Elementary Teachers’ Perspectives on Student Mental Health

By

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Abstract

Mental health problems and illnesses are extremely common among Canadian youth, and educators have an opportunity and responsibility to support students living with such challenges to the best of their abilities. This study used semi-structured interviews to explore two Ontarian teachers’ perspectives on student mental health. Teachers reported perceiving many impacts of mental health problems or illnesses in their students, including impaired academic performance and stigma, and they identified key barriers they felt limited their ability to support such students, including heightened workload, inadequate training, and ineffective relationships with parents. However, teachers also reported a range of strategies and supports they felt have helped them respond to the mental health needs of their students, including collaborating with appropriate support professionals. Additionally, teachers reported that improving their organizational abilities and lesson-planning in general has better-positioned them to support students with mental health problems or illnesses. These findings suggest that teachers may not feel that they are being adequately prepared in teacher education programs, or in their schools, to address the mental health needs of their students. Schools, school boards, administrators, and unions should provide, promote and support efforts to better prepare teachers in this regard.

Keywords: teachers, perspectives, experiences, student mental health
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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.0 Research Context and Problem</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Purpose of the Study</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Research Questions</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Reflexive Positioning</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Overview</td>
<td>6</td>
</tr>
<tr>
<td>Chapter 2: Literature Review</td>
<td>7</td>
</tr>
<tr>
<td>2.0 Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2.1 Mental Health Problems and Illnesses in Students</td>
<td>7</td>
</tr>
<tr>
<td>2.1.1 Academic impact</td>
<td>7</td>
</tr>
<tr>
<td>2.1.2 The effect of bullying on mental health</td>
<td>9</td>
</tr>
<tr>
<td>2.1.3 Stigma</td>
<td>9</td>
</tr>
<tr>
<td>2.2 School and Educator Preparedness for Mental Health</td>
<td>11</td>
</tr>
<tr>
<td>2.2.1 Educators’ readiness levels and perceptions</td>
<td>11</td>
</tr>
<tr>
<td>2.2.2 Barriers to fostering mental health in schools</td>
<td>12</td>
</tr>
<tr>
<td>2.3 Interventions for Mental Health in Schools</td>
<td>13</td>
</tr>
<tr>
<td>2.3.1 School-based mental health initiatives</td>
<td>13</td>
</tr>
<tr>
<td>2.4. Canadian Teachers’ Perspectives</td>
<td>15</td>
</tr>
<tr>
<td>2.5. An Ontario Exemplar</td>
<td>17</td>
</tr>
<tr>
<td>2.6 Conclusion</td>
<td>18</td>
</tr>
</tbody>
</table>
Chapter One: Introduction

1.0 Research Context and Problem

In 2007, the federal government created the Mental Health Commission of Canada, in a response to the alarming findings of the Standing Senate Committee on mental health (Mental Health Commission of Canada [MHCC], 2015). According to the MHCC (2013), more than 6.7 million Canadians are living with a mental health problem or illness. Within this group, more than one million are children and adolescents ages 9-19 (MHCC, 2013). To put this in perspective, 23.4% of young people in Canada are living with a mental health problem or illness as of 2011(MHCC, 2013). Children and adolescents with mental health problems or illnesses are also at a much higher risk of experiencing mental health problems or illnesses as adults (MHCC, 2013).

Unlike many other prevalent health concerns – which tend to affect people in their later years (e.g., heart disease or diabetes) – mental health problems and illnesses are most likely to onset and affect people earlier in their lives (MHCC, 2013; Santor, Short, & Ferguson, 2009). 12-month prevalence of mental health problems and illnesses peaks in early adulthood and again in those over 80 years of age (MHCC, 2013). Of particular note is that 70% of young adults living with a mental health problem or illness say that their symptoms first appeared when they were children (MHCC, 2015).

Amongst the one million children and adolescents living with mental health problems or illnesses, the most prevalent are mood and anxiety disorders including depression, substance use disorders, attention deficit hyperactivity disorder (ADHD), and behavioural disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD) (MHCC, 2013). Additionally,
thousands of Canadian youth (those aged 15-24) commit suicide each year, making it the second leading cause of death for the age group behind accidents (Statistics Canada, 2009).

For most mental health problems and illnesses, there is no single specific cause (MHCC, 2013). Instead, a “complex interaction among social, economic, psychological, biological and genetic factors” is thought to be responsible (p. 4). As a result, certain groups are at an increased risk for mental health problems and illnesses, and may also experience higher rates of discrimination and stigma (MHCC, 2015). LGBTTQ (lesbian, gay, bisexual, transgender, two-spirit, and queer) individuals, for example, have higher rates of mental health problems and illnesses, including depression, anxiety, suicidality, substance use, and post-traumatic stress disorder (Canadian Mental Health Association [CMHA], 2015). LGBTTQ youth face an increased risk of being bullied or assaulted, which increases the risk of developing mental health problems or illnesses (CMHA, 2015; MHCC, 2015). Furthermore, LGBTTQ individuals might face additional challenges when accessing mental health services due to prejudice and discrimination from healthcare workers (CMHA, 2015; MHCC, 2015).

Another group that is at particular risk for mental health problems and illnesses are First Nations, Inuit, and Métis (FNIM) peoples (MHCC, 2015). This is due to a variety of factors, including historical injustices (e.g. colonization, residential schools etc.) a lack of access to mental health professionals, and ongoing “racism, poverty, and other systemic issues” (p. 23). The suicide rate in First Nations youth is five to six times that of non-indigenous youth, and the suicide rate for Inuit overall is 11 times the national average; it is 28 times the national average for young Inuit men specifically. As the MHCC notes there are certainly varying experiences betwixt different FNIM individuals and communities, but these examples demonstrate how mental health problems and illnesses do not affect the country uniformly.
Beyond the suffering and other potential challenges felt by individuals living with mental health problems and illnesses, there are tremendous costs to the economy. According to the MHCC’s 2013 report, mental health care and related social services cost the Canadian economy $50 billion per year; this does not even account for additional costs such as those incurred by the education and justice systems or incurred by families caring for a family member with a serious mental illness.

The facts and figures discussed above translate into significant challenges for students, educators and schools. In Ontario, Students with mental health problems or illnesses miss 40% more school days their peers, and 30-50% of them underachieve academically (Santor et al., 2009). Since educators are well-situated to identify mental health problems or illnesses of children and address them since they spend so much time with students, it is imperative that they are aware of the needs of their students, as well as appropriate interventions.

Since mental health promotion, prevention, and early intervention have all been associated with better mental health outcomes (MHCC, 2013), teachers and schools could potentially be instrumental in any effort to ameliorate mental health problems and illnesses in their students. In fact, The Ontario Ministry of Children and Youth Services released a mental health policy framework in 2006 entitled *A Shared Responsibility*, which explicitly states that teachers should be an integral part of supporting and providing interventions when it comes to meeting children’s mental health needs.

Research into this issue as to how teachers are identifying and addressing students with mental health needs is therefore critical. To that end, I spoke to teachers about their experiences with student mental health.
1.1 Purpose of the Study

The purpose of this study was to explore how elementary school educators in Ontario understand and respond to students’ mental health problems and illnesses. To study this topic I interviewed educators about: challenges or barriers they face with regard to teaching students with mental health problems and illnesses; their training and self-perceived preparedness to address students’ mental health problems or illnesses; and how other students, parents, and other educators in their context of practice respond to and/or address these issues.

As described above, mental health problems and illnesses are extremely common in Canadian youth, and educators have an opportunity and responsibility to support students living with such challenges to the best of their abilities. I intend to share my findings with the research community in order to identify strategies and tools for educators to better educate and support students with mental health problems or illnesses.

1.2 Research Questions

The primary questions which guided this investigation were: What are Ontario elementary educators’ experiences of supporting students with mental health problems or illnesses? The following sub-questions were used to further guide the study:

• To what extent, if at all, do teachers understand their students’ mental health needs? What sort of training have they received? What sorts of resources are available to them?
• What sort of accommodations do educators report making for students with mental health problems or illnesses (if any)? Do they report any barriers to accommodating these students?
• From the perspective of educators, how do mental health problems or illnesses manifest? (i.e. how might they affect academics, student interactions etc.)
What are educators’ perspectives regarding how others in the school community (students, parents, other educators, etc.) respond to students with mental health problems or illnesses?

1.3 Reflexive Positioning

As someone who has had friends, family, and students with mental health problems or illnesses through school and beyond, I developed a keen interest in investigating the ways in which educators support such individuals. Additionally, as a Registered Nurse (RN), I have seen first-hand the ways in which the health-care system systematically fails to meet the needs of individuals with mental health problems or illnesses, and I was curious to investigate the ways in which educators might understand and address students’ mental health needs.

I do not think I was explicitly advised during my nursing degree or training as an RN to be reflexive, but it certainly did occur as a by-product of being encouraged to reflect quite regularly. I do recognize that my patterns of thinking about any health issues are very much inspired by my nursing studies and subsequent work experience. For instance, I was trained to always try to look beyond the obvious medical or physiological factors underlying patients’ condition and consider the social determinants of health and equity underlying the stated diagnosis. I think this was an asset as I interviewed teachers, but I am also aware that despite my training I was prone to ‘medicalize’ a student’s experience with a mental health problem or illness more than a typical educator might be.

I was not initially sure how my social positioning would impact my research, but I was mindful of it as I proceeded. I recognized myself as someone who was already quite biased in relation to this topic – expecting to hear about minimal supports for students with mental health
problems in the education system, and I was pleasantly surprised in this regard to hear about some interesting supports and interventions which teachers report being used in practice.

Lastly, being a relatively privileged life as a middle-class male with no serious mental health problems or illnesses, I did find it challenging at times for me to understand the lived experience of some students whose stories came up in my interviews with educators, though I think my professional background as an RN did help somewhat in this regard.

