Mental Health Education In Canada

Teacher Education Literature Review

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.

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About the AstraZeneca Young Health Program

The AstraZeneca 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 (YHP) is working in partnership with three leading Canadian charitable organizations to improve the mental and emotional wellbeing of youth ages 10-19. YHP 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.

AstraZeneca Canada provided essential support for this independent research through the AstraZeneca Young Health Program, a global, community investment initiative that aims to address the impact of non-communicable disease among youth around the world. Learn more about the Young Health Program at www.younghealth.ca.

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Executive Summary

Mental health has become the focus of many initiatives and programs as we recognize the negative influence and long-term impact on the academic engagement and success for children and youth in our school systems, and adults in our society. Teacher candidates in Canada are not adequately prepared to meet the complex demands of supporting and teaching children and youth with mental health problems in today's classroom. There is also a lack of education and support for their own mental health and well-being which results in high levels of stress and burnout, and early exit from the profession.

Past research has suggested that pre-service programs do not adequately prepare teachers for identifying and addressing mental health issues, and thus, they may need help developing competencies and resiliency not only when it comes to student mental health, but personal mental health (Corcoran & Tormey, 2012; Rothi, Leavey, & Best, 2007). These findings are very relevant, especially for improvements in the structure of our teacher education programs in Canada. Educating and building confident, flexible, and resilient teachers is a crucial foundation upon which they will build not only their own careers, but also those of the children they impact.

Both initial teacher education and in-service professional development opportunities should include planned and targeted components that prepare teachers for the challenges and rewards of working with students with mental health problems and disorders. It should prepare them to be part of an effective system of care that provides safe and caring learning schools that emphasizes the promotion of holistic well-being, the prevention of mental health problems, and the promotion of success for all students and those who teach them.

Current research and promising practices exist that point the way for teacher education, and it is through advocacy, commitment, and sustained and collaborative efforts that changes may be made that, in the long term, will result in healthier schools, students and teachers.

Teacher Education Literature Review

Mental Health and Prevalence of Mental Health Issues among Children and Youth

In Canada, an estimated 13%–18% of children and youth under the age of 25—or over 1 million youth—suffer from a mental health issue (Kutcher, Hampton, Wilson, 2010; Waddell, Offord, Shepherd, Hua & McEwan, 2002) although some researchers have estimated the percentage of young people affected to be as high as 25% (Boyle & Georgiades, 2009). Of these affected youth, as few as 17% (Offord et al, 1989) to 40% (Kutcher, 2010) will access some form of mental health care services or support; these limited services will not necessarily be effective, evidence-based, or well matched to children's needs (Canadian Institute for Health Research, 2010; Tolan & Dodge, 2005). Though this current state of poor mental health is not inconsistent with data from three decades ago—the Ontario Child Health Study (OCHS), a landmark survey carried out in 1983, found 18% of four- to sixteen-year-olds experienced at least one mental health issue (Offord et al., 1989)—it is alarming in that Canada's youth suicide rate has now climbed to the third-highest adolescent suicide rate among Organization for Economic Cooperation and Development (OECD) countries; nationally, suicide is the second leading cause of death among those 15–24 years of age (Kutcher et al. 2010).

Though the Canadian statistics on mental health are cause for concern, they are not dissimilar to research findings abroad. Within the UK, suicide is the third most common cause of death for youth, alongside an increased prevalence of childhood depression, anxiety, eating disorders, self-harm, and anti-social behaviours (Coppock, 2010; Weare, 2010), with 43% of affected youth having no contact with appropriate mental health supports and services (Coppock, 2010). Similarly, the incidence rate of mental health issues among children and adolescents is a reported as 20% in the US and as approximately 14%–20% in Australia (Coppock, 2010). Globally, poor psychological health affects 10%–20% of youth worldwide and accounts for five of the top ten leading causes of disability for those aged five years and older (Shatkin & Belfer, 2004).

Defining Mental Health & Wellness

Over the last several decades, various discourses, concepts, and theories have informed the mental health field, the very conceptualizations of mental health and illness, as well as the resulting models of mental health (Coppock, 2010). In 1958, the World Health Organisation (WHO) first defined "health" as "physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity" (WHO,

1986). Since then, the concept of "whole-person" health as necessarily involving wellness of mind, body, spirit, and community has been articulated through an integrated, holistic model for wellness and prevention which demonstrates the interconnectedness of psychological health with physical health and social health (Witmer & Sweeney, 1992; 2000). Specifically, this model maintains a perspective on the continuum of

psychological health, in recognizing not only what is needed to develop adequate mental health for basic daily functioning but also what is necessary for optimum health and functioning (Witmer & Sweeney, 1992).

Positive mental health or well-being has been widely defined as a state in which the individual is capable of realizing her or his own abilities and engaging in fulfilling relationships with others; is able to adapt to change and to cope with the normal stresses of life; and can work productively while making a contribution to her or his community (WHO, 2001; Institute of Medicine, 2009; Surgeon General's Report, 1999). Most importantly, psychological well-being is not only critical to personal health and functioning; it is also vital to the health of families, interpersonal relationship, communities, and greater society.

