Supporting Students and Promoting Mental Health:
Experiences of Secondary School MHFA-Certified Teachers

By

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Abstract

Mental health is a fast growing area of research due to increasing awareness of the prevalence of mental health problems. Most mental illnesses and problems first arise in adolescence and so secondary schools are especially important environments to promote positive attitudes and increase mental health literacy. Educators also have a unique opportunity to provide support to students experiencing mental health problems, promote mental health literacy, and challenge stigma. However, research shows that many educators feel unprepared for this role. This research study focused on how secondary school educators with Mental Health First Aid training support students with mental health problems. This qualitative study included a literature review and semi-structured interviews with Mental Health First Aid-trained secondary school educators working in the Greater Toronto Area. Findings suggest that these educators had a strong understanding of their role in supporting their students and were confident in their ability to identify and support students with mental health problems. Furthermore, they highlighted the importance of destigmatizing discussions around mental health. Implications of these findings include that stigma around mental health in secondary schools still exist despite improvements and that school boards might benefit from standardizing programs to adequately prepare educators for their role in promoting mental health in secondary schools.

Key Words: mental health, Mental Health First Aid, mental health literacy, secondary schools, educator role
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Chapter 1: Introduction

1.0 Research Context and Problem

In recent years, mental health has garnered increasing attention. It has now become one of the most regularly talked about social issues in Canada. This may be in part due to the efforts of campaigns such as Bell Let’s Talk or the initiatives of the Mental Health Commission of Canada. Bell Let’s Talk is an initiative by Bell Canada that began in 2010 with the goal of starting new conversations around mental health and reducing the stigma associated with the topic. Each year on Bell Let’s Talk Day, Bell Canada donates five cents to mental health initiatives for every text, call, tweet, Instagram post, Facebook video view and Snapchat geofilter. To date, Bell has donated 86.5 million dollars to mental health initiatives (Bell Canada, 2017). The Mental Health Commission of Canada (MHCC) is an organization dedicated to improving Canada’s mental health system and changing Canadians’ attitudes and behaviours with respect to mental health issues. The MHCC gets its mandate from Health Canada to bring together leaders and organizations from across the country to meet these goals (MHCC, 2017).

In February 2010, Mental Health First Aid Canada came under the leadership of the Mental Health Commission of Canada. The Mental Health First Aid Program was initially developed in Australia in 2001. The program has since been developed, evaluated and adopted by 18 countries all around the world, including Canada. Australia and Scotland have both incorporated the program into their national mental health strategies.

The increased awareness around mental health in recent years can not be solely attributed to awareness campaigns. Mental health has become a major issue to the general public due to its impact on society. One in five Canadians will experience some form of mental health problem in any given year (Smetanin, Briante, Stiff, Ahmad, & Khan, 2015). This is a statistic that is well
known and concerning; it has brought significant attention to the issue of mental health, and society as a whole is beginning to respond. One reason this issue may be gaining so much traction is that, in addition to affecting so many people, the costs associated with mental illness in Canada is close to 50 billion dollars (Lim & Dewa, 2008; Smetanin et al., 2011).

In many ways, Canada is considered one of the most developed and progressive countries; until recently, however, the nation has been quite behind in the field of mental health. As of 2008, Canada was the only country in the G8 without a national health strategy (Kirby, 2008). Fortunately, in Ontario the provincial government has begun to respond. Since 2003, the government of Ontario has increased funding for community mental health by 80%, and by 49% for addictions programs (Ontario Ministry of Health and Long-Term Care [OMHLTC], 2011). The government has also expanded a variety of programs such as intensive case management, assertive community treatment, crisis intervention, early psychosis intervention, as well as various initiatives to help keep citizens with severe mental health problems out of the criminal justice and corrective systems.

According to Ontario’s Ministry of Child and Youth Services (2012), one in five young people are dealing with mental health problems, and 70% of all mental illnesses have their onset in childhood and adolescence. Recognizing this, Ontario has made supporting the mental health of youth the first priority in their “Comprehensive Mental Health and Addictions Strategy”. This strategy, titled Open Minds, Healthy Minds states goals for improving support for the mental health in its first three years. These goals are to: Provide children, youth and families with fast access to high quality services, identify and intervene in child and youth mental health and addictions issues early and to close critical service gaps for vulnerable children and youth, children and youth at key transition points, and those in remote communities (OMHLTC, 2011).
The document also specifically outlines ways in which schools may play a role in supporting the mental health of youth. The strategy acknowledges that school may be the first place where there is an opportunity to recognize youth that are facing mental health problems. In order to help educators recognize this, the strategy claims that the government will “implement mental health literacy and cross-sectoral training on early identification and intervention for educators, implement programs through schools and community-based agencies to enable early identification and referral for treatment [as well as] enhance mental health resources in schools” (OMHLTC, 2011, p. 14).

While the Open Minds, Healthy Minds strategy was the beginning of Ontario’s initiatives to improve mental health services in the province, it has created several more specific programs as a result to address more specific issues. For example, the Ministries of Child and Youth Services, Education, Health and Long-Term Care, and Training, Colleges, and Universities, partnered together and created Moving on Mental Health which is an action plan to specifically improve mental health services for youth in the province. The plan consists of two parts, first to create and support pathways to care, and to define core services that will be made available in communities across Ontario. In order to support this action plan and remain accountable the government has established community led agencies, created a new funding model, and built a new legislative and regulatory framework (OMCYS, 2012).

The action plans provided by the government of Ontario acknowledge that improving supports for the youth of mental health is a priority and they are broad plans to improve and completely restructure the support system for mental health in the province. However, the Ministry of Education has also created a plan specific to improving mental health supports in schools across Ontario. Instead of creating another action plan specific to school support
systems, the Ministry of Education created *Supporting Minds*, a document that is meant to serve as a resource for those who work in the field of education (OME, 2013). This Ministry of Education document is a resource for educators that provides guiding principles for teachers as they strive to promote mental health in schools through early recognition and effective classroom strategies. The document was compiled using “a comprehensive survey of current research as well as consultation with experts and practitioners in the field” (p. 4). This document is not only one of many responses stemming from the broader *Open Minds, Healthy Minds* policy, but also supports the priorities set out by the Ministry of Education in Ontario which are: high levels of student achievement, reduced gaps in student achievement, and increased public confidence in publicly funded education. In *Supporting Minds*, the Ministry acknowledges the important role teachers play in their students’ lives, and the opportunity that educators have to support their students’ mental health. It describes three ways educators can do this: by promoting positive mental health at school, by identifying students who may have mental health problems, and by connecting those students with appropriate services (OME, 2013).

The document includes two parts, the first part gives general information about mental health and discusses how mental health plays out in an educational context, this includes the role of teachers, and the best way for educators to communicate with important stakeholders regarding mental health (OME, 2013). This section also gives guidelines for creating a positive classroom environment, and how educators might decrease stigma associated with mental health in their classrooms. The second part of *Supporting Minds* includes information about specific types of mental health problems and mental disorders, as well as how educators might be able to help support students with these problems (OME, 2013).
Mental health is a universal issue that affects everybody; however, it is important to note that 70 percent of mental illnesses onset in childhood or adolescence (Mental Health Commission of Canada, 2012). Not only do mental health issues usually first arise at a young age, but suicide is the second leading cause of death in Canadian youth (Leitch, 2007). Mental health is of growing concern, and it is especially important to pay attention to the well being of young adults. By promoting mental health for young adults, we ensure that mental health will continue to receive the attention it deserves as we move into the future. While the Open Minds, Healthy Minds (OMHLTC, 2011) document is a comprehensive strategy for the province of Ontario to improve its mental health services for everyone within the province, the document acknowledges that in order to bring about long term change, it needs to first focus on “early intervention and support to protect our children from the many associated costs of mental illness and addictions and help steer them on the road to safe, healthy, and happy futures” (p. 4). In order to achieve this goal, the government of Ontario has implemented a number of more specific resources and programs to improve its ability to support the mental health of youth.

While adolescence is often when mental health problems first arise (Leitch, 2007), studies show that only one in five Canadian children with a mental disorder actually receives treatment (UNICEF Canada, 2007). Both the Canadian and Ontario governments have recognized the importance of supporting the mental health of Canadian youth by making this a major focus and the first priority in their strategies to improve mental health services. Additionally, many researchers agree that schools are the most effective setting in which to support the mental health of youth (Power, Cleary, & Fitzpatrick, 2008; Schonert-Reichl & Hymel, 2007).

The research shows that mental health problems often initially arise in adolescence, and so secondary schools are an environment where educators are in a position to make a difference
and establish a healthy understanding of the importance of mental health. Not only that, but educators are in a unique position to support students experiencing mental health problems. It is for this reason that speaking to educators directly about their experiences in this role is crucial to understand how educators are able to support students with mental health problems.

It is pertinent to clarify definitions as they are used in this paper, specifically the difference between mental health problems and disorders. The Centre for Addictions and Mental Health (CAMH) defines mental health problems as changes in a person’s ability to cope and function, as compared to mental health illnesses which are mental health problems that are diagnosed and treated by mental health professionals (CAMH, 2012).

1.1 Purpose of Study

The purpose of this study is to explore how secondary school teachers in the Greater Toronto Area with Mental Health First Aid (MHFA) certification are working to support students with mental health problems and mental disorders. I explore this topic by interviewing a sample of these teachers about: identifying students with mental health problems, challenges they face when supporting students with mental health problems; strategies they used in supporting these students’ mental health and perceived outcomes; and the perceived effects of their MHFA training on their practice. By asking secondary school educators with MHFA training about their experiences supporting their students’ mental health, the study intends to find out how the MHFA program is helping educators discuss mental health in and outside the classroom, and then use these findings to suggest how teachers can be better supported in this endeavor and how MHFA can be utilized in the future as part of this endeavor. Hopefully this will contribute to better support for students and staff in the school communities with regards to mental health and well being.
1.2 Research Questions

The central research question guiding this study is: How are secondary school educators with Mental Health First Aid training working to support students with mental health problems or disorders? Sub-questions for the study are:

- How do these teachers reportedly identify students with mental health problems in their classrooms, and how confident are teachers in this ability?
- What strategies, programs, and resources do these teachers reportedly implement in their classroom to promote mental health and support students with mental health problems?
- How prepared do these teachers feel to support students facing mental health problems, and promoting mental health in their schools and has MHFA helped with this?
- What challenges do teachers face in supporting students’ mental health?