1.4 Overview

To respond to the research questions, I conducted a qualitative research study and interviewing educators about their experiences supporting students with mental health problems or illnesses. In Chapter Two I will review the literature on educators’ perspectives and responses to mental health problems and illnesses in schools. In Chapter Three I will elaborate on the research design. In Chapter Four I will report my research findings and discuss their significance in light of the existing research literature, and in Chapter Five I will identify the implications of the research findings for my own teacher identity and practice, and for the educational research community more broadly. I will also articulate a series of questions raised by the research findings, and point to areas for future research.
Chapter Two: Literature Review

2.0 Introduction

In this chapter I review the literature regarding mental health in schools. More specifically I review themes related to school preparedness, impacts, and interventions with regard to students who have mental health problems and illnesses, including both emotional (e.g. anxiety, depression) and behavioural (e.g. oppositional defiant disorder) disorders. I start by reviewing the research on some of the impacts and factors affecting mental health in schools, in order to discover and highlight specific challenges, and focus on the Ontarian and Canadian contexts as much as possible. Next, I review the literature in the area of school preparedness, and I consider the training educators receive regarding mental health, as well as any barriers they encounter in practice. Finally, I review some of the types of interventions utilised to date with regard to mental health in students, such as ‘school-based mental health’ initiatives.

2.1. Mental Health Problems and Illnesses in Students

As discussed in Chapter One, student mental health problems and illnesses often present incredible challenges for both students and educators, ranging from issues of behavioural management (Grothaus, 2013), to reduced academic participation and success (Suldo, 2008; Whitley, 2012). This section will examine these impacts in further depth, and examine some pertinent themes that appear in the literature relating to student mental health, such as stigma and bullying.

2.1.1 Academic impact. Most of the research surveyed regarding the impact of mental health problems or illnesses on academic measures such as attendance, academic success, and dropout rates appears to come from the psychology or education literature. A common theme is that mental health illnesses such as anxiety, depression and ADHD negatively affect academic
success (Gietz & McIntosh, 2014; Loe & Feldman, 2007; Mendelson et al., 2010; Owens, Stevenson, Hadwin, & Norgate, 2012). Although one can imagine that mental health could affect academic success for a variety of reasons, many of the authors cited in this paragraph do not offer any particular mechanisms or processes for why this may be. One exception was Owens et al. (2012), who found evidence suggesting that the worry associated with anxiety and depression reduces academic success by impinging on central executive working memory.

These studies are not without other limitations, however, as many of them rely on standardized testing scores (Gietz & McIntosh, 2014; Loe & Feldman, 2007) to measure academic success, and as such are only as reflective of students’ academics as the tests themselves are (Kearns, 2011). That is not to say these authors do not recognize the shortcoming of this approach, and in fact Loe and Feldman (2007) distinguish between academic ‘underachievement’, which includes low standardized test scores, and academic ‘performance’, which includes “completing classwork or homework” (p. 644). However, these terms are infrequently used throughout the literature and this paper will use the term 'academic success' to address both concepts in general.

In addition to the direct impact on students’ academic success, mental health problems or illnesses have also been implicated in a variety of other challenges for students and educators. Suldo and Shaffer (2008) found that middle school students who had high ‘social well-being scores’ – which are equated with good mental health – had better attendance records and reading skills, as well as better social support from classmates and peers, when compared to students with 'poor' mental health. However, these findings are only correlative, and do not prove causation. It is conceivable, for example, that poor social support could be a cause of poor mental health and not the other way around, or that other factors are also responsible.
2.1.2 The effect of bullying on mental health. Bullying is frequently identified in the reviewed literature as either a cause - or result - of mental health problems or illnesses at schools in Canada and internationally (Arsenault et al., 2006; Gietz & McIntosh, 2014; Haltigan & Vaillancourt, 2014; Rivers, Poteat, Noret, & Ashurst, 2009; Whitley, Smith, & Vaillancourt, 2012). A 2010 population-based study (Vaillancourt et al., 2010) of 16,879 Canadian students from Grades 4 to 12 found that 32% of students admitted to bullying others, and 38% reported being victims.

Both those who bully and their victims across all school ages have higher rates of mental health problems or illness including anxiety, depression, ADHD, and somatization (Haltigan & Vaillancourt, 2014). Notably, it is not just those who bully and their victims who appear to have an increased risk of mental health issues but bystanders as well (Rivers et al. 2012). In a separate study, Rivers et al. (2012) found that those who bully, victims, and bystanders all had higher rates of anxiety and paranoid ideation, and bystanders were especially at risk for the latter.

2.1.3 Stigma. Another phenomenon which appears to be intimately intertwined with mental health in schools is stigma. Stigma is frequently cited as a significant reason that young people with mental health issues do not seek help, be it from educators, peers, or health professionals (Bowers, Manion, Papadopoulos, & Gauvreau, 2012; Hartman et al., 2013; Rickwood, Deane, Wilson, & Ciarrochi, 2005). This is unfortunate, since educators are well-positioned to be a critical support people for these students in need (Andrews, McCabe, & Wideman-Johnston 2014; King et al, 2014; Whitley et al., 2012). Potentially adding to this is the issue that students and teachers themselves have both reported teachers as generally unprepared or untrained to deal with the needs of students suffering from mental health issues (Andrews et
Students with mental health disorders have identified various individuals including peers, family members, and teachers as potential sources of stigma (Hartman et al., 2013; Rickwood et al., 2005). Additionally, individuals with mental health issues may also experience self-stigma, which occurs when one internalizes myths and negative stereotypes about their illness (Hartman et al., 2013).

In order to combat the stigma felt by students with mental health issues, Hartman et al. (2013) designed a single-session anti-stigma intervention, which was employed a total of eight times across five different Ontario high-schools with a total of 254 students. These sessions were each 75 minutes in length, and included a presentation by a medical student on mental health (specifically schizophrenia), an interactive stigma-based skit, and an autobiographical talk delivered by a woman living with schizophrenia, who detailed her struggles with stigma and journey of recovery.

The intervention was found to significantly increase the students’ knowledge about schizophrenia, and effectively reduce levels of self-stigma in student participants who identified as suffering from mental health issues. Any schools interested in designing a similar program might benefit from adapting it to include other mental health problems or illnesses such as anxiety, depression, and ADHD, in order to support a greater number of students. There does not appear to be any research involving any recent anti-stigma interventions in relation to these problems and illnesses in Ontario schools.

Academic problems, bullying, and stigma are just some of the challenges students living with mental health problems or illnesses might face, but they present recurring themes in the
literature. The following section will consider the role that teachers and schools play in addressing these and other challenges.

2.2. School and Educator Preparedness for Mental Health

As discussed above, teachers are in a great position as role models and mentors to support their students suffering from mental health issues. Furthermore, as discussed in the context section of Chapter One, the Ontario Ministry of Child and Youth Services’ (2006) mental health policy framework entitled *A Shared Responsibility* explicitly outlines that educators should be an integral part of supporting and intervening when it comes students with mental health needs. This section will review the literature with regard to the preparedness of educators and schools regarding the mental health of students, including the training or lack thereof, and any additional barriers relevant to the context.

2.2.1 Educators’ readiness levels and perceptions. As discussed in section 1.3 above, many educators are unprepared to support their students’ mental health needs (Andrews et al., 2014; Bowers et al., 2012). One study with high school teachers in Southwestern Ontario (Andrews et al., 2014) and another with elementary teachers in a range of rural, suburban, and urban school districts in the United States (Reinke, Stormont, Herman, Puri, & Goel, 2011) both found that approximately only 35% (36% and 34% respectively) of teachers felt that they had the appropriate knowledge or skills to meet the mental health needs of their students. This is alarming, because as Reinke et al. (2011) suggest, within schools it is most often teachers who are asked to implement school-based mental health initiatives. As Wells, Barlow, and Stewart Brown (2003) note in their systematic review of approaches to mental health promotion in schools in various countries (primarily the United States), interventions involving the whole
are most effective, so it is likely insufficient if only 35% or so of teachers feel they are prepared.

Unfortunately, most (65%) of the 75 Ontario teachers in the aforementioned study by Andrews et al. (2014) indicated that they had no plans to take any courses relating to mental health, despite the fact that only 5.3% reported that their Bachelor of Education programs had mandatory mental health courses (8% reported that there were optional courses), and only 17.4% had taken additional courses (e.g., Additional Qualification or “AQ” courses) dealing with mental health. Furthermore, “cost, location, and transportation” were all identified in the survey as reasons teachers cited for not being interested in AQ courses (p. 270). Understandably, the authors suggest that mental health education needs more representation in teacher education programs. While this may help eventually, such a measure alone would not ensure that the entire existing workforce of teachers would receive any formal mental health education on the matter.

2.2.2 Barriers to fostering mental health in schools. In addition to factors already discussed such as stigma and a lack of educator preparedness, there are many additional barriers to fostering the mental health of students. Much of the related literature comes from the United States and thus may not all apply to the Ontarian or Canadian context in the same way; however, much of it might still be relevant. Barriers in this largely American literature include a lack of: mental health professionals, funding, parental engagement or adequate parent support programs, administrative support, teacher support, teacher training, and prevention programs (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010; Reinke et al., 2011). Another common finding is a lack of mental health literacy in schools, that is, the knowledge and ability to understand and support individuals living with mental health problems or illnesses (Bowers et al., 2012, Whitley et al., 2012). This is supported by the aforementioned finding that teachers generally lack
sufficient knowledge about mental health (Andrews et al., 2014), and reinforced by the fact that their students with mental health issues tend to feel that their teachers lack this knowledge as well (Bowers et al., 2012). Overall, the above research seems to suggest that teachers do not feel prepared to address student mental health, and there is a lack of supports, such as training or other professionals, to help teachers in this regard.

2.3. Interventions for Mental Health in Schools

For students, educators, schools, and families hoping to ameliorate youth mental health issues in their communities, these and other barriers already discussed make a challenging situation – i.e., the alarming rates of mental health problems and illnesses in children, as discussed in Chapter One – even more challenging. Fortunately, there is a vast amount of literature from Canada and abroad that can help inform all relevant parties - including students, educators, and policy-makers - of some possible interventions.

