Teachers' Perceptions of Student Life Stressors: Teacher knowledge of mental health issues and supports

by

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Abstract

Given that teachers are often the first to observe changes in behavior, both socially and behaviorally; assessing their mental health literacy is important in playing this role of early detection. The objective of this study is to evaluate teachers' knowledge of student life stressors; knowledge of mental health issues; and knowledge of supports for youth with mental health. Participants were experienced teachers who were enrolled in a graduate education degree program with the Faculty of Education at Mount Saint Vincent University located in Nova Scotia, Canada. Participants completed an online questionnaire that contained open-ended questions, 5-point Likert Items, and several demographic questions. The questionnaire explored participants confidence in identifying distress in the classroom; perceived self-confidence in providing support; knowledge of mental health supports available; and to identify barriers within their school and community. While participants demonstrated competence in their ability to identify and support students with mental health concerns, it was found that most perceived a lack of resources and suggested funding for professional development as well as additional staff trained to assist students with mental health concerns.

Keywords: adolescence, prevention, early intervention, school, mental health literacy, teachers, Nova Scotia, thematic analysis

Chapter 1: Introduction and Review of Literature

The majority of mental health problems can be detected prior to the age of 24, and of these, 50% exhibit difficulties before the age of 14 (Kessler, Berglund, Demler, Jin & Walters, 2005). When youth are provided with mental health literacy information there is an increased identification and increased awareness of prolonged or inadequate responses to stress (Jorm et al, 2006). Communities can increase their collective knowledge of mental health literacy and demonstrate understanding in order to increase the success in youth navigating through presented stressors (Jorm et al, 2006).

When it comes to rural communities, Nova Scotia is a province facing socio-economically challenges, and the availability of services such as housing, education and training being far limited in comparison to the rest of Canada (Rural Communities Impacting Policy Project [RCIP], 2003). In addition to these challenges, a report presented by Frank (2016) found Nova Scotia has the third-highest child poverty rate in Canada – and the highest in Atlantic Canada – with six communities having a child poverty rate over 30%. Five of these communities were in Cape Breton – Glace Bay, New Waterford, North Sydney, Sydney Mines, and Eskasoni – all within Cape Breton (Frank, 2016). The other community is Yarmouth, at a rate of 41.8% (Frank, 2016).

It could be assumed that communities in Nova Scotia, dealing with socio-economic challenges, may find difficulty in providing the resources required in adopting and sustaining programs that can be effective in the positive psychological development of children and youth.

In most communities, the key gathering area for children and youth is the local school since a significant amount of time in the classroom and engaging with teachers. Schools can be a hub and resource in the presentation and facilitation of such education within a community.

The present study will provide further information on teachers' perceptions of the types of stress experienced by children and youth in Nova Scotia, as well as the type of formal and informal supports being used. The aim is to ascertain teachers' perceptions on mental health in the classroom and to discern their view of the main stressors experienced by Nova Scotia's children and youth.

Mental Health Literacy

For common physiological health concerns, most people have the knowledge to identify, prevent, manage/cope, and seek treatment. This could be due to public health initiatives, media, in-school education and presentations. For example, most individuals will know the warning signs of a stroke with the assistance of public awareness campaigns; others may have attended first aid training and be able to assist an individual having a stroke. Understanding the impact of poor health and creating awareness can allow for greater reduction in the *physical* ailments of an individual. The same level of literacy and awareness is beginning to be applied to mental health.

Mental health literacy has been an area of research and call to action for fifteen years (Jorm, 2012). Mental health literacy has many components, including "(a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental health disorder or are in a mental health crisis" (Jorm, 2012, p. 231). Individuals with adequate knowledge of these components can have a vital role in the prevention, recognition and supportive aspects of mental health.

In contrast, a lack of appropriate identification and intervention when experiencing psychological distress often leads to a delay in seeking formal support and treatment (Jorm et al, 2006). The longer the period between addressing the concern and seeking professional help, the poorer the outcomes and efficacy of treatment (Kessler et al, 2006; Jorm et al, 2006; Jorm, 2012). During critical stages in development, such as adolescence, the ability for others to recognize and facilitate in help-seeking becomes of greater importance.

Youth often require the help of parents and other supportive adults in identifying and responding to the concerns and distress they experience. Jorm and colleagues (2006) found that only a small percentage of youth noted that they would engage the help of an adult with concerns of a depressed peer. Furthermore, Kessler and colleagues (2005) found that most did not know how to respond to a friend in distress in a way that would be *positively* effective. It therefore becomes of greater importance for supportive adults to have adequate knowledge on how to identify and support youth with mental health concerns.

Importance of Mental Health Literacy During Adolescence

Adolescence is an area of critical importance for mental health literacy since 1 in 5 individuals will develop or experience a mental health disorder during this stage of development (Kutcher, Wei & Morgan, 2015). With the first onset being most prevalent in youth and early adulthood, a study in the United States found the median age of onset for anxiety disorders was 11 years of age; 30 years of age for mood disorders; and 20 years of age for substance-use disorders (Kessler et al., 2005).

Common sources of distress, or types of life stressors, are often related to familial and relationship conflict, death of a close family member, academic performance, and social

pressures (Hamdan-Mansour et al., 2008). Inadequate management and response to a stressor contributes to a range of psychosocial problems, including poor academic performance, conduct problems, anxiety, depression, suicide, eating disorders and aggressive behaviors (Farrington, 2006; Eacott & Frydenberg, 2009). For example, when an adolescent is grieving, their energy is directed away from their tasks and learning and interferes with their school performance and age-appropriate psychosocial development (Farrington, 2006). If not properly addressed, traumatic stress and grief can create difficulties in development when transitioning into adulthood (Kramer, Laumann, & Brunsonm, 2000).

Stressors that the adolescent may be experiencing can be severe and infrequent, or chronic and consistent. To be resilient, the individual must incorporate biological, psychological, and environmental resources (Gordon Rouse, 2001). Dealing with chronic and consistent grief due to life stressors can lead to risky behavior, depression, suicidal ideation, separation anxiety, and/or death anxiety (Let Dillen et al., 2009).

The approach or attempt to manage these stressors, during adolescence, often becomes the learned coping method when transitioning into adulthood – and hinders development (Hamdan-Mansour et al., 2008). Most youth can approach their issues directly even without the intervention of formalized support and treatment; they appraise a situation, determine how it will affect them, and take the necessary steps in coping with the stressor (D'Imperio et al., 2000). These youth are less at risk for negative internalization of feelings (2000). A resilient adolescent can react using socialization and their internal locus of control to persevere when dealing with chronic stress or crisis (Gordon Rouse, 2001).

Sources of Support

D'Imperio and colleagues (2000) provide a closer look at the relationship between exposure to stressors and self-competence. Participants that were resilient were found to have higher levels of self-competence because of several supporting factors: personal attributes or predispositions, family supports, and formalized support (D'Imperio, Dubow, & Ippolito, 2000). Adolescents most at risk for developing behavioural problems had poor academic performance, poor socialization skills, and family poverty as contributing factors (Zins & Elias, 2006). The more of these factors, the more difficult it is individuals to develop positive competencies – such as bonding to school environment, empathy, and social decision-making (Zins & Elias, 2006). These positive factors can be found within the child when there is support from family and community level (Zins & Elias, 2006).

Familial and Extrafamilial Support. Positive adaptation following exposure to adversity can be assisted with informal resources such as familial and extrafamilial supports. However, a life stressor can sometimes be avoided and unspoken about within the family, in an attempt to protect one another rather than overtly expressing concerns and feelings (Lin et al., 2004). Social support from peers can also be an active agent in aiding youth, as there is no power difference (McCarthy, 2007). However, it should be noted that McCarthy (2007) also found that a peer might abandon the individual in distress because they do not know how to handle the situation. Despite this, the support from familial and extrafamilial sources, along with social competence, has been found to have the most profound effect when coping with a life stressor (D'Imperio, Dubow, & Ippolito, 2000; McCarthy, 2007; Zins & Elias, 2006); it may provide structure where there is a lack of formal resources.

Building competencies builds resilience. Intrapersonal factors, like self-concept and internal locus of control, are important in building resilience and assisting in mental health distress: self-concept and internal locus of control (D'Imperio et al., 2000; Eacott, & Frydenberg, 2009; Gordon Rouse, 2001; Zins & Elias, 2006). Self-concept pertains to beliefs about abilities or self- esteem and perceived environmental responsiveness and support; whereas internal locus of control is the belief that the individual can have control over their life (Gordon Rouse, 2001).

Developing skills that encourage competence is significant to the formation of these protective factors and aid in the appraisal and response to a stressor (D'Imperio et al., 2000). Programs that were delivered universally, to the entire class, with primary focus on social-emotional learning were significant in promoting self-competence in adolescents (Zins & Elias, 2006). This acute sense of self establishes a better understanding on the intrapersonal impacts of a life stressor, allowing them to react in a positive and healthy manner – reducing the use of unproductive and stigmatized reactions to grief (Eacott & Frydenberg, 2009).

