

Mental Health Education In Canada

An Analysis of Teacher Education and Provincial/Territorial Curricula

Prepared for Physical and Health Education Canada

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About Physical and Health Education Canada

Physical & Health Education Canada (PHE Canada) is the national voice for physical and health education. We work with educators and on-the-ground professionals to develop the resources, understanding, and networks to ensure that all children have the opportunity to develop the knowledge, skills and attitudes necessary to lead healthy, physically active lives, now and in their future. The foundation of our work is advocating for strong health and physical education curriculum, and providing the support to ensure its delivery by qualified educators supported by engaged administrators. We strive to achieve our vision by fostering healthy school communities where all students can develop the resiliency to be the citizens of our future.

Learn more about us at www.phecanada.ca.

About the AstraZeneca Young Health Program

The Young Health Program is about helping young people in need around the world deal with the health issues they face, so that they can improve their chances of living a better life. In Canada, the AstraZeneca Young Health Program is working in partnership with three leading Canadian charitable organizations to improve the mental and emotional wellbeing of youth ages 10–19. The Young Health Program supports the advocacy efforts of PHE Canada to ensure that teachers are equipped with the skills to project a positive mindset and to teach the skills that lead to positive mental health for Canadian youth.

For more information please visit www.younghealth.ca.

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Executive Summary

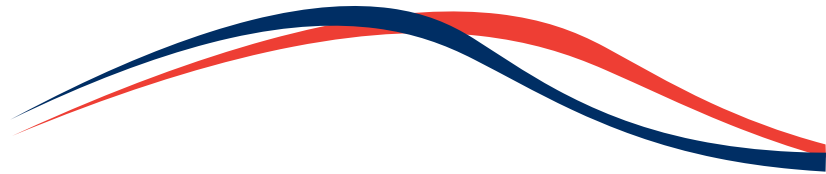
This review of the current state of teacher education and mental health curricula for children and youth in Kindergarten to Grade 12 allowed an opportunity to systematically examine how we currently support and educate both teachers and students about mental health. A large team of researchers engaged in this investigation in order to help provide some important context and support for change in the way we do both of these important endeavours.

There is a clear need for a strategic and systematic approach to promotion and prevention with respect to mental health in our schools. Without a national strategy, we look to promising practices in various domains. The School Mental Health ASSIST program in Ontario seeks to support school boards in building the organizational culture to facilitate change in how we support children's mental health in schools. This exemplary program, now rolled out across Ontario, provides structure and a firm foundation on which the effects of new policies, resources, interventions and successes, may be built.

There are models that exist that can be very helpful in conceptualizing a school-based mental health approach. In their proposed framework for teacher education, Weston and colleagues (2008) suggest the six principles for a teacher mental health competencies curriculum framework, including key policies and law; provision of learning supports; collection and use of data; communication and relationship building; engagement in multiple systems, and a focus on professional growth and well-being.

It is clear that we must include teachers, children, and youth in our appraisal of what is necessary to support mental well-being. By placing a focus on self-care and awareness for teachers, we provide an open door to consider that in the same way they need support at home, with good healthcare practices and from those around them at school, children and youth will benefit from the similar considerations. The "Whole-Child" approach to mental health could also be termed the "Whole-Person" approach, and include those in the role of student, teacher, or supporter.

As part of consideration of the whole person, a key concern is examining the opportunities that are available that may be systematically denied or compromised because of poverty, oppression, or access. We may have as an aspiration that each person will have the opportunity to grow personally and develop resilience, but we must invest in our vision through committed action.



Context

Epidemiological studies reveal that one in five children in Canada under the age of 18 suffers from at least one mental health problem or illness, a risk that rises for children from indigenous populations and youth in adverse conditions (Canadian Pediatric Society, 2009; Mental Health Commission, 2012). About half of all mental illnesses, including anxiety, depression, severe emotional disorder, and attention-deficit/hyperactivity disorder, begin in childhood or adolescence (Kirby & Keon, 2004). Suicide is currently the second leading cause of death among Canadian youth (Health Canada, 2006), ranking us third in the industrialized world for this tragedy (Canadian Mental Health Association, 2014). Further, and of importance here, only a minority of children and youth (approximately 1 in 6) receive professional help for mental health issues, and for those who do, services are often inadequate (Canadian Psychiatric Association, 2012; Koller & Bertel, 2006).

There are good reasons to focus on the school and school performance when considering children's mental health. First, while most children attend school, few will have access to mental health treatment services through the health care system (Canadian Psychiatric Association, 2012). Second, mental health has a significant impact on academic performance, absenteeism and drop-out rates (Koller & Bertel, 2006; Owens, Stevenson, Hadwin & Norgate, 2012). Third, children spend approximately eight hours a day in the presence of education professionals (Kirby & Keon, 2006), often longer than they do at home or in leisure activities. More than ever, teachers are called upon to attend to the mental health of their students, yet with limited training in mental health awareness or care, they have little support to effectively fulfill this role (Koller & Bertel, 2006; Short, Ferguson & Santor, 2009).

Increasingly, schools are viewed as a potential part of a system of care in support of child and youth mental health service. Ontario's past Education Minister, Laurel Broten, recognized this fact in her recent address at the People for Education conference with her pledge to make the response to child and youth mental health within a school context a significant part of her tenure as Education Minister. The Centre of Excellence in Child and Youth Mental Health commissioned a recent review entitled "Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario" (Santor, Short & Ferguson, 2009). Canada's Mental Health Association (2014) has identified school-based mental health as a major target of service development in our nation's future system of care, and The Canadian Policy Network has identified that the strongest return on investment was for children's mental health (including emotional and behavioural disorders) in schools (Roberts & Grimes, 2011).

However, how we develop these systems of care and how we make them functional and visible to stakeholders is of primary importance. The above developments place a priority on understanding of the mental health needs of children and youth in the context of education. Education plays a gate-keeping role in our society and success in education is connected with employment success, financial independence, and healthy living. The need for a comprehensive understanding of the relevance of school-based

mental health services also includes those who work most directly with students—their teachers. Their roles are changing as they take their place on the front lines of child and youth mental health. It is, however, a role for which they feel inadequately prepared (Rothi, Leavey & Best, 2007), but about which they are “unanimously keen to learn more” (Gowers, Thomas & Deeley, 2004).

Teachers play a pivotal role; not only do they have a fundamental responsibility in supporting child development and learning, but they are shaping generations to come. Research strongly supports the notion that teachers and school communities play a significant role in shaping healthy child and youth development. Teachers hold a particularly influential role in the learning and development of children and youth through their ability to observe students over an extended period of time, and through relationship building that occurs on a daily basis. This becomes particularly important when considering issues of mental health and the trust that it takes for a student in need to reach out for help, as noted by Western University Professor, Dr. Alan Leschied from the Faculty of Education:

“Teachers are on the front lines. They are very often the most trusted, if not the only person in whom a child in need might confide”.

Teacher education candidates report learning about internalizing mental health symptoms (i.e., anxiety, depression, low self-esteem) mainly through practicum experiences and discussions with supervising teachers, rather than through formal teacher training through faculties of education (Bryer & Signorini, 2011). Additionally, almost all teachers report having little or no child mental health training (Gowers, Thomas & Deeley, 2004). At most, teachers may complete a basic general educational psychology course which focuses on instructional theory but which excludes mental health principles and their relationship to learning (Koller & Bertel, 2006). In-service mental health assistance also falls short of providing teachers with proper supports to help their students and is limited by the availability of mental health professionals who consult with schools (Walter et al., 2006). For those training programs teachers do receive, most are centred on being reactive (as opposed to proactive), and lack strategies associated with prevention (Koller & Bertel, 2006). For example, many Additional Qualification (AQ) courses that we examined in the scan of Canadian B.Ed. programs were directed at helping students already diagnosed with a “disorder”; although important, this is representative of a small part of the student body, whereas prevention and promotion efforts reach all students.

A survey of experienced elementary teachers (average of 15 years teaching experience) revealed that few educators received initial teacher education or in-service training regarding major mental health problems facing children, such as attention deficit/hyperactivity disorder, disruptive behaviour disorder, depression, anxiety, and suicide. This lack of education was congruent with their limited knowledge and self-efficacy in managing mental health problems. When asked what barriers were associated with improper mental health provision in their schools, teachers most frequently reported a lack of information and training (Walter, Gouze & Lim, 2006).

Student Experiences: Mental Health

Across Canada, one in five children under the age of 18 will experience at least one mental health illness or mental illness influence (Canadian Psychiatric Association, 2012). Of these affected youth, as few as 17% (Offord, Boyle, Fleming, Blum & Grant, 1989) to 40% (Kutcher, Hampton, & Wilson, 2010) will access some form of mental health care services or support, though the limited services will not necessarily be well matched to children’s needs, offered in a timely way, effective, or evidence-based

(Canadian Institutes of Health Research, 2010; Tolan & Dodge, 2005). Converging evidence comes from Dr. Stan Kutcher, a noted scholar and champion of child and youth mental health awareness in Canada, and Dr. Simon Davidson (2007), who noted that many persistent mental disorders tend to develop around the ages of 10–15.

Not only do these statistics represent the prevalence and negative effects mental illness can have on children and youth, but they also highlight the need to make changes to properly address these issues early on. But why should educators be concerned about mental health needs when their role is to educate? Research has found that often, mental health challenges are pervasive, impacting many developmental outcomes and, of particular importance here, academic performance. More specifically, direct links have been found between mental health problems and difficulty with social relationships, physical health, academic engagement, school achievement, and retention.

All Canadians have a vested interest in promoting mental health in this country. Smetanin et al (2011) projected the cost of mental illness to the Canadian economy to be \$48.6 billion per year. In all, the economic burden that mental health concerns place on our country is staggering and has been identified as the single largest drain on economic productivity in the Canadian workplace (Stephens & Joubert, 2001). However, it must be noted that this is not just Canada's challenge; the World Health Organization has forecast that mental illness will become the single largest burden of disease worldwide within the next decade (WHO, 2007).

Teacher Experiences: Mental Health

Given this snapshot of the mental health challenges experienced by our children and youth, and given the prime role that educators play in terms of child and youth development and ongoing relationship building, it is essential to shift our national focus to how we can promote the role and resources of schools in supporting Canada's students. Educators' roles are changing as they take their place on the front lines of child and youth mental health. As was discovered in this study, it is a role for which they feel inadequately prepared, but keen to learn more.

Teacher education can have substantial impact on teachers; it is during this period of education that novice teachers acquire the resources necessary to their success as professionals and are provided with the knowledge commonly seen as critical to their competence as educators. It is therefore important to develop an understanding of where Canada stands nationally in terms of providing these key stakeholders in child and youth wellness with access to mental health literacy, not only to assist them in their teaching-related roles, but for the promotion of health for generations to come.

Educators themselves face high levels of stress in both their job roles and from the greater socio-political context around them. As one can imagine, this results in many personal challenges as experienced by teachers in this country. For example, according to the Ontario College of Teachers' 2006 survey findings, 13% of Ontario's teachers reported "feeling stressed all the time", compared to only 7% of the general public work force (Jamieson, 2006). What is more, the College also found that stressful working conditions accounted for the second most highly cited reason for leaving the profession (McIntyre, 2006). It was further noted in this report that:

"[Teachers] are stressed. By time constraints. By parents' blame. By school politics. By trying to help children from dysfunctional homes. By performance appraisals."

