SEEKING EQUITY FOR MENTAL HEALTH IN PUBLIC EDUCATION IN ONTARIO:

A CRITICAL DISCOURSE ANALYSIS OF FOUR POLICY DOCUMENTS

by

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Master of Arts
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Abstract

Through the use of critical discourse analysis (CDA), this research study conducts a comparative policy analysis which deconstructs the implicit and explicit policy components representing children's mental health in the revised *Health and Physical Education Curriculum* (2010), *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010). Underlying assumptions and contradictions regarding children's mental health in these policy documents are identified. Findings indicate that mental health remains misunderstood, poorly represented, and highly stigmatized in Ministry of Education policy documents, and that neither separately, nor together, are these policies sufficiently able to educate and address the reality of mental health challenges and mental illness among children.

Keywords: policy analysis, children's mental health, school based mental health, inclusion, stigma

"Children and youth are important because early intervention makes an enormous difference over a lifetime. More than 70% of adults living with mental illness say the onset occurred before they were 18 years old" (Out of the Shadows Forever: Annual Report 2008-2009, Mental Health Commission of Canada, 2009, p. 14).

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To my incredible and inspirational children; Jesse, Jordin, Melissa, and Christopher. I am both honoured and blessed to be given the opportunity to be your mother, and your friend.
You give meaning to everything I do.

Last but not least, to my wonderful husband, Sean. Thank you for being my very best friend. You support and encourage everything that I ever set out to accomplish, and never question why. I never could have done this without you.

I love you all so very much.

To all these, and more, I am eternally grateful.

Dedication

This research paper is dedicated to the memory of my mother.

So much of who I am today is because of her.

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Author's Preface

As a researcher, I approach this research paper and the Master of Arts in Early Childhood Studies program after fourteen years working in the field of Early Childhood Education and Children's Mental Health. My first exposure to the challenges associated with mental health and mental illness came when I was twelve years old and my brother was diagnosed with schizophrenia. At the time, mental health was not a topic that was openly discussed in public settings. At a young age, I found myself advocating in an effort to reduce the public misunderstanding, stigma and stereotypes of mental illness that plagued our family. Years later, I began my studies in Early Childhood Education as a response to the struggles my son was having with mental health, which appeared to be most prevalent in his elementary school environment. As a parent, I only knew from trial and error what worked to support my son's anxiety and stress, and I was struggling to feel heard in my advocacy for his needs without specific knowledge in child development. When I completed my Early Childhood Education Diploma, I furthered my studies through a two-year post diploma certificate in Inclusion Practices. The focus of this program was to further develop skills which promote the inclusion of all children and develop a professional specialization. Upon completion of this certificate in 2002, I accepted a position as a Children's Mental Health Consultant with the largest Children's Mental Health Agency in Ontario. Training opportunities, which were held both internally and externally, combined with the completion of my Bachelor of Professional Arts in Human Services, assisted me in recognizing the complexity of influencing factors on the mental health of children. This allowed me to gain a deeper understanding of mental health and strategies which promote mental wellness. As a consultant, a portion of my responsibilities have been to provide consultation to schools and child care centers in the development of plans designed to support the social, emotional, and behavioural

challenges of children who are struggling with their mental health. I have also presented topics related to children's mental health locally, nationally, and internationally at a wide variety of conferences and professional development opportunities for individuals working with children and families.

Chapter 1

Introduction

In Canada, the accountability for health and education services are the separate responsibility of each Province and Territory. The Canada Health Act (Canada Health Act, 1984) legislates five core principles which must be met in order for Canadians to be able to attain funding for services. These principles are portability, universality, comprehensiveness, public administration, and accessibility (Canada Health Act, 1984, c.6, s. 7). However there is no equivalent federal level department of education, which regulates core components for education across Canada, nor a formal framework for collaborative integration of health and education services in Canada. The World Health Organization (2011) defines mental health as, "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. It is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (p. 1). The attention of policy makers towards mental health as it relates to education is crucial, as unaddressed needs related to children's mental health adversely affect their academic, social, emotional and behavioural development (National Institute for Health Care Management, 2005). Despite the absence of a formal, federal framework which strategically integrates health and education services, there has been a dramatic increase in both universal and targeted service models for school-based mental health prevention and intervention across Canada, and a growing commitment from both policy makers and practitioners to find effective means to integrate school-based mental health service delivery (Mental Health Commission of Canada, 2009).

In 2006, the Senate Committee on Social Affairs, Science and Technology released the report *Out of the Shadows At Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Kirby & Keon, 2006). The authors of this report reviewed more than 2000 submissions related to mental health, mental illness and addiction across Canada, as well as held online and in-person consultations nationwide (Kirby & Keon, 2006). The findings of this report reaffirmed the need for establishing a Canadian Mental Health Commission in order to develop a national strategy for addressing the needs of mental health, mental illness, and addiction (Kirby & Keon, 2006). In 2007, Canada's Health Minister, the Honourable Tony Clements, sought an Advisor on Healthy Children and Youth in an effort to improve the health and wellness of Canada's children and youth (Leitch, 2007). In response, the report *Reaching for the Top: A Report by the Advisor on Healthy Children and Youth* (Leitch, 2007) was produced and identified three key issues impacting the health of Canadian children and youth: "injury prevention and safety, obesity and healthy lifestyles, and mental health and chronic illness" (Leitch, 2007, p. 16). Through round table consultations with over 750 groups and individuals nation-wide, as well as a review of over 500 written documents and reports, and the consolidation of the results of an online quantitative survey used for public consultation completed by 7,270 individuals (Leitch, 2007), Dr. Kellie Leitch identified Canada as ranking 21st out of 29 OECD nations in child well being, including mental health (Leitch, 2007). The report provided recommendations related to existing federal government programs, the need for new policy directions and programs, and the suggestion for a concept of establishing an office for the health and wellness of children and youth.

In 2007, the Government of Canada announced funding for the development of the Mental Health Commission of Canada "to act as a catalyst to improve the mental health system in Canada, develop a mental health strategy for Canada, reduce stigma and discrimination faced by people

living with mental illness and mental health problems and create a knowledge exchange centre" (Woodman, K., Damberger, L., Wanke, M., Brower, K., Deroche, F., & Shuller, T., 2011, p. i). In one faucet of its work, in 2009 the Mental Health Commission of Canada established a School-Based Mental Health Consortium to synthesize literature and conduct an assessment of the state of mental health and addiction service delivery in Canadian schools with a view towards making national recommendations for best principles and practices.

Mental health has also been gaining much recent attention at the provincial level. In 2004, the Ontario Ministry of Children and Youth Services (MCYS) announced new funding for children and youth mental health services. Within this funding lay an expectation for the strategic development of a collaborative system to respond to the needs of children related to their mental health (Children's Mental Health Ontario [CMHO], 2002). The MCYS highlighted in this announcement that integrated service delivery systems, which had the capability to develop cross-sectoral relationships between education, children's mental health services, child welfare, and youth justice, were critical components for meeting the mental health needs of Ontario's children and youth (CMHO, 2002). In 2006, the Ontario government introduced *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (MCYS, 2006). This document outlines strategic goals and priority areas for the actions of government and community partners which will support meeting the mental health needs of children and youth while establishing a foundation for inter-ministerial and cross-sectoral collaboration and dialogue. Recognizing this vision, in 2011, the MCYS released *Open Minds, Healthy Minds* a 10-year comprehensive mental health and addiction strategy targeted to transform the mental health system. This strategic plan was developed in partnership with the MCYS, the Ontario Ministry of Education, and the Attorney General of Ontario, while also working closely with the Ministry of

Health and Long Term Care (MCYS, 2011).

In addition to the endeavors to develop integrated services and collaborative systems, the Ministry of Education in Ontario has also undertaken a variety of related new initiatives intended "to help schools build a culture of caring and address issues of safety and inappropriate behaviour in schools" (Ontario Ministry of Education, 2010a, p. 5). One of these initiatives was introduced by the Ontario Government in 2009 as *Realizing the Promise of Diversity: Equity and Inclusive Education Strategy*, which stated, "We need to strive to achieve a truly equitable and publicly funded education system, in keeping with our values of human rights and social justice" (Ontario Ministry of Education, 2009, p. 24). This statement provided the potential for a curriculum and practice, which would incorporate discussions and strategies focused on supporting mental wellness as an integral part of an equitable and inclusive curriculum.

On January 18, 2010 Kevin Costante, Deputy Minister of the Ontario Ministry of Education, introduced revisions to the *Ontario Health and Physical Education Curriculum* which incorporated components to strategically educate children about mental health (Ontario Ministry of Education, 2010b). The modifications related to incorporating mental health "focus on promoting and maintaining mental health, building an understanding of mental illness and reducing stigma and stereotypes" (Ontario Ministry of Education, 2010c, p. 33). Mandatory implementation of this revised curriculum was slated to take effect as of September 2010. In his memorandum, Mr. Costante states that, "The revised health and physical education curriculum aligns with other existing and newly released government policies and documents such as *Ontario's Equity and Inclusive Education Strategy* and the *Foundations for a Healthy School Framework"* (Ontario Ministry of Education, 2010b, p. 2).

The Ontario Ministry of Education defines *inclusive education* as; "education that is based

on principles of acceptance and inclusion of all students. Students see themselves reflected in their curriculum, their physical surroundings and the broader environment in which diversity is honoured and all individuals are respected" (Ontario Ministry of Education, 2009, p. 4). This study aims to assess whether the Ministry of Education's discourse of mental health being taught and modeled for elementary school children in the revised *Health and Physical Education Curriculum* (2010), aligns with the policies that frame inclusive education as identified in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010).

CDA methodology is best suited for this study as it seeks to achieve a thorough analysis of the dominant discourses entrenched in policy documents while allowing for a variety of approaches and theoretical frameworks in its execution (van Dijk, 1998). Thus, this project will analyze provincial policy and curriculum documents regarding children's mental health and well being. This analysis is set with the theoretical framework of Bronfenbrenner's ecological theory (Bronfenbrenner, 1979). A comparative policy analysis is undertaken which critically deconstructs the implicit and explicit policy components that may represent underlying assumptions about children's mental health. It is hoped that light can be shed on any assumptions and contradictions regarding children's mental health in government policy documents and that the sharing of this information with policy makers, administrators, educators, and service delivery partners, will lead to increasing the mental health literacy of each party, and assist in building alignments within system initiatives that improve identification of and access to support for children's mental health (Health Canada, 2002). Such an analysis may benefit the Ontario

Ministry of Education in ensuring the development of its policies and practices as related to the incorporation and inclusion of children with challenges to their mental health are transparent and consistent with one another, so that each policy may reinforce similar messages to educators, children and families.

Research Questions

This study seeks to answer the following key questions: (1) How are children with challenges to their mental health represented in these policies? (2) How is mental illness characterized explicitly and implicitly in these policies? (3) How are stigma and stereotypes influenced through these policies? In order to inform the study, the literature review will explore the following themes (1) mental health prevalence and influence on children's development, (2) dominant challenges to children's mental health, (3) factors which influence children's mental health, (4) the influence of stigma on children's mental health, (5) the impact of children's mental health on families, (6) educator perspectives related to mental health, and (7) understanding and including mental health in elementary schools.

Chapter 2

Literature Review

This section outlines the relevant foundational context and concerns related to children experiencing challenges in their mental health, and the inclusion of mental health in elementary school settings.

1. Mental health prevalence and influence on children's development from infancy through adolescence.

Challenges to mental health such as depression, anxiety, emotional, and behavioural difficulties are increasing in school-aged children (Knitzer, Steinberg, & Fleisch, 1990; Lowenhoff, 2004; Wadell, Hua, Garland, Peters, McEwan, 2007; Weinburg 1998). Research indicates that approximately 20% of children in Ontario have a mental health disorder, which causes significant distress and impairs their functions at home, school, with peers, and in the community (Health Canada, 2002; Offord, Boyle, Szatmari, Rae-Grant, Links, Cadman, Byles, Crawford, Munroe Blum, Thomas, & Woodward, 1987; Santor, Short and Ferguson, 2009; Wadell et al., 2007). This prevalence has been demonstrated to be significantly higher for Aboriginal children and youth (Kirby & Keon, 2006). In addition, approximately 40-50% of children with mental health challenges have more than one disorder at the same time (National Institute of Mental Health, 2010; Rae-Grant, Thomas, Offord, & Boyle, 1989). According to Children's Mental Health Ontario (2002), "early childhood mental health services can benefit families and communities by supporting healthy child development and positive parent/child interactions" (p. 18). However, in Canada, only 1 in 5 children who require mental health services are currently receiving them (Leitch, 2007). The Mental Health Commission of Canada has described the condition of child and youth mental health services as the most neglected piece of the Canadian health care system (Eggerton, 2005).

Research continues to highlight how early serious mental health challenges may arise (Giaconia, 1994; Offord et al., 1987). Difficulties with mental health have been shown to begin as young as infancy, though explicit predictions of onset times vary according to gender, age, and particular challenge (Giaconia, 1994). Children's Mental Health Ontario (2004) states that "statistics indicative of ill mental health increase with age and that challenges are best dealt with early, before they become entrenched and the spiral of school problems and antisocial relationships is established" (p. 4). Early onset of one disorder is associated with continued impairments in behavioural and emotional functioning in late adolescence and greatly increases the risk of being diagnosed with one or more *other* disorders by the time the child reaches 18 years of age (CMHO, 2002; Giaconia, 1994).