In contrast, poor psychological health has been categorized along a continuum, ranging from mild to severe in its impact upon daily functioning, and varying in the intensity and duration of changes in regular mood, thinking, or behaviour (Institute of Medicine, 2009). Categorizations such as "mental health distress", "mental health problems", and "mental health disorders/illness" have been developed to indicate the continuum along which the regular ability of the individual to live a satisfying life has been compromised either mildly, moderately, or severely (Kutcher, 2012). At the mildest stage of "distress", Kutcher stresses that it is necessary to recognize the distress as a signal to adapt to life's changes; support is also key in dealing with specific "distress" issues such as grief, loss, and demoralization. It is critical to recognize that these are not yet "problems" or "disorders" and that "distress" affects a significant portion of the population throughout their lives (2012). "Mental health problems", though more severe in intensity and/or duration than "distress", affect a relatively smaller portion of the population in comparison to "distress" and individuals can benefit greatly from exposure to mental health promotion, prevention, and treatment (Institute of Medicine, 2009; Kutcher, 2012). While "mental health disorders" affect a relatively small portion of the child and youth population, they are the most debilitating to the individual due to the intensity and duration of symptoms, and as a result require timely access to appropriate mental health services for improvement (Institute of Medicine, 2009; Kutcher, 2012).

Mental Health and Wellness for Educators

There is a growing appreciation for the need to support the well-being and health of those who stand at the front lines of education and support the needs of students. Overall, the mental health needs of post-secondary students are growing and the Ontario Ministry of Training, Colleges and Universities (MCTU) has recently committed $20M in additional funding to provide counselling at colleges and universities in Ontario. The research literature on mental health and well-being, including stress, burnout and compassion fatigue, consistently places workplace stress and a feeling of being overwhelmed at the centre of the reasons many teachers decide to leave the profession. Stress is increasingly a concern among people of all ages, as life speeds up and people are expected to do more with less, and often alone, so it stands to reason that this would include teachers. We can do a lot (potentially) to provide people with the skills and knowledge they need for work/life balance and well-being.]

Impact of Mental Health Issues: Psychological, Social, Economic Costs

When left unaddressed, mental health issues can have tremendous impact on the well-being, development, educational achievement, and everyday functioning of a child or adolescent (National Institute of Mental Health, 2001). These issues often persist into adulthood (Kessler et al., 2001) causing significant losses in terms of psychological, relational, social, and economic functioning directly to those affected, and indirectly to the greater community and society (Institute of Medicine, 2009; Kutcher, 2010).

An estimated 75% of adults report the onset of a mental health issue to have been in childhood or adolescence (Kessler et al., 2005; Tolan & Dodge, 2005), though of the $85 billion spent annually on mental health care in Canada only $11 billion is spent on services for those under the age of 21, with a marginal portion of this being devoted to prevention and promotion of psychological wellness (Tolan & Dodge, 2005). Specifically in Canada, $35 is spent per pre-school-age child, $163 per school-age child, and $293 per adolescent annually on mental health care (Tolan & Dodge, 2005).

Current research has underscored this disproportion in funding in relation to the needs of youth and urged greater promotion of psychological well-being as well as earlier prevention and intervention treatments, all of which can synergize to greatly reduce the overall healthcare burden and human costs in preventing more serious mental health problems and disorders (Tolan & Dodge, 2005; Kutcher et al., 2010). Research-based evidence also supports the implementation of a comprehensive system of mental healthcare policies and practice for children and youth as the most effective way to improve young people's psychological, social, and economic well-being (Tolan & Dodge, 2005). Practices and policies of this comprehensive system should be guided by: 1) reforms to the system of care in order to ensure timely access to appropriate, effective, well-coordinated, and community- and school-based services; 2) a strong focus on mental health literacy, universal promotion, prevention, and early interventions; 3) training educators and primary healthcare providers to improve mental health awareness and promotion; and 4) the development of infrastructure, policies, and initiatives which view psychological development as a key component of basic health and development so that all settings that care for children are educated in the importance of psychological well-being in child development (Tolan & Dodge, 2005; Mental Health Commission of Canada, 2010).

Recommendations for such comprehensive approaches to youth mental health care have been previously made by the World Health Organization, which has urged that health and wellness promotion initiatives be underpinned by principles which 1) utilize holistic approaches to health; 2) promote positive health as well as prevention (not merely focusing on reactive treatment); 3) respect diverse cultures and beliefs; 4) work at individual and structural levels which address social and economic inequalities, promote mental health in schools, and address stress at work; and 5) use participatory methods to involve individuals as full participants, not simply as recipients (1986).

More recently in their 2001 annual World Health Report, entitled Mental Health: New Understanding, New Hope, the WHO re-emphasized the need for further mental health awareness and literacy building as critical to changing social understandings, misconceptions, and attitudes toward mental health and thereby reducing certain barriers to access to services (WHO, 2001).

Though many valuable recommendations have been made nationally (Mental Health Commission of Canada, 2010; 2012; Tolan & Dodge, 2005; Santor, Short, & Ferguson,

2009) as well as transnationally (WHO, 1986; 2001) as to viable mental health promotion, literacy building, prevention, and treatment services, a number of multi-level barriers remain to be addressed in order for youth mental health initiatives to succeed (Canadian Institutes of Health Research, 2010).