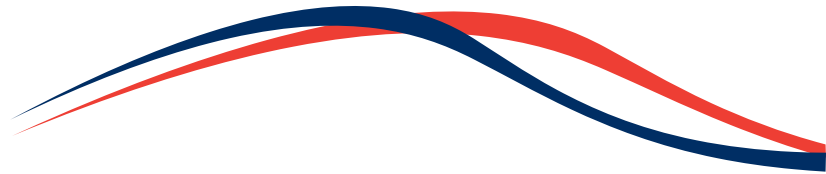
Importantly, student behaviour has been found to be closely connected with teacher stress. In their study examining teacher experiences of depression, anxiety, and job satisfaction, Ferguson, Frost, and Hall (2012) found that workload and student behaviour were significant predictors of depression. While these factors, along with employment conditions, were significant in predicting experiences of anxiety, it was also found that stress and depression had a negative impact on job satisfaction. Taken together, these findings clearly indicate that the mental health of Canadian teachers is being impacted by their jobs. Furthermore, a plethora of research exists supporting the notion that mental health concerns impact not only one's overall job satisfaction as seen here, but their job-related productivity, performance, and absenteeism (WHO, 2010).

Systemic and policy-based stressors have also been of concern in terms of contributing to teachers' current state of mental health, and thus, their ability to perform their job-related roles. As will be discussed later in this paper, overall school climate is an important factor in determining the status of student and teacher mental health. With the current top-down policy structures, emphasis on standardized testing, and frequent reform strategies, it is very important to step back and ask how these structures impact the overall mental health of our schools, the stakeholders in them, and ultimately the ability of our teachers to do their jobs effectively.

Are these structures actually working to improve the health of our students and teachers or are they really hindering them? Acknowledging the importance of systemic and policy-based processes and how these forces impact educators' mental health (and ultimately teacher effectiveness), Pasi Sahlberg (2007) points out Finland's position among the top-ranking countries in terms of academic achievement. In this paper entitled, *Education policies for raising student learning: the Finnish approach*, he attributes Finnish successes to the stark contrast between their education system and policy relative to the traditional Canadian approach as well as in other developed nations. Specifically he notes:

"In education systems that undergo wave after wave of reforms, frequent emphasis is often on implementation and consolidation of externally designed changes. The main result is frustration and resistance to change rather than desire to improve schools. Sustainable political and educational leadership has enabled Finnish schools and teachers to concentrate on developing teaching and learning as they best see it to be needed. Rather than allocating financial resources and time to implement new reforms repeatedly, teachers in Finland have been given professional freedom to develop pedagogical knowledge and skills related to their individual needs. After a decade of centralized in-service teacher education, following the launch of comprehensive school reform in the 1970s, the focus of professional development programs has shifted to meet authentic demands and expectations of schools and individuals."

In summary, today's educators are facing significant stressors extending from behavioural concerns arising in the classroom to policy-level decisions that are made externally with expectations for conformity to them. This results in personal and job-related stress, de-professionalization of qualified teaching staff, feelings of powerlessness and lack of flexibility in performing job-related tasks, difficulty attending to student needs, and ultimately burnout, and contributes to the large number of individuals leaving this profession annually. Knowing this, it is important to prepare Canada's future teaching workforce with the knowledge and tools needed to not only promote mental health for children and youth, but remain healthy and resilient themselves. When teachers are supported and healthy themselves, we believe there is good evidence to suggest that they will be more effective in their ability to support students' mental health and well-being and, ultimately, student success.



A Theoretical Framework

As outlined above, teachers face many work-related stressors, both at the immediate level of the classroom, and more broadly, at the systemic and policy-based levels. Working in a “top-down” system where mandates, reforms, and policies repeatedly trickle down to our front-line teachers is of considerable concern, as cited earlier by Sahlberg (2007) and as noted from our focus group work, which will be discussed in a later section of this paper. Not only does this create stress for teachers via the dreaded fear of “just one more thing” added to a lengthy list of expectations, but it also results in frustration and resistance to change.

Relational Cultural Theory (RCT) offers some insight regarding why this may be happening (Miller, 1976). This contextually-focused theory of well-being differs from other theories of development as it posits that people develop more fully through meaningful relationships with others, rather than through separation and independence. Looking at influences of power imbalances and the resulting marginalization that arises, RCT stresses the importance of relationships, trust, and equal voice and participation in these relationships, that are necessary for positive growth (Duffey & Somody, 2011). When teachers feel that increasing demands are being “dumped” on them from up the ladder without equal voice in the matter, this breaches the RCT assumptions for positive growth in the teacher (front line)/ministry (leadership) relationship.

The Capability Approach (Sen, 1992) also provides a critically important perspective in examining the “what is”. Sen argues that people must have the opportunities to experience, learn, and make choices in their lives, and further argues that oppression, poverty and politics will influence who is afforded opportunities. When we are discussing people making choices in terms of healthy behaviours, for example, we must ask ourselves if people have the opportunity, or capability, of making such choices.

Finally, the Comprehensive Framework for Implementation Research (CFIR), from Damschroder and colleagues (2009) suggests that in order for successful implementation of any new program or initiative, five groups must be considered that represent inter-related domains. These dynamically interacting domains include 1) the intervention itself; 2) the inner setting ; 3) the outer setting; 4) the individuals involved; and 5) how implementation is to be accomplished (see examples in the chart below: Considerations from Implementation Science). When these domains are considered in the planning phases before implementation, this can assist with a meaningful and smoother transition into the implementation phases themselves. The work of School Mental Health ASSIST, an Ontario-wide initiative to build capacity within school boards to support student mental health, led by Dr. Kathy Short (<http://smh-assist.ca>), embodies the principles of implementation science, evidence-based practice, and relationship building.

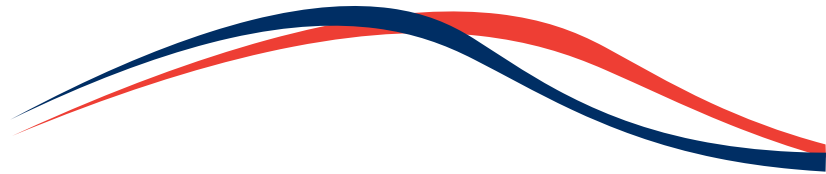
Overview: Project Methodology

Over the past year, we have worked in partnership with Physical and Health Educators of Canada, and their sponsor, Astra Zeneca, with the goal of surveying mental health curricula for both K–12 schools and teacher education programs across Canada. This included conducting interviews and focus groups with Canadian youth, teachers, and teacher educators. Knowledge gleaned from these sources was combined with reviews of contemporary literature and theoretical models. The result is the current document, which includes a synthesis that outlines current key issues, identifies gaps, and provides recommendations for action.

The methodology of both parts of the project is described in this review, with separate reports for the Teacher Education and Mental Health Curriculum K–12 to follow.

The research took place in three steps:

1. Environmental scans (from publicly available information)
 - a. all mental health–related courses present in Bachelor of Education programs across Canada
 - b. the K–12 mental health curriculum in each province and territory
2. Reviews of the relevant literature pertaining to mental health in Canada
 - a. Teacher education courses relating to mental health
 - b. Child and youth mental health curriculum
3. Focus groups and interviews featuring stakeholders relevant to these topics from various locations around Canada.



Teacher Education

Environmental Scan

An environmental scan was completed that provides an overview of mental health–related courses available to Canadian pre-service teachers enrolled in Bachelor of Education programs. The programs included at this step were drawn from post-secondary institutions offering Bachelor of Education programs across Canada. For the scan, we examined 66 post-secondary institutions offering courses that could be applied towards teacher certification, as recognized by the organization regulating teacher education and certification in their province or territory. It should be noted that some of these institutions had multiple campuses. We found a total of 213 courses that met some or all of our criteria for a mental health literacy course. It must be noted here that in order for a course to be included on the list, it was necessary that it address mental health for all students, not just students with exceptionalities (i.e. not a “special education” course). The complete criteria are outlined in the Methodology section.

The purpose of the environmental scan as interpreted by the research team was to identify courses which addressed issues of child and youth mental health or emotional well-being (the “what”), those which offered strategies or approaches to building helping relationships and working effectively to support healthy development in children and youth who may be experiencing mental health problems (the “how”), and were available to all students in a teacher education program.

Scan Methodology

In preparation for the scan of B.Ed. courses, we searched websites of provincial/territorial registrars responsible for issuing teaching licenses to approved candidates upon completion of their prospective B.Ed. program.

Provinces/territories provide outlines of a list of accredited post-secondary institutions on their websites; these were used to develop the list of accredited B.Ed. programs. This in turn provided the guide for which schools to include in our scan. In circumstances where provincial/territorial websites did not provide a list of schools offering accredited B.Ed. programs, the research team contacted registrar offices directly, asking for a list of these schools. Once a list was compiled of all accredited B.Ed. programs across Canada, we began our scan. It is of importance to note here that we examined only programs intended to prepare students for work in the public school system. Future research may consider broadening its scope to look at more specialized teacher preparation programs, in terms of aboriginal education and service with the private sector, for example.

Next, researchers viewed the current course offerings in the teacher education programs offered at each Faculty of Education, via the publicly available information on their official websites. For each Faculty, courses that included the following words, either in the title of the course or in the course description, were recorded:

- Mental
- Emotional
- Well-being
- Health
- Stress

The following information about each course was gathered:

- Province or territory
- University/College, and school or Faculty of Education
- Course number
- Course name
- Course description
- Mandatory or elective course
- Restricted access or open to all students

The information for over 400 courses offered at 66 institutions was then entered into the database.

In order to develop an understanding of the fit of the courses to the stated objective of promoting mental health literacy for teachers, we created an aggregate score using four components that represent the degree to which any individual course met the criteria described above; that is, each course could be awarded one “point” for the presence of each of the following elements:

- The “what” (Topic): the course description included the words “mental” “health” “emotion/al” “stress” or “wellbeing” or a specific mental illness (i.e. “depression”, “anxiety”, “eating disorder”, etc.) that appeared in the course description.
- The “how” (Practice): the course description indicates that students will learn about supports, strategies, resources, or other things related to implementation, practice, or working effectively.
- Relationships: the course description indicated that students would learn about being a helper, forming helping relationships with students, or understanding the importance of relationships for well-being.
- The title: the course was awarded one “point” if the title clearly signalled that the course was about “mental health”, “stress” and/or “well-being”.

Using this rating system, the minimum and maximum scores for courses could range between 0 (does not reflect any of the required elements) to 4 (has all the required elements). Note that no courses that scored a “0” are included in this scan.

The research team shared initial training with the principal investigator and rated courses until consensus was achieved and each member shared a common understanding of the rating system. Adjustments and decisions were shared by the members of the team, ensuring shared practices. Following this, each member of the team independently rated 6 courses and ratings were tested for inter-rater reliability; further training was undertaken until consistency reached 95%.

Scan Findings: Assets

Classroom Management

Most schools offered courses on classroom management, and several of these mentioned the impact of teachers' attitudes and behaviours on both student behaviour and academic achievement. These courses also routinely mentioned how teachers could increase students' motivation through behavioural techniques. However, few course descriptions mentioned the impact of teachers' attitudes and behaviours on students' emotional health or well-being.