One Ontario-based intervention was already discussed in section 2.1.3 above, regarding anti-stigma, but there are a host of other interventions being utilized worldwide. The most frequent interventions encountered in the literature fall under the umbrella term ‘school-based mental health initiatives’, which simply refers to the fact that the interventions take place within the school system as opposed to the healthcare system (Corrieri et al., 2013; Reinke, et al., 2011; Rempel, 2012; Wells et al., 2003). Each school-based intervention reviewed in the literature in unique and specific to a setting (e.g. school, district, or country) or goal, and will therefore be largely described independently, with attempts to highlight any common themes throughout.

2.3.1 School-based mental health initiatives. England has a nationally mandated school-based mental health program called ‘Targeted Mental Health in Schools’ (TaMHS), which primarily targets high-risk (i.e. socio-economically deprived) schools (Wolpert et al.,
The primary strategy of TaMHS is to increase students’ access to evidence-based mental health interventions from local health services and professionals, with the ultimate goal of ameliorating the challenges felt by children with emotional (such as anxiety or depression) or behavioural disorders.

Unfortunately, Wolpert et al. (2015) found that the intervention was only successful in modestly reducing behavioural issues, and failed to reduce emotional issues altogether despite increasing access to community health resources. The authors suggest various reasons why this may have happened, which might be useful for anyone planning or analyzing school-based mental health initiatives. One possibility suggested was that the single year in which the study operated was not enough time to show an effect on emotional issue, which tend to be less immediately observable than behavioural issues. Alternatively, the researchers suggest that teachers might just be more skilled in addressing behavioural issues or that behavioural issues are simply given a priority over emotional ones due to their more obvious impact on classroom management.

In a systematic review, Corrieri et al. (2013) analyzed dozens of school-based mental health strategies used in schools in schools across the world, and hence provides a rich source of data on this topic. The most common trend amongst effective interventions was the incorporation of cognitive behavioural therapy (CBT) in the school setting. CBT focuses on identifying and changing negative thought patterns and behavior, requires training to conduct, and is well established within the medical literature as a highly effective intervention for anxiety and depression in children (Compton et al., 2004). However, several of the reviewed studies on interventions that were not effective also utilized CBT. This suggests that CBT may not be a sure-fire method or that there could be variability in its effectiveness depending on the therapist.
Other strategies that were common among the effective studies reviewed by Corrieri et al. (2013) include substance misuse prevention programs, which should be mentioned since substance misuse is one of the most prevalent mental health problems or illnesses in Canadian youth (MHCC, 2013).

Another school-based mental health approach that has been recently studied involves teaching students how to use mindfulness as a tool to promote mental health or reduce the impact of mental health problems or illnesses. The impact of mindfulness on students’ mental health has been mostly positive (Kuyken et al., 2013; Mendelson et al., 2010; Rempel, 2012), although some studies (Huppert & Johnson, 2010) failed to show significant results, suggesting that further research is needed.

2.4. Canadian Teachers’ Perspectives

In 2012, the Canadian Teachers’ Federation (CTF) conducted a national survey of elementary and secondary school teachers from across the country (which received over 3900 respondents with an unknown response rate, according to the report), with a variety of questions about their perspectives on mental health problems and illnesses in students. The study itself is not scholarly and is therefore not included or discussed in Chapter Two, but it does present some valuable context with regard to common trends in the perspectives of teachers across the country. There are too many individual findings to discuss at length (due to the number of questions asked in the survey), but there are some key points that are related to themes discussed in Chapters One and Two.

Respondents of the CTF (2012) survey reported their most pressing concerns concerning individual mental health problems or illnesses. The CTF report listed the concerns that had the highest rates of ‘agreed’ or ‘strongly agreed’ responses regarding whether or not a given mental
health problem or illness was a 'pressing concern'. The most frequently identified concern was ADHD (91.9% answered ‘strongly agree’ or ‘somewhat agree’), followed by learning disabilities (90.9%), stress (79.4%), anxiety disorders (73.1%), depression disorders (59.3%), and substance use disorders (46.5%). These findings are difficult to interpret because they do not necessarily speak at all to the prevalence of the concerns themselves in the students, but they might indicate how teachers tend to prioritize their concerns about these various mental health problems or illnesses versus one another. For instance, a given teacher could potentially just not be as concerned with a given problem or illness over another, despite them both being prevalent. Furthermore, it might be that certain mental health problems or illnesses are more obvious or disruptive than others in the classroom.

Another key set of findings from the CTF (2012) survey related to factors identified by Canadian teachers regarding barriers to the provision of student mental health services in their schools. The survey found the following factors to be most frequently identified as potential barriers: an insufficient number of school-based mental health professionals (89% responded that this was a potential barrier), a lack of staff training with regard to student mental illness (87%), a lack of funding for school-based mental health services (85%), and insufficient numbers of community-based mental health professionals (78%). While these findings are valuable in identifying some potential barriers worth investigating as part of the present research, the fact that teachers had to remark on a provided set of factors rather than identifying their own, which means that there could be other unstated factors which are just as significant, and will be investigated as part of this research study.
2.5. An Ontario Exemplar

Many of the studies and findings discussed above were based in Ontario or in Canada more widely. However, I located one final article featuring Ontarian educators’ perspectives which I will discuss before concluding this review. This study by King et al. (2014) is especially relevant to this paper because it was based in Ontario and investigated the “development of expertise” in educators (in this case teachers and principals) as well as children’s therapists (p. 277). This qualitative study focused on interviewing five educators as well as nine therapists in order to elucidate themes of 'expert' knowledge common between the groups, as well as any differences regarding their perspectives when working with children with mental health problems or illnesses. The authors found that both groups of professionals tended to adopt one or more of three general perspectives.

The first perspective described by King et al. (2014) is the “open perspective”, which refers to the ability to be open to receiving feedback about what practices work or do not work, as well as being open to recognize what one does not know. The “broad and flexible perspective” includes understanding the ‘big picture’ and considering the “whole child”, including their family situation (p. 284). Lastly, the “relational perspective” emphasizes the “importance of having a good relationship with the child and family” (p. 284).

Though the ‘relational perspective’ was common to both groups of professionals, it is also where their style was slightly different (King et al., 2014). The authors found that the educators interviewed tended to focus on a student-centred approach when dealing with mental health problems and illnesses in children, while the therapists tended to adopt a family-centred approach. While it is not mentioned by the authors, it may be reasonable to assume that this
difference in approach might occur because educators may tend to spend more time with the children on their own (i.e., apart from their families).

One other finding from the study by King et al. (2014) which was specific to educators’ perspectives on mental health problems and illnesses was the idea that focusing on the psychosocial needs of students should be a priority over curriculum or other academic-related expectations. These and other findings from this chapter are compared to findings from the present research study in Chapter Four.

2.5 Conclusion

In this chapter I reviewed research on mental health problems and illnesses with regard to their consequences for students and educators, in addition to school and educator preparedness for these challenges, as well as a range of interventions. This review elucidates the extent that attention has been paid to the challenges that mental health problems and illnesses present for the students who live with them, as well as for the educators of these children. It also raises questions about the readiness of educators to properly address these needs in their students, and points to the need for further research on barriers preventing this, as well as more effective interventions for students with mental health problems or illnesses. In light of this, the purpose of my research was to thoroughly examine additional Ontarian educators’ perspectives with regard to the topic of mental health problems and illnesses in their students. Hopefully, this research may further clarify what educators need to support Ontarian children with mental health problems and illnesses, so they can be better informed and more able to do so.
Chapter Three: Methodology

3.0 Introduction

In this chapter I explain, justify, and discuss the methodology chosen for this research study of Ontarian teachers’ perspectives with regard to students’ mental health problems or illnesses. I start with a discussion of why a qualitative approach was chosen, and follow with an explanation of why semi-structured interviews were used for data collection. I then discuss the methods used to sample participants, specify the sampling criteria, and provide some anonymous background data on the participants. I continue with a description of the type of data analysis performed, and proceed with a discussion on the ethical procedures and considerations taken throughout the study. Finally, I discuss the limitations and strengths of my methodological approach, before concluding the chapter.

3.1 Research Approach and Procedures

This study utilized a qualitative research design. There is no consensus on a precise definition of ‘qualitative research’ (Ormston, Spencer, Barnard, & Snape, 2013), but this section will explore those that are offered and discussed by various authors, and justify throughout why a qualitative approach was chosen for this study.

Although there may not be a single, precise definition of qualitative research, there are characteristics, methods, and philosophical ideas frequently associated with the style of inquiry (Creswell, 2007; Denzin & Lincoln, 2011; Ormston et al., 2013). Denzin and Lincoln (2011) insist that the definition of qualitative research depends on the historical moment or context within which one discusses it. The authors list eight such moments from the “traditional” moment (1900-1950) to the moment of today: “the future” (2010—), and suggest that these moments operate simultaneously in the present. As an example, the future moment includes the
idea that “the social sciences and humanities become sites for critical conversations about
democracy, race, gender, class, nation-states, globalization, freedom, and community” (p. 3).
Despite this complexity, Denzin and Lincoln do offer a generic definition of qualitative research,
describing it as a “situated activity that locates the observer in the world”, and which “consists of
interpretive, material practices that make the world visible” by transforming it into interviews,
photos, memos, or other representations (p. 4). They add that qualitative researchers “interpret
phenomena in terms of the meanings people bring to them” (p. 4). This definition just offered
demonstrates one reason why a qualitative research design was suitable for the present study, in
that transforms teachers’ interpretations or ascribed meanings of the world of their students’
mental health problems or illnesses into a representation that is accessible to a larger audience of
interested parties (e.g., researchers, educators).