Barriers to Mental Health Care: Proactive versus Reactive Initiatives and System-Level Barriers

A number of researchers in the area of mental health, counselling education, and psychiatry have argued that the value assigned to preemptive approaches such as proactive promotion of mental health and prevention strategies—versus a more reactive investment in treatment of ill-health—is affected by the very way in which mental health is conceptualized and the mental health models that result from such conceptualizations. They have cautioned that when a health service model focuses on "illness" and "dysfunction" the commitment that follows from this, in terms of services and resources, is focused primarily on remediating problems of dysfunction and illness rather than proactively promoting wellness and investing in prevention of ill health and social problems (Witmer & Sweeney, 1992, 2000; Secker 1998). To this end, a health service model that is heavily focused on treating illness can act as a barrier to viable preemptive strategies for mental health education, literacy, promotion, and prevention.

System-level barriers, such as fragmentation of services and inadequate funding of services and initiatives, present additional challenges (Canadian Institutes of Health Research, 2010). Fragmentation of services has been heavily criticized for disconnecting various mental health services from other mental health initiatives as well as from general health care, resulting in a lack of collaboration and coordination among community programs, specialist services, and mental health education initiatives (Canadian Institute for Health Research, 2010). For this reason, among others, school-based centres for mental health as well as universal-approach school-based mental health promotion initiatives have been recognized initiatives which effectively facilitate the many aspects of mental health education, promotion, prevention, and service within the school site (Santor et al., 2009; Rowling, 2007b; 2009). Funding of services, as well as the distribution of funding to particular mental health initiatives, poses significant challenges in terms of the very availability of particular services or initiatives (Santor et al., 2009). Reform of the system of care and reconceptualization of mental health toward a more comprehensive model have been key recommendations in ensuring that mental health education, literacy, promotion, and prevention initiatives are also supported (Tolan & Dodge, 2005; Santor et al. 2009).

Barriers to Mental Health Care: Stigma

Many who suffer from a mental illness have experienced discrimination and stigma because of their diagnosis (Kirby & Keon, 2006). Dr. Ian Manion, the Executive Director of the Provincial Centre of Excellence for Child and Youth Mental Health, described the stigma associated with having mental health issues by drawing a parallel between mental health and physical ailments, such as a fractured arm or ear ache.

When someone breaks their arm or has an ear ache they quickly seek medical attention and support. Friends, family, and work colleagues often call to check in and see how the injured person is doing; they might even send a card or flowers. Employers often inform their employees as to why their colleague will not be at work for a period of time and the explanation is accepted. When someone is suffering from a mental health issue such as depression, friends and family often do not call to see how the sufferer is

doing and employers do not inform employees as to why their colleague has not been attending work; this creates rumours and questions (Manion, 2012). The questions which needs to be addressed are: why is it acceptable to acknowledge a physical ailment yet not a mental one, though both create distress in the life of the sufferer, and how can this be changed? The parallel drawn between mental health ailments and physical health ailments raises serious questions about the attitudes and stigma present socially toward mental health issues and the mental health education, literacy, and promotion efforts needed to help in the reduction of negative or uncomfortable connotations, misconceptions, and beliefs.

According to Health Canada (2002) stigma develops from a lack of understanding and knowledge, fear of things that we think are different, and results in embarrassment and stereotyping, as well as avoidant and aggressive behaviours. Stigma and discrimination pressure those with a mental health issue to be less forthcoming about their difficulties; they are less likely to seek treatment. In a study by Bowers, Manion, Papadopoulos, and Gauvreau (2012), the researchers investigated perceptual differences between Canadian youth and school-based mental health service providers on the topic of stigma and its impact on mental health help seeking. Forty-nine high school youth ages 13–20 answered an online questionnaire, while 63 mental health service providers did as well. Results indicated 70% of students identified stigma to be a major preventative factor for seeking mental health help, compared to 51% of the mental health providers.

Moreover, 68% of students indicated they were either “very concerned” or “concerned” about the substance abuse or mental health issues at their schools and 64% felt there were no available mental health resources at their schools.

When considering stigma and gender differences in willingness to accept mental health support, Chandra and Minkovitz (2006) found of the 247 grade 8s interviewed, 59.1% said they were too embarrassed by the potential opinions of others to access mental health services, 51.8% did not want to discuss mental health issues, and 34.6% had moderate to high levels of mental health stigma according to the Stigma Scale for Receiving Psychological Help. It was also found that boys were two times less likely than girls to accept mental health support. These findings highlight a strong need for stigma reduction initiatives among youth, especially males.

Another form of stigma which negatively impacts students affected by mental health issues is self-stigma (Hartman et al., 2013); it has been shown to have significant impact on a person’s willingness to obtaining professional help (Vogel, Wade, & Hackler, 2007). Self-stigma occurs when an individual affected by mental health difficulties internalizes the prevalent negative stereotypes and misconceptions of mental health illness. In a promising attempt at self-stigma reduction, Hartman and colleagues (2013) conducted single-session interventions on the anti-stigmatization of mental health difficulties with high school students from Ontario; following their session, participant scores indicated more willingness to seek psychological aid and a reduction in self-stigmatization.