“Comprehensive Health”, “Holistic Health”, and “Relational” Approaches to Mental Health

We found that the abovementioned themes emerged from within the course offerings of many colleges and universities. These approaches were often characterized by their acknowledgement of the interdependence of the many factors contributing to psychological health, including physical health and nutrition, healthy family and peer relationships, and presence of stress or hardships. Such courses also often included an element of preventive practice and mental health promotion while highlighting aspects of not just physical, but holistic aspects of health. However, courses specifically focused on prevention and promotion of holistic health seemed to be lacking; courses were more apt to focus on intervention of already apparent mental health concerns, rather than preventing them.

Focus on the Screening, Assessment, and Diagnosis of Mental Illnesses

Most schools offering programs with a psychological focus included at least one course regarding how mental illnesses are screened, assessed, and/or diagnosed. In contrast, comparatively fewer of these courses also described the care or support of students with mental illnesses. Also, few courses contextualized mental health as being on a continuum of health; this neglects to see other aspects of mental health outside of a diagnosis.

Scan Findings: Gaps and Needs

A general need for more mental health classes

As can be seen from Figure 1 below, only two courses across all provinces and territories met all four criteria for a mental health literacy course for teacher candidates. That there is such an absence is not surprising; teacher education programs must balance many priorities to educate teachers who understand theory, curriculum, pedagogy, and policy. It is important to realize, however, that programs do have the freedom to develop and offer courses on any topic they see as relevant for teacher education, including those designed to develop an understanding of what mental health is, how it looks in a classroom, how to work with children who have mental health problems, and how to foster mental health well-being, just as we work to foster physical well-being.

Need for common conceptualization of mental health and well-being

In reviewing the Bachelor of Education programs and courses from across Canada, we discovered a wide array of terminology, approaches, and perspectives relating to “mental

health”. Though some programs opted to conceptualize this area as “mental health” and “psychological health” or “psychological well-being”, many programs broadened their conceptualizations to “holistic health”, “whole child health”, and “comprehensive health and wellness” as reflected through course offerings. These differences are not only linguistic but also indicative of dynamic changes in the field. We found that while some courses referenced specific mental health challenges—such as stress, anxiety, depression, anorexia etc.—others, in contrast, focused on the cultivation of qualities or skills, such as empathy, hope, sustainable happiness, appreciation, and positive relationships. Thus, in order to design and offer more classes to our country’s B.Ed. students, we need to understand and come to a common conceptualization of what exactly comprises mental health and well-being.

Assign a higher priority and more access to mental health courses

In our review of offered courses, we noted the degree of priority assigned to each course through its “Mandatory” or “Elective” status within each stream and program. Though course offerings varied significantly among Bachelor of Education Programs, we discovered that many programs did not prioritize access to mental health–related courses which, when available and accessible to B.Ed. students, were often not mandated/required but were presented as elective options.

Promote a proactive approach and universal appreciation for mental health versus a reactive and “othered” approach to mental health

We found that many courses took reactive approaches to a minority of students in need when considering mental health—dealing with students already in emotional crisis, students demonstrating behavioural challenges, or students at risk of school failure because of emotional difficulties. In contrast, physical “health” courses tended to take a proactive or protective approach for all students, helping all students develop healthy eating habits and teaching students to enjoy regular physical exercise. This approach fails to acknowledge that mental health, like physical health, is on a continuum; we all have mental health and all experience different parts of the continuum from time to time. Therefore, there is a great need for mental health courses that make it clear that ALL (rather than special needs) students may encounter mental health challenges, and that we can all do things to promote mental health and resilience, regardless of where students fall on the continuum. As such, we found little mention of courses designed to sustain or improve the mental health of all students. In summary, courses specifically focused on prevention and promotion of holistic health seemed to be lacking; courses were more apt to focus on intervention of already apparent mental health concerns, rather than preventing them and promoting well-being for everyone.

Literature Review

Next, the research team conducted a literature review of the knowledge base regarding mental health and teacher education. The goal here was to provide a finished written document outlining formal pre-service education practices and policies, as well as strategies related to teachers’ preparation to instruct mental health and deal with issues surrounding children and youth mental health.

Review Methodology

The research team came together to draft an outline on specifically what should be included in this document based on PHE’s requests, and how this should be structured. As such, the following outline was created:

- Background

- ▶ Mental Health and Prevalence of MH Issues among Children and Youth
- ▶ Defining Mental Health and Wellness
- ▶ Impact of Mental Health Issues: Psychological, Social, Economic Costs
- ▶ Barriers to Mental Health Care
- Strategies and Promising Practices
 - ▶ Capacity Building: What can Schools do?
 - ▶ Capacity Building: What can Teachers do?
 - ▶ Implementation Science: Translating Research into Effective Practices
- Overview of Teacher Mental Health Education
 - ▶ Teacher Education Practices and Mental Health Education
 - ▶ Educator and Staff Mental Health
 - ▶ The State of Child and Youth Mental Health Policies in Canada
 - ▶ Current Practices
 - ▶ Successful Strategies and Approaches / Best Practices

The research team then completed a search of relevant databases (ERIC, Google Scholar, Psych Info) to find research on this topic. The key words used in database searches included:

- Mental Health and Wellbeing
- Teacher Education
- Preservice and Teacher Education Candidates, Students and Teachers
- Mental Health Policy
- School-Based Mental Health Practices
- School-Based Promotion of Mental Health

From the information that the research team collected based on previous research, a written document came together. Each member of the team reviewed and provided edits for the final document's completion.

Review Findings: Assets

Support for mental health training

Jourdan, Samdal, Diagne, & Carvalho (2008) found that teachers who had received health promotion training tended to be involved more frequently in their school's health promotion projects and had more comprehensive perspectives on school-based health promotion. However, the researchers also noted that in order for health promotion initiatives to be successfully integrated and sustained within schools, it was critical to embed such initiatives within the socialization, learning, and daily life of the school, and to not introduce such initiatives as additional or supplementary add-ons to existing school curricula (Jourdan et al. 2008). It was also noted that school-based health initiatives need to be made meaningful to educators as well as relevant to their educational perspectives and to the necessity of the specific school context. For this reason, the use of bottom-up or "home-grown" school initiatives was preferred for the reason that it would simply be context-relevant.

The need for a strategic and coordinated approach

The work of School Mental Health ASSIST, led by Dr. Kathy Short and her team for the Ontario Ministry of Education, highlights the importance of a strategic, coordinated, and planned approach to school-based mental health and how this provides a stable platform from which to conceptualize teacher education. Through the work of implementation scientists, Laura Damschroder and colleagues (2009) point out that for any intervention to be successful, there needs to be consideration of organizational, personal, and professional variables. We know that all effective change follows a plan, and that changes can be detected and measured in ways that are meaningful. The work of mental health education specialists, including those who educate teachers, promotes a core set of three values that speak to broad competencies within a framework that is cohesive and inclusive:

1. Teaching practices much be culturally relevant and strengths-based, and incorporate a child-centered, family-driven approach
2. Strong school-family-community partnerships are a necessary foundation for provision of appropriate and effective learning supports
3. "Whole child" perspectives and developmentally appropriate approaches are essential (Weston, Anderson-Butcher, & Burke, 2008).

Building on strategy and efficacy

As a possible solution to the concerns over teachers' health, the development of teacher emotions, emotional competencies, or emotional intelligence has also been implicated by others as a way to improve educators' psychological well-being, resilience, and teaching success (Vesely, Saklofske, & Leschied, 2013). Researchers from Western University argue that because the core factors of teacher efficacy overlap to an extent with competencies identified under the Emotional Intelligence model, it may be feasible to develop emotional intelligence training as a well-rounded attempt at decreasing teachers' work related stress levels, while increasing teacher efficacy and job satisfaction (Vesely et al., 2013).

Review Findings: Gaps and Needs

Mental health: teachers report feeling under-prepared

Pre-service education can have substantial impact on teachers. It is during this period

of education that novice teachers acquire the resources necessary for their success as professionals and are provided with the knowledge commonly viewed as being critical to their competence as educators. However, when asked to comment on mental health awareness and literacy, teachers today often express concern over having to support students with mental health issues in spite of the fact that they lack training in this area (Gowers et al., 2004; Reinke et al., 2011). The critical value of appropriate in-class and practical teacher preparation, especially in the area of whole health and mental health, is underscored by research which suggests that the more preparation teachers receive, the more efficacy and success they will achieve with their students (see Darling-Hammond, 2000). Not only does adequate and appropriate training help individuals feel more competent in their profession, but also the education they receive works to change their personal epistemologies, beliefs, and attitudes toward a given topic (Chai, Deng, & Wong, 2010; Brownlee, Petriwsky, Thorpe, Stacey, & Gibson, 2011). The repercussions of such findings for mental health education would be significant, as such research implies that educating teachers, early in their career development, in the area of mental health literacy, promotion, and prevention can have considerable positive impact on their own awareness, attitudes, perspectives, and approaches to mental health—both their own and that of their students—in the school setting.

Helping teachers stay healthy

There has been concern highlighted for teachers' own mental health in the literature, and the potentially negative outcomes if left unaddressed. Related research has supported this concern by demonstrating that teachers who felt unsupported, under pressure, and untrained in mental health had an increased tendency to show strain under pressure within classrooms, and react harshly through disciplinary control techniques such as shouting and humiliation (Lister-Sharpe et al., 1999). An abundance of research supports the notion of increased levels of stress as experienced by teachers. According to the Ontario College of Teachers' 2006 survey findings, 13% of Ontario's teachers reported "feeling stressed all the time", juxtaposed to only 7% of the general public work force (Jamieson, 2006). Moreover, the College also found that stressful working conditions accounted for the second highest reason for leaving the profession (McIntyre, 2006). Thus, it is important that teacher education programs better educate and prepare students with coping strategies for the stressors they will experience once they are a part of the workforce.

Lack of policy and clear goals

As of 2010, Canada (Kutcher, Hampton, & Wilson, 2010), unlike many G8 nations, did not have an overarching policy framework for mental health; only four of the ten provinces, and none of the territories, had policies or plans specific to child and youth mental health. Presently, the Mental Health Strategy for Canada is under development by the Mental Health Commission of Canada (Canadian Institutes of Health Research, 2010). A complementary document, *Evergreen*, which outlines a framework specific to the mental health needs of children and adolescents, has also recently been released. Without clear policy objectives and frameworks, it is difficult for faculties to educate their teacher education students on responding to mental health concerns. What is more, this lack of policy around mental health concerns in children and youth sets a poor example of what our country expects its front-line staff to do regarding matters of mental health, when it clearly has not made such issues a priority despite the great need.

Focus Groups/Interviews

The final step in the data collection phase involved focus groups and interviews with relevant stakeholders across the country. The goal here was to once again, identify current gaps within B.Ed. programming around mental health, and ideas for improvement.

Focus Group/Interview Methodology

Focus groups and interviews were conducted with individuals across Canada, from various stakeholder groups. Participants came from the provinces and regions listed below.

- New Brunswick
- Quebec
- Northern Ontario
- Southwestern Ontario
- Alberta
- British Columbia

Participants came from the following stakeholder groups.