Creswell (2007) takes a different approach to defining qualitative research, by explicitly
emphasizing the design of the research itself. This definition is extensive, but includes
“beginning with assumptions”, studying the “meaning individuals or groups ascribe to a social or
human problem”, and data analysis which “establishes patterns or themes” (p. 37). The author
notes that the final report includes the “voices of participants, the reflexivity of the researcher”,
as well as a “description and interpretation of the problem” (p. 37). These features just discussed
are incorporated into this study, which again justifies why a qualitative approach is most
appropriate. For instance, this research sought to study the meaning teachers ascribe to the
mental health problems or illnesses of their students, and establish patterns and themes such as
barriers from supporting students (as just one example), and communicating them in a way that
keeps the participants' voices intact.
Ormston et al. (2013) add that qualitative research is often associated with words or images as opposed to numbers, and that some writers define qualitative research in contrast to quantitative research and its aims and methods. Ormston et al. also add some characteristics common to qualitative research, including that it “respects the uniqueness of each participant” and is open to “emergent categories and theories at the analysis and interpretation stage” (p. 4). Again, the features of this definition demonstrate why a qualitative design was appropriate for the present research, most notably that it sought data that would not properly be conveyed with a quantitative research design, such as experiences and narratives involving teacher’s actions and opinions regarding students' mental health problems or illnesses.

Due to many of the features just discussed, a qualitative research design was particularly suitable for the purposes of the present research study. The next section will discuss how the chosen format of semi-structured interviews in particular served to elucidate valuable insights and perspectives about mental health problems or illnesses in schools.

3.2 Instruments of Data Collection

Qualitative interviewing typically consists of single, face-to-face interviews with participants, consisting of a collection of questions answered through an open dialogue (Flick, 2007). There can of course be exceptions to this, such as longitudinal studies – which include multiple interviews with a given participant over time– or studies which include group interviews (Flick, 2007). In most cases, the interviewer follows an interview guide consisting of topics or questions to help facilitate the conversation (Flick, 2007).

Interviews are generally categorized as one of three major types (Flick, 2007). The first, structured interviews, consist of standardized, closed format questions which follow an organized schedule or plan. The second, unstructured interviews, are more flexible, do not
include closed format questions, and do not follow a strict format. Lastly, semi-structured interviews are somewhere in between, in that they contain structured and unstructured sections and may include a range of question types (closed, open etc.) (Flick, 2007). Regardless of the type of interview, conversations must be recorded and transcribed in order to analyze the data (Walliman, 2011).

One major advantage of interviews, and one reason I utilized them in this study, is that the interviewer can access “areas of reality that would otherwise remain inaccessible such as people’s subjective experiences and attitudes” (Peräkylä & Ruusuvuori, 2011, p. 529). In the case of my topic, I think that it was fair to assume that there are many teachers in Ontario with knowledge about mental health problems and illnesses of students, and so it was fitting for me to interview these individuals and tap into that experience.

Specifically, I used semi-structured interviews, rather than structured or unstructured, for a variety of reasons. Compared to structured interviews, semi-structured interviews generally contain fewer leading questions (Shank, 2002), and encourage participants to more fully express themselves and speak “in their own words” (Packer, 2011, p. 43). Compared to unstructured interviews, semi-structured interviews better allow the researcher to ensure that certain questions or themes are discussed by all participants, and are generally more successful for novice interviewers like myself (Shank, 2002).

In order to help facilitate my interviews, I created an interview guide, as already mentioned (see Appendix B). I developed my guide during two in-class workshops, in addition to some work thereafter. I decided to organize my guide into three main sections. The first section went over background data on the participant, which served to build rapport, but also provided some useful context for the remainder of the interview. The second section I titled 'Observations'
and aimed to elucidate as much as possible about the participants' perspectives of student mental health, including incidence and impact. The final section was called 'Interventions, Supports, and Barriers'. This section is quite long and I was originally going to break it up into two sections but it seemed that these three concepts were all tied together in being related to what actions are being taken to support students, including relevant supports and barriers. Here are some examples of questions from my guide:

- Could you tell me about a typical day in your classroom?
- Could you describe in general how you see student mental health problems or illnesses affect teaching and learning in your school?
  - How about?
    - Academic success
    - Attendance
    - Peer interactions/bullying
    - Classroom management/teaching.
- What sort of barriers would you say you’ve encountered that may have prevented you from supporting students with mental health problems or illnesses in the past?
  - How do you overcome those barriers? (if it was possible)

3.3 Participants

This section will have three subsections. The first will discuss the criteria to be used to sample individual participants, the second will describe the actual procedures used to sample the participants, and the final subsection will provide some brief, anonymous biographical data on the participants.
3.3.1 Sampling criteria. In order to find individual participants who will provide the depth of experience and insight desired for this study, I created a list of criteria which were used during sampling. They were as follows:

1. Participants have been working within schools for at least five years.
2. Participants will currently be elementary school teachers in Ontario.
3. Participants will currently be working in Ontario.
4. Participants will have worked with students who have mental health problems or illnesses.

I felt that it was important for participants to have at least a few years of experience working in schools, simply because they should have a larger pool of students or classes to draw examples from. I was looking for participants who were currently practicing in Ontario, because it appeared to be a dearth of literature on the topic in this province, as highlighted in Chapter Two. Since the plan from the outset was to interview just two or three educators, it was also important that they had considered the topic of this study in the past. I assumed, given the statistics described in Chapters One and Two, that all educators would have encountered students living with mental health problems or illnesses, but I thought it was key that they would have considered these issues enough to contribute enough insight.

3.3.2 Sampling procedures. As Flick (2007) notes, sampling in qualitative research is generally not random. As the author notes, it is often more deliberate in nature, seeking out cases or participants which inform the specific phenomenon of interest. This method is called *purposive sampling*, and is the most common style used in qualitative research (Flick, 2007). Creswell (2007) adds that sampling in qualitative research can technically extend to “events,
settings, actors, and artifacts” used in a design, but since this study exclusively used interviews for data collection, it only required the sampling of actors or participants (p. 126).

One type of purposive sampling is called *snowball sampling*, where existing participants refer the researcher to additional individuals who might participate in the study (Mack, Woodsong, MacQueen, Guest, & Namey, 2011). This method gives the researcher access to groups not otherwise accessible or discovered through other sampling methods (Mack et al., 2011). Another type of sampling used in qualitative research is called *convenience sampling*, where the researcher finds participants based on ease, or convenience, should only be chosen because of a lack of success in using other sampling (Flick, 2007).

Since the purpose of this study is to explore educator’s experiences and perspectives with regard to students’ mental health problems and illnesses, I intended to use purposive sampling, as just described, in order to find participants who are experienced and positioned to provide maximum insight. As Rubin and Rubin (1995, as cited in Flick, 2007, p. 33) argued, qualitative sampling should be iterative and flexible, and open to modifying sampling strategies based on insights gained during data collection. Ultimately, I ended up using convenience sampling due to a lack of success with other methods.

**3.3.3 Participant biographies.** The first participant, Pedro (pseudonym), has been teaching Ontario for seven years, after attending teacher’s college at a university in Southern Ontario. He teaches a variety of subjects to junior and intermediate students at a French Immersion school in the Greater Toronto Area (GTA). The second participant, Inga (pseudonym), has been teaching in Ontario for six years, after attending teacher’s college in the United States. She also teaches at a French Immersion school in the GTA, but teaches Grade Four exclusively. Both participants expressed enthusiasm at participating in this study, and
reported having taught many students who they perceived as living with mental health problems or illnesses.

3.4 Data Analysis

As Creswell (2007) explains, data analysis in qualitative research is usually organized into three stages. The first stage involves organizing the information gathered during data collection (e.g., interview transcripts). In the second stage, this organized data is then broken down into themes, or ‘coded’. Lastly, the coded data is represented in some manner, including figures or a discussion section. As Creswell notes, there will inevitably be variations to this strategy, particularly if using a theoretical framework, but this is the general approach used in most qualitative research.

I essentially used the above steps in performing the data analysis for this study. I recorded the audio of each interview, which I then transcribed onto a computer. I then combed through the data several times in order to code, or group it, based on common features or sub-topics. Finally, I distilled the coded data into themes, which I present in Chapter Four: Research Findings.

3.5 Ethical Review Procedures

Qualitative researchers must consider a range of potential ethical issues when designing and undertaking their study (Creswell, 2007). Every step of the process has ethical considerations, from preparing the research questions, to sampling, to collecting data, and then analyzing it (Flick, 2007). This section will explore some of the potential ethical issues faced throughout conducting a qualitative research study, and address specific concerns related to the topic of educator’s perspectives of students’ mental health problems or illnesses.

One way to approach thinking about ethical issues in qualitative research is to consider the principles associated with ethical conduct (Lichtman, 2012). As Lichtman (2012) argues, the
“cornerstone of ethical conduct” is the principle ‘do no harm’ (p. 54). This means that researchers must take precautions to ensure that participants are not harmed in any way, and that the research should be halted should any harm occur (Lichtman, 2012).

When approaching potential participants for research, it is also important to obtain informed consent (Flick, 2007). This means that potential participants are aware of the exact nature of the research, what is expected of them should they agree to participate, as well as details regarding how their information and data will be stored and kept confidential (Flick, 2007) (see Appendix A for the consent letter used for this study).

During data collection, there are a number of considerations for the researcher. For instance, researchers should avoid disturbing the daily lives of participants any more than necessary, should avoid being too pushy and recognize the limits of respectable behaviour when interacting with participants (Flick, 2007). When I was sampling and then interviewing participants, I kept these things in mind and was professional when it came to scheduling and communicating with them so as to minimize disruption.

Another important ethical issue to consider throughout is privacy and anonymity. This means that any identifying information gleaned during the research process is not revealed publicly, including of course names but also recordings, as participant’s voices may be recognizable to others (Lichtman, 2012). An extension of this is that participants have the right to confidentiality, which forbids revealing the identity of any participant. To that end, I provided the participants with pseudonyms, which are used throughout this paper.

For this study specifically, I was mindful of the potentially sensitive nature of the topic of mental health. I thought it to be certainly possible (and likely, given the statistics discussed in Chapter One) that my participants could have loved ones living with mental health problems or
illnesses, or that they may be living with a mental health problem or illness themselves. In order to be sensitive of this, I ensured to use appropriate language and questioning in order to avoid any feelings or suggestions of stigmatization, which is a serious concern with this topic as discussed in Chapter Two.