Research suggests that the emotional and social difficulties experienced by youth must be directly addressed to improve their situation (Freilich & Shechtman, 2010). Social and emotional learning is the individual's ability to recognize and manage emotions, problem-solve, and build positive skills (Zins & Elias, 2006). Mental Health programs focused on social-emotional learning has a positive impact on academic performance, physical health, interpersonal relationships, and reduces substance abuse and maladaptive coping skills (Zins & Elias, 2006).

Importance of community in supporting mental health. Having a sense of community has a positive outcome in the development of resilience in adolescents as they

navigate the creation of their individual support systems (Moritsugu, Wong, & Duffy, 2010). In particular, rural communities are seen as having cohesion and being supportive of members (Armstrong, Birnie-Lefcovitch and Ungar, 2005). Brown-Urban, Lewin-Bizan, and Lerner (2009) suggested that having a nurturing community was most advantageous within rural areas of limited resources and that, in general, supportive community systems had a positive impact on the psychological development of the individual. In fact, community-based interventions – when combined with family participation – can positively impact youth with existing mental health concerns (Browne et al, 2004).

Mental health literacy can be improved at the community level with universal delivery of intervention and individual training programs (Jorm et al, 2006). For example, *Beyondblue: the national depression initiative*, an Australian-based community program that aims to raise awareness and understanding of depression and related disorders, has shown positive impacts at the community level (Jorm et al, 2006). This program is a community-based education program that uses various platforms for delivery to provide various points of access and visual awareness – media campaigns, free education through print or digital, the use of prominent individuals as advocates and speakers, and sponsoring large events. *Beyondblue* has shown improvement in the understanding and awareness of depression, with increased ability to recognize distress, and reduced stigma (Jorm et al, 2006).

When it comes to the support of community, Gordon Rouse (2001) found that students that were most resilient had acknowledged their schooling environment as being supportive of cognitive and social goals, and actively facilitating goal planning (Gordon Rouse, 2001; Murnaghan, Morrison, Laurence, & Bell, 2014). The environmental facilitation of goals could enrich the resilient students' self-concept, motivation, and overall goal accomplishment.

(Gordon Rouse, 2001). Eacot and Frydenberg (2009) found that by encouraging youth to take control of their decisions, youth were able to effectively approach life stressors. Adolescents were able to review their essential skills used to actively cope and promote healthy adjustment over an extended period (2009).

Using Schools as a Platform for Mental Health Literacy

As a contributing environmental factor, schools become an ideal ground for encouraging mental health literacy with their high-risk age group and educational setting. Providing individuals with knowledge on mental health disorders and how to effectively aid in recognizing, managing, preventing mental disorders increases help seeking and reduces associated stigma (Kutcher, Wei & Morgan, 2015). Stigma is more prevalent with youth as this stage of development that emphasizes fitting-in and is rooted in belonging with peers (Langeveld et al, 2011).

When it comes to reducing stigma, having open communication, providing knowledge, and increasing awareness of mental health disorders, is most effective (Langeveld et al, 2011). A study at a Toronto high school found that after teachers had incorporated mental health training into the classroom, youth felt more readily able to identify mental health concerns and had also reduced the stigma surrounding mental disorders (Kutcher, Wei & Morgan, 2015).

Dray and colleagues (2017) conducted a study to evaluate the effectiveness of a universal school-based intervention programs that target resiliency factors in youth. Schools were provided with program support for implementation as well as a specialized intervention officer to be on site to oversee the programming. In addition, school intervention officers and intervention school staff were provided with the opportunity to complete a mental health first aid or related course. In majority, similar studies have indicated significant positive outcomes when

measuring the impact of intervention on the internalization of negative mental health factors (Dray et al, 2017). While the study was found to have no significant impact in evaluating the effectiveness of a universal school-based intervention program, it highlighted the difficulties in creating sustainable programs for mental health.

When programs that require additional resources to implement are presented to schools, difficulties arise due to costs, time and sustainability. are presented to schools, that may require additional resources to implement, they are difficult to implement because costs, time and sustainability. It is important to consider these factors when navigating through communities that are unable to economically sustain programs and who may lack the additional resources for their implementation. With communities across Nova Scotia, it can be assumed that there would be difficulty in adopting and sustaining programs that can be effective in the positive development of adolescents. This is because the majority of communities across Nova Scotia have been struggling with the challenges of faltering economy, increased out-migration, and aging population (RCIP, 2003; Statistics Canada, 2011).

School-Based Programs to Support Mental Health of Students

Mental health literacy and intervention within schools is gaining increased attention as a result of the importance placed on services and programs that strengthen the mental health of adolescents helps to improve their "mental health immune system" (Browne et al, 2004). Challenged communities would require additional supports and programs that can provide greater information on the measured impact, sustainability and low cost for implementation to be considered for use (Browne et al, 2004). Among the challenges for schools and their

communities is the selection of appropriate evidence-based programming from the various potential approaches.

When considering programming, the literature suggests that universal (delivered to all children) and prevention-based programs that encourage the development of resiliency are more effective than programs that focus on the reduction of existing negative behaviours (Browne et al., 2004). Universal delivery, or school-wide delivery, of programs that focus on the positive behaviours of students can be as effective as programs that focus on the intervention of negative behaviours and delivered to those at-risk or experiencing crisis (Nocera, E., Whitbread & Nocera, G., 2014). Nocera and colleagues (2014) discuss the benefits of school-wide positive behaviour supports in a junior high school setting – this included decreased absenteeism and improved academic and behavioural outcomes. School-wide positive behavior support programs are aimed at reducing punitive intervention and the direct focus on reducing negative behaviours. It rewards positive behaviour, promotes social and academic competence, and is delivered to the whole school, as well as engages students, staff, and families. Positive behaviour support programs encourage appropriate behaviour and monitor student performance.

Programs that are focused on building social and academic competence, builds resilience (Gordon Rouse, 2001). Supports and programs that are based around the creation and harnessing of social competence and planning skills will increase the positive behavioural adaptations of the adolescent, specifically in relation to stressors (D'Imperio et al., 2000). For students that are unresponsive to this initial approach, more direct interventions are utilized. While, Browne and colleagues found that while a broad approach is best in practice, specialized long-term programs with interactive components aimed to address specific problems have a greater effect (Browne et al., 2004).

The following sections offer some examples of mental health programs directed toward adolescents and are currently used in Canada.

Curriculum-based programming - *The Guide*. *The Guide* was developed through collaboration of mental health experts, educators, and the Canadian Mental Health Association and is endorsed by the Canadian Association for School Health. *The Guide* is delivered by teachers directly in the junior high and high school curriculum. It aims to improve student mental health literacy. Incorporating this program into existing curriculum has the potential to reach all students, reduce stigma, and engage teachers and is currently embedded into the grade nine school curriculum in Nova Scotia (Mcluckie, Kutcher, Wei & Weaver, 2014). Research on the overall improvement of mental health literacy found student knowledge scores to be higher (64%) than baseline student knowledge scores (53%) acquired prior to their exposure to *The Guide* (Mcluckie, Kutcher, Wei & Weaver, 2014).

The program delivers six modules that cover topics including knowledge of specific mental health illnesses, personal stories, the impact of mental illnesses on individuals and families, help-seeking, and the importance of positive mental health (Mcluckie, Kutcher, Wei & Weaver, 2014). *The Guide* also includes self-directed modules for teachers, which provides more detailed lessons on the program. Teachers attend a single day of training to learn more about the modules delivered. *The Guide* has been found to have a positive impact on their knowledge and attitudes regarding mental health literacy (Mcluckie, Kutcher, Wei & Weaver, 2014).

WITS Program. The WITS program encourages youth to "Walk away, Ignore, Talk it out and Seek help" (Leadbeater, Gladstone, & Sukhawathanakul, 2015, p. 120). This evidence-based program aims to create communities that actively reduce bullying among children and youth in grades one through six by encouraging the development of protective skills – such as

social responsibility, self-competence, leadership and sense of community (Leadbeater, Gladstone, & Sukhawathanakul, 2015). This program is integrated directly into the academic lesson plans and coincides with learning objectives – reducing the impact that implementation can have on teachers (Leadbeater, Gladstone, & Sukhawathanakul, 2015). The program was evaluated for implementation and sustainability among eight rural Canadian elementary schools had been in use for two years. The evaluation showed that five schools had fully implemented the program and three were maintaining aspects of the program (Leadbeater, Gladstone, & Sukhawathanakul, 2015). Little information was available on the outcomes of the implementation of the program.

Community Care Access Centre Program in Ontario. In 2013, Champlain Community Care Access Centre in Ontario created an outreach program for youth. In this program, nurses are tasked with providing outreach to student both in home and school. Nurses were available for individual meetings, monitoring medications, educating the community about mental health and providing referrals. In addition, teachers were educated on how to help students who are returning to school after receiving in-patient treatment for mental health reasons since teachers were often unsure of how to respond to these students (Santor, Short & Ferguson, 2009). This program bridges the gap between the school community and medical facilities. The largest number of requests and referrals are expected to come from high school students (Santor, Short & Ferguson, 2009).