Much research has also highlighted that contact with individuals experiencing mental health difficulties, as well as open discussion about mental health topics, does foster greater acceptance of such issues and individuals as well as decreasing stigma (Tognazzini, Davis, Kean, Osborne, & Wong, 2008). The value of mental health education, promotion, and prevention (Hartman et al., 2013) and the promotion of mental health literacy in schools (Kutcher & Wei, 2012) have been emphasized as critical components in the reduction of stigma and self-stigma which serve as barriers to further mental health initiatives. Schools, specifically, have been shown to be promising sites of universal mental health education and promotion as well as being successful in facilitating mental health services in an accessible, non-stigmatizing manner (Stephan,

Weist, Kataoka, Adelsheim, Mills, 2007).

Barriers to Mental Health Care: Educators' Own Mental Health Needs

Recent findings suggest that Canadian teachers are experiencing significant levels of occupational stress. 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 feeling this way (Jamieson, 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."*

Additionally, the College also found that stressful working conditions accounted for the second highest reason for leaving the profession (McIntyre, 2006).

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. These factors as well as employment conditions were also significant in predicting experiences of anxiety, and overall it was 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. A plethora of research exists supporting the notion that mental health concerns then impact not only one's overall job satisfaction as seen here, but their job-related productivity, performance, and absenteeism (WHO, 2010). Thus, when teachers are supported and healthy, Canadian children can also benefit.

However, Ferguson et al (2012) note that there may be some important barriers to educator health that need to be acknowledged and addressed before we can achieve a healthy school culture. They note that the lack of awareness of teachers' experienced stress and mental health needs among parents, administrators and community members leads to misunderstanding and stigma. Previous work by these authors has highlighted the stigma around educators' mental health needs, and has noted this to be a problematic barrier such that the frequency of discussing experiences of stress among other teacher colleagues, or with one's doctor, increases the likelihood of educators perceiving high levels of stigma related to this stress (Ferguson et al., 2007). These authors hold that all members of the school community should be able to express feelings of stress without fear of stigma-related judgement; however, the above findings suggest that the shame associated with such stigma remains a barrier to promoting healthy teachers, and thus, a healthy school climate for everyone.

Moreover, research findings also suggest that teachers exhibiting high self-efficacy and emotional intelligence are less prone to experience job-related burnout. That is, having the confidence and openness to approach new concepts, as well as the skills to process emotion in a healthy way, can serve as protective factors against burnout (Taylor 2001; Han & Weiss, 2005). On this important note, past research has suggested that pre-service programs do not adequately prepare teachers for identifying and addressing mental health issues; thus, they may need help developing competencies and resiliency not only when it comes to student mental health, but personal mental health (Corcoran & Tormey, 2012; Rothi, Leavey, & Best, 2008).

These findings are very relevant, especially for improvements in the structure of our teacher education programs in Canada. Educating and building confident, flexible, and resilient teachers is a crucial foundation upon which they will not only build their careers, but those of the children they impact.

Barriers to Mental Health Care: A Systemic Context

Recent news reports suggest high levels of student and teacher stress present within Canada's provincial education systems. For example, recent statistics from the Toronto District School Board indicate that 66% of grade 9–12 students reported feeling stressed sometimes or all of the time (CBC, 2012; 2013). Additionally, much concern has been raised about stress levels in Ontario with recent strike action and labour disputes between Ontario's teachers and the province. Given the findings regarding student and teacher mental health needs, it is important to consider the possibility of systemic barriers to achieving a healthy school climate.

While schools are places of opportunity, the demands placed on students and teachers (performance pressure on standardized testing, top-down policy mandates placed on teachers with little to no changes in support, students being victimized/bullied, to name a few) may be contributing to stress and challenges to a healthy school environment. There may be a bi-directional interaction; that is, while schools should be an integral part of a system of care beyond what their location as educational forums is, schools themselves may also be the problem unless they are safe places in which students, teachers, administrators, and communities can learn and work.

Recent publications examining the Finnish education system may shed some light on these complex systemic questions. In his paper entitled *Education policies for raising student learning: the Finnish approach*, Pasi Sahlberg (2007) points out Finland's position among the top-ranking countries around academic achievement. The interesting point that he makes about Finnish successes is the stark contrast in education systems there, compared to other developed nations.

A constant theme in this paper is the suggestion that the current Finnish system is not the result of a concrete national reform, but through "continual adjustment of schooling" to meet the changing and unique needs of individuals and the greater society. With this point, it is emphasized that system changes have not resulted as a means of top-down policies thrust upon school districts, but through transfer of decision-making processes and power to schools to best use resources and adapt teaching styles to the needs of their students there.

Specifically, Sahlberg highlights three main categorical differences that set Finnish schools apart from other developed nations' reforms:

- Standardization versus Flexibility and Loose Standards
    - ► Rather than establishing concrete, high and centrally prescribed standards for all schools in a province or the entire country, Finnish schools aim to build on existing good practices within curriculum, and set learning targets via steering by information and support.
- Focus on Literacy and Numeracy versus Broad Learning combined with Creativity

- ► Rather than disproportionately emphasizing knowledge and skills around literacy and numeracy in curriculum, Finnish schools take a broader approach to learning by assigning equal value to all aspects of individual students' growth around constructs of personality, morality, creativity, knowledge, and skills

- Consequential accountability versus Intelligent Accountability with trust-based professionals

    - ► Rather than setting up accountability measures that stem from consequential means, such as weighing school and teacher performance on standardized testing outcomes as the sole measures of success, Finnish schools aim to adopt "intelligent accountability" policies where teacher and administrator professionalism is valued by allowing them to judge what is best for the students of their school. This not only builds a culture of trust within the school and community, but allows teachers more room to expand learning topics in a way that best meets students' needs at that time and place.