1.3 Background of the Researcher

As someone who has had many close personal relationships with friends, peers, and other young adults who have struggled with varying forms of mental health problems ranging from minor to debilitating, I have become extremely interested in mental health. My experiences with friends who have experienced mental health problems have often been in university, but a common theme is that despite showing signs of mental health problems in high school, they were never given any support, nor did they ever learn anything about mental health. Instead, the only experience these individuals had with mental health was the stigma in talking about their experiences. Given my interest in a career as a secondary school educator, I am especially interested in the role teachers can play in identifying and supporting students who struggle with mental health issues within the school setting. However, having never been clinically diagnosed with any form of mental illness myself, I approach this topic as somewhat of an outsider looking
in. I hope to identify the challenges teachers face in their attempts to provide valuable support to students struggling with mental health, as I believe teachers to be in a unique position to help students in these situations.

As a Sikh Canadian, and second generation immigrant, I am also aware that cultural perceptions of mental health are an important consideration when dealing with mental health problems, and especially in seeking support. In general South Asian immigrants often hold views that are especially stigmatizing with regards to mental health, and often avoid seeking help or expressing the mental health problems they may be facing. Canada and the GTA in particular are very multicultural areas, and schools in the GTA serve many students of varying cultural backgrounds; therefore, my experiences lead me to believe that it is especially important for schools to play a role in supporting students in taking care of their mental health, as they may not be receiving the support or resources they need to ensure their mental well-being in other areas of their life.

1.4 Overview

To respond to the research questions, I conducted a qualitative research study using purposeful sampling to interview five teachers who have training in Mental Health First Aid about their efforts to support students with mental health problems. In Chapter 2 I review the literature in the areas of mental health, and mental well being, specifically in the context of supporting secondary school students. Next, in Chapter 3 I elaborate on the research design. In Chapter 4, I report my research findings and discuss their significance in light of the existing research literature, and in Chapter 5 I identify the implications of the research findings for my own teacher identity and practice, and for the educational research community more broadly.
also summarize the challenges teachers described and ask further questions in the hopes that eventually solutions can be found to resolve these challenges in the future.
Chapter 2: Literature Review

2.0 Introduction

In this chapter, I review the literature on mental health in Ontario, with a particular focus on mental health in secondary schools and how young adults experience mental health. In particular, I focus on research regarding the prevalence of mental health Ontario Secondary Schools. I also discuss what research has found about social factors that may make it more like for individuals to experience mental health problems or mental illnesses. Finally, I review the literature on relevant programs that have been implemented in secondary schools, and what has been found regarding their effectiveness. I pay particular attention to findings on the efficacy of the MHFA program. Throughout this paper, I strive to use the most appropriate language, as the use of certain terms associated with mental health are often stigmatizing; however, as the language around mental health is changing very rapidly, often different studies choose to use different language, so in this literature review I will use the language chosen by the authors of the various included studies.

2.1 Social Factors Associated with Youth Mental Health Problems

Mental health is something that everybody has, and mental health problems can affect anyone; however, there has been extensive research done regarding various social factors that are associated with higher rates of mental health problems or mental illness. While this research can be important and helpful, the findings can often be misinterpreted in ways which are not helpful and may actually be harmful increase stigma. Some of the social factors that researchers have found to be associated with higher or lower rates of mental health problems or disorders include race, sex, chronic illness, experiences with violence, and socioeconomic status, among many others.
2.1.1 Race, ethnicity and culture

There has been a significant amount of research regarding how different cultures and ethnic groups experience mental health, which I will review in this section (Brooks, Harris, Thrall, & Woods, 2002). However, the findings of this research are not always consistent. On the one hand, some studies have found that various minority groups experience mental health problems and illness at a higher rate (Cauce et al., 2002; Chow, Jaffee, & Snowden, 2003; Garland et al., 2005; Harris, Edlund & Larson, 2005), whereas others find that being of certain minority groups or belonging to certain cultures actually has a protective effect (Brooks et al., 2002). In fact, while not unanimously (Cauce et al., 2002), the literature does seem to agree that African Americans have better mental health than the average population (Brooks et al., 2002; Harris, Edlund, & Larson, 2005). On the other hand, Indigenous populations have been identified as having the highest rate of mental health problems and illness (Cauce et al., 2002; Harris, Edlund, & Larson, 2005).

Another consistent finding is that minority youth do not receive support, or even seek support, as often as white adolescents. In the United States, Hispanics, African-Americans, Asian-Americans, Pacific Islanders, and Native Americans have all been found to use mental health support services at a significant lower rate than white youth when comparing to similarly “at-risk” populations (Brooks et al., 2002; Cauce et al., 2002; Garland et al., 2005). One study found that 7 out of 10 American adolescents with mental health problems do not get support while the same statistic was 80% for Latino youth (Zwillich, 2000). A similar study found that 75% of students who were identified as “high-risk” used mental health services, but among those “high-risk” students, use was 70% for Latino students, 64% for African-American students, 59% for Asian-Americans and Pacific Islanders, but 79% for non-Hispanic white students (Garland et
al., 2005). These results indicate that mental health supports and supporters should be more culturally relevant, or at least be more aware of cultural differences and how various ethnic groups perceive and experience mental health.

Numerous studies have found that belonging to different cultures plays a significant role in how an individual experiences mental health. Some cultures are much more supportive, some cultures have greater stigmatization of mental health within them, and some cultures have different perceptions about how to best maintain mental well-being (Cauce et al., 2002, Yeh, M., McCabe, Hough, Dupuis, & Hazen, 2003). Even the experience of adolescence itself can be different in different cultures. These differences are extremely important to consider in how they factor into an adolescent’s mental health and how they might experience the process of seeking mental health support (Cause et al., 2002). This is especially true in a diverse Canadian context when the culture of a teenager’s parents, may conflict with the broader “Canadian” or “Western” culture they experience at school. There is research to support this argument as studies have not found this same difference between minority and non-minority use of public services related to physical health. Furthermore, this suggests that the stigma around mental health may at least contribute to minorities not utilizing mental health support programs (Cauce et al., 2002; John, 2011). One explanation may be that ethnic minorities are also more likely to be of a low socioeconomic standing; this is another social factor that predicts a lower likelihood of seeking and receiving mental health support (John, 2011; Smith et al., 2013). However several studies have taken this into consideration, and even when socioeconomic status is controlled for, the difference in use of mental health supports is still significant lower in ethnic minorities. (John, 2011; Smith et al., 2013)
One limitation of the research on ethnicity, culture and mental health is that there does not seem to be much research done in Canada. Most research is based on American data, while Canadian research focuses on immigration status and mental health instead of culture and ethnicity, which tend to be emphasized in American studies. There are a few possible reasons for this difference. For one the demographics of these two countries is somewhat different, but maybe more importantly there is a difference in attitude and approach towards minorities and immigrants between Canada and America, as far back as 1996, Palmer (1996) described this difference as the mosaic versus the melting pot. However, Peach (2005) uses the same terms. Both authors describe Canada as the mosaic, where individuals belonging to different minority groups and cultural backgrounds are encouraged to maintain their cultures and differences which are celebrated. In comparison, the melting pot described by Peach (2005) and Palmer (1996) in America encourages these individuals to integrate and assimilate into one unified culture of shared values. Soroka, Johnston, and Banting (2006) speak on this further, through their study on new Canadians. They found that immigrant Canadians do not differ from British/northern European Canadians on a number of measures, including pride in being Canadian, trust, sense of belonging, and values. This is what Soroka Johnston, and Banting (2006) refer to as social cohesion. So despite the mosaic that Canada strives to create by maintaining diverse cultures of immigrants, in a relatively short period of time these immigrants form a sense of social cohesion with fellow Canadians. Perhaps this is why Canadian researchers feel less need to differentiate between various ethnicities.

2.1.2 Gender and sexuality

In adolescence many people explore and learn about their sexuality and gender identity. While these are now recognized as two different constructs, research on these topics are often
reported in the same studies. Literature comparing the mental health of males and females has found that females consistently have higher rates of mental health problems and illnesses. They are also more likely to report these problems and seek support (John, 2011). In one study (Brooks et al., 2002), females were three times more likely to report mental health problems than males. However, Smith et al., have claimed that men may only be less likely to report mental health problems to a certain threshold, or may delay seeking support for mental health until they consider it “severe” enough to require professional help (Smith et al., 2013).

Interestingly, there has been a fair amount of research regarding how gender actually affects the way in which other social factors impact mental health. Males have been found to be more likely to experience mental health problems as they get older (Brooks et al., 2002). Males who reported being involved in more physical fights, and who had unprotected sex were also more likely to experience mental health problems (Brooks et al., 2002). On the other hand, females who used tobacco were more likely to experience mental health problems. Interestingly, adolescent females who were sexually active were also more likely to experience mental health problems, unless they were not using birth control. Less surprisingly, females with healthy diets were less likely to have mental health problems (Brooks et al., 2002).

Research regarding gay, lesbian, bisexual, transgendered and queer youth has only recently become more prevalent, but the information thus far indicates that sexual minorities and transgendered adolescents experience more mental health problems than those who are heterosexual and/or cisgender (Borowsky et al., 2001; D'Augelli et al., 2001; Goldfried, 2001; Gould, Greenberg, Velting, & Shaffer, 2003; Paul et al., 2002; Russell & Joyner, 2001; Udry & Chantala, 2002).

2.1.3 Socioeconomic Status
Children in families with low socioeconomic status are two to three times more likely to have mental health problems; however, the association in the study weakened in adolescents (Reiss, 2013). Improvements in socioeconomic status are associated with improvements in mental health in youth as well. Adolescents of lower socioeconomic status are less likely to receive mental health support than those of higher socioeconomic standing (Amone-P’Olak, 2009; Cummings, 2014; Reiss, 2014). These findings hold true even when controlling for other factors that are often correlated with low socioeconomic status including being an ethnic minority. Cummings (2014) explains this finding by referencing the greater demand for mental health supports in less affluent areas. There is evidence to support this as the gap between demand and availability is significantly greater in areas that are less affluent.

To summarize, there are a number of social factors that intersect with mental health supports. Studies in the US find that minority groups often access mental health supports at lower rates relative to their white counterparts, but conflict when reporting which ethnic groups experience mental illnesses at higher rates. There also seems to be a relative lack of research with regards to Canadian differences in mental health between racialized minorities. In terms of gender and sexuality, females experienced higher rates of mental health problems, and were also more likely to report these problems, and members of the LGBTQ community universally reported higher rates of mental health problems. There was also a greater gap between demand and availability of mental health supports in less affluent areas.

2.2 Mental Health in Secondary Schools

Mental health problems are quite prevalent in youth, and are complicated by various social factors. As shown in the introduction, provincial and federal governments have recognized this and identified supporting youth as the best way to improve mental health care moving forward.
Schools have been identified as a particularly important setting in which to support mental health. The question then is how to go about improving mental health supports for youth, especially in schools, and secondary schools in particular. In this section, I review literature regarding the role of teachers in supporting mental health, the importance of reducing stigma, and how effective programs are at improving mental health supports in secondary schools. Finally youth in families of lower socioeconomic status were found to have higher rates of mental health problems, and were less likely to access mental health supports, however this association was weaker in adults.