Durham Talking About Mental Illness (TAMI) Coalition. The Durham TAMI Coalition provides mental health education to youth and professionals throughout Canada and seeks to collaborate and maintain relationships with community agencies, schools, youth and community members in order to maintain and sustain programming (Pietrus, 2013). This

program was developed by the Centre for Addiction and Mental Health in Toronto and has been

maintained and enhanced by Ontario Shores Centre for Mental Health Sciences with community

organization support (Pietrus, 2013). The program has a 5-part module curriculum for grades 7

to 12 and includes professional development workshops for teachers; the other program offered

is an anti-stigma summit that brings together schools for a one-day event to education and

deliver experiential learning (Pietrus, 2013).

Web-based programming – *mindyourmind***.** Based out of London, Ontario, the

mindyourmind program is directed toward grade 11 students and provides information about

mental illness, resources, personal experiences, and interactive coping tools (Pietrus, 2013). The

overall aim of the web-based program is to increase knowledge and youth help-seeking

behaviour and to reduce stigma (Pietrus, 2013). Research found that 67.5% of participants using

the *mindyourmind* program had reported having a mental health issue or concern (Halsall,

Garinger & Forneris, 2014). According to Halsall, Garinger and Forneris (2014), this high

frequency of responses may indicate that youth dealing with mental health issues are seeking out

web-based programs as it offers an informal approach along with anonymity and ease of access

(Halsall, Garinger & Forneris, 2014).

SchoolsPlus program. This program is provided at the majority of regional school sites

across Nova Scotia provided by the Nova Scotia Department of Education and Early Childhood

Development. (NSDECD). The program is supported by a facilitator and community outreach

worker and acts as a liaison between school and community to advocate and provide additional

supports to students and their families. Some sites have access to school psychologists. The

additional purpose of SchoolsPlus is to identify opportunities to enhance and expand the array of

services and programs for children, youth, and their families. SchoolsPlus promotes the use of

school facilities by students, families, and the community by bringing service providers and programs to the school site (NSDECD, 2018). When applicable SchoolsPlus is available to consult with families with children and/or youth that may require additional mental health supports.

SchoolsPlus was evaluated in 2012 (Crinean, Donnelly, and Leblanc, 2012) and found that the student participants showed improvement when able to access their program. These are students accessing the program for various reasons, including mental health services.

Bringing Empowered Students Together (BEST). BEST is a program created by Alberta's Mental Health Capacity Building initiative which is funded through Alberta Health Services. This program was implemented in the Grande Yellowhead Public School Division to provide mental health programming and build a sense of community in students. BEST defines positive mental health as "the capacity to feel, think and act in ways that enhance the ability to enjoy life and deal with challenges" ("BEST: Bringing Empowered Students Together", 2018). Each school in the division is assigned a Wellness Coach. This coach creates and oversees programming unique to the resources available within the community. Programs focus on mental health and are delivered to all students in a classroom setting and include, but are not limited to, the following: anxiety and stress, transitioning to new grades/school, grief and loss, friendship skills, and self-esteem. Teachers are required to participate in the delivered programming to build upon their capacity and knowledge. It is to be noted that there is currently no evaluative information or measured outcomes available for this program.

Painting a Landscape of Nova Scotia

According to the 2011 Census, the overall population has been steadily decreasing in rural areas of Nova Scotia. Although a decline has been reported, Nova Scotia also has the

highest rural population in Canada with a greater proportion of *employed* people living below low-income cut-offs (RCIP, 2003). Research done on rural communities in Nova Scotia found that, in general, Atlantic Canadians have less than ideal health when compared to other Canadians (RCIP, 2003). This may also be due, in part, to rural and remote schools and communities having major challenges in accessing services due to the distance from formalized services and transportation difficulties for youth and families (Crinean, Donnelly, and Leblanc, 2012). Reviewing perceptions on aspects of mental health within schools across Nova Scotia provides insight on current understanding and knowledge of the functioning of youth.

Teachers' Perspective on Mental Health in Nova Scotia's Classroom

To dramatically increase success of individuals following an initial episode of a presenting mental health disorder, the time between onset and intervention should be minimized (Langeveld et al, 2011). The duration of untreated mental disorders is often longer for adolescents than in adults (2011). Teachers' ability to recognize these early signs of distress and risk factors could assist in identifying students requiring support.

Programs run by schools or communities promote positive youth development in a variety of ways. They help to establish structure, psychological and physical development, sense of belonging and purpose, supportive relationships, skill building and opportunity for family, school, and community integration (Brown-Urban, J., Lewin-Bizan, & Lerner, R. 2009). Where such resources and supports are limited, an assessment of needs can determine what factors are having an impact on adolescence to determine effectiveness despite social-economic challenge.

Chapter 2: Methodology

Participants

The population of interest for this study included elementary and secondary school teachers residing in Nova Scotia. Participants represented a cross section of educators with an interest in further education and are located in a variety of urban and rural areas of Nova Scotia. A sample of 40 teachers who were, at the time of this study, enrolled in a Masters of Education program at a Nova Scotian University were invited to complete an online-questionnaire anonymously.

Measures

To assess teachers' perceptions and literacy of student mental health a questionnaire was created (see Appendix C). The researcher developed the questionnaire so there were no restrictions on the use of the research tool (e.g. copyright material) and no additional permissions were needed (e.g. recruitment permission from offsite locations, data provided by outside agencies). This questionnaire would provide the researcher with demographic information, experiential-based responses, and would enable thematic investigation specific to the subject in question.

Participants were invited to complete an online questionnaire that contained open-ended questions, 5-point Likert Items, and several demographic questions. Scale items were on a 5-point interval scale ranging as follows: 1 = "Not Significant/Competent", 2 = "Low Significance/Level Competence, 3 = "Significant/Average level of competence", 4 = "Fairly Significant/Moderately high level of competence", and 5 = "Highly Significant/Very Competent". Demographic questions included gender, age, level of education, current teaching placement (elementary or secondary), and teaching experience. While personal information such

as age, gender, and education were collected from participants to situate and explore the data, there is no way to identify individual participants. Participants anonymously responded to the online questionnaire.

The questionnaire explored teachers' awareness and knowledge of mental health issues pertaining to children and youth in their schools, experiences with specific types of mental health issues and stressors presented in the classroom. The questionnaire asked participants to identify supports available to those experiencing emotional distress. Participants were asked to comment on their experience with the types of mental health issues and stressors being experienced by their students – relative to academic, social, familial, personal and career related factors. Using open-ended questions provide specific feedback related to the classroom and schools. Questions encouraged comments around supports provided to youth, barriers in support of youth with mental health concerns, and areas for improvement regarding mental health within the classroom and community. Furthermore, participants were also asked to share their recommendations for school boards, government and teacher education programs relative to mental health literacy and awareness of issues and supports.

In creating the questionnaire, it is important to note that initial research was aimed at gathering data from adolescence directly using the measurement tool called Coping Response Inventory – Youth, or CRI-Y (Moos, 1993). The CRI-Y version was created as a tool to identify resources currently available to individuals for managing stress, psychological functioning, and evaluated their coping skills. The CRI-Y assisted in the development of the questionnaire created, as it identified key areas for exploration. These areas were resources available, experience and manifestation of specific mental health disorders, and perceived coping strategies.

A pilot questionnaire was created with the consultation of MSVU faculty members with extensive research experience in the field of educational psychology and child and youth study. The pilot questionnaire was delivered to a group of teachers enrolled at the graduate level for feedback and revision. This included updating on the language, clarity and concepts. Consultation with faculty and piloting with a target group (teachers) contributed to the validity and reliability of the questionnaire.

Design

Thematic analysis of the data gathered enabled the researcher to develop a deeper knowledge into the responses provided by the participants. The researcher found broad patterns in the data, which were not imposed or predetermined. Items on the questionnaire captured statements and direct responses to questions. Throughout the responses, themes emerged and were used to create codes. Frequency of occurrence was recorded based on the coded responses.

The transcribed data was reviewed and re-read to ensure the accuracy of the transcription. Open-ended questions with thematic responses were combined with other similar answers to aid in the generation of themes in teacher responses and to determine percentage of frequency. This assisted the researcher in visualizing and considering relationships between themes. After a review of the responses, themes were noted, and response variables were coded. At this point any themes that did not have enough data to support them, or were too diverse, were considered to be minority opinions or outliers.

Thematic coding for the open-ended responses regarding the types of mental health issues encountered in the classroom were created using the Diagnostic and Statistical Manual of Mental Disorders - V (American Psychiatric Association, 2013), herein abbreviated as DSM-V.

