A comprehensive mental health literacy learner resource for pre-service and practicing teachers

TEACH MENTAL HEALTH

Course Overview

Welcome

Welcome to the Teach Mental Health course for educators. This course is designed for teacher candidates currently in Faculties of Education and for educators currently working in schools, including classroom teachers, administrators and other specialized roles such as Resource or Learning Support Teachers, for example. This course is for you.

Developed by education and mental health professionals, this seven module (8 to 10 hours) course will give you a foundation of mental health literacy, including effective strategies to use in your educational settings and, in your own life.

We sincerely hope that this course will deepen your interest in, and encourage your critical thinking about, mental health.

Enjoy the learning!

Dr. Stan Kutcher, Dr. Yifeng Wei, Dr. Wendy Carr, Dr. Susan Rodger and Dr. Chris Gilham.

Why did we create this resource?

National surveys report that about 70% of Canadian teachers identify a need for more knowledge about mental health/mental illness. A national scoping exercise found that a comprehensive mental health literacy curriculum resource is not available in most Canadian Faculties of Education. This online mental health literacy for pre-service teacher education resource has been developed to address that gap.

What is the purpose of this educational resource?

This resource aims to:

- Enhance mental health literacy of teacher candidates in Canadian Faculties of Education.
- Provide classroom congruent materials that can be used both during practicum and after graduation to help address mental health literacy of students.

This resource does NOT educate how to diagnose or treat mental illnesses. If you are concerned about a student's mental health, talk to the leadership team in your school and consult with health professionals in your school or at the school district level and provide information they need to better support that student. As part of the school-based team of professionals, determine what your role will be to better support your student.

Setting the Stage

Let's set the stage. You are becoming an educator or are already working in schools. Your focus is naturally very much on student success. The question, "How can I best support my students to be successful?" drives much of your work.

As you know, your roles as educators can extend beyond the classroom. Your influence is far reaching. It is important for you to understand that what impacts you as a person may impact your students as well.

An educator's role is not only to help children and youth achieve academic success, but also to help foster their growth and development, including their mental health. This perspective is supported by child and youth mental health strategies nationally and internationally. For example, Canada's recent national child and youth mental health strategy, Evergreen: A Child and Youth Mental Health Framework for Canada, states:

Educators, in particular, identified that with the proper information, training and supports, they may be the best positioned to challenge stigma, enhance mental health literacy and raise awareness of child and youth mental health (Kutcher & McLuckie, for the Mental Health Commission of Canada, 2010)

Educators' roles

What roles can educators play with regards to student's mental health?

Consistent, trusted adults can have significant positive impacts in the lives of children and youth. Educators often become positive role models (students want to be like them), mentors (who coach and support students) and watchful interveners (identify students in need of additional assistance and help them on the pathway to receive care when they need it).

Educators are ideally placed to be watchful interveners for student mental health since most people who will develop a mental disorder can be diagnosed prior to age 25 years. Most students fall within that age range. In addressing student mental health, educators can:

- Teach mental health literacy in the classroom to promote the understanding of mental health and mental illness, decrease stigma about mental illness, enhance the importance of positive mental health among students and help provide them with the tools and competencies to seek appropriate mental health care if they need it. In addition, educators become better informed participants in their own care should they require it.
- Identify students who may be experiencing a mental health problem or mental illness and provide advice on where to seek help and link them with school based resources.
- Provide extra support in the classroom and in the larger school environment to students who are in need.
- Role model how to break down the stigma against people who have a mental illness.

What educators are not?

It is important to remember that educators are not mental health care providers. Their profession is different from that of counsellors, psychologists, nurses or doctors. Educators cannot, and should not, diagnose mental illness nor should they provide mental health care. However, educators can be an important component of the caring community of professionals and other adults (e.g., coaches and school administrators) who can surround and support the student in need.

This Resource

Who created this resource?

We are a team of educators, researchers and mental health care professionals who have worked together collaboratively over the past five years to develop, evaluate and produce this resource. We did so based on our research that identified a need to enhance the mental health literacy of educators.

Our team consists of Dr. Stan Kutcher (Teenmentalhealth.org and Dalhousie University), Dr. Yifeng Wei (Department of Psychiatry, Dalhousie University), Dr. Wendy Carr (Faculty of Education, University of British Columbia), Dr. Susan Rodger (Faculty of Education, Western University) and Dr. Chris Gilham (Faculty of Education, St. Francis Xavier University). Key project participants included Vanessa Bruce (Teenmentalhealth.org), Dr. Melanie-Anne Atkins (Western University), Amy MacKay, Mina Hashish, Kate Elliot, Mallory Comeau, Jillian Thorpe and Amanda Higgins (Teenmentalhealth.org). The Educational Technology Support Unit in the

Faculty of Education, University of British Columbia created the online version of this material .

Funding for this work was provided by a private foundation in western Canada that wishes to remain anonymous. No funds were received from either the pharmacology or psychotherapy industries. Over thirty institutions and national organizations assisted in the role of Participant Observers, reviewing the materials and making suggestions about how to improve them. Field-testing of the materials was conducted in a number of Faculties of Education, and the information obtained was used to improve the materials in the resource. We hope that all educators, including faculty members who teach educators, find this course helpful.

What does this resource cover?

This resource is composed of seven modules. They are:

- Module 1: Introduction and Background
- Module 2: Stigma and Mental Health
- Module 3: Human Brain Development
- Module 4: Understanding Mental Health, Mental Illness and Related Issues in Young People
- Module 5: What is Treatment?
- Module 6: Seeking Help and Providing Support
- Module 7: Caring for Students and Ourselves

Each module includes a Core Materials section that contains a **Self-Assessment** and a **Supplementary Learning Resources** component. Course users should complete the self-assessment at the end of each module prior to moving onto other modules. Course users who want to explore the subject matter covered in the modules in more detail can engage with the Supplementary Learning Resources and materials in the Deeper Dive section.

Engaging with this resource

This resource was designed to be used by teacher candidates and practicing educators alike. School administrators, trustees, board members, policy makers and others involved in education may also find this useful to help inform their work.

This resource is presented as **Core Material** and **Deeper Dive** material in each module. The core material constitutes the content designed for use by teacher candidates, as part of their academic learning components. This can also be the focus of continuing professional development for certified educators. The Deeper Dive material constitutes a more in-depth treatment of each module topic. It can be used to supplement the core material and as additional learning for those interested. Also, if taken together, the combined Core Materials and Deeper Dive materials can be used in post graduate education courses (for example, MEd programs) or for additional self-directed learning.

How to use this resource

If you are a faculty member:

You are welcome to use this resource as an entire course that can be done by your students online. If so, you may want to develop a method for tracking this and an evaluation format that will provide you with the assessment information you require. Alternatively, you may choose to use various modules to support or supplement different components of courses that you are already teaching. There is no prescribed way to approach this material.

Teacher candidates who take the entire course and successfully complete each of the Self-Assessment quizzes at the end of each module can receive a certificate of completion from the four partner institutions.

Your own faculty may decide to accept this as a credit equivalent should you choose to do so.

If you are a certified teacher:

You can take the Core Material course and receive a professional education recognition certificate from the Faculty of Education at the University of British Columbia. Alternatively, you can pick and choose the modules you wish to engage with as part of your own professional learning needs.

Module 1

Introduction and Background

In Module 1 we explore what the phrase mental health literacy means, and further our understanding of the various components of what we understand to be the various dimensions of mental health. Successful completion of Module 1 provides a solid foundation for engaging with the rest of the modules in this resource.

Section 1: What is Mental Health Literacy?

Learning objective

In this section, you will:

- Get a better understanding of the definition of mental health literacy (MHL) and its four inter-related components.

Activity 1:1.1: Before we start, think about this question: What does mental health literacy mean to you? Write down your definitions.

Activity 1:1.2: Please watch the following video created by Dr. Kutcher that addresses the question "What's mental health literacy"?

Mental health literacy (MHL) is composed of four separate but inter-related components:

- Understand how to obtain and maintain **good mental health**
- Understand and identify **mental illnesses and their treatments**
- Decrease **stigma**
- Enhance **help-seeking efficacy**: know where/when to go; know what to expect when you get there; know how to increase likelihood of "best available care" (skills and tools)

Based on additional work by the Canadian School Mental Health Literacy Roundtable and the School-Based Mental Health and Substance Abuse (SMHSA) Consortium, Mental Health Commission of Canada (2012) we can think about how this definition can be applied in schools.

The knowledge and competencies held by school personnel can help create conditions that enhance both staff and student capacity in improving mental health, knowledge about mental illnesses, reduction of stigma, improved help-seeking efficacy and the support needed to assist students along the Pathway Through Care*.

How is mental health literacy related to literacy and health literacy?

Activity 1:1.3: Here is another question for you to think about: based on what Dr. Kutcher talked about in the video, how do you think mental health literacy is related to literacy and health literacy? Consider the definition of literacy by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and the definition of health literacy by the World Health Organization (WHO); and compare their similarities and differences.

Please take a few minutes to Google the information you need.

*See Deeper Dive: Pathway Through Care

Now, let's review together how WHO defines health literacy

Health literacy is a means and an outcome of actions aimed at promoting the empowerment and participation of people in their communities and of people in their health care (WHO, 2013)

Mental health literacy is both a derivative from and component of health literacy. Similar to health literacy, MHL is an evolving construct. It has gone beyond its original concept of “illness identification” to include the various domains identified in the video blog you just viewed. Similar to health literacy, mental health literacy is understood to be a significant determinant of mental health and thus has the potential to improve both individual and population health. According to WHO, health literacy is:

A stronger predictor of an individual’s health status than income, employment status, education and racial or ethnic group (WHO, 2013)

Similarly, our understanding of mental health literacy is consistent with the literacy definition by UNESCO.

Literacy is a fundamental human right and the foundation for lifelong learning. It is fully essential to social and human development in its abilities to transform lives. For individuals, families, and societies alike, it is an instrument of empowerment to improve one’s health, one’s income, and one’s relationship with the world. (UNESCO)

Section 2: The Inter-Relationship of Mental Health States

Learning objectives

In this section, you will:

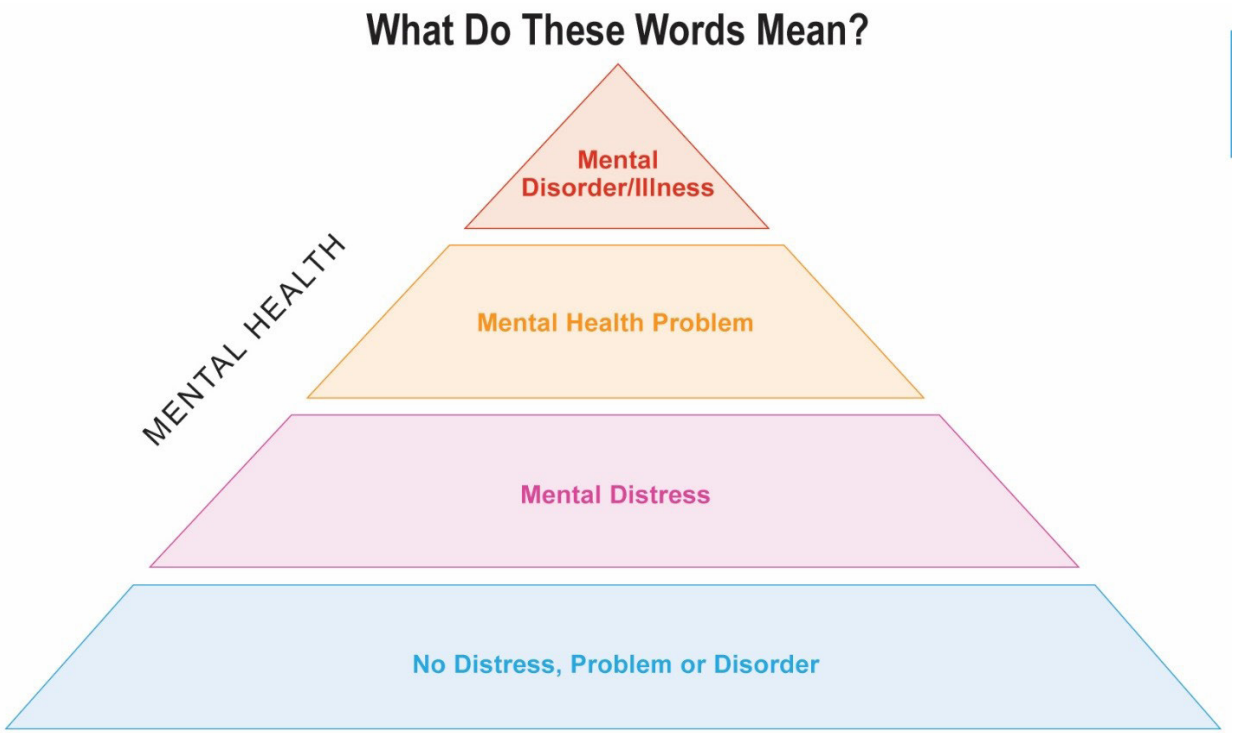
- Get a better understanding of the definitions of basic concepts: mental health, mental illness, mental distress, mental health problems;
- Be aware how different levels of mental health states inter-play with each other;
- Learn how mental health promotion, prevention and intervention/treatment can be applied to mental health states.

Activity 1:2.1: Please reflect on the following questions:

- Have you felt distressed in the last 24 hours? If so, what has happened to cause those feelings?
- What is a mental health problem? What challenges in your life could be connected to a mental health problem? Can you give some examples of how these (events and states) may be experienced?
- Is there a time when you have experienced both mental health distress and mental health problems? Can you think of examples?

We, as human beings, possess multiple and complex mental health states, and experience various emotions and cognitions and exhibit various behaviours at different points of our life. These emotions, cognitions and behaviours are influenced by the complex interactions that are continuously occurring between our brain and the environment. The environment (everything that exists outside the brain) influences how the brain functions and the brain influences and changes its environment (more about this complex interaction in an upcoming module).

Activity 1:2.2: The following diagram describes the interrelationship of mental health states using a triangle figure (mental distress, mental health problems, mental disorder/illness).



These states are not mutually exclusive. Any person can experience some or all of these mental health states within a short period of time (such as an hour), or over a longer period of time (weeks, months or even years).

Every person in Canada will experience three of these mental health states (no distress problem or illness; mental distress; mental health problem) over the period of their lifetime. These three states are all part of usual life and together constitute mental health. Worldwide, about 20% of people will additionally experience a mental illness. They will also experience each of the other three states. A person can have mental health and mental illness concurrently.

Note:

- Mental health states are not a continuum.
- People DO NOT progress from mental distress to developing a mental illness. Otherwise, everyone will end up with a mental illness.
- People can experience one or more states at the same time. Different mental health states should be addressed differently.

What is mental health and what are mental illnesses?

World Health Organization (WHO) defines mental health as "a state of wellbeing 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." http://www.who.int/features/factfiles/mental_health/en/

The Surgeon General of the USA provided a clearer definition of mental health (1999): "Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to change and cope with adversity"

Compare the two definitions. Note how the second one may be considered to be more empowering and it focuses on applying competencies to challenge the demands of life.

Which definition is more in keeping with the concept of resilience? Which definition is more closely aligned with the WHO definition of health literacy?

The Diagnostic and Statistical Manual, 5th edition, of the American Psychiatric Association (DSM-5) defines mental illnesses or mental disorders as dysregulation of mood, thought and/or behaviour (http://www.cdc.gov/mentalhealth/basics/mental-illness.htm)

Activity 1:2.3: What do you think is the answer to these questions?

1. What percent of Canadians aged 12-19 rate their mental health as good or excellent?
2. What percent of Canadians aged 15-24 rate their mental health as fair or poor?
3. What percent of Canadian teenagers report that they are usually happy and interested in life?

Write down your answers to the questions above. We will come back to them later.

What is mental distress?

Mental distress is the common, expected and normal response to the stresses of everyday life, for example: writing an exam, going to a job interview, etc. It is a signal to you, from your brain, telling you that you need to adapt to the environment and it is the basis for adaptation and resilience.

Consider this example of distress: You are leaving a movie theatre by yourself late at night, and you take a short-cut through a dark and deserted alley on your way to your parked car. As you make your way, you hear footsteps behind you. Your heart starts to race, you begin to sweat, your hearing becomes attuned for more sounds (is someone following you?). You recall a news story about a person who was assaulted in this part of town a few months ago and you inwardly curse yourself for taking the short-cut. You begin to run, not stopping until you reach your car. As soon as you get to your car, you get in and very quickly lock all the doors, even though that isn't your usual practice. You start the engine and drive away. All of these responses are normal and expected responses to the situation you have been in. You made a decision regarding your route and as a result of that decision, you felt a threat, your body reacted, you felt frightened and you enacted a number of behaviours in response to that physical sensation. To the extent that these new behaviours were successful (i.e. you avoided being assaulted), you learned from this experience, making it likely that you will not take a short-cut down a deserted alley at night again. In this way, you decrease your future risk of being assaulted, you have learned how to adapt to your environment better, and in the process, have developed greater resilience (and, perhaps, wisdom).

How do we deal with mental distress?

Mental distress should not be addressed using professional intervention. On the contrary: people are able to adapt by themselves naturally, or with usual support and advice from the family or community. For example, a student is distressed because they are going to be late for school. Then they may get up earlier the next day for school. Learning the skills needed to be able to deal with life's challenges is an important component of prevention. These skills can be used to learn how to cope with and decrease the impact of future life challenges.

A parallel: A parallel to this is that of the body's immune system. Every day our bodies are invaded by a multitude of germs (bacteria and viruses) but most of the time our bodies shrug them off. We may feel a bit off at times, cough or sneeze or get a mild stomach-ache, but these are merely symptoms that tell us our bodies

are doing exactly what they have evolved to do. We don't need to go and see a health provider for help. And we can help ourselves by doing a few useful things – such as washing our hands before eating, but the key component here is that our body handles all these stressors on its own, naturally.

Activity 1:2.3: Can you come up with examples of mental distress in your everyday life?

What are mental health problems?

Mental health problems are indicators of adaptation being challenged by the magnitude of the stressor. They are characterized by negative emotions, challenging cognitions and various difficulties with behaviour that can be severe at times and of either short or long durations (for example: death of a loved one, loss of a job, etc.) Almost everyone will experience these states many times during their life.

How to deal with mental health problems?

People with mental health problems, such as grief, may need extra professional help, such as counseling, in addition to family and community support.