- Researchers in the field
- Administrators
- Teachers (both elementary and secondary)
- Community Organizations/Advocacy Groups
- Parents
- Pre-service students and recent grads from B.Ed. programs in Canada
- Secondary school students and recent graduates

Participants were recruited by sending out recruitment emails to conference attendees at various education- related conferences around the country, school boards, and schools and youth connected with various mental health agencies. Participants who responded to these email recruitment notices were included, and interviews or focus groups were arranged at a place and time convenient for them. In all, there were about 50 participants in the focus groups and interviews; they ranged in age from 16 to 60+ years.

After data collection had occurred, recordings were transcribed and reviewed by the research team for thematic analysis.

Participants were asked the following questions:

What are your thoughts or experiences around:

- *The inclusion of mental health concepts in school curriculum for grades 4–12? What are they learning now? Are there gaps that need to be addressed around mental health in the current curriculum? Do you have any thoughts around how these gaps may be addressed?*
- *The role of teachers on the front lines of mental health?*
- *Their roles and responsibilities? Are these being addressed sufficiently in pre-service education programs?*
- *The barriers and facilitators to effective practices? How do personal attitudes and philosophies impact this?*
- *The needs of teachers, children, youth, families, schools and communities with respect to child and youth mental health and pre-service education in the context of child and youth mental health?*

The questions for the youth focus group mirror those above, asking (in appropriate language) about their experience as a student, learning the current mental health curriculum and being part of a classroom/school community:

What are your thoughts or experiences around:

- *The inclusion of mental health concepts in school curriculum for grades 4–12? What are you learning now? Are there gaps that need to be addressed around mental health in the current curriculum? Do you have any thoughts around how these gaps may be addressed?*
- *The role of teachers as people who connect daily with students, and on the front lines of mental health?*
- *The barriers and facilitators to creating a safe and inclusive school and classroom experience, with respect to mental health? How do personal attitudes and philosophies impact this?*
- *The needs of teachers, children, youth, families, schools and communities with respect to child and youth mental health and pre-service education in the context of child and youth mental health?*

Focus Group/Interview Data: Gaps and Needs

Lack of mental health preparation in B.Ed programs

Unanimously, focus groups and interview participants indicated that B.Ed. programs are not adequately preparing teacher education students for identifying and addressing the mental health needs that they will see in their classrooms once in the field. Moreover, it was noted that training and education around student mental health largely focuses on awareness of legalities; how to protect one's self legally, not the awareness or relationship aspect of how to approach students and parents. Teacher education students and current teachers would like more help in learning how to approach students and parents about suspected mental health concerns. This was also reflected

by some secondary school students:

"I think that even with, like, physical health and as well as mental health, teachers, want to help generally, it's just they don't know how to. And when you don't know how to help someone, it just makes you feel uncomfortable because it's like, what if I say something wrong and then it just makes everything worse, right? Like, I think teachers generally want to help you; that's why they're teachers. I mean, I'd like to think that, so... I mean, like, they're working with kids and stuff that do need help."

"Now, I think there's more and more about, like, different learning styles, or like if your student has dyslexia or if your student, you know, has a learning disability [...] maybe they provide more education to teachers about, like, how different approaches should help those students. So maybe if they kind of put that mental health piece in as well. Like, [...] if you see a student sitting in the corner all kind of sad, of course they're going to respond. Maybe if they provide them with, like, concrete strategies that have been shown to work or, like, researched or, like, from information like this, then that would probably help as well. 'Cause it's kind of simple if they just attach it like, in a course."

A recent B.Ed graduate also commented on this, saying:

"There's a big gap between what we're learning here in the teachers college and what we're facing frontline as a teacher, it just doesn't jibe, it just- it doesn't cover it [...] But school may be the safest place, your class might be the safest place, and you might be the safest person, and will you be prepared if the day comes when a child chooses you to open up to?"

The youth had some advice about how to effectively include mental health literacy in the B.Ed. curriculum. Here are some comments from a focus group with an interviewer (I) who was herself a recent graduate of a Bachelor of Education Program, and some youth (there were four youth in this meeting, they are all identified as "Youth"):

The conversation about mental health in the schools had focused on "just another thing" that people had to learn and teach, a reactive, not proactive undertaking. Here, the interviewer shares that the Faculty of Education at Western is designing a mental health literacy course for implementation in the fall:

I: We are starting, in September we are starting a Child and Youth Mental Health course for our teachers college teachers, and we're kind of piloting it ...But I'm wondering about the psych adding on thing, right So it feels like another thing you have to do...How can we avoid that? How can we do that so it doesn't feel like another thing that teachers, students have to do?

Youth: Maybe infuse it in, kind of subtly infuse it in everything so it's not like an additional thing, it's kind of like boil—let's say you guys are learning about, like, teachers in teachers college are learning about, like, biology, how to teach biology, and then, you know, just kind of have like a role play where it's like, okay, well let's say we had a student that was really, really struggling with learning about, you know, this and that and they seem kind of anxious. Like, what might we do to make it easier for them to learn the information or, like, deal with their homework? Or something. Kind of just like subtly put it in there, and then they might not even notice ...that they're learning about mental health.

[Laughter]

I: It's like hiding vegetables in your dinner.

Youth: (together) – Exactly!

They then moved on to the topic of teachers' competency to teach – a variety of topics, including biology and math were mentioned, when they went on to talk about what a teacher might feel like if a student comes to them for help with mental health, and the teacher doesn't know the "answer":

Youth: You know? If you aren't able to explain something or teach them, then you don't know what you're talking about.

Youth: I think the problem is that teachers, like, because, like, teachers are intelligent people, like, when it comes to academics, specifically, so I think, like, the problem is that they'll, like, pathologize everything. Like, this person's sad. They're not doing their homework. Depression. I think that's a problem, because they're so used to everything having an answer. Whereas sometimes there isn't an answer with mental health, and if they—and I think if you put that course, like that course, like, the most important lesson that they're going to learn is that they probably won't know the answer, they just need to be there to help.

They just like, know that, I guess like even to raising awareness, but know that, like, they aren't therapist. It's like it's not their job—or they're not psychiatrists. It's not their job to diagnose anyone with anything; it's just their job that it's something that's so apparent in society that they need to know. So...

I: I love that, what you said about how teachers, academics, are people, they like to know answers, the answer, right?, and that the biggest thing that they can learn about in a course of a mental health is that they may not always be able to deliver that answer to them. That's really powerful.

Mental health is at the bottom of the priority list

Mental health and relational courses are often not mandatory and fall far behind the importance placed on pedagogical, policy, and curriculum-oriented courses. One recent B.Ed. graduate noted frustration around this, saying:

"...that's great that you're [Faculties of Education] preparing us with math and English, but, I mean that is 45 minutes, you know, five days a week for math. That relationship [student/teacher] is Monday to Friday, six hours a day, ten months out of the year. Don't you think that requires a little bit of attention?"

What is more, an elementary school teacher remarked on this issue, noting that their B.Ed. experience was very academic-oriented. However, their experiences in the field have been that not all children are ready to learn, and also, that learning is only one part of development, highly impacted by other areas of development occurring simultaneously. Here, they have stressed the need of education faculties to teach beyond academic development only, and teach about "the whole child":

"At the pre-service level, we need to teach pre-service teachers, or teacher candidates to teach the whole child. We're not just moulding their brains or their academic minds, 'cause for me [my B.Ed. experience] was very academic-oriented [...] So you need to be ready when you come out of teachers' college

to meet any kid, not just the kid who's on his A game, ready to learn the quadratic equation. There's not many of them."

This was also reflected systemically by a recent secondary school graduate, noting that mental health–related supports in their school seemed to be among the first to be cut:

"I just remember there was this child and youth worker person or somebody who kind of dealt with all that stuff, and like, we don't have—like, where did that go? It just got up and disappeared."

More from the youth, regarding mental health curriculum:

Youth: Ours was physical and then we had, like, a week of sex education and that was it.

I: So pretty much just physical health, a little bit of sex ed. and nothing about mental health. Youth: No. (why?) ...but like, it literally was just like, "Ah, well. Funding."

Another youth recounted a different experience:

Youth: Uh, we did a lot of different kinds of stuff. Like, we had projects on things like bullying, we had projects on, like, we each, there was one point where we each, for our final project, had to pick a different issue, like, I picked, I think, like self-harm, a friend of mine picked eating disorders, like, depression and stuff like that, and we had to present on them. We would watch, like, movies about things like, like a documentary about eating disorders, or we would discuss things like assisted suicide and things which aren't necessarily related but we'd go on to these weird things where we'd talk about world issues and then relate them back, and it was pretty good. We talked about a lot of different kinds of mental health issues and bullying, and she was, she always said, like, our [inaudible – 3:06] our grade 7 health teacher would always be like, "If you need anyone to talk to about any of the issues that we discussed, or about anything else, come talk to me" and she'll talk about, like, home issues and—Yeah, she was one of the first people I went to when I was like, hey, I have some mental illnesses and stuff. I didn't know that this is what they were, but I would be like, hey, you know. I'm the one I would go to because she had said that where, like, all the rest of my teachers would approach me and be like, "What's going on 'cause you haven't done your homework in four weeks and you cry every day? What's up?" and I'd just be like, I don't know, I just cry, and be, like, I don't know. But she was the one that I went to the first time.

Job role and boundary confusion

Policies that are not yet written or that change frequently, resource shortages, attitude differences in staff from school to school, union and leadership pressures, and ongoing new legislative practices are all factors that contribute to teachers' confusion around the boundaries of their job roles. Teaching staff express uncertainty about the location of boundaries with respect to helping students with mental health challenges. Many recognize that their primary role is to educate, yet some students are not able to learn effectively due to ongoing mental health issues. The question that most frequently emerged was, "When and how involved do teachers become in helping these students?" Teachers are being asked to be "the caring adult" on the front lines of student mental health, while at the same time told that legally and procedurally only mental health professionals should be dealing with issues related to mental health. Some teachers

remarked that they would be approached by students for help, only to be disciplined by leadership within the school and told to refer students to the guidance department, despite the students feeling uncomfortable to go there, noting:

“My students come to me because they know me, and trust me. They are well aware that guidance is there yet, they chose to come to me. You have to have trusting relationships for that to happen, and that happens most often with teachers who are with them every day.”

Teachers may find that although their job role may be clearly defined on paper, their experiences in the classroom are more complex and fall outside of what is neatly defined by a list on paper, as seen in this quote:

“Well, my job description says one thing, and what my job is says another thing. Like, I am to ensure by the end of grade 4, let's say, they know how to divide two-digit numbers. There's my job and that's the curriculum. But that's not what I do. Sometimes I succeed in doing that, and a bit more; sometimes I don't succeed in teaching them division, but maybe I've given them some confidence. Like you know, what my job description says and what I do are different things, and I'm trained to do the job description. I'm trained to teach math, I'm trained to teach literacy, but I'm not trained for the rest of the stuff that comes with it.”

Many teachers expressed uncertainty about what resources were available in either the school or the community, and shared that they did not always feel confident in talking with parents and students about their concerns or their ideas for next steps. Concerns about waitlists, resource shortages, and failure to follow up on guidance referrals were common. Many student participants noted that their school guidance counsellors are more specialized in helping students with academic counselling rather than mental health counselling. Also, many of their experiences included lengthy waits before accessing mental health services through the board's mental health services. One student spoke of experiencing a mental health crisis on a Friday and was asked if they could wait until Monday to see the social worker who came in only once a week. There was also the issue that some teachers experienced with referrals where procedurally, they were directed to refer students experiencing mental health challenges to guidance or mental health staff; however, students did not feel comfortable accessing those resources, so help was not obtained.