2.2.1 The teacher’s role

One of the reasons why schools are such an important place to promote good mental health is how much time children spend there. Teachers generally spend the most time with their students after their family, and have an enormous amount of influence on their students. In this way, educators have a unique opportunity to support their students’ mental health because schools are central to the lives of youth and adolescents, which are critical periods of time to foster mental health literacy. (Mazzer & Rickwood, 2015; Rodger et al., 2014; Whitley, Smith & Vaillancourt, 2013). Unfortunately, mental health literacy in schools is currently inadequate (Bowers et al., 2013). Mental health literacy is used here to describe a general understanding of mental health problems and disorders, and a familiarity with terminology used in the field. Despite acknowledging the importance of mental health, and its impact on their students’ lives, teachers across Ontario and around the world may feel unprepared for the task of supporting their students’ mental health (Chandra & Minkovitz, 2007; Mazzer & Rickwood, 2015; Short, Ferguson, & Santor, 2009). The issue begins with initial teacher education. In one study (Andrews, McCabe & Wideman-Johnston, 2014), only 5.3% of Ontario teachers reported having
a mandatory mental health course in their teacher education and 8% took an optional course. In fact, the majority claimed that, despite wanting to support their students’ mental health, they must instead rely on special education teachers, school psychologists, counsellors, and parents when dealing with students who have mental health problems.

This problem extends past initial teacher education. 68% of Canadian teachers have reported having no mental health training, despite almost universally expressing a desire for more knowledge on the topic (Canadian Teachers’ Federation, 2012). Only half of teachers surveyed by Andrews, McCabe and Wideman-Johnston (2014) were aware of resources and information that could help them support such students. Training teachers has been found to help improve the knowledge and attitude of teachers towards mental health (Kutcher, Wei, McLuckie & Bullock, 2013). This is especially important because research has found that teachers’ perceptions of their preparedness tend to be correct (Rodger et al., 2014). Ontario Teachers have been found to lack knowledge on mental health which can hinder their ability to support students with mental health problems (Whitley, Smith & Vaillancourt, 2013). A vast majority of Ontario teachers surveyed by Brackenreed and Frost (2002) also felt that they were not being supported by the professional mental health community; meanwhile, mental health workers surveyed in the same study agreed that teachers needed more training in order to better support students’ mental health.

### 2.2.2 Reducing stigma

One of the biggest barriers to supporting the mental health of youth is the stigma surrounding mental health, and seeking help with mental health problems (Bowers et al., 2013; Hartman et al., 2013; Kranke, Floersch, Townsend, & Munson, 2010; Moskos et al., 2007). Both young people and service providers have identified stigma as the greatest barrier to accessing
mental health support; however, this perception was still more common among students than service providers. This shows that, despite awareness of stigma, some service providers might be underestimating the magnitude of the challenge that is overcoming stigma (Chandra & Minkovitz, 2007; Short, Ferguson, & Santor, 2009). Stigma is also prevalent amongst both those with and without mental health issues (Hartman et al., 2013). Stigmatizing attitudes are developed as early as middle school, as some studies (Chandra & Minkovitz, 2007; Hartman et al., 2013) have found middle school students already show stigmatizing attitudes towards using mental health services. Middle school students surveyed by Chandra and Minkovits (2007) described the anticipated reaction of their family and peers, as well as other perceived social consequences of seeking mental health support. Similar to educators, young people are reportedly concerned with the lack of resources available to support mental health; however, despite this concern they can be quite ignorant of how prevalent mental health problems are (Bowers et al., 2013). Bowers et al. found that young people can severely underestimate how many other young people experience mental health problems. However, young people are aware of the stigma, and identified it as the biggest barrier to accessing mental health supports. This study also found that stigma effects are more prevalent in males than females.

Stigma also appears to be quite difficult to reduce. Even after a 12-hour program educating participants about mental health, mental health literacy rates increased and were sustained with the exception of stigmatizing views of individuals with schizophrenia and similar mental illnesses (Hartman et al., 2013). While it may be difficult, reducing stigma is not impossible, and educating people early may be the key to eliminating stigma. In the middle school study above, for example, Chandra and Minkovits (2007) found that the more
knowledgeable middle school students were regarding mental health, the more positive their attitudes were regarding mental health and mental health support.

2.2.3 Programs and efficacy

There have been a variety of educational programs used to promote mental health awareness. These programs have differing goals and success rates. In general, the programs tend to increase the knowledge of participants; however, reducing stigma and changing attitudes regarding mental health proves to be a much more difficult challenge to overcome. One example of a program that was studied was The Guide (Mcluckie, Kutcher, Wei, & Weaver, 2014). The Guide was a mental health curriculum that was implemented in Ontario schools. The implementation of the curriculum resulted in improvements in students’ general knowledge regarding mental health and exposure to this particular curriculum actually was associated with more positive attitudes about mental health (Mcluckie et al., 2014). This same program was implemented in Nova Scotia and an evaluation of the program within the Halifax Regional School Board found significant improvements in mental health literacy and reduced stigma among educators who received the training (Kutcher et al., 2013).

Wei and Kutcher (2014) evaluated a program called “‘Go-to’ educator training” which is closely related to the guide and was actually offered in combination with The Guide. This program was intended to be used as a follow up to The Guide and its goal was to provide training not only to increase mental health literacy but also to identify and support students with mental health problems and provide strategies to work collaboratively with health providers, parents and other members of the community (Wei & Kutcher, 2014). The evaluation of this program by Wei and Kutcher (2014) in the Halifax Regional School Board found that it significantly improved teachers’ knowledge of how to identify students with mental health problems and connect them
to the appropriate services for support. Furthermore, it helped establish and enhance positive attitudes towards mental disorders and participant feedback indicated that the program met the needs of educators’ and increased confidence in their ability to effectively support students (Wei & Kutcher, 2014). Another study found that a simple one hour workshop could reduce some stigma in high school students, and that these results were maintained a month after the workshop (Ke et al., 2015).

The Mental Health Association of East Tennessee (MHAET) has created a two-part program to reduce suicide rates and promote mental and emotional well-being of students. The first part is a curriculum that was developed by the organization in collaboration with various educators, the result was Mental Health 101, which is now implemented widely throughout East Tennessee (Harrington, 2015). Between 2004 and 2014 the suicide rate in Eat Tennessee decreased 24% for children aged ten to nineteen, while suicide rates in the same age group increased 48% statewide (Harrington, 2015). The second part of the program was to implement an in-service teacher training program called Typical or Troubled which educators secondary school teachers on how to identify and open dialogues with students who may be experiencing mental health programs and the importance of referring them to appropriate supports. The program was implemented in 2008, and in the years following there were significant increases in the number of students accessing mental health support services (Harrington, 2015).

2.3 Research on Mental Health First Aid

The Mental Health First Aid (MHFA) program has been evaluated around the world, but especially in Australia, and has been found to improve overall knowledge of mental health, reduce stigma, and increase the amount of help MHFAiders provided to others. A meta-analysis of 15 studies confirms these claims, and found the results to have at least a moderate to high
effect size (Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014). When evaluated in the context of a school, researchers found that teachers who received MHFA training increased their knowledge and were able to reduce some stigma towards mental health. The same study also showed that teachers with the training passed on more knowledge regarding mental health to their students. However, there was little evidence to show that the teachers became more supportive of students with mental health problems (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010), although this may have been due to the short time frame in which the study was conducted. Another factor was that students may not have seen teachers as a source of support, which may be an entirely different challenge, and may not reflect on the effectiveness of the MHFA training (Jorm et al., 2010).

While there is a lot of promising literature regarding the efficacy of Mental Health First Aid, there is less literature regarding its use in Canada, and specifically in Canadian schools. Massey, Brooks, and Burrow (2014) did evaluate the effectiveness of the program among student support staff at an Ontario university. This study reaffirmed the results of other literature, providing more evidence that the program is effective at increasing knowledge, reducing stigma, and increasing confidence of staff in dealing with mental health and supporting students.

2.4 Conclusion

In this chapter, I reviewed literature on social factors associated with youth mental health, mental health in the context of secondary schools, mental health programs for educators, and the MHFA program in particular. Among scholars, low socioeconomic status and the LGBTQ community have been found to have higher rates of mental illness, whereas the literature is more conflicted regarding the association, if any, between ethnicity or race and mental health problems.
Scholars have found that teachers are concerned about being underprepared to support students’ mental health and that stigma is prevalent in secondary schools, but that there are promising programs that can help prepare teachers to better identify and support emotional and mental well being among their students. There still needs to be more training available and resources need to be provided to teachers as they strive to provide support and guide students who are dealing with mental health problems. Teachers do not need to replace mental health service providers, but they need to be aware and prepared to help support their students as mental health continues to be a major issue for adolescents. While the issue of supporting students in maintaining their mental well being seems daunting, resources such as Supporting Minds, and programs or initiatives provided by the MHCC such as Mental Health First Aid training show promise of being effective.

Although education is important, stigma can be difficult to eliminate, and so it has been found necessary to foster positive attitudes regarding mental health at a young age, especially in Canada and the GTA where communities are so diverse and there are so many other factors influencing children’s perceptions about mental health.

By speaking to educators directly, this study provides the perspective of teachers who have had training, specifically MHFA training. These educators care about supporting student mental health, and have experience implementing their training and supporting students. Therefore they are able to share their experiences and what they find helpful and difficult as they try to promote mental and emotional well being in their students.
Chapter 3: Research Methodology

3.0 Introduction (Chapter Overview)

In this chapter I describe the methodology of the study. I identify and explain the various methodological choices that I made, based on my research questions and purpose. I begin by describing the general research approach and procedure, followed by the data collection process. Next, I focus on the participants of the study, elaborating on the sampling criteria, the recruitment process, and finally brief bios of each participant. I go on to explain how the data was analyzed as well as the ethical considerations associated with the study. Finally, I discuss the methodological strengths and limitations of the study before concluding with a summary of these methodological decisions and justifications.

3.1 Research Approach & Procedures

The research approach for this study is qualitative in nature. It involves a review of the literature relevant to the purpose and research question. The study also makes use of semi-structured interviews with 2 educators. Maxwell (2012) defines qualitative research as “research that is intended to help you better understand: the meanings and perspectives of the people you study, how these perspectives and are shaped by, and shape, their physical, social, and cultural contexts, and the specific processes that are involved in maintaining or altering these phenomena and relationships” (p. viii). Furthermore, qualitative research is focused on specific processes while quantitative research is based on variables that can be measured, varied and compared across contexts. This focus on processes in qualitative research is echoed by Trumbull (2015) and Given (2008).