A parallel:

A parallel to this is when there is a powerful new germ (bacteria or virus) that the immune system has not encountered before or perhaps the body is in a weakened state due to another illness (for example: cancer). In this setting the immune system can become temporally overcome by the invader and you experience some significant and substantial symptoms (for example: fever, sore throat, fatigue, muscle aches and pains, etc.). However, most of the time with the proper interventions (usually sleep, fluids and some medications to dry up secretions and/or help with too much coughing) you bounce back and within a few days to a week you are back to your usual self. Medical treatment is not usually necessary unless complications, such as pneumonia, develop.

What are mental illnesses?

People who experience mental illnesses (diagnosed according to internationally agreed upon criteria) on the other hand require best available evidence-based treatments/interventions from properly trained health care providers. These treatments/interventions are provided in addition to the supports often given to people who experience mental distress or a mental health problem. Treatments can improve symptoms and functioning, they may prevent the illness from recurring as well as preventing the negative impact of the illness on life success (e.g., early effective treatment of Depression may prevent job loss or relationship breakdown).

A parallel:

The parallel is that of a disease such as HIV/AIDS or Tuberculosis, where the invading organism overwhelms the body's defenses. In these cases, you will get many of the same kinds of symptoms that characterize a bad cold or the flu. However, unlike a cold, without the proper medical interventions (rapid access to evidence-based treatment), the outcomes are not very good. In this case, professional help is both needed and necessary.

Activity 1:2.4: The following video reviews each of the above described states. Take a few minutes to listen and think about what you hear. Video link: https://www.youtube.com/watch?v=LsowyMnqCRs&t=26s

Mental health promotion for all

Regardless of the status of someone's mental health, mental health promotion for all can be helpful.

Mental health promotion refers to the enhancement of capacities of

individuals, families, groups and communities to promote positive mental health, which is one of the desired outcomes of health promotion. (WHO, 2002)

Positive mental health means being able to successfully adapt to life, not having only positive emotions. Negative emotions are often normal and a necessary part of positive mental health.

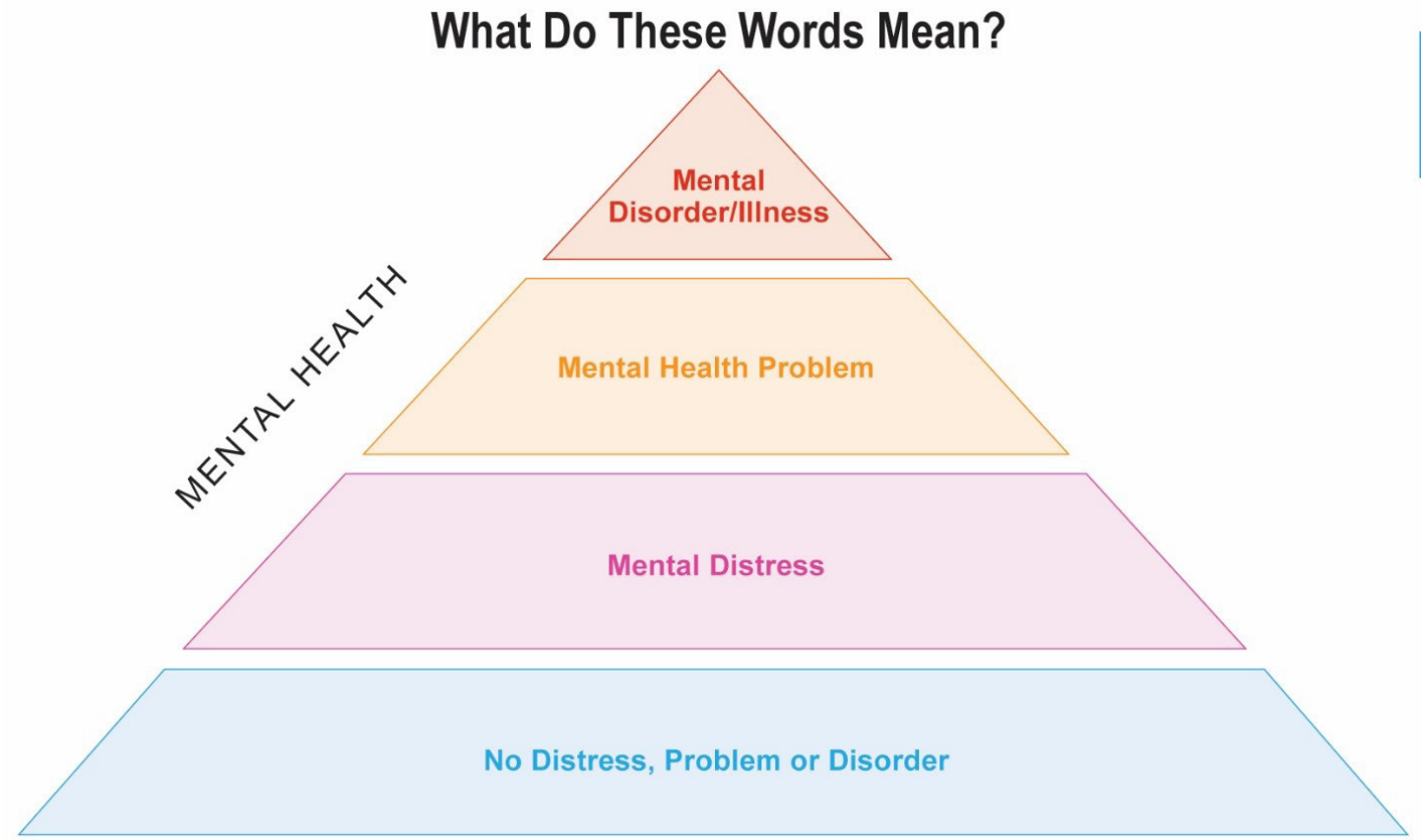
Mental health primary prevention

Primary prevention is related to preventing disease from ever occurring. However, it not only involves targeting risk factors and early symptoms of the disease, but can also involve promoting associated activities that improve the overall quality of life of people and improving various social factors such as reduction of poverty, gender equality and the rule of law, that can increase risk for mental disorders or poor outcomes for those who experience them.

Mental health secondary prevention and treatment as prevention

In recent years, the concept of treatment as prevention has gained solid scientific ground – mostly from evidence related to the prevention of HIV/AIDS. For example, antiretroviral treatment (ART) of HIV/AIDS has been successfully used to decrease the risk of HIV transmission. This potential awaits study with regards to mental disorders. Secondary prevention of mental illness is more established. For example, effective early treatment of an Anxiety Disorder may prevent the occurrence of Depression or Substance Use Disorder. This is yet another reason to provide early effective treatments to young people who have a mental illness. Overall, mental health promotion, prevention and treatment/intervention are all related activities that are used to promote good mental health, treat illness effectively with evidence-based treatments/interventions, prevent associated morbidity and perhaps secondarily prevent illness from occurring.

Activity 1:2.5: This following exercise (adapted from www.teenmentalhealth.org/curriculum) requires you to match the words in the box to various mental health states of the triangle. What do you think could be the consequences of using the word “depressed” to describe each of the different mental health states?



Pensive, sad, unhappy, disappointed, happy, disgusted, angry, bitter, blue, down, sorry, glum, forlorn, serene, disconsolate, thoughtful, satisfied, distressed, despondent, depressed, content, dejected, pessimistic, heartbroken, sorrowful, peaceful, demoralized, grieving, mournful, despairing, calm, delighted, upset, annoyed

Section 3: Facts About Mental Illness

Learning objectives

In this section, you will:

- Get a better understanding of the importance of talking about mental illness in the school setting;
- Be exposed to basic epidemiology of mental illness;
- Understand the impacts of mental illness and related issues.

We have discussed the concept of mental health literacy and we have been exposed to a consideration of various levels of mental health states. Now it's time to examine why we talk about mental illness in schools. Reports by the WHO have demonstrated that about 1 in 5 (20%) people will develop a mental illness (such as: Depression; Panic Disorder; Attention Deficit Disorder; etc.) and about 70% of these mental illnesses can be diagnosed before the age of 25. Since most children and youth go to school, teachers can play an important role in understanding how to identify and support young people who may be developing or who are living with a mental illness.

Activity 1:3.1: The Module 1 PowerPoint "Facts About Mental Health and Mental Illness" provides some important facts about mental health and mental illnesses, discussing how common they are and the impact they can have. Please take this time to review both presentations. Write down one fact you learned that was surprising to you*

*Source: Canadian Institute for Health Information (May 2015) Public Health Agency of Canada. Positive Mental Health Surveillance (2017)

Section 4: Schools: An Important Venue in Which to Address Mental Health Literacy

Learning objectives

In this section, you will:

- Recognize why it is important to address mental health literacy in schools;
- Be exposed to historical school health models and how mental health literacy is missing in these models;
- Realize that teachers can play a fundamental role in improving student mental health literacy and helping them succeed.

Why is school mental health literacy important?

The Canadian Council on Learning (2009) pointed out that schools are important sites to address student mental health because untreated mental health problems and mental illnesses may lead to:

- Learning difficulties;
- Poorer academic achievements;
- Dropping out of school;
- Substance abuse;
- Negative relationships with peers and teachers;
- Greater risk of suicide.

Health promotion has been integrated into Canadian schools for decades but mental health has been historically separated from overall health. However, the brain is a fully integrated part of the body, there is no

separation between physical health and mental health. What is good for your bicep is good for your brain and vice versa. Changes in our understanding of this relationship are just starting, and teachers are placed in a unique position to make and push this change.
*See Deeper Dive section

Schools can be...

- Schools can be sites where both teachers and students can enhance their mental health literacy.
- Schools can be community hubs where mental health literacy activities are made available to parents and interested members of the community.
- Schools can be sites where young people who may have a mental illness or mental health problem can be identified, referred for care and supported.
- Schools can be sites where mental health care can be delivered – such as through school health clinics/ youth health centres or school-based mental health care providers.

Activity 1:4.1: Here are the answers to the questions in Activity 1:2.3. Compare the answers to your answers. How close did you come to the answer? If you were really off, why do you think that might have been?

1. What percent of Canadians aged 12-19 rate their mental health as good or excellent? **ANSWER: 75%**
2. What percent of Canadians aged 15-24 rate their mental health as fair or poor? **ANSWER: 8%**
3. What percent of Canadian teenagers report that they are usually happy and interested in life? **ANSWER: 77%**

Conclusion

The introduction and background has included much complex and important information. We have addressed why it is important to create this mental health literacy resource for pre-service teachers and we provided basic information about mental health and mental illness. As you now should understand, health, including mental health, and education are inextricably related and together, they play a fundamental role in the development of children and youth. As teachers, you may start thinking about how and what you can contribute to improving mental and physical health outcomes for your students.

You may apply the information in this module in your future teaching career to advocate for improvements in the delivery of mental health literacy in your schools and community or you may adapt it to be used in your future classroom to educate students about mental health.

Supplementary Materials

Want to learn more about mental health literacy? Check these out:

World Health Organization. Health Literacy: the solid facts.
WHO Regional Office for Europe, Copenhagen. 2013
http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf

Public Health Agency of Canada: Health Literacy
www.phac-aspc.gc.ca/cd-mc/hl-ls/index-eng.php

The Canadian Journal of Psychiatry. Mental Health Literacy: Past Present and Future. www.ncbi.nlm.nih.gov/pmc/articles/pmc4813415/

European Child and Adolescent Psychiatry: Enhancing Mental Health Literacy in Young People. www.ncbi.nlm.nih.gov/pubmed/27236662

Mental Health Literacy in Secondary Schools: A Canadian Approach
www.ncbi.nlm.nih/gov/pubmed/25773321

Mental Illness and Addictions: Facts and Statistics. CAMH www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx

Health at a Glance. Statistics Canada. Mental and Substance Use Disorders in Canada www.statcan.gc.ca/pub/82-624x/2013001/article/11855-eng.htm

Self-Assessment

1. Mental health literacy includes being knowledgeable about why schools are not health providers.
2. Mental distress should be treated by psychotherapy as soon as possible, to limit negative mental health outcomes.
3. Effective treatment for Social Anxiety Disorder that decreases risk for substance abuse is an example of secondary prevention.
4. Untreated mental disorders independently increase risk for physical illnesses such as diabetes and heart disease.
5. In Canada, mental illnesses contribute about 15% of the burden of disease.
6. Schools can be sites to BOTH advance mental health literacy and provide mental health care for students.

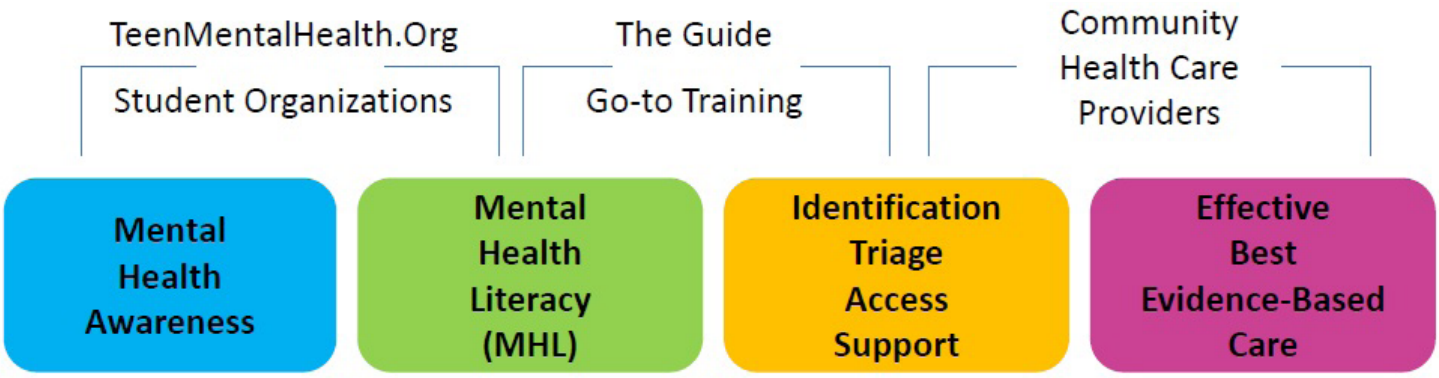
Self-Assessment Answer Key
1) F 2) F 3) T 4) T 5) T 6) T

Module 1: Deeper Dive

The Pathway Through Care (PTC) is a term used to denote a horizontal linkage between necessary conditions that working in concert can assist a person who is in need of mental health care to be able to rapidly access the kind of care that they need.

Figure DD 1.1: provides a schematic of a PTC approach, demonstrating how at the population level the different components of mental health awareness, mental health literacy, case identification and provision of effective mental health care link together.

Figure DD 1.1



For a brief video presentation describing the PTC approach check out: http://teenmentalhealth.org/pathwaythroughcare

Activity DD 1.1: Consider what kinds of supports or structures can be embedded into school settings that would facilitate the application of the Pathway Through Care that could be easily accessed by students.

Check out these papers:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2874625/

What do you think about the model that they discuss? What kinds of mental health related supports for students are available in the schools you are familiar with? What is the research evidence for effectiveness of any school based mental health related services that you are familiar with?

The impact of mental illness

Mental illnesses are chronic diseases. Their impact on a society is measured using the concept burden of disease.

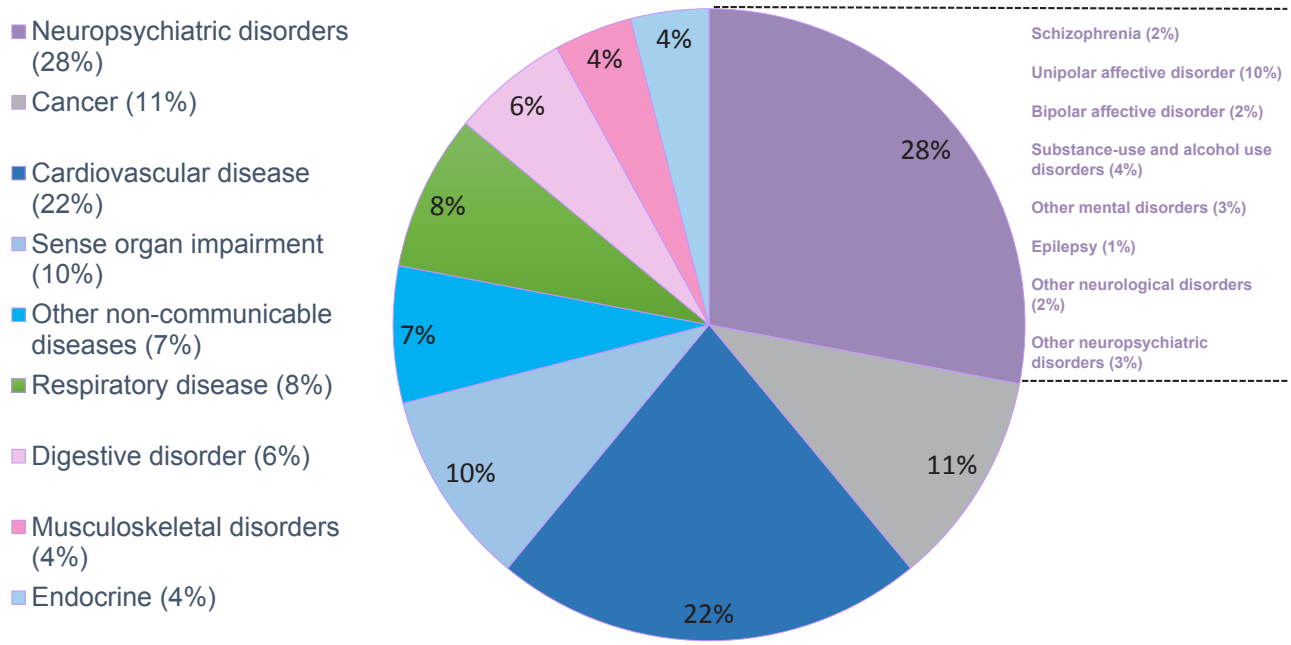
The burden of disease is the impact of an illness as measured by mortality, morbidity, cost or other types of agreed upon indicators. Its outcomes are often reported using a metric called disability adjusted life years (DALYs) which quantifies the number of years lost due to the disease.

The Lancet Global Burden of Disease Study is the most recent attempt to capture the comparative impact of different illnesses using this methodology. Here is a link to this publication collection: http://www.thelancet.com/gbd which you can review if you choose.