Attitudes, Beliefs, and Stigma

Different attitudinal beliefs and values are likely to influence one's willingness to see the importance in mental health and its relationship with academic engagement and performance. Unfortunately, there still remains a large amount of stigma, lack of awareness, lack of knowledge, and misinformation around mental health. These factors can have an additional impact on the attitudes and beliefs of our society that includes teacher education candidates. One parent commented on how stigma and lack of information at school impacted their family's experience with mental health challenges:

“There is that stigma attached to it. When the youngest one was diagnosed with Tourette's, that added another level to our, I guess, mental health, right?, because people didn't understand, and there was no medication for Tourette's. So he became labelled, as some administrators do, they called him evocative victims or provocative victims. So he was bullied because he tic'd. So if you didn't tic, you wouldn't be picked on, you know. Or if as a gay student you didn't walk so gay, you wouldn't be picked on, and so our experience at our school

was when he was in grade 3, he was tic'ing quite a bit, and when he went to the front of the classroom to ask a question and he turned around, his grade 3 teacher imitated his tics in front of the classroom, and we couldn't figure out why he was so angry that year, but a volunteer came to our home to tell us that he was being imitated by his teacher in front of the class, which then allowed the entire class to pick on him, which then allowed the entire class to say I don't want to be in a group with that kid because the teacher obviously doesn't like him."

Confusion

Some youth expressed confusion in trying to understand the "partitioning" of roles in the schools, especially with respect to who was available when:

Youth: Or like a lot of times they'll say, you know, on Monday the mental health nurse is here .And you're like, oh, good, I'll try to plan my crisis for Monday. Okay, every Monday morning. That be it. Like, yeah.

Teachers own health

There has been a significant need identified for helping teachers to remain healthy at work. If teachers cannot keep themselves healthy, it is difficult for them to model health and in turn, encourage health in their students. One student participant picked up on this, noting (I= Interviewer; P= Participant):

I: Well, you said that, you know, you think the teachers want to help but they just don't know how or they're afraid of saying the wrong thing.

P: Yeah, especially, like, if you consider the fact that the teacher might have a mental illness. Like, you never know. Like, teachers are people, too. Anyone can be affected by it, right? So...

I: How would that affect how they will react to students?

P: Well, I mean, there could be a teacher with a type of anxiety, like, any kind, like maybe they just have, like, generalized anxiety disorder, any kind of, like, subcategory of it and, you don't know and, like, that might prevent them from going beyond the curriculum because it's like, alright, I want to be a teacher, I want to help people, but, like, I don't know if I can. So I think it might prevent them from, like, getting personal with anyone, I guess. Like, there's like that boundary for them. 'Cause I think for everyone, like, there are teachers that you talk to about things and then there are other teachers that you talk to them about homework and that is the line. Like, that's it. Your teacher does not need to know anything else about you, so...

Teachers also identified strongly with the stress of having "one more thing" added to their already full plates:

"The thing is, when we talk about adding training, we're like, oh god! Adding more on my plate is like, making me seize up."

Recommendations

Based on the asset and needs gaps identified as themes in the environmental scan, the literature review, and the focus groups/interviews, some proposed solutions were identified. In this section, the research team has put forth some recommendations

based on the present assets, needs, and offered solutions. These include the following:

- Fostering a participatory culture of inclusivity; working with teachers to understand and support them in their roles on the front lines of mental health
- Making Mental Health a Priority in B.Ed. Programs
- Teaching the Whole -Child
- Including Prevention and Promotion
- Adding Context
- Student-Centred vs. System-Centred Procedures: A look at Systems of Care
- Addressing Teachers' Own Mental Health
- Helping teachers be aware of cultural components of mental health and stigma about mental health and help-seeking

Include teachers: Recognize the importance of mental health and their roles on the frontline

It does not seem to matter how wonderful a school's mental health initiatives are, if teachers and administrators have not been included in the process of planning and implementation, and if they are lacking awareness and understanding of why mental health initiatives are important, then these efforts will not work. Mental health programming or mandates will be seen as "just one more thing" the ministry has "dumped" on them. Policy makers need to work with our teachers and principals to create awareness of the need surrounding mental health, the importance of addressing it, and together, design an implementation strategy that will avoid being "one more thing" for teachers. There are lessons that can be learned from implementation science.

The successful implementation of any capacity building effort has been the subject of a great deal of research (see, for example, Fixsen 2004). In developing the Comprehensive Framework for Implementation Research (CFIR), Damschroder and colleagues (2009) suggest that in order to ensure the successful implementation of any new program, five groups of inter-related domains need to be considered. These dynamically interacting domains include: 1) the intervention itself; 2) the inner setting; 3) the outer setting; 4) the individuals involved; and 5) how implementation is to be accomplished (see examples in Table 1, *Considerations from Implementation Science*). Considering these domains in the planning phases prior to implementation can assist with a meaningful, successful and smoother transition into the implementation phases themselves. As can be seen here, an individual's knowledge is a key contributor to the process of implementation. Not only does adequate and appropriate training help individuals feel more competent in their profession, but also the education they receive works to change their personal epistemologies, beliefs, and attitudes toward a given topic (Chai, Deng, & Wong, 2010; Petriwsky, Thorpe, Stacey, & Gibson, 2011). Imagine then a graduate having developed mental health literacy and their likelihood of seeing mental health as important and how this knowledge and belief would shape their decisions to help students with mental health challenges, or to participate in school-wide initiatives. It is critical then, that these constructs be elaborated on in the context of mental health in B.Ed. programs.

Make mental health a priority

Faculties can help by increasing the number of mental health-specific courses, and

The Intervention	The Setting: Outer	The Setting: Inner	Individuals Involved	How: The Implementation Process
<p>Intervention source: internal or external development</p> <p>Evidence strength and quality</p> <p>Advantages over other approaches</p> <p>Adaptability to meet local needs</p> <p>Trialability: ability to test on small scale</p> <p>Complexity</p> <p>Design quality and packaging: how intervention is presented</p> <p>Cost</p>	<p>Community needs and resources</p> <p>Cosmopolitanism: degree of networks associated with intervention</p> <p>Peer Pressure: stemming from a great need or others who are 'doing it well'</p> <p>External Policies and Incentives offered</p>	<p>Structural characteristics: age, maturity, size of organization</p> <p>Networks and Communication: nature and quality of social networks</p> <p>Culture: norms, values, beliefs present</p> <p>Implementation Climate: capacity for change and receptivity of those involved</p> <p>Tension/Need for change</p> <p>Compatibility of intervention with community culture</p> <p>Relative Priority</p> <p>Incentives and Rewards</p> <p>Communication of Goals / Feedback</p> <p>Learning Climate</p> <p>Readiness for change</p> <p>Leadership Engagement</p> <p>Available resources</p>	<p>Knowledge and Beliefs about Intervention</p> <p>Self-Efficacy: Team beliefs in their ability to carry process out</p> <p>Stages of Change: which stage team is in</p> <p>Individual identification with organization and cause</p> <p>Other Personal Attributes: personal traits</p>	<p>Planning</p> <p>Engaging and attracting appropriate individuals to assist with implementation (opinion leaders, formally trained leaders in implementation, champions, external change agents)</p> <p>Execution: according to plan</p> <p>Reflecting and Evaluating: quantitative and qualitative feedback about progress</p>

Table 1 - Considerations from Implementation Science

making them mandatory for all teacher education students, rather than leaving them as elective courses or only open to students in the special education stream. An example comes from our Faculty of Education at Western University. Having recognized a gap in mental health courses available to pre-service students, our faculty has created an online mental health course for B.Ed. students. The course features nine units including relevant literature, videos, and interviews around:

- The Lives of Children
 - ▶ Considerations for teaching the following groups of children: children in foster care, aboriginal children, children experiencing parental divorce, children with same-sex parents, children of parents with mental health and substance use disorders, children living in poverty, children new to Canada
- Understanding Mental Health and Well-being
- Information on Specific Mental Health Challenges
- Stigma and Discrimination
- Experiences with Mental Health Challenges
- Seeking Help and Finding Support
- The Value of Mental Health and Well-being
- Responding to Mental Health Needs
- Linking Violence and Mental Health Adjustment

Providing students with more mental health–specific courses in an accessible and safe format, such as online, is a step towards better preparing our teachers of tomorrow.

Teach the whole child

It is important that when teaching teacher education students about health and development, holistic concepts regarding “the whole child” are kept as a central focus. Helping students to understand how mental, physical, emotional, social, and cognitive health impact each other will be paramount in not only helping students address these concerns that arise at school, but also in understanding how they impact learning and functioning within a classroom. Helping teachers to expand their knowledge and skills pertaining to mental health and how it impacts other dimensions of health will be key in this. It is also important to remember that as children and youth develop, so too do each of these dimensions of health; they develop in a dynamic nature, not in vacuums. We must help students to be aware of this.

Expand the focus to prevention and promotion

Working from a strengths-based, health promotion and prevention perspective, and following the calls to action by research and practice fields (see for example, Bradley & Greene, 2013), the need to develop, deliver and rigorously evaluate health education and school-based supports and resources for our children and youth is clear. It is important to note here that mental health is not simply the lack of a mental disorder, but is a status of well-being where an individual is able to effectively cope with the stressors

they experience in everyday life (WHO, 2001). A person is considered mentally healthy when they have the ability to handle change effectively, create and sustain important relationships with others, possess the ability to manage emotions, and acknowledge thoughts and communicate them effectively. Mental health is critical in being able to cope with stress and decrease the chances of the development of mental illnesses and issues (Mental Health Commission of Canada, 2012). Being mentally healthy allows people to have a sense of worth, as well as an ability to understand internal and external processes (Bhugra, Till & Sartorius, 2013).

Therefore, we must help students to see that, like physical health, mental health too is on a continuum, and that we are all on this continuum. Mental health classes at the teacher education level must expand their focus to include concepts of prevention and promotion. While knowing specific interventions for mental health challenges is important, it is equally important to understand mental health as a continuum and work to promote the health of all in their schools and classrooms, and thereby help keep students and staff resilient to mental health challenges to begin with. This understanding and awareness of the importance of mental health promotion, prevention, and intervention on a school-wide level can begin in teacher education. In the words of Dr. Alan Leschied: “It is better to build up children rather than fixing adults.”

What is more, helping our students to learn the knowledge and skills around promotion and prevention of mental health and well-being not only benefits everyone health-wise, but also economically strengthens both individuals and the collective. Prevention and promotion efforts can drastically save resources that would otherwise be used on costly interventions. Dr. Diane Sacks, president of the Canadian Pediatric Society, has highlighted a critical issue in Canada’s current response to childhood mental illness and health:

“The greatest omission in the work that I see is that it fails to stress the reality that most of the mental health disorders affecting Canadians today begin in childhood and adolescence. Failure to recognize this fact leads us to dealing with a stage-four cancer, often with major secondary effects, instead of a stage- one or stage-two disease. Like obesity, mental health issues, if not addressed early in life, threaten to bankrupt our health care system. (Standing Senate Committee on Social Affairs, Science and Technology, 2005)

Add Context

Another recommendation for addressing the gaps in our B.Ed. programs pertaining to mental health focuses on helping to provide context for students. We need to help our pre-service teachers understand the different models of health. While it is helpful in many ways to provide education on the medical model outlining various mental health pathologies, it is equally important to promote understanding of the ecological factors contributing to that child’s experience and behaviour. In our mental health course, we do this by having students take a look at Bronfenbrenner’s Ecological Model, which asks students to consider ecological effects of forces at each level.