Maxwell (2012) asserts that the goals of qualitative research are the reason why most qualitative studies have an inductive, open-ended approach, and rely on textual or visual data as
opposed to numerical data. These goals also align well with my research question and purpose, which is to learn, from the perspective of educators with Mental Health First Aid training, how this shapes their experiences of supporting students in a secondary school context, and the processes that are associated with supporting the mental health of adolescent students. This is much more in line with the research questions than any variables that could be measured and manipulated.

Ormston, Spencer, Barnard, and Snape, D (2013) also argue that the aim of qualitative research is directed at in-depth and interpretative understanding of the participants’ world through learning about “their social and material circumstances, their experiences, perspectives and histories” (p. 23). Similarly, Given (2008) reiterates that it focuses on the experiences of participants, and through this, gain further insight into the human elements of the topic. They contrast these “why” oriented questions with the “who” or “what” questions that are more often found in quantitative research. Maxwell (2012) similarly contrasts the different methodological approaches, and claims the main goal of qualitative research is particular understanding rather than generalizations across person and settings.

Qualitative research methods can be used in order to describe routine and problematic moments in teachers’ lives, as well as “describing multiple realities, developing deep understanding, and capturing everyday life and human perspectives” (Trumbull, 2015, p. 101). This is very much the reason qualitative studies are used in this particular study, as the research purpose was to learn from the daily experiences of educators who have additional training in supporting and promoting mental health. Similarly, the thoughts and feelings of these educators are an important aspect of the study, which Given (2008) describes as an essential aspect of qualitative research.
3.2 Instruments of Data Collection

A major method for collecting data when doing qualitative research is conducting interviews (Jamshed, 2014). For the purpose of this study, semi-structured interviews were utilized. Jamshed (2014) describes semi-structured interviews as in-depth interviews with pre-set, open-ended questions. They are usually conducted once with an individual, and typically last anywhere from 30 minutes to over an hour. The interview is based on a guide, and the purpose is to explore respondents’ experiences systematically and comprehensively, while maintaining the focus on the topic of interest.

With that being said, Fylan (2005) reminds us that semi-structured interviews are still conversations – albeit guided ones – and that these conversations are free to vary, and can be substantially different from one participant to another. This is contrasted with structured interviews, which bear much more resemblance to verbally administered questionnaires, or unstructured interviews, where there is still a general topic of investigation but there is very little in the way of boundaries to the issues that should be covered (Fylan, 2005).

This method of data collection is ideal for my research purposes as my goal was to learn specifically about supporting and promoting mental health in secondary schools. The topic is specific enough that an unstructured interview would lack the required focus, but a structured interview would be too restrictive of the conversation, and would limit the participant’s ability to share their perceptions and experiences. This flexibility goes back to the contrast of asking “why” rather than “how many” or “how much” and the goal of gaining a deeper understanding of the research question through conversation with the participants (Fylan, 2005). Furthermore, the scale of this study is also well-suited to semi-structured interviews. As Drever (1995) argues, the
semi-structured interview’s flexibility is ideal for small scale studies, but may not be suitable for studies involving larger numbers of participants.

My interview protocol (Appendix B) was divided into 5 sections beginning with the participant’s background information, followed by questions about identifying students with mental health problems, then challenges they face in promoting mental health. This was followed by a section on resources, programs and strategies used to promote mental health, and finally how the educator’s MHFA training has, or has not, helped them in their endeavor to support students’ mental health. Examples of questions include:

- Can you describe a time you found it challenging to support a students’ mental health?
- Given your experience, what strategies do you believe are effective in promoting mental health?
- How does your MHFA training impact your practice in supporting students’ mental health?

3.3 Participants

In this section I will outline the sampling criteria used to select participants, as well as the justifications for these criteria. I will go on to address how I recruited these participants followed by brief biographies for each participant. Qualitative studies do not generally call for large sample sizes, as they are more concerned with in-depth analysis and narrative description than with generalization through statistical analysis (Trumbull, 2005). Again, this fits well with the research purpose which is to learn from teachers’ accounts of their perceptions and experiences.

3.3.1 Sampling criteria.

I looked for the following criteria in participants for my study:
1. Participants must be OCT certified secondary school teachers.

2. Participants must be employed in a public school within the GTA.

3. Participants must have received Mental Health First Aid certification.

4. Participants must have supported or worked with a student with an active mental health problem or mental disorder since receiving MHFA certification.

5. Participants must have at least 2 years of experience working as a teacher.

In order to recruit participants who were able to provide insight into supporting and promoting mental health in their classrooms, my sample must have only included teachers who were able to speak about these topics from their own experiences. I looked to speak to OCT-certified teachers who were working in schools within the GTA because the GTA has a diverse population that is reflected in both teachers and students. Furthermore, it was important that the teachers who participated in this study were secondary school teachers, because as mentioned in the preceding literature review, studies have found that many mental health problems begin in adolescents. This is an important age where the issue of mental health becomes crucial, and so high school teachers are uniquely placed to support mental health, and as such their insight will be useful in learning more about the research question. Similarly, I endeavoured to find teachers who were employed in public schools and had at least 2 years of experience in their position as a teacher. I wanted teachers with at least two years of experience because new teachers are still learning to teach, and figuring out their place within the school community (Feimen-Nemser, 2003). They are also less likely to have had the opportunity for MHFA training and to apply what they learned through their experiences. While I was not initially concerned with how long the educators I spoke to had been employed, I realized that years of experience was a pertinent factor to the research at hand. In order to speak about experiences and perspective regarding
mental health of students, the participants must have had time to have these experiences. With that being said I suspect that newer teachers may be more likely to have Mental Health First Aid certification, and that even two years of experience may be enough for them to speak about the issues I am interested in. I also hoped to speak to educators in the GTA because of the diverse population that exists within this geographic area (Siemiatycki & Isin, 1997). I wanted to speak to educators who taught a diverse student body so that I might be able to learn about these educators’ experiences with a wide variety of students.

3.3.2 Sampling procedures

In qualitative research, purposeful sampling is most often used as it best serves the purpose of many qualitative studies (Devers & Frankel, 2000). Namely, purposive sampling is used because the researcher is interested in hearing from particular people about their perspectives and experiences, and so certain criteria are used to select particular participants (Ritchie, Lewis, Elam, Tennant, & Rahim, 2013). In my study, I made use of purposive sampling based on the criteria outlined and justified in the previous section.

Due to the small size and parameters of the methodology of this study, I also used convenience sampling which is simply a cost-effective means of sampling by accessing resources and networks that are readily available to the researcher. Convenience sampling is to make it as simple and economical as possible for the researcher to get a set of data (Ferber, 1977). As a pre-service teacher I have access to a fairly large network of teachers, and through these contacts I had hoped to find teachers who met the outlined sampling criteria. Furthermore, I have a number of family members and community contacts who are employed as educators, and had hoped these contacts would also help me to find other teachers who fulfill the sampling criteria. Unfortunately, neither of these panned out, as I realized there are not many educators in
my network who have completed Mental Health First Aid training. Fortunately, I was able to make use of snowballing to help find more participants. Snowballing refers to asking existing participants of a study to help identify other potential participants (Ritchie et al., 2013). This strategy was helpful in finding teachers who have MHFA training because teachers who have the certification are likely to know other teachers who have also completed the course. However, I ended up utilizing the MHFA instructor contact list on the MHCC website for the majority of my recruitment efforts. I emailed the majority of instructors focusing on those who specialized in the course with the focus on individuals who regularly interact with youth.

3.3.3 Participant biographies

My first participant, Orange, has been an educator for 14 years. She has taught grades 9 through 12 and has typically taught Canadian World Studies, but has been a guidance counselor for several years. She is also involved in extracurricular activities such as mock trial and model UN. Orange completed her MHFA training a year before I spoke to her, but has completed several other qualifications related to mental health including SAFE talk and ASSIST among others.

My second participant, Blue, is a social science teacher. She has mostly taught at the senior level and has also been involved in several leadership roles within the school including being the lead on a mental health awareness group. She has been teaching for 13 years and completed her MHFA training in 2013. She has been the mental health lead at her school for 8 years and has also completed ASSIST training among other mental health training programs.

3.4 Data Analysis

In qualitative research methods, data analysis is descriptive and interpretive (Trumbull, 2005). Elo and Kyngäš (2008) describe the two approaches to data analysis in qualitative studies:
inductive and deductive. Deductive analysis can be used when there is significant prior knowledge on the topic being studied, since this is not the case for my particular study, I will use inductive analysis. This form analysis moves from the specific to the general (Elo & Kyngäs, 2008). This fits the research purpose which is to learn about the general topic of supporting mental health in secondary schools, from the specific experiences of teachers with MHFA training.

In inductive analysis, the data first has to be organized. The data in most qualitative research comes from observation or transcripts, both of which contain large amounts of textual data (Pope, Ziebland & Mays, 2000). In this case the data being analyzed were interview transcripts. The process of organizing this data included coding, creating categories, and abstraction (Elo & Kyngäs, 2008). Coding involves making notes and headings from the data, this is to prepare for the creation of appropriate categories. Once categories have been generated and organized, abstraction can begin. Abstraction is the process of creating general descriptions about the research topic through the generated categories (Elo & Kyngäs, 2008).

In the analysis of the interview transcripts the null data was also considered. This is the absence of certain observations or experiences throughout the data. This can be important as the absence of certain experiences or perspectives can be as telling as what is discussed. This is especially true in this research study, where stigma can play a significant role in preventing participants from discussing certain aspects of mental health.

3.5 Ethical Review Procedures

In qualitative research more broadly and interview studies in particular, participants will often be asked to share intimate aspects of their lives; this can be uncomfortable, and so it is extremely important that interviews are conducted ethically (Brinkmann & Kyale, 2005). When
writing about ethical practice in research, Miles and Gilbert (2005) list 4 Cs: consent, confidentiality, competence, and conduct. Consent and confidentiality are explicitly addressed in this study in the form of the consent letter found in Appendix A. All participants signed the letter to give consent to the interviews and their use in the research project. Confidentiality was also ensured as all transcripts were anonymized and names were replaced with pseudonyms throughout the transcripts. Confidentially is also ensured beyond the transcripts, as participants were assured that their participation would not be disclosed to anyone in any form whatsoever.

Competence refers to the researcher’s ability to effectively analyze the data, which ensures this is not a waste of the participants’ time, and finally conduct comes down to treating participants with respect (Miles & Gilbert, 2005). This is especially important to this particular study, as the topic of mental health can be quite sensitive, and so conducting the interviews with the utmost respect of the participant was extremely important.