Have a look at Figure **DD 1.2**. It provides information about the comparative prevalence of mental disorders globally. Notice how common the mental disorders (called neuropsychiatric disorders) are compared to all

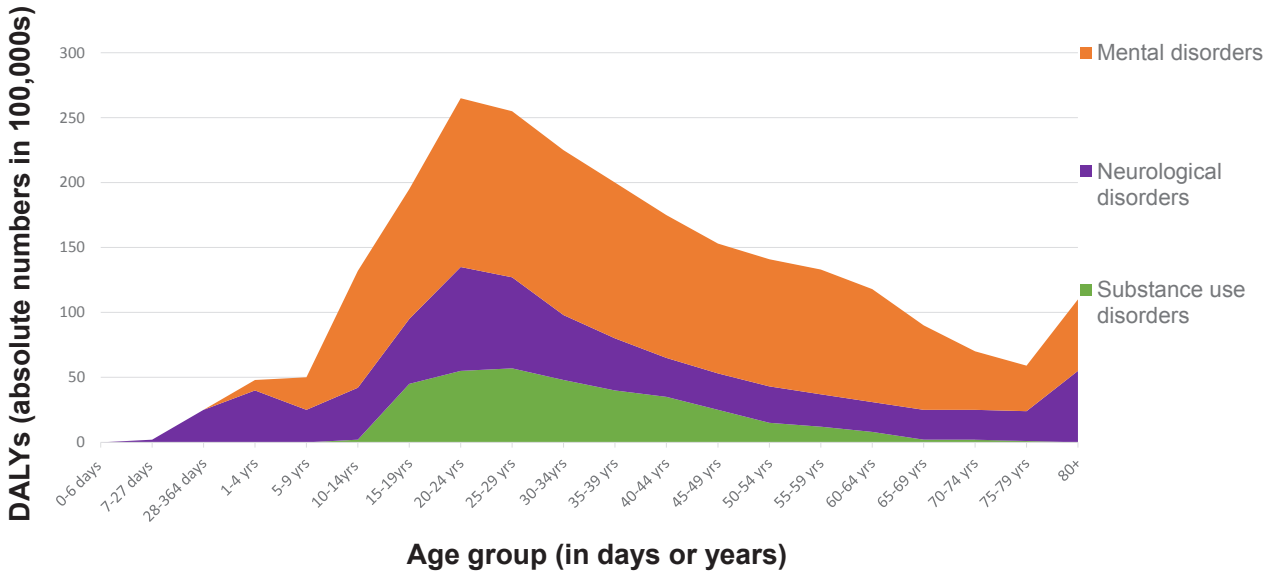
other illness.

Figure DD 1.2



Also, it is important to remember that most mental illnesses can be diagnosed prior to age 25 years. That is information that you reviewed in the Core Materials in this module. However, not only do mental illnesses begin early in the life span, but their proportional share of the burden of disease is greatest in the period of time between ages 12 and 25 years. This is illustrated in Figure DD 1.3.

Figure DD 1.3 The Burden of Mental Illness across the life-span



Note: DALYs = disability-adjusted life years

Activity DD 1.2: Given what you have learned in this module, how would you design a Pathway Through Care that can meet the needs of students in primary, junior high and secondary school? What similarities and differences are found amongst these categories in your designs? Are there designs that would meet student Pathway Through Care needs in all three categories?

Additional self-study resources:

To learn more about the Deeper Diver materials addressed above, check out these resources:
Disease Burden:

1. https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/measures-disease-burden
2. https://ourworldindata.org/burden-of-disease
3. http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00505-2/abstract

Early Interventions for Child and Adolescent Mental Illness

1. http://journals.sagepub.com/doi/abs/10.1177/0706743717698670
2. https://www.longwoods.com/content/22359
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5026677/

Module 2

Stigma and Mental Illness

In Module 1 we learned that one of the four components of mental health literacy is effective and sustained reduction of stigma. In Module 2, we focus on understanding the different types of stigma related to mental illness and learn about evidence-based strategies that effectively address it and how these can be applied in the school setting.

Learning objectives

In this module, you will:

- Enhance your understanding of stigma and how that relates to mental illness;
- Learn about some evidence-based strategies that can be used to reduce stigma in the school setting.

Warming-up activities

Activity 2.1: Write down 5 words that first come to mind describing a person who has a mental illness.

Next, write down 5 words that first come to mind describing a person who is a teacher.

Review your descriptor words. How many words that you have used have negative connotations (such as crazy; sick; disturbed; unwell; stressed out; etc.), how many have positive connotations (such as: hard working, dedicated, understanding, considerate, friendly, creative, etc.) and how many have neutral connotations (such as: person, male, female, tall). If you are like most people, many of the words you wrote to describe a person who has a mental illness will tend to have negative connotations and the words you wrote to describe a person who is a teacher will have positive connotations.

Note: Mental illness affects approximately 1 in 5 people worldwide with a similar proportion in Canada. People with mental illness could be an acquaintance, a friend, a family member, a co-worker, a neighbor, a classmate, a celebrity, and so on. Indeed, statistically, approximately 1 in 5 people who are teachers in Canada will have a mental illness. However, we tend to think of people who have a mental illness differently without even realizing it. This is called stigma. Everyone has some stigma, and some people have more than others.

Activity 2.2: Take a minute to think about where your images of people who have a mental illness come from.

1. Movies ?
2. Television or other media?
3. Books?
4. Family or friends?
5. Personal experience?

Question for reflection

How has your exposure to people with mental illness or knowledge about mental illness made a difference in the way you think about it? The way we perceive others, including people with mental illness, has been greatly influenced by social, cultural and other factors. Historically there was a general lack of knowledge about mental illness and today there are often negative and often false stereotypes found in mass media. This leads to portrayals such as a psychotic killer as an example of people with schizophrenia. Just think of some examples of uninformed opinions about mental illness and negative descriptions of people with mental illness we have been exposed to from mass media. Remember that this also pertains to treatments for mental illnesses. How many times have you read negative stories about treatments for mental illnesses compared to negative stories about treatments for other illnesses?

Note: It is important to note that mental illness is not the only medical condition that has historically been stigmatized or that is now still being stigmatized. Just bring to mind the stigma against epilepsy, leprosy, HIV-AIDS and even cancer. Why do you think that there may be less stigma against those diseases now? Do you think that knowledge about what causes those illnesses and awareness of how effective treatments can be have made a difference in stigma?

Activity 2.3: Meet Joan. She is a grade 9 student who enjoys English literature and soccer. She was a student in one of your classes for about five months prior to her hospitalization for a mental illness called Depression and you have always been on friendly terms with her. She has just returned from a two-week inpatient stay for treatment of her Depression after trying to end her life by suicide.

1. What do you expect when you meet Joan?
2. How do you prepare for her arrival? List 5 things that you may do.

Review your answers:

1. How many of the things on your list had to do with you expecting to be a caregiver?
2. How many things on your list were about you feeling or thinking that you need to make things easier for her?
3. How many things on your list involved asking her what she's good at, and what she needs to feel supported in doing?
4. How many things on your list were about setting reasonable expectations for academic outputs?
5. How many things on your list were about talking to school based student services providers (such as counsellors or psychologists) to discuss what you could do in the classroom?

Next, watch this video about Joan: https://www.youtube.com/watch?v=hsaZwJHgYYM&feature=youtu.be

1. Now that you've watched the video, what was your first reaction to Joan's story?
   - What did you want to know more about?
   - What are you left wondering about?
2. What might have caused a teacher to tell Joan to drop out?
   - What could have been done instead?
   - What would you as a teacher say in this circumstance?
3. Joan described two kinds of teachers she encountered at school. What were they like?
4. What did Joan mean when she said that some teachers "don't believe that mental health is an actual thing"? Did she herself show that she knew the difference between mental health and a mental illness? Why do you think people use the words mental health when they mean mental illness? Could that use of language be an example of stigma?
   - Have you ever encountered a teacher who felt or thought similarly?
   - What did you do or say to that person?
5. What did Joan say was the best support you can give? What will you do next?

Note: The attitudes, knowledge and feelings we have about mental illness end up influencing our behaviours toward people who have mental illnesses and also impact what we say to others about mental illnesses. Teachers can play an important role in helping students and others change how people with mental illness are perceived and treated. As future teachers, you have the power to help determine the kind of environment in which students learn.

What is stigma anyway?*

Origin of stigma:

1. In ancient Greece, the term stigma was used to signify a tattoo or mark that may have been used for decorative or religious purposes, or to brand slaves to indicate their ownership, and criminals to indicate heir social transgressions
2. A sharp stick, termed a stig, was used for tattooing, hence the origin of the word stigma and its subsequent association with a mark or a brand of shame.

* See Deeper Dive: How do we understand stigma in our historical time

3. In "western" society, the term stigma started to be used to signify social degradation in the late sixteenth or early seventeenth centuries when mental illnesses became linked with the theological construct of sin (in the Bible the mark of Cain in the story of Cain and Abel illustrates this link). There have been many definitions of stigma in general. For example:

"A mark or sign of disgrace or discredit."
(The Concise Oxford Dictionary, 1990)

"A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria."
(The Shorter Oxford English Dictionary)

"A mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing."
(The Shorter Oxford English Dictionary)

What is stigma in relationship to mental illness?

Remember that mental illnesses are only one of many medical conditions that have been stigmatized over the years. Others include diseases such as leprosy, epilepsy, HIV/AIDS, cancer, etc. There are many similarities amongst stigmas across these different conditions. Keep this understanding in mind as you continue to work through this module. What has changed that may have contributed to decreasing stigma in other medical conditions? How could our knowledge about that help decrease the stigma about mental illness? What do you think the impact of modern scientific knowledge about the causes and treatments of these diseases had on stigma related to them?

Many definitions of stigma have focused on negative attitudes and behaviours directed towards those who have a mental illness. Here are a few examples:

Mental illness stigma is defined as the culmination of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and enact behaviours of discrimination against people with mental illness (p. 49, Pinto, Hickman, Logsdon, & Burant, 2012)

Stigma refers to beliefs and attitudes about mental health problems and mental illnesses that lead to the negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families (p. 82, Mental Health Commission of Canada, 2009)

Activity 2.4

What do you think about those definitions? Do you think that stigma against mental illness extends to stigma against those professionals who treat people with mental illness? Do you think that stigma against mental illness extends to treatments for people with mental illness?

Stigma of mental illness prevails in everyday life. It may or may not be possible to eradicate all stigmas but awareness of stigma and how it can negatively impact our own beliefs and actions is a good place to start.

Stigma Type	What It Is	Example
Personal Stigma	Personal attitudes toward people with mental illness	I do not think students with mental illness should go to this school.
Emotional Responses	Feelings and emotions toward mental illness	I fear people with psychosis; I am embarrassed that my child has an Anxiety Disorder.
Perceived/Public Stigma	Beliefs about how others (general public) perceive mental illness	People think a person who is mentally ill should not get married or should not run for public office or not serve on the Supreme Court.
Social Distance	The degree to which people are willing to accept those who have a mental illness into their social lives	I don't want people with mental illness living in my community
Self-stigma	A situation in which people with mental illness internalize social myths and prejudices about mental illness	I am stupid because I have ADHD.
Stigmatizing Experiences	Experiences by people with mental illness in social life	I have difficulties finding a job because of my Depression.
Stigma Against Treatment	Ignores evidence of effective treatment	Don't take medicines. Psychotherapy is nothing but talk.

Note: Your students will experience and learn from your attitudes, ideas, and beliefs about mental illness by how you behave in the classroom, the school and in your community (including what you say and what you do not say). It is very important to remember that not speaking out against stigma is often understood by others to mean that you condone it.

What are the consequences of stigma of mental illness?

Stigma can lead to discrimination, and may "impede social integration, interfere with the performance of social roles, diminish quality of life, and prevent timely access to treatment, effectively creating a vicious cycle of social disadvantage and disability" (Stuart, 2005, p. S22).

Stigma related to mental illness impedes or prevents individuals with mental illness from achieving numerous individual and social successes and can limit a person's access to health care.

Stigma for me, the most agonizing part of my disorder. It cost friendships, career opportunities, and most importantly - my self-esteem. It wasn't long before I began internalizing the attitudes of others, viewing myself as a lesser person (Simmie and Nunes, 2001, p.308).

I would do everything to have breast cancer over mental illness. I would do anything because I (would) not have to put up with stigma (The Standing Committee on Social Affairs, Science and Technology, 2006, p.2)

Effectively addressing stigma

Activity 2.5: Can you think of some strategies that may be effective in changing the stigma related to mental illness? What role does language have in creating or perpetuating stigma? Write down your thoughts and then continue to the end of activity 2.7. Review your notes and reconsider what you wrote.

What can we do?

So what does it take to decrease stigma? Let's look at some of the work we could do to change our minds and change our behaviours.

Evidenced-based strategies to fight stigma

Now imagine that one of your students has just received a diagnosis of a mental illness. What does it feel like to be surrounded by images, rumours, and popular beliefs about people with mental illnesses? **What happens when that student accepts those images and beliefs as the truth about their chances of success in life?** It must take some serious bravery to keep going in the midst of all of the negative perspectives and assumptions about "people like that".

But how can we make that change? Researchers have identified a number of evidence-based strategies that could be used to change someone's attitudes and behaviours about mental illness. Remember, that given the complexities of stigma, some of these strategies may work better than others and some may work better in some unique groups or settings or at different ages (such as: young people, schools, community organizations, political parties, etc.). Some of these strategies have been fairly well studied and others have not. While much more is yet to be learned, these interventions provide us with a good place to start.

1. Education, which involves correcting false information about mental illness and replacing it with information based on best available scientific knowledge about the causes and treatments of mental illnesses. There is good evidence that this approach works for teachers and for students in the school setting.
2. Another strategy is known as "contact education" or "first person experience". This includes getting to know someone who has a mental disorder and learning about mental illness through that relationship (there is a video clip related to this in activity 2.7).
3. Advocacy is a strategy to encourage us as citizens to participate and be engaged in our community and increase the priority of mental health promotion and provision of rapid access to effective mental health care on agendas of decision makers (such as politicians). For example, becoming part of an advocacy group working to improve the provision of mental health care for young people or monitoring the media and responding to stigmatizing messages about mental illness or its treatment can be a good way to address stigma.

Activity 2.6: The following PowerPoint "Myths and Realities of Mental Illness" is taken from the Mental Health & High School Curriculum Guide (www.teenmentalhealth.org/curriculum/). Have a look through the PowerPoint. Write down 2 - 3 myths that you may have held that have been addressed in it.

Activity 2.7: Watch the following video clip: https://www.youtube.com/watch?v=pcKyyQvCFtM

What do you think about the illness that Laura has after watching this clip? What do you think about how she has lived her life with her illness? How does what you have seen compare to what you wrote in activity 2.5?

Note: This video clip shows us that people with mental illness can live a productive life and contribute significantly to their fields of work if they receive appropriate medical treatment and ongoing support from their families, friends and community. However, people who stigmatize mental illness **tend to keep their distance.** There's even a name for it: social distance. **Keeping our distance from people who have a mental illness makes it *harder* to understand life from their point of view, and makes it easier for us to keep believing what we assume is true about them.**

So what can I do about stigma?

In the classroom teachers meet students almost every day, and having students with mental illness in the classroom can be challenging and at the same time rewarding. It is important to remember that every student who has a mental illness is not alike. Students bring their own personalities, histories and unique selves to every situation, including having a mental illness. Also, mental illnesses differ from each other. Schizophrenia is a mental illness and so is Anorexia Nervosa and so is Panic Disorder and so is Depression. Yet the impact of each of these illnesses is different. Finally, the severity of the illness matters, as does how well the student is responding to the treatments being provided. All these different components enter into the mix of how any intervention on your part assists any particular student who has a mental illness and how your intervention will play itself out. Nonetheless, keeping that important point in mind, here are some practical tips that may be helpful in your classroom teaching.

1. Keep learning about the scientifically understood causes and evidence-based treatments of mental illnesses.
    - This module only scratches the surface of what you can do to make things better for people struggling with the effects of stigma of mental illness. If you have a passion for eliminating prejudice and discrimination in schools and beyond, reach out to credible organizations (such as the Canadian Mental Health Association) that have a mission and competencies to respond to stigma and get involved.
2. Start talking about it – mental illness touches us all in some way, directly or through a friend, family member or colleague. Raising awareness by talking about mental illness can be useful. BUT – **talk smart**. Become mental health literate before you talk too much. Talk based on opinion and not on understanding and knowledge may do more harm than good.
    - Let your students know that your classroom is a safe space where they are accepted as themselves. Remember it is a **person** who has a mental illness that you are interacting with, not a mental illness you are interacting with.
3. Words have power.
    - Pay attention to the words you use, try not to use stigmatizing language and speak up when you hear someone else using stigmatizing language.
    - You can explain how using words like "psycho", "crazy" or "nut" can lead to feelings of shame and guilt about having emotional difficulties or a mental illness, and how this can discourage people who need support from getting help.
4. Silence is NOT neutral.
    - Where you see discrimination and don't name it, you endorse it. Support your students through your

words and actions.

5. Listen more than you speak.
    - It might be tempting to trivialize someone's illness when we know of someone who is going through worse times. Instead, try saying: "I'm sorry to hear that, it must be a difficult time. Is there anything you can share that might allow me to be helpful?

Cultural considerations

In today's increasingly diverse classrooms, it is essential that teachers are aware of and practice within a framework that respects that diversity. Not all students come from backgrounds that share the same understanding of or types of stigma against mental illness. Furthermore, students may have different understanding and different levels or types of stigma than their parents or cultural communities about mental illness. These differences may impact on how you as a teacher can best support your student if they have a mental illness. Recognition of this reality is important.

Activity 2.5 (again): Please return to the notes you made in Activity 2.5. Is there anything you would add? Is there anything you would re-consider?

Conclusion

Back to Joan: She is a person who has strengths and weaknesses. She has emotions, thinks about many things and has a wide repertoire of behaviours. She has good days and bad days. She's had positive and negative experiences at school, and is proud of her achievements and her success at overcoming obstacles. She also happens to have a mental illness – it's called Depression. As a result of that illness she may need some additional assistance from you. Most importantly to you as an educator right now, Joan recognizes the significant role that teachers can play in her life. If you focus on Joan's strengths while you assist her with her challenges, you may help her better walk the road of a productive and fulfilling life. Over the course of your teaching career, you will meet many young people, with unique hopes, dreams, interests, and personalities. When you get to know your students, you can get to know how best to help them.

As a teacher, get to know yourself too, so that you know how to build on your strengths and address your weaknesses. We would like to conclude this module with the following quote. Who has to change first: the students or the teacher?

> **The reframing changed my negative, critical attitude toward April's behaviour to a positive, supportive outlook. As a result, the exercises and movement no longer upset or distracted me. Once I became comfortable with the reframing, April's behaviour really improved. (p. 3, Weiner, 2006)**

Culturally responsive teaching

In Canada, our communities and classrooms are experiencing increased diversities in many different domains, including but not limited to: class, race, ethnicity, religion, sexual orientation, first language or others.