These levels are depicted from figure 1, as produced by the Australian Government (2013).

Moreover, looking at context can allow pre-service students to examine how the context of their own lives shapes the way that they think about and approach teaching, as well as the forces at work that contribute to their own mental health status.

Student-centred vs. system-centred procedures: A look at systems of care

A concern that was made very apparent through the focus groups and interviews

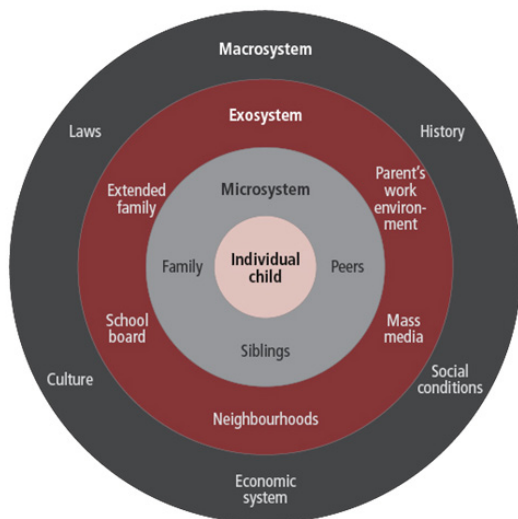


Figure 1 - Bronfenbrenner's Ecological Model

was the disconnect, or dilemma teachers face in being a “caring adult” while coincidentally following the seemingly inflexible job descriptions and union demands in finding their boundaries around how far they can extend themselves in helping students.

Frequently due to a number of factors such as liability and board procedures, teachers are forced to refer students to services that they may feel uncomfortable accessing due to unfamiliarity, or due to waitlists and resource shortages. Deprofessionalization of the teaching profession has led to the belief that mental health professionals are the only ones capable of helping students who experience a mental health need. All of this “red tape” has placed the onus on the most vulnerable person, the student in need, in reaching out for help to a system that expects them to conform to their procedures. Would the procedural system really look the way it does if it were student-centred? Teachers noted that it takes a trusting relationship with a trusted person for students to access help, and they

are frequently that person. Kutcher and colleagues found that even with more mental health nurses available in schools, service use did not increase significantly. With resource shortages, it is doubtful that more mental health professionals will be placed in schools and moreover, if it does take a trusting relationship for students to reach out for help, then we need to be looking at where and how they seek help, not what boards feel is the best procedure.

However, teachers alone cannot be responsible for the many and diverse mental health needs of their students; it takes a village. As mentioned above, there are many domains that contribute to our development (physical, mental, emotional, social, spiritual, cognitive, etc.); therefore, a re-organization of our current system is needed to better meet the needs of our students. We suggest that a student-centred approach would be more facilitative of effective service than one that is system-centred. A Systems of Care model encourages student-centred care.



Figure 2 - A child-centred approach

Situated within the school, this system aims to wrap a collaborative team of professionals around students to work holistically together to meet their various needs. This is demonstrated in Figure 2, as produced by the City of Alexandria, Virginia (2013). All members of the “wrap around team” are seen as valued and equally important in the care and well-being of the student. Relational Cultural Theory, where relationships are valued and based on equal participation and power, best describes an approach that promotes positive growth. Within a Systems of Care approach, teachers are treated as important and contributing members to this team, but not alone in providing care for the child. This system encourages resource sharing and not necessarily hiring new staff. Pre-existing agencies within the community are anticipated to re-structure their service delivery to work with schools and other health providers to put students first at the centre of the system.

So what does this mean for B.Ed. program recommendations? As mentioned above, it is important to support our students' awareness of the multiple and dynamic constructs of development. As such, teachers are bound to work with students who present with complex health and development issues that will impact their learning and behaviour in the classroom. Currently, there would appear to be confusion regarding how boards, unions, and ministries expect their staff to handle these issues. As such, students and teachers report feeling that large gaps in care exist and there is a lack of knowledge regarding how to navigate a system that puts the onus on our most vulnerable to seek services within a complex and often confusing system. Responding to student health needs requires the collaboration of many frontline providers. We recommend that this point be made clear to students in B.Ed. programs, and that advocacy skills for a more accessible and collaborative system reflected in a System of Care be brought into schools such that students may get the help they need. We also strongly advocate that teachers be included and supported as valued members in caring for our country's school-aged children and youth.

Address teachers' own health

The theme of teachers' own mental health arose repeatedly throughout many phases of this project. There has been a significant need identified for helping teachers to remain healthy at work, both in the literature and in the focus groups/interviews that we completed. What is interesting that throughout this country, this is a topic that was rarely found within the B.Ed. course descriptions that we analyzed. This is problematic in that if teachers do not address their own health, it is difficult for them to model health and encourage health in their students. Research has supported this concern by demonstrating that teachers who felt unsupported, under pressure, and untrained in mental health had an increased tendency to show strain under pressure within classrooms and react harshly through disciplinary control techniques and the use of shouting and humiliation (Lister-Sharpe et al., 1999).

We strongly recommend that B.Ed. programs take the time to invest in the health of their own students, covering topics such as coping skills, stress management, and how to access appropriate supports. One teacher commented that some of their coworkers were neither aware that an EAP program existed nor how to access it.

As mentioned in the literature review section, promising work is being done at Western University around emotional intelligence and teacher efficacy. As a possible solution to the concerns over teachers' health, the development of teacher emotions, emotional competencies, and emotional intelligence has been found to improve educators' psychological well-being, resilience, and teaching success (Vesely, Saklofske, & Leschied, 2013). That is, improving teachers' emotional intelligence may impact resilience and lessen stress and burnout. Teaching pre-service students awareness regarding strategies to enhance their emotional intelligence may unlock ways to improve teaching efficacy, and thus reduce burnout. While this is a promising internal strategy that we can help to foster in our next generation of teachers, external forces affecting job-related stress should also be addressed.



K-12 Curriculum

In a broad sense, the purpose of education is to provide students with the skills, knowledge, and resources necessary to become engaged and active members of society. In particular, the goal of health education is to teach students how to maintain good health and avoid unhealthy behaviours. It is critically important that we recognize and address the link between academic success and health-promoting behaviours. Bradley and Greene (2013) recently presented the results of a comprehensive review of research concluding that, “among adolescents, health-risk behaviors are inversely related to academic achievement. While this inverse relationship is not new information, the reported strength of the interrelationship is compelling and suggests that a unified system that addresses both health behaviour and academic achievement would have reciprocal and synergistic effects” (p. 523). Specific curriculum guidelines can provide clear definitions of the knowledge, skills and attitudes that students will develop. These outcomes are most likely to be achieved as a result of a planned learning experience, reflected in broader curriculum programs and comprehensive approaches to the promotion and development of a wide range of competencies. These strategies in turn support an overarching learning objective which in this case includes mental health and emotional well-being and education for resiliency.

Resilient students are thought to be able to communicate effectively, and to have high expectations and high academic confidence. They are described as possessing an ability to successfully adjust to situations despite challenging conditions and developmental threats (Woolfolk, Winne, & Perry, 2012), (Borman & Overman, 2004). Brown, D’Emidio-Caston and Benard (2001), in addressing resilience education, position teachers as responsible for creating a reciprocal relationship in which their creativity supports students’ goals and dreams, while allowing students in the school environment to be supported and not penalized with “decisions about their interests and strengths” (xi).

The education system and educators can help foster resilience through being dependable sources of both emotional and academic support, working with students to solidify their strengths, and evaluating missing experiences and resources that are necessary for successful learning (Ormrod, 2011). When considering mental health in education, research indicates educators report they lack sufficient knowledge on mental health and how to support student mental health issues (Gowers, Thomas & Deeley, 2004; Rothi, Leavey & Best, 2001).

Moreover, based on the current review, mental health curriculum programming does not make a consistent or significant appearance in Canadian schools. Teachers report being under-prepared to support children who may be at risk or struggling to develop resilience as a result of their emotional well-being or mental health issues. Often, they may not have the resources to experience academic achievement. This convergence of evidence provides a solid foundation from which to consider the benefits of developing and delivering mental health literacy for teachers, and promoting change in mental health-related curriculum for students.

Environmental Scan

A scan was undertaken to examine each province and territory's mental health K–12 curriculum. Learning objectives outlined in this scan were drawn directly from ministry documents as found on each official education website.

Scan Methodology

The construction of this scan began through consultation with each province and territory's Ministry of Education website. These ministries are responsible for curriculum development and approval. The websites allowed for a search of curriculum documents under the "Curriculum" options on the various sites. It was typical for each ministry's website to provide a breakdown of the curriculum by grade and/or academic subject; this allowed for relative ease of searching. Curriculum documents were searched, guided by the following health-related titles:

- Health Education
- Health and Career Education
- Health/Career and Life Management
- Physical Education
- Physical and Health Education
- Mental and Emotional Well-being Class
- Personal Development
- Personal and Social Management / Education
- Planning
- Wellness

The scope of this environmental scan provided an overview of the mental health–related curricula being delivered within Canadian public schools. We would suggest that future work will need to be extended to more specialized areas such as aboriginal and private sector education. Thus, only curriculum-based expected outcomes concerning mental health content from the classes above are outlined.

Mental health-related topics included curriculum content involving the following terms and topics that follow. While most curriculum documents had specified "mental" or "emotional" health units, it was just as typical for mental health concepts and skills to be woven into topics on other determinants of health such as sexual/relationship health, career development, and religion. This finding furthered an emphasis to examine mental health dynamically within the context of other health-related determinants rather than viewing it in isolation.

The following terms were identified and used for both general and specific expected learning outcomes within the Canada–wide curriculum documents.

- "Mental Health"

- “Emotional Health”
- “Well-Being”
- “Expression of Feelings”
- “Sexual Health”
- “Substance Use”
- “Personal Development”
- “Relationship / Interpersonal Health”
- “Family Health”
- “Career / Life Development “
- “Religion / Ethics”

Documents for grades 4 through 12 were retrieved where possible, limited only by the availability and access to each ministry’s and territory’s online services. It was apparent from the scan that each region had mandated health-related classes from kindergarten to grade 9. Beginning in grade 10 there was more variability regarding health options that secondary students could access; some provinces/territories offered specific health courses continuously through to grade 12, whereas others made this a smaller component of optional physical education classes.

In order to develop an understanding of the fit of the curriculum to the stated objectives of promoting mental health for students in ways that are congruent with contemporary theory and research, we created a set of criteria for effective mental health curricula and examined each province or territory’s curricula against these:

1. Holistic: positioning mental health in the context of the whole child, their health, well-being, and ability to be an active member of a thriving community;
2. Strengths-based: working from a place of strength, recognizing and honoring the assets a child has and brings with them to the classroom, and those of the family and community;
3. Inclusive: promoting a sense of belonging; mental health, as with all other conditions, exists on a continuum, and each person has a place in our families, classrooms and communities;
4. Rooted in their lived experience: addressing the multiple layers of influence (family, community, political structure, etc.) and the child’s context;
5. Developmentally sensitive: taking into account the cognitive, physical, emotional and social development of the children in the “target” age group; using concepts of cognitive and social development from Piaget and Vygotsky, and emotional development from theorists such as Erikson, to provide a backdrop for language, activities, and assessment;
6. Focus on promotion/prevention;

7. Emphasis on practice and modeling of health-related skills

Each province or territory's Junior, and Intermediate/Senior curriculum, was examined using these criteria.

