotion of student mental health. Furthermore, all participants perceived a causal link between teacher engagement in vigilance and accommodation, and a positive shift in school culture, including a decrease in stigma among students and an increase in openness to discuss, and seek help for, mental health struggles.

Thus, the findings presented in this paper have several implications for Canada’s educational sector. Despite the research’s case study methodology, which limits the validity, reliability, and generalizability of the findings, the themes discussed in this paper nonetheless provide valuable insights into the ways in which schools and individual educators have taken on the moral responsibility of prioritizing student mental health. The strategies being implemented at Devane and Applewood with the goal of promoting student mental health contribute to the growing pool of resources for educators interested in learning about, or engaging in, the development and implementation thereof. The present study has also illuminated a need for changes in teacher education programs and professional development, as well as government and ministerial support in streamlining and formalizing models and guidelines for implementing strategies aimed at promoting student mental health across the country. Finally, this paper serves as a guide to the potential obstacles educators may face in attempting to promote mental well-being among students.
Research Limitations and Directions for Further Research

While the data I collected over the course of this study did enable me to answer my research question by revealing strategies being used in independent secondary schools with the goal of promoting student mental health in Ontario, as well as some of the perceived obstacles to implementing these strategies, I could not adequately assess the effectiveness of the methods I examined. Indeed my research questions focus on strategies with the aim or goal of promoting student mental health, rather than strategies that do promote mental health among students because the task of proving or disproving their effectiveness is an impossible one. I did, however, pose questions regarding strategy effectiveness to the participants in order to gain an understanding of the criteria they may be using to measure the success of their attempts to promote student mental health, as well as to learn more about their motivation for choosing to continue in their efforts. All three participants admitted to having trouble assessing the effectiveness of the strategies being used to promote mental health among students at their respective schools. When asked whether she feels Devane’s efforts to increase mental health literacy among students have been successful, Elizabeth responded as follows:

I think it's too early to know because for us, this sort of goal shift to talking more about mental illness, with Bell Let's Talk Day, with the curriculum, our Guidance program, it's still new. So, I don't know if it's helping. I hope it's helping, and if it helps one student, I think it's helping [laughs]. And I do think I've seen enough tangible examples of even, you know, one student coming forward after a presentation of someone talking about their mental illness – that to me is success. We're talking about it. So, I think it's positive. I don't have exact, sort of, numbers on that.
Elizabeth thus suggested that the only data on which she could rely at this point is anecdotal in nature.

As Karen pointed out in her interview, this kind of reliance on anecdotal evidence of success and the inability to acquire what she termed “hard data”—presumably meaning quantifiable measurements of strategy effectiveness—could pose a threat to the development and implementation of strategies aimed at promoting student mental health:

I mean success is interesting. And I think this is the struggle for a lot of schools because whenever you – you know, I don't want to paint with too broad a brush— but often, when you start a new initiative, you want to see what's your matrix for success, right? The principal wants to know, how valuable is this? So, success, I feel like, with mental health is a challenge. How do I know if what I just laid out to you– how do I know if that was successful? I don't have a number. I don't have– you know, "58 people identified themselves as anxious in September, and by June we had that number down to 40." I don't have that number.

As Karen suggested, getting the desired level of support from a school’s administration team may be difficult if the value of the proposed initiatives cannot be adequately demonstrated.

Indeed, even if Karen did have records indicating the number of students who struggled with mental health issues at the start of the academic year, and the number of students who did so at the end of the academic year, they would do little to validate or invalidate the school’s efforts to promote student mental health. As Elizabeth pointed out during her interview, it may simply be “too early” to draw conclusions based on obtained data. The strategies being implemented are still being developed, improved, and streamlined. Moreover, many of the strategies discussed in the interviews and presented here have been applied at the participants’
respective schools for only a year. If, for instance, one of Devane’s strategies aimed at promoting student mental health is to provide students with a mental health curriculum at each grade level, attempting to measure the success of the strategy after a year may be fruitless. For, the strategy entails providing each grade with mental health units that build on previously learned curricula. As such, data obtained one or two years after the curriculum was first implemented would not provide a holistic overview of its effectiveness.