Culturally responsive teaching is, according to Willis and Lewis (1998), about allowing students to be who they are, and having a socio-political consciousness that allows teachers to not only have a greater sense of community, but also be in a position to critique their own education. This self-reflection must also include self-consideration about privilege and taken-for-granted experiences such as having a stable home life and adults who care(d) for us (Herman, 2004), healthy relationships (Jordan, 2009), and freedom (Sen, 1992). In other words, cultural awareness is central to culturally responsive teaching.

Cultural competency is one way to approach this – the knowledge, behaviours and values that are congruent with leading a classroom or school that is inclusive of all cultures.

Given the complexity of multiculturalism, it has been suggested that cultural humility should be a core value in the educational context.

Cultural humility is not a set of knowledge or skills, but rather a way of operating. It is defined as the ability to maintain an approach that is open to others in relation to the aspects of cultural identity that are most important to the person (Hook, Davis, Owen, Worthington & Utsey, 2013). In other words, it is not about us, but about the other.

There are three features of cultural humility that we can adopt and enact:

1. A lifelong commitment to self-evaluation and self-critique. We need to be brave enough to look critically at ourselves, our beliefs and behaviours, curious enough to learn, and patient enough to understand that we will never be 'finished' with learning.
2. A desire to fix power imbalances where none ought to exist. Teachers and learners come to the classroom with strengths, capabilities and vulnerabilities. We can seek to listen, understand, and advocate for change within the relationships we have with students, families, peers and communities, but we must also work for change within the larger, structural institutions. Cultural humility is larger that our individual selves – we must work to change the systems.
3. Develop partnerships with people and groups who advocate for others. Even though individuals – such as Malala, who has raised the awareness of the struggle and rights for girls' education worldwide – can create positive change, the sustainability comes when we work together across sectors, schools, classrooms and relationships. As we develop capacity for change, we share those skills with those who need them. As we are met with barriers to change, we reach out to those who may be able to help us successfully negotiate them.

Supplementary Materials

British Journal of Psychiatry: Evidence for effective interventions to reduce mental health related stigma in the medium and long term: systematic review
www.bjb.rcpsych.org/content/207/5/377

Cancer and Stigma: A Brief History
http://ncbi.nlm.nih.gov/books/NBK12903/

HIV Stigma and Discrimination Persist, Even in Healthcare
http://journalofethics.ama-assn.org/2009/12/oped1-0912.html

You may also want to check out this video:
TEDx Youth – Kevin Breed: Confessions of a depressed comic
https://www.youtube.com/watch?v=-Qe8cR4JI10

Interested in Human Rights and stigma? Check these out.

World Health Organization. WHO Resource Book on Mental Health: Human Rights and Legislation. Geneva, World Health Organization. 2005

Mfoafo-M'carthy M. and Huls S. Human Rights Violations and Mental Illness: Implications for Engagement and Adherence.

SAGE Open. January-March 2014: 1-18

Self-Assessment

1. The concept of stigma includes a variety of different constructs, including: social distance, self-stigma and treatment of mental illnesses.
2. Mental Illnesses are the only medical conditions that are the target of stigma.
3. Discrimination is the belief that people are not worthy of support.
4. Cognitive control is an effective way to decrease stigma.
5. Mental Illnesses are often caused by the food people eat.
6. While some people who have a mental illness can be violent, most violence is not due to a mental illness.

Self-Assessment Answer Key

1) T 2) F 3) F 4) F 5) F 6) T

TEACH MENTAL HEALTH

Module 2: Deeper Dive

How do we understand stigma in our historical time?

Social scientists have created various models and frameworks (approaches) to help understand and interpret the concept of stigma in mental illness. These approaches are often based on ideas that have not yet been well validated scientifically. These approaches are often commonly called “theories” (for example: Labeling Theory) although they are more properly considered to be hypotheses. A hypothesis is an idea that has not been independently and critically tested. A simplified description of one such approach to how stigma may develop is this:

Labeling differences

- People distinguish and label human differences
- This may be due to misinformation/differences in understanding

Stereotypes

- Stereotypes are common societal or cultural beliefs about people with mental illnesses
- To stereotype is to generalize

Prejudice

- A negative prejudgment of a group (e.g. people with mental illness) and its individual members
- Prejudice is a negative attitude
- Prejudice indicates a separation of “them” from “us”

Discrimination

- It is the behavioural consequence of labeling, stereotypes, and prejudice
- These include conscious or intentional behaviours and unconscious or unintentional behaviours (avoidance, rejection etc,)
- It also includes the policies and practices that result from these behaviours

Note: Such hypotheses about how stigma develops illustrate the complexity of the issue. Stigma includes emotions, cognitions and behaviours of: the individual, and of relatively homogeneous social groups (however those are defined – for example, by profession; income; religion; etc.) and of relatively heterogeneous social groups (such as countries or political jurisdictions). Stigma is also not just “present” or “absent”. Indeed, it can be present in degree or in kind. For example, a person may not have negative attitudes towards mental illness but support health policies that discriminate against a person with a mental illness. Alternatively a person may support legislation that improves access for people who have a mental illness to health care but at the same time will not support a budget allocation to increase the amount of funding for treatments of mental illnesses. A good critical consideration is that we need to carefully consider all these complexities that go into our understanding of stigma and not jump to conclusions about the preferred use of one definition over another.

Note: Self-stigma is a component of stigma that occurs when an individual internalizes negative cultural/social/religious stereotypes and comes to feel that they are of less value as a person than those who do not have their condition. This may lead to: avoidance of needed treatment; a reduction in hope; decreased self-esteem, self-efficacy, empowerment and morale; poor recovery from the illness; lowered quality of life; etc.

Structural stigmatization (system – such as in health care and societal level – such as in the community where the person with mental illness lives) perpetuates discriminatory policies, practices, and organizational structures (e.g., low levels of priority for governments and funders in allocating resources for the treatment of people with mental illnesses, less availability and quality of care, difficulty to recruit medical or nursing students to choose a career working with people who have a mental illness).

Stigma is not unique to mental illness: Since we have so much media and social media discussion about stigma at this historical time, it is easy to forget that stigma is not limited to mental illnesses. Indeed some of the most stigmatizing illnesses have included infectious diseases such as leprosy and tuberculosis in past

centuries and HIV/AIDs in modern times. Stigma was until relatively recently common for epilepsy (indeed in many parts of the world it still is, check out: http://www.who.int/mental_health/neurology/en/epilepsy_poster.pdf

In these illnesses, successful stigma reduction involved knowledge about the disease, the widespread application of effective treatments and collaboration between scientists, clinical health care providers, governments and civil society organizations. This is an approach that is very different than the social marketing campaigns against mental disorders that we commonly see today. It is very useful to become better educated about how stigma has been addressed in other illnesses in addition to mental illness. There is much that can be learned from those approaches.

Activity DD 2.1: Read the following brief papers and then consider what you learned about stigma in these illnesses. Does stigma still exist for these illnesses? How did stigma reduction in those illnesses occur? How could you apply what you learned to better address stigma about mental illnesses?

Epilepsy and Stigma
https://www.sciencedirect.com/science/article/pii/S1059131110002487

Cancer and Stigma
https://academic.oup.com/annonc/article/23/suppl_3/66/207372

HIV/AIDS and Stigma
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835402/

Separating out stigma reduction from public self-promotion

In the social media world of anti-stigma activities there has been concerns raised about a phenomenon called "virtue signaling" arising within these anti-stigma activities. Virtue signaling is defined as: "the conspicuous expression of moral values done primarily with the intent of enhancing standing within a social group." (https://en.wikipedia.org/wiki/Virtue_signalling). The Oxford English Dictionary defines it as: "The action or practice of publicly expressing opinions or sentiments intended to demonstrate one's good character or the moral correctness of one's position on a particular issue." (https://en.oxforddictionaries.com/definition/virtue_signalling). Examples often used to illustrate this include such songs as "Do They Know it's Christmas" by Band Aid; the "ice bucket challenge" in support of ALS; wearing a pink shirt to stop bullying, etc. Here is an interesting commentary on this issue related to mental health: https://blueprintzine.com/2017/11/30/discussing-mens-mental-health-on-twitter-too-much-virtue-signalling-too-little-virtue/

Activity DD 2.2: What are the arguments for and against the concept of virtue signalling? What do you think about the issue of virtue signalling as it applies to mental health? What is the relationship (if any) between celebrity endorsement of mental health activities and virtue signalling?

Module 3

Human Brain Development

Mental health is brain health and mental illnesses arise from perturbations in usual brain functioning. In module 3, we will learn educator useful basic information about the developing human brain and its 6 fundamental functions. This is not a neuroscience course but completion of this module will help provide you with knowledge about the brain and its functions that you will find useful in your teaching career.

Learning objective

In this module, you will:

- Better understand the human brain and its functions in health and illness;
- Appreciate the importance of a healthy brain for mental health.

It is not possible to understand mental health or mental illness without understanding our brains. All our emotions, cognition, behaviour and everything that makes us human comes from our brains, the most complex entity known.

The brain is a remarkable organ that controls the complex activities which help define our humanity. It is never fully developed because it is constantly evolving and reshaping as a result of our experiences.

What is the human brain made of?

Commonly referred to as the “master control centre”, the brain controls everything from physical functioning (such as our ability to digest food, throw a ball and breathe) to complex creative processing (such as our ability to produce art, literature, music and ideas that define our humanity) – and everything in-between!

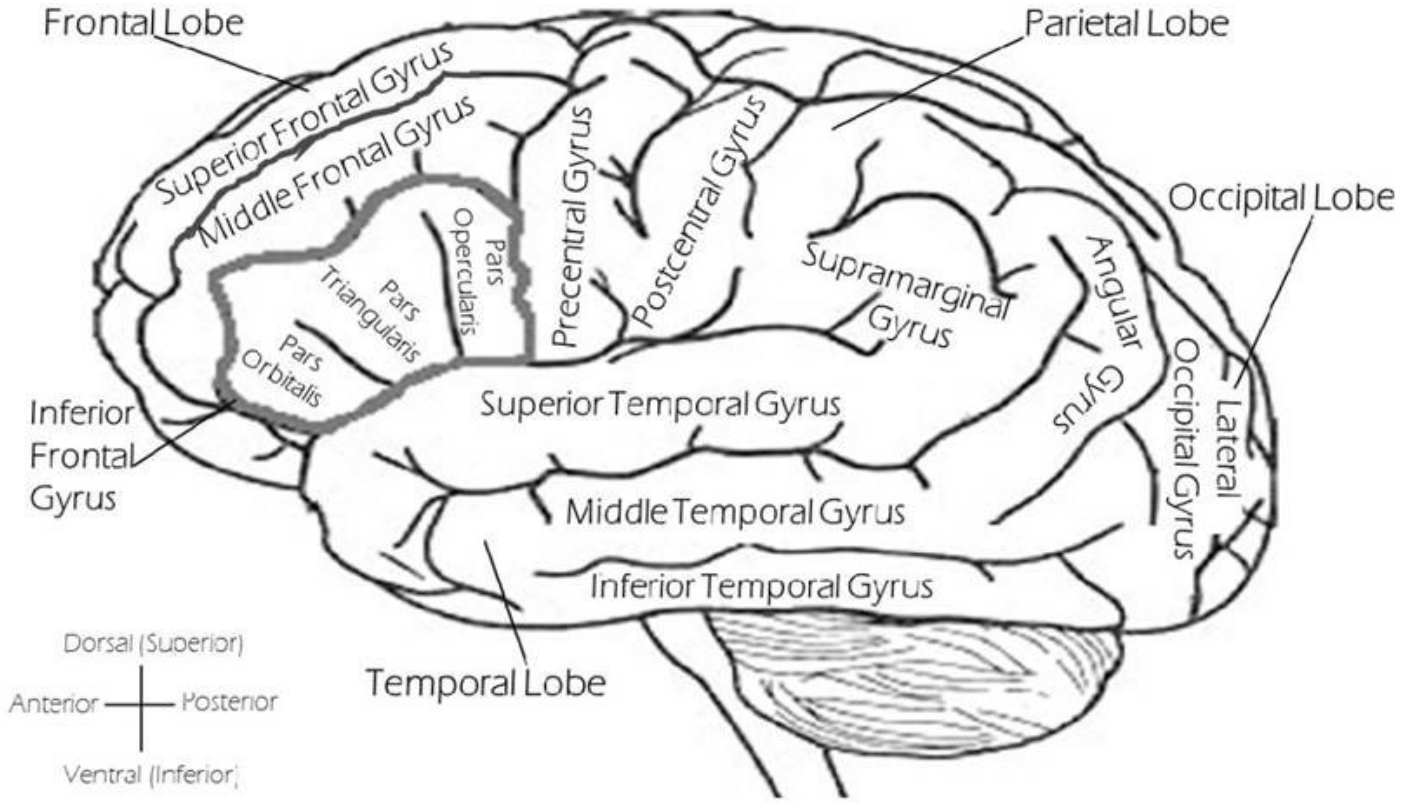
The brain is made up mostly of water and fat, which are the building blocks of cells called neurons, glial cells which support neurons and perform various brain functions and other components as well. Neurons are a type of nerve cell that send and receive information through the use of chemical (called neurotransmitters) and electrical messengers. Neurons are arranged in complex networks called circuits. These circuits control specific brain functions and are connected directly or indirectly to most other circuits controlling other functions within the brain. Every brain activity is controlled by one or more brain circuits.

We are learning more about the brain almost daily. Indeed, just over the past few years, entire sets of cells (the mirror cells) and systems that are related to immune response and brain health (for example the glymphatic system) have been discovered. Much is known about the brain but more is yet unknown and research into how the brain functions in health and in disease is one of the major international research directions of this decade.

The outer layer of the brain is called grey matter, and it is made up of densely packed neuronal cell bodies (or soma), dendrites and glial cells. Grey matter contains the brain’s processing and learning centres. The axons (connecting parts) of these cell bodies make up another component of the brain called white matter. It is called white matter because the myelin sheath (which speeds up signals in the brain) that covers the axons is fatty, giving the tissue an off white colour.

The brain is divided into sections called lobes which are further subdivided into unique areas. These areas are involved in various types of brain function but most brain functions involve many different areas.

Fig. 3.1 Mapping the functions of the brain



Human brain development*

The brain develops and changes over our entire lifetime beginning from the time of conception. It is important for educators to understand human brain development because the relationship between a child's learning and social development and their brain is fundamental. It is our brains that help us successfully adapt to the challenges and opportunities of our lives. Without healthy brain functioning we can have neither health nor mental health. Our brains mold our environments and in turn, our environments mold our brains. It is this bi-directional relationship that allows us to develop and express all those things that make us human.

Brain Plasticity

Brain plasticity describes how experiences can reorganize and change the connections in our brains at any age. As we learn, the neural networks in our brains are constantly changing. The connections between the neurons in our brains can change such that new connections are made (for example, learning and remembering new concepts in the classroom), existing connections are strengthened (for example, mastering a previously learned skill), or existing connections are weakened (for example, forgetting a concept that is no longer perceived as important). It's important to realize that all students' brains demonstrate plasticity. This means that not all students who experience a learning or behavioural difficulty should be perceived as unchangeable. New skills and ways of doing things can be learned across the life span. However, not everyone learns equally well. Individual differences exist within the overall and different brain regions (and the connections amongst them develop at different rates and time across the lifespan.*

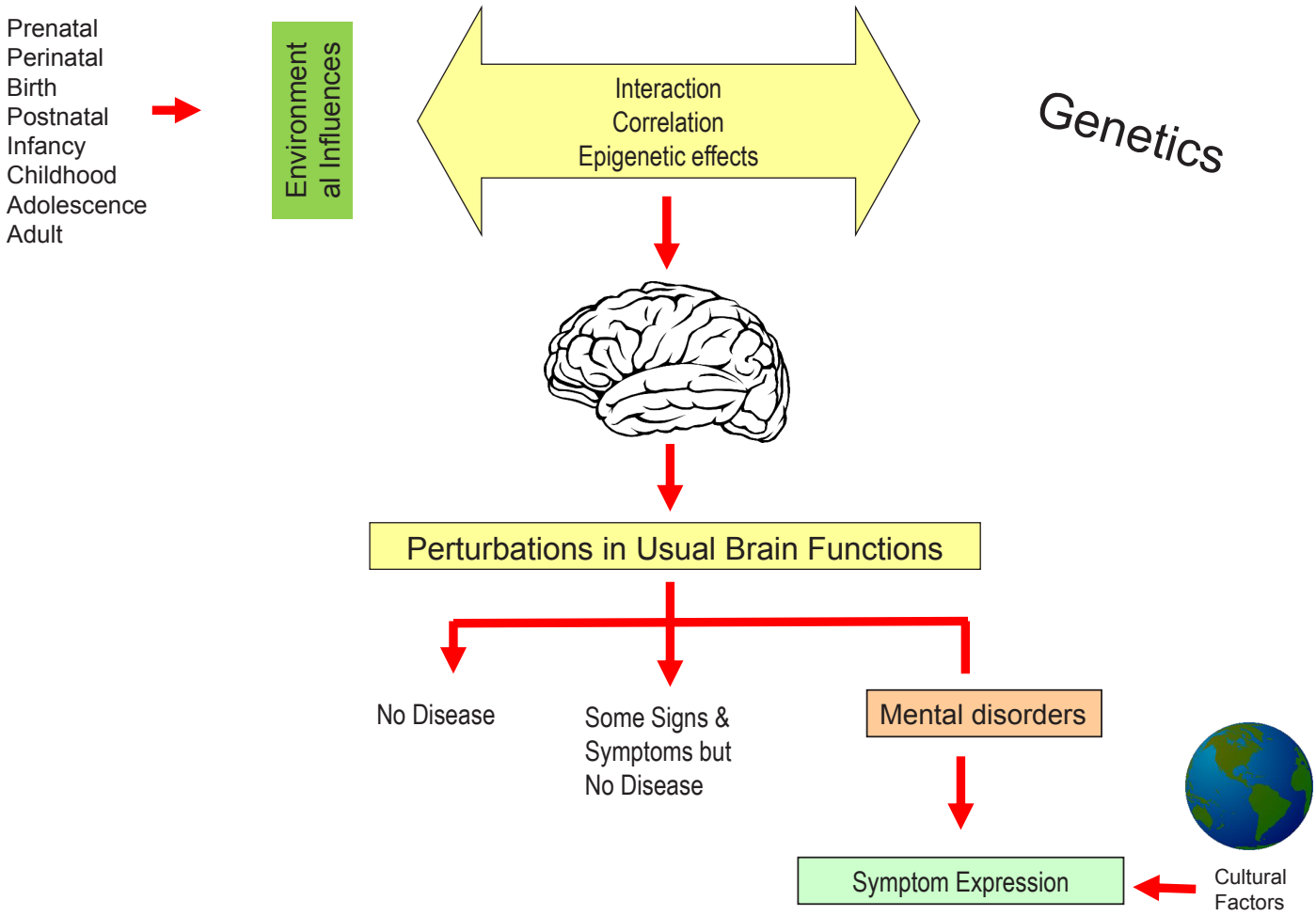
In some ways, the brain is never fully developed because it is constantly reshaping to meet the demands of everyday life