The prevalence of mental health challenges among children suggests that early indicators of poor mental health are of notable developmental significance in recognizing and preventing the continuing patterns of mental illness which may become detrimental and potentially fatal. Poor academic achievement, substance abuse, school leaving, conflict with the law, inability to live independently or hold a job, health problems, and suicide are all prospective consequences of mental health challenges in children which affect not only the children themselves, but families, schools, communities, and the province as a whole (Ebrahim, 2011; Health Canada, 2002). In 1987, Offord et al indicated that mental health problems were continuing to grow among children and youth, and were predicted to increase by over 50% internationally by the year 2020, to become one of the five most common causes of morbidity, mortality, and disability among children. The World Health Organization (2003) further indicates that challenges to mental health continue to be on the rise, and states that four of the six leading causes of years lived with disability are due to neuropsychiatric disorders such as depression, alcohol-use disorders, schizophrenia and bipolar

disorder (p. 4). The World Health Organization (2003) contextualizes mental functioning as it relates to morbidity and mortality:

> It is becoming increasingly clear that mental functioning is fundamentally interconnected with physical and social functioning and health outcomes. For example, depression is a risk factor for cancer and heart diseases. And mental disorders such as depression, anxiety and substance use disorders in patients who also suffer from physical disorders may result in poor compliance and failure to adhere to their treatment schedules. Furthermore, a number of behaviours such as smoking and sexual activities have been linked to the development of physical disorders such as carcinoma and HIV/AIDS (World Health Organization, 2003, p.9).

Suicide is a significant issue relating to children within this population. Though suicidal behaviour in itself is not a mental illness, it is highly co-related with mental illness (Health Canada, 2002) and therefore should be given consideration. Coulman (2003) noted that, "the overall rate of suicide in the very young more than doubled between 1980 and 1993 – and the younger the children, the more dramatic the increase [in these rates]" (p.1). Statistics Canada (2010) laid truth to these claims and predictions by listing suicide as the second leading cause of death in Canadian children in both the 10 – 14 and 15 – 19 year-old categories, with an increase of over 53% in 10 – 14 year-old children between 2003 and 2005. In Canadian Inuit and First Nations populations, suicide is the leading cause of death for youth up to 24 years of age, accounting for 83% of all Inuit youth deaths (Leitch, 2007).

2. Dominant challenges to children's mental health.

In Ontario**,** mental illness may be diagnosed following an assessment by a registered medical doctor, psychiatrist, or psychologist (CMHO, 2002). According to the American Psychiatric Association (2011), the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is "the standard classification of mental disorders used by mental health professionals" (p. 1). Increasingly, elementary school children (kindergarten to Grade 6) are being diagnosed with mental illness (Coulman, 2003). The Ontario Ministry of Children and Youth Services (2006) states that "in Ontario approximately 467,000 to 654,000 children and youth have at least one diagnosable mental health disorder that causes significant distress and impaired functioning at home, at school, with peers or in the community" (MCYS, 2006, p. 2). Mental health disorders are comprised of distinguishing variety of features and characteristics, and the impact of each of these disorders on children range from mild to severe (Canadian Mental Health Association, 2002; Public Health Agency of Canada, 2002). Children's struggles with mental health are commonly divided into externalizing and internalizing challenges (O'Connor, Dearing, & Collins, 2011). Externalizing challenges are characterized by behavioural disinhibition, over activity, impulsivity, and aggressive behaviours (King, Iacono, & McGue, 2004; O'Connor et al, 2011). Children experiencing externalizing challenges tend to be less engaged in school and do less well academically (Barriga et al., 2002, as cited in O'Connor et al., 2011). Internalizing challenges are characterized by depressive mood states, social withdrawal, and inhibition (King et al., 2004; O'Connor et al, 2011). Children with internalizing challenges tend to exhibit academic underachievement and deficient problem solving skills (Kovacs & Devlin, 1998, as cited in O'Connor et al, 2011).

Though there are a variety of mental health disorders which impact children, this research study has utilized the content of the literature review to identify and incorporate a characterization of some of the most prevalent challenges to mental health in young children (CMHO, 2002; Wadell et. al, 2007), so that the analysis of the policy documents may be contextualized in relation to concerns associated with children's mental health that are identified in current literature. It is important to recognize that this is not a conclusive list and there are other challenges to children's mental health which, though not as common, bear recognition in future research. In addition, it is also critical to remain aware of the substantial amount of literature which indicates dramatic rates of overlap and co-morbidity among children with challenges to their mental health, which increase the complexity of identifying and managing these disorders (CMHO, 2002; Maughan et al., 2004; Bell, 2006, Frick & Dickens, 2006; Sokolova, 2003).

2.1 Aggressive behaviour disorders.

2.1.1 *Conduct disorder (CD).*

"Conduct disorder is a psychiatric syndrome occurring in childhood and adolescence, and is characterized by a longstanding pattern of violations of rules and antisocial behavior" (Russell-Searight, Rottnek, & Abby, 2001, p. 1). Children with conduct disorder portray a range of severe, anti-social behaviours, which may exhibit either aggressive or non-aggressive attributes (Frick & Dickens, 2006; Maughan, Rowe, Goodman, & Meltzer, 2004). Often the behaviour is characterized by a lack of awareness and adherence to social expectations and rules, with a tendency to overestimate their abilities, disrespect towards others, and a desire to dominate others (Mack, 2004; Maughan et al., 2004). Children with CD are incredibly disorganized in their daily living skills and show preference towards unpredictable situations in their lives (Holcomb and

Kashani, 1991, as cited by Mack, 2004). Many children who exhibit signs of CD have experienced attributes which are categorized as risk factors in developing challenges with mental health (CMHO, 2002; Mack, 2004). Conduct disorder (both aggressive and non-aggressive) occurs in an estimated 6% to 10% of boys and 2% to 9% of girls (Fornarotto & O'Connell, 2002 as cited by Bell, 2006) and has been identified as being well established by the age of ten, and the predominance increases steadily with age (Maughan et al., 2004). In fact, there is consistent documentation which indicates that some children begin showing mild conduct problems as early as preschool or early elementary school (Frick & Dickens, 2006). Often children with CD grow to experience other psychiatric problems as adults. (Holcomb and Kashani, 1991, as cited by Mack, 2004; Frick & Dickens, 2006). Children who experience CD have been shown to frequently be rejected by their peers and have an increased probability of dropping out of school early (Frick & Dickens, 2006).

2.1.2 *Oppositional defiant disorder (ODD).*

"Oppositional defiant disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., as a recurrent pattern of developmentally inappropriate, negativistic, defiant, and disobedient behavior toward authority figures" (Sutton-Hamilton & Armando, 2008, p. 1). Fornarotto & O'Connell (2002) cited in Bell (2006) estimate 2% to 16% of children are affected by oppositional defiant disorder. ODD is distinguished by "a recurrent pattern of developmentally inappropriate levels of negativistic, defiant, disobedient, and hostile behavior toward authority figures" (Sutton-Hamilton & Armando, 2008, p. 1). Sutton-Hamilton & Armando (2008) also state that "children with oppositional defiant disorder have substantially impaired relationships with parents, teachers, and peers" (p. 1). According to the DSM IV (2000), the diagnostic criteria for ODD includes the presence of four or more of the following

symptoms within the past six months;

Often loses temper

Often argues with adults

Often actively defies or refuses to comply with adults' requests or rules

Often deliberately annoys people

Often blames others for his or her mistakes or misbehaviour

Is often touchy or easily annoyed by others

Is often angry and resentful

Is often spiteful or vindictive (p. 94)

A diagnosis of ODD represents a persistent pattern of behavioural challenges that cannot be attributed to the child's developmental stage and that damages a child's functioning (CMHO, 2002). Evidence for gender differences in the prevalence of ODD has been shown to be inconsistent (Maughan et al., 2004), however in the research conducted by Maughan et al. (2004) ODD was found to be significantly more prominent in boys than girls.

2.2 Anxiety disorders.

Though moderate levels of anxiety are adaptive and are experienced by most children as they develop (CMHO, 2002), an anxiety disorder is characterized by excessive and developmentally inappropriate levels of fear, apprehension or angst as well as anxiety-based distortions of behaviour (Coon, 2000; Kerr and Nelson, 2006). According to epidemiological studies, anxiety disorders are the most common type of mental health problems in children (Rockhill, Kodish, DiBattisto, Macias, Varley, & Ryan, 2010), and are present in 6 to 18% of the child population (Castellanos & Hunter, 1999). Though there may be multiple origins for anxiety disorders including a child's genetic make up (Public Health Agency of Canada, 2002), home and

school environments may each also contribute to the manifestation of this disorder (Link-Egger et al., 2003). Children are impacted by several types of anxiety disorders, each of which has separate, specific criteria for diagnosis (Rockhill, et al., 2010). The categories of childhood anxiety disorders include: social anxiety disorder, post-traumatic stress disorder, panic disorder - with or without agoraphobia, obsessive-compulsive disorder, specific phobia, generalized anxiety disorder, and separation anxiety (Anxiety Disorder Association of Canada, 2007; Coon, 2000; Kerr and Nelson, 2006). Clinical levels of anxiety have been shown to impact behaviour, thoughts, emotions and physical health (Canadian Mental Health Association, 2011). When a child's anxiety levels are elevated, there is a heightened state of physiological arousal which restricts the child's focus and impairs his or her concentration on academic tasks and the recall ability of previously learned knowledge (Wood, 2006). Research shows that children who are faced with anxiety disorders are at higher risk to perform poorly in school and in social functioning (Wood, 2006). Clinical anxiety also contributes to increased prevalence of school refusal and truancy (Link-Egger et al., 2003). Though anxiety disorders can be effectively treated (Coon, 2000; Kerr and Nelson, 2006), many individuals may minimize their anxiety and/or ignore the seriousness of their condition due to a fear of how they may be perceived by others and therefore not seek or receive intervention (Public Health Agency of Canada, 2002).

2.3 Attention Deficit Hyperactivity Disorder (ADHD).

DSM-IV-TR criteria for attention deficit hyperactive disorder distinguish between three basic types of Attention Deficit Hyperactivity Disorder: predominate inattentive type (ADHD-I); predominately hyperactive-impulsive type (ADHD-H); and combined type (ADHD-C) (American Psychiatric Association, 2000). Children with ADHD demonstrate developmentally inappropriate degrees of attention, impulse control, and physical restlessness (CMHO, 2002).

ADHD is diagnosed in up to 16% of school-aged children (Sciutto, Nolfi and Bluhm, 2004). ADHD is diagnosed 2 – 4 times more frequently among male children than female; however research indicates that this inconsistency in prevalence may in part be a result of subjective bias of the referring teachers (Sciutto, Nolfi, & Bluhm, 2004). Children with ADHD often exhibit behavioural challenges such as oppositional behaviour and aggression (Greene et al., 2002). In addition, teachers report a significantly greater level of stress in their interactions with students with ADHD as compared to their classmates without ADHD (Greene et al., 2002). The classroom environment can either intensify or diminish the struggles in self-regulation, social functioning, and rule-governed behavior of students with ADHD (Greene et al., 2002). A meaningful percentage of children with ADHD also demonstrate evidence of severe social impairment (Carlson, Lahey, Frame, Walker, & Hynd, 1987; Greene et al., 1996; Greene, Biederman, Faraone, et al., 2001), and these social difficulties are predictive of the adverse long-term outcomes often seen in youth with the disorder (Greene, Biederman, Faraone, Sienna, & Garcia-Jetton, 1997).

2.4 Childhood depression.

Though depressive disorders are estimated to occur in approximately 2 – 4% of children (CMHO, 2002), the qualities which characterize childhood depression are not as sharply defined in children under 7 than in older children and adults (CMHO, 2002). Unlike adults who are experiencing depression, children are often irritable rather than sad or withdrawn (Sokolova, 2003). Childhood depression can be characterized by attributes which are associated with differences in mood, such as sadness, low self-esteem, worthlessness and suicidal ideations (CMHO, 2002). Other characteristics include lack of interest in previously enjoyed activities, self criticizing, pessimism, lack of energy, difficulty at school, difficulty sleeping, and potentially

physical symptoms such as stomach aches and headaches (Hazell, 2003). In addition, depressed children may also demonstrate aggressive behaviour towards other children and defiance towards adults (CMHO, 2002). Evidence for gender differences in the identification of childhood depression indicates that there appears to be no difference between the prevalence in female vs. male children (CMHO, 2002). Over 10% of both boys and girls experience clinical levels of depression between the ages of 4 – 11 years of age (Kirby, 2007).

3. Factors which influence children's mental health.

3.1 *Risk factors.*

Research indicates that mental illness is the result of a complex interaction of genetic, biological, personality, and environmental factors (Health Canada, 2002). Children's Mental Health Ontario (2002) categorizes characteristics of a child and the child's family and community environment which are associated with negative child development outcomes as risk factors (CMHO, 2002). Attributes such as stress, poverty, poor quality attachment, challenges with parental mental health, limited parenting skills, alcohol and drug abuse, prematurity, and low birth weight contribute to detrimental effects on early brain development and children's mental health (CMHO, 2002; Mack, 2004; Mustard and McCain, 1999; Rutter, 1985). There is also substantial evidence to suggest that financial and/or emotional stress may affect parenting behaviours, which in turn affects the mental health of their children (Knitzer et al., 2007). Despite the potential for negative influence on children's mental health as a result of exposure to risk factors, research indicates that these dynamics do not cause poor outcomes, but rather increase the possibility for them to occur (CMHO, 2002; Rutter, 1985). By addressing the psychological and social determinants of mental health there is the potential to promote a positive mental health and prevent mental illness (Health Canada, 2002). The determination of causal aspects of mental illness and

challenges to mental health cannot be adequately explained when focus is placed on single risk factors or single domains of risk factors (Fricker & Dickens, 2006). Concentration instead should be placed on considering how these risk factors disrupt the normal developmental trajectory of the child (Fricker & Dickens, 2006).