Furthermore, the kind of data discussed by Karen may be misleading as well. For example, an influx of students seeking mental health resources from Student Services may be an indicator that the school’s efforts have been successful, just as it may be an indicator that the school’s efforts have been unsuccessful. On one hand, in this hypothetical scenario, the strategies implemented by the school could have reduced stigma attached to mental illness and help-seeking, thereby making students with existing mental health concerns feel more comfortable approaching Guidance for support. On the other hand, there remains the chance, however improbable, that the implementation actually aggravated existing mental health issues, or contributed to the development of new ones, among students. Indeed, recent findings suggest that mental health is, to a degree, contagious. Controlling for a wide range of factors, studies have found that changes over time in depression and happiness are strongly correlated within social networks (Rosenquist et al., 2011; Fowler and Christakis, 2008). Likewise, self-destructive behaviours, like suicide, have also been found to be contagious, with research suggesting time and time again that media coverage of suicide can lead to imitative behaviour (Gould, Jamieson, & Romer, 2003; Pirkis, Burgess, Francis, Blood, & Jolley, 2006). Findings on the apparent link between media and imitative suicide have led to the development of specific media guidelines, including avoiding sensationalism and glorification of suicide, as well as abstaining from
disclosure of details pertaining to the methods used to commit the act (Pirkis, et al., 2006).

However, there is a profound lack of research evaluating the effect that these guidelines have had on media professionals, let alone suicide rates (Pirkis, et al., 2006). Accordingly, no definitive conclusions can be made as to which factors may be at the root of the correlation between media coverage and imitative behaviours.

The research has implications for school-based mental health initiatives because it highlights the complexity of developing and implementing such programs by shedding light on the potential risks of doing so. By raising topics pertaining to mental illness and encouraging conversation among students and staff, educators at the helm of mental health programs may risk contributing to the kind of contagion effects found in recent research on mental health, even if they adhere to guidelines like those set for the media when delivering content on mental health. In fact, this particular risk remained a significant concern for Karen:

I think it's a struggle and a wrestle because, you know, there's been research out that talks about, you know, "If you talk a lot about eating disorders, do you get a lot of copycat people taking, you know, the stories of people, wanting to, you know—"and, you know, I've asked about that with mental health, with some of the professionals we've worked with, and it seems early—I mean, I've mostly been hearing, "No, that's not the case," but I think in the case of cutting, or things like that, it can cause a school to feel a bit nervous about, "If we really come out, and talk about this, do we have enough support for, you know, a thousand students to really know we're ok to do that?" What's the follow-up? Karen went on to explain that she had not only considered potential risks, but sought to learn more about them by asking a social worker about the chance of inciting imitative self-destructive behaviours, and by conducting her own research. However, despite uncovering little information
to suggest the involvement of serious risk, Karen remained concerned about the possibility of the school’s strategies backfiring, or at the very least, leading to unanticipated, and potentially problematic, consequences, such as an increase in students needing and seeking support resources that the school would be unable to support due to understaffing and a lack of resources among other possible reasons.

Additional risks faced by those involved in the strategies being implemented at Devane and Applewood are attached to the use of education and contact with the goal of promoting student mental health. While the interviewed educators perceived a causal link between providing students with education about mental health as well as contact with persons who have struggled with mental health, and an increase in students’ openness to speak about, and seek support for, mental health problems, their assumptions regarding causality are only partially supported by the literature (Corrigan & Shapiro, 2010). Although Corrigan and Shapiro’s (2010) findings have suggested that education and contact have a positive effect on stigmatizing attitudes, and that these approaches to stigma reduction are more effective than protest, they also revealed a potential risk of rebound effects. For instance, the study found that when educational programs presented mental illness as a brain disorder, they had both negative and positive effects on stigmatizing attitudes because they made students more likely to believe that individuals with mental illness are unresponsive to treatment and unable to overcome their difficulties because the condition is hardwired in their system (Corrigan & Shapiro, 2010). Similarly, contact can have an adverse effect on stigmatizing attitudes. As suggested by Corrigan and Shapiro (2010), in order for contact to be an effective form of stigma reduction, it must occur within particular circumstances. Specifically, contact must be made between people of relatively equal status, who possess common interests and goals, and are engaged in a rewarding activity (Corrigan &
Shapiro, 2010). Based on these findings, by sharing their personal mental health struggles with students, as was done at Devane Academy, school staff members may actually contribute to an increase in stigma among students because the individuals involved—students and educators—are not of equal status.