Anxiety Disorders would include selective mutism, generalized anxiety disorders, and social anxiety disorders. Personality disorders would include Paranoid Personality Disorder and Borderline Personality Disorder. Based on this type of analysis, the categories would include crossover among disorders. The intent of the classification was not meant to be a definitive clinical analysis but a means of approximating the types of general disorders found in the classroom based on the perception of teachers and the information they may have from specialist sources. The following thematic variables were found based on frequency of responses:

- Depressive Disorders

- Attention Deficit Hyperactivity Disorders

- Trauma- and Stressor-Related Disorders

- Obsessive Compulsive and Related Disorders

- Disruptive, Impulse-control, and Conduct Disorders

- Autism Spectrum Disorder

- Oppositional Defiant Disorder

- Anxiety Disorders

- Schizophrenia Spectrum and Other Psychotic Disorders

- Personality Disorders

Procedure

Between April 2017 and May 2017, the researcher-developed questionnaire, utilizing an open-ended response format and Likert rating scales, was sent, online, to teachers completing a graduate education degree at Mount Saint Vincent University (MSVU). Permission was obtained from the Faculty of Education at MSVU to distribute a covering letter (Appendix A), via Department of Education staff, to current graduate students on their distribution list. The

covering letter contained a link to the Informed Consent letter and Research Questionnaire

(Appendix B). This method ensured that the researcher had no access to the confidential

distribution lists. Graduate students were then invited to complete the questionnaire

anonymously online. Two email prompts were given to encourage respondents.

The Informed Consent letter explained the purpose of the study and outlined participant

rights. Participants were all mature individuals over 21 years of age who opted to complete the

questionnaire. The participants were not required to answer any question they were

uncomfortable answering and were provided the option to withdraw throughout the study. The

questionnaire took approximately 20-30 minutes to complete.

Chapter 3: Results and Analysis

Microsoft Excel was utilized for inputting participant responses and analysis of the data.

The variables were explored for themes, frequency of occurrence and extreme outliers.

Percentage and measures of central tendency were utilized to facilitate analysis.

Demographics

There were 13 participants (10 female; 3 male) with 9 (69%) teaching at the elementary

school level; 4 (31%) participants teaching at the secondary level. Approximately 39% of

participants indicated that they had 6 to 10 years or more teaching experience at the time of this

study. Demographic characteristics of participants are shown in *Table 1*. Frequencies were

rounded to the nearest ten in *Table 1*.

Table 1. *Frequencies and Percentages for Demographic Characteristics of Participants*

Variable	Frequency of Responses (n)	Percentage of Responses (%)
Gender		
Male	3	23.00
Female	10	77.00
Age		
21-30	3	23.00
31-40	6	46.00
41-50	4	31.00
> 50	0	00.00
Degrees Completed		
Bachelor Level	9	69.00
Masters Level	4	31.00
Teaching Experience		
1-5 years	3	23.00
6-10 years	5	39.00
11-15 years	3	23.00
16-20 years	2	15.00
> 20 years	0	00.00
Currently Teaching		
Elementary	9	69.00
Secondary	4	31.00

Nature of Mental Health Issues in the Classroom

The World Health Organization defines mental disorders as "a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated" ("Mental Disorders," 2018). Question 1 of the survey stated that "Mental health concerns appear to be more prevalent among elementary and secondary students" and asked, "How would you define mental health problems?". It was the intention to explore definitions provided by participants and determine their knowledge of the term "mental health problems," while also reviewing responses for a consensus on the definition.

The explanations provided ranged from detailed definitions to those that may have found difficulty in adequately defining "mental health problems," or may have required further clarity of the question. For example, Participant 11 (Question 1) said that, "Mental health problems can be defined as any condition that interrupts or cause difficulties for students in the performance of day-to-to day activities". Another participant states that mental health problems are "overwhelming to the educational system, health system and justice system" (Participant 6, Question 1). While this definition may not be adequate in relation to the question, it is how the question was perceived and the participant deemed this to be relevant to the nature of mental health problems. In reviewing the responses provided, there was no substantial consistent or cohesive definition of "mental health problems" among participants. The following is a list of definitions provided:

- Mental health problems are students struggling with things that only time and discussion can heal. They are not physical concerns where antibiotics will fix the problem. They need guidance and counselling – someone to talk to essentially who can help them work through their problems. Many problems that plague my students are eating disorders, anxiety, fear of separation, OCD, depression, aggression and so on. (Participant 1, Question 1)
- From my perspective, mental health occurs in people from all walks of life. This can be depression, anxiety and more. They can be found in people who are quiet, trying to hide it, or speak about it. Problems can occur from genetics or environmental factors. (Participant 2, Question 1)
- "Varying by individual" (Participant 3, Question 1).

- "Problems with regulating emotions, handling stress, relating to others and making good choices" (Participant 4, Question 1).

- "I would define mental health problems as either genetic or related to traumatic episodes in an individual's past" (Participant 5, Question 1).

- "Mental Health concerns are reoccurring thoughts and behaviors that impede a student's daily life" (Participant 7, Question 1).

- "Unsure" (Participant 8, Question 1).

- Mental health problems arise due to a chemical imbalance in the brain resulting in effects that the individual needs to develop coping mechanisms for, which may or may not require medication. Mental health problems can affect people of all ages, races, and genders. They may be lifelong struggles, or temporary in nature (almost like remission.) They present in a variety of ways, and affect the daily living of those experiencing them. (Participant 9, Question 1)

- "A person's emotional state inhibiting everyday life" (Participant 10, Question 1).

- "As something that needs attention in ALL schools. I have worked at several schools in the past few years ranging in various socioeconomic areas […] and there were students struggling from various metal health issues" (Participant 12, Question 1).

- Mental health problems are anything psychological that is negatively affecting the child. A mental health problem could impact how a child is able to self-regulate, how they are able to cope, how they are able to express their emotions, how they interact with peers and adults, the relationships they form, etc. Mental health problems can be labeled as anxiety, depression, etc. (Participant 13, Question 1)

In the first part of Question 2 of the survey, all participants indicated that they have experienced mental health in the classroom. In continuation of Question 2, teachers were asked to comment on the types of mental health concerns they have experienced in the classroom. Most participants provided disorders in point form and were able to be easily categorized, as shown in *Table 2*.

While most participants provided point form disorders and behaviors, Participant 13 provides further detail of experience in dealing with mental health concerns in the classroom:

> As the resource teacher, I support students with social emotional needs which oftentimes stem from mental health concerns. Many of these consist of students not being able to regulate their emotions. Many times this is shown through anger outbursts and aggression. [Students] become stressed easily and will run from the classroom. Several students […] are dealing with anxiety. This may be related to school or home. Hyperactivity is [also] a common concern seen in many children. (Question 2)

Table 2 shows the frequency of various types of mental health issues encountered in classroom by teachers. 100% of participants included anxiety in the most experienced mental health concern in the classroom. Participant 1 wrote, "[the student was] anxious about everything. I had to 'prep' them for every change they would face each day" (Question 4). Participant 9 wrote that anxiety related disorders involved "panic attacks, stress-induced seizures" and that the exhibiting students were "nervous of not meeting expectations (to the extreme" (Question 4). 5 out of 13 participants included absenteeism in their response to Question 4.

Table 2. *Frequency of Types of Mental Health Issues Experienced in the Classroom.*

Type of Disorder	Frequency of Responses (n)	Percentage of Responses (%)
Anxiety Disorders	13	100.00
Disruptive, Impulse-control, and Conduct Disorders	11	84.62
Attention Deficit Hyperactivity Disorders	10	76.92
Obsessive Compulsive and Related Disorders	8	61.54
Depressive Disorders	6	46.15
Trauma- and Stressor-Related Disorders	5	38.46
Autism Spectrum Disorder	5	38.46
Oppositional Defiant Disorder	4	30.77
Schizophrenia Spectrum and Other Psychotic Disorders	2	15.38
Personality Disorders	1	7.69

Based on participants' responses, the top three mental health concerns experienced in the classroom were anxiety disorders; disorders that involve anger management (e.g. disruptive, impulse-control, and conduct disorders); and attention deficit hyperactivity disorders. This finding is consistent throughout the data set.

Participant 9 commented on the depressive symptoms experienced in the classroom and wrote that students with depressive disorders had "difficulty completing assignment, [are] withdrawn from others, often [have a] negative outlook (things will never get any better or easier), [a] loss of vitality (does not care about outward appearance, and [a loss of] interest in school clubs and events "(Question 4).

62% of participants responded to having experienced obsessive compulsive and related disorders in the classroom. Participant 10 wrote that students exhibiting signs of obsessive compulsive and related disorders "repeatedly erase work, [and that these] students often rearrange items in classroom" (Question 4).

77% of participants responded to having experience with Attention Deficit Hyperactivity Disorders in the classroom. Participant 9 wrote that students have an "inability to focus on task at hand, [are] unorganized (loss of completed work, can't find required materials), [and are] easily distracted in the classroom [and] forget easily" (Question 4). Other reported ways this manifested in the classroom was through the inability to focus, inability to stay seated, and by continually distracting and interrupting others during a lesson.