Scan Findings: Assets

Promotion and prevention

Many of the curricula focused on promotion and prevention, providing early exposure and knowledge to topics that helped children and youth understand the importance of health and well-being, and the preferred behaviours to support these objectives. Safety was a key component in most curricula.

Holistic

Health concepts that related to mental and physical health, emotional well-being, and social and interpersonal strengths were typically part of an overall approach to health curriculum.

Developmentally sensitive

In examining curricula systematically, most provinces begin with concrete examples and activities, and introduce moral behaviour. For example, students by grade 7 begin to have the cognitive ability to engage in conceptual development around issues such as moral behaviour. This was well exemplified in the Saskatchewan Intermediate/Secondary curriculum.

Modelling and Practice

Many of the curricula not only emphasize, and make room for, skill development, but also encourage teachers to provide opportunities for practice and feedback.

Scan Findings: Gaps and Needs

Lived Experience of Children:

Choice

Overwhelmingly, curricula included an emphasis on making choices congruent with mental health, and physical and mental well-being. As mentioned in the introduction to this section, it is recognized that "choice" is largely about having the opportunity to choose between two outcomes. The curriculum makes an assumption that all children have equality of choice and this is simply not the case. Some children may be forced to offer up prescribed ADHD medication, for example, to others who exploit them for their prescription. Some youth will use substances to cope with trauma to survive, and some children will not eat well because the family does not have the necessary resources. Sen's Capability Approach (1992) points out that in order for us to have "choices", people must have agency and opportunity.

Cultural Safety, Diversity

There was very little mention of diversity in terms of cultural heritage or alternative views of wellness. Considering the vast numbers of children who are newcomers to Canada, and the fact that the aboriginal population is the fastest growing population in Canada, it is surprising to note that diversity is not more fully represented. Using the Seven Grandfather Teachings as an example could be very helpful for all children, as could the inclusion of alternative, ancient medicine traditions. When students do not see themselves or their culture represented in the curriculum, it is difficult to imagine how they can integrate within themselves.

Inclusive

Mental health was not presented in terms of a continuum, and this is considered problematic in terms of enhancing and promoting a sense of belonging for all. The focus in curriculum was noted on providing support about how not to get bullied, which does not align with accepted principles of accountability (that is, it can be seen as victim-blaming).

Literature Review

Review Methodology

The Literature review was undertaken using the same key words as used in other sections of this report along with “curricula’ and “curriculum” in bringing together both the peer-reviewed and practice literature regarding effective mental health curricula in Canada. In this undertaking, we were surprised by the lack of relevant data. As outlined in the literature review, there does not appear to be a province, school board, school or classroom that adopts research studies to evaluate mental health curricula. Most research investigating any type of mental health education for students involved the evaluation of mental health education programming outside of formal curricula.

Review Findings: Assets

Understanding stigma and its impact

The research literature reflects a growing appreciation for the negative influence of stigma on seeking help, internalizing shame, and the negative appraisal of others. This has led to the development of stigma-reduction strategies, such as open discussions, that have been shown to be effective in the school setting (Tognazzini, Davis, Kean, Osborne, & Wong, 2008), educating our students about mental illness (Hartman et al., 2013), and promoting mental health literacy in schools (Kutcher & Wei, 2012).

School-Based mental health

Research has called for a push toward school-based mental health resources such that schools and teachers play a significant role in shaping healthy child and youth development (CYAC, 2010). There has been shown a convincing link between mental health problems and difficulties with academic engagement, school achievement, absenteeism, retention/dropout, and social relationships (Tolan & Dodge, 2005; Owens et al., 2012; Bradley & Greene, 2013). In fact, researchers completing a large meta-analysis in the US concluded that “The status of...adolescents’ emotional well-being is a strong predictor of their educational achievement and that emotional well-being mediates the relationship between poverty and educational achievement” (Sznitman, Reisel, & Romer, 2011, 135). As a system we may not be in a position to eradicate child poverty, but we are most certainly in a position to positively influence adolescent emotional well-being. A significant movement toward school-based mental health draws on a system of care approach to promote effective, accessible, and efficient mental health care for children and youth.

Review Findings: Gaps and Needs

Overall, there is an urgent need to thoroughly evaluate mental health curricula across Canada to assess the degree to which they meet the stated learning objectives. Until this is undertaken, a statement regarding its efficacy cannot be made.

Who will teach the curriculum?

Teacher responses indicated they felt their job, in relation to mental health, was centred on employing behavioural interventions with students in the classroom. The view appears to be that it was the responsibility of school psychologists to screen for mental health, teach socio-emotional lessons, perform behavioural assessments, and make referrals to community and school based services. These perceptions are no doubt predicated on the fact that 36% of teachers sampled reported they did not have the necessary skills to properly support their students' mental health needs. In addition, it is noteworthy that part of the legacy of the medical model is a view that the need to address health is only apparent when a more severe problem arises; this model renounces the strengths that teachers can bring to the situation and creates an unhealthy dependency on those who are solely viewed as possessing the expertise in mental health intervention. Rather, approaching mental health from the perspective of a spectrum rather than pathology allows for the inclusion of many in the promotion and prevention of this aspect of health. Thus there is a strong disconnect between 89% of teachers indicating they believe they should play a role in attending to student mental health juxtaposed to only 34% who report possessing the skills to do so.

Focus Groups

Focus groups and interviews were conducted with individuals across Canada from various stakeholder groups. Participants came from the provinces and regions listed below.

- New Brunswick
- Quebec
- Northern Ontario
- Southwestern Ontario
- Alberta
- British Columbia

Participants came from the following stakeholder groups.

- Researchers in the field
- Administrators
- Teachers (both elementary and secondary)
- Community Organizations/Advocacy Groups
- Parents
- Pre-service students and recent grads from B.Ed. programs in Canada
- Secondary school students and recent graduates

Participants were recruited through emails to conference attendees at various

education-related conferences around the country, school boards, and various mental health agencies connected with schools and youth.

Participants who responded to these email recruitment notices were included, and interviews or focus groups were arranged at a place and time of mutual convenience. 50 participants were represented in focus groups and interviews ranging in age from 16 to 60+ years.

After data collection had occurred, recordings were transcribed and reviewed by the research team for thematic analysis.

Participants were asked the following questions:

What are your thoughts or experiences around:

- *The inclusion of mental health concepts in school curriculum for grades 4–12? What are they learning now? Are there gaps that need to be addressed around mental health in the current curriculum? Do you have any thoughts around how these gaps may be addressed?*
- *The role of teachers on the front lines of mental health?*
- *Their roles and responsibilities? Are these being addressed sufficiently in pre-service education programs?*
- *The barriers and facilitators to effective practices? How do personal attitudes and philosophies impact this?*
- *The needs of teachers, children, youth, families, schools and communities with respect to child and youth mental health and pre-service education in the context of child and youth mental health?*

The questions for the youth focus group mirror those above, asking (in appropriate language) about their experience as a student, learning the current mental health curriculum and being part of a classroom/school community:

What are your thoughts or experiences around:

- *The inclusion of mental health concepts in school curriculum for grades 4–12? What are you learning now? Are there gaps that need to be addressed around mental health in the current curriculum? Do you have any thoughts around how these gaps may be addressed?*
- *The role of teachers as people who connect daily with students, and on the front lines of mental health?*
- *The barriers and facilitators to creating a safe and inclusive school and classroom experience, with respect to mental health? How do personal attitudes and philosophies impact this?*
- *The needs of teachers, children, youth, families, schools and communities with respect to child and youth mental health and pre-service education in the context of child and youth mental health?*

Focus Group: Assets

Good relationships

Many students talked about strengthening relationships with teachers, and teachers talked about their awareness that forming good relationships with students is important to them.

Curriculum Resources

Teachers indicated that they had the curriculum resources to teach the students. One teacher said,

“I just wanted to say there’s no dearth of curriculum out there. If anything, there’s always people wanting to develop curriculum and resources aren’t the issue. There’s a ton of resources. I have boxes I could give you. It’s not about resources.”

Focus Group: Gaps and Needs

Holistic

Some elementary and secondary teachers spoke to the importance of a holistic curriculum, delivered as a whole school approach, as seen in the following quotes:

“And [there] was a real focus on healthy eating and then the PE teachers got involved so within the PE curriculum, especially in the elementary schools, they tried to get daily PE going and those kinds of things, so to have a single curriculum that is going to—you teach that is going to change attitudes and behaviours isn’t going to work. It has to be a whole school philosophy.”

“I looked at grade 8 [curriculum] ‘cause I teach grade 8 gym, and so there’s all the physical, you know, play this sport, catch this ball, do whatever. Then there’s a little thing on mental health. I think it said something like, you know, teach kids to be aware of good habits for mental health. For example, in brackets it said, getting 8 hours of sleep [...] Like, obviously that stuff’s important, but sometimes you’re dealing with a bigger issue than a kid who’s tired.”

Strengths-Based

“Yes, yes. On a personal level, of course, too, ‘cause I have that in my family, I have those mental health issues, and then just seeing it in children, that sometimes when you have behavioural problems, that the child, I could feel compassion for them because I could see that they couldn’t help themselves, that there’s something more, and then we would have to address this differently, that you know, punish them because they’re being bad isn’t going to work, and I found gentleness, kindness, love, just trying to support them, and I had amazing results with that. Even today, like, now that that student has been identified with a mental illness, we have something in place. We came up with a plan, and for this child, the child needs to be removed from his environment, and exercised or just a complete change of atmosphere, and while he was exercising, I continued reading what he was supposed to be working on, and his answers were remarkable. Remarkable answers. And just to see that it causes a positive feedback, and that child was so excited, too, about his answers that he could hardly wait to get back to class ‘cause he wanted all the students to know what he came up with.”

Inclusive

Some teachers expressed their hesitation to teach mental health curriculum (what does that message send to our students, and what are we failing to do at the B.Ed. level that would make teachers not want to teach this?):

“And a lot of comments I would get from teachers would be, I’m fine to have these kids, y’know, have a class with all these topics, but I don’t want to be the one who teaches it—”

And here, where a couple of teachers speak about not including the child in the planning process:

Teacher: And some plans to put in place for those who are struggling.

I: Okay. Practical stuff.

Teacher: ‘Cause we have plans to put in place when we do IEPs, and that’s for learning disabilities. You know, these children can learn, too. I mean, it’s just we have to change things up a bit, too.

Teacher: And the funny thing is, when we do an IEP, like, if a child is identified with a learning disorder or even a mental health disorder, we do the IEPs, and sometimes it’s in consultation with the school psychologist, but sometimes it’s not. Like, sometimes I need to give an educational plan that says, you know, this child needs extra time or clear instructions and a written schedule on the board, but I don’t know what he really needs.

Rooted in Children’s Lived Experience:

As shared by some teachers:

I: And you had a wellness thing going too?

Teacher: Yeah, we had a wellness, yeah I was the teacher, or the counsellor involved in the wellness group that we had at the high school and the kids kind of did wellness stuff around the school. Posters and presentations and stuff like that.