3.2 *Protective factors.*

There is strong evidence to support that many children are able to overcome life's challenges (Garmezy, 1991). Some children seem to circumvent risks to their mental health through exhibiting resiliency when faced with challenges and risk factors in the environment (Garmezy, 1991; Rutter, 1985). Resilience is thought to be encouraged through exposure of the child to protective factors in themselves, their family and environment (CMHO, 2002; Garmezy, 1991; Rutter, 1985). Rutter (1985) defines protective factors as "influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome" (p.600). In addition to reducing risk factors, cultivating personal and familial strengths, strengthening support and understanding in school and community environments, can assist in developing protective factors for children, which can influence positive outcomes and are associated with resistance to psychiatric disorders (CMHO, 2002; Mack, 2004; Rutter, 1985). Advances in biological and neuropsychological research have found that neither behaviour nor developmental potential are fixed by genetic factors or limited by strict critical periods (CMHO, 2002). Furthermore, researchers have underscored the ability for mental health promotion and prevention activities to enhance the development and well being of children from all social classes and cultural groups (CMHO, 2002).

4. The influence of stigma on children's mental health

The prevalence of mental health challenges in children indicates that most children will have

had direct exposure to a mentally ill peer and will have encountered the dominant cultural attitudes and prejudices related to such conditions. There is a stigma associated with challenges to mental health that stems from a lack of knowledge and empathy, superstition, and a tendency to fear and exclude people who are different (Health Canada, 2002). The Centre for Addiction and Mental Health (2009) identify stigma as "any attribute, trait or disorder that causes a person to be labeled as unacceptably different from normal people" (p. 1). In 2001, the World Health Organization declared stigma related to mental health to be the "single most important barrier to overcome in the community" (Canadian Mental Health Association, n.d., p. 1). The stigma attached to mental illnesses imparts a serious obstruction to both the diagnosis and treatment as well as to acceptance of the child in the community (Health Canada, 2002). Research indicates that often children will disregard mental health care despite recognizing a need for mental health services (Elliott & Larson, 2004). In a study conducted by Simon Davidson and Ian Manion of the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario (1996) approximately 63% of youth indicated that embarrassment, fear, peer pressure, and/or stigma are major barriers to seeking help for mental health problems. Cultural differences also may play a role in producing barriers to accessing mental health services. Ebrahim (2011) states that "Immigrant families may shy away from mental health services due to cultural values around mental health, mistrust with mental health practitioners, and fears of disclosing confidential personal information" (p. 12).

The portrayal of mental illness in the media has been widely researched and been found to be overwhelmingly negative and linked to the adult perception and negative attitudes about mental illness (Lawson and Fouts, 2004). Opportunities to rectify these misconstrued perceptions can take place in the day-to-day interactions and discussions in the school setting. Educating children

about mental health may have a significant impact towards reducing the stigma for the 20% of children who suffer from mental illness (Kirby & Keon, 2006). Recognizing and addressing normalization of mental health challenges through a universal, population approach for children may have long term benefits to intervention attempts:

> Research suggests that many mental health problems and disorders in children might be prevented or ameliorated with prevention, early detection and intervention. Overall, prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial and cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention [...] early intervention efforts can improve school readiness, health status, and academic achievement and reduce the need for grade retention, special education services, and welfare dependency. (National Institute for Healthcare Management Research and Education Foundation, 2005, p. 3).

The report *Out of the Shadows at Last* (Kirby & Keon, 2006), identifies the school setting as the optimal, yet most under developed site for identifying and providing services to children who are at risk or who suffer from mental illness. The development and implementation of policies which address discrimination towards individuals who experience challenges to their mental health will encourage greater acceptance and understanding of mental illness and provide an incentive for change (Health Canada, 2002). Acknowledging that mental health can be effectively treated puts pressure on the school system to remove the stigma and reduce stereotypes so that support is accessed more frequently by children and families. Dispelling the myths and stigma associated with mental illness requires community education (Health Canada, 2002). This

can begin by weaving discussions about emotions, resiliency, mental illness, stress, etc. into the daily school curriculum; "By providing accurate information and opening up dialogue between students and people who have experienced mental illness, the program helps correct misconceptions and provides insight into living with a mental illness" (Centre for Addiction and Mental Health, 2009, p. 1). Through this technique, educators will be assisting in reducing the stigma associated with mental health through promoting acceptance and supporting children at an early age to recognize that challenges with mental health are common.

5. The impact of mental illness on families.

Research has recognized the overwhelming impact of mental illness on families as it relates to family/caregiver burden, feelings of grief, loss, guilt and economic burden, social isolation and stigma (Ebrahim, 2011 citing Maurin & Boyd, 1990; Health Canada, 2002; Pejlert, 2001). The profound demands on the caregivers of individuals dealing with challenges to their mental health may lead to caregiver burnout (Health Canada, 2002). The family environment is thought to be a major influence in the overall development of children's behavior, both from a positive and negative perspective (Wicks-Nelson & Israel, 1997, as cited by Mack, 2004). Parents and family members may be blamed and stigmatized for raising a child with challenges in mental health (Ebrahim, 2011). In addition, Kinsella & Anderson (1996) note that, "Family conflict, financial problems, marital discord, social isolation, stigma, and lack of support - all common to families with mental illness - have been found to influence an already at risk child's potential for pathology" (p. 24).

Though there has been considerable research done on the impact of mental illness on families, most investigations have specifically focused on the effects on parents and spouses (Bank

and Kahn, 2004; Lobato, Faust and Spirito, 1988). Sibling relationships exist throughout the life cycle, and yet they are typically excluded in the literature resulting in minimal documentation on the effects mental illness has on siblings as well as the key aspects for ensuring effective supports for these family members (Friedrich et al., 2008; Gerace, Camillieri, & Ayres, 1993; Lobato et al., 1988). Beyond biological composition, and the commonly identified familial variables, the dyads found in sibling relationships, their function, power, and influence may present a prevailing domination within the relationship (Gerace et al., 1993; Stalberg et al., 2004). However, the current research of family interaction, which primarily focuses on the influence of the parents on the psychosocial development of their children, dramatically underrates the influence and importance of relationships among the siblings themselves (Bank and Kahn, 2004). The disregard of these relationships may present a substantial gap in the significance of developing systemic supports to address these family issues which may be beneficial in ongoing treatment and assistance.

6. Educator perspectives related to children's mental health.

Teachers face many challenges around classroom management and teaching practices (Achinstein and Barrett, 2004). Though the majority of teachers are committed to mental health education, many teachers are in disagreement with the expectation of balancing teaching and providing mental health support to students, indicating that regardless of pre-service or in-service training, their position is a teaching role and not a welfare role, and they believe the two to be mutually exclusive (Graham, Phelps, Maddison, & Fitzgerald, 2011). Though there is a recognition that mental health challenges arise in the everyday context of teaching, there is also a heavy dependence on outside experts to assist with addressing these challenges (Graham et al., 2011).

The difficult behaviours of children are often demonstrated as a symptom of struggles with mental health. Children with challenges to their mental health add an immense strain to resources, and educators who experience a disparity in supports may quickly become frustrated with children exhibiting externalizing behaviours and potentially engage in power struggles or other counter-productive behaviours (Mack, 2004). As a result, students with emotional disorders have been rated as significantly more stressful to teach compared to their classmates with other challenges (Greene et al, 2002; Gunter et al, 2002). In Ontario, teachers have ranked mental health problems as a key issue of concern and acknowledge that the current approaches in the school environment regarding mental health are not managing these challenges systematically and effectively (Santor et al., 2009). Research conducted by Nelson, Maculan, Roberts, & Ohlund (as cited by Graham et al., 2011) indicates that teachers often feel poorly equipped or reluctant to consider emotional health in their practice. This perception may lead to occupational stress manifesting in job dissatisfaction and attrition (Graham et al., 2011). In the study conducted by Graham et al. (2011) it is stated that;

> Many teachers expressed an urgency and frustration in their need for additional support, including the need for more training, school counselors, time, funding, resources, coordinated approaches between all services, parental involvement, and better processes to help with student mental health problems. Teachers highlighted that they needed training to recognize the signs and symptoms of mental health problems and that they were just expected to cope and find resources in the community. (Graham et al., 2011, p. 489)

Irving Rootman and Deborah Gordon-El-Bihbety define *health literacy* as "the ability to access, understand, evaluate, and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course" (as cited by Ontario Ministry of Education,

2010c, p. 4). Teachers' mental health literacy is critical in shaping their ability to strengthen their awareness and respond appropriately to children with mental health challenges (Graham et al., 2011; Kutcher and Short, 2010). The oppositional and aggressive behaviours often associated with mental health difficulties are known to adversely affect the manner in which students are perceived by their teachers (Bell, 2006; Greene et. al, 2002). Despite the additional pressure these children present, the attitude with which teachers approach interactions with these children is critical, as teachers are important role models for students (Gunter and Coutinho, 1996; Ontario Ministry of Education, 2010). High quality teacher-child relationships are vital influences to children's socio-emotional and behavioural development (Graham et al., 2010; O'Connor, 2010), however, teachers' pre-service training is primarily focused on content delivery and skill, rather than the interpersonal aspects of the teaching profession which are required such as empathy and communication (Graham et al., 2011). It may be difficult for teachers to understand and role model acceptance for children struggling with mental health or mental illness if they receive no base training in understanding formal mental health issues as a part of their own educational curriculum (Canadian Mental Health Association, 2010; Graham et al., 2011). Bell (2006) states that in her clinical experience, "when students who present with a behavior problem are sent for assessment, teachers typically are hostile; they react to how the student's behavior is affecting them and not to the fact that these children are presenting with a mental disorder" (p. 1). Enhancing the mental health literacy of educators will support providing teachers with the knowledge and strategies required so that they may relate to the functions of children's behaviour in a manner which models awareness, acceptance and understanding for all children (Canadian Mental Health Association, 2010).

Children with challenges to their mental health require understanding related to the factors that comprise their diagnosis so that those who work with them will be better equipped (Graham et al., 2011; Mack, 2004). Bell (2006) observes that "literature on children with disruptive-behavior disorders shows a remarkable gap between research on childhood psychiatric disorders and teachers' accurate knowledge and implementation of effective strategies" (p. 14). This may subsequently have an effect on future responses to the child by their peers and educators: "Teachers' ratings of children are critically important for the child's reputation in the school and among future teachers, as well as to parents and medical professionals, even if there is some slippage from the objective 'truth' about a child's mental health" (Milkie and Warner 2008, p. 13). Vygotsky's theory of social constructivism (1978) conceptualizes development as intertwined with social context and dependant on interactions with people and the tools that the culture provides to help form their own view of the world. This theory suggests that children may learn acceptance of others by watching the manner in which teachers interact with those who are exhibiting symptoms which indicate challenges in their mental well being. Bell (2006) states "Teachers may inadvertently contribute to social structures that encourage defiant, aggressive, or bullying behavior, either through ineffective disciplinary procedures or through lack of awareness of social hierarchies that exist in class" (p. 21). In addition, the subjective interpretation relating to the functions of children's behaviour may inappropriately influence the manner in which mental health may be addressed. "Adults often interpret behaviour from the perspective of their own life experiences and current circumstances. These perspectives affect the observer's expectations for the student" (Ontario Ministry of Education, 2010a, p. 21). For example, if students with emotional disorders experience frustration as a result of difficulties with their work, it could contribute to a negative reinforcement paradigm between the child and teacher which becomes

non-instructional or even disruptive (Gunter and Coutinho, 1996). Understanding teacher attitudes and perceptions related to mental health is significant in order to promote timely assessment, diagnosis and effective treatment (Bell, 2006). In addition, providing training and education so that educators may improve early recognition of challenges related to children's mental health may be a critical component in creating a supportive environment for the individual (Health Canada, 2002).

Another area of consideration is the role that the teacher's own mental health may have on the influence of children's behaviour. If teachers themselves are experiencing increased levels of psychosocial stress, they may be encounter additional challenges in developing and maintaining positive learning environments and successful behaviour management (Li Grining, Cybele Raver, Champion, Sardin, Metzger, & Jones, 2010). These stressors may also restrict the ability or motivation for educators to participate in intervention techniques which are intended to assist them in developing effective behaviour management techniques in their classrooms.

7. Understanding and including mental health in elementary schools.

Researchers recognize that the foundation of mental health challenges begins in childhood (Giaconia, 1994; Gitterman, 2010; Offord et al., 1987) and argue they can be treated effectively (Health Canada, 2002), however there is a gap between the necessity for service and the resources available (CMHO, 2004). It is assumed within various child and youth service sectors, that children and youth mental health services are readily available and capable of addressing the needs within the children and youth service system (CMHO, 2004), however estimates indicate that approximately 75-80% of children do not receive specialized treatment (Gitterman, 2010; Leitch, 2007). According to Statistics Canada (2006), the population of Ontario's children is 3,977,005. In applying the prevalence rate of 1 in 5 children having a mental health disorder (Offord et al.,

1987; Santor et al., 2009; Wadell et al., 2007) this would mean that in Ontario, approximately 795,401 children have at least one diagnosable mental health condition. According to Children's Mental Health Ontario (2004), Children's Mental Health Centres have the capacity to serve approximately 140,000 children annually. This is a deficit of 655,401 children lacking service, which translates as merely 1 in 5 children who require the support actually receiving service.

In recognizing this gap, it is critical to acknowledge that society cannot be solely reliant on the health care system to meet the mental health needs of children. As there is a direct co-relation between mental health, academic success and early school leavers (Santor et. al., 2009), schools are a natural environment for children, and yet are the most under-used site for mental health service delivery in Canada (Kirby & Keon, 2006). Schools play a critical role in children's socialization and emotional development (Graham et al., 2011; O'Connor, E, 2010). Developing communities and policies which promote mental health and reduce stigma and discrimination will build a stronger foundation to develop healthy, resilient and inclusive communities (MCYS, 2011). By incorporating opportunities for students to develop their mental health literacy throughout the instructive curriculum, students are provided the educational foundation for understanding mental health and mental illness that may contribute to healthy, resilient and inclusive communities (Teen Mental Health, 2010). As part of this effort to address both the academic impacts of mental health challenges, and the service deficiencies in the children's mental health sector, expanding opportunities to improve the mental health literacy and awareness of educators, coupled with further development of protocols to better meet the mental health prevention and intervention needs of students will assist in closing critical service gaps for vulnerable children and youth by enhancing the capacity of schools to respond effectively and in a timely manner to early signs of mental illness (MCYS, 2011).