Brinkmann & Kvale (2005) also highlight some key ethical considerations when conducting interviews. First is the asymmetrical power relation of the interview, in which the interviewer has to be responsible and aware of their position of power (Brinkmann & Kyale, 2005). A second consideration is the one-way dialogue, this is more pertinent to structure interviews, and the semi-structured nature of the interviews in this study alleviate this particular concern, and can be used to make the interview more of a dialogue (Brinkmann & Kyale, 2005). With that being said the third consideration is that the interview is not in fact a natural conversation but an instrumental dialogue, or a means to serve an end. Brinkmann & Kvale’s (2005) fourth consideration is that the interview can be manipulative in that researchers may not want participants to know the “answers” they are “looking for”, while this should still be kept in mind, this particular study is quite candid in its research purpose and questions. Lastly,
Brinkmann and Kvale (2005) point out that the interviewer has a monopoly on interpretation. Although participants are given the opportunity to review and retract the transcripts, they are not a part of the analysis of the data, and so it’s up to the researcher to accurately interpret and represent the experiences and perspectives the participants have shared.

3.6 Methodological Limitations and Strengths

One limitation of the study imposed by the ethical parameters of the study, is only getting the perspective of educators. It would have been helpful to get the perspective of students with regards to their experiences being taught by an educator trained as a Mental Health First Aider, and how their mental health was supported. The small sample size dictated by the methodology limits the study as the findings can not be generalized amongst all teachers, or even all educators trained in Mental Health First Aid, but again, this is not the purpose of the study (Miles & Gilbert, 2005). Other limitations of qualitative research include the attention that is paid to infrequent or rare occurrences as opposed to what actually commonly occurs, and ambiguities in language can be difficult to interpret (Atieno, 2009).

Instead the purpose of the study fits the strengths of the qualitative research design which is to get an in-depth understanding of the processes of the topic by learning from the participants lived experiences (Miles & Gilbert, 2005). This strength plays out most obviously through the dynamic nature of the semi-structured interviews. These interviews are not limited or constrained, and their flexibility allow the researcher to listen to the participants and ask them in-depth questions regarding the experiences they describe (Fylan, 2005). In this particular study I was able to ask the educators I spoke to about their experiences and perspectives on mental health, and expand on any challenges or strategies that teachers with Mental Health First Aid
training have come across in their endeavors to support the mental health of secondary school students.

3.7 Conclusion

In this chapter I described the qualitative research methodology that would be used to carry out the research study. I began by broadly describing the qualitative approach and research methodology and how this methodology aligned with my research purpose and questions. This was followed by a description of the semi-structured interviews that were used as the sole instrument of data collection. Next, I described the sample criteria I applied to find my participants as well as an outline of how I found these participants, which included purposive, convenience, and snowball sampling. I went on to describe how the data was analyzed through coding, categorization, and abstraction. This was followed by a description of the ethical considerations associated with the study. Lastly I briefly described some of the limitations of the methodology, including the inability to generalize findings, and being limited to educators as participants, as well as some strengths including the flexibility and dynamic nature of semi-structured interviews, which allow for a deeper understanding of the research topic. In Chapter 4, I will report on the findings of the research.
Chapter 4: Research Findings

4.0 Chapter Introduction

Mental health has been identified as an issue that is prevalent in Canada, and that schools are particularly important environments where students can be supported during adolescence where mental health issues often first arise. However, researchers find that teachers often feel unprepared in their roles, despite being aware that they should be supporting students and promoting their well-being. I spoke to MHFA trained educators at the secondary school level within the Greater Toronto Area in semi-structured interviews to gain their perspective on how they support students with mental health problems and promote the emotional and mental well-being of their students.

In this chapter, I discuss my interpretation and analysis of two research interviews to report my findings in order to answer my research question: how are secondary school educators with mental health first aid training working to support students with mental health problems or disorders? I will try to draw connections between the experiences and perceptions of the educators who were interviewed with literature that was reviewed in the second chapter of this MTRP. The findings are organized into three themes:

1. Connecting Students to Other Resources: The Primary Teacher Role
2. Identification of Students with Mental Health Problems
3. Stigma Regarding Mental Health

Some of these themes are further divided into sub-themes describing more specific relations between the participants’ perceptions and experiences to aspects of the broader theme. In each section I first describe the theme broadly, then describe what the participants of the study had to say about these themes, and finally I compare the views of the participants to what studies have
already said about each theme. Finally, I will summarize the findings and make suggestions for the future based on my interpretations of the results.

4.1 Connecting Students to Other Resources: The Primary Teacher Role

Both educators believed that their primary role in supporting students with mental health problems was to connect students to more comprehensive support systems within their communities. Both educators were also confident in their ability to fulfill this role.

The participants of the study recognized that they have a role to play in promoting mental health and supporting their students with mental health problems. However, one thing that was made clear by both educators throughout their interviews was that their primary role was not to support students directly, but rather to direct students to more comprehensive support systems within the broader community. Neither educator said this was the sole form of support they provided. Instead, they felt that getting students connected with the appropriate resources and support systems was the best way they could support the students they work with, given their qualifications. Orange articulated this best when she was asked to describe how she supports students: “[h]onestly that’s my job... I don’t have a masters in counselling. So for my skillset it really is being a person in the building who they can trust, and then, beyond that... making sure that they are accessing services in the broader community.” Orange believes that her primary role is not to provide support to students herself, but to direct students to other community resources that might better serve their needs. However, it should be noted that this does not mean that Orange does not support students herself as well, as she often described situations where she did provide support directly. However, she believes that connecting students with resources and support systems that will be able to better fulfill her students’ needs, is the best way for her to support the students she works with.
Blue similarly expressed this belief by frequently referring to scenarios in which she connected students to community resources, including in her role as a facilitator of a student-led mental health advocacy group at her school. Blue described her reported role in supporting students’ mental health as follows: “[m]y job is simply to get people in need to someone who can support them…. I am NOT that person. I can listen and help but can not FIX them.” Blue further articulated that she views her role not as the person who can provide solutions to help overcome her students’ mental health problems, but rather as someone who can assist in connecting them to available resources within the community, where they will hopefully be able to receive more comprehensive support from professionals.

When speaking about their role in supporting students, the educators interviewed, not only had a clear and consistent idea of what their role was, but they were confident in their ability to carry out that role. Both educators’ spoke with confidence throughout the interviews in their belief that they were prepared to carry out their responsibility of educating and connecting their students with broader community resources. When prompted to speak about her role and how confident she felt in it Blue replied that

[i]n my classes I simply see someone who needs support and then I do my best to find them the right person, and support...I feel like I have a good ability to [identify] students [with mental health problems] and feel confident in my skill set.

Blue’s experiences, and perhaps her various training, including MHFA, have allowed her to gain a thorough understanding of her role in supporting students, and build confidence in this role and skillset, such that she feels comfortable with these responsibilities. Orange similarly expressed this clear understanding when she said “[E]arlier in my career I had…less… understanding of what was expected of me [in terms of] helping kids... Now it’s clearer… I sometimes support
students directly… through conversation, but more often I’m just there to connect ‘em to someone more qualified… I don’t have a counselling degree”.

The role both educators defined for themselves with regards to supporting students is consistent with the findings of Mazzer and Rickwood (2015), in which Australian teachers reported being comfortable with their role in supporting students, particularly in connecting them with external resources. Both participants in this study, as well as those interviewed by Mazzer and Rickwood, had clearly-defined ideas regarding their roles in supporting students. Australia is where the Mental Health First Aid Training program was developed, and much of the research regarding mental health comes from that part of the world. Educators with a background or training in mental health seem to have a clear idea of how they can support their students as educators.

This understanding of the educator’s role in supporting students is also consistent with that which is outlined in the Supporting Minds document which describes the role of educators as threefold: promoting positive mental health at school, identifying students who may have mental health problems; and connecting those students with appropriate services (OME, 2013). While the educators interviewed focused particularly on the third aspect, both other aspects were acknowledged by both educators as well.

Relative to teacher participants reviewed in other studies (Chandra & Minkovitz, 2007; Mazzer & Rickwood, 2015; Short, Ferguson, & Santor, 2009), Blue and Orange expressed a more definitive confidence in their role. A few studies included by the literature review by Whitley, Smith, and Vaillancourt (2013) regarding teachers’ sense of self-efficacy with regards to their ability to support and promote mental health with their students showed much more muddled results. Many teachers indicated that they did not feel they were well-prepared to
support students with mental health problems, despite their desire to increase their mental health literacy (Chandra & Minkovitz, 2007; Mazzer & Rickwood, 2015; Rodger et al., 2014; Short, Ferguson, & Santor, 2009). This is in contrast to the educators interviewed in this study, who indicated more confidence, not only in their ability to identify and support students with mental health problems, but also in their understanding of their role in supporting these students.

According to the Canadian Teachers’ Federation (2012) 68% of teachers had no form of mental health training, and a survey by Andrews, McCabe and Wideman-Johnston (2014) found only half of the teachers who participated reported being aware of available resources to support students with mental health problems. Given this context, the confidence and knowledge demonstrated by the teachers interviewed in this study may be a result of their MHFA training, or perhaps the many other opportunities that they have taken advantage of in order to improve their mental health literacy. This would be consistent with the findings of Massey, Brooks, and Burrow (2014) who found that MHFA training increased confidence of staff in dealing with mental health and supporting students as well as increased knowledge in the area.

4.2 Identification of Students with Mental Health Problems

When asked about how they identify students, neither Orange nor Blue gave a simple answer; instead they each revealed that they rely on a multitude of methods to identify students with mental health orders including: administration, team meetings, other educators, self-identification, students’ peers, parents, and guidance counsellors. The ways in which educators support students with mental health problems is important; however, in order to provide any support, educators must first be able to identify students who might be struggling with mental health problems. While both educators referred to using all these resources to identify students...
with mental health problems throughout their interviews, each of them highlighted different methods of identification as the ones they relied on most.

Blue reported that, often, students themselves either self-identified or identified peers they were concerned about:

In my classes I simply see someone who needs support and then I do my best to find them the right person, and support... I have encountered MANY students who are having mental health problems, and sometime those who have already been diagnosed with an illness. These students typically come to me and I will often go with them to find the right support person, just to ensure they feel comfortable, especially since seeking help can be so challenging. [And] most students will come to me themselves, or actually a lot of times students will bring a friend to me, knowing that I have been one to be supportive in the past.