I: And was that a formalized group? Or was that something that emerged within the school and the students and yourself?

Teacher: Yeah, we just formed it and did various activities and things for the school. Yeah.

I: Before I go into something else, I just want to follow up on that. What led you to form that group?

Teacher: Well, basically seeing the need for it in the school to have more of a whole school, like school wellness includes all aspects of the school environment and we just felt that if we could bring some of those issues to the forefront like suicide, eating disorders, those kinds of issues, for kids to see on posters and have little presentations, that we thought that would be good.

I: And how was it received?

Teacher: Yeah, yeah. I mean, the kids looked at the posters and seemed

to be interested and I think from that, then, as counsellors, we found, y'know, sometimes that led to kids coming to see us, because—

I: You were making it visible?

Teacher: Yes.

And:

“...especially for parents who had not either been successful in schools themselves or who were coming from a different culture or a different language, it was really difficult for them to understand what the problems were and how we could work together to improve them and I found this to be one of the best spaces ever for me.”

And:

“I was going to say, that one of the positive things of trying to implement this comprehensive program is, at the same time, we tried to do a lot of in-service around school climate and school wellness and whatever, so there's a lot of awareness amongst those teachers when I was working about the need for, the importance of these issues even though they may not want to touch it with a ten-foot pole and they certainly, well a lot of them certainly didn't like the depth of it, even though anybody who works in the field knows that if you want to impact behaviour, you have to go into it in a lot of depth. Yeah, so that's what I was going to say about them, as far as—so you can teach information, but if you—you also have to have—support those, practicing those positive behaviours within the school environment, and then a lot of them, like the substance abuse, I mean, you have to look at the home environment, if there's going to be any impact and so then it becomes almost overwhelming, well, what can we really achieve here?”

And: This came from looking at the pictures, but I think that there are valuable pieces that are relevant to how curriculum is delivered too:

“Y'know, so, I mean there's a thousand ways to interpret this, right? We always bring our experience to it. I mean how many times have I talked about something from my experience when I've heard something from yours, because I'm relating to it in some way and I think that this is a powerful piece too because if we've got people who don't have those experiences and we only give them one lens, that's problematic, I think we have to make sure that it's opened in a way that helps them not just frame it, but think about other possibilities or other ways to read a situation.”

From the youth:

Youth: “Or like a lot of times they'll say, you know, on Monday the mental health nurse is here. And you're like, oh, good, I'll try to plan my crisis for Monday. Okay, every Monday morning. That be it. Like, yeah.”

Developmentally Sensitive

Youth: “I think it's better to, with the whole mental health versus mental wellness for younger children, 'cause I think it's a little—like, it's very, um, hard for some of them, if you're really young to, like, wrap your head around certain things, so I think not focusing on the big words like 'depression' or 'suicide', so

rather just being like, you know what?, you need to keep yourself healthy, like mentally and physically, is better for the younger, and then move your way in.”

Focus on Promotion and Prevention

Teacher: “I understand the economics behind it, but when you dump all of these schools into these gigantic schools where nobody knows their name, it has to have an impact and, y’know, the answer is not going to be that we’re going to return to the schools that weren’t economically viable before, I don’t know what the answer is, I just feel that somehow, we’ve lost that sense of community.”

Teacher: “Absolutely, and I was just thinking back, when I was at the junior high, the school was small enough that we counsellors would make a point of going into every grade 8, well, every, the new kids coming in, so they would have been in grade 8. Every grade 8 classroom during the year to talk to them and point out that there’s counsellors and talk about some of the issues and that seemed to be really good and they knew who we were. At the high school level, we’re now in a school of, 1500 kids, there was no time to do that. We could not do that. There were so many issues we were dealing with kids that we never could get out there, so it was band-aid stuff all the time and y’know, you have to do some of that preventive...”

Emphasis on practice and modelling of health-related skills

As shared by some teachers:

“Skills, attitudes, knowledge, not only—wasn’t only a matter of presenting the information, it was how do we actually present it in such a way that it will affect children’s behaviour, because you can talk to a kid until the cows go home, but that doesn’t mean that they’re going to change their behaviour out on the playground, say, with bullying, or with the substance abuse issue is very difficult. And then the resistance on the part of secondary teachers and it—Career and Personal Planning 11 and 12 became a requirement for graduation, so that was the clout, to make sure that students received this information.”

And:

“So one of the things that has happened in the media literacy area is to not just try to give these things to the kids, but to actually have them participate in creating solutions, like get them involved as knowledge generators instead of knowledge receivers. So, y’know, as you’ve been talking, it’s made me think, maybe our approach to continually be giving, giving, giving is not quite hitting the mark.”

Accessibility

From the youth, we have this:

“I think that the problem with it is that, like, it’s really good if you take, like, gym and you have health class, but if you’re someone like me that doesn’t have a chance, I don’t have room to take gym or health in my schedule, and I take, like, Sciences and stuff you don’t necessarily learn about it, so, and, I mean, when you get into a science and everything, you have so much stress on your back that it’s critical that you do know about it, so I think the problem is it’s not equally distributed.... Yeah, so I mean, like, if you’re going to put mental health, like, in one class, like, it really should be in every class.”

Youth offered the suggestion that the mental health curriculum could be put into the (note: mandatory in Ontario) Careers course:

Youth: "Cause I guess it's like what we were saying, where would you, how would you kind of implement it. Would it be like a class? Would it be like, you know, a part of the day, a portion of the day where you just, like, instead of having, like, a recess, you have like a mental recess, or, like—but that would—they don't even want to have recess as it is sometimes. So it's kind of like they don't—like, how would you put something new when they're trying to get rid of a whole lot of things..."

Youth: "You have, like, the beginning of the day and you have recess and you have lunch time. Maybe if you just had, like, a mental, like, alright everybody kind of just like take 15 minutes and if you need to, like, listen to music for 15 minutes, if you need to read a book for—especially in high school, just kind of take like a mental recess, and not like where you can go in the halls and talk to your friends because sometimes that can make it worse, but just like, okay guys, we're going to have, you know you'll be able to have time dedicated just to kind of like destress and regroup at some point in the day. So I think that, as simple as it is, would be helpful. And then, like, have somebody to talk to if you needed to. Or, like, if the skills were implemented, then you could use those skills."

Using social media

Youth: You kind of know what people are feeling more because there's blogs and there's Facebook and there's like Twitter and there's stuff like that. So maybe before if you were depressed when there was just phone lines, you wouldn't necessarily, like, call your friend and be like, "Oh, like, I'm feeling sad today because this and this", whereas Facebook, you can kind of just be like, "Oh, shitty day today. Like, I wish things would go better", and then you probably might get a message from a friend saying, "Oh, like, how are things going?" and everything's more pervasive and then, like, there's a TV show about that, and then you hear about your neighbour that maybe was really depressed or you hear about, like, your friend that maybe committed suicide [inaudible – 8:54]. Do you know what I mean?"

I: "So the more that we use social media to communicate, then a broader audience kind of gets to know about how people are feeling."

Youth: "And is that because such large companies are getting behind it now? Like the whole Bell Let's Talk thing? Like, it's almost impossible for it not to trend because everyone sees it, right? There's commercials, there's social media campaigns, and the majority of youth are on social media, so, like, it's—I don't know if it's trendy, but I think it is kind of cool to volunteer with mental health now, but at the same time, it's kind of a good trend because even if people are getting involved in it, for whatever reason that they have, they're still getting involved in it, which is a good thing."

Talking about their teachers

Youth: "... like, if it wasn't scheduled but, like, have teachers understand that sometimes you just need to put your music in for a few minutes, or you need to take out your book for a few minutes, because I know that if I'm in, like, French class and I take an English book, like, my teacher's going to scream at me. But, like, reading is like a catharsis for me. Like, when I read, everything's okay. So sometimes, like, I just need it. If I'm sitting there stressed out, I just

need to forget about everything's that's happening. But if your teacher's yelling at you because you need to just calm yourself down, like, I think teachers just need to be aware of that, and even that would be a good first step."

Recommendations

From the literature review, scans, and focus groups we noted some overall themes, and have some general recommendations.

The whole child/whole school approach

There are compelling reasons along with a convergence of evidence to suggest that the whole-child, and whole-school approaches are necessary, and have the most promise for change. A single (and "siloed") curriculum or program promoting physical health or mental health will not achieve the objective of a healthy student and school community; rather, this needs to be part of a cohesive set of practices, professionals, and institutional commitments. Children and families live within complex systems and including all components and drivers in the system is critically important.

It was noted that the curriculum reflects a strong bias toward teaching children to make "good choices". The notion that each person has the opportunity to actually make choices does not take into account the lived experience with children. Providing children and youth with support to address challenging circumstances (for example, poverty) may be much more effective than working from the assumption that all children have similar opportunities to make "choices".

The curriculum

Teachers shared that there is not enough content in the mental health curriculum, that there was a large discrepancy between what was devoted to physical as compared to mental health. This signals a degree of confusion regarding the relative importance of mental health. Hence it is easy to see how mental health can be deprioritized. Expanding the curriculum specifically about mental health to provide balance and connection with physical health and well-being would be beneficial from a number of perspectives and could be extended to classes outside of physical education, thus supporting the whole-child/whole-school approach described above.

A sustained effort

Teachers are asking for stable and sustainable programs, policies, the freedom to work in effective ways, and resources. Students are asking for predictable and visible means of support. Many people talked about the "flavour of the month" approach to education as being not only ineffective, but potentially destructive to professional identity and self-efficacy, along with a lost sense of responsibility. Students shared confusion about whom to go to, when that person would be available, and what resources could be accessed. Having programs and policies that bridge the important transition from elementary to secondary school, for example, would provide students with a sense of familiarity, even in a new environment. "One-shot" programming and training is ineffective, and it is imperative to find ways for mental health efforts to be integrated within school priorities.

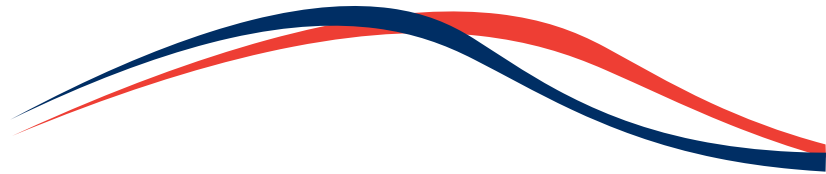
Relationships

An overarching theme, relationships here refer to the full spectrum: peer relationships among teachers, and between teachers and school leaders; inter-professional relationships; student-teacher relationships; student-peer relationships; and teacher-parent relationships. Teachers and youth highlighted the importance of relationships, and this is supported by the research literature. Spending time on relationship building

and relationship skills (for example, empathy-building, awareness of the feelings and experience of others) would be terrific additions to the curriculum. Importantly, teachers talked about not knowing how to talk to parents about their child's mental health and expressed their strong desire to develop or improve these skills. Building strong relationships with parents will only enhance the teacher's and school's role in supporting student mental well-being.

Research

The dearth of research available that evaluates curriculum is a key priority in aiding our understanding about mental health, mental health curricula, and the potential for making a positive difference in the lives of children and youth. Importantly, there is also a lack of research evidence on the presence and effectiveness of teacher education (both pre-service and in-service) regarding mental health, and the self-care practices of teachers in preparation for work in a stressful environment.



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