The United Nations Convention on the Rights of the Child (UNCRC) states, "Parties agree that the education of the child shall be directed to a) the development of the child's personality, talents and mental and physical abilities to their fullest potential" (as cited by Graham et al., 2011, p. 480). This promotes protection of children's rights through establishing a standard for inclusion in education. In the field of education, inclusion presents as having many interpretations and definitions, however the phrase generally imparts an expectation of an individual having active, meaningful and productive involvement in an environment which is best suited to their individual needs (Bennett, 2009). Research suggests that high quality teacher-child relationships are important contributors to the prevention of mental illness, as well as the inclusion, socio-emotional and behavioural development of children with challenges to their mental well-being, specifically as it relates to peer relations, behaviour challenges, classroom adjustment, and academic achievement (Maldonado-Carreno & Votruba-Drzal; 2011 O'Connor et al., 2011). Warm and responsive teacher-child relationships are distinguished in part by decreased anger and severity which is linked to children's greater academic achievement and social competence (Li Grining et. al., 2010; O'Connor, 2010).

Despite substantial research related to the prevalence and impact of challenges to the mental health of young children and the demands that this places on educators, the Ontario Ministry of Education does not currently provide a specific definition for mental health, which would identify or classify the child's mental health needs as an exceptionality requiring strategic inclusive teaching techniques and support. However, Legislation through the *Ontario Education Act* mandates equitable educational opportunities for all children:

> Some students have special needs that require supports beyond those ordinarily received in the school setting. In Ontario, students who have behavioural, communicational,

> intellectual, physical or multiple exceptionalities may have educational needs that cannot be met through regular instructional and assessment practices. These needs may be met through accommodations, and/or educational program that is modified above or below the age appropriate grade level expectations for a particular subject or course. Such students may be formally identified as exceptional pupils. (Ontario Ministry of Education, n.d)

Further exploration into the Ontario Ministry of Education definition of *behaviour* which satisfies the mandate for this categorization identified the following explanation:

> A learning disorder characterized by specific behaviour problems over such a period of time, and to such a marked degree, and of such a nature, as to adversely affect educational performance, and that may be accompanied by one or more of the following:
>
> a) an inability to build or to maintain interpersonal relationships;
>
> b) excessive fears or anxieties;
>
> c) a tendency to compulsive reaction;
>
> d) an inability to learn that cannot be traced to intellectual, sensory, or other health factors, or any combination thereof. (Ontario Ministry of Education, 2000, p. 32)

This classification of exceptionalities focuses on the symptoms of mental illness (ie – behaviour) receiving recognition and support, but does not account for the formal diagnosis or absence thereof related to mental illness itself. Mental health and substance abuse issues are of critical importance for school systems (Gitterman, 2010) and until recently have been underrepresented in the school system (Kirby & Keon, 2006). In an address at the Annual Children's Mental Health Ontario Conference, 2010, Aryeh Gitterman, Assistant Deputy Minister Policy Development and Program Design Division, Ontario Ministry of Children and Youth

Services stated that, “A paramount concern is that mental health disorders and difficulties are closely associated with declining academic performance and poor graduation rates.” (Gitterman, 2010, p. 2).

Teachers have the ability to deliver timely intervention for children who display early signs of challenges to mental health (O’Connor et al., 2010). Through integrating programs and interventions which develop high-quality teacher-child relationships, as well as training and information regarding the protective role that teachers play in reducing and preventing externalizing and internalizing challenges, educational settings will assist in the prevention of these children from contributing to maladaptive recursive cycles (O’Connor et al., 2010).

Chapter 3

Theoretical Framework

Few studies from the literature reviewed in this study explicitly identify the theoretical lens and conceptual framework which have been used in the research. In terms of theoretical assumptions, the reviewed literature primarily seems to address the issue of children’s mental health through an ecological theory lens which seeks to address children’s mental health as a systems issue. In developing and maintaining mental wellness, children experience a number of systemic barriers such as stigma and discrimination, economic disadvantage, and clinical support capacities which are disproportionate in meeting the demands. The theoretical framework which supports this research study is Uri Bronfenbrenner’s Ecological Systems Theory (1979).

There is vast evidence that children’s mental health is influenced not only through genetics, but through a wide variety of environmental influences. Ecological Systems Theory is grounded in recognizing that individuals develop within various nested, complex and comprehensive relationships between themselves and society in a broader context.

Bronfenbrenner (1979) identifies several environmental influences on development and categorizes these systems into four key classifications: micro-system, meso-system, exo-system, and macro-system. The micro-system is the most minute setting in which the individual lives. It includes, but is not limited to, aspects such as the immediate family, friends, and school. The biological make up of an individual also may be considered as a component of the micro-system.

In the meso-system, Bronfenbrenner explores the relationships and interactions between the micro-systems. For example, the impact of family experiences on educational experiences, such as parent-teacher relationships. The exo-system refers to connections between the micro-system and settings where the individual does not have an active role, however does actively experience the impact; such as the experience of challenges to a child's mental health being influenced by pre-service or in-service training for teachers related to understanding mental illness. The exo-system may also refer to the operational policies which frame the intervention such as the interpretation of behaviour guidance policies. The macro-system refers to the cultural context in which the individual resides, including socioeconomic status, ethnicity and political policies and their implementation.

It was not until several years after Bronfenbrenner identified the four systems in the Ecological Systems Theory that he revised the theory to include what he refers to as the chrono-system, which considers historic experiences as well as identifying the influence of environmental events and changes that occur throughout the life of the child (Dawes and Donald, 2004). The ongoing transitions evident in the chrono-system configure life events, and develop the child's perspective of historical experiences; expectations for future involvement and engagement have the potential to further complicate the effects of challenges on the mental health on children.

When there is disconnection of the interactions within Bronfenbrenner's (1979) meso-system, it can have a dramatic impact on the treatment of mental illness and the associated social construction of the illness by others. For example, when the views of families arise from different assumptions and end with different implications for action than do the views of the educators or clinicians (Gerace et al., 1993). With presumably little or no experience and knowledge of mental illness at the time of initial diagnosis, the family's approach to the illness and subsequent treatment may initially be greatly dependent on educators to provide factual information to understanding the illness, and encourage a collaborative approach to intervention. Another factor, which may be complicating the quality of the meso-system interactions between educators and the family, may be the constraints and interpretations within the exo-system, specifically regarding policies related to addressing symptoms and supports for mental illness in the school setting.

The normalization minimizing a need for supports for the odd behaviours related to a child experiencing challenges in their mental health by families may be considered a result of the interactions within the macro-system. In mainstream culture, the stigma of mental illness is widespread and reinforced continually through casual use of terminology being commonly accepted such as "It drives me crazy!" and "It is just psychotic!" Social media perpetuates the preconceptions and stereotyping of mental illness by sensationalizing distorted portrayals of characters in movies and television (Stout, Villegas, & Jennings, 2004). Throughout various media, the continual reinforcement of this stereotypical and inaccurate representation of mental illness will continue to foster incorrect perceptions and fuel the associated stigmas and fears: "Cultivation theory suggests that heavy exposure to consistent and recurrent messages on television will reiterate, conform and nourish values and shape perceptions of social reality to

conform to those presented on television" (Stout et al. citing Gerbner et al. 2002, p. 544). This may present barriers or biases when engaging parental or educator awareness of the child's needs regarding their mental health.

Research indicates that there are benefits to children in having structures that create strategic alignments in the coordination of policies, and the work of educators, family members, and children's mental health service delivery partners (CMHO, 2002, MCYS, 2006, Auditor General, 2008, MCYS, 2011). Only when considering all aspects of systemic involvement and the interconnected persuasions throughout each of these categorizations does the vast complexity of children's mental health become truly apparent. Recognizing the individual and integrated influences that various environmental systems have on the mental health of young children responds to the recurrent theme in the literature review for the need to broaden the understanding, awareness and strategies related to children's mental health at multiple levels within communities, organizations and governments.

Governments are often slow to embrace major, progressive innovations in social policy (Wharf & McKenzie, 2004) which is an element of the macro-system. This is reflected in the journey of children's mental health services in Ontario. In 1979, the responsibility for children's mental health was transferred from the Ministry of Health to the Ministry of Community and Social Services; however as various services for children and youth mental health remained situated in or governed by hospitals, the responsibility for service in these sites remained with the Ministry of Health. The outcome of this was the development of split influence and authority over children's mental health services (CMHO, 2004). Decades later, planning across ministries continued to be sporadic and ineffective, creating funding inequities and impeding the synchronization of referral and service delivery methodology (CMHO, 2004). Funding, which

was specifically targeted at creating collaborative mechanisms for managing the needs of children's mental health, was announced by the Ontario Ministry of Children and Youth Services in 2004. Following this, the Ontario Ministry of Children and Youth Services released *A Shared Responsibility: Ontario's Policy Framework for Children and Youth Mental Health* (2006) which formalized a framework and vision for child and youth mental health in Ontario. Implicitly embracing the values of Ecological Systems Theory, this policy framework set the stage for cross-sectoral community and government planning;

> This framework aims to foster collaboration amongst everyone who shares responsibility for the healthy development of Ontario's children and youth: communities, including families/caregivers and all child- and youth-serving providers and sectors (for example, health, education, child protection and well-being, youth justice, social services, recreation, heritage and culture), the adult mental health sector and all levels of government. (MCYS, 2006, p. 1.)

Until recently, there has been minimal Ministry direction regarding the services provided and the various child serving ministries have not collaboratively prioritized and integrated initiatives in order to effectively meet the mental health needs of children (Auditor General, 2008). *A Shared Responsibility: Ontario's Policy Framework for Children and Youth Mental Health* (2006) and *Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada* (2006) have been pivotal regarding recent systemic policy developments and recommendations for practice. It is with these developments and recommendations in mind that this study applies the Ecological Systems Theory when analyzing how the components of mental health in the *Health and Physical Education Curriculum* (2010) which are intended for delivery to children in educational settings relate to the policies which frame the inclusion of children

experiencing challenges with mental health in the school community.

Chapter 4

Methodology

This study uses a Critical Discourse Analysis (CDA) as its methodological approach. The focus of this analysis is to a) critically examine how children with challenges to their mental health are represented in the *Health and Physical Education Curriculum* (2010) and b) compare how this representation supports or contradicts the policies that frame the role modelling and culture of inclusion in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010). CDA offers researchers a means of investigating language use within social contexts (Henderson, 2005). As stated early on in this paper, this methodology is best suited for this study as it seeks to achieve a thorough analysis of the dominant discourses entrenched in policy documents while allowing for a variety of approaches and theoretical frameworks in its execution (van Dijk, 1998). Critical Discourse Analysis is strongly influenced by the work of Norman Fairclough, however van Dijk (1995) outlines concisely the criteria and intention of CDA. CDA:

1 Addresses an important social issue.

2 Takes a critical stance when addressing text and talk.

3 Is multi-disciplinary (in this research it will bridge the fields of Education, Social Services, Psychology, Sociology and Political Science).

4 Not only considers the semantics, word choices and grammar of communications, but

also how and when text is organized and presented.

5 Focuses on how relationships of power and dominance in society are created, maintained, and reproduced through text/talk.

6 Attempts to address underlying ideologies in text/talk.

7 Seeks to reveal what is "not immediately obvious in relations of discursively enacted dominance" (van Dijk, 1995, p.18)

Van Dijk (2003) states that "Critical Discourse Analysis (CDA) is a type of discourse analytical research that primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context" (p. 352). Fairclough approaches CDA with the fundamental belief that "language is an irreducible part of social life, dialectically interconnected with other elements of social life, so that social analysis and research always has to take account of language." (Fairclough, 2003, p.2).

For the purpose of this study, the analysis will focus on written language text, though remaining aware of two other aspects of analysis developed by Fairclough (1995) for use in the analysis of discourse; "analysis of discourse practice (processes of text production, distribution and consumption) and analysis of discursive events as instances of socio-cultural practice" (Fairclough, 1995, p. 2). CDA methodology encourages the researcher challenge unstated assumptions related to language through "questioning the taken for grantedness of language and enabling explorations of how texts represent the world in particular ways according to particular interests" (Henderson, 2005, p. 9). Fairclough (2001) states that "CDA provides opportunities to consider the relationships between discourse and society, between text and context, and between language and power (as cited by Henderson, 2005, p. 9). Through the use of CDA, the discourse patterns within the aforementioned policies will be examined in order to expose any implicit or

explicit biases or inequalities relating to the support and inclusion of children with challenges to their mental health.

Concerns associated with the early development of CDA methodology relate to the inherent subjectivity of authors (Sheyholislami, 2001). Challengers of this methodology reinforce this notion of subjectivity through highlighting differences between audience and analyst interpretations of discourse, as well as indicating the need to broaden the scope of the analysis to include both inter-textual and textual investigation (Sheyholislami, 2001). CDA acknowledges that there is a subjective component to any analysis, which is always partial, and based on the analyst's perception and understanding of the text (Fairclough, 2003), however, Fairclough (1995) acknowledges concerns about subjectivity through recognizing that the early development of CDA made assumptions in regards to the interpretive practices of audiences, and that interpretation of the text by the audience may differ from that of the analyst. In the field of scientific research, often investigation outcomes may be disregarded without an adequate level of objectivity. In order to address and reduce this concern, CDA has the goal of increasing "moral and political questions about contemporary society" (Fairclough, 2003, p.14). This underscores the importance for both researchers and consumers to be aware of this subjectivity of the analysis, as well as recognize and challenge the variety of assumptions, ideologies, and grammatical and semantic tools which are embedded in written text (Fairclough, 2003). Individuals should be encouraged to question the principles and beliefs entrenched in the information provided, and engage in critical dialogue, in order to examine whether or not the information reflects a reliable and comprehensive presentation of the content.