*See Deeper Dive: Brain growth and development

Epigenetics, a new brain frontier:

Although we do not know everything we need to know, we have learned a fair bit about how brains work, in health and in disease. All brain activities depend on the genes in the brain. These genes are received from our parents (and from our grandparents, and back down the historical road of all of our ancestors) and turn on and off in response to their own internal clocks. However, we now also know that our environments may also play a role in how these genes work. Scientists have only recently discovered the process through which the environment (remember the definition of environment described above) can impact on how the genes in the brain function. There is now an entire branch of brain science dedicated to research in this area. It is called "epigenetics". The following diagram (Figure 3.1) provides a simple illustration on how the brain and environment interacts with each other, which leads to various outcomes:

Figure 3.2 – The Complex Relationship Between Genes and Environments



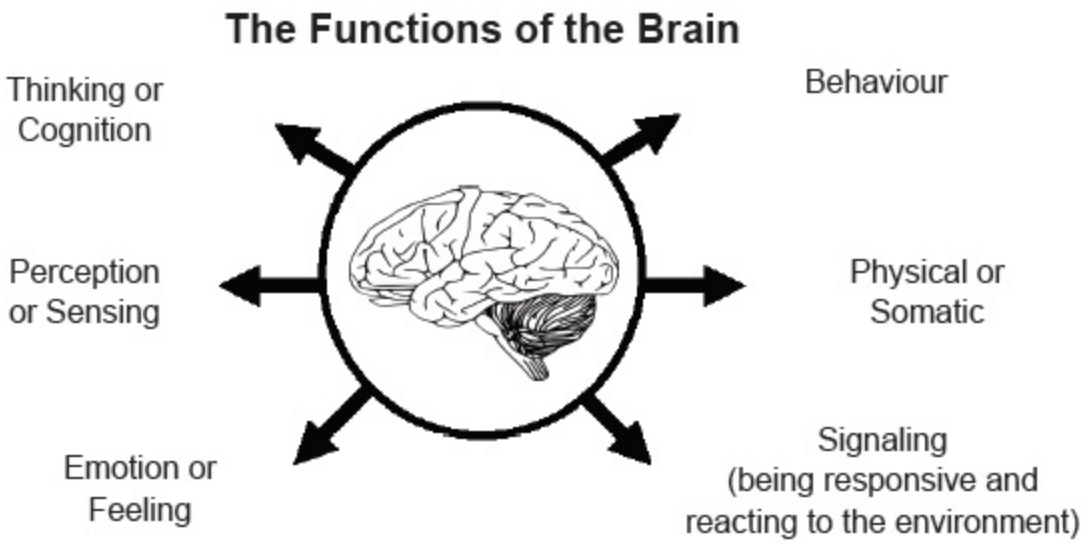
TEACH MENTAL HEALTH

Epigenetics, strictly defined is any process that can alter gene activity without changing the DNA sequence of a gene (so, a gene mutation or the natural selection that occurs in evolution would not be considered to be part of epigenetics). Our behaviour and all other brain functions is influenced by our genes and how they are expressed (are they turned on or turned off), and scientists have determined through the study of epigenetics that some gene expressions can be altered by our environment (meaning that there can be environmental factors that influence how genes work). Essentially, the blueprint for our DNA is already there, but our experiences and circumstances in life can either "turn on" or "turn off" combinations of genes that can express illness, whether it be mental or physical. The study of epigenetics can help to explain why some people are more susceptible to mental illness, while others are more resilient – it's a combination of nature and nurture! Epigenetics explains how these work together.

This is a very complex process and we still have much to learn about it. And, no doubt as we learn more we will refine our understanding. At this point we can say that all brain activity (and therefore everything about us) depends on the activity of genes but that gene activity itself depends upon a complex interplay between the person and their environment that begins at the time of conception and continues across the life span. And, because we are all genetically different and yet very similar at the same time, and because we all have shared and unshared environments, we will all have life paths that are both different and the same. This understanding can help us avoid simplistic explanations for why we are what we are and at the same time can encourage us to learn more about our brains and how they function to make us what we are.

Six main brain functions

We can break down the main functions of the brain into six separate but integrated components. These include: 1) thinking or cognition, 2) perception or sensing, 3) emotion or feeling, 4) signaling, 5) physical or somatic and 6) behaviour.



1. Thinking or Cognition

Thinking or cognition includes all of our internal mental processes and functions. As the “master control centre”, the brain is constantly working by receiving and sending signals to put together the different pieces of our world. This includes but is not limited to:

- Planning • Reasoning • Calculating • Decoding symbols • Self-awareness • Focusing
- Sequencing • Paying attention • Making judgments • Memory storage • Comprehension
- Contemplation • Social understanding • Social decision making

The frontal lobes are responsible for the majority of conscious thoughts.

2. Sensation and perception

Sensation and perception are complimentary processes that determine how we experience our world. Sensation is when our senses gather information from our environment through sight, sound, smell, taste and touch, and send that information to the brain via the peripheral nervous system. Perception is the way our brain interprets these sensations to make sense of what is around us. Our individual experiences shape how we perceive external stimuli, which makes our own perceptual set somewhat unique from others. It is important to understand that it is the brain that creates the perception that we experience. We do not see with our eyes, we see with our brains. We do not touch with our fingers, we touch with our brains.

3. Emotion or feeling

Our brain is responsible for our ability to experience, label, describe and express feelings. It also is able to inform us of what others are feeling or likely to be feeling. Our emotions are personal and subjective, but the human brain spontaneously creates and/or processes our experiences into feelings we all experience, which include, for example:

- Joy
- Anger
- Sadness
- Consternation
- Demoralization
- Happiness
- Shame
- Loneliness
- Guilt
- Resentment
- Serenity
- Annoyance

We have developed a rich lexicon to categorize and describe nuances in our emotional states. For example, disgruntled and disappointed are somewhat similar yet very different emotional states.

4. Signaling

Signaling is our-hard wired response mechanism to external stimuli. Our brains are constantly experiencing and responding to stressors from the environment. One of the most important jobs our brains have is to create successful responses to our environments and to remember (learn) what responses worked well and which did not work so well for use in the future (adaptation).
Our signaling mechanism is what allows us to employ our “fight-or-flight” mechanisms and our “excite and delight” mechanisms. It is the signal that our brains use to tell us adaptation is needed – to a challenge or an opportunity.

Our signaling system is important to consider in the context of mental health because it is directly related to Anxiety Disorders. Usual daily stressors are both ubiquitous and necessary for growth and development. The “stress response” is usually our friend, not our enemy. It drives us to adapt and learn – to become resilient. But, a dysfunction in one or more of the neural circuits of the signaling mechanism may lead to an Anxiety Disorder.

In this situation, the danger response signals operate in the absence of danger.

5. Physical

All of our physical functions are under the control of our brain. This includes the respiratory, circulatory, genitourinary, digestive, musculoskeletal, endocrine and immune systems. For example:

- Regulation of our breathing (respiratory system)
- Regulation of heart-rate and blood pressure (circulatory system)
- Being aware of sensory information from our bladder (genitourinary system)
- Drinking and eating behaviours, and conscious control of our muscles for eating and elimination (digestive system)
- Sensory receptors in our body send signals to the brain about body position and in turn our body sends signals to our muscles to make us move in a particular way (musculoskeletal system)

6. Behaviour

Behaviour is the way we act; it's our ability to interact with others and our environment through 'doing'. Our behaviour includes our actions in response to internal or external stimuli. Every behaviour is the result of a complex interplay between all of the other brain functions. We use all of these brain functions every second of every day and are largely unaware that we are doing so. Our brain integrates all of these functions to enable us to do even the simplest task. These include:

- Social interactions
- Sexual activity
- Acts of kindness
- Acts of aggression
- Goal directed activities
- Relaxation activities

Mental health/mental illness and the brain

Understanding brain development and how the brain works is essential to our understanding of mental health and mental illness. Everyone has mental health, which is synonymous to brain health. If you recall Module 1, we all experience mental distress (the brain's expected and usual response to the stresses of everyday life) and mental health problems (the brain's response to a severe or persistent negative life event(s). In these situations, our brains are functioning as they have evolved to function.

At different times in our lives we experience our mental health in different ways – sometimes more positively and other times less so.

It is important to note that mental health does not mean having only positive thoughts and emotions. Most negative emotions are a sign of good mental health. A mental illness, however, is when the brain is not functioning as it is supposed to function, leading to significant and persistent problems in a person's everyday life (these will be discussed more extensively in Module 4). In over-simplified but conceptually solid terms, the brain is the part of the body that provides the basis for everything that we consider being part of mental health and wellness. We cannot have mental health without a healthy brain and we cannot understand mental health or mental illness unless we have knowledge about our brains and how they function. Talking about mental health without knowing about the brain is akin to talking about exercise without knowing anything about our muscles or our heart.

Mental disorders are usually caused by a combination of genetic and environmental factors that interact with

each other over time to create the phenomenon which results in a diagnosis of a mental illness. Careful, painstaking basic science and social research has gradually over time led us to a much better understanding of how our brains work, but compared to what we can know about the brain, what we actually do know is still a very small amount. What we have learned however, is that many, if not most, historical explanations of why people act in a certain way or why some people develop a mental illness are not only overly simplistic but actually incorrect. Unfortunately many of these historical explanations are still embraced by some people and continue to get in the way of better understanding. As our knowledge about the brain grows and becomes more widespread, we will hopefully move beyond simple-minded mantras to embrace the complexity of human existence with humility. So, if we don't understand how our brains function, we can't understand health, mental health or who we are as humans.*

Activity 3.1: We have covered a lot of new ground in this module, and some of it may be new information to you. Good pedagogy suggests that a review of key information may be helpful. Please go through the PowerPoint "The Human Brain". Enjoy the review.

Supplementary resources

The Teen Brain www.teenmentalhealth.org/learn/the-teen-brain-2/

There is increasing awareness about the impact that brain injury (such as concussions) can have on the health and mental health of young people. If you are interested in learning more about brain injury (concussions) in teenagers, check out:

Brain Injury www.teenmentalhealth.org/learn/brain-injury/

Recovery from Concussion https://www.cdc.gov/headsup/basics/concussion_recovery.html

Self-Assessment

1. The human brain is the source for both mental health and mental illness.
2. The different brain function are controlled by various circuits that include neurons and use various chemical messages for communication between neurons.
3. Epigenetics is the study of how the human brain differs from the brains of other primates.
4. Some of the functions of the brain include: cognition, perception and behaviour.
5. The adolescent brain undergoes many changes including cerebral dissemination.
6. The limbic system plays an important role in emotions.

Self-Assessment Answer Key

1) T 2) T 3) F 4) T 5) F 6) T

Module 3: Deeper Dive

The Human Brain

Brain growth and development

The foundation for all of the organ systems of a newly developing individual, including the nervous system (brain and peripheral nerves), is already in place by two months after conception. Between 2 ½- 5 months of pregnancy, there is a rapid burst of cell division in the emerging brain that generates new neurons, called neuronal proliferation. Neuronal migration, when neurons move to where they will reside, follows. Connections between neurons, called synapses, begin to form in a process called synaptogenesis. These developments are genetically programmed and happen to every developing human everywhere in the world.

There are many factors that affect in utero brain development. These include genetic makeup and inputs from outside the brain (called environmental stressors) such as: psychoactive drugs (e.g., nicotine, caffeine, alcohol), infections (such as measles or other viruses), malnutrition (such as lack of protein) and severe and persistent social stressors (such as war). Due to genetic differences amongst human brains, all environmental stressors do not equally affect the brain and not all brains are equally affected by any one of these factors.

Following birth our brains develop rapidly. Childhood is the time during which we learn language, begin to appreciate social conventions and develop complex motor skills (and so much more). The human brain grows mostly outside the womb – this is what makes it uniquely able to adapt itself to the environment that it is in. Many of the connections between different parts of the brain result from environmental influences. Those neural circuits that are used solidify, while those that are not used very much are deleted. It's a "use it or lose it" phenomenon.

Critical periods in the course of brain development are periods of time during which pruning (the cutting of connections) or selection of active neural circuits take place during certain windows of time.

Myelination (improving connectivity amongst brain parts) is another important part of brain development. By age 6, the brain is about 95% of its maximum size. Future developments are not about growing the size of the brain; they are about enhancing the activity of and connectivity within the brain.

For more information on brain growth and development, check this out: http://teenmentalhealth.org/learn/the-teen-brain/

The adolescent brain

The brain of an adolescent undergoes dynamic developmental changes. Research has shown that the adolescent brain is not one of an older child or that of an adult, but rather a unique entity under construction in its own right. It is characterized by sequential maturation of different brain areas and an increase in networking and speed of communication among different brain regions.

For more on the adolescent brain, check out:

The Nature of Things "Surviving the Teenage Brain". http://www.cbc.ca/natureofthings/episodes/surviving-the-teenage-brain

Teacher Network, The Guardian. Dec.4, 2015. Secrets of the Teenage Brain: a psychologists guide for teachers
www.theguardian.com/teacher-network/2015/dec/09/teenage-brain-psychologist-guide-teachers-classroom

Dahl RE. Adolescent Brain Development: A period of vulnerabilities and opportunities. Annuals of the New York Academy of Sciences 102:1 (1-22), 2004.

Wright, L. & Kutcher, S. (2016). Adolescent Brain Development. Colloquium Series on The Developing Brain.

doi:10.4199/C00133ED1V01Y201602DBR012

More on understanding our brains

Activity DD 3.1: Watch the following video (https://www.youtube.com/watch?v=EGdlpaWi3rc) for an overview of the developing adolescent brain that is suitable for use in the classroom (grades 8-10).

Development of the adolescent brain can be divided into three processes:

- Proliferation: rapid growth of brain matter and the formation of new connections within the brain.
- Myelination: the insulation of brain pathways to make them faster and more stable. White matter, associated with myelination of neuronal axons, continues to increase across development unlike grey matter which does not.
- Pruning: the cutting away of unused or unimportant connections. This is shown in the form of a reduction of grey matter.

Researchers suggest that the mismatch of maturation timing of the limbic system (where emotions arise) and the still developing prefrontal cortex (where cognition resides) is what makes adolescents prone to risk-taking behaviours, but also allows them to innovate and adapt to their environment more easily.

Activity DD 3.2: The complexities of the brain's structure may be easier to understand through a 3D exploration of its components. To complete this activity, download the "3D Brain App" on your mobile device (available on iPhone/Android/Windows). When you launch the application, the different parts of the brain will appear in a list.

1. Click on "Structures", and choose the prefrontal cortex to begin. Rotate the brain on your screen to explore the structures in 3D. Click on "Info" and read through the overview, the case study, associated functions, associated cognitive disorders, and associated damage.
    - Can you think of a situation in the classroom during which a student's prefrontal cortex would be in use? Draw from your own experiences and the associated functions listed to make a connection.
2. Click on "Structures", and choose the limbic system. Rotate the brain on your screen to explore the structures in 3D. Click on "Info" and read through the overview, the case study, associated functions, associated cognitive disorders, and associated damage.
    - After reading through this section, write a brief summary about the importance of the limbic system for healthy functioning. The limbic system plays an important role in regulating emotions, so be sure to include this in your reflection piece.

Activity DD 3.3: Watch the following TED Talk titled "After watching this video your brain will not be the same" (https://www.youtube.com/watch?v=LNHBMFCzznE) for more information on the adolescent brain. This takes some time but it is time well spent. As you watch the video, pay attention to the segment that discusses the relationship between the development of the prefrontal cortex and the limbic system.

Activity DD 3.3 (cont): After watching the video, you can begin to appreciate the complexity of the developing brain. In some ways, the brain is never fully developed because it is constantly reshaping to meet the demands of everyday life. As well as being shaped in part by its environment, the human brain changes the environment that it is in. There is a complex and continuing bidirectional interaction between brain and environment that persists across the life span. Within the brain, maturation of the pre-frontal cortex and improved linking of different brain areas (such as the limbic system and prefrontal cortex discussed above) is thought to be a key turning point at which the adolescent brain graduates into adulthood.

For a concise but useful introductory to the human brain basics, check out this video (How the Human Brain Works): https://www.youtube.com/watch?v=9UukcdU258A

Module 4

Understanding Mental Health, Mental Illness and Related Issues in Young People

Module 4 includes two sections. Section 1 provides an overview of key considerations regarding understanding of mental illness and common mental illnesses found in children. Section 2 focuses specifically on mental illnesses that are commonly found in adolescents.

Learning objectives

After completing this module, you will:

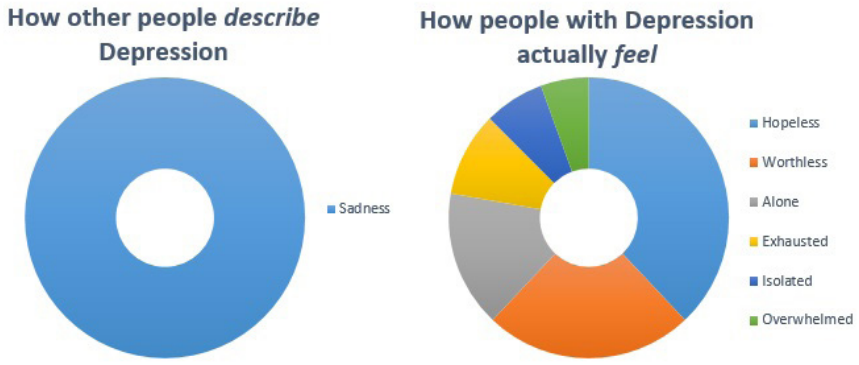
- Have a better understanding about how a mental illness is diagnosed;
- Have a better understanding of many of the more common mental illnesses affecting young people;
- Know about some useful classroom strategies that can be applied to help a student who has a mental illness.

Introduction

Earlier in this course you learned about stigma and how to use language to better identify different emotional states and how to use it to help separate normal and expected emotional states (such as mental distress and a mental health problem) from the language used to classify mental illness. For example: sad, unhappy, disappointed, dismayed, demoralized and disenchanted are not the same as Depression and worrying, feeling nervous and apprehensive are not the same as Anxiety. A similar phenomenon is found in using language that describes emotions that are intense, prolonged and which may increase risk for a mental illness to describe normal and usual everyday experiences. One of the more common examples of this is the use of the word "trauma" to describe feeling upset. Umbrage, inconvenience and anger are not traumatic experiences – sexual and physical abuses, neglect, living in a war zone, are.