Despite the fact that she repeatedly referenced a multitude of ways she identifies students, Blue finds that most often she ends up supporting students who actually come out and identify themselves, or because a peer has identified them. She believes that she has established a connection and understanding with the students and demonstrated that she has the ability to be supportive. This rapport with her students reportedly allows them to feel comfortable identifying themselves or their peers as having mental health problems. However, Blue also recognizes students who may be experiencing mental health problems on her own as well. When asked about a time she identified a particular student she recalled that “[this student] had always demonstrated social isolation, lack of personal hygiene, awkward social skills, missed work, poor attendance.” Blue’s experience has given her a skillset and the confidence to be able to pick up on behaviour and other indicators that a student may be dealing with mental health problems.
On the other hand, while Orange also identified all the various ways of identifying students that have already been discussed, as a guidance counsellor she highlighted team meetings and administration as the primary means of identifying students who needed support. When asked how she identifies students with mental health problems, she responded “I’d say one of the kind of main ways a kid ends up in my office is that they can be identified through administration... so a vice principal, or they may be identified through a team meeting”. As a guidance counsellor Orange no longer has the same interaction with as many students, so she also relies on administration and other staff members to identify students with mental health problems. Having said that, Orange was still able to build a similar trust with students such that they felt they could identify themselves. She later mentioned that

[p]robably about half of them self-identify. So, through the course of a counselling session, or like typically they come in to talk about something else, and then they’ll raise a concern or issue… or their friends will ...either physically bring them into the office, or say they have concerns with so-and-so who is cutting themselves, or ‘can you look at this text message that they sent me? I’m really worried about them.’

Similar to Blue, Orange has established a rapport with students such that they feel comfortable identifying themselves as having mental health problems, or sharing concerns about their peers.

Despite describing a multitude of ways that they were able to identify students with mental health problems, both teachers also admitted that they believe they likely miss out on identifying many of these students. Blue commented that “[s]ome kids do a very good job of hiding their feelings. I believe that the more we talk about it, the more “normal” the conversation becomes...but I’m sure there are kids who struggle quietly, and are never identified be it by their teacher or a parent.” Orange agrees, when asked if she thinks she ever misses students who
would benefit from support she said “Of course. I think there are tons of kids who have mental health issues who are never supported by the school system or who are never diagnosed”. Despite the fact that both teachers felt confident in their abilities, and could list many different methods of identifying students who might need support, they both still felt like there are students who need support who don’t receive it.

Studies have described educators as being in a unique position to identify students with mental health problems (Roger et al., 2014). However, as discussed in the previous section, there have been studies (e.g., Chandra & Minkovitz, 2007; Short, Ferguson, & Santor, 2009) that show many teachers don’t feel confident in their abilities or knowledge of the topic. In contrast to these findings, the two MHFA-trained educators in this study were both knowledgeable regarding resources and indicators that might help them identify students, and were confident in these abilities, but they still recognized that they likely miss out on supporting students who need it. This discrepancy between literature on teachers generally with the teachers I interviewed may again be attributed to the training and experience these educators have had which have allowed them to increase their mental health literacy.

4.3 Stigma Regarding Mental Health

Throughout the interviews, both educators spoke extensively about the stigma surrounding mental health and mental health support, and felt that stigma was pervasive in secondary school environments, is not limited to students, and also exists in parents, other educators, and even themselves. Despite acknowledging stigma as a barrier to supporting their students’ mental health, however, both educators also noticed improvements in recent years, although they qualified these observations. Finally, both educators believe that open discussion
can help to “normalize” the topic of mental health and is the best way to eliminate, or at least reduce stigma surrounding the topic.

4.3.1 Stigmatizing views of educators, parents, and students

Orange and Blue both referenced their views on stigma both explicitly and implicitly throughout their interviews. Their discussion of stigma was not limited to any group, as both recognized that stigma was an issue that was pertinent in every single stakeholder in the secondary school setting in which they practice. These include students, other educators, administration, parents, and even themselves. When prompted to speak about stigma explicitly, Orange responded by speaking about the false perception that high-functioning students must not have mental health problems. This was highlighted several times throughout the interview, especially when discussing her coworkers as a barrier to supporting her students. In speaking about these issues, Orange highlighted how pervasive she finds the stigma within her school community. This is also evident when she was asked about barriers to supporting students:

So some of the barriers are other staff members ... and my own bias in dealing with some kids, and some of my knowledge of the kids. I’m like ‘really? Again?’ . And I deal with it all the time, so I shouldn't be that person, but some days it's like ‘are you kidding me?’ . ‘You're doing this again?’ . So there is a belief among some staff, and parents too, that it's kind of not a real thing?

Orange describes the stigma here by referencing the bias of other staff, especially towards high-functioning students when discussing their mental health problems. She describes this stigma in the form of bias and preconceived notions about these students. Orange begins by referencing other staff members but she also addresses the fact that this stigma is also present in parents, and even herself. In describing her experiences, she recognizes the pervasive nature of stigma in the
secondary school environment. Stigma was also the first thing Orange mentioned when asked about barriers she faces in supporting her students, again highlighting the significance of stigma in educators’ experiences supporting students with mental health problems. Blue also spoke broadly about stigma being present in all stakeholders in the secondary school environment including staff, students, administration, parents, and even herself at times. While Blue did not expand into as much detail on the subject, she repeatedly responded affirmatively when asked if she believed stigma was still a barrier preventing students from accessing mental health supports. When asked generally about how stigma plays a role Blue expanded:

Of course [stigma still plays] a big role. Both in staff and students. I have seen an improvement in the last 5 years or so though… It just makes it harder for students to talk to staff and even peers about their various mental health problems… The preconceptions people have about mental illness definitely are a barrier at times… even myself, although I do think I do my best… perhaps at times… I still struggle not to assume too much.

Throughout the conversation, Blue did speak optimistically about the improvements, repeatedly saying she “sees improvements” and “it’s been getting better”.

The literature seems to support the viewpoints presented as a number of studies have similarly found stigma to be one of the prominent barriers to adequate mental health support (Bowers et al., 2013; Hartman et al., 2013; Kranke et al., 2010; Moskos et al., 2007). While Chandra and Minkovitz (2007) and Short, Ferguson, and Santor (2009) found that young people were less likely to underestimate the prevalence of stigma in comparison to service providers, the participants in this study seemed to believe that stigma was deeply embedded in the culture of the secondary schools in which they worked. This may again be a result of their MHFA training or other experiences which have helped improve their mental health literacy. This finding is
supported by a meta-analysis of the efficacy of MHFA training by Hadlaczky et al. (2014) which found that the program improved overall knowledge of mental health, reduced stigma, and increase the amount of help MHFAiders provided to others

4.3.2. Stigmatizing language

When speaking about her experiences, Orange in particular often referenced language as a stigmatizing factor that needs to be addressed. When explicitly asked about stigma, she replied

I also think in terms of the language that we use ...and I’m guilty of it ... saying things like “they're crazy” and all those terms that we shouldn't be using because they are stigmatizing and offensive and hurtful to kids and other staff members. So the language we use can be stigmatizing

Here, Orange not only recognizes that problematic language is an issue, but also recognizes that she herself still struggles to avoid it. Orange also recognized that stigmatizing language is harmful not only to students, but also to other staff members. In addition to being mindful of the language she uses herself, Orange also stressed the importance of being vigilant in correcting language of students in classrooms as well:

I would say in terms of a classroom, I think just not putting up with the language that kids choose...I know some teachers just let it go, and it's not just mental health stuff, but like the derogatory use of “gay” ... there's lots of language that … our kids have appropriated, ...and for them it doesn’t have the same kind of negative association that maybe it has for my generation. Or my parents’ generation. But I think it’s important that we talk about language and how these can have unintended consequences, so kids saying “gay”, “crazy”, all those kind of terms. They might not be using them in that way, but that’s maybe how they’re received
In her response, Orange identifies language as being of critical importance in addressing mental health in the classroom. In her experiences the language both students and staff use is vital in maintaining a positive dialogue surrounding mental health, and is often one of the most identifiable way stigma presents itself. However, Orange also noted that it was not only language surrounding mental health, but even other harmful language that can be problematic, and hurtful to maintaining the wellbeing of all students.

While Blue placed less emphasis on stigmatizing language explicitly, she did refer to language as being an issue. When asked how she promotes mental health she responded “I challenge stigma as much as I can in all my classes. Whenever I hear students saying anything stigmatizing, I don’t tolerate those attitudes… I also challenge this in both the classroom and the staffroom”. When asked about strategies she uses to reduce stigma, Blue also referred to the importance of how mental health is spoken about. Blue explained that “Really I just try to talk openly. It’s important to have, um, open, honest, healthy discussions about [mental health]... You reduce stigma when you’re having healthy conversations about the topic”.

Surprisingly there seems to be little research done on stigmatizing language in relation to mental health, despite many studies done on stigma with regards to mental health more broadly. Perhaps this is an area for future research, and especially in the context of secondary schools.

4.3.3 Decreasing stigma in recent years

While both Orange and Blue commented on the pervasive nature of stigma in secondary schools, they did have positive views of the progress being made not only at the school level, but across their boards. After discussing how stigma acts as a barrier, Blue said that
I have seen an improvement in the last 5 years or so though...I do think it’s getting better.

[We just have to] stick with the mental health awareness campaign. It is SO important and is finally being given the priority it should have received years ago.

Here, Blue acknowledges that people are beginning to become informed, but that this also needs to continue through the spread of mental health campaigns. Blue believes that this improvement is merely the general public “catching up” if anything, but that this progress has especially been noticeable in recent years.

Orange similarly commented on improvements in recent years when discussing stigma but qualified her statements, especially in the context of the perception of stigma on the part of students:

I think it's becoming less of a barrier with kids, but I think it still is... Because no kid wants to [be seen as different, or standing out]. Like if you have cancer, it's very visible usually right, and people treat that very differently than if you have a diagnosis of anxiety, or depression or ... So I think the kids feel like it's...a legitimate illness, and I think a lot of them feel relief once they’ve been diagnosed, or are receiving support. But at the same time, they don't typically want to advertise it.

Here Orange was commenting on the attitudes of students, and their perceptions of the stigma that exists in schools on the part of other educators, as well their peers. However, when speaking about stigma more broadly and not in the specific context of students’ fears, she was much less reserved about the improvements in attitudes towards mental health saying that “I do think it’s quite remarkable how much attitudes are shifting. I started teaching in 2002, and even in my last four years as a guidance counsellor… there has been a huge, a remarkable improvement in terms of support and resources being provided to kids in our community.” In contrast to when she
spoke specifically about how students perceived stigma in the context of secondary schools, Orange did not feel the need to qualify her comments on her perception of decreasing stigma in the broader community and society as a whole. She even felt this improvement went beyond reduced stigma and positive attitudes and crossed over to improved mental health supports in the community she services.

There have been studies showing that stigma is still a relevant issue, as cited earlier, and both educators interviewed in this study agree on this score; however, they also both seem to indicate, even if cautiously, that there seems to be improvement, both within their schools, and also more broadly as they believe mental health literacy seems to be improving in the general population. Research regarding stigma has mostly focused on its prevalence and not the trends over recent years, or on programs used to reduce stigma in various settings. This is to say that the research often focuses on statistics, and the fact that stigma exists, as opposed to the fact that it seems to be decreasing as indicated by both Blue and Orange, or even why this decrease is occurring. However, research comparing stigma over time might be valuable, especially in the context of secondary schools as boards increasingly put initiatives in place to decrease stigma.