Anger Management was placed under Disruptive, Impulse-control and Conduct Disorder category in *Table 2*, as it was considered to be related to this category. For those that identified Anger Management as one of the top three mental health issues experienced in the classroom, 6 participants went on to describe physical aggression (fighting with teacher or other students, throwing objects), as one of the main behaviors exhibited. Participant 4 wrote that "many profanities expressed by the student [was] scaring others" (Question 4). Participant 10 noted that, to them, anger management "presents as anger, frustration, aggression towards others both physical and verbal" (Question 4). Participant 7 wrote that students would "[throw] chairs and items around [the] room and at students or adults" (Question 4). In fact, when it comes to aggression in the classroom, 3 participants noted that objects such as chairs would be thrown across the classroom at the teacher or students during moments of extreme elevation exhibited by the individual.

Important Findings

In Question 5 of the survey, participants were asked to provide a comment on the perceived key area(s) that impact the student with presenting mental health. 62% of participants responded with concerns regarding academic performance. *Table 3* demonstrates the key themes presented in the responses. Most participants provided various potential areas that can impact a

student experiencing mental health. *Table 3* shows the prominent and repeating themes, as provided by participants. Comments considered to be in relation to academic performance ranged from the inability for the student to focus on the lesson; absenteeism; and lower grades. Second most frequent area impacted was the social impact on the individual among peers. Participant 8 wrote, "They often do not fit in with their peers, [and] are isolated (Question 5)", while another participant writes that the presenting mental health issues in the student lead to "lower grades, fewer friends, support group shrinkage, broken friendships, [and] feelings of isolation & rejection (Participant 9, Question 5)."

Table 3. *Impact on Student with the Presenting Mental Health Issues*

Area Impacted	Frequency of Responses (n)	Percentage of Responses (%)
Academic performance	8	61.54
Peer relationships	5	38.46
Adult relationships	1	7.69
Intrapersonal	6	46.15
Additional Supports Used	3	23.08
Ability to Cope	2	15.38
No Response	2	15.38

The lack of academic support and performance was noted by 8 of the participants when asked how the mental health issues impacted the individual. Participant 11 noted that "it is very frustrating for the students, as they want to do well but are not able to (Question 5)," while another participant went on to say that "the students with mental health issues had a hard time coping. Changes are not positive for those students and it's exhausting trying to remember to

prepare kids for every change they will face daily. They need coping strategies (Participant 1, Question 5)."

When categorizing the open-ended questions for Question 5 on the teacher perceptions of the impact on students with mental health problems, three major areas were identified. It was found that the students with presenting mental health issues were affected *personally* (disillusioned, negative self-image, unsupported and/or suicidal); *socially* (isolated, rejected); and *academically* (lower grades, missed class time, work incomplete).

In Question 6, participants were asked to comment on their perceptions of the impact on the *other* students in the classroom when mental health is encountered in the classroom. Responses were also able to be placed into the same identifiable categories. The other students were affected *emotionally* (frustrated, fearful and uneasy); *socially* (inability to cope with students with mental health issues or avoiding students with mental health issues); and *academically* (lessons being interrupted, or student's focus being taken away from academics).

Participant 1 (Question 6) wrote, "It is scary and frustrating for the other students to have to listen to the aggressive and hyperactive kids be spoken to. Activities are always 'on hold' while issues are dealt with. It's annoying not to be able to teach one full lesson without someone having a meltdown or outburst."

When discussing how students with mental health issues has impacted the participant, as a teacher, and their ability to deliver lessons and manage a classroom, one respondent wrote that "as a teacher, I didn't feel properly trained in this area. It is very upsetting to see children so mentally unwell. It is mentally draining on the teacher making accommodations and dealing with such issues. As a learning centre teacher, I feel I deal with a lot of mental health issues" (Participant 10, Question 7).

77% of participants made changes to their classroom management to accommodate the students experiencing mental health issues. Their changes included being strict in their routines such as to avoiding sudden change and having a carefully arranged seating plans for students. Participant 8 wrote the following about the impact a student's mental health has on the teacher and classroom:

> It has made it more stressful for sure. I do not often feel that I am effective with both the students with special needs or the other students. Classroom management has become a major part of my day instead of instruction. (Question 7)

Another reoccurring response from participants was the concern over energy and time focused on accommodating individual students, and the impact this had on the performance on the other students in the classroom. One participant commented that "the pace of instruction is slowed, other students become resentful of students' constant needs. Students with extreme conditions can bring on mental health issues in other students - i.e. screaming students with Autism, who are experiencing sensory overload, create stress and anxiety in other students."

Table 4. *Teachers' Self-evaluated Competence in Dealing with Mental Health in Classroom*

	Level of Competence (%)				
	Not Competent	Low level of competence	Average level of competence	Moderately high level of competence	Highly Competent
Recognizing mental health issues in my classroom			60.00	20.00	20.00
Providing general support to students with mental health issues		9.09	63.63	27.27	
Implementing mental health programs for individual students		27.27	63.63	9.09	
Talking with students about their mental health issues		27.27	9.09	54.54	9.09
Talking to parents about their child's mental health issues		27.27	36.36	27.27	9.09
Referring students for assessment of mental health issues			18.18	36.36	45.45
Your current level of knowledge on mental health issues		20.00	50.00	20.00	10.00

Participants had average or higher self-reported competence in the ability to recognize mental health issues in the classroom and provide general support to students with mental health issues.

Lower levels of competence were found on the following items: ability to implement mental health programs for individual students; talking with students about their mental health

issues; and talking to parents about their mental health issues. 64% reported having moderate to high levels of competence in talking with students about their mental health issues. In contrast, 64% reported having average or lower competence in their ability to speak with parents about their child's mental health issues. 91% of participants reported having average or lower competence implementing mental health programs for individual students. The majority of respondents, 82% had reported being moderately-to-highly capable of referring students for assessment of mental health issues. Despite findings showing competence in participant ability to speak with students, providing support by way of speaking with students and their confidence in referring students for mental health assessments, 60% of participants reported having an average to low level of knowledge on mental health issues.

Access to Supports

When investigating the types of supports students had access to within the school and community, most participants felt that guidance counselors and school psychologists were the most accessible. In addition to these responses, participants provided examples of supports such as: Community Centre programming; Mental Health Services; SchoolsPlus Program; African Nova Scotia Student Support Worker; and the individual school's Learning/Resource Centre.

In Question 14, participants were asked to describe the role of the teacher in dealing with mental health issues in the school/community. Most participants noted that they were often "first responders" (Participant 11, Question 14). Participant 5 wrote that the role of the teacher is "disproportionately large and done without adequate training" (Question 14). Participant 1 expressed concerns experienced when dealing with mental health in the school:

> The teacher becomes the main sounding board for kids with issues. The problem with
> that is that we can be good listeners but are not trained in what advice to give back that

would be helpful. We can identify and refer kids but waiting lists are so long it takes a

long time to be seen at mental health. (Question 14)

Participant 7 wrote the following:

The teacher is key in providing and environment where all students feel comfortable

being a part of regardless of their abilities/needs. Every opportunity should be taken to

provide such environments to the best of a teacher's ability. (Question 14)

Participant Recommendations

In Question 12, participants were asked to comment on their recommendations for the

types of supports they would like students to have access to, in relation to mental health services.

The following responses were given:

- Full time guidance counselor

- More trained mental health professionals

- Social programming

- Peer meditation

- More school psychologist support

- More Schools Plus program availability

- More training for teachers about effective teaching strategies

- Izaak Walton Killam Hospital for Children (IWK) Mental Health programming

  opportunities

- Less wait time for Psych Ed assessments

- Information sessions for parents on parenting strategies

- Addiction services

- Employment opportunities

The overall majority of responses were related to the need for additional supports and services within participants' community. Of these responses, while 6 of the 13 participants provided no responses or were "unsure", of those that commented, 7 (54%) called for more guidance counselors and mental health professionals to provide ongoing services.

Question 15 asked participants to comment on what specific supports should be in place to help teachers address the mental health needs of their students. 75% of respondents suggested teacher education and professional development. The remaining responses called for the need for specialized on-site support workers such as school psychologists or guidance counsellors. Participants were then invited to provide recommendation for school boards, government, and teacher education programs in preparing teachers. The following recommendations were given:

- "Small class sizes to recognize and spend more time with individuals, more outside help, more support" (Participant 2, Question 16).

- "Make training on mental health issues a mandatory part of teacher education and professional development programs" (Participant 5, Question 16).

- "We need more investment toward helping these students. If we cannot support their mental health in an evidence-based way then their academics fail, and their social well-being can crumble" (Participant 7, Question 16).

- "Hire more specialists" (Participant 8, Question 16).