Additionally, the topic of mental health may lead to conversations about emotional events, including suicide. As a result, I took every precaution to ensure that the participants were not unduly uncomfortable throughout the interviews. To this end, I explained to participants that they had the right to withdraw their participation at any point throughout the process (as described in the consent letter in Appendix A).

3.6 Methodological Limitations and Strengths

As suggested in section 3.1, qualitative research provides an excellent way to explore experiences and perspectives of participants in great depth. As Duffy (1986) explained, it allows for a more holistic focus which gives a “deeper, more valid understanding of the subject than could be achieved through a more rigid approach” (as cited in Carr, 1994, p. 718). It also allows participants to share ideas on specific issues not accounted for in a more structured design (Carr, 1994). Carr also argues that qualitative research tends to be more valid than quantitative research, in that the lack of strict controls on the study means that cases are closer to real life.

Carr (1994) presents some cautions and potential limitations of qualitative research as well. One limitation is that the closeness of the researcher can threaten validity if the researcher is “unable to maintain the distance required to describe or interpret experiences in a meaningful way”, such as if it researcher inadvertently enters a therapeutic role (p. 718). In these situations, the relationship of the researcher and participant can distort the data being collected or analyzed. Throughout my research I was considerate of the fact that mental health could present a higher
than usual risk in this regard, due to the potentially emotional nature of the topic, so I was vigilant by remaining professional and reflexive throughout my interviews.

Another limitation of qualitative research is that it lacks generalizability, because the sample sizes are generally small and non-random (Carr, 1994). However, since the purpose of this research was to study the experiences and perspectives of a few educators in depth, it was not meant to be generalizable. Rather, by providing a detailed description of my participants and their educative setting, I aimed to provide transferability, such that readers may decide whether or not the findings are comparable to other situations or their own experiences (Curtin & Fossey, 2007).

3.7 Conclusion

In this chapter, I discussed how I will be using a qualitative research design, in order to explore educator’s experiences and perspectives regarding students living with mental health problems or illnesses. I described how I used purposive sampling to sample two educators using the criteria described in section 3.3.1, in order to enhance the depth of experience and insight explored with my participants. I then added how I used semi-structured interviews with participants in order to explore my topic in depth, using an interview guide I developed and which can be found in Appendix B.

I then explained that when all of my interviews were recorded and transcribed, I proceeded with data analysis, including organizing my data and coding it into themes. I proceeded to discuss how I was mindful throughout the entire process to address ethical considerations such as confidentiality and informed consent, by using pseudonyms and being clear about the exact roles associated with being a participant in this study. Lastly, I explored some of the methodological limitations of my research design, such as a lack of generalizability,
while reiterating its intended purpose to be in-depth and transferable. In the upcoming chapter, I will be reporting my research findings, and discuss their relevance in light of the existing literature discussed in Chapter Two.
Chapter Four: Research Findings

4.0 Introduction

In Chapter One I introduced my topic: teachers’ perspectives on student mental health, by describing the context of mental health in Ontario, and suggesting that teachers are well-positioned to support such youth in need. In Chapter Two I reviewed the literature and found that themes such as stigma and bullying are factors in student mental health, but that school-based initiatives and other interventions have shown promise in overcoming these and other barriers. In Chapter Three I described my methodology, including two qualitative interviews with GTA teachers who have worked with students with mental health problems or illnesses in order to contribute additional perspectives from the Ontario context. In this chapter I will discuss the findings from these interviews, which I have organized into the following themes:

1. Impacts reported by teachers relating to mental health problems in students
2. Barriers teachers report encountering when addressing student mental health.
3. Teacher training and supports related to student mental health.
4. Strategies used by teachers to address student mental health.

The above themes are organized into four associated sections below. Each section will begin with a statement about the theme, discuss the related findings from interviews of teachers in this study, and then consider said findings in the context of the literature reviewed in Chapter Two. The first theme which will be discussed is related to teachers’ perspectives on the impacts of mental health problems in students, since they provide pertinent context for subsequent themes. In the following chapter, I will then discuss some key implications and recommendations stemming from these themes.
4.1 Impacts Reported by Teachers Relating to Mental Health Problems in Students

Teachers report that the impacts of mental health problems and illnesses are often visible in students, and can include impaired academic performance, stigma, and trouble fitting in with peers. Both of my participants repeatedly suggested that they have perceived reduced academic performance as one of the more obvious impacts of mental health problems that they have seen in students. They each expressed that they have noticed a relationship between mental health problems and impaired academic performance in general, and gave specific examples to support this perception. Inga expressed that she has noticed a relationship between impaired academic performance and stress, which she reported was common in students who lived in what she referred to as ‘broken homes’:

They’re not sure of themselves...the students, you know, who come from broken homes. That’s stressful in itself and plays a huge part and you can see the ones where they’re spending a week here, a week there, and this is, I don’t know if it’s a stereotype I’m saying but...they’re low achievers...their organizational skills are poor, they’re scattered, they’re required so much reminding about the simplest or most menial of tasks.

Both Inga and Pedro noted that the mental health challenges they perceived as being related to what they described as a troubled home environment were associated with impaired academic performance, including poor working habits and motivation, as expressed above.

This possible association between stress and academics is something I encountered in the literature discussed in Chapter One; in a policy-oriented paper reviewing student mental health in Ontario, Santor et al. (2009) described that an alarming rate (30-50%) of Ontario students with mental health problems underachieve academically. That study, as well as studies discussed in Chapter Two (e.g., Suldo, 2008; Whitley, 2012) did not distinguish between different types of
mental health problems and their association with decreased academic performance, but I think the perspectives of teachers in this study are consistent with those findings in general.

Of note, both of the participants in this study denied that they had noticed any connection between mental health problems in students and reduced attendance, which has been found by Suldo and Shaffer (2008) to be a possible impact alongside decreased academic performance. Both participants suggested that this could be because they teach elementary school where students might need a parent to be home with them, in contrast to Suldo and Shaffer, who were studying middle-school students who would generally have more independence.

In addition to academic impacts, both participants in this study reported that stigma about mental health problems had a noticeable impact of mental health problems in students, although Pedro noted that encouragingly, his older elementary students were more open and “prone to talking about those kinds of things”, thereby reducing stigma, compared to his Junior students, whom he did not feel were able to express themselves about this topic since they might not be as aware of or able to articulate it.

Inga reported noticing that students with mental health problems of a behavioural nature in particular faced stigma from fellow students:

They’re either very shy, or they do odd things, or they’re impulsive, so then it becomes very well known amongst peers that, you know, let’s just say John can’t control himself and he has these outbursts, and you hear ‘I don’t want to work with him anymore because the teacher is always having to redirect him and consequence him’ so they pick up really fast who those students are.

A few times throughout the interview, Inga mentioned her observation that students with behavioural mental health problems often exhibited “extremes” of being withdrawn or over-
bearing, and that this was a potential cause of stigma. She then explained that she thinks this stigma can often propagate, to the point that parents then express that they do not want their children associating with or being disrupted by these students. These perceptions relate to the finding in the literature discussed in Chapter Two: that stigma is often a consequence of mental health problems, and that it can come from sources such as peers and parents (Hartman et al., 2013; Rickwood et al., 2005).

One finding from the literature which was not noted by my participants was with regard to bullying. Haltigan and Vaillancourt (2014) found that bullies and their victims both had higher rates of mental health problems. Participants in this study did not address whether mental health problems could result from bullying, but both denied that they had witnessed higher rates of bullying involving students with mental health problems. Pedro explained that he does witness bullying, but said “I think it’s more just bullying in general”.

As will be discussed in the following section, both participants perceived that stigma can act as a barrier when trying to address mental health problems in students, since it can make parents reluctant to have their children assessed and then labelled, for fear of further stigma.

4.2 Barriers Teachers Report Encountering When Addressing Student Mental Health

According to the teachers in this study, there is a range of factors, often involving stigma, which may act as barriers preventing them from supporting students with mental health problems or illnesses. This section will discuss the most prominent factors which arose during the interviews, including student workload, teacher workload, and lack of support from parents.

Both participants identified student workload as leading to increased levels of stress and anxiety in their students. Pedro identified homework as being one of the primary causes of this stress:
Homework can be an issue sometimes, and the amount of work that’s being asked from different teachers. A lot of the kids are on rotary, so they maybe have four or five teachers in a given day. So, depending on the teacher they often give a lot more homework, and unfortunately, I think a lot of the kids do end up being stressed.

Pedro went on to explain that this issue is compounded by the fact that the students he teaches are in French immersion, which increases the workload and stress on students. Inga also felt that workload was a major stressor and that French immersion accentuated this stress, but that the clear expectations for entering French immersion in the first place, and the “way that the program is promoted” generally results in classes that are quite strong academically. Inga, being a Grade 4 teacher, did feel that age/grade can also be a factor in how much workload affects stress in students, as she has noticed that the transition from Primary to Junior can be quite overwhelming for many students, and could possibly contribute to mental health problems.

Based on the accounts of Pedro and Inga, it is difficult to discern whether the amount of stress and anxiety they have noticed in students is always at the point where it might be considered a ‘mental health problem or illness’. I recognize that perhaps I look at this situation a bit differently than Pedro or Inga since I am a registered nurse, and I have been trained to categorize and understand ailments as diagnoses, which are generally classified by strict guidelines and thresholds. In other words, based on the interviews, I am not sure whether or not these teachers’ reports of their students’ reactions to their workload would be classified as clinically significant within the healthcare system, or if they might in many cases simply be students complaining about having work in general, as perhaps anyone might. I do recognize that from a teacher’s perspective, it may not matter whether a student has been formally diagnosed or
not, but rather whether or not a child’s learning is being impacted by the suspected mental health problem.