When we use the terminology of mental illness to describe common emotions or behaviours, we begin to associate normal states with illness. This may unintentionally increase stigma as the depth, severity and impairment that exists with mental illness can be underestimated and thus belittle and undervalue the experience of someone who has a mental illness. This incorrect use of words can also have the opposite impact. It can suggest that normal and usual emotional states are mental illnesses and that people who are experiencing these need professional treatments. This can lead to unnecessary therapy or medication use and the volume of demand can overcome the limited supply of trained care providers, thus having the unintended consequence of making it even more difficult for those who have a mental illness to access the care that they need.

Here is how a person who lives with the mental illness Depression showed this difference:



While a person who has a mental illness will also experience the normal range of emotions, the nature, quality,

intensity and duration of the symptoms of the Mental Illness that they experience are significantly different than those arising in everyday life. In addition, they will experience numerous other symptoms associated with the illness (such as fatigue, pain, loss of interest, social isolation, etc.) and will exhibit functional impairment (such as doing poorly at school) as a result of the illness. Teachers can help students better understand this essential point. One way to help differentiate a mental illness from a normal emotional state is to capitalize the word describing the illness. For example: Depression (the illness) instead of depression (a negative emotional state).

Over 70% of all mental illness can be diagnosed prior to age 25 years, making childhood and adolescence a crucial time for the identification of symptoms suggestive of a mental illness, decreasing stigma associated with mental illness and enhancing access to effective mental health care for those who need it. This underlines the importance of ensuring that the individuals who interact with children and youth on a daily basis, particularly teachers, are mental health literate.

What is a diagnosis of Mental Illness?

Mental illnesses are diagnosed according to internationally defined criteria. There are two different diagnostic systems currently used. One is the Diagnostic and Statistical Manual (the DSM, currently in its 5th edition) and one is the International Classification of Disease (the ICD, currently in its 11th edition). Because no independent biological markers have yet been identified (such as an EEG in a "heart attack") that are specific to any mental disorder, diagnoses are assigned on the basis of signs and symptoms that occur together in clusters, predict outcomes in the absence of treatments and exhibit similar outcomes in response to specific treatments. Diagnoses are comprised of signs (what an independent observer can see) and symptoms (what the person experiences). Because of the nature of how the brain functions, various signs and symptoms can occur in more than one diagnosis. For example, inattention and excessive activity are both found in Mania and in Attention-Deficit/Hyperactivity Disorder. But how they are expressed and how they are experienced differ. Thus, diagnoses need to be applied only in the context of a complete assessment conducted by a person with substantial mental health expertise. Also, because signs and symptoms may be confusing and complex a diagnostic review for mental illness is not usually something that can be done quickly or by checklist alone. It takes time and experience to do a diagnostic assessment effectively.

A diagnosis is always considered to be a hypothesis about what is happening to the brain's usual functioning that leads to the signs and symptoms the person is exhibiting/experiencing. A diagnosis is not a label and it does not describe a person – it provides direction about what kind of treatment may be more likely to help, and what kinds of treatment are unlikely to help. As new information is obtained (including how the person responds to the treatment), an initial diagnosis may be modified or changed.

What does treatment mean?

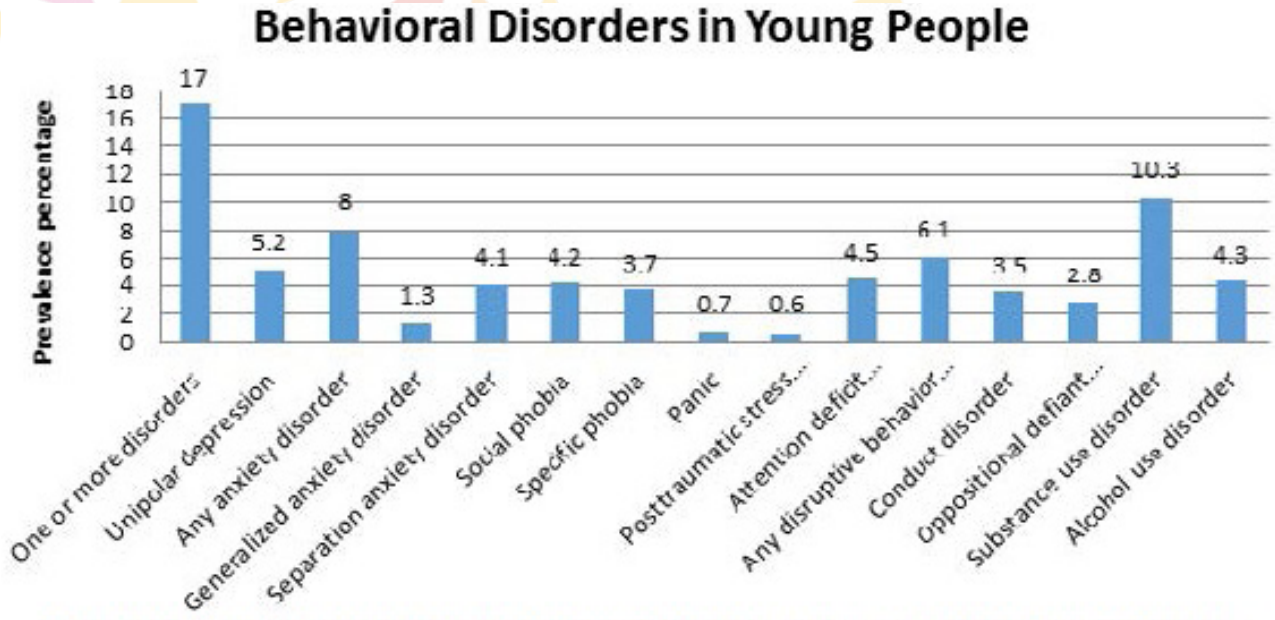
A treatment for a mental illness has three different purposes. The first is to help relieve the signs and symptoms of the illness. The second is to help the person recover from their illness. The third is to prevent the illness from recurring.

Different treatments can be used together to achieve these goals. One treatment alone may not be able to effectively address all the person's needs. Treatments are always applied using a risk: benefit ratio analysis. The questions that are asked are: what are the risks of no treatment; what are the risks of the treatment; and what are the benefits of the treatment? Decisions about providing a treatment are based on the answers to those questions. Evidence for effectiveness and safety of treatment is necessary to help determine which treatments could be likely to help more. Also, just like in the rest of medicine and because every person is unique, not everyone responds similarly to any specific treatment. Sometimes a period of trial and error in trying out treatments is necessary before the "best" treatment for any individual person is found. A more

detailed discussion about treatment is found in Module 6.

Common Mental Illnesses

Approximately one in five Canadians will develop a mental illness in their lifetime and 70% of those people could have been diagnosed before they turned 25. In childhood and adolescence, mental illnesses contribute the largest single amount to medical disability and are much more common than other kinds of illnesses. They also make the largest contribution to early mortality through suicide in young people (about 90% of youth who die by suicide in Canada are thought to have a mental illness). Early diagnosis allows for earlier treatment and more successful outcomes, when symptoms are often still mild to moderate in intensity and respond better to evidence-based interventions. Early treatment can also prevent the development of negative life events that can arise as a result of the illness (such as failing a grade or beginning to abuse drugs). This makes childhood and adolescence a crucial time for the identification and treatment of young people who have a mental illness and underlines the importance of ensuring that the individuals who interact with children and youth on a daily basis (e.g., teachers) are mental health literate.



Source: National Research Council and Institute of Medicine of the National Academies: Preventing mental, emotional, and behavioral disorders among young people. 2009

Mental illnesses are medical illnesses; however, instead of a disorder of the pancreas, such as diabetes, mental illnesses are disturbances of usual brain function. The brain has six key functions: thinking, perception, emotion, signaling, physical movements and behaviour, which were described in Module 3. A mental illness occurs when one or more of these brain functions fail to work as they should. By understanding not only the signs and symptoms of the mental illness, but the underlying mechanisms that are not functioning properly, we can develop interventions (clinical, academic and social) to best help students who are experiencing a mental illness.

With respect to mental illness, **the role of the teacher is not to diagnosis or treat** but rather to recognize that there may be a problem, refer appropriately and work effectively in the classroom and in collaboration with other professionals (such as school counselors, psychologists and mental health clinicians) to assist and support children and adolescents once they have been identified.

Activity 4.1: Review the PowerPoint “Understanding Diagnosis of Mental Illness” and reflect on the following.

How are mental illnesses diagnosed? Why does language used to describe negative emotions need to be clearly differentiated from language used to describe mental illness? How can teachers help their students better use language to describe and differentiate various emotional states?

Activity 4.2: Watch this video blog before we delve into the common mental illnesses in childhood and adolescence. https://www.youtube.com/watch?v=l0aNQ4cwsjw&feature=youtu.be

Section 1: Mental Illnesses in Childhood

(See later in this module for common Mental Illnesses in adolescence)

The following descriptors provide you with some basic information about these more common mental illnesses that can be diagnosed in childhood. For more information about these and for the criteria applied to make these diagnoses check out the relevant sections of the Diagnostic and Statistical Manual of Mental Disorders (5th Edition).

Additional information is also found in the Teacher Knowledge Update (http://teenmentalhealth.org/curriculum/teacher-knowledge-update/activity-2-teacher-knowledge-update-self-study-guide/) that accompanies this online course.

Note: The Teacher Knowledge Update is online in our toolkit and can be found in the Mental Health and High School Curriculum Guide.

Autism Spectrum Disorder (ASD)

ASD is a neurodevelopmental disorder, occurring more commonly in males, that affects about one percent of the population. In the last decade this diagnosis has increased significantly, perhaps due to an expansion of the diagnostic criteria or for other reasons. ASD is characterized by substantial, pervasive and sustained impairment in: reciprocal social communication and social interaction; restricted and repetitive behaviours, interests and activities and functional impairment. The severity of these varies and the diagnosis is usually made in the first 2 to 5 years of life. Some people with ASD exhibit severe language and/or intellectual impairment as well as challenges with motor skills and various types of behavioural challenges. Others will have mild to moderate symptoms.

ASD has a genetic basis involving many different genes, but the exact pattern or patterns of heritability has not yet been fully established. ASD is not caused by vaccinations or diet nor is it the same thing as childhood onset schizophrenia. Some people with ASD may demonstrate exceptional capabilities in one or more domains, such as encyclopedic information about sports statistics, numeric manipulation, etc.

For some young people with ASD, early application of an intervention called Applied Behavioural Analysis can result in significant symptomatic improvement. The earlier a diagnosis is made and an effective treatment is applied, the more likely it is that improvement may occur. Specialized ASD diagnostic and treatment centers, usually associated with pediatric hospitals and universities, are available in most Canadian provinces.

Classroom strategies for students with ASD need to be developed based on the needs, capabilities and strengths of each individual child. Information about teaching tips and strategies have been developed by many credible educational organizations and are easily found online. An example is one hosted by the Ontario Teacher's Federation, which can be found at: https://www.teachspeced.ca/teaching-strategies-students-special-needs?q=node/667.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder with a strong genetic

component characterized by a persistent pattern of hyperactivity, impulsivity and substantial difficulties with sustained attention that is outside the population norm and is associated with substantial functional impairments at school, home and with peers. This disorder begins early in life, affects about 5 percent of the population and continues into adolescence and for some people, into adulthood. ADHD is more commonly found in boys. Girls who have ADHD often do not have similar problems with hyperactivity although they have problems with sustaining attention and impulsivity. Young people who have learning disabilities and youth with Tourette's Syndrome have higher rates of ADHD. Young people with Conduct Disorder may have ADHD which has not been recognized or treated and which may contribute to their social and legal difficulties. About 30% of youth with ADHD have a concurrent learning disability. ADHD should not be confused with symptoms of over-activity or difficulties focusing attention due to other factors (such as, lack of sleep, social deprivation, etc.).

Youth with ADHD exhibit difficulties with sustained attention. When tasks are more enjoyable or meaningful they will be able to better focus. Because they persistently orient to stimuli that others may ignore, students with ADHD appear more symptomatic in stimulus rich environments, such as open classrooms. Most young people with ADHD have trouble sitting still and are very active – often they will fidget, talk excessively, make noises during quiet activity and generally seem 'wound up' or 'driven'. Impulsivity is often shown as impatience or low frustration tolerance. Young people with ADHD will often interrupt others, fail to listen to instructions, rush into novel situations without thinking about the consequences, etc. This type of behaviour may lead to accidents.

These difficulties can be less pronounced in activities that require a great deal of physical participation and are constantly engaging. Sometimes young people with ADHD seem less distracted when they are playing games that they like – especially games that do not require sustained attention (such as video games). Symptoms are more likely to be noticed when the young person is in a group setting in which sustained and quiet attention is needed or when they are working in an environment in which there are many distractions.

ADHD can be treated with a combination of medications and other assistance – such as social skills training and cognitive behavioural therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine if a learning disability is present. Sometimes youth with ADHD will benefit from modifications to their learning environments such as having quieter places in which to work or having homework done in small amounts over longer periods of time.

Some young people with ADHD will develop conduct disturbances or substance misuse. Many will become demoralized because of constant reminders from teachers, parents and others about their 'bad behaviour'. Remember that these young people are not bad - they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficulty doing - focus on their strengths as well.

Classroom strategies should be developmentally appropriate and teachers can often participate in assessing the impact of medication interventions. Specific classroom interventions need to be tailored to the needs of the student. Some good sources for these can be found through the following link: www.education.alberta.ca/admin/supportingstudent/diverselearning/adhd.aspx

Watch a video on ADHD, suitable for sharing with students: https://www.youtube.com/watch?v=rLghxG3mGMM

Separation Anxiety Disorder (SepAD)

SepAD is found equally in both sexes and usually diagnosed by mid-childhood and is characterized by developmentally inappropriate and intense fear or anxiety related to separation from home, parents or other attachment figures. It should not be confused with shyness or a "slow-to-warm up" temperament. The prevalence of SepAD is about 4 percent in childhood and decreases over the life span. In school age children,

SepAD often manifests itself as refusal or severe reluctance to go to school. Students with SepAD may also demonstrate challenges in participating in various independent (away from home) activities such as not going to camp and not participating in sleep-overs. In adolescents, this can be expressed as not going on school trips or participating in other similar types of activities.

Treatment is primarily psychological, with behavioural therapy or cognitive behavioural therapy usually applied as a first line intervention. Teachers may be involved in supporting these behavioural interventions. Avoidance is common and should not be encouraged or supported as it makes the symptoms of SepAD worse and decreases the chance for young people to learn adaptive strategies.

Watch an animated video on SepAD, suitable for sharing with students:
https://www.youtube.com/watch?v=jEkFp0Ux4OQ&t=18s

Obsessive-Compulsive Disorder (OCD)

Although Obsessive-Compulsive Disorder (OCD) is most commonly diagnosed in adolescents and adults, approximately 25% of males who develop OCD will develop it before age 10. For a detailed description of OCD, please refer to the OCD part of the Common Mental Illnesses in Adolescences: Fast Facts for Teachers document.

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)

ODD can usually be diagnosed prior to puberty and is more common in boys. It is a persistent pattern of defiant, hostile and disobedient behaviours combined with common mood states of irritability and anger as well as frequent vindictive acts. ODD is more common in boys and the population prevalence is about 3 percent. Parent management training may be helpful in decreasing symptoms of ODD as harsh, inconsistent and neglectful parenting have been associated with a child developing ODD. Bullying can be a school-based manifestation of ODD. Clear rules and non-punitive natural consequences for problematic behaviours paired with positive reinforcement for pro-social behaviours should be applied as consistently as possible.

Severe, persistent and challenging behaviours that threaten the safety, security or physical integrity of others are the phenomena that comprise Conduct Disorder (CD). Youth with CD act with aggression and even violence towards others, either in response to challenge or without provocation. They threaten (verbally and physically) and intimidate others and can cause physical harm to others, including assault with a weapon. They commonly engage in property damage or theft and frequently violate norms of social behaviour. Running away from home, lying, school truancy and bullying of others occurs. Young people with CD have higher rates of substance misuse, difficulties with the law (for example: arrests and convictions), traffic accidents, school non-completion and poorer economic/vocational outcomes. They may be involved in various illegal activities including crimes against people and property. A sub-group of those with CD may later in life meet diagnostic criteria for Anti-Social Personality Disorder and rates of Attention Deficit Hyperactivity Disorder and Substance Use Disorder are higher in youth with CD.

Classroom strategies for ODD and CD are similar. For some useful links check out: https://www.brandonuteachertools.net/conduct-disorder.html and http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf

Section 2: Understanding Mental Illness in Adolescents

This section of Module 4 is presented only as a PowerPoint (Activity 4.3). It may be helpful if you print off the "Understanding Mental Illness in Adolescents: Fast Facts for Teachers" (found in the Deeper Dive section) and use the hard copy format to make notes as you follow the slide presentation.

Activity 4.3: Review the PowerPoint "Understanding Mental Illness in Adolescents".

Supplementary Resources

The Mental Health and High School Curriculum Guide http://teenmentalhealth.org/product/mental-health-high-school-curriculum/

Know Before You Go http://teenmentalhealth.org/product/know-before-you-go/

Transitions http://teenmentalhealth.org/ransitions/

Self-Assessment

1. A diagnosis of a mental disorder must include a biological test (such as a brain scan) to be considered useful.
2. Treatment is primarily directed at understanding the root cause of the problem.
3. Separation Anxiety Disorder is always due to environmental factors, such as overprotective parenting.
4. Medications (such as psychostimulants) are often an effective treatment for the symptoms of ADHD.
5. Autism Spectrum Disorder is known to have a genetic component but the exact genes involved have not yet been identified.
6. Most mental disorders can be diagnosed before age 25 years.

Self-Assessment Answer Key

1) F 2) F 3) F 4) T 5) T 6) T

Module 4: A Deeper Dive

Understanding Mental Health and Mental Illness

This section contains a PowerPoint presentation as well as an easy to reference fact sheet, 'Understanding Mental Illnesses in Children: Fast Facts for Teachers'.

Activity DD 1.1: Please review the PowerPoint "Common Mental Illnesses in Children". Reflect on the following. How can I as a teacher better learn to identify students who may be experiencing a mental illness? Why is the role of a teacher not to diagnose or prescribe treatments? What is the role of a teacher in helping a student who has a mental illness be more likely to succeed?

Understanding Common Mental Illnesses in Children: Fast Facts for Teachers

Fast Facts: Separation Anxiety Disorder

Prevalence

Approximately 4% of children and 1.6% of adolescents in Canada.