I will control for bias in my research by ensuring external validity (transferability) through the provision of detailed descriptions, policy quotes and coding of findings. The findings and

direct quotes from the policies will allow for increased objectivity through triangulation of themes or perspectives (Creswell, 2009). Lastly, objectivity will be promoted throughout the process by stating my own bias as a parent and a Children's Mental Health Consultant, as well as by describing my theoretical views.

Data Collection

This analysis will focus on four, uni-directional policy documents issued by the Ontario Ministry of Education; specifically, *Ontario Health and Physical Education Curriculum, Revised* (2010), *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010). By definition, *uni*-directional communication indicates that the receiver of the text cannot or does not typically directly respond to the author.

Data Analysis

Through the use of CDA, an in-depth, discursive analysis of the text within the four aforementioned policy documents will be examined in order to comparatively analyze the way in which the written language supports or contradicts a culture for role modeling, and inclusion regarding children's mental health. CDA will be applied to expose patterns of written form, such as the location of the text, grammar, and sentence structure, that may reinforce any explicit or implicit biases, or assumptions that may be made by the Ontario Ministry of Education, related to the social or educational practices which marginalize certain groups of people in responding to or addressing the mental health of children through these policies. Wood and Kroger (2000) identify three separate approaches to applying critical linguistics;

1. Social semiotics – for analyzing socially constructed processes
2. Socio-cultural change – the connection between linguistics and social deconstruction
3. Socio-cognitive studies – to reveal political hegemony (p. 206)

In order to increase objectivity and transparency in this research, the following listing is a guideline of the forms of critique which will be applied when reviewing the data.

Question	**Definition of terms**
Is *conversationalization** present?	***Conversationalization*** occurs when formal, public documents embrace speech that would be typical of everyday language. This technique breaks down the barrier between information and entertainment as well as public and private spheres. A concrete example would include colloquial vocabulary and idioms.
What *speech function* does the document primarily consist of? (i.e., demand, offer, question, statement)	***Speech function*** consists of demand, offer, question or statement.
Are statements *realis*, irrealis, or *evaluations*?	Statements are further categorized into: ***Realis*:** Statements that can be considered fact – what is, was, or has been the case (Fairclough, 2003, p.109). ***Irrealis:*** Statements that are hypothetical or predictive in nature (Fairclough, 2003, p.109). ***Evaluation***: Statements that possess implicit or explicit judgments based on value assumptions (Fairclough, 2003, p.215).
Is the text oriented to *strategic action* or *communicative action*? How?	***Strategic action:*** Speech functions that encourage people to act in ways which are oriented to achieving results (Fairclough, 2003, p.110) ***Communicative action:*** Action which is oriented to reaching understanding (Fairclough, 2003, p.110)
How is the text structured so as to *legitimize* dominant discourse(s)?	***Legitimization*** is "A widespread acknowledgement of the legitimacy of explanations and justifications for how things are and how things are done" (Fairclough, 2003, p.219)
Is there evidence of *nominalization*?	***Nominalization*** is defined as "A type of grammatical metaphor which represents processes as entities by transforming clauses (including verbs) into a type of noun…It is a resource for

	generalizing and abstracting which is indispensible in, for instance, science, but can also obfuscate agency and responsibility" (Fairclough, 2003, p.220)

Note. Descriptive note. Adapted from "A Matter of Choice: A Critical Discourse Analysis of ECEC Policy in Canada's 2006 Federal Election", by B. Richardson (2011).

As discussed in the finding section, four different discourses present within the policies are identified in this study: ***Recognizing and Valuing Diversity, Valuing Community and Family Partnerships, Actively Seeking to Create Conditions for Success,*** and ***the Role of Teachers and Administrators in Addressing and Responding to Children's Mental Health*.** Kozak (2009) states, "Discourse can be described as *language used to construct some aspect of reality from a particular perspective*" (Kozak, 2009, citing Chouliaraki and Fairclough, 1999, p. 31). In this study, it is recognized that though there were cross-sectoral, community forums, which collaboratively worked to develop the content of these policies, ultimately, the language utilized in the policy documents are influenced by the perspectives of the policy makers. Often there is a disconnect between the producer of the written text and the interpretation by the receiver (Kozak, 2009, citing Widdowson, 2007). In the context of this study, the former is the Ontario Ministry of Education, and the latter are the stakeholders (children, families, educators, administrators and community partners). "The disconnection between the intended policy function and its interpretation by stakeholders can occur if texts are constructed solely by the producer without input by the receiver(s); leaving a piece of writing susceptible to biased messages, assumptions, and omissions that oppress the receiving group of people" (Kozak, 2009, p. 26, citing Gall et al., 2005). The comparative analysis of the written text in the *Ontario Health and Physical Education Curriculum, Revised* (2010), *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special*

education needs through progressive discipline, kindergarten to grade 12 (2010), will provide the opportunity for identifying inconsistencies across the policy documents, which may in turn influence each policy interpretation and implementation.

Through the application of CDA, this researcher will engage in deconstructing the implicit and explicit policy components that may hold underlying assumptions which reinforce disparities in recognizing, supporting, and addressing children's mental health. As mentioned previously, this research thus seeks to provide information that may benefit the Ontario Ministry of Education in ensuring the development of its policies and practices related to the incorporation and inclusion of children's mental health are both transparent and consistent with one another, in order to ensure consistent messaging to educators, children and families.

Chapter 5

Synthesis and Analysis of Key Findings

The analysis of the *Ontario Health and Physical Education Curriculum* (2010), *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) identified a range of supports and potential barriers to representing and responding to children's mental health in the school system. The **speech function** in each of the four documents presents elements of both **strategic** and **communicative** actions. **Realis** statements found in the *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy, such as "According to Children's Mental Health Ontario (2002), one in five children and

youths in Ontario will struggle with his or her mental health"(p. 22), and "Positive mental health and emotional well-being are closely related to the development of psychological and emotional resilience" (p. 33) are advantageously utilized to orient the reader to the prevalence of mental health difficulties, and the significance of including mental health awareness and supports in policy documents. **Irrealis** statements such as "Equitable, inclusive education is also central to creating a cohesive society and a strong economy that will secure Ontario's future prosperity" (Ontario Ministry of Education, 2009, p. 5), and "The curriculum recognizes that the needs of learners are diverse, and helps all learners develop the knowledge, skills, and perspectives they need to be informed, productive, caring, responsible, healthy, and active citizens in their own communities and in the world" (Ontario Ministry of Education, 2010c, p.3) are strategically used to promote an economic value in the acceptance and implementation of these strategies, while also rationalizing the recommended strategic approach through implied confidence and regard for human capital to support the long-term economic effects of an educated population.

Many of the findings are complementary and distinguish essential components which are required for successful support, inclusion, and integration of mental health. However, there are also occasions where policy incoherence remains, resulting in key thematic elements of representation of mental health being excluded. The most prominent example of this can be found in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), in which the terms *mental health, mental illness, mental wellness,* and *mental well being* are not used at all. This policy document defines *equity* as "a condition or state of fair, inclusive, and respectful treatment of all people. Equity does not mean treating people the same without regard for individual differences" (Ontario Ministry of Education, 2009, p. 4), however by failing to pointedly define and/or identify any aspect of mental health as an inclusion and equity issue, this

policy does not pay recognition to the additional challenges in academic achievement and pro-social behaviour that an estimated 20% of the student population encounters. This perpetuates the potential for an ongoing stigma and negative characterization of children who struggle with their mental health, as the consumers of this document maintain ignorance about mental health challenges, and the associated attributes and characteristics which children may demonstrate in both the school setting and in their academic performance. Though the document goes on to highlight other key aspects that are essential for inclusion and equity, the absence of *mental health* is a critical omission for children and families representing this population, and the reader should be cognizant of the impact that this exclusion may have on the interpretation and implementation of inclusion and equity through this policy. In the following section, the policies are synthesized into four key findings, and accompanied by the critical discourse analysis of the text.

Key finding 1: Recognizing and valuing diversity.

The significance of recognizing and valuing diversity is embedded throughout three of the four policy frameworks with varying degrees of specificity. The one policy document which does not include the term *diversity*, nor directly acknowledges the diversity in families or in children's individuality, is *Ideas and Shared Practices: Foundations for a Healthy School* (2006). Consistent messaging in the other three documents employs **strategic action** and **evaluation statements** in order to promote an importance for recognizing and respecting the diverse needs of both adults and children as a social responsibility, in addition to encouraging respectful interactions between all adults and children. Examples of such statements include: "Whatever the specific ways in which the requirements outlined in the expectations are implemented in the

classroom, they must, wherever possible, be inclusive and reflect the diversity of the student population and the population of the province" (Ontario Ministry of Education, 2010c, p. 16), "A caring and safe school is a place where all partners – students, staff, parents, and community members – treat others fairly, with respect and kindness and act in a socially responsible way towards all members of the school community, including students with special education needs" (Ontario Ministry of Education, 2010a, p. 11), and "To achieve an equitable and inclusive school climate, school boards and schools will strive to ensure that all members of the school community feel safe, comfortable, and accepted. We want all staff and students to value diversity and to demonstrate respect for others and a commitment to establishing a just, caring society."(Ontario Ministry of Education, 2009, p. 10). *Realizing the Promise of Diversity:* Ontario's *Equity and Inclusive Education Strategy* (2009) uses a powerful **strategic action** statement to solidify the value it has placed on diversity; "Our schools should be places where students not only learn about diversity but experience it" (Ontario Ministry of Education, 2009, p. 15). The *Ontario Health and Physical Education Curriculum* (2010) and *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009) build upon the **strategic action** statements to pay specific attention for the need to identify and eliminate discriminatory biases which influence attitudes and beliefs towards the diverse population within both the school and provincial settings.

Although the term diversity is integrated within both the *Ontario Health and Physical Education Curriculum* (2010), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010), each of these policy documents neglects to provide a concrete definition which may be used as **communicative action** to establish specific contextualization for understanding and interpreting diversity in these policies. *Realizing the Promise of Diversity: Ontario's Equity and Inclusive*

Education Strategy (2009) defines diversity as "The presence of a wide range of human qualities and attributes within a group, organization, or society. The dimensions of diversity include, but are not limited to, ancestry, culture, ethnicity, gender, gender identity, language, physical and intellectual ability, race, religion, sex, sexual orientation, and socio-economic status" (Ontario Ministry of Education, 2009, p. 4) Utilizing this definition as the policy's' foundational interpretation of diversity, this policy document promotes the importance of respecting and valuing the full range of differences among Ontario's population, and uses an **evaluation** statement in order to identify diversity as one of the provinces greatest assets (Ontario Ministry of Education, 2009, p. 5). The policy further indicates a commitment to reducing achievement gaps and increasing student success, while using **realis** statements in order to highlight students who may be at risk of lower achievement due to diverse ecological or biological factors (Ontario Ministry of Education, 2009, p. 5).

Each of the four policies is encompasses a formal tone, and there is little evidence of incorporating the more relaxed, casual technique of **conversationalization** in conveying the key messages throughout these documents. The discussion of diversity represents an example where conversationalization may be implied, however there is a disconnect in the accessibility of language that is required for a shared understanding of its intent. By failing to include an operational definition for diversity, readers - who may not otherwise be exposed to the concept or intentional meaning of this term - are left without a framework for comprehension and interpretation of the intended perspective related to diversity in these documents. Therefore, although statements such as "Healthy relationships are based on respect, caring, empathy, trust, and dignity, and thrive in an environment in which diversity is honoured and accepted" (Ontario Ministry of Education,, 2010c, p. 55) appear to be using **conversationalization**, the absence of a

foundational conception of *diversity* precludes this.

Although there is attention paid to valuing diversity through each of these policies, children with mental health needs are not directly represented. Several opportunities for the introduction or acknowledgement of mental health as a topic related to diversity are present in discussions and examples of considerations for the range of diverse composition of children and families. By failing to include mental health in these discussions, as well as omitting diversity as an essential factor in *Ideas and Shared Practices: Foundations for a Healthy School* (2006), the policies neglect to characterize the complexity of mental illness and the challenges which may accompany mental health. Despite a commitment to reduce bias and stereotypes that negatively impact the educational experience of children and families (Ontario Ministry of Education, 2010c, Ontario Ministry of Education, 2009), the absence of mental health for consideration related to diverse factors which influence biases towards children and families demonstrates that it is not explicitly being considered by policy makers in the development of these policies, and may reinforce dominant cultural attitudes and prejudices related to mental health and mental illness.

Key Finding 2: Valuing Community and Family Partnerships

Each of the four policy documents incorporates discussions regarding establishing partnerships between schools, families and community. This discourse appears to be embedded in the ecological systems theory, by disbursing the accountability for the successful integration and potential impact of the policies beyond that of the educators and administrators of the school. **Strategic action** statements such as "To improve outcomes for students at risk, all partners must work to identify and remove barriers and must actively seek to create the conditions needed for student success" (Ontario Ministry of Education, 2009, p. 5) encourage every individual to act in a

manner that supports the ongoing incorporation and development of an environment which bolsters student achievements.