This is not to diminish the role that workload might play when considering student mental health, but rather to recognize that not all students who complain about homework would be thought of as having a mental health problem or illness. The literature does support the idea that mental health problems such as stress and anxiety are common in students, that workload is a contributing factor, and that these problems can lead to other serious impacts including impaired academic performance, as discussed in the previous section and in Chapter Two (Gietz & McIntosh, 2014; Loe & Feldman, 2007; Mendelson et al., 2010; Owens, Stevenson, Hadwin, & Norgate, 2012).

In addition to student workload, teachers in this study report that their own workload and a lack of time can be a barrier to addressing the mental health needs of their students. Pedro insisted that primarily teaching rotary and having up to 29 students in his class at a time meant that there was little time to follow-up on concerns he had about student mental health and behaviour. Inga shared this sentiment, and said that it can be difficult to deal with the mental health needs of individual students because it takes “so much time gearing towards that one child”.

Teacher workload and time as a barrier to supporting student mental health is not something that I encountered in my literature review, but I think it could be part of the wider phenomenon discussed in Chapter Two of teachers being unprepared and untrained to deal with the mental health needs of their students (Andrews et al., 2014; Bowers et al., 2012). This theme of teacher readiness and its connection to time as a barrier will be further elaborated in section 4.3 below.
In addition to workload, the teachers in this study both expressed that parents can be one of the biggest barriers to addressing student mental health. Connecting to the discussion of workload and French immersion above, Inga shared her observation that:

Some parents just don’t really take any consideration that [French immersion] is not their child’s strength and keeps them in it, and then you get the causes of [mental health problems]. Now they’re not feeling confident, they become withdrawn, they’re not engaged, and then they become probably more stressed with, you know, they’re not succeeding and they can feel that.

Inga did believe that the French immersion program tends to attract students who are strong academically, as mentioned in the previous section, but as she also feels that parents may insist that their child remain in the program, leading to stress and impaired academic performance. Pedro’s perspective was quite similar, and he pointed out that “it almost seems like they are being forced into this through their parents”. Following the above statement, Inga proceeded to share an example of a student she suspected was living with a mental health problem, to corroborate her perception that parents sometimes resist efforts to have their child assessed for mental health issues:

He was hyperactive, he was violent, but the parents were so hesitant to want to have him diagnosed, or have him be assessed, because they didn’t want the stigma that would go along with it. They didn’t want the paper trail, they didn’t want the labels in his record. This quote highlights Inga’s opinion that parent reluctance can be related to stigma, as mentioned earlier, and act as a barrier which prevents students from accessing the help they might need.

These findings are unsurprising in that they are consistent with the findings discussed in Chapter Two which found that a lack of parental engagement was identified by teachers as a major
barrier to school-based mental health interventions in both observational (Reinke et al., 2011) and interventional (Langley et al., 2010) studies.

In addition to the factors just discussed, there is one other prominent barrier described in the literature which arose throughout the course of both interviews: a lack of teacher training with regard to mental health. This factor will discussed next in Section 4.3, as it seems fitting to discuss it within the broader topic of teacher preparation and supports.

4.3 Teacher Training and Supports Related to Student Mental Health

In this study, both teachers reported feeling that they had not received adequate training to properly address the needs students of with mental health problems or illnesses, and that access to supports such as psychologists were often limited. This section will discuss teachers’ perspectives on their own readiness to address the diverse mental health needs of their students, and examine their thoughts on how other professionals within their schools have assisted them.

One trend found in the interviews was that these teachers felt that their individual ability to address the mental health needs of students was limited. When discussing the needs of a particular student living with severe anxiety, Inga expressed:

Parents are leaving their children with you for six hours a day and it’s almost like you’re supposed to be like their mother when they’re not there, and it’s like, I’m not a doctor, I don’t know what to do about this, we don’t have any diagnosis, I just don’t know.

Evidently, Inga felt like she alone lacked the ability to address these students’ needs, and she later reflected feeling that even though there might be various professionals within the school who might be able to assist her, such as special education teachers, that nobody in particular fulfilled the role of managing students’ mental health needs. She did mention that psychologists
have visited the school in the past for special meetings to discuss serious cases, but that this generally only happens twice in a given school-year.

Pedro shared the sentiment that his ability to address students’ mental health needs on his own was limited, but did feel that gaining more experience as a teacher, and participating in school initiatives such as Mental Health Week have helped him:

I kinda feel like I know a lot about the subject from the things that we’ve done and I seem like I’m aware of it. I think I’m able to recognize signs, especially in students, if something is wrong. And I see these students every day, so it is very easy to kinda get a sense if something is wrong. I just don’t think I would be able to deal with it without help.

However, even though Pedro did note feeling an increased competence when it came to recognizing and assisting students with increased mental health needs, he still felt that his abilities were insufficient. He shared that even when he did assist the students and connect them with support such as a special education teacher, he found that there was always a lack of follow-up, and that he would rarely ever learn of the outcome of particular assessments or other interventions being done outside of his own classroom. Overall, these findings are consistent with the literature discussed in Chapter Two, including Andrews et al. (2014) who surveyed high school teachers in Southern Ontario and found that the majority did not feel adequately prepared to deal with students’ mental health needs, and Bowers et al. (2012), who studied high school students in Ontario who reported feeling that their teachers seemed to largely be inadequately prepared to address student mental health. However, in my literature review I did not encounter the finding from this study of inadequate follow-up.

The final factor I will discuss in this section is teacher training surrounding mental health problems in students, as it is presumably related to this issue of teacher readiness just discussed.
Neither of the participants could recall exactly what they had studied in teacher’s college with respect to mental health, though Pedro did recall studying some mental health content as part of a larger course. Since then, neither teacher has taken any AQs related to mental health, although as will be discussed in the final section below, Pedro has found that taking AQs unrelated to mental health have helped him assist with such issues anyway.

Each teacher did share that there has been mental health content included in professional development sessions in their schools in the past year, such as Mental Health Week in Pedro’s school, as mentioned above. Pedro described one aspect of it as follows:

We focus on different activities...last year we had people from the outside come in and they had mental health issues and they talked about their issues with our students. Maybe they overcame them, and if the students have any [mental health problems], they know where they can go to seek extra help, that kind of thing. It was really worthwhile to hear, and really captured it.

This activity is reminiscent of the anti-stigma intervention discussed in Chapter Two (Hartman et al., 2013), where individuals living with schizophrenia visited several high schools in Ontario. As was found with the interventions described by Hartman et al., Pedro noticed that students responded positively, and he noticed an increased level of respect from them with regard to individuals living with mental illness.

Inga reported that her school does not have Mental Health Week like Pedro’s, but she did detail an initiative starting this year where teachers will have the opportunity to go to professional development sessions at their board office, and then return to their schools and disseminate what they have learned to their colleagues. Though she did not know if she will be able to participate in this initiative yet, she did express hope for the program in saying that
“awareness is being raised and that’s always a good sign”. The literature discussed in Chapter Two did not specifically include any mention of the specific activity Inga shared, but it did consistently note that such school-wide initiatives are one of the most effective ways to address issues related to student mental health such as stigma and mental health literacy (Corrieri et al., 2013; Reinke, et al., 2011; Rempel, 2012; Wells et al., 2003).

Although both teachers expressed not having sufficient training and often feeling inadequately prepared to address student mental health issues, they described the above activities with optimism. In the next and final section, I will share some of the additional strategies and perspectives teachers in this study have used both to personally cope and also support their students.

4.4 Strategies Identified by Teachers to Address Student Mental Health

In response to the barriers described above, teachers in this study described various strategies they utilize to help prevent or address mental health problems in their students. In this final section, I will outline these strategies, and relate them to the literature discussed in Chapter Two before concluding this chapter.

As discussed in the preceding sections, teachers in this study and findings in the literature reported that stigma can be both a consequence of mental health problems, as well as a barrier to addressing them. A school-wide anti-stigma intervention was just described above, but Inga also reported a strategy that she as an individual teacher has used to help reduce stigma in her classroom. Inga gave an example of a story where she allowed students to freely choose their groups, and a student living with a variety of mental health and behavioural problems was excluded from several groups because students did not want to work with him. In order to prevent the stigma and distress associated with such an event from happening again, Inga
reported that she now employs purposeful grouping, which ensures that students are never excluded from groups. I did not encounter this type of strategy discussed in the literature, but I wonder if it could possibly reduce stigma as well since more students would get to know students living with mental health problems or illnesses and hopefully have any negative preconceptions dispelled.

Pedro shared another strategy which he has found effective in caring for the needs of his students living with mental health problems or illnesses, which is simply to be patient with students, listen to them, and make an effort to build relationships with them. Speaking about a particular student living with a mental health problem, Pedro stated:

I think being patient with them really goes a long way. Listening to them as well, that’s something that I’ve really learned to do. With the one student I was talking about...it’s not like it was taught to me that I should do this - I just really listened to him because a lot of the teachers I find don’t listen to him. They are the ones that are quick to dismiss something - give him a consequence, be mad at him, yell at him. And...I found towards the end of the year last year it got better, and to some extent I just really listened to what was bothering him and I empathized with him.

This type of attitude is consistent with the finding of King et al. (2014) discussed in Chapter Two that teachers tend to adopt a student-centred approach when addressing mental health needs in students, as opposed to therapists who tend to adopt a family-centred approach. That literature did not seek to explain which approach might be better or more appropriate, but Pedro in the least has found his style to be effective.

Although Pedro did mention in the above quote that specific teachers have been harsh on students living with mental health problems, he did describe collaborating with staff members as
one effective strategy. Additionally, both Inga and Pedro insisted that in their own experiences they have always found raising their concerns with their principals has generally helped them support students with mental health problems.

As mentioned in the previous section, Pedro also proposed that taking AQs unrelated to mental health have given him strategies that have helped him to support students living with mental health problems. As described in Section 4.2, time was identified by both participants as being a significant barrier, and Pedro explained that taking various subject-related AQs has helped him learn to “maximize time” and give him more opportunities to address the mental health needs of students. Though this is not something explicitly mentioned in the literature discussed in Chapter Two, it would arguably be related to the theme of teacher readiness discussed in the previous section, since Pedro does overall feel more able to address mental health problems in students as a result of freeing up more time.