4.3.4 Dialogue as a tool to destigmatize mental health

When speaking about ways that they tried to reduce stigma, both educators felt that recognizing and acknowledging its existence is a start, but that the best way to destigmatize mental health is to sustain healthy dialogue about mental health. When asked about how she addresses stigma, and throughout the interview, Blue kept coming back to the importance of having these conversations:

I speak about mental health in all of my classes. Students need to realize that we ALL have mental health and that our healthiness fluctuates. Teaching resiliency is
key. Students need to know how common mental illness is and that there are many supports available...my subject area deals with it, being in the social sciences, its quite relevant. We talk about it in quite a few of our courses, we try to make it a priority in our department…

Blue addresses the fact that she thinks speaking about mental health is important, and tries her best to incorporate the subject in her classroom and that she goes out of her way to prioritize the subject. She went on to explain that she feels this is important to normalize the conversation: “Some kids do a very good job of hiding their feelings. I believe that the more we talk about it, the more ‘normal’ the conversation becomes”. By constantly having open and informative discussions regarding mental health, Blue tries to normalize the topic of mental health so as to destigmatize the topic and remove misconceptions and misinformation. However, Blue not only discussed the importance of having conversation to combat stigma in her classes, but also outside of the classroom. When asked about what strategies she uses to support students with mental health and combatting stigma she replied very concisely: “talking openly.” When asked if she could expand on this she mentioned that “I try to challenge [stigma] both in the classroom and the staff room.” This idea was also consistent with the ideas of Orange who also stressed the importance of speaking openly with all members of the school community to fight stigma. This also goes back to the fact that both educators felt that stigma was problematic not only amongst students, but also among other staff members and parents as well.

While there has been research identifying stigma as a significant barrier to effective mental health supports as previously discussed, research has been less successful at identifying effective methods of reducing said stigma. Hartman et al. (2013) found that participants of a study who underwent a 12-hour mental health education program still held some stigmatizing
views regarding mental health despite increasing their knowledge in the subject area. There has been at least one study (Ke et al., 2015) that found a one-hour workshop was able to at least reduce some stigma in high school students and these results were maintained after a month. Chandra and Minkovits (2007) also found that the more knowledgeable middle school students were regarding mental health, the more positive their attitudes were regarding mental health and mental health support. This indicates that educating students on mental health can at least reduce some stigma they might hold towards seeking support. The difficulty of reducing stigma indicated in the literature is echoed by answers given by Blue and Orange who have said that they have seen improvements over time, but yet both acknowledge that despite these improvements stigma is still prevalent. They do their best to challenge this by correcting problematic language and speaking openly and honestly about the topic. The educators I spoke to did not specifically reference MHFA training, but their increased knowledge as a result of this training may be helping them to challenge stigma through their open conversations and confidence in having that dialogue.

4.4 Conclusion

In my analysis of two interviews with MHFA trained educators, I found their responses fit into three themes. First, I found that these educators had a precise understanding of their role in supporting students with mental health problems, and that they were confident in their ability to fulfill this role. Secondly both educators acknowledged that they identified students that needed support with mental health problems in a variety of ways including identifying students themselves, students who identified friends, administration, team meetings, and parents. Although both educators claimed they felt confident in their ability to identify students who needed support, they also admitted that they likely miss students who “suffer” quietly.
Finally, I found stigma to be something that both educators focused on throughout their interviews. They identified stigma as pervasive in secondary school environments, and that it was a problem that was not limited to students, but that the educators also found that that other educators, administration, parents, and even they themselves held stigmatizing views of mental health problems. Both educators identified stigmatizing language as a particularly important issue that needed to be addressed, but both educators noticed reduced stigma in their communities in recent years despite qualifying these comments. Both educators also identified open dialogue and frequent conversations on mental health as the best way to reduce stigma in their schools.

As a whole, Blue and Orange were consistent with the literature when speaking about the current state of mental health in secondary schools. However, they pointed out that they have noticed improvement not only in increasing access of mental health supports but also in decreasing stigma. Both educators had a very strong understanding of their role as educators in supporting students with mental health problems, and were confident in their ability to connect these students with the appropriate supports. With that being said, both educators acknowledged that stigma in students, families, and staff makes their job difficult. While neither Blue nor Orange specifically credited MHFA training with their confidence or understand of mental health issues, they did reference the fact that MHFA improved their mental health literacy. Perhaps this training has helped them in understanding that they can best help students by ensuring they are accessing appropriate mental health support systems that are available to them in their communities.

In the next chapter, I will end this paper by summarizing the findings I have outlined in this chapter and discussing both broad implications of the findings for the education community.
as well as narrow implications specific to me and my role as a teacher candidate as I prepare for the same role as an educator. I will end by outlining some recommendations moving forward and identify areas that might benefit from future research within this field.
Chapter Five: Conclusion

5.0 Chapter Introduction

I will conclude this MTRP by first summarizing my findings and their significance, and then discussing their implications. The implications will be divided into two parts, broad implications for the education community and beyond, and more narrow implications relevant to myself and my own teaching practice. Finally, I will conclude with some recommendations based on my findings and make some calls for further research in the field of mental health.

5.1 Overview of Key Findings and their Significance

The purpose of this MTRP was to speak to educators in the Greater Toronto Area with Mental Health First Aid training in order to learn about their experiences in supporting the mental health and well-being of their students. In interviewing two educators with Mental Health First Aid Training regarding their experiences in supporting and promoting students’ mental health, I found three recurring themes.

First and most prominently, both of the educators had a clear understanding of their role with respect to student mental health. They understood that they could not play the role of therapists or counsellors, but rather that they needed to connect students with these mental health service providers along with information regarding more comprehensive supports that were available to them in their school and their community. These supports included, but were not limited to, guidance counsellors, therapists, mental health nurses, community centres, physicians, mental health centres, school clubs, religious support groups, suicide hotlines, among others. However, these educators were careful not to deflect responsibility themselves, they recognized the importance of being supportive and open while connecting students to more appropriate supports.
These educators both have a clear understanding of their role in supporting the mental health of students and they are confident in their ability to fulfill the task. Both educators felt comfortable that they were relatively knowledgeable about the available supports and their ability to connect students to the best option for them. They recognized a need for greater accessibility to these resources but also cited improvements in recent years.

Next, when speaking about identifying students with mental health problems, both educators recognized there were a variety of ways that they came to identify students with mental health problems. Some students identified themselves, others were identified by community members including peers, admin, or other staff. These teachers also mentioned that they felt fairly confident in their ability to identify students with mental health problems themselves, but admitted that they still likely miss students who could benefit from mental health supports.

Finally, the interviewed educators found that stigma was a factor that could not be ignored when discussing mental health in secondary schools. They both believe that stigma remains pervasive in all members of secondary school communities, including themselves, but again cited improvement in recent years. These educators also identified problematic language as a particularly significant form of stigma. The two participants also identified their beliefs that open communication on the issues of mental health and greater awareness would be beneficial in reducing stigma around mental health.

5.2 Implications

This section will outline some of the implications of the participants’ experiences as educators with Mental Health First Aid training with regards to supporting the mental health of their students. These implications will be divided into broader implications for the education
community as a whole, and the narrower implications I see impacting my professional identity, and day-to-day practice as I prepare to support my own students’ mental health as a secondary school educator with Mental Health First Aid training.

5.2.1 Broad implications: The educational community

The educators that were interviewed for this study had Mental Health First Aid Training, so the results of this study suggest that Mental Health First Aid training instils an acute awareness in educators’ of their role in how to support their students’ mental health. It seems that the training encourages educators to be aware of the resources available in their communities, and gives them the confidence they need to connect students to those resources. This suggests that it is possible for programs and courses to be effective in increasing educators’ abilities to promote mental health and well-being in secondary schools.

Both the educators that I spoke to credited their school board with promoting mental and emotional well-being especially in recent years. However neither credited the Mental Health First Aid Program specifically with contributing significant amounts of novel information, rather they saw it as reinforcement of knowledge they had gained in other mental programs they had been involved in. Perhaps it is school boards that have the responsibility to ensure it has educators who understand their role as it relates to promoting mental health in their communities. Another suggestion could be that educators with MHFA training also generally tend to have other mental health training due to being passionate about the issue. This makes it hard to distinguish whether it is the individual who makes the difference or if it is the training, or even if it is larger organizations such as school boards that make the biggest difference.

Despite continued improvements in awareness, accessibility, and diversity of mental health supports, these supports still need improvement with respect to each of those factors. The
educators I spoke to found that these improvements were not enough to sufficiently support adolescent students’ mental health needs. Furthermore, both educators acknowledged that they were fortunate to work at schools with strong mental health initiatives, and that they received support and encouragement from administration but that this was not representative of all schools in Ontario. This suggests that there may actually be an even greater deficiency of mental health supports in secondary schools across the province.

Students in secondary school do seem to be knowledgeable to some degree about mental health issues; both educators mentioned that students often came to them either with concerns regarding their own mental health, or the mental health of their peers. However, by no means did either educator think the progress that has been made is sufficient, they both indicated that that students still hold stigmatizing beliefs regarding mental health supports and mental health broadly. Even more concerning was the indication from both educators that they felt that teachers in Ontario, and parents still generally held stigmatizing attitudes, that were often problematic and prevented students from receiving adequate supports.

5.2.2 Narrow implications: My professional identity and practice

Speaking to experienced educators about their role and experiences with supporting the mental health of their students has instilled confidence in my own abilities to do the same as a beginning teacher. Both educators thought that my involvement and certification in MHFA was commendable and that interest in mental health was so important. However, to hear these educators speak on issues of the accessibility of mental health supports, and their knowledge and experience in supporting their students allowed me to feel that this is not a task that is impossible, and the training that I have completed will be beneficial to me as I strive to support students the best way I can as well.
Moreover, despite the increased confidence in my own abilities, I also feel that I am now more aware of the reality I will face as a secondary school educator. There will be challenges both in supporting students, and in challenging stigmatizing language and attitudes both in students and staff. Mental health has, and always will be one of my priorities, so ensuring that I support my students’ mental health and well being was already central to my teaching philosophy. However, after hearing from experienced teachers about the challenges they face and how they go about promoting mental health, I feel that I am more prepared for the reality and challenges that I too will face in my role.