- NS teachers are entitled to upgrade their licenses - think that the first upgrade should be mandated as either resource for diverse needs or counselling - it doesn't mean the teacher is leaving the classroom - it means they are better prepared to meet the needs of the included classroom. I also think that BEd programs need to identify these issues in their preparatory courses. Often teachers are taking 6

years to prepare for teaching - one 3/4 year degree, plus a 2 year teaching degree -

think the degree should be 2 years of prep transferred to a 4 year ed degree so

there is more opportunity to prepare teachers for the reality of the classroom. I

think it should look something like the nursing degree. (Participant 11, Question

16)

- "100% guidance counselor, less wait time for psych-ed assessment" (Participant

  12, Question 16).

- "A wide range of educational experiences to prepare teachers for various

  classrooms. The government has been given a clear picture of the state of today's

  classrooms and they are choosing to ignore it" (Participant 13, Question 16).

- (Teachers) need to have a basic understanding of many different types of mental

  issues so they can identify them and later refer them. Teachers need to know the

  proper steps to go through if they suspect something is up. Funding needs to be

  given to schools for more psychologists (so they don't spend all their time testing)

  and also guidance counselors. Mental health needs funding so their wait lists

  aren't so long. Kids are committing suicide while waiting to talk with someone.

  (Participant 1, Question 16)

Participant Perception of Obstacles to Support for Children and Youth

Among the responses, three obstacles were noted as hindering the successful support of

children/youth with mental health issues in the classroom. These were lack of family support,

lack of budgetary support and lack of education and resources. One participant wrote that there

is a perceived "lack of budgetary support in collective agreement imposed by government" when

it comes to barriers in supporting students with mental health issues in schools (Participant 5,

Question 13).

Approximately 30% of participants noted lack of family support. This included responses

related to the lack of parent involvement and engagement and parents refusing to agree to

support. Participant 6 wrote that they experienced "parents refusing to agree to support (be it

Mental Health services from the IWK, service plans, educational assistant support, testing

through the school psychologist etc.)" (Question 13). Participant 13 commented that they

perceived a "lack of parent involvement, engagement, and participation" and that "parents' [are]

not seeking support prior to child entering school" (Question 13).

Chapter 4: Discussion, Recommendations & Conclusion

Discussion

The results of this study were reflective of a variety of issues and barriers surrounding

the mental health of youth within Nova Scotia schools. Teachers identified unemployment, lack

of resources and funds as pressing obstacles that hinder successful support of children and youth

with mental health issues.

Teachers' perceptions of mitigating factors. A key finding in this study are the barriers

in the allocation of proper support to students with mental health concerns. Participants were

asked to provide up to 3 stressors in their community they perceived to be contributing factors

related to mental health. Using thematic analysis, *Table 3* categorizes the types of stressors and

captures the frequency in responses. It is to be noted that 3 participants provided no response to

Question 9, and that an additional 3 participants provided only one type of stressor. A key area

of concern for participants was the perceived lack resources for mental health support and

education provided within schools across Nova Scotia. Participant 11 wrote that the "lack of

funding for support – both emotionally and academically, lack of funding for diagnosis, and lack

of education provided to teachers" are significant types of barriers contributing to mental health

overwhelm in their community (Question 9).

Table 5. *Most Significant Stressors in Teachers' Community.*

Type of Stressor	Frequency of Responses (n)
Lack of resources	6
Socioeconomic	5
Peer	3
Familial	2
Academic	2
Drug and Alcohol	1
Social Media	1
Academic	1

Communities with a lower socio-economic status were identified as the most pressing

barrier to providing adequate mental health support. Unemployment, lack of resources and a lack

of funds were found to be the highest when ranking the types of barriers communities in Nova

Scotia face when it comes to stressors.

31% of participants discussed parental concerns, such as refusal of services, inability to

cope with the mental health issue, family problems, and lack of engagement from parents as

being significant sources contributing to mental health distress. Participant 11 discussed the

barriers some families have with supporting a child or youth with mental health issues is in the

"parents' inability to cope with the mental health issues, which begins and continues the mental

health crisis cycle for these families. Families do not have the skills, education or experience to

deal with mental health problems - parents can't help themselves, therefore they cannot help their

children […]" (Question 13).

Support from familial and extra-familial sources, along with social competence, can have the most profound effect when coping with a life stressor (D'Imperio, Dubow, & Ippolito, 2000; McCarthy, 2007). Having access to involved supportive individuals, both familial and extra-familial, may provide structure where there is a lack of formal resources. Many of the participants had concerns regarding familial involvement. D'Imperio, Dubow and Ippolito (2000), found that this is an area that should be highly regarded, as it can have the most effect on youth with mental health issues or distress.

Teachers' perception of impact on classroom management. Participants noted that students with mental health concerns often had poor academic performance due to their inability to focus, lack of engagement, absenteeism, and/or needing more academic support. Participant 13 wrote that "the more time I spend supporting students with mental health concerns, the less time I am able to spend supporting students with academic concerns" (Question 7). Participant 7 wrote the following:

> I changed my teaching style to the best of my ability to support the multitude of learners in my classroom. I found having structured days with little interruptions and/or change helped those with anxiety, and having visual schedules for the whole class to look upon was a good first step. I tried to incorporate themes of interest to these students as best I could to encourage participation and a motivation for work. (Question 7)

Participant 11 wrote, "I have often felt that no matter how hard I worked I was failing to meet all the needs in the classroom and that left me feeling inadequate and incompetent" (Question 7). Participant 1 wrote, "I had to be very strict with my routines and not deviate too far from them. I had to ensure certain students were not near each other at all. I had to prep students for change. I couldn't be sick because they couldn't deal with a sub!"

Teachers' perception of impact on learners. Participants were asked to describe how having students with mental health issues in the classroom affected other students. 7 out of 13 participants indicated that other students experienced intrapersonal distress as an impact having an individual experiencing mental health concerns stressors can have on personal concerns like self-concept, and mood. Inadequate responses to life stressors contributes to a range of psychosocial problems including poor academic performance, conduct problems, anxiety, depression, suicide, eating disorders and violence (Farrington, 2006; Eacott & Frydenberg, E., 2009). The results of this study alluded to similar reactions and manifestations of mental health in the classroom. Participant 9 wrote the following on the impact on other students:

> Students can be extremely cruel to each other. Often the student with mental health issues is teased/tormented in a manner that does not draw the attention of adults in the vicinity. Bullying can increase, and cause further harm. In the case of the suicide mentioned above, the student body was left feeling guilt and confusion. The group dynamic was shattered, as were the lives of his closest friends. Students with anger management and/or impulse control issues put the safety of the other students in the room at risk. Outbursts of violent anger also disrupts the learning processes of other students, causing them to possibly develop mental health issues of their own. (Question 6).

Participant 7 wrote that "other students felt fearful and uneasy about coming to school, being in the classroom. They spoke to me privately about their concerns, and sometimes parents expressed their concerns to myself or administration" (Question 6). Other responses included the impact on academic performance and decreased pace of instruction due to interruption and accommodation.

Recommendations

Overall, the results were categorized and coded into four overall recommendations: teacher education/professional development, a specified guide, behavioral interventions, and specialized staff like resource teachers, guidance counselor and/or school psychologists. More specifically, teachers recommended the following: increased funding for school and community supports; hiring of more mental health professionals; a reduction of wait times for services; increase mental health programming; offering community information sessions on mental health; delivery of professional development sessions for teachers; and lower student-teacher ratio.

It is recommended that further research would be beneficial to more fully understand the issues, challenges and options available to support youth and their teachers using the best evidence-based practices. Offering courses on mental health literacy and best practices will allow teachers to familiarize themselves with conditions, symptoms, behaviors and treatments. Assisting teachers in developing the skills and knowledge of underlying concerns and the presenting characteristics associated with conditions can allow for time and adequate responses to a student dealing with mental health issues in the classroom. This may include the creation of awareness and importance of documenting student behaviours, attitudes, changes and potential situational stressors. This can help current and future teachers within the same school system to access the details to prepare themselves in how to approach a student, techniques to positively engage, understand limitations, and know when it is time to refer to formalized mental health supports.

Conclusion

As noted in the beginning, providing teachers with mental health literacy can assist in the early identification of mental health concerns and increase awareness of prolonged or inadequate response to stress in youth (Jorm et al, 2006). Participant 11 wrote that "for many of our students, our school is the only warm place, with food, and safety for extended periods of time" (Question 11). The school site should be perceived as being a safe and non-judgmental by both educators and students, making it an important and ideal location for base level mental health literacy. Most participants felt that teachers should have more training in regard to mental health literacy, specifically in the classroom setting. Participant 8 stated, "teachers are often expected to deal with mental health issues that they are not trained nor qualified for" (Question 14). Approximately 46% of respondents stated that there was a need for more professional development and training on mental health. Participant 7 stated that "more education on evidence-based strategies for use with these students, more time to program plan/liaison with all partners in the student's health care team [and] more support from Guidance/School Psychologist" should be in place to help teachers address the mental health needs of their students (Question 15). It could be suggested that universal certifications/programs such Mental Health First Aid be a base-level recommendation in providing teachers with a general increase in confidence when facing mental health in the classroom,

Where students spend a majority of their time in the school, it is no surprise to find that teachers felt that they were key in identifying concerns and supporting youth. As one participant wrote, "teachers are the first responders - they see it and it is their responsibility to report it, but often teachers are not adequately trained to identify, and offer supports and worry about doing

more harm than good." As participants noted, the concerns over the lack of funds, resources and education in their communities were prominent among the views expressed.