These three systemic principles of the Finnish education system serve as the foundation stones of their acclaimed student and teacher successes. These successes are further achieved and maintained by other key aspects of policy, including the five areas listed below. While the scope of this paper will not allow a full exploration of these important structural components to the success of the Finnish system, we encourage readers to access Sahlberg's paper and read it in full.

- Same basic school for all
- Well trained teachers
- Intelligent Accountability
- Culture of Trust
- Sustainable Leadership

In summary, Sahlberg (2007, p. 158) 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."*

As such, a review of this system leaves us with much to think about in terms of structuring policy and training constructs such that our schools are a safe place for all and promote a system of care, rather than being a place that contributes to mental health concerns.

Capacity Building: What Can Schools Do?

Dr. Stan Kutcher, a leading expert and advocate in the area of children and adolescent mental health, has proposed a model for capacity building within schools which integrates 1) access to and training in mental health awareness and promotion for all school community members; 2) mental health literacy within the school community; and 3) a higher level of mental health expertise for those support staff specifically involved with school-based mental health (Kutcher, 2012). Though much research has identified schools to be the preferred, community-based, non-clinical site for the promotion of mental health, mental health literacy, and universal approaches to prevention (Santor et al., 2009; Rowling & Jeffreys, 2006; Rowling, 2007b; Lister- Sharpe, Chapman, Stewart-Brown, & Sowden, 1999), researchers have also cautioned that schools must re-evaluate and change the way they understand and address stress, emotional well-being, and social/interpersonal issues so that children are not being molded to better fit schools, but rather, that school environments and staff-student relations are being transformed to better support children's psychological and social needs (Coppock, 2010). This was highlighted in a series of interviews with school-aged children when the UK based organization, Young Minds, found that students identified "school" as a significant source of their stress and preferred to discuss their personal difficulties with peers rather than with professionals and teachers (2007).

There are a number of levels of support that can be provided to make schools a healthier place to be: mental health literacy and awareness are two of these. According to the Canadian Alliance on Mental Illness and Mental Health (2008), mental health literacy can be defined as the awareness of and abilities people have which enable them to understand, apply, and access information for better mental health. There is an emphasis on doing more than just making information on mental health available but rather supporting people in developing skills so they can make informed choices in how best to promote mental health. The key to mental health literacy is that as people acquire and are better able to be critical about information, social and individual empowerment increases. This then leads to collective action on the contextual and social causal factors of mental health and mental health issues.

Santor, Short and Ferguson (2009) created a document to help educational policy makers integrate more mental health awareness and programs into schools. In the document the researchers call on policy makers to include strategies to increase mental health literacy not only in students, but in teachers and staff as well. They emphasize the role schools play in helping children with mental illness detection and mental health promotion and awareness, and emphasize the fact that this should be a priority. With Kirby and Keon's (2006) emphasis on early intervention and education for children on mental health, it is logical for there to be a push for greater mental health education and training in schools.

Researchers in the United States viewed schools as a uniquely positioned instrument which can serve as a conduit for improving access to mental health services and also support mental well-being. The pathway conceptualized by Stephan, Weist, Kateraoka, Adelsheim and Mills (2007) shows that schools could serve this function through stigma reduction, suicide prevention, broadening/improving mental health programs, and helping to identify and treat co-occurring disorders. In response to this and other publications, Kutcher and Wei (2012) found that most of the interventions and research in this area could not demonstrate empirical efficacy for these programs. The researchers stated much of the research is plagued with poor research designs, the heterogeneity of school environments creates difficulty for researchers to implement cross-location designs, and the relative youthfulness of the topic results in an empirical

"learning curve". They also added that a more critical and focused lens must be worn by researchers in this field.

A quantitative study by Canadian researchers in Nova Scotia examined student use of school-based mental health services, and among those who used the services, examined the issues that drive service use. Just over 1600 students from three high schools were asked to complete questionnaires relating to demographics, background variables, risky behaviours, and need for mental support. Results indicated 49.3% of students were aware of the need for mental health support, while overall, 20.4% of females and 5.3% of males indicated they used the school-based mental health services at least one time during the school year. Depression, suicide ideation, and substance abuse were found to be the most prevalent issues. The researchers noted the large disconnect between students' perceived need for mental health support and the lack of support seeking, especially among males. They suggested that perhaps because the school-based mental health service was housed in the health centre at the participating schools, students may not have been aware of the mental health services offered. Also, the cultural view that the centres are more of a sexual health clinic, stigma, and concerns over confidentiality many have resulted in the low percentage of help-seeking behaviour by students (Szumilas, Kutcher, LeBlanc & Langille, 2010). Other studies have demonstrated confidentiality concerns as a major factor for not seeking support (Juszczak, Melinkovich & Kaplan, 2003), especially among those with mental health issues (Lehrer, Pantell, Tebb & Shafer, 2007). A way to help students become more aware of services and reduce the stigma of mental health could be through the help of teachers.