Through interviewing experienced educators, I have also learned the importance of continuous learning and development. Both educators were actively involved in bettering themselves in one way or another, whether it was leading new initiatives the schools they were employed in, or being active in the broader community these teachers were doing much more than what was required. I found this energy and initiative inspiring, both teachers expressed interest in learning more, and were constantly seeking opportunities for further development. Teacher candidates such as myself and new teachers generally are so anxious about finding a job and career security we tend to focus on developing ourselves so that we are more marketable, and forget that professional development should be something we are constantly doing to become better teachers, but also better ourselves as a whole so that we can continue to contribute positively to our schools and broader communities.

As a Sikh, and an active member of the Sikh community, I hope to use what I have learned to challenge stigma in my own communities as well. In my experience, South Asian families and communities have had trouble having open constructive conversations around mental health, and mental illness. Speaking to experienced educators, I see how productive and
important those conversations are to reducing stigma, and improving mental literacy. I hope to try to start more of these discussions within the communities I belong to.

Finally, through the process of completing this research project, I have become a better researcher, and academic. The process of writing this paper has improved my ability to think critically about research not only in the field of mental health, but generally as well. I am also much more confident in my ability to conduct research. This experience has made me realize how important it is to stay up to date on literature that is relevant to my life, and to use this information to inform my practice, as a teacher-researcher, and in my day to day life.

5.3 Recommendations

The strongest recommendation I can make after speaking to educators about their experiences supporting the mental health and well-being of their students is that more educators should have some form of training with regards to mental health. Mental health literacy is crucial and should be a requirement for all educators, as it also helps to reduce stigma in secondary school environments. One way this should be done is in the form of an Additional Qualification (AQ), as of this moment no such AQ exists. I think providing such an AQ would be something many teachers would be interested in and would be a way to provide a standardized course vetted by the Ontario College of Teachers, where educators could learn more about mental health generally, and about supporting student mental health and well-being. While this may be a long term solution, I think it is important that it is developed as a way for educators to commit to supporting mental health, and can be used as a way for administrators to seek out teachers who can effectively promote mental health literacy in secondary schools.

Another recommendation I would make in the interim would be to have more Professional Development in secondary schools dedicated to mental health. This would be harder
to regulate, but administrators, particularly in secondary schools should make mental health a priority and dedicate some time for professional development in this area. In order to do this successfully, they could have MHFA instructors come in and train either a subset or their entire staff in Mental Health First Aid. If not, they could have educators within their schools who have any form of mental health expertise run workshops to increase mental health literacy in their schools. In speaking to two educators who I would consider literate in mental health, they spoke about the stigma and lack of knowledge in other educators, but also praised administration that were supportive of mental health initiatives. I think it is important to have as much staff and administration be informed to increase the overall mental health literacy of the entire school community. This can then extend to students through student initiatives and clubs that can be run with support of staff with some form mental health training. These are all short term solutions, but can have a large lasting impact.

Another long term recommendation would be for teacher education programs. I strongly believe that mental health should be a stronger focus within teacher education programs. With the transition to a two-year program for all initial teacher education programs, there should be at least one course, or equivalent dedicated to promote and supporting mental health and well-being. New teachers will undoubtedly come across students with mental health problems, and the research has shown that teachers feel unprepared to support these students. With that being said, the educators I spoke to with MHFA training clearly expressed that they felt more prepared to support students with mental health problems, and have a clear understanding of their role in supporting their students’ mental health. Therefore, similar training should be mandatory for all newly certified teachers.
In short, there needs to be an increase in mental health literacy in secondary schools. This can be done at all levels. Educators should seek out training and professional development themselves, administration should encourage workshops, professional development, and training for all staff and include mental health programs and clubs in their schools. On a longer term scale, there should be a greater emphasis on mental health in teacher education programs, and the OCT should create an AQ, or several, on the topic mental health and well-being.

5.4 Areas for Further Research

There has been a substantial amount of research done, especially in recent years, about mental health broadly. This is a great start, but I think there is still a great need for more specific research with regards to mental health in secondary schools, especially in the area of decreasing stigma, and increasing mental health literacy. In particular, I think there needs to be more research done on the efficacy of mental health training, and programs intended to promote mental health literacy. If the research can identify the success of these programs in actually promoting mental health and well-being in students and decreasing stigma in schools, these programs can then be recommended for all teachers, administrators, and even students. For the time being there are many indicators, this MTRP included, that suggest that programs can increase awareness and decrease stigma regarding mental health, however I think there is still room to more clearly establish whether or not these programs are successful in improving mental health literacy in school communities, as well as if they are successful in reducing, or eliminating stigma.

Another area of research for the future is the prevalence of programs available to educators in the area of mental health literacy. From my experience looking for educators for this MTRP, I found it difficult to find participants who met the sample criteria, particularly teachers
with MHFA training were difficult to find. In speaking to these educators I found that there is only a small subset of educators who have formal training in the area of mental health. This is consistent with research done on how prepared educators feel in supporting students’ mental health, but of the educators who do have some formal training, it would be beneficial to know which programs are most prevalent, and which make the biggest difference both in educators’ perceptions and stigma, but also on how supported the students of those educators feel.

Finally, I think it is important for more research to be done regarding the experiences of students with mental health problems, and their perspective regarding the supports they receive in schools. There has been research done in this context, but not enough in my opinion, specifically getting the perspective of students. As the end-receivers of the support, more research needs to be done to find out how students feel they can be supported, and how well the supports that are in place are working for them. This will allow researchers to better understand the present situation, and where the most improvement can be made with respect to supporting students’ well being.

5.5 Concluding Comments

Mental health has garnered increasing attention in recent years. Awareness of the importance of this issue has and continues to increase. The attention to the mental health campaign is promising, however the next step is to use this awareness and attention, and turn it into action. This has already begun, there are more and more programs and supports available to everyone to get informed about mental health. However more can still be done to ensure we are increasing mental health literacy, especially in secondary schools, where mental health is of particular importance. Stigma surrounding mental health is still pervasive both in school communities and outside of school walls, in the form of problematic language and stigmatizing
attitudes. It is crucial that students’ mental health problems are addressed and not dismissed. Secondary school educators in particular are in a great position to make a difference and support students experiencing mental health problems. Not only that, but they have an opportunity to teach students about mental health, in order to fight stigma, and promote mental health literacy for the next generation. I hope that the momentum surrounding mental health advocacy continues, and results in improvements of mental health supports for secondary school students.
References


Scotland: The SCRE Centre.


health strategy for Canada. Calgary, AB: Author.


Appendix A: Letter of Consent

Date:
Dear ______________________________,

My name is Devan, 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 how educators support students’ mental health in secondary schools. I am interested in interviewing teachers who have MHFA training as well as experience supporting students with mental health problems and disorders. 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,
Devan Singh

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 Devan Singh 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

Thank you for agreeing to participate in my research study. The goal of this research is to learn how educators with training in Mental Health First Aid are working to support students with mental health problems and disorders. This interview should take approximately 60 minutes, and is comprised of approximately 19 questions. The interview protocol has been divided into 4 sections, beginning with some background information, followed by questions about identifying students with mental health problem. Next, will be a section on challenges you face in promoting mental health. This will be followed by a section on resources, programs and strategies used to promote mental health, and finally how your MHFA training has, or has not helped you in your endeavor to support your students’ mental health. I want to remind you that you can choose not to answer any question, and can remove yourself from participation at any time. Do you have any questions before we begin?

To begin can you state your name for the recording?

Section A - Background Info

1. What grades and subjects do you teach/have you taught?
2. Do you have any other roles/duties in the school beyond being a teacher?
3. How long have you been teaching?
4. When did you receive your MHFA training?
5. Aside from MHFA, do you have other background in or experiences with mental health?
6. What made you interested in learning more about mental health?

Section B – Identifying and Supporting Students with Mental Health Problems

7. Since you completed MHFA, can you estimate how many students you have worked with or supported who have active or apparent mental health issues?
a. How did you come to be aware of these students and their mental health status?

b. Were you responsible for identifying them as someone with a mental health problem or disorder?
   
   i. if yes, what did you find helpful in identifying the student?
      
      1. (Resources, signs, behavior, interaction with peers, information from other staff/administration, paperwork, identified themselves?)
   
   ii. if no, have you encountered students who have been identified as having a mental health problem or disorder
      
      1. If yes, can you describe the situation
      2. If no, do you believe you have had students with mental health problems that have been missed, or that there have not been students with mental health problems?
         
         a. (either response) Why?

d. Do you find it difficult to identify students with mental health problems?
   
   c. Why or Why not?

9. I’m going to ask you some questions now to help you describe an experience where you directly supported a student with an active mental health issue.

   PROMPTS: What occurred in the time prior to the support you provided?
   What occurred that resulted in the support being provided?
   Tell me about how you recognized that the student was dealing with a mental health issue.
   Were there signs that concerned you?
   Was it something that gradually progressed/developed?
Did it occur suddenly, or unexpectedly?
Can you describe the support you provided?
Duration/Frequency?
How did the student respond to the support?
Did you notice any changes in the student as a result of the support?
Did the support lead to the student accessing other resources?
Did the support end? If so, why?
What did you notice after the support ended?

FOLLOW UP QUESTIONS

What was challenging about this supporting this student?
What did you find helpful in the process of providing support to the student?

10. What are some barriers you typically face in supporting the mental health of your students?
   a. How have you managed the barriers you described?

11. What are some ways in which mental health stigma appears in your school?
   b. Is stigma a factor that makes it difficult to discuss mental health with students (not only those with an active MH issue)?
   c. Has there been a time you found stigma to be a barrier to discussing mental health?
      i. PROMPTS: Stigma in the students’ peers’, other teachers, administration, the students’ family?
      ii. Your own stigma (perhaps unconsciously)?
iii. Stigmatizing views of the student themselves?

Section D – Strategies, Programs, Resources used to support students’ mental health and perceived outcomes

1. Could you describe the mental health supports/programs/resources available at this school?
   a. Do you think these supports are adequate?
   b. How could they be improved?

2. Tell me about how you promote mental health in your classroom. Could you give me an example of a time that you promoted mental health in your classroom?
   i. Stigma in the students’ peers’, other teachers, administration, the students’ family?

3. In your experience, what strategies have been effective in reducing stigma surrounding mental health in your own classroom (if any)?

Section E - Perceived effects of MHFA training on practice, and feelings of preparation

1. Overall, do you feel adequately prepared to support your students’ mental health?
   a. Do you believe the MHFA training had any role in how prepared you feel?

2. How do you think your MHFA training impacts your practice in supporting students’ mental health?

3. Can you describe a time you explicitly used what you learned in MHFA training?

CONCLUSION

1. Do you have any advice for me as a teacher candidate with MHFA training myself as I begin a career as a secondary school educator?
a. How about in regards to supporting and promoting mental health of students and trying to de-stigmatize the topic?

2. Would you care to share any final thoughts? Anything I had missed, or you would like to share with me before we end the interview.

Thank you, sincerely, for your time and considered responses.