The Guide may be of interest as it is currently already embedded into the provincial grade 9 curriculum in Nova Scotia (Mcluckie, Kutcher, Wei & Weaver, 2014). This program has a significant impact on teacher confidence and knowledge of mental health (Mcluckie, Kutcher, Wei & Weaver, 2014) and – pending on further evaluation and resources – could be quite beneficial if expanded into other grades across the province. The same could be said for the implementation of programs like BEST, the Alberta school-based mental health initiative (p. 17).

Further, it is recommended that more research be undertaken to fully understand the issues, challenges and options available to support youth and their teachers regarding evidence-based practices. Specific programs that provide knowledge of best practices for learning strategies and techniques to help students cope with mental health issues in the classroom should be subject to further study and use.

Limitations of Study

A major limitation of this study is the low participant numbers. Online questionnaires were utilized in the collection of information from teachers. This may have had an impact on response rates and depth of information shared by participants. If an attempt to replicate this study occurs, it is suggested that a larger sample be collected or perhaps conduct focus groups to gather more insights. Despite a low feedback rate, it has provided the researcher with teachers' current knowledge of mental health literacy and preparedness, while investigating the major themes and areas of concern when it comes to experiencing mental health issues in the

classroom. This has served to highlight the challenge being faced in the day-to-day role by a group of educators.

Current findings were based on a sample from one location and as such, might not generalize to all teachers. This sample was taken from a group of students enrolled in a graduate education program at Mount Saint Vincent University in Nova Scotia. This is a very specific location and socio-economical area which may not transfer well when used to compare to similar studies. Given the advanced credentials of participants, the level of education might not generalize to all teachers.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Armstrong, M., Birnie-Lefcovitch, S. & Ungar, M. (2005). Pathways Between Social Support, Family Well Being, Quality of Parenting and Child Resilience: What we know. Journal of *Child and Family Studies*, 14(2). doi:10.1007/s10826-005-5054-4

Beauregard, C. (2014). Effects of classroom-based creative expression programmes on children's well-being. *The Arts in Psychotherapy*, 41, 269–277. doi:10.1016/j.aip.2014.04.003

BEST: Bringing Empowered Students Together (2018). Retrieved from https://www.gypsdbest.com

Browne, G., Gafnia, A., Robert, J., Byrnea, C., & Majumdara, B. (2004). Effective/efficient mental health programs for school-age children: a synthesis of reviews. *Social Science & Medicine*, 58, 1367–1384. doi:10.1016/S0277-9536(03)00332-0

Brown-Urban, J., Lewin-Bizan, & Lerner, R. (2009). The role of neighborhood ecological assets and activity involvement in youth developmental outcomes: Differential impacts of asset poor and asset rich neighborhoods. *Journal of Applied Developmental Psychology*, 30, 601–614.

Crinean, K., Donnelly G., and Leblanc, S. (2012). Evaluation of Schools Plus – Year Three Final Report. *Collective Wisdom Solutions.*

D'Imperio, R., Dubow, E., & Ippolito, M. (2000). Resilient and stress-affected adolescents in an urban setting. *Journal of Clinical Child Psychology*, 29(1), 129 – 142.

Dray, J., Bowman, J., Campbell, E., Freund, M., Hodder, R., Wolfenden, L., Richards, J., Leane,

C., Green, S., Lecathelinais, C., Oldmeadow, C., Attia, K., Gillham, K., & Wiggers, J. (2017). Effectiveness of a pragmatic school-based universal intervention targeting student resilience protective factors in reducing mental health problems in adolescents. *Journal of Adolescence*, 57, 74-89.

Farrington, J. (2006). Gone. *Current Health 2*, 33(1), 26-29.

Frank, L. (2016). *The 2016 report card on child and family poverty in Nova Scotia: Another year, no improvement.* Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/Nova%20Scotia %20Office/2016/11/2016_NS_Report_Card_Child_Family_Poverty.pdf

Freilich, R., & Shechtman, Z. (2010). The contribution of art therapy to the social, emotional, and academic adjustment of children with learning disabilities. *The Arts in Psychotherapy*, 37, 97–105. http://dx.doi.org/10.1016/j.aip.2010.02.003

Gordon Rouse, K. (2001, August). Resilient Students' Goals and Motivation. *Journal of Adolescence*, 24, 461 – 472. DOI:10.1006/jado.2001.0383

Halsall, T., Garinger, C. & Forneris, T. (2014). Mindyourmind: An Overview and Evaluation of a Web-Facilitated Mental Health Program that Applies Empowerment Strategies for Youth, *Journal of Consumer Health on the Internet*, 18:4, 337-356, DOI: 10.1080/15398285.2014.952998

Hamdan-Mansour, A., Kim, Y., Puskar, K., & Amer, H. (2008). Psychometric Qualities of the Coping Response Inventory-Youth Form. *Issues in Mental Health Nursing*, 29, 371 – 385.

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *The American Psychologist*, 67(3), 231-243. doi: 10.1037/a0025957

Jorm, A., Barney, L. J., Christensen, H., Highet, N. J., Kelly, C. M., & Kitchener B. A. (2006).

    Research on mental health literacy: What we know and what we still need to know.

    Australian and New Zealand Journal of Psychiatry, 40, 3-5.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005).

    Life time prevelance and age-of-onset distributions of DSM-IV disorders in the national

    comorbidity survey replication. *Arches of General Psychiatry*, 62, 593-602. doi:

    10.1001/archpsyc.62.6.593

Kramer, L., Laumann, G., & Brunsonm, L. (2000). Implementation and diffusion of the

    Rainbows Program in rural communities: Implications for school-based prevention

    programming. *Journal of Educational and Psychological Consultation*, 11(10), 37 – 64.

Kutcher, S., Wei, Y. & Morgan, C. (2015, December). Successful application of a Canadian

    mental health curriculum resource by usual classroom teachers in significantly and

    sustainably improving student mental health literacy. *Canadian Journal of Psychiatry.*

    60(12), 580-586.

Langeveld J., Joa I., Larsen T., Rennan J., Cosmovici E. & Johannessen J. (2011). Teachers'

    awareness for psychotic symptoms in secondary school: the effects of an early detection

    programme and information campaign. *Early Intervention in Psychiatry*, 5, 115-121. doi:

    10.1111/j.1751-7893.2010.00248.x

Leadbeater, B., Gladstone, E., & Sukhawathanakul, P. (2015). Planning for Sustainability of an

    Evidence-Based Mental Health Promotion Program in Canadian Elementary Schools.

    American Journal of Community Psychology, 56, 120-133. doi:10.1007/s10464-015-9737-

    8

Let Dillen, Johnny R. J. Fontaine & Leni Verhofstadt-Denève (2009) Confirming the

Distinctiveness of Complicated Grief from Depression and Anxiety Among Adolescents,

Death Studies, 33(5), 437-461. doi: 10.1080/07481180902805673

Lin, K., Sandler, I., Ayers, T., Wolchik, S., Luecken, L. (2004). Resilience in Parentally

Bereaved Children and Adolescents Seeking Preventive Services. *Journal of Clinical*

Child & Adolescent Psychology, 33(4), 673-683.

Mcluckie, A., Kutcher, S., Wei, Y., & Weaver, C. (2014). Sustained improvements in students'

mental health literacy with use of a mental health curriculum in Canadian schools. *BMC*

Psychiatry, 14, 379. http://doi.org/10.1186/s12888-014-0379-4

McCarthy, R. (2007). 'They all look as if they're coping, but I'm not': The Relational

Power/lessness of 'Youth' in Responding to Experiences of Bereavement. *Journal of*

Youth Studies, 10(3), 285 – 303.

Michael Pietrus: Opening Minds Interim Report, Calgary: Mental Health Commission of

Canada (2013). Retrieved from

https://www.mentalhealthcommission.ca/sites/default/files/opening_minds_interim_report

_0.pdf

Moos, Rudolph (1993). Coping Response Inventory-Youth Form Professional Manual. Odessa,

FL: Psychological Assessment Resources, Inc.

Murnaghan, D., Morrison, W., Laurence, C., & Bell, B. (2014). Investigating Mental Fitness and

School Connectedness in Prince Edward Island and New Brunswick, Canada. *Journal of*

School Health, 84(7), 444-450.

Rural Communities Impacting Policy (RCIP) Project. (2003). *Painting the landscape of rural*

Nova Scotia. Halifax, N.S.: RCIP.

Nocera, E. J., Whitbread, K., & Nocera G. P. (2014). Impact of School-Wide Positive Behavior Supports on Student Behavior in the Middle Grades. *Research in Middle Level Education Online*. 37(8).