In the *Health and Physical Education Curriculum* (2010), the discourse of community and family partnerships is structured to legitimize the curriculum guideline and recommendations. Through statements such as "Learning is validated and reinforced when students see healthy practice in family and community role modeled in school policies" (Ontario Ministry of Education, 2010c, p. 6) the intention of the school policy is then **legitimized** as something that values the family and community learning opportunities first and foremost, and emphasizes that the curriculum is utilizing the school setting to build a conduit to reinforce these values for children. However, this message is contradicted through the way these partnerships are represented elsewhere in the policy. In this policy the representation of collaboration between parent and school is often uni-directional towards meeting the needs of the child in the school context. For example, the policy uses **communicative action** to explicitly outline the roles and responsibilities of students, parents, teachers, principals, and community partners in health and physical education. In this section, responsibilities of parents include gaining knowledge about the curriculum in order to enhance the parent's ability to "discuss children's work with them, to communicate with teachers, and ask relevant questions about their child's progress" (Ontario Ministry of Education, 2010c, p. 9). The policy also states "Effective ways in which parents can support their children's learning include the following: attending parent-teacher interviews, participating in parent workshops and school council activities (including becoming a school council member), and encouraging their children to practise at home and to complete their assignments" (Ontario Ministry of Education, 2010c, p. 10). The responsibility of the teacher reinforces this responsibility by stating; "As a part of good teaching practice, teachers should

inform parents about what their children are learning and when various topics are to be addressed. Such practices allow parents to work in partnership with the school, providing opportunities for discussion and follow-up at home and for reinforcing the student's learning in a family context." (Ontario Ministry of Education, 2010c, p. 10). The structure of responsibilities of both the parent and the teacher then contradict the notion of collaboration and bi-directional partnership, as there is not an explicit responsibility on behalf of the parent or the teacher to seek, support, or convey knowledge regarding the child in context at home. This uni-directional communication creates a power differential between home and school, as it does not pay equal recognition or value to the knowledge that families possess, which may in turn influence the development and implementation of the curriculum at the school.

Conversely, the relationship between the school and the community partners in the *Ontario Health and Physical Education Curriculum* (2010) explicitly identifies the knowledge and expertise that the community partner can provide, not only for the child, but for the school staff and families; "Community partnerships provide access to resources and services that can provide additional support to school staff, students, and families in the development and implementation of healthy school initiatives"(Ontario Ministry of Education, 2010c, p. 8). Through including school staff in the population that will benefit from access to resources and services, the power differential which is identified in the relationship between home and school, is reduced through acknowledging that the school staff may not always be the expert, and increasing the symmetry in the roles each may play in supporting each other to meet the needs of the child. The policy also offers suggestions for how the school can support the community partners needs, such as; "Schools may consider offering assistance with childcare, or making alternative scheduling arrangements in order to help caregivers participate" (Ontario Ministry of Education, 2010c, p. 57). Suggestions

such as this contribute towards building a collaborative partnership between the school, community, and parents, as it recognizes barriers that may be faced which limit parental and community involvement, and encourages schools to identify the role they may have in reducing these barriers.

The *Realizing the Promise of Diversity:* Ontario's *Equity and Inclusive Education Strategy* (2009), *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010), and *Ideas and Shared Practices: Foundations for a Healthy School* (2006) each approach parent and community partnership with enhanced attention to the bi-directional collaboration between parents, community partners, and schools. In *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), parent engagement and involvement are promoted in a manner which requires schools and school boards to elicit parental input and advice towards the ongoing development and enhancement of equitable and inclusive education (Ontario Ministry of Education, 2009, p. 20). This policy document also recognizes that there may be barriers to the development of meaningful parent and community involvement, and uses **strategic action** to commit to implementing "strategies to identify and remove discriminatory barriers that limit engagement by students, parents, and the community, so that diverse groups and the broader community have better board-level representation and greater access to board initiatives" (Ontario Ministry of Education, 2009, p. 21). Similarly, the *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy highlights the ongoing need to include parents, students, staff, and community members in order to reach a shared understanding related to values and beliefs which are essential to a caring and safe school, as well as to gain an accurate depiction of what is

working, and identify improvements, that are required or proposed, to address the 'gap' (Ontario Ministry of Education, 2010a, p. 14). This policy document identifies the educational system and school leaders as those who establish the tenor of the school environment. Though the policy indicates the intention of the document is primarily to be supportive to students and teachers, statements such as; "The communication in the document recognizes that this leadership can not be done in isolation. School leaders need detailed, specific information about how all aspects of school life are perceived by students, school staff, parents and community members" (Ontario Ministry of Education, 2010a, p. 8), acknowledge that the *perception* of school life may differ from that which is intended or perceived by the school leadership team, and that this may be an additional contributing factor to student performance and success.

The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy uses **communicative statements** such as "commitment to safe schools is a shared responsibility of government, school board trustees and administrators, principals, teachers, support staff, students, parents, police and other community partners" (Ontario Ministry of Education, 2010a, p. 11, citing Safe Schools Action Team, 2006) to identify a desire for a conscientious, shared effort at building a safe and caring community. *Ideas and Shared Practices: Foundations for a Healthy School* (2006) builds upon this **communicative action** by providing concrete suggestions regarding methods which may be used to link the home, school, and community partnership, including providing communication between the community partner and the parent via the school newsletter, providing a school based health centre, and building a familiarity for how to access resources and support related to mental health.

Realis statements which draw attention to the significance of family and community in

supporting the needs of children are used throughout each of the documents. Examples such as;

> Resilience is promoted by healthy lifestyles, but it also depends on many other things. Our lives are affected by a variety of individual characteristics, family circumstances and community and environmental factors, some of which increase our resilience by protecting us from emotional and psychological harm and some of which reduce it by exposing us to emotional and psychological risks. (Ontario Ministry of Education, 2010c, p.33)

contextualize the potential of benefits or barriers for children to be influenced through family or community factors. In this policy, the educator is portrayed as having the responsibility to teach children to manage these risk factors; "learning about mental health and emotional well-being helps students understand and manage the risk and protective factors that are in their control so that they will be better able to build and maintain positive mental health" (Ontario Ministry of Education, 2010c, p. 33). This once again neglects to establish bi-directional collaboration between schools, families and community partners, in order to be responsible to students, and continues to deflect accountability from the educator and the school system as a factor (or factors) that is potentially contributing to the root cause of the emotional or psychological risks to children.

Key finding 3: Actively seeking to create conditions for success.

Each of the four policy documents depicts a shared value for creating conditions for student success. This is done in *Ideas and Shared Practices: Foundations for a Healthy School* (2006) through identifying key foundational components for a healthy school, including; high quality instruction and programs, a health physical environment, a supportive social environment, and community partnerships (Ontario Ministry of Education, 2006). The other documents incorporate **strategic action** statements such as "Our government is committed both to raising the

bar for student achievement and to reducing achievement gaps" (Ontario Ministry of Education, 2009, p. 5), "Ontario elementary schools strive to support high-quality learning while giving every student the opportunity to learn in the way that is best suited to his or her individual strengths and needs" (Ontario Ministry of Education, 2010c, p. 3), and "A quality education is about more than academic achievement - it is about the development of the whole person." (Ontario Ministry of Education, 2010a, p. 11), in order to illustrate the significance of creating conditions for student success. Each of the four documents uses **communicative** messaging to explicitly denote their perceived elements for these conditions. These aspects include, but are not limited to: considering the individual needs of children, establishing a caring and considerate culture, building upon positive interactions, relationships, and learning environments, and children being able to see themselves reflected in the curriculum and environment. These criteria establish a foundation that recognizes the conditions for student success are reliant on more than academic parameters.

Value assumptions regarding society's beliefs towards the education system are made in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009) in order to **legitimize** the discourse of engaging students as learners; "Publicly funded education is a cornerstone of our democratic society. Ontarians share a belief in the need to develop students as learners and prepare them for their role in society as engaged, productive, and responsible citizens." (Ontario Ministry of Education, 2009, p. 6). The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010), and *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), build upon this value statement by using shared definitions of *equity* and *inclusion* in order to contextualize looking beyond academic achievements, to bestow parity in

opportunities for student learning through further consideration of factors that may influence students success. Though the terms equity and inclusion are not incorporated in *Ideas and Shared Practices: Foundations for a Healthy School* (2006), a similar **legitimization technique** is used in this document through adopting **realis** statements to define the objectives of the four key foundational components (listed above) which are identified as requirements for student achievement. The *Ontario Health and Physical Education Curriculum* (2010) unites each of these policies in their commitment to creating conditions for student success, through explicitly referencing each as being designed to "foster caring and safe learning environments in the context of healthy and inclusive schools" (Ontario Ministry of Education, 2010c, p. 56).

The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy states "A positive school culture is linked to students' sense of belonging and acceptance, which is further linked to improved academic and behavioural outcomes" (Ontario Ministry of Education, 2010a, p. 12). School culture is also discussed in each of the other policy documents as a priority to bear in mind when establishing conditions for student success. Consideration is given specifically to addressing stigma and stereotypes, and implementing anti-discrimination initiatives which build a culture of caring, and address the safety and inappropriate behaviour of students. The *Ontario Health and Physical Education Curriculum* (2010) recognizes that children's readiness to learn is dependent on both physical and emotional development (Ontario Ministry of Education, 2010c, p. 69). Further, the relevance of mental health as it relates to school culture is explicitly discussed in both the *Ontario Health and Physical Education Curriculum* (2010) and *Ideas and Shared Practices: Foundations for a Healthy School* (2006). Each of these documents uses **communicative statements** to address the need for policy and practice to provide both students

and staff the opportunities to build understanding and awareness of mental health and mental illness in the school. **Strategic action** statements in *Ideas and Shared Practices: Foundations for a Healthy School* (2006) indicate specific strategies which should be considered when incorporating mental health discussions and awareness, for example "programming that does not stigmatize mental disorders and that promotes positive healthy behaviours" (Ontario Ministry of Education, 2006) and "Establishing a protocol to ensure that mental health resources used are consistent with the messages of the school and board" (Ontario Ministry of Education, 2006). The **legitimization** for the explicit incorporation of mental health content is seen in **irrealis**, **predictive** statements such as "learning about mental health and emotional wellbeing helps students understand and manage the risk and protective factors that are in their control so that they will be better able to build and maintain positive mental health" (Ontario Ministry of Education, 2010c, p. 33).

Key finding 4: The role of teachers and administrators in addressing and responding to children's mental health.

The role of both teachers and administrators in addressing and responding to children's mental health is explicitly and implicitly discussed as a prevalent discourse in three of the four policy documents. Through the analysis of this discourse, the absence of mental health in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009) once again becomes evident. Implicitly addressing the role of the exosystem in supporting children's mental health, *Ideas and Shared Practices: Foundations for a Healthy School* (2006) indicates that school policies are a factor in establishing and sustaining "a supportive social environment" (Ontario Ministry of Education, 2006). The *Caring and Safe Schools in Ontario:*

Supporting students with special education needs through progressive discipline, kindergarten to grade 12 (2010) reinforces a similar message through statements such as "Promoting positive behaviour through a caring and safe learning environment and an individualized approach to behaviour issues begins with system and school leaders, who set the tone for the system and schools" (Ontario Ministry of Education, 2010a, p. 4) and "Ontario school boards have developed and implemented policies and procedures in accordance with the safe schools provisions of the Education Act, regulations under the act, and Ministry of Education requirements as set out in policy/program memoranda" (Ontario Ministry of Education, 2010a, p. 7). Though the *Ontario Health and Physical Education Curriculum* (2010) states that "Mental health concepts are included within all content areas of the Healthy Living strand" (Ontario Ministry of Education, 2010c, p. 33), it does not discuss implicitly or explicitly any policy framework developed or required in order to support and respond to children's mental health. As such, there is an unstated divide between the contrasting values of physical versus mental health. An example of this is the heightened attention that is given to the importance of conveying medical conditions;

> It is vitally important that parents inform appropriate school staff members of any medical conditions, including allergies, diabetes, or hemophilia, that might affect their children's participation in physical activities. Sabrina's Law: An Act to Protect Anaphylactic Pupils requires all school boards to have an anaphylaxis policy. Boards must provide regular training of school staff in dealing with life-threatening allergies, and school principals are required to maintain individual plans for pupils who have an anaphylactic allergy, and have emergency procedures in place for anaphylactic pupils. (Ontario Ministry of Education, 2010c, p. 47)

Through not directly addressing challenges to mental health as requiring policies for

support, or as a potential medical condition which may impact participation, this policy document take no notice of an opportunity to convey a clear message regarding mental health awareness, and minimizes the significance of addressing and supporting children's mental health in curriculum implementation. In fact, the only time policy development or framework for mental health is addressed in the *Ontario Health and Physical Education Curriculum* (2010), is when the document cites *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (2009), as a *reference* in the Glossary section, defining *mental illness*, *protective factors*, *resilience*, and *risk factors*.

Strategic action statements such as "Providing staff in-service training on recognizing signs and symptoms and using appropriate intervention strategies when dealing with issues about mental health" (Ontario Ministry of Education, 2006, p. 2), and "To meet student needs, support student success, and respond appropriately to the full range of student behaviour, system and school leaders need to acquire information about a variety of factors that influence students' achievement and behaviour. They need knowledge of the types of intellectual and emotional challenges students may face" (Ontario Ministry of Education, 2010a, p. 8) call for opportunities for both teachers and administrators to receive training related to recognizing, understanding, and approaching mental health. However, this explicit message relating to formal training requirements is not replicated in the *Ontario Health and Physical Education Curriculum* (2010). Instead, the responsibility and accountability for training is reduced to an encouragement for teachers to recognize their individual training needs, and pursue their own knowledge gathering opportunities;

> To increase their comfort level and their skill in teaching health and physical education and to ensure effective delivery of the curriculum, teachers should reflect on

> their own attitudes, biases, and values with respect to the topics they are teaching, and seek out current resources, mentors, and professional development and training opportunities, as necessary (Ontario Ministry of Education, 2010c, p. 11).

The policy identifies teachers as being "important role models for students" (Ontario Ministry of Education, p. 11), and emphasizes teacher's attitudes and beliefs are essential elements for successful implementation of the curriculum. However, by proposing that teachers use self reflection techniques in order to identify training and resource needs, the policy presumes the ability of teachers to identify and recognize the biases and beliefs which may influence their practice, before receiving training which informs the educators of why some beliefs may be problematic, and what these thoughts and biases may be.