In 2010 the Mental Health Commission of Canada created the Evergreen Framework in an attempt to promote mental health improvement among children and youth. In the document, directions for promotion were outlined by the authors and of the 30 directions listed, directions 12 and 13 call for action in education. Specifically, direction 12 calls for action in creating and supporting secondary school well-being through trained personnel who can provide mental health interventions to students in need; while direction 13 calls for mental health supports for grades 7 and 8.

Although the document does not explicitly refer to teacher involvement, their role was implied; teachers must play an essential role in the mental health support of children and youth in order for school-based mental health to work.

Capacity Building: What Can Teachers Do?

Based on a decade of research on the implementation and evaluation of school-based mental health initiatives in Australia, Louise Rowling has identified school leadership and professional learning as areas that are highly relevant to the successful implementation of whole-school mental health and well-being programming (2009).

Like Fullan (2005), she stresses that schools need many leaders on many different levels in order to successfully sustain and foster whole-school initiatives and that such distributed leadership necessarily involves teachers in an important role in whole-school mental health as well as mental health education reform (Rowling, 2009).

A study by Reinke, Stormont, Herman, Puri and Goel (2011) examined elementary school teachers' perceptions of student mental health and their roles in supporting student mental health. Of the 292 teachers who completed the study's questionnaires, 97% identified disruptive behaviours as a mental health concern in children; followed by inattention and hyperactivity, 96%; family stressors such as divorce or death of a

parent, 91%; and peer-related social problems, 87%. Additionally, 89% of educators agreed or strongly agreed with the statement that teachers should be an integral part of school mental health initiatives, although many also indicated that they did not feel they had the necessary skills to properly support students' mental health needs. Perhaps as a result of their concern over the lack of mental health training, teachers also indicated they felt their job was more centred around employing behavioural interventions with students in the classroom, while it was perhaps more the responsibility of school psychologists to teach socio-emotional lessons, to screen for mental health issues, and to make referrals to community and school-based services. Consequently, there was also a strong disconnect between the 89% of teachers who indicated their willingness to play a role in school-based mental health and in the support of their students versus the 34% who believed they actually had the skills to do so (Reinke et al., 2011).

Rothi, Leavey and Best (2008) also detected a disconnect between what teachers felt their roles should be in school-based mental health and their level of competency in the area. Using semi-structured interviews with 32 teachers, the participants generally acknowledged their responsibility in the mental health of their students but mentioned concern over the number of mental health issues that go unnoticed and are inadequately addressed by schools. These teachers felt more training was necessary in order to properly address student concerns; thus, it is important teachers are provided with opportunities to increase their competencies in the area of mental health, not only for their own benefit but for the benefit of their students and student well-being.

Mental health educational researchers Meldrum, Venn and Kutcher (2009) emphasized the critical position educators are in to help make a positive change in childhood mental health. They suggested teachers must 1) advocate for policy reform and support those that integrate mental health into education; 2) advocate for mental health to be part of the curriculum; 3) establish a mental health program, involving the community, in their schools; and 4) attend and ask for mental health professional development in order to better understand and recognize the issues children today are facing.

In Kirby and Keon's (2006) call for mental health action, they emphasized the importance of increasing teacher knowledge and training so they can better help and identify those students with mental health issues rather than referring them to resource-strapped emergency rooms or counselling agencies with long waiting lists. Moreover, they recommended teachers be given the resources and time needed to understand and be competent with their new mental health ambassador role.

Research by Gowers, Thomas and Deeley (2004) supports both Kirby and Keon's (2006) and Meldrum et al.'s (2009) suggestions. Gowers et al. (2004) surveyed 291 primary school teachers about children's mental health and its role in education.

Exactly half of the sample indicated awareness of children in their classrooms with mental health issues and 81% said these issues caused them difficulty while teaching. When asked about their competency of mental health issues, 56% indicated either inadequate or fairly inadequate understanding while a staggering 98% stated they had little to no initial training on mental health when entering the field. Furthermore, 95% indicated the training they had received on managing child behaviour was inadequate or fairly inadequate. Reinke et al. (2011) too found that 78% of their sample felt they lacked sufficient training to support their students' mental health needs. The researchers emphasized many teacher service programs inadequately prepare future teachers with effective behaviour support strategies and classroom management skills. Reinke et al. thus called for more teacher training. It is important to provide teachers with the knowledge and resources necessary so that they can feel adequately prepared to support their students' mental health needs. Ways in which this can be done is

through pre-service teacher education and professional development programs. Some programs are in existence in Canada with a limited amount of research examining their efficacy.

Translating Mental Health Research Into Effective Implementation

In an effort to promote effective, sustainable, and adaptable implementation of health research into specific settings, Damschroder et al. (2009) have synthesized an overarching typology—the Consolidated Framework for Implementation Research (CFIR)—by unifying key constructs from existing published implementation theories.

The framework outlines 5 key domains: 1) intervention characteristics; 2) outer settings; 3) inner settings; 4) characteristics of the individuals involved; and 5) the process of implementation. These are further subdivided into component constructs (Table 1).