Nova Scotia Department of Education and Early Childhood Development (2018). *SchoolsPlus*. Retrieved from https://www.ednet.ns.ca/schoolsplus/en

Santor, D., Short, K., & Ferguson, B. (2009). Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario. Ottawa, ON: The Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario. Retrieved from http://www.excellenceforchildandyouth.ca/sites/default/files/resource/policy_sbmh.pdf.

Statistics Canada. (2011). Retrieved from http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/hlt-fst/pd-pl/Table-Tableau.cfm?LANG=Eng&TABID=1&T=209&SR=1&RPP=25&S=0&O=D&CMA=225&PR=0#C2

World Health Organization. (2018). *Mental Disorders.* Retrieved from www.who.int/mental_health/management/en/

Zins, J. & Elias, M. (2006). Social and emotional learning: Promoting the development of all students. *Journal of Educational and Psychological Consultation*, 17(2&3), 233-255.

Appendix A

Letterhead

Dear Student,

My name is Denise Harrietha, and I am currently enrolled in the Master of Arts (Child and Youth Study) program at MSVU. As part of my degree requirements, I am conducting research exploring teacher's awareness and knowledge of mental health issues pertaining to children and youth in their schools. Specifically, participants will be asked to define mental health from their perspective and to identify and describe prominent mental health issues they have experienced in their classrooms. The findings from this study should have practical implications for teachers working with learners who are experiencing mental health concerns and should result in recommendations for improved supports, practices and policies particularly in school boards, government and teacher education facilities.

I am requesting that you click on the link below, read the Informed Consent Letter and complete the attached questionnaire. The Research Questionnaire contains a few demographic items such as age range, gender, education, and teaching experience as well as some opened-ended questions on participants' perceptions of their comfort, knowledge, and experience with mental health issues in their classrooms. Other questions deal with the supports and services that may have limited/assisted teachers in their efforts to deal with mental health issues. Estimated time for completion is 20-30 minutes. The process should take approximately 20-30 minutes.

Should you have any further questions regarding this study, please contact me, Denise Harrietha at Denise.harrietha@msvu.ca or my thesis supervisor, Dr. Frederick French, at frederick.french@msvu.ca . If you have any questions regarding how this study is being conducted, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International office at (902) 457-6350 or via e-mail at research@msvu.ca . If completing this questionnaire caused you unexpected distress, you can contact MSVU Counseling Services at 457-6567.

Thank you for considering my research project. If you are willing to participate, please click on the following link (**link to Informed Consent Letter and Research Questionnaire**).

Sincerely,
Denise Harrietha
Graduate Student, MSVU

Appendix B

Informed Consent Letter

Dear Student,

My name is Denise Harrietha, and I am currently enrolled in the Master of Arts (Child and Youth Study) program at MSVU. As part of my degree requirements, I am conducting research exploring teacher's awareness and knowledge of mental health issues pertaining to children and youth in their schools. Specifically, participants will be asked to define mental health from their perspective and to identify and describe prominent mental health issues they have experienced in their classrooms The findings from this study should have practical implications for teachers working with learners who are experiencing mental health concerns and should result in recommendations for improved supports, practices and policies particularly in school boards, government and teacher education facilities.

I am requesting that you complete the attached Research Questionnaire. The Research Questionnaire contains a few demographic items such as age range, gender, education, and teaching experience as well as some opened-ended questions on participants' perceptions of their comfort, knowledge, and experience with mental health issues in their classrooms. Other questions deal with the supports and services that may have limited/assisted teachers in their efforts to deal with mental health issues. Estimated time for completion is 20-30 minutes.

Participation in this research is completely voluntary. You do not have to answer any questions that causes you discomfort. All information will be anonymous and no identifying information will be required on the questionnaire. The focus is on group results.

The data will be collected and stored on a password protected MSVU account. To allow time for dissemination of the information through conference presentations and published articles, the electronic data will be backed-up in a password-protected MSVU account and kept for five years following the thesis defense. After five years, the account will be deleted from the computer.

Please indicate whether you are willing to participate in this research by checking the appropriate box at the end of this letter. If yes, please continue and complete the Research Questionnaire. You have the right to withdraw from the study at any time without any repercussions and can do so by checking the appropriate box at the end of each page. If you choose to withdraw before completing and submitting the questionnaire, then all of your data will be eliminated. As the Research Questionnaires are completed anonymously, there is no way for the researcher to identify individual questionnaires. This means your questionnaire cannot be withdrawn after if it has been completed and submitted.

The process should take approximately 20-30 minutes. A summary of the results of this study will be sent to all students initially contacted by the MSVU Department of Education.

Should you have any further questions regarding this study, please contact me, Denise Harrietha at Denise.harrietha@msvu.ca or my thesis supervisor, Dr. Frederick French, at frederick.french@msvu.ca . If you have any questions regarding how this study is being conducted, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International office at (902) 457-6350 or via e-mail at research@msvu.ca . If completing this questionnaire caused you unexpected distress, you can contact MSVU Counseling Services at 457-6567.

Thank you for considering my research project.

Sincerely,
Denise Harrietha
Graduate Student, MSVU

I am willing to participate in this research study.   Yes

                                                                       No

Appendix C

Research Questionnaire

Please answer the following questions. You do not have to answer any question which causes you discomfort.

Gender:

Female   _____

Male   _____

Other   _____

Age in Years:

21-30   _____

31-40   _____

41-50   _____

>50   _____

Education:

List all Degrees Completed _____

Teaching Experience:

1-5 years   _____

6-10 years   _____

11-15 years   _____

16-20 ears   _____
>20 years   _____

Currently Teaching:

Elementary   _____

Secondary   _____

Please check this box if you wish to withdraw from the study at this time.

(This option was at the bottom of each page on the Limesurvey created.)

Continue

Open-Ended Questions

Please answer the following questions. Take care not to provide any identifying information when describing the mental health issues of students. You do not have to answer any question which causes you discomfort.

1. Mental health concerns appear to be more prevalent among elementary and secondary students. How would you define mental health problems?

2. Have you had students in your classroom who had mental health issues?

   Yes ____   No ____

   If yes, what types of mental health issues have you encountered in your classroom as a teacher. (You do not need to identify individuals, just the types of issues/concerns you have encountered. For example, stress, anxiety, anger management, hyperactivity, obsessive behaviors).

3. What do you feel were the top three mental health issues you faced in the classroom?
   1.
   2.
   3.

   Please indicate whether these top three issues could be categorized as primarily academic, social, personal or career related in nature.

   1.
   2.
   3.

4. Please describe the nature of the top three issues, how they manifested in the classroom.

   1.
   2.
   3.

5. How did these problems impact the student with the mental health issues?

6. Describe how having students with mental health issues in the classroom affected other students.

7. Describe how having students with mental health issues in the classroom affected you and your teaching/classroom management.

8. On a scale of 1 to 5, with 5 being Very Competent and 1 Not Competent, note how comfortable are you with:

Statement	Not Competent				Very Competent
Recognizing mental health issues in my classroom	1	2	3	4	5
Providing general support to students with mental health issues	1	2	3	4	5
Implementing mental health programs for individual students	1	2	3	4	5
Talking with students about their mental health issues	1	2	3	4	5
Talking to parents about their child's mental health issues	1	2	3	4	5
Referring students for assessment of mental health issues	1	2	3	4	5
Your current level of knowledge on mental health issues	1	2	3	4	5

9. What do you feel are the three most significantly mental health stressors in your community?

   1.
   2.
   3.

10. There are many potential life stressors that can impact children and youth. Please rate each of the following according to the potential impact it has for your students in your community from rarely (1) to highly significant (5).

   Academic   1   2   3   4   5

   Peer Relationships   1   2   3   4   5

   Social Challenges   1   2   3   4   5

   Family Challenges   1   2   3   4   5

   Alcoholism   1   2   3   4   5

   Financial Challenges   1   2   3   4   5

   Gambling   1   2   3   4   5

   Lack of Community Supports   1   2   3   4   5

Sexuality	1	2	3	4	5
Peer Pressure	1	2	3	4	5
Personal Concerns (self-concept, mood)	1	2	3	4	5
Difficulties with stigma	1	2	3	4	5
Other - please describe	1	2	3	4	5

11. Please share the types of supports you see <u>students</u> as being able to access in their community and/or school to help them with mental health issues you have observed/experienced in your students.

12. Please indicate the types of supports you would like to see <u>students</u> being able to access in their community and/or school.

13. Please identify some of the obstacles that have hindered the successful support of children/youth with mental health issues in your classroom. (Please remember this is anonymous information, as we do not wish to know your school or community).

14. How would you describe the role of the teacher in dealing with mental health issues in the school/community.

15. What supports do you feel should be in place to <u>help teachers</u> address the mental health needs of their students?

16. What recommendations, relative to the mental health needs of children and youth would you offer to school boards, government, and teacher education programs in preparing teachers for today's classrooms?