Though not through AQs, Inga also noted that adjusting her teaching strategies has enabled her to address students with mental health problems. For instance, she has found that including more activities with multiple learning centres or stations has benefitted her students diagnosed with ADHD, and has noticed that they are able to stay engaged for longer periods of time. In the literature review I did not seek out strategies for addressing the needs of students with ADHD specifically, but I think Inga’s example is worth mentioning since ADHD was identified in a survey of over 3,900 Canadian teachers as being the most prevalent mental health issue in their students (Canadian Teachers’ Federation, 2012), as mentioned in Chapter Two.

Finally, both of the teachers in this study identified parents as being one of the primary barriers to addressing students’ mental health problems. Pedro imparted this strategy that he has used to try and overcome this barrier:
I’m really trying to open up communication with them a little bit more...trying to recognize positives. If...there are so many things wrong with the student, I’m still trying to point out some of the positive things that they do first...they want to hear what they’re doing actually well, other than all the negatives.

He did not give any particular examples of such relations with parents leading to positive outcomes with students, but a lack of parent support was discussed as being a major barrier in this chapter and in Chapter Two (Reinke et al., 2011). Overall, these findings suggest that teachers are utilizing a range of strategies and supports in attempting to address the mental health needs of their students.

4.5 Conclusion

In this chapter I have discussed the themes synthesized from my interviews with two GTA elementary teachers regarding their perspectives on mental health problems and illnesses in students, and related it to the relevant literature reviewed in Chapter Two. First, I introduced some of the impacts of student mental health problems as reported by these teachers, including impaired academic performance, and stigma. Next, I discussed various barriers described by these teachers, which included student workload, teacher workload, and a lack of support from parents. In the third section, I elaborated on the training and other supports these teachers reported receiving to date, which they suggested had been limited and left them feeling largely unprepared to address students’ mental health needs. Lastly, I relayed some of the strategies these teachers report using to address the barriers identified above, including purposeful grouping, building relationships with students and parents, and reaching out to supportive staff including special education teachers and principals when possible. Overall, it appears as if teachers feel that they are well-attuned to the mental health needs of their students, that they
report utilizing a range of strategies and supports, but that they perceive a range of barrier complicating their efforts. In the next and final chapter, I will consider the importance of the findings just discussed, including implications for teachers and the educational research community, and myself as a future teacher. Additionally, I will suggest some key recommendations for teachers, administrators, schools, school boards, teachers’ unions, and teacher education programs, as to how each may better support students living with mental health problems or illnesses.
Chapter Five: Implications

5.0 Introduction

In this chapter I explain key implications gleaned from this research study on teachers’ perspectives on student mental health. I begin by reviewing key findings discussed in Chapter Four, in order to provide context for this chapter. Secondly, I highlight implications of these findings, which are separated into two categories: broad implications, which are for the educational community at large, and narrow implications, which specifically relate to my own professional identity and teaching practice. Next, based on these implications, I make recommendations with regard to student mental health for teachers, parents, administrators, schools boards, and for Ontario’s Ministry of Education. Finally, I comment on areas for further research, before concluding the chapter and paper.

5.1 Overview of Key Findings and Their Significance

In Chapter Four I detailed my findings based on interviews with two Greater Toronto Area (GTA) elementary school teachers, who have taught in Ontario for over five years, and who reported teaching students living with mental health problems or illnesses. Based on those interviews, I synthesized four key themes regarding teachers’ perspectives of student mental health.

First, teachers reported that the impacts of student mental health problems or illnesses are often visible, and can include impaired academic performance, stigma, and trouble fitting in with peers. These teachers reported perceiving a relationship between stress and reduced academic performance in students whom they described as coming from ‘broken homes’, as well as from stress in general. They also reported feeling that mental health problems of a behavioural nature
in particular were associated with stigma from other students and parents, which they suggested often leads to trouble fitting in socially.

Secondly, teachers in this study reported perceiving a range of factors which they felt can act as barriers preventing them from supporting students with mental health problems or illnesses, including student workload, teacher workload, and a lack of support from parents. With regard to student workload, teachers reported that they felt enrollment in French Immersion acted as an additional barrier, and often created additional stress for students.

The third theme was that both participating teachers reported feeling that they had not received adequate training to properly address the needs of students with mental health problems or illnesses, and that access to supports such as psychologists was often limited. One participant did note that despite this challenge, he felt that gaining more experience as a teacher, and attending school-based initiatives such as Mental Health Week was helpful. Additionally both of these Ontario teachers noted that their schools and school boards have provided them with professional development opportunities related to mental health, but that they have not participated in them thus far.

The fourth and final theme was that teachers described having various strategies they utilize to help prevent or address mental health problems. The key strategies reported include: utilizing purposeful, mixed grouping to prevent stigma; seeking out assistance from administration and support professionals at school when needed; building better relationships with parents through positive communication whenever possible; and listening to students and building relationships with them in order to understand and better support their mental health needs.
Altogether, these findings contribute to the existing educational research landscape for two key reasons. As noted in Chapter Two, there appears to be a dearth of literature on teachers’ perspectives of student mental health in Ontario, so these two teachers’ voices help fill that gap. Much of the research that has been done seems to be about the United States or about Canada as a whole, and I think these teachers have provided some insight into some potential challenges, such as French Immersion, which may be quite different between jurisdictions. Secondly, I think the findings in this study are valuable in that they communicate the perspectives of relatively new teachers with regard to student mental health, which is something I did not encounter in the literature. I think newer teachers’ perspectives could prove valuable for parties interested in supporting these teachers, and they also potentially show a more current reflection of how modern teacher education programs are preparing teachers with regard to this topic. These and other implications will be discussed in the following section.

5.2 Implications

In this section, I discuss the implications of my findings in two associated sub-sections. The first sub-section will detail broad implications for the educational research community, while the second will discuss more narrow implications, specifically with regard to my own professional identity and practice as a teacher and researcher.

5.2.1 Broad implications: The educational research community. In this sub-section I will highlight what I believe to be some of the implications of my findings for the educational research community. Findings from the two interviews discussed in Chapter Four suggest that generalist teachers in the GTA are noticing mental health problems and illnesses in students, but that they do not feel especially prepared or supported in trying to address them. It might be the case that despite a general increased awareness that teachers may be demonstrating for this issue,
that teacher education programs and further professional development offerings may have been insufficient in addressing this challenge thus far. It could also be the case that these teachers have not been given the adequate time to attend these opportunities. Additionally, given that both teachers in this study identified parents as being regular barriers to addressing their students’ mental health problems or illnesses, it might be the case that efforts to address these concerns are not doing enough to meaningfully engage or partner with parents.

Despite this, it may be that efforts to address student mental health in schools are having some positive results. Both teachers in this study indicated that their schools have had initiatives or events regarding student mental health, which may not have always been the case in years prior. Additionally, it might be the case that even if teachers are not learning or using any strategies specific to addressing student mental health, that their increased awareness for the topic and their more general expertise as teachers may be allowing them to support students with mental health problems or illnesses to an appreciable degree.

5.2.2 Narrow implications: My professional identity and practice. Beyond these broad implications for the educational research community, the findings of this study highlight some implications for me as both a researcher and future teacher.

As I discussed in my reflexive positioning statement in Chapter Two, my training and identity as a Registered Nurse (RN) affect the way that I approach this topic, since it is something which I have prior experience with in nursing school and in a healthcare setting. Because of this, I recognize that I may be placing altered or higher expectations of teachers and on the educational system with regard to this topic as a result.

As a result of my training and experience as an RN, I think these findings have particular implications for me. As discussed above, it might be that many teachers are not sufficiently
prepared to support students with mental health problems or illnesses, but I cannot share their excuse. I have had specialized training and experience regarding mental health in children and adults, so I think I have an extra responsibility to support students, and to advocate for mental health awareness in schools and beyond.

Despite this, I also recognize that I have limited experience addressing mental health problems or illnesses in an educational setting, and that I likely need to develop a complementary set of strategies for use in a school environment. As I enter the teaching profession, I commit to seeking out and participating in opportunities which will give me these skills, in addition to of course developing my skills as a teacher in general. Additionally, I think that I have a responsibility to raise the issue of student mental health with students, parents, and other educational professionals in my own future practice, in order to prevent and address stigma, since it was identified as a major barrier both in the literature and in this study, as discussed in Chapters Two and Four respectively.

I believe that the core purpose of education, and of teachers by extension, is to help raise and nurture children to reach their potential to be the most happy, healthy, and critically thinking adults that they can be. Due to socioeconomics, mental health, and a range of other factors, I think that some children stand to benefit from education more than others, and it is these children in particular that I think teachers need to look out for most closely. I think schools have a critical role to play in this regard and be equalizers which buffer and even correct much of the inequity present in our society. With these implications in mind, in the following section I will highlight the recommendations that I have developed for various stakeholders regarding student mental health.
5.3 Recommendations

This section will highlight the recommendations I have developed for teachers, administrators, schools, school boards, teachers’ unions, and teacher education programs, which I consider to be the primary parties influencing teachers’ readiness to support student mental health.

Generalist elementary school teachers are in an excellent position to get to know their students at quite a depth, and should utilize that opportunity so that they can recognize when students might be living with mental health problems or illnesses. If teachers feel that they are unable to recognize or support these students, they should seek out professional development opportunities at the earliest opportunity until they feel prepared. Since parents were identified in this study as potential barriers to addressing the mental health needs of students, teachers should also reach out and partner with them by engaging in constructive dialogue on a regular basis and as needed. Lastly, in order to combat stigma in schools, teachers should tactfully bring stories and lessons into the classroom which involve mental health, so that students develop a respectful understanding of the topic. Aside from professional development opportunities, all of these recommendations should carry little to no cost, and should be initiated immediately.