However, yet again, if the use of contact and education did backfire and negatively impact student mental health, educators would be unable to determine with great certainty which factors may produce, or prevent, such consequences. Strategies that are effective in promoting student mental health should not, in theory and practice, instigate harmful imitative behaviours among students, or contribute to the spread of mental health issues. At the very least, they should counteract the spread of mental illness and harmful imitation. However, members of staff would not be able to establish causal links between the implementation of particular strategies and observed changes in the students. In fact, one would have to consider the possibility that the strategies had no effect on student mental health, and that any seeming effects were precipitated by other factors.

Likewise, positive changes in the psycho-emotional well-being of a student observed by educators and members of the Guidance department could be attributed to the work of skilled counselors, medication, or a supportive social circle among countless other factors, not merely to the implementation of school-based mental health initiatives. The effects of individual strategies could not be separated from one another either because they simply could not be measured individually. The optional nature of most professional development sessions on mental health, and all extra-curricular events aimed to promote student mental health at Devane and Applewood, adds an additional barrier to conducting a fruitful analysis of the data. Moreover, as Wei et al. (2013) have pointed out in their review of studies on school-based mental health initiatives, a
lack of randomization, control for confounding factors, validated measures and report on attrition, among other methodological errors, would render any attempt to conduct a meta-analysis to synthesize the study results, establish causality, and evaluate strategy effectiveness not merely challenging, but impossible.

Furthermore, in order to measure the effect of a strategy’s design and implementation, a researcher would need to analyze data obtained not only after, but also before, implementation occurred. However, like Devane and Applewood, schools tend to develop and execute mental health programs without first collecting extensive, reliable data that could later be compared to data acquired after implementation. Of course, as mentioned, the threat of confounds would have to be minimized by controlling for a wide spectrum of factors, including each student’s age, cultural background, mental health history, and medical history. An appropriately randomized control sample would also help validate measures. As none of these precautions were taken by the parties involved in the present study, I cannot use the collected data and uncovered themes to draw any causal links between the strategies discussed and the anecdotal observations shared by my participants. Nor can I present findings that are generalizable.

Nonetheless, the perceived effects of implementing the strategies discussed in this paper, as stated by my participants, should not be entirely discounted. The impossibility of establishing a causal link between a process and a potential outcome can coexist with the possibility that the link is present. While studies like this one may not be able to prove that strategies like the ones outlined in this paper are truly fulfilling their goals, they likewise cannot prove the opposite. My participants, in particular, acknowledge that the design and implementation of the strategies used at their respective schools with the aim of promoting student mental health are not flawless and that they cannot be entirely sure of their success at this point in time. However, they all
expressed the belief that the advantages of developing and implementing these strategies outweigh the disadvantages of doing so. Elizabeth said that she saw “zero” disadvantages to the process, explaining her stance on school-based mental health initiatives as follows:

Mental health is out there. Mental illness is out there. You know, a lot of kids don’t need to suffer in silence. So, you know, there are absolutely zero negative things that—like, there’s nothing bad that can come of it. The only thing that can come out of it is that more kids are talking about it. And hopefully we help them. And even if in one case they start talking about something, and it's painful for them, it's still—they're reaching out for help, right? Teachers are getting educated, and the teachers educate themselves, and then they can take it into their own lives. You know, we're coming together as a community. Mental illness is something that needs to be talked about. Just like homosexuality needed to be talked about. Just like racism needs to be talked about, you know? It's all about just conversations, and making it *totally* normalized. And the only way we can do that is if we integrate it into our school, and sort of have, like, this cloud that's just sort of there. It has to be something that's just as casual as, "Oh, I'm going to English class, oh I'm going to go to that mental health workshop; oh, I'm not good at math, oh, I'm feeling a little stressed."

When asked about the risk of inciting harmful copycat behaviour, Elizabeth said she felt that such risks could not be avoided, and that they were outweighed by the advantages of making mental health a topic in education and a subject of conversation among students and teachers. In response to my question, Elizabeth made the point that students who would be compelled to engage in imitative behaviours would likely have underlying mental health issues. She suggested
that such students would therefore still benefit from the initiatives because they would be more likely to be identified and supported by the school’s Guidance Counselors.