Though the Consolidated Framework for Implementation Research is a very pragmatic tool which can help translate research into meaningful implementation outcomes, Damschroder at al. (2009) point out that it is limited in its ability to depict interrelationships

Intervention Characteristics	**Outer Setting**	**Inner Setting**	**Characteristics of Individuals Involved**	**Process of Implementation**
Intervention source: internal or external development Evidence strength and quality Relative advantage Adaptability Trialability Complexity Design quality and packaging Cost	patient needs and resources Cosmopolitanism Peer pressure External policies and incentives	Structural haracteristics Networks and communication Culture Implementation climate: 1. tension for change 2. compatibility 3. relative priority 4. organizational incentives & rewards 5. goals & feedback 6. learning climate readiness for implementation: 1. leadership engagement 2. available resources 3. access to information & knowledge	Knowledge and beliefs about intervention Self-efficacy: Individual stage of change Individual identification with organization Other personal attributes	Planning engaging: 1. opinion leaders 2. formally appointed internal implementation leaders 3. champions 4. external change agents Executing Reflecting and evaluating

Table 1 - *Considerations from Implementation Research*

or impacts of specific ecological factors. It is therefore critical to remain mindful of the breadth and complexity of conditions present in various school settings, as well as processes and structures unique to school contexts, when borrowing tools from health sector interventions. For this reason, Rowling (2009) highlights research on school characteristics that are essential factors in the capacity of schools to successfully implement mental health promotion.

Overview of Teacher Mental Health Education

Teacher Education practices & mental health education

Pre-service teacher education is designed to introduce candidates to the profession of teaching, and provides knowledge in pedagogy, curriculum, and social issues alongside practical experience. As with any professional education, it is during this time that we can have the most substantial impact on these emerging professionals; novice teachers acquire the resources (including knowledge, skills and attitudes) critical to their professional success.

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, due to a lack of training in this area (Gowers et al., 2004; Reinke et al., 2001). The critical value of appropriate in-class and practical teacher preparation, especially in the area of holistic 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 on in the areas 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 students—in the school setting.

In support of this, Jourdan, Samdal, Diagne, & Carvalho (2008) have found that teachers who had received health promotion training did tend 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 not to 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. The use of bottom-up or "home-grown" school initiatives was preferred simply because it would simply be context relevant.

Currently, working groups such as MHEDIC (Mental Health Education Integration Consortium) are leading the charge for a comprehensive teacher education program that focuses on school mental health. They emphasize three core values: 1) the

importance of teaching practices that are culturally relevant; 2) strong school-family-community partnerships are a necessary foundation of effective learning supports; and 3) "whole-child" perspectives and developmentally appropriate approaches are essential. They propose that a teacher mental health competencies curriculum framework address these six "targeted competence domains":

1. Key policies and law
2. Provision of learning supports
3. Collection and use of data
4. Communication and building relationships
5. Engagement in multiple systems
6. Focus on personal and professional growth and well-being (Weston, Anderson-Butcher & Burke, 2008)

Educator & Staff Mental Health

As schools are learning environments for students and working environments for educators and staff, it becomes impossible to divorce the psychological, social, and emotional well-being of students from that of their educators and caregivers (Rowling, 2009). Louise Rowling (2007a, b; 2009), based on her implementation and evaluation research of the Australian whole-school-based mental health initiative, MindMatters, draws clear connections between the issue of students' mental health and educators' level of morale, communication within the school, and attitudes. "Teacher morale is a mental health issue" (Rowling, 2009, p.364), though certainly one which many whole-school health as well as school-based mental health initiatives tend to overlook. 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, react harshly through disciplinary control techniques and the use of shouting and humiliation (Lister-Sharpe et al., 1999). Given that the public health sectors are to work collaboratively with the education sector in supporting mental health initiatives within the school setting, it is only reasonable that the well-being of school staff becomes an equal part of the whole school-based mental health initiative, as the well-being of staff and that of students are synergistic (Mason & Rowling, 2005; Rowling, 2009).

Concerns over the emotional well-being of teachers—and especially the way this influences students' cognition, motivation, behaviours, and well-being—have also been addressed by Sutton and Wheatley (2003) in their review of literature on the effects of teachers' emotions and teaching. The concerns raised by Sutton and Wheatley pertain to evidence in the literature of teachers' negative emotions and frustrations in regards to students' behaviour (Hargreaves, 2000; Sutton, 2000); teachers' anger and frustration toward uncooperative colleagues and work environments (Bullough, Knowles, & Crow, 1991); teachers' anger and frustration that become exacerbated by tiredness and stress (Bullough et al., 1991; La Porte, 1996; Sutton, 2000); beginning teachers' anxiety due to uncertainties about their own skill level and achievement of teaching goals (Bullough et al., 1991; Erb, 2002); and the lack of teacher supports or mental health supports for teachers in dealing with these issues. Furthermore, Sutton and Wheatley's research indicates that teachers' emotions may impact teachers' motivation negatively and that students are very much aware of and influenced by the

negative emotions and frustrations of their teachers (2003).

Given such findings, it can be concluded the overall health of students and of the school environment are quite interdependent with that of the teachers'; this warrants that whole-school initiatives necessarily address the health of their staff also.

As a possible solution to the above concerns over teachers' health, the development of teacher emotions, emotional competencies, and 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).