Another related but separate inconsistency in the manner that the role of teachers and administrators is positioned in the *Ontario Health and Physical Education Curriculum* (2010), is in reference to the curriculum content delivery expectations. The terms *mental health* and *emotional well-being* are embedded recurrently throughout this policy document (see Table 2). The term *well-being* is also stated an additional 50 times with generic associations towards both physical and psychological wellness, most frequently it is presented as *health and well-being.* The frequency of the utilization of these terms, coupled with strategic placement throughout the policy document, implies a significant awareness and value of the incorporation of mental health in the execution of the policy document. However, there are two key elements that contradict this implicit message.

First, unlike the other content areas of the *Health and Physical Education* Curriculum (2010), clear expectations of the knowledge and skills each student is expected to acquire, demonstrate, and apply are not explicitly stated. Instead, the policy utilizes a broad-brushed

communicative statement which indicates "Mental health concepts are included within all content areas of the Healthy Living strand. The focus is on promoting and maintaining mental health, building an understanding of mental illness, and reducing stigma and stereotypes" (Ontario Ministry of Education, 2010c, p. 33). By not seeking meaningful and measurable outcomes related to student knowledge and skills pertaining to understanding mental illness and reducing the stigma and stereo types, there is no explicit accountability for practice or policy which ensures effective integration of these concepts across all content areas. Second, in discussing the implementation of the curriculum, the *Health and Physical Education Curriculum* (2010) explicitly and implicitly acknowledges challenges related to mental health that may be experienced by educators, thus effecting implementation;

> Some topics within the Healthy Living strand can be challenging to teach because of their personal nature and their connection to family, religious, or cultural values. These topics can include but are not limited to topics covered in the Growth and Development section of the 1998 curriculum, as well as topics such as mental health, body image, substance abuse, violence, harassment, child abuse, gender identity, sexual orientation, illness (including HIV/AIDS), and poverty. These topics must be addressed with sensitivity and care. It is important that both teachers and learners have a comfort level with these topics so that information can be discussed openly, honestly, and in an atmosphere of mutual respect. (Ontario Ministry of Education, 2010c, p. 30).

Table 2. Frequency of Key Terms in body of policy document

Key term	Health and Physical Education Curriculum	Inclusivity and Equity Policy	Foundation for a Healthy School	Safe and Caring Schools Policy
Choice	**Defined:** NO **Utilized:** 173 times (including 54 times referring to food choice)	**Defined:** NO **Utilized:** Two times	**Defined:** NO **Utilized:** Two times	**Defined:** NO **Utilized:** Four times
Mental health	**Defined:** YES **Utilized:** 40 times	**Defined:** NO **Utilized:** ZERO times	**Defined:** NO **Utilized:** 10 times	**Defined:** YES **Utilized:** 29 times
Diversity	**Defined:** NO **Utilized:** 21 times	**Defined:** YES **Utilized:** 31 times	**Defined:** NO **Utilized:** One time	**Defined:** NO **Utilized:** 10 times
Emotional Well-being	**Defined:** NO **Utilized:** 12 times	**Defined:** NO **Utilized:** ZERO times	**Defined:** NO **Utilized:** Zero times	**Defined:** NO **Utilized:** One time
Well-being	**Defined:** NO **Utilized:** 50 times	**Defined:** NO **Utilized:** One time	**Defined:** NO **Utilized:** Zero times	**Defined:** NO **Utilized:** 4 times
Stigma	**Defined:** No **Utilized:** Two times	**Defined:** NO **Utilized:** ZERO times	**Defined:** NO **Utilized:** One time	**Defined:** NO **Utilized:** One time

These challenges to teaching combined with the potential for a lack of knowledge and awareness relating to addressing the topic of mental health, and unclear direction for the intended content to be delivered, presents as a substantial disparity in the incorporation of this topic, and may influence the effectiveness of the intended objectives relating to mental health in this policy. The concept of teacher and administrator self reflection is also discussed in the *Caring and Safe*

Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12 (2010) policy document. The critical difference in which this approach is positioned in this document, is through the foundational components of the policy framework which corresponds to the methods that are utilized in addressing challenges, and promoting positive outcomes for students. These components include "understanding of student behaviour" (Ontario Ministry of Education, 2010a, p. 8), "knowledge of strategies and resources" (Ontario Ministry of Education, 2010a, p. 8), and "implementation of a progressive discipline approach" (Ontario Ministry of Education, 2010a, p. 8). In the implementation of progressive discipline section, educators and administrators are instructed to "plan for ongoing monitoring, reflection, and adjustment, in order to identify further needed improvements and integrate them into their implementation processes" (Ontario Ministry of Education, 2010a, p. 8). The pre-requisite of developing a knowledge base regarding understanding the variety of factors which influence behaviour, as well as identifying appropriate strategies, tools, and resources that can be used to address specific challenges and needs, establishes a strength based, preventative approach to addressing challenges to children's behaviour (and indirectly to children's mental health).

Chapter 6

Unsaid Discourses

1. **The relationship between bullying and mental health.**

Bullying is discussed either explicitly or implicitly in each of the policy documents. As challenges with mental health are often characterized by behavioural disinhibition, and aggressive behaviour (King et al., 2004; O'Connor et al., 2011) it is critical that policy and practice consider the relationship between bullying and mental health. Though each of these four policy documents

approach the topic of bullying slightly differently, the key messaging in each of the policies related to bullying is consistent, and indicates that bullying will not be tolerated. For example, the *Ontario Health and Physical Education Curriculum* (2010) promotes that every student is entitled to learn in a safe, supportive environment, which is founded on healthy relationships (Ontario Ministry of Education, 2010c, p. 55). Though not explicitly referencing *bullying*, this policy qualifies the term *healthy relationship* by stating "Healthy relationships do not tolerate abusive, controlling, violent, harassing, or inappropriate behaviours" (Ontario Ministry of Education, 2010c, p. 55). This policy also references each of the other three documents in order to communicate a message of shared values relating to the concept of safe and supportive learning environments; "Several provincial policies and initiatives, including the Foundations for a Healthy school Framework, the Equity and Inclusive Education strategy and the Safe Schools strategy are designed to foster caring and safe learning environments in the context of healthy and inclusive schools." (Ontario Ministry of Education, 2010c, p. 55, 56). The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy also does not refer explicitly to *bullying*, however there is a strong prevalence of discussion which promotes the importance of quality relationships, encouraging positive behaviour, and establishing caring, safe learning environments.

Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy (2009) contextualizes bullying as a discrimination issue, and specifically references racism, religious intolerance, homophobia, and gender-based violence as areas of concern (Ontario Ministry of Education, 2009, p. 7). Though mental health is not explicitly mentioned in the discussion about discrimination, the document completes the introduction to discrimination with the use of a **realis statement** to legitimize the concerns about bullying in schools; "Research

findings about the effects of rejection and bullying on young people are clear and consistent. Rejection, exclusion, and estrangement are associated with behaviour problems in the classroom, lower interest in school, lower student achievement, and higher dropout rates" (Ontario Ministry of Education, 2009 citing Osterman, 2000, p. 9). Throughout the policy document, bullying is no longer explicitly referenced; instead the discourse revolves around discrimination and anti-discrimination education.

Statements such as "Establishing a diversity club to provide students with an opportunity to discuss ways to make all students feel welcome in the school" (*Ontario Ministry of Education,* 2006, p. 1), as well as;

> In health education, the study of healthy relationships, particularly with respect to bullying/harassment and violence prevention, should include a focus on sexist, racist, and homophobic behaviour. Examination of other types of harassment, including weight-based teasing or teasing based on appearance or ability, should also be addressed. (*Ontario Ministry of Education,* 2010c, p. 56)

seem to present the policies as approaching the concept of bullying as a discrimination issue. In *Ideas and Shared Practices: Foundations for a Healthy School* (2006) however, bullying is explicitly discussed, and a bullying prevention strategy is identified as a key component for the development of a healthy school foundation (Ontario Ministry of Education, 2006). The elements of this strategy are suggested to be comprised of resources and education related to bullying prevention for staff, students, and parents, establishing student confidence in developing *bully-free* zones and in reporting bullying incidents, as well utilizing community partners for the delivery of conflict resolution and self esteem development programs.

Although the discourse explicitly or implicitly related to bullying in each of these

documents includes references to establishing positive relationships, supportive environments, and bullying prevention programs, the implicit messaging of each of the documents appears to be focused on a reactive approach to bullying, that centers on building resilience in relationships, and an awareness of pro-social behaviour. An example of this comes from the 'Health Living Strand' in the *Ontario Health and Physical Education Curriculum* (2010), where it states "As they become more independent and more responsible for their own safety and that of others, they also learn how to assess risk, respond to dangerous situations, and protect themselves from a variety of social dangers, including bullying, abuse, violence, and technology related risks. (Ontario Ministry of Education, 2010c, p. 115). Through embracing this *protective* approach, as well as viewing bullying as a discrimination issue, the documents fail to recognize the role that mental health may be playing in bullying situations, not only for the victim, but also for the bully. Consistent with previous research that linked an increased prevalence of psychological distress among both bullies and victims (Kumpulainen et al., 1998; Stephenson & Smith, 1989), an eight-year longitudinal study conducted by Sourander, Helstel, Helenius, & Piha (2000) found that children who bullied *or* were victimized had extensive challenges in externalizing and internalizing behavior, as well as in social competence. Specifically, there was a powerful link between bullying and externalizing behavior problems, and between victimization and internalizing challenges (Sourander et al., p. 878). The connection between bullying and mental health is strong, and yet neither an explicit, nor implicit reference to understanding the influences of mental health on bullying behaviour is identified. The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12,* (2010) sets the stage for future consideration relating to mental health and bullying when it states;

Because responses to surveys and other types of assessment will differ depending on who

> completes them, it is important to ensure that representatives from all sectors of the school and school community participate in assessment activities. There is much information to be gained by seeking out multiple perspectives. For example, to get an accurate picture of the school culture, it is essential to gather data from students, since research about bullying suggests that adults in a school do not witness the majority of this student behaviour. (Ontario Ministry of Education, 2010a, p. 13)

Despite the call for student representation in the assessment methodology, it is important to also recognize, that in order to draw specific connections between the influence of mental health on the bullying behaviour, strategic and tactical consideration and approaches must be considered when initiating assessment measures.

2. Mental health as a choice.

The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) describes mental health problems as being "Mental and emotional dysfunctions that affect a person's ability to enjoy life and deal with everyday challenges such as making choices and decisions, adapting to and coping in difficult situations, or talking about one's needs and desires" (Ontario Ministry of Education, 2010a, p. 28). However, the *Ontario Health and Physical Education Curriculum* (2010) contradicts this message through making repeated references to the term 'choice' in discussing mental health and emotional well being. Examples of this include "applying health knowledge, making decisions about personal health and well-being" (Ontario Ministry of Education, 2010c, p. 18), and;

> Teachers can help students see connections between what they learn and their ability to make important decisions related to various aspects of their health and well-being, and they

> can remind students of the importance of thinking carefully about decisions that could have a major impact on all parts of their lives – physical, emotional, social, mental, and spiritual. (Ontario Ministry of Education, 2010c, p.12)

The direct consequence of this ideology is that it favours the state of mental health as being an option, and implies that children always have the opportunity to choose mental wellness. Though there are strategies which can be adopted to prevent and reduce the influence of challenges to mental health, representing the achievement of mental wellness as a choice promotes a misrepresentation and stigmatized perception of challenges to mental health and mental illness as it does not provide space for building an awareness or understanding of those who are experiencing mental illness.

Chapter 7

Discussion and Recommendations

1. Policy influence on stigma and stereotypes.

The analysis of these policy guidelines presented in this paper indicate that neither separately, nor together, are they sufficiently able to educate and address the reality of mental health challenges, and mental illness among children. A core underpinning which reinforces this gap throughout each of the policy documents is the fact that the Ontario Ministry of Education does not formally define challenges to mental health as an exceptionality that requires strategic intervention and support. Embracing challenges to mental health as *exceptionalities* has the potential to dramatically shift some of the disparities in supporting children which are found in the policy documents. Each of the policies indicates a desire to develop a healthy, supportive school environment, where students, parents, and community partners feel welcome, however without

explicit discussion and implementation of tactics to address and conquer the stigma and stereotypes related to mental health, the voice of children who struggle with mental health or mental illness is absent in this ideology. Research that indicates the benefits of early identification and intervention to the trajectory of mental health is extensive; however stigma and stereotypes remain the primary barriers to seeking help for mental health (Davidson and Manion,1996; Elliot & Larson, 2004). Stigma is acknowledged as being an area of concern in three of the four documents, but is not mentioned explicitly or implicitly in *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009). Given that a reported 63% of students cite stigma and stereotypes as major barriers to seeking support (Davidson & Manion, 1996), both an explicit discussion of mental health, as well as strategies to address and respond to stigma and stereotypes must be key elements of this policy document. *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009) uses the **nomitive statement** "As an agent of change and social cohesion, our education system supports and reflects the democratic values of fairness, equity, and respect for all. The schools we create today will shape the society that we and our children share tomorrow" (Ontario Ministry of Education, 2009, p. 6). By not including mental health and/or reduction of stigma and stereotypes in this policy, the document does not demonstrate an acknowledgement of challenges with mental health as being an equity or inclusivity concern, and therefore reinforces commonly held misconceptions and beliefs about mental illness which continue to stigmatize individuals by characterizing mental wellness as a *choice*.