With regard to the cost of professional development, administrators and school boards should provide funding and organized opportunities for all teachers to learn about mental health problems and illnesses. These initiatives should be provided at the earliest opportunity, considering budgetary needs and program availability. In this study, administrators were identified as important perceived supports for teachers with regard to their efforts to address student mental health problems or illnesses, thus all administrators should recognize that they have the potential to fill this role and should regularly communicate this support to their staff.
over time. Additionally, teachers and administrators should partner to seek out and invite guest speakers or agencies involved with mental health to the school in an effort to increase mental health literacy and reduce stigma.

Ontario teachers’ unions should support teachers’ efforts to establish relationships with parents, even if it means spending time outside of official work hours communicating with them. Unions should also consider supplementing any costs associated with their members participating in professional development opportunities relating to mental health, beginning within the next three years if they are not already doing so.

The Ontario Ministry of Education should mandate that within three years, all teacher education programs in the province must have a mental health component, which should include content on working with children living with mental health problems, recognizing signs and symptoms of mental health illnesses, anti-stigma and suicide prevention strategies, as well as practical suggestions for collaborating with relevant professionals within the school setting and partnering with parents. Supplementally, within their official practicum guidelines, teacher education programs should include an orientation to the policies and procedures of placement schools or school boards regarding mental health issues. This should be implemented immediately or by commencement of the next school term.

5.4 Areas for Further Research

Beyond the recommendations just discussed, there are several areas for further research with regard to student mental health. This study found that teachers perceive that French Immersion programs might be contributing to mental health problems in students by accentuating workload and stress. I did not encounter French Immersion as a factor in student mental health in the literature review, and I believe that further research into this potential effect
is warranted, especially in an Ontario context, as language immersion programs presumably vary by jurisdiction.

Participants in this study also identified parents as being a regular barrier to their ability to support students with mental health problems or illnesses, so future research could investigate relationships between parents and teachers and student wellness. Additionally, student perspectives of barriers and supports could yield critical insight and inform best practices regarding mental health in Ontario schools, since this also appeared to be lacking in the literature. Additional research could also look further at strategies regarding student mental health, including anti-stigma strategies, that are being used within Ontario schools, as there appeared to be a lack of this in the literature. Finally, as this study was small and only interviewed two practicing generalist teachers, future research could look at a wider range of teachers, including teachers and other professionals within the school setting who may have specialized knowledge regarding student mental health.

5.5 Concluding Comments

In conclusion, this study identified that GTA teachers may perceive a range of mental health problems or illnesses in students, and that there are numerous barriers and supports affecting their ability or readiness to address this topic. I think this research matters for anyone within the realm of education, including parents or guardians of students, simply because mental health problems are so prevalent in Ontario and beyond.

As an RN and future teacher, I look at this topic through the dual lenses of healthcare and education, and in the coming years I hope to see this topic of student mental health addressed through collaborations on many levels, but especially between professionals in healthcare and education, which may require initiation or additional collaboration between the Ministries of
Education and Health and Long-Term Care. I recognize that my training and experience regarding mental health might make me have unreasonably high expectations of teachers with respect to their ability or role to identify mental health problems in students and support them, but given the amount of time they spend with students I think their potential in this realm must not be under-estimated.

I believe there is a general perception that mental health awareness is increasing over time, but I think it remains to be seen whether this attention is leading to meaningful outcomes for students and others living with mental health problems or illnesses. This attention has a tremendous potential to reduce stigma and improve well-being across the population, but it is also quite uncertain how long this awareness will endure. Therefore, it is essential that appropriate measures are taken promptly while there is widespread attention and a presumed increase in public support.
References


Appendix A: Letter of Consent for Interview

UNIVERSITY OF TORONTO
OISE | ONTARIO INSTITUTE
FOR STUDIES IN EDUCATION

Date:

Dear ______________________________,

My name is Sean MacLeod and I am a student in the Master of Teaching (MT) program at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). A component of this degree program involves conducting a small-scale qualitative research study. My research will focus on educator’s perspectives of student mental health. I am interested in interviewing teachers who have experience educating students living with mental health problems or illnesses, who live in the GTA, and have taught in a classroom setting for at least 5 years. I think that your knowledge and experience will provide insights into this topic.

Your participation in this research will involve one roughly 60-75 minute interview, which will be transcribed and audio-recorded. I would be grateful if you would allow me to interview you at a place and time convenient for you, outside of school time. The contents of this interview will be used for my research project, which will include a final paper and informal presentations to my classmates. I may also present my research findings via conference presentations and/or through publication. You will be assigned a pseudonym to maintain your anonymity and I will not use your name or any other content that might identify you in my written work, oral presentations, or publications. This information will remain confidential. Any information that identifies your school or students will also be excluded.

The interview data will be stored on my password-protected computer and the only person who will have access to the research data will be my course instructor. You are free to change your mind about your participation at any time, and to withdraw even after you have consented to participate. You may also choose to decline to answer any specific question during the interview. I will destroy the audio recording after the paper has been presented and/or published, which may take up to a maximum of five years after the data has been collected. There are no known risks to participation.

Please sign this consent form, if you agree to be interviewed. The second copy is for your records. I am very grateful for your participation.

Sincerely,

Sean MacLeod

MT Program Contact: Dr. Angela Macdonald-Vemic, Assistant Professor – Teaching Stream
Consent Form

I acknowledge that the topic of this interview has been explained to me and that any questions that I have asked have been answered to my satisfaction. I understand that I can withdraw from this research study at any time without penalty.

I have read the letter provided to me by Sean MacLeod and agree to participate in an interview for the purposes described. I agree to have the interview audio-recorded.

Signature: ________________________________________

Name: (printed) _______________________________________________

Date: ______________________________________
Appendix B: Interview Protocol

I’m Sean MacLeod, and I’m a student in the Masters of Teaching program at OISE at the University of Toronto (in between my first and second year), and as part of that we do an original research project. Thank you so much for agreeing to participate.

My research project is looking at student mental health in schools, from the perspective of educators. I’m hoping to learn about how teachers perceive mental health in the classroom, including how it impacts teaching and learning, but also what sorts of supports or barriers you’ve encountered.

So over the next 60-75 minutes I will be asking a number of questions regarding experiences you may have had regarding mental health in your classroom, as well as what supports or barriers you’ve encountered as an educator of students living with mental health problems or illnesses.

Section A: Background Information

1. How long have you been teaching in Ontario?
   a. Have you taught anywhere else other than Ontario?
      
      Where and for how long?

   b. How long have you been at this school?

   c. Where did you attend teacher’s college?

2. What grades, subjects and streams do you currently teach?
   a. Which have you taught in the past?
3. Could you tell me about a typical period in your classroom?

4. In addition to your role as a teacher, are there any other roles you fill in the school that you would like to share? (extra-curricular activities etc.)

5. Tell me about the neighbourhood in which your school is situated. How would you describe the demographics? (including that of students and families)

6. I’ve asked you a number of questions about yourself and your school. Is there anything you’d like to add that hasn’t come up before we proceed to talking about mental health specifically?

**Section B: Observations**

7. Could you describe in general how you see student mental health problems or illnesses affect teaching and learning in your school?

    a. How about?

        i. Academic success

        ii. Attendance

        iii. Peer interactions/bullying

        iv. Classroom management/teaching.

8. Could you tell me about any factors you feel might be making school a more challenging experience for students living with mental health problems or illnesses?

    a. How about?

        i. Stress

        ii. Social pressure

        iii. External factors (such as family issues etc.)

        iv. Stigma
9. In your experience as a teacher thus far, can you estimate how many students have you worked with who had mental health problems or illnesses?
   a. Were these students all formally diagnosed?

10. I’m going to ask you to tell me in some more detail (anonymously) about some of these students. Could you give an example of a student you have worked with who was living with a mental health problem or illness?
   To your knowledge:
   a. What mental health problem or illness was the student living with?
      i. Was it formally diagnosed?
      ii. If not, how did you come to be aware of it?
   b. What words did the student use to describe their problem or illness? (if applicable)
      i. How do you recall other students responding to or interacting with this student?
   c. In what ways did the mental health problem or illness appear to affect the student?
      i. Academically
      ii. Socially
   d. Was the student receiving formal assistance of any kind for their mental health problem or illness?
      i. Externally (e.g., from a health care professional)
      ii. Internally (at school).
   e. How was the student’s family involved? (if applicable)
   f. In your opinion, was the student's’ situation addressed sufficiently at school?
      i. How could you tell?
      ii. (If yes to f.) How was this accomplished?
iii. (If no to f.) What could have been done differently?

g. Did you feel sufficiently prepared to address the particular needs of the student?

[Optional – repeat the above sequence for an additional student.]

X. Why do you think you chose to speak to me about these particular student(s) today?

Section C: Interventions, Supports, and Barriers

11. Describe a typical way your school might support students with a mental health problems or illnesses (including administration, guidance etc.).

   a. Are there any resources available in the school that are specific to mental health, to your knowledge?

12. Does student mental health ever come up in conversation between you and your colleagues?

   a. In what way has mental health been discussed during staff meetings? (if at all)

13. Can you tell me of any examples of mental health coming up at all in class conversations and being discussed by or with students?

   a. If so, how would you say your students generally respond to the topic?

14. Have you ever taken or been offered professional development around mental health? (Professional Development, AQs, Teacher’s College courses).

   a. If so, from where?

   b. If so, Can you describe how that learning has supported you in teaching students with mental health problems or illnesses?

   c. To your knowledge, would you say that teachers have enough access to this sort of education?

15. What sort of barriers would you say you’ve encountered that may have prevented you from supporting students with mental health problems or illnesses in the past?
a. How do you manage those barriers? (if it was possible)

b. In your opinion, what should schools do to manage these barriers to best support students living with mental health problems or illnesses?

16. As a teacher candidate hoping starting to teach next year, is there any advice you could share with me about supporting students with mental health problems or illnesses?

Those are all of the questions I have. Thank you so much for agreeing to participate in this study. I particularly appreciate the sort of insights you’ve had and your experience. Do you have any questions for me?