Child & Youth Mental Health Policies in Canada

In 2001, the World Health Organization released its Mental Health Policy Project's *Policy & Service Guidance Package*. The package was designed to provide assistance to countries on the national level with the development and implementation of policy statements and recommendations of the 2001 WHO World Health Report. In 2003, a publication of the WHO Mental Health Programme, entitled *Caring for Children and Adolescents with Mental Disorders: Setting WHO Directions*, emerged; it outlined information on the burden of mental health issues, barriers to care and services/ interventions, and made specific recommendations to improve access, such as encouraging the development of national child and youth mental health policy; increasing psychoeducation and awareness of psychosocial development; and improving family communication.

As of 2010, Canada (Kutcher, Hampton, & Wilson, 2010), unlike many G8 nations, did not have an overarching policy framework for child and adolescent mental health; however, only four of the ten provinces, and none of the territories, had policies or plans specific to youth mental health (Table 2). 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 which outlines a framework specific to the mental health needs of children and adolescents, entitled Evergreen, has also recently been released. The following table has been adapted from a summary of Canadian mental health policies pertaining to children and youth presented by the Canadian Institutes for Health Research (2010).

As the WHO template is the only internationally recognized and internationally developed mental health policy framework available (Kutcher et al., 2010), Kutcher and others have emphasized the value of using the framework as a measure in assessing the quality of existing policies nationally. Table 3 summarizes the seven criteria and indicates the provinces and territories which have fulfilled these as outlined by WHO.

Province	Child & Youth Mental Health Policy Document
British Columbia	*Child and Youth Mental Health Plan for British Columbia*
Alberta	*Positive Futures: Optimizing Mental Health for Alberta's Children & Youth*
Saskatchewan	*A Better Future for Youth: Saskatchewan's Plan for Child & Youth Mental Health Services*
Manitoba	none; mental health & addictions plan under development
Ontario	*A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health*
Quebec	has a suicide prevention strategy; recently released the *Plan d'Action Santé Mentale* which does include a section specific to children & youth
New Brunswick	none; Community Mental Health Centres are mandated to provide services tailored to children and youth
Nova Scotia	none; Nova Scotia has identified *Strategic Directions* for their mental health system, including established standards of care although child and youth mental health needs are not specifically addressed in these
Prince Edward Island	none; both the *Substance Abuse and Addictions Strategy* and the *Mental Health Service Delivery Plan* reference priorities specific to children & youth
Newfoundland and Labrador	none; *Newfoundland's Mental Health and Addictions Framework* identifies children and youth as a special population
Yukon Territory	none; this territory has no mental health plan nor related plans or programs
Northwest Territories	none; this territory's *Mental Health and Addictions Action Plan* does reference the need to promote child and youth mental health
Nunavut	none; has released a suicide prevention strategy and a mental health and addictions strategy

Table 2 - *Child and Youth Mental Health Policy Documents*

WHO Criteria	Provinces & Territories that fulfill criteria
1. gather info/data for policy development	QC, ON, SK, AB, BC
2. gather evidence for effective strategies	QC, ON, SK, AB, BC
3. undertake consultation & negotiation	QC, ON, SK, AB, BC
4. exchange with other countries	N/A
5. develop the vision, values, principles, objectives of the policy	ON, SK, AB, BC
6. determine areas of action	QC, ON, SK, AB, BC
7. identify the major roles/responsibilities of different stakeholders & sectors	QC, ON, SK, AB, BC

Table 3 - *WHO Criteria for Effective Policy Documents*

Current Practices

Ontario: In its *Special Education Update*, released October 2012, the Ontario Ministry of Education delivered a new update to its 2011 *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, hereafter "*Comprehensive Strategy*" (MOE Special Education Update, 2012). This tri-ministry initiative (Ministries of Health and Long-Term Care; Education; and Children and

Youth Services) was heralded in a government announcement in the 2011 Ontario Budget which promised an investment for a *Comprehensive Strategy* with a specific three-year focus on children and youth; the current update includes additional funding allocation for Mental Health Leaders in year two of the *Comprehensive Strategy* as well as specific mental health and addictions supports for school boards. Overall, the investment for the three-year strategy will grow to $93 million by 2013–2014. The aim of this Strategy is create a more integrated and responsive child and youth mental health and addictions system by providing efficient access to quality services; identifying and intervening in child and adolescent mental health and addictions needs early; and closing critical service gaps for children and youth deemed vulnerable (MOE Special Education Update, 2012).

Currently, Mental Health Leaders have been put in place in all 72 Ontario school boards, with about 144 mental health RNs and RPNs in place as well. The primary role of Mental Health Leaders is to work with School Mental Health ASSIST in order to provide leadership support in their development of board-level comprehensive mental health and addictions strategy.

School Mental Health ASSIST is a provincial implementation support team designed to guide all 72 Ontario school boards in their work to facilitate and promote student mental health and well-being; its role is also to develop resources designed to increase mental health awareness and promotion throughout the 72 school boards.

In September of 2013, a 154-page document, *Supporting Minds: An Educator's Guide to Promoting Students' Mental Health and Well-being* was released as a key resource for Mental Health Leaders and teachers to assist them in supporting children and youth in schools with mental health concerns. (http://www.edu.gov.on.ca/eng/document/reports/SupportingMinds.pdf)

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