The *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) document cites the Canadian Psychiatric Association when introducing the topic of mental health; "Depression, stress, suicide,

and eating disorders are issues of concern for teens; and fear, embarrassment, peer pressure, and stigma are barriers to getting help (Ontario Ministry of Education, 2010a, p. 27). This statement excludes children who have not reached the teen years, and implicitly implies that these challenges to mental health are not a concern for young children. This being said, the document is also the only one of the four which distinguishes between mental health problems and mental illness (Ontario Ministry of Education, 2010, a, p. 27). Through this distinct identification, the voice of children who are experiencing challenges to their mental health is strengthened, and the characterization of challenges to mental health and/or mental illness is increasingly defined. Promoting flexibility in the approach and implementation of disciplinary action through statements such as "Boards and schools are required to take into account a variety of mitigating circumstances and other factors when making decisions about whether a particular behaviour calls for suspension or expulsion (Ontario Ministry of Education, 2010a, p. 50) implicitly assists in encouraging schools to consider influencing factors contributing to children's behaviour, potentially including challenges to mental health. However, the Ontario Human Rights Commission (2008) indicates that the understanding and implementation of this policy has resulted in subjective interpretation and inconsistencies in disciplinary approaches across the province;

> Education and school boards are giving two contradictory messages to school administrators and the general public. As a result, while some school administrators may apply the mitigating factors, others may practice zero tolerance. A practice of zero tolerance inevitably conflicts with anti-discrimination legislation, particularly if it targets disability-related behaviour" (Ontario Human Rights Commission, 2008, p.10).

When seeking to develop inclusive learning environments, the needs of all parties must be

considered when dealing with situations related to behavioural misconduct. The very nature of mental illness and mental health challenges often present with social, emotional, and behavioural challenges. Children inherently are not bad or are inclined to behave badly, nor should they be characterized as such. Practicing zero tolerance fails to take into account mitigating factors as to the purpose of the behaviour in question. Another challenge in implementing the *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010) policy is that it requires the educators and administrators to have a thorough understanding of mental health, and reserved attributions related to the child. For example, the policy clearly outlines that "to manage behaviour effectively, educators need to consider not just the behaviour itself – what the student is doing – but also the underlying cause(s) of the behaviour" (Ontario Ministry of Education, 2010a, p. 21), however on the same page it also indicates that the "expectations for a student who is unaware of the inappropriateness of a specific behaviour would be different from our expectations for a student who is aware, and we would adapt our response accordingly" (Ontario Ministry of Education, 2010a, p. 21). By specifically incorporating this subjective leeway to implementation of policy, educators may be inadvertently reinforced in maintaining unhelpful beliefs and negative attributions towards the child and his/her behaviour.

Ideas and Shared Practices: Foundations for a Healthy School (2006) commits to addressing the stigma associated with mental health through "Providing programming that does not stigmatize mental disorders and that promotes positive healthy behaviours" (Ontario Ministry of Education, 2006, p. 2), as well as "Providing students with information and training on mental health and with an opportunity to plan and organize a committee to address mental health issues in the school" (Ontario Ministry of Education, 2006, p. 2). In this document, the ideological

assumptions lay in the way in which *parents* are characterized. In the commitment to addressing mental health, this policy states a necessity for "Sending out a student and/or parent survey to establish the areas of mental health that need to be focused on in the school" (Ontario Ministry of Education, 2006, p. 2) and "Establishing a school council committee to discuss and coordinate mental health initiatives in the school and community" (Ontario Ministry of Education, 2006, p. 2). Though these may be valuable initiatives, the very nature of mental health challenges presumes that parents who respond to the survey's that establish the areas of mental health to be focused on at school, or who coordinate mental health initiatives in the school and community, are likely not the ones who are currently struggling with their own mental health. Should this be the case, the risk may be that parents who may be experiencing pressures with their own mental health may become characterized as being uninvolved, lazy, or uncommitted to valuable initiatives at the school. This characterization would then reinforce the stigma and stereotypes commonly held regarding the characterization of those who struggle with mental health.

The *Ontario Health and Physical Education Curriculum* (2010) is the policy document which explicitly mandates an integration of mental health in the curriculum. In addition, it states that the integration of mental health throughout all areas of the healthy living strand has a "focus is on promoting and maintaining mental health, building an understanding of mental illness, and reducing stigma and stereotypes" (Ontario Ministry of Education, 2010c, p.33). However, despite this explicit commitment to reducing stigma and stereotypes, the only other area that stigma is addressed in the policy document is in an example of a teacher/student prompt that is found in the *Personal Safety and Injury Prevention* section (Ontario Ministry of Education, 2010c, p. 146). The curriculum framework for the policy suggests lessons which address recognizing sources of stress, as well as discussions about substance abuse throughout the elementary and

secondary health curriculum beginning in grade one, as part of a comprehensive approach to incorporating foundational requirements for healthy schools. A discussion of mental illness itself on the other hand isn't being taught in detail until grade 11 and 12, when health education courses are no longer compulsory studies for students. The revised curriculum specifically indicates several opportunities for physical health education and practical implementation of scaffolded learning opportunities to be built into the syllabus; however it does not reflect equal consideration for learning related to mental health. The policy indicates that mental health and emotional well being are addressed across all topic areas, however the healthy living strand appears to be the area which will predominantly addresses mental health.

In the overview of the curriculum for each grade there is minimal reference to direct components of mental health and mental ill health that are mandated to teach. Though the curriculum module of substance abuse may implicitly infer discussions about mental health, there is no explicit expectation which addresses mental health and mental illness directly. While there may be benefits to addressing the topic of substance abuse, this discussion alone does not meet the ongoing needs of de-stigmatizing mental illness among children and addressing indicators of ill mental health such as depression, anxiety and stress. The Centre for Addiction and Mental Health (CAMH) has developed lesson plans in English and French that meet the expectations of the substance use and abuse component of the new grade 1-10 Ontario Health and Physical Education Curriculum and the mental health component of grade 11-12 (CAMH, 2009). Though these lesson plans provide a comprehensive approach to teacher support and teaching children about mental health, they are still focused on discussions about drug use specifically and are not currently mandated to be utilized by educators. Through extensive literature and media searches, there does not appear to be a similar document or framework relating to integrating the core

concepts of mental health that are said to be incorporated throughout the health curriculum. Establishing clarity regarding the incorporation of mental health and mental illness in the *Ontario Health and Physical Education Curriculum* (2010) would benefit all stakeholders of this curriculum. In addition, the representation and characterization of children's mental health would be strengthened. As this document clearly outlines the roles and responsibilities of students, parents, teachers, administrators, and community partners, the recommendation is to build upon this component of the document to also recognize the role of policy makers in developing clear guidelines and training regiments relating to mental health, in order to support the needs of all students.

In legitimizing the prevention and strength-based approach to addressing the topic of mental health, the *Ontario Health and Physical Education Curriculum* (2010) states

> Behaviours that promote mental health are not always correlated with the prevention of mental illness, which can also have a biological component. However, learning about mental health and emotional well-being helps students understand and manage the risk and protective factors that are in their control so that they will be better able to build and maintain positive mental health (Ontario Ministry of Education, 2010c, p. 33).

Though research supports the benefits of using a population health approach (Saskatchewan Health, 2003; Wadell et al., 2004; Wadell et al. 2007), the absence of formal and informal discussions about mental illness silences the voice of those experiencing mental health challenges or mental illness, and continues to stigmatize these individuals and/or those who may have a parent or other influential person experiencing challenges with their mental health. As a result, mental illness implicitly becomes characterized as *abnormal*. This implicit messaging is reinforced through the ideological assumptions regarding *parents* and *parental support* in this

policy document. In the Ontario Health and Physical Education Curriculum (2010), parents are characterized as being the primary educators and significant role models for children. The policy indicates that parents can provide support for children through making healthy lifestyle choices themselves, particularly relating to eating, relationships, substance use, and personal care (Ontario Ministry of Education, 2010c, p. 10). The policy document strategically outlines methods which parents can support their child's learning;

> Effective ways in which parents can support their children's learning include the following: attending parent-teacher interviews, participating in parent workshops and school council activities (including becoming a school council member), and encouraging their children to practice at home and to complete their assignments. Parents can be supportive by promoting and attending events related to healthy, active living at their children's school. Many parents also have expertise in a range of disciplines that can contribute to a healthy school environment. Parents who work in the health or recreation fields, for example, may be able to contribute as guest speakers or as volunteers during health or physical education classes or cocurricular activities (Ontario Ministry of Education, 2010c, p. 10).

The expectations regarding parental support and role modeling, presume healthy practice within the child's family and home based community. This policy standard reinforces a negative stigma towards challenges with mental health, as it pointedly reflects the belief that all children live in healthy environments, and silences the voice of those who do not, and all parents who may struggle with their mental health; including those who may additionally be challenged with correlated side effects such as substance abuse, eating disorders, and abuse or other substantial relationship challenges. Although it may be empowering for some parents to be viewed as the

primary educator for their child, and there may also be benefits to establishing an atmosphere for parent participation and engagement, pressuring them to do so may prove to be daunting for others.

2. Adequate training and assistance to support children's mental health.

Though recognizing the range of skills and abilities school staff provide in supporting students, successful integration of mental health will require strategies to build the confidence and comfort of the teacher in incorporating and normalizing discussions of mental health and mental illness. Access to adequate resources and supports required to effectively train educators to implement the new *Health and Physical Education Curriculum* (2010), as well as to provide environmental adaptations and strategies for children's mental well being is essential. Although schools have been identified as suitable locations for early identification and support of children's mental health, teachers lack the mental health literacy required to recognize and understand strategies that they may utilize to integrate mental health promotion, and prevention, as well as to support the development of mental well-being of young children (Graham et al., 2011). Policy makers must collaborate with Ontario's teacher education programs, as well as the Ontario College of Teachers to develop teacher education programs which include extensive training on skills required for achieving the intended goals of the policy documents relating to mental health, and building safe, supportive environments. These education programs must also support teachers in becoming fully aware of their biases and stereotyped thought patterns related to mental health. Without strategic, targeted pre-service and in-service training for teachers and administrators, the potential for subjective interpretation in defining the functions of children's behaviour may inappropriately influence the manner in which it is addressed. "Adults often interpret behaviour from the perspective of their own life experiences and current circumstances.

These perspectives affect the observer's expectations for the student" (Ontario Ministry of Education,2010a, p. 21). Given the prevalence of challenges related to mental health, attention must also be given to the mental health of teachers and administrators. Recognizing the mental health needs of educators by establishing school based supports for adult mental health, or other mental health promotion initiatives, may positively influence the quality of teacher/student interactions, and thus the functioning of the classroom.

Even with the development of mental health literacy, there are several aspects of the educational system which may make it difficult for teachers to develop and role model a responsive curriculum that educates students in mental health. For example, the discourse related to bullying represents a **legitimization** tactic that appeals to the moral values associated with the victimization aspects of bullying, and only considers discrimination as a contributing factor to bullying behaviour. Externalizing challenges to mental health often present as poorly defined social skills, and aggressive, oppositional behaviour. Policy initiatives must be revised to also consider bullying behaviour from a mental health perspective, so that educators perceive that the policies relating to addressing and preventing bullying behaviour are consistent with their knowledge of challenges to mental health, and those innovations that include recognizing and responding to challenges with mental health also become a prime objective of anti-bullying initiatives.

Another aspect of the educational system that contradicts the potential for teachers to role model a curriculum which is responsive and supports children's mental health is the very nature of assessments and standardized testing. For example, standardized testing such as the Education Quality and Accountability Office (EQAO) may counteract the message which is to be promoted in the revised health curriculum by establishing an environment that produces anxiety for children,

teachers and parents. This may be problematic as children are then receiving the message in the health curriculum that teachers are responsible for providing physically and emotionally safe environments, however, may at the very same time have environmental factors which are activating their stress responses, anxiety, and challenges to their mental well being. In order to effectively model equity and inclusion, foundational changes to assessment strategies are required that address the impact of these and other environmental challenges for children struggling with mental wellness.

Chapter 8

Limitations of the Study

In recent years, there has been a heightened concentration towards policy developments, innovations, and discussions regarding mental health identification and support in schools. New approaches, funding, policies and research outcomes are being made available regularly which will influence the trajectory of the approach to supporting mental health in schools and communities. As this research study was specifically intended to focus on four key Ministry of Education policy documents, the central limitation to this study lay within what is *not* included. Policy oriented papers such as *Taking Mental Health to Schools* (Santor, et. al., 2009) and *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (MCYS, 2011) are anticipated to influence the course of mental health supports in both schools and communities. In addition, several regions and/or individual school boards are also developing a variety of innovations and projects that are targeting some of the areas which have been highlighted as gaps in the analyzed policy documents. Future research that evaluates the effectiveness of these initiatives would be beneficial to collect as it evolves. This research may include investigating changes in educator knowledge and perspectives relating to mental health,

changes in the prevalence of bullying behaviour, and tracking student outcomes such as academic achievement, reduction in office referrals or other disciplinary action, and a longitudinal study that investigates the overall trajectory in children's mental health following the integration and implementation of these initiatives.

Concluding Comments

Policies and procedures that characterize and support the mental health of children have an important role in establishing the context for the development of effective role modeling of awareness and acceptance of varying degrees of mental wellness. However, despite growing initiatives to inclusively support exceptional children, until recently, mental health has not been prioritized in these proposals. Historically, school initiatives to address mental health have been indirect and focused primarily on addressing symptoms of mental illness (such as managing misbehaviour and making schools safer) rather than prevention or intervention. The prevalence of challenges to children's mental health are a reality that cannot be ignored. Through the analysis of the *Health and Physical Education Curriculum* (2010), *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy* (2009), *Ideas and Shared Practices: Foundations for a Healthy School* (2006), and *Caring and Safe Schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12* (2010), underlying assumptions and contradictions regarding children's mental health in these Ontario Ministry of Education documents have been identified through this CDA. Findings indicate that mental health remains misunderstood, poorly represented, and highly stigmatized in Ministry of Education policy documents, and that neither separately, nor together, are these policies sufficiently able to educate and address the reality of mental health challenges and mental illness among children. The inequity of mental health representation in public education in

Ontario should not be tolerated. The Ministry of Education, regional school boards, individual schools, administrators, educators, parents, and community partners, each must recognize the role that they play in changing the trajectory of mental health for children. Each must identify the power that they possess to take a stance in removing the stigma from addressing and supporting challenges to mental health, and each must then pledge a commitment to all children to do what is within their power to execute change.

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