Symptoms

Excessive and developmentally-inappropriate anxiety about being separated from a loved one or attachment figure, which may occur during a separation or in anticipation of a separation. Other symptoms include:

- fear that something bad will happen to caregiver
- fear that they may be kidnapped or otherwise taken away from caregiver
- refusal to leave home
- not wanting to be alone or go to sleep
- nightmares about separation
- physical symptoms (e.g., nausea, headache) in response to separation.

These symptoms must be pervasive and severe and last at least 4 weeks in children and adolescents (6 months in adults).

Causes

Genetics, life stress and possibly parenting style. Separation Anxiety Disorder appears to be largely heritable and may be triggered by significant life stress, like a major loss. Some research has found a relationship between Separation Anxiety Disorder and overprotective and intrusive parenting.

Evidence-based Treatments

The most effective and commonly used treatment for Separation Anxiety Disorder is Cognitive Behavioural Therapy (CBT), which helps people change the way they think about situations that cause anxiety, which then changes their feelings about that situation (e.g., their anxiety) and consequently, their behaviour. For moderate to severe cases of Separation Anxiety Disorder, medication may be used in combination with CBT. The most commonly used medications are Serotonin-Specific Reuptake Inhibitors (SSRIs).

Fast Facts: Oppositional Defiant Disorder (ODD)

Prevalence

Rates of ODD range from 1 to 11% of the population, depending on age and gender.

Symptoms

A period of at least 6 months where the person is irritable, angry, argumentative, defiant and/or vindictive. The symptoms must be persistent and severe. Examples include:

- Losing their temper
- Being easily annoyed
- Acting angry or resentful
- Arguing with authority figures
- Actively defying rules or requests
- Deliberately annoying others
- Blaming others for their actions

Causes

Combination of genetic and environmental factors, including parenting. A number of neurobiological differences are noted in people with ODD, particularly in how they process and regulate emotion. Harsh, inconsistent or neglectful parenting may also be related.

Evidence-based Treatments

The most effective and commonly used treatments for ODD are Parent Management Training and Family Therapy. Both treatments help parents to better understand their child and learn how to manage their behaviour, putting the parent back in charge. Problem-solving and social skills training programs also can be helpful for the child or adolescent.

Medication is rarely used to treat ODD but may be prescribed to treat a co-occurring disorder, such as ADHD, which frequently co-exists with ODD.

Fast Facts: Conduct Disorder

Prevalence

Rates of Conduct Disorder range from 2 to over 10% of the population (depends on where the sample was taken). It is more common in males, and in teenagers than children.

Symptoms

A period of at least one year (and occurring in the last six months) during which the person consistently violated the rights of other people or defied common social norms and rules. Symptoms need to be severe and persistent. Examples include:

- Bullying, threatening or intimidating others
- Initiating physical fights
- Using a weapon that can cause serious harm
- Being physically cruel to people or animals
- Theft
- Committing sexual assault
- Setting fires
- Intentionally destroying another person's property
- Lying to or "conning" others
- Ignoring curfew (if younger than 13)
- Running away
- Skipping school

Causes

Combination of genetic and environmental factors, including parenting. A number of neurobiological differences are noted in people with Conduct Disorder, particularly in how they process and regulate emotion. Genetics may play a stronger role in childhood-onset Conduct Disorder. Children and adolescents who develop Conduct Disorder may also be more likely to have parents who: were negligent, rejecting or criminals, were sexually or physically abused, experienced peer rejection or a lack of supervision or live in a violent neighbourhood.

Evidence-based Treatments

Parent Management Training, Family Therapy and Social Skills Training can all be effective for Conduct Disorder. Individual psychotherapy may also be beneficial to help the student understand and problem solve their reactions. Supports in schools and communities can help prevent relapse into antisocial behaviour. Occasionally, residential/inpatient programs may be necessary to provide a stable environment for the student while they are in treatment. For some students, medication may be added (typically antipsychotics, antidepressants or mood stabilizers).

Environmental factors play an important part in the perpetuation of Conduct Disorder.

Fast Facts: Attention-Deficit Hyperactivity Disorder (ADHD)

Prevalence

Approximately 3-7% of school-aged children have ADHD. It occurs more frequently in males. Although it's present from birth, it is often not diagnosed until the child is in school.

Symptoms

ADHD has two core areas of symptoms. These must be severe, persistent and exceed developmentally expected norms.

Inattention:

- Not paying attention to details
- Making careless mistakes
- Trouble sustaining attention
- Difficulty playing quietly
- Acting "on the go"
- Talking excessively
- Frequently interrupting
- Trouble waiting turn
- Forgetful

Hyperactivity and Impulsivity:

- Fidgeting or squirming
- Moving around or standing up when seated
- Failing to listen when spoken to directly
- Not following instructions
- Not finishing tasks
- Disorganized
- Absent minded
- Easily distracted

These symptoms have to last at least 6 months in multiple settings and have been noticeable since childhood. Symptoms can be predominantly either inattention or hyperactivity and impulsivity, or a combination.

Causes

Combination of genetic and environmental factors. People with immediate family members with ADHD are much more likely to also have ADHD. Environmental factors that may be related include smoking or drinking by the mother when pregnant, infections like encephalitis, very low birth weight, exposure to lead and a childhood history of abuse or neglect.

Evidence-based Treatments

The most effective and commonly used treatment is stimulant medication, which helps increase the student's ability to pay attention and focus and decreases their impulsivity and hyperactivity. Stimulants are safe, effective and fast-acting for most people but side effects may be problematic for some. Occasionally, other medication may be used.

Psychosocial interventions can be a helpful addition to medication. Behaviour Therapy can help improve the student's academic and social functioning. Parental Behaviour Training can help parents better understand how to work with their child. Classroom Interventions can help adapt the classroom and learning environment to suit a student with ADHD.

Fast Facts: Autism Spectrum Disorder (ASD)

Prevalence

Approximately 1-2% of the population has Autism Spectrum Disorder (ASD). Boys are more than five times as likely to develop ASD as girls. Although symptoms are not always apparent until the child is 2 or 3 years old, ASD is present from birth.

Symptoms

Someone with ASD has impairments in social communication and social interaction, as well as unusual repetitive and stereotyped behaviours and interests. Because ASD symptoms exist in a spectrum, various symptom severities may be present but all symptoms will be persistent. Symptoms include:

- No back-and-forth conversation
- Stereotyped motor movements
- Not initiating or responding to social interactions (e.g., stroking face)
- Stereotyped object use (e.g., continuously rolling a toy car's tires)
- Poor verbal and nonverbal abilities
- Abnormal eye contact
- Stereotyped speech (e.g., repeating one word or phrase)
- Failure to understand gestures (e.g., pointing)
- Extreme difficulty with change
- Lack of facial expression
- Rigid adherence to routines
- Failure to develop relationships
- Restricted and intense interests (even with parents)
- Unusual reactions to various senses (e.g. not noticing temperature)
- Lack of interest in peers
- Deficits in imaginative play sounds or textures, excessive visual interest in certain lights or movements

Causes

Combination of genetic and environmental factors. People with immediate family members with ASD are much more likely to also have ASD. Environmental risk factors include older parents at the time of conception, low birth weight, fetal distress, being a twin or multiple and fetal exposure to certain toxins. ASD is not caused by vaccines or diet.

Evidence-based Treatments

Early intervention is crucial for people with ASD and treatment is most effective if started before age 4. Applied Behaviour Analysis (ABA) is the most effective treatment. ABA combines a number of evidence-based

techniques that ask the child to complete a task (either something staged or something in their natural environment) and then reward the child when correct (usually with a small bit of food or access to a toy) and prompt the child when incorrect.

Understanding Common Mental Illnesses in Adolescents: Fast Facts for Teachers

Fast Facts: Social Anxiety Disorder

Prevalence

Approximately 4% of 14 to 25 year-olds.

Symptoms

Significant fear or anxiety about social situations where they might be judged (e.g., presentations, performances or social interactions). This fear is:

- intense (leading to avoidance of the situation)
- out of proportion to the actual threat caused by the situation
- persistent (lasting 6 months or more)
- pervasive (almost always experienced in response to the situation)

Those experiencing this fear may also experience:

- avoidance of social situations
- panic attacks in a social situation

Causes

Genetics, the environment and learning. A person with Social Anxiety Disorder has difficulty determining when there is or is not a threat, and consequently experiences a signal of danger when no danger (or very little danger) is present.

Evidence-based Treatments

An effective and commonly used treatment is Cognitive Behavioural Therapy (CBT), which uses Cognitive Restructuring and Exposure to reduce symptoms. Cognitive Restructuring refers to changing the way someone thinks. By changing the way people think about situations that cause them anxiety, their feelings about that situation change (e.g., their anxiety), and consequently, so does their behaviour (e.g., avoidance of the situation).

Exposure refers to gradually exposing the person to situations that cause them anxiety. This is done in a controlled environment with the support of a trained mental health professional who can help the person develop and practice healthy coping strategies as they face and conquer situations that cause increasing amounts of anxiety.

Medication is also used in some cases of Social Anxiety Disorder when appropriate. The most commonly used medications are Serotonin-Specific Reuptake Inhibitors (SSRIs).

Fast Facts: Panic Disorder

Prevalence

Approximately 2% of 12-25 year-old Canadians.

Symptoms

Recurrent panic attacks that occur without obvious cause, coupled with persistent fear of having another panic attack and avoidance of situations from which escape is difficult (should a panic attack occur).
A panic attack is a sudden and intense burst of fear that reaches its peak within minutes and usually lasts no more than 10 to 20 minutes. Symptoms occurring in a panic attack include:

- racing heart
- sweating
- trembling or shaking
- difficulty breathing
- feelings of choking
- chest pain
- nausea
- dizziness
- chills or hot flashes
- numbness or tingling
- feeling outside your body
- fear of losing control or “going crazy”
- fear of dying

Causes

A combination of genetic and environmental factors are at play. Smoking cigarettes or cannabis may trigger the illness in someone who is susceptible.

Evidence-based Treatments

Panic Disorder is very treatable. The most effective and commonly used treatment is Cognitive Behavioural Therapy (CBT), which helps people change the way they think about situations that cause panic, which then changes their feelings about that situation (e.g., their panic), and consequently, their behaviour (e.g., avoidance of the situation).

Medication is also used in some cases of Panic Disorder when appropriate. The most commonly used medications are Serotonin-Specific Reuptake Inhibitors (SSRIs).

Fast Facts: Posttraumatic Stress Disorder (PTSD)

Prevalence

Approximately 5% of adolescents in the US have been diagnosed with PTSD in their lifetime.

Symptoms

Persistent, severe and recurring intrusive symptoms following violence, serious injury, experiences or witnesses such as:

- memories, nightmares and/or flashbacks (where the individual believes they are actually re-experiencing the event)
- avoidance of any thoughts or situations that may trigger memories of the event in an attempt to prevent:
  - psychological distress (e.g., panic attack or dissociation)
  - physiological distress (e.g., vomiting, passing out)
- difficulty remembering part or all of the event
- distorted understanding of what caused the event or the consequences/fall-out from the event

- persistent negative emotional state and difficulty mustering positive emotion
- loss of interest in important events (e.g., birthdays, weddings, graduations)
- feeling detached or estranged from others
- exaggerated negative beliefs about themselves and the world (e.g., “all ___ can’t be trusted”)

In children, symptoms may appear during imaginative play and storytelling.

Causes

Exposure to a traumatic life event in combination with genetic and environmental factors (e.g. previous mental illness, severity and nature or repeated exposure to trauma).

Evidence-based Treatments

There are two main evidence-based treatments for PTSD:

- Trauma-Focused Cognitive Behavioural Therapy (TFCBT) with Exposure Therapy, where thoughts about the trauma are evaluated and the individual is carefully exposed to triggers and helped to cope adaptively
- Medication is sometimes prescribed

Fast Facts: Obsessive- Compulsive Disorder (OCD)

Prevalence

Approximately 1-2% of Canadians will develop OCD in their lifetime. Although it occurs equally in males and females, the onset is usually earlier in boys, starting in late childhood or early adolescence.

Symptoms

Distressing and time-consuming obsessions and/or compulsions. Obsessions are unwanted ideas, thoughts, images, feelings or impulses. Common obsessions include:

- becoming contaminated with germs
- doubts about whether an action was performed
- possessions or actions having to occur in a specific order
- committing a violent or horrible act

Compulsions are persistent, repetitive behaviours designed to reduce anxiety caused by an obsession. They are often completely unrelated to the obsession. Common compulsions include:

- washing hands
- placing things in a specific order or requiring symmetry
- asking for reassurance
- repeating actions (e.g., tapping a desk)
- counting items (e.g., floor tiles, cars in a parking lot, general numbers)
- repeatedly checking to make sure a task has been completed (e.g., the oven turned off)

Causes

Combination of genetic and environmental factors. People with immediate family members with OCD are twice as likely to have OCD, and ten times as likely if they developed OCD as a child or adolescent. Certain life events, like abuse in childhood or exposure to specific bacterial infections may also be related to the onset of OCD in some people.

Evidence-based Treatments

The most effective and commonly used treatment is a combination of medication (usually SSRIs) and Cognitive Behavioural Therapy (CBT), which includes:

- Psychoeducation: Teaching people about OCD
- Cognitive Restructuring: Helping people change the way they think about the obsession
- Exposure and Response Prevention: Helping people face the obsession without giving in to the compulsion in a safe and supported environment

Fast Facts: Depression

Prevalence

Approximately 5% of 12 to 25 year-old Canadians.

Symptoms

Occurrence of a Major Depressive Episode (MDE), which is a period of at least two weeks where for most of the time, most of the day and every day the person:

- Feels sad or depressed
- Is disinterested or unable to enjoy usually pleasurable activities
- Eats much less than usual because they are not hungry or can't be bothered to eat
- Sleeps much more than usual
- Has a persistent and substantial lack of energy and increased fatigue
- Has difficulty concentrating or making decisions
- Feels worthless or guilty
- Has thoughts of suicide/has made an attempt to die

Causes

Genetics and the environment. Certain people's genetics may make them more susceptible to developing Depression following major life stressors. Depression also runs in families, making it more likely that someone will develop Depression if a first-degree relative (parent or sibling) also has Depression, even in the absence of a major life stressor.

Evidence-based Treatments

The most effective treatment for Depression is a combination of Cognitive Behavioural Therapy (CBT; i.e., talk therapy) and a medication called Serotonin-Specific Reuptake Inhibitors (SSRIs). However, treatment may vary for different people depending on their individual needs.

Fast Facts: Bipolar Disorder

Prevalence

Approximately 1% of Canadians.

Symptoms

Occurrence of a Manic Episode (also called Mania), which is a period of at least one week, where for most of the time, most of the day and every day the person:

- Has a very elevated, euphoric or irritable mood
- Engages in abnormally persistent goal-directed activity (even if no obvious goals are accomplished
- Has persistent and unrealistic elevated self-confidence

- Experiences persistent, elevated energy
- Is noticeably more talkative than usual and jumps from subject to subject
- Experiences racing thoughts
- Is easily distracted by irrelevant information
- Experiences of marked inability to sleep, often awake late into the night
- Engaged in out-of-character risky behaviour without awareness or concern for the consequences (e.g., unprotected sex, drug use, excessive shopping sprees)

Many people with Bipolar Disorder also experience Major Depressive Episodes (MDEs). See "The Facts: Depression" for more information). The person may cycle between episodes of Mania, Depression and normal mood in a matter of days, weeks, months or longer.

Causes

Genetics and the environment. Bipolar is one of the most highly heritable disorders, meaning that someone is more likely to develop Bipolar Disorder if a first-degree biological relative (parent or sibling) also has Bipolar Disorder.

Evidence-based Treatments

The most effective treatment for the symptoms of Bipolar Disorder is medication. There are multiple medications that may be effective, depending on the person's individual needs (e.g., mood stabilizers, antidepressants, anti-psychotic medication). The individual and their physician may need to try several combinations of medication and dosage amounts to find the one that works best. Most people with Bipolar Disorder need to remain on the medication continually to prevent new episodes of Mania or Depression from occurring. Psychotherapies, such as Cognitive Behavioural Therapy, Family-Focused Therapy and Psychoeducation may also be helpful to combat the impacts of the illness in combination with medication.

Fast Facts: Anorexia Nervosa (AN)

Prevalence

Approximately 0.4% of women. Rates in men are unclear but believed to be much less common. Onset is typically in adolescence.

Symptoms

Restriction of food intake to the point where body weight is dangerously low, combined with an intense fear of gaining weight and persistent activity to prevent weight gain. Self-perception is unrealistic and largely influenced by weight and size.

Causes

Not well understood but much more complex than just "wanting to be thin."

Evidence-based Treatments

All treatment begins with Nutrition Restoration or "refeeding", which is a controlled and supervised process in which the person's weight is returned to normal. Weight restoration must be addressed for treatment to be effective because malnutrition has a host of negative psychological consequences and treatments are not effective during a psychological starvation state.

Family-Based Treatment is usually recommended for adolescents, because it requires heavy involvement from the parents and puts them in charge of returning the child's eating behaviours to normal, with support from the therapist.

Medication is not helpful for AN.

Fast Facts: Bulimia Nervosa (BN)

Prevalence

Approximately 1-1.5% of women. Rates in men are unclear but believed to be much less common. Onset is typically in adolescence.

Symptoms

Repeated cycling between episodes of binge eating and purging.

Binge Eating: Eating significantly more in a discrete period of time than the average person would eat in the same amount of time, coupled with feeling out of control.

Purging: Inappropriate behaviours designed to compensate for the excessive eating; most commonly self-induced vomiting. Misuse of laxatives or diuretics, fasting and excessive exercise may also be used.

Self-perception is heavily influenced by weight and shape.

Many individuals with BN are not underweight, but rather of normal weight or overweight.

Causes

Not well understood but much more complex than just “wanting to be thin.”

Evidence-based Treatments

Most commonly, BN is treated with Cognitive Behavioural Therapy (CBT), which may be combined with medication. Family-Based Treatment may also be helpful.

- **CBT:** Helps the adolescent to challenge their maladaptive thought patterns, which impact their emotions, and consequently their binge eating and purging behaviour.
- **Medication:** Antidepressants such as SSRIs can be helpful to reduce binge-eating behaviour in the short-term, but binge eating may return when medication is stopped if not paired with another form of treatment.
- **Family-Based Treatment** requires heavy involvement from the parents and puts them in charge of returning the child’s eating behaviours to normal with support from the therapist.

Fast Facts: Schizophrenia

Prevalence

Approximately 1% of Canadians. Occurs equally in males and females but onset is typically earlier in males (late adolescence).