Like Karen and Samantha, Elizabeth justified her faith in her school’s efforts to promote student mental health with anecdotal observations of changes in her school’s culture. When asked whether she felt Devane’s efforts to promote mental health literacy among students have been successful, Elizabeth recalled her experiences as a Guidance Counselor:

So, the success I see is that the kids come in here to talk about things, whereas they wouldn't do that before. Because there's a stigma—there was a stigma—even walking through this door, there was a stigma. It meant, “Oh god, what's wrong with them? They're crying about something.” Now, kids just kind of walk in, and they make appointments—and whether it be anxiety or just wanting to reach a goal, or whatever. They're coming in and they're not ashamed. They're not as ashamed as I've seen them in the past, or, like, not wanting to talk about anything. They're more open in the Guidance classes, I find, putting up their hands, saying “Oh, my family has this,” or, “Oh, this is in my family.” So, just form what I've witnessed, there's been a shift in the school, I think, even within the year.

Samantha also spoke to the idea of stigma, revealing that when she first began her career at Devane almost a decade ago, she developed the sense that students at the school believed “that it’s a weakness in character if you give up anything about you feeling vulnerable.” Now, however, students approach her more often to share their personal concerns and expose their vulnerability. Samantha said that even the way students and staff members pass each other in the halls has changed, with the rate at which people make eye contact, smile, and greet one another having increased dramatically in recent years. She also shared a more striking example of what
she interpreted as an indicator of the strategies’ effectiveness, recalling the effect that curricular integration of mental health education appeared to have on one of her pupils:

I had in my grade 9 mental health curriculum–there was a kid who wanted to be a doctor, and he said, “you know, I never understood why you had to talk about all this mental health stuff and why doctors had to learn all this.” And then we went through the unit, and at the end of this, he said, “I understand now.” And I thought, these kids are going to be in leadership roles, they're going to be dealing with a lot of people, so if we could get that info to them so that they do get it, that's going to change the world!

The study participants measured strategy success using anecdotal examples that pertained not only to students, but to educators as well. All three participants noted changes in the staff members’ openness to sharing their own experiences with mental health issues, and to learning more about mental health and school-based initiatives. Karen, Elizabeth, and Samantha all spoke about a growing interest in topics pertaining to mental health among the staff at their respective schools, and said that, over the past few years, educators more frequently pose questions regarding mental health at staff meetings.

All three research participants also framed administrative support as a predictor, as well as an indicator, of success. Nonetheless, while the participants did use this as a measure of success, a causal link, yet again, cannot be drawn between the implementation of the strategies and the school administration’s growing support for the implementation of mental health initiatives, as other factors may underlie the correlation. Still, the interviews I conducted for this study provided me with multiple anecdotal examples of teachers acting, at least partially, in response to the implementation of strategies aimed at promoting student mental health. For instance, after a staff member at Devane came out as gay at an assembly in order to promote a
Day of Pink event focusing on issues connected to mental health, she was approached not only by students who self-identified as LGBTQ, yet had felt too stigmatized to come out to anyone, but also by a colleague whom the assembly had inspired to share her mental health experiences with the rest of the school in hopes of further de-stigmatizing mental illness. On a different occasion, Samantha was approached by a colleague whose attitudes toward mental health initiatives appear to have changed partly because of the Devane Academy’s efforts to promote student mental health. She explained that some of her older colleagues in the Phys. Ed. department referred to the clubs that aimed to promote student mental health as “fluff,” and recalled the moment when she began to see a change in their views:

And then I did a presentation with staff at the June meeting on just what we've done through [the clubs] and that. And when I got back to the office, my office mate, said to me, “This is the future.” He says, “I can see this as the future.” And it's like those moments, those moments when they're finally open to it and then you can start having those dialogues, you know? And that's where growth happens because, you know, when you start talking about it, engaging it with your own life, then [mental health education] more naturally flows out of you and your teaching.

Ultimately, all three participants used connectedness, supportiveness, and openness to learn and discuss topics pertaining to mental health among staff and students as key measures of effectiveness when asked to evaluate the strategies being implemented at their respective schools. Connectedness, supportiveness, and openness among staff and students have thus come to serve as emergent success criteria for the informal assessment of these strategies at both Devane and Applewood. However, while variations of these criteria may yield valuable results for future research, forthcoming studies should work towards developing a practical list of measures that
could be used by schools and researchers to guide strategy development and implementation, as well as to evaluate the effectiveness with which strategic goals are met. Additionally, in order to fill gaps in the existing research, more comprehensive studies must be conducted, ones that examine perspectives of educators, counselors, administrators, and students themselves.

The need for further research on school-based mental health promotion strategies is a dire one. With the number of school-aged Canadians struggling with mental health problems on the rise, student mental health is a subject that deserves everyone’s attention, and researchers and educators alike must make every effort to ensure that young Canadians are prepared as best as possible to avoid, manage, and overcome mental health challenges. The friend whom I mentioned in the first chapter of this paper still suffers from recurring mental health issues which he, like 70% of adults living with mental health problems, began to develop before reaching adulthood (Canadian Teachers’ Federation, 2012). His struggles continue to alienate him, and his stigmatizing attitude towards mental illness and mental health resources persistently hampers his recovery. Schools have an opportunity to equip individuals like my friend with skills and resources that can help them lead psychologically, emotionally, and socially healthier lives. However, without further study to help elucidate how best to use this opportunity, schools risk investing time and resources into initiatives that have no effect on student mental health, or, worse yet, raise stigma and contribute to the spread and development of mental illness among students. The conversation on mental health must be sustained, but mere discussion is not enough. An effort must be made to provide schools with the tools and direction necessary for the successful promotion of student mental health. To quote Samantha, we cannot afford to let our collective effort to promote students’ mental well-being get “lost in the momentum [until] it loses its function.”
REFERENCES


APPENDICES

Appendix A: Letter of Consent for Interview [printed on University of Toronto letterhead]

Informed Consent Form

Study Topic: Mental Health Education in Toronto Secondary Schools

Researcher: Lana Dubinsky, Master of Teaching candidate, OISE, U of T

Dear Participant,

You are invited to participate in a study that is being conducted by Lana Dubinsky, a Master of Teaching candidate at the Ontario Institute for Studies in Education, under the supervision of Dr. Elizabeth Campbell. Your participation is entirely voluntary. You may stop the study at any time and you have the right to refuse to answer any question without penalty. You may also request to look over the interview transcript to ensure accuracy or to ask that pieces of information be omitted. If you choose to withdraw from the study before its completion, all data obtained from your participation in the study will be deleted. If you choose not to have your data published upon the completion of the study, data obtained from your participation will be deleted and will not be used in the study, as long as the request is made prior to the presentation and/or publication of the findings.

The purpose of the study is to examine the extent to which mental health education is being integrated into the curriculum in private and public secondary schools, as well as the strategies being implemented to achieve curricular integration in an effort to raise mental health literacy among students. Your participation in the study will directly benefit the researcher and readers of the published paper by providing insights into school-based mental health education.

Additionally, in providing data for the present study, you will be aiding the researcher in completing a compulsory major research project for the Master of Teaching program at OISE.

Participation in the present study consists of one interview, lasting a maximum of one and a half hours at a place that is convenient for you. You may be asked to take part in a follow-up interview, lasting a maximum of forty-five minutes, again at a place that suits you. Compensation for public transit will be offered if required. Further consultation may be required via email or phone. Interviews will be recorded on an audio device and the researcher may take notes during the interview. The interviews will be fully transcribed. The data obtained from the interviews will be kept in a secure file and stored in a locked filing cabinet accessible only to the researcher and research supervisor. All data (i.e. recordings, notes, and transcripts) will be destroyed no later than 5 years after the researcher’s completion of the Master of Teaching program.

The findings obtained from this study will be published on a University of Toronto website (“T-Space”) and will also be presented to other OISE students at a research conference. The results
of this research may also be published in a scholarly publication and/or reported in a scientific presentation. Pseudonyms will be used for all names of people, schools, and boards. There is minimal risk for you as a participant. As you may be asked to discuss issues relating to mental illness, it is possible that you may experience emotional and/or psychological discomfort during your participation in the study. There are, however, no other foreseen risks.

Again, this is not a binding contract and you may withdraw from the study at any point. If you have any questions or concerns, the researcher will be happy to address them. If you are interested in receiving feedback about the study results, please contact the researcher. If you have questions about your rights as a research participant, or would like to speak with someone not directly involved in the study, please feel free to contact the Ethics Research Office. You will also be provided with a copy of this consent form, as well as the contact information of the researcher, research supervisor, and course instructor attached to this study.

Thank you for your participation!

By signing below you indicate that you have read the consent form and understand and agree with to the terms presented therein.

____________________  ____________________________  ______________________
Printed Name          Signature                     Date

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Appendix B: Interview Questions

*Note: Some questions have been omitted from this list, as responses to these questions were not analyzed due to irrelevance to the research question

1. To the extent of your knowledge, have you ever taught students with a mental illness?
   a. If so, please give 1 to 3 specific examples.
   b. If not, why do you think this might be?

2. What is your definition of mental illness?

For the purpose of this interview, mental illness will be defined as: “a range of disorders characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning.” Examples of mental illness include and bipolar disorder, anxiety disorders, schizophrenia, personality disorders, eating disorders, and substance dependency.

3. In your opinion, what should the school’s role be in teaching students about issues of mental health? Please explain your position.
   a. Do you believe that schools have a moral responsibility to educate students in matters of mental health?

4. How is student mental health prioritized in relation to other school/student concerns at your institution?

5. Are there any specific educational strategies being used to increase mental health literacy among your students? What are they and how are they being used?
   a. Please describe in detail 1 to 3 specific examples (i.e. assemblies, guest speakers, seminars, clubs, pamphlets, etc.).
   b. To what extent do you believe that these efforts have been successful? Why do you believe this? How do you measure success in this situation?
6. Has the school made an effort to integrate mental health education into the school curriculum?
   a. If so, how is this goal being achieved? How do you know this? How do you measure the school’s achievement in this area?
   b. To what extent do you believe that these efforts have been successful? Why do you believe this? How do you measure success in this situation?

7. What efforts have been, or are being, made to raise mental health literacy and awareness among staff?
   a. Please describe in detail 1 to 3 specific examples.
   b. To what extent do you believe that these efforts have been successful? Why do you believe this? How do you measure success in this situation?

8. Do you find that your knowledge of mental health issues informs your everyday pedagogical practices? To what extent?
   a. Please provide 1 to 3 specific, detailed examples.

9. Do you find that the methods being used to increase student mental health literacy have affected the prevalence of mental illness, as well as stigmatizing and help-seeking attitudes, among students?
   a. If so, please describe the effects you have observed.
   b. If not, please state your opinion as to why you have not noticed any impact.

10. Do you find that the methods being used to increase the staff’s mental health literacy have affected the prevalence of mental illness, as well as stigmatizing and help-seeking attitudes, among students?
    a. If so, please describe the effects you have observed.
b. If not, please state your opinion as to why you have not noticed any impact.

11. What are your views on the level, effectiveness, and adequacy of the support and guidance being provided to you by the school board with regards to implementing mental health education programs and integrating mental health literacy into the curricula at your school?

12. Do you believe that the voice and perspective of students with mental health issues is well-represented and listened to at the school level? At the board level?
   a. How do you know this? Please provide specific examples.

13. Did you, or do you, see evidence of school-based mental health education programs improving over time? If so, how is it improving?

14. Did you, or do you, see evidence of the school board’s implementation of school-based mental health education improving over time? If so, how is it improving?

15. Do you feel that, overall, public schools adequately address mental health issues and equip students with the skills to avoid, manage, and overcome mental illness?

16. How do you feel your school compares to other public and/or private schools with regards to addressing mental health issues and equipping students with the skills to avoid, manage, and overcome mental illness?

17. Have you observed or can you foresee any disadvantages to integrating mental health education into the school curricula? If so, please discuss them.
   a. Do you think that disadvantages such as those you just listed outweigh the benefits of integrating mental health education into the school curricula?
   b. Do you think that there may be ways to minimize or eliminate the disadvantages you have listed?
i. If so, please discuss the ways in which this could be done.

ii. If not, please explain why you feel this way.

18. Have you, or do you, face any obstacles in incorporating mental health education into the school curricula and/or implementing school-based mental health literacy programs? If so, please list them and explain how they have been, are being, or can be addressed.

19. What goals/ways, if any, do you have for finding out new ways to integrate mental health literacy into your school’s curricula?