Symptoms

Difficulty differentiating what is real from what is not. Symptoms can include:

- **Delusions:** Belief in something that is not true.
- **Hallucinations:** Realistic sensory perceptions (e.g., sounds, sights, tastes) that are not happening.
- **Disorganized Thoughts or Speech:** Thoughts and/or speech move loosely from topic to topic with no clear connection. Speech may be difficult to understand or incoherent.
- **Grossly Disorganized or Catatonic Behaviour:** Extreme agitation, repetitive or stereotyped movements, inappropriate silliness, rigid posture for extended periods of time (catatonia) and poor self-grooming or self-care.

- **Negative Symptoms:** Absence of typical and expected goal-directed behaviour, emotion, speech, pleasure or social interaction.

Causes

Combination of genetic and environmental factors. People with immediate family members with Schizophrenia are at a much higher risk for developing the disorder. Birth trauma and fetal brain damage may play a role in certain cases. Cannabis use may trigger the onset of Schizophrenia in people who are at genetic risk.

Evidence-based Treatments

Long-term medication use is the most common treatment for the symptoms of Schizophrenia and is usually combined with various psychological interventions:

- **Antipsychotic Medication:** Usually need to be taken for the duration of the person's life.
- **Cognitive Behavioural Therapy (CBT):** Can help reduce severity of symptoms by helping the individual identify problems and develop healthy coping strategies.
- **Family-Based Services:** Educating the family about Schizophrenia and providing them with tools for coping, crisis intervention and emotional support.
- **Assertive Community Treatment:** Frequent contact with key health care providers in community to decrease hospitalizations and homelessness.
- **Supported Employment:** Help looking for work and working effectively.
- **Skills Training:** Help developing social, independent living and community skills.

Hospitalization may sometimes be necessary and early intervention is key.

Fast Facts: Attention Deficit Hyperactivity Disorder

Occasionally ADHD is first diagnosed in adolescence, but symptoms in conjunction with functional impairment must have been present in childhood. Undiagnosed and untreated ADHD in adolescence may be found together with Conduct Disorder. If an assessment for a learning disorder has not been done, this must take place now. For more information on ADHD, see Module 4A.

Fast Facts: Separation Anxiety Disorder

In some young people, SepAD may be first diagnosed in adolescence, but symptoms in conjunction with functional impairment must have been present in childhood. For more information on SepAD, see Module 4A.

Fast Facts: Self-Harm

Definition

Any attempt to cause oneself harm that is not an attempt to die. Self-harm is not a suicide attempt. It is a maladaptive but often effective strategy for dealing with intense emotion in the short term. Cutting, burning and scratching are common self-harm behaviours. This is also called self-injury or non-suicidal self-injury (NSSI). Data demonstrates substantial increases in self-harm beginning in the late 1990s. It can also exist in cultural sub-groups (usually girls who self-harm as a method of belonging) but may also signal the onset of a mental illness.

Prevalence

Approximately 14% of Canadian high school students report that they have self-harmed. It typically begins in adolescence and is more common in (but not limited to) females.

Causes

People who self-harm are more likely to have experienced bullying, loss, abuse or neglect. They are also more likely to have high self-criticism and poor coping strategies. They may also have peers or family members who self-harm. Special care should be taken when discussing self-harm, as it can be triggering for vulnerable individuals.

Warning Signs

People are often secretive about self-harm behaviour and will attempt to hide any evidence or injuries. Watch for:

- Cuts or scars on the arms, legs or stomach
- Wearing long sleeves or long pants in situations where it does not make sense (e.g., a hot summer day)
- Having razors or other sharp objects on hand
- Unexplained or poor excuses for injuries
- Difficulty handling emotions
- Problems with relationships

What To Do

Remain calm and don't blow things out of proportion. Inform the appropriate designate at your school (likely the principal or guidance counsellor). Contact the student's parents. Encourage the student to seek help but understand that they can't "give up" self-harming without first putting more adaptive coping strategies in place.

Fast Facts: Suicide

Definition

Deliberately taking one's own life.

Prevalence

Approximately 200 youth in Canada between 15 and 25 years old die by suicide each year. While a tragic event, it is rare – youth suicide rates in most provinces are about 4/100,000. It is the second leading cause of death among young people in Canada and the third leading cause globally (46-65 year olds have twice (or greater) the number of suicides compared to 15-25 year olds).

Causes

Suicide is found in every culture and is likely the result of complex social, cultural, religious and socio-economic factors, in addition to mental illness. People who die by suicide often have mental illness (e.g., Depression, Bipolar Disorder and Schizophrenia) or substance abuse/misuse.

Warning Signs

Although most people who exhibit these behaviours will not die by suicide, signs that someone is considering suicide include:

- Hopelessness
- Withdrawal from family, friends and/or society
- Increased alcohol or drug use

Other possible but not yet fully established warning signs may include:

- Marked agitation or intense anxiety
- Dramatic mood changes

- Expressing no reason for living or sense of purpose in life

What To Ask

Many people are hesitant to ask youth if they are thinking about suicide because they are worried it will trigger a suicide attempt. Within the context of a professional helping relationship, asking if someone is feeling suicidal will not trigger suicide. If you're concerned about a student, ask: "It seems that things are difficult for you lately; is there anything that you feel you would like to share with me?" or "I've noticed you haven't seemed like yourself lately. Is something wrong?" If you are still concerned about the student, notify the appropriate individual in your school so they can investigate further.

What To Do

If a student tells you they feel suicidal, remain calm and stay with the student. Do not leave them unattended or promise to keep it to yourself. Tell your student that you have to tell someone because you care about their life and safety. Contact the appropriate designate in your school (e.g., principal or guidance counsellor) and have them take control of the situation.

Suicide post-vention in schools

Suicide is an emotional issue and affect drives responses to any situation in which suicide occurs. This is understandable but often not helpful for rational responses to the situation. While recognizing the affect that arises in those impacted by the event, it is imperative that school-sited responses are based on best available evidence and reasoned analysis, including a thorough review of the situation at hand. Acting on emotion prior to conducting an appropriate review of the situation and critically considering the most appropriate response is not helpful. The law of unintended consequences can be at play in suicide post-vention. Different types of responses may inadvertently lead to unnecessary emotional burden for students and staff and may possibly contribute to a cluster or contagion phenomenon. Wanting to do something is not the same as doing the most helpful thing.

There are four key questions to be asked when considering a school-sited response to the death of a student or teacher by suicide:

1. Is the school response the same for death by suicide as it is for death by any other cause (eg: cancer, traffic accident)? If not, how is this different response justified? Overall, death by suicide should be addressed at the school level in the same way that any death of a student is addressed.
2. Is the school developing a response based primarily on emotional inputs or external/internal pressures, or on best available evidence and a critical/rational assessment of the situation?
3. Is the response that the school is considering potentially harmful? Will it help decrease risk for suicide in vulnerable students or potentially increase risk for suicide in vulnerable students?
4. Is the school responding to pressure from the suicide prevention industry* or vocal crusaders in the community? If so, why? What are the possible costs/benefits of such response?

There are four key considerations that should guide school-based responses to the suicide of a student or teacher.

1. Primum non nocere (first do no harm)
2. Reduce the potential for suicide contagion and development of suicide clusters
3. Facilitate the ongoing and usual operation/activities of the school (including avoidance of memorialization).
4. Appropriately support individuals who have been affected by a suicide death and identify of those who may need additional support/intervention

Here are some key considerations arising from the research literature available. Always keep in mind that not

all students and teachers will respond to the situation in the same way and that the circumstances surrounding death by suicide may be quite different in different cases. There should be a school policy regarding student death in which death by suicide should be a part.

1. Engage the school crisis response team and ensure that all members are clear about their role and the strategy for school-based responses. Make sure that all necessary information has been obtained and considered. Obtain appropriate external support and advice. Ensure notification of all appropriate administration and operational personnel. Develop a "go-forward" plan.
2. Avoid the creation and deployment of memorial sites or activities that glorify, vilify or stigmatize the deceased. Avoid school-wide assemblies or on-campus gatherings. Do not create on-campus memorial sites (such as crosses, flower placements, teddy-bear placements, etc). Do not provide psychological debriefing, critical stress debriefing, critical stress management or similar interventions.
3. Provide clear leadership, a simple clear message and a single administrative point-of-contact for parents, students and the public. When informing students, parents and teachers of the death, pair the information with resources that are available in the school and in the community.
4. Provide a space in the school (such as a classroom) where individual students who want to chat with a school counselor or other trained educators can go outside of usual class time. Have this available for an hour or so prior to school starting, during lunch and for an hour or so after school ends.
5. Do contact your local mental health services to inform them of the situation as there may be patients from the school that are being treated there and some of these patients may be more vulnerable than other members of the school community.
6. Do have a senior administrator reach out to the family of the deceased to offer condolences. Be prepared to provide information about where services to assist the family are available in your community.
7. Do engage in an appropriate supportive activity such as creating a Book of Condolences that both students and staff can write a note in. Make sure this is kept in the administration office and that the senior administrator or their designate reads the book before presenting it to the parents/guardians or others.
8. Do "touch base" with more vulnerable or higher-risk persons in the school. These include close friends and teachers of the deceased. This "touch base" can be done by a school counselor or on-site health/mental health provider as a "check-in."
9. Do acknowledge the grieving rituals of the community and provide appropriate support for them. For example, give friends, teachers and staff of the deceased time to attend a community based memorial service. Remember that different cultural groups may often have different grieving rituals – learn what these are and be respectful and supportive of how they are carried out.
10. Do provide an unobtrusive follow-up "check-in" for students, teachers and staff some 4-6 weeks after the event to identify individuals who may be in need of additional support.
11. Avoid the use of terms/phrases such as crisis, trauma, epidemic, "committed suicide" or "successful suicide" in your communications.
12. Do not endorse, create or apply school-wide "screening" for suicide ideation, intent or actions.
13. Do not endorse, support or summon an external service (including grief counselors) to provide student bereavement support (unless in exceptional circumstance when school internal capacity is exceeded).
14. Do not rush into purchase of programs that claim to be able to prevent suicide in the community (no programs currently in the marketplace have ever been shown to do so)*.
15. Avoid creating on-campus spaces, opportunities and publicity for suicide awareness speakers and self-proclaimed experiential experts.
16. Do not encourage media reporting and keep reporters and other media activities away from the campus. Designate one senior administrator to deal with all media requests.

17. As part of usual school curriculum, provide best available evidence-based mental health literacy interventions embedded in usual classroom settings taught by classroom teachers trained in the materials.

Additional readings

Suicide postvention programming: Ontario Center of Excellence (2015): http://www.excellenceforchildandyouth.ca/sites/default/files/resource/EIS_Postvention.pdf

Cox, G. et al. BMC Public Health (2016): 16:180 – 188: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-214

Szumilas and Kutcher. Canadian Journal of Psychiatry (2011): 102(1): 18-29: https://pdfs.semanticscholar.org/ad05/c9d06c6dc0d7bf76f1793830063fd0c8ce44.pdf

The suicide prevention industry

Unfortunately, there exists a suicide prevention industry selling various products (usually training programs) that purport to be able to prevent suicide in the school setting. Expert at marketing, they use a "fear" versus "hope" model to sell their products. At the point of this writing (January 2018) no marketed school-based suicide prevention program has been shown to decrease suicide rates in the school setting. Indeed, in some cases, suicide rates have increased when such a program was applied. Prior to investing in any school-based suicide prevention program make sure that the vendor clearly shows evidence that the program they are selling or promoting actually has been shown to prevent suicide in the school setting.

For a detailed examination of this, see:

1. https://www.nationalelfservice.net/mental-health/suicide/vexing-challenge-suicide-prevention-research-informed-perspective-recent-systematic-review/
2. http://journals.sagepub.com/doi/abs/10.1177/0706743716659245?journalCode=cpab

Module 5

What is Treatment for a Mental Disorder and How do we Know What is Likely to Work?

For a young person receiving mental health care, school life can be a challenge. Having teachers who understand best evidence-based treatments for mental disorders can be a big help. This knowledge is also useful for teachers and their family members, as about 1/6 will themselves receive treatment for a mental illness. This module provides you with best available evidence-based information on what treatments are, how they work and how they may impact those who receive them.

Learning objectives

Upon completion of this section, you will be able to:

- Understand the purpose of treatment(s)
- Describe some of the commonly used treatments available to students who have a mental illness
- Understand how evidence is used to determine the impact of treatments

Overview

Once the parents and student have accepted the referral for treatment request (more on this in the module "Seeking Help and Providing Support"), it can be helpful for you as a classroom teacher to understand what a treatment is, what kinds of treatments are usually provided and how you can be involved as part of a comprehensive treatment strategy for your student.

The following questions will be considered:

- What treatments are available?
- How is a decision about treatment made?
- How will treatment likely affect the student?
- How can you tell if a treatment is working for your student?
- What does recovery look like?
- How can you help?

Through this process, the classroom teacher continues to play an important role in supporting and participating in the treatment and recovery plan.

Treatment for a student with a mental illness: What do you need to know? What does a health care provider mean when they use the word "treatment"?

The word treatment describes what a health care provider will do to help your student.
There are many different types of treatments, but all of them share a number of common elements. Each treatment:

1. is provided with the purpose of helping a person decrease their symptoms and improve how they are functioning
2. impact and change the functioning of the brain
3. should be based on best available evidence for effectiveness, tolerability and safety
4. is provided by a health professional who has the training and competencies to apply and evaluate the treatment

Treatments are provided because they can change the course of the illness. They have a greater probability of decreasing the negative impacts of an illness compared to what would happen if the treatment

was not provided. With chronic illnesses (such as Heart Disease, Diabetes and mental disorders), treatments are not designed to "cure," but to manage the disease. Treatments help us better live with the disease we have. Not all mental illnesses are the same, nor do they all require the same type or types of treatments. Some treatments are designed to address a mental illness in general (for example: a medicine or psychotherapy for Depression) and some are designed to address specific symptoms that are part of one or more illnesses (for example: a medicine or psychotherapy for anger outbursts in a person who has ADHD). Some treatments are highly specific (that means that they are usually used primarily in one condition (e.g., psychostimulant medications for the treatment of ADHD), whereas others demonstrate positive impacts in many different conditions (e.g., CBT in Depression and Anxiety Disorders or SSRI medications in Depression and Anxiety Disorders).

Not all treatments work the same for all people. Just as different mental illnesses arise in different people due to different genetic and environmental factors that affect their development, the impact of any specific treatment on an individual is also influenced by different genetic and environmental factors.

Not all people with the same mental illnesses will require the same treatments. For example, if a person has mild Depression, often CBT alone can provide the anticipated results. However, if the Depression is more severe, medication will likely be required in addition to CBT, and additional interventions such as modification of academic activities will be needed. If the Depression is very severe and the usual treatments have not proven to be effective, admission to a hospital for other kinds of treatment may be needed.

Depending on the type and severity of mental illness, different types of treatments may be applied. Each of these treatments should be based on the best available scientific evidence and individualized to the person's needs in support of their goals. Remember, treatments should be provided to people who have a mental illness, not provided to mental illnesses. That is why there may be different treatments being used for different people who have the same mental illness.

Just as there is stigma against people who have a mental illness, so too is there stigma against treatments for mental illness. For example, you may hear:

- "if just talking to someone makes you better, it's not a real illness"
- "medications should not be used"
- "it's OK to use medicines to treat a physical illness such as Diabetes but not a mental illness such as Depression"
- "all you need is love and acceptance, not treatment"
- "it costs too much to treat mental illnesses"
- "treatments for mental illnesses are less effective than treatments for any other type of illness"
- "all you need to do is eat healthy and exercise to recover from a mental illness"

Just as we need to address stigma against mental illnesses, it is necessary to address the stigma against the treatments for mental illnesses.

The kinds of treatments that are available and used by health providers will change over time, because of new knowledge, scientific research and availability in the health system. Existing treatments can be improved, new treatments previously not available become available and treatments that are less effective or have more negative side effects become less applied.

Activity 5.1: Write down what you think the purpose(s) of a treatment for a mental disorder is/are. Then read the section that follows. After you finish, return to what you have written and revise your answers.

What are treatments supposed to do?

The goal of treatment is to improve your student's symptoms, their ability to function in all aspects of their lives

(at home, at school, with others, etc.), and stop the mental illness from coming back. Most treatments do not work immediately; they usually take some time to be effective and improvements are usually gradual. For example: CBT for Depression may take 12 weeks or longer to demonstrate its most effective impact. Many people find that the process of treatment is like a series of peaks and valleys. Some days may be better than others. However, over time treatment should help your student have more good days than bad, and help them cope more easily with the bad days. As treatment progresses, you may find that your student's emotions are more stable, that they are more social and more able to complete work at school and that they are now more able to reach their goals.

For more on what treatments are supposed to do, see the Deeper Dive section of this module.

Why is it that some students will start treatment right away, yet others wait before starting treatment?

There are many different factors that interact to determine if a person will engage with or begin a treatment. In some cases, the person may not think they need treatment, in spite of the recommendations from family, friends and expert health care providers. The reasons for this are many but may include:

- stigma against the treatment
- the impact of the illness on cognition and decision making capacity
- lack of knowledge about the illness and its treatment
- belief systems of the person, the family or their community

In some cases, the person needs time to review their treatment options and decide on what treatment(s) they would like to try first. In some cases, the diagnosis is not clear and further assessments are needed (e.g., a second opinion, blood tests, neuropsychological testing, etc.), which take time to organize and apply. In other cases, the treatment that the person wants or needs is not immediately available and they have to be put on a waitlist. The types of treatments available may also vary from place to place. For example, hospital-based care cannot be accessed in every community.

One important myth to address is that treatments are not effective unless the person who is receiving that treatment wants to get better (often referred to as "wants to change"). This concept is a historical hold-over from the days of psychoanalytic therapies and stigmatizes people who have a mental illness. It makes it their fault if they do not respond to a treatment. This is not the case. People do not fail treatments, treatments fail people.

How does a health care provider know if a treatment is going to be beneficial for my student?

To figure out which treatments are most likely to help your student, properly trained health care providers consider the available scientific research, their own knowledge/experience and the wishes of the youth and family. They use all of these factors to identify treatment options and suggest specific treatments over others. Health care providers look for evidence that suggests a treatment would likely be beneficial and that the benefits are not outweighed by harms. They also use specific criteria to determine which treatments are best suited for your student's needs. These criteria have been developed from the results of scientific research studies.

For more, check out Deeper Dive: Understanding Categories of Treatment.

Medications

Medications are substances that, in the case of treating mental illness, are taken with the purpose of improving brain functioning. Not every youth who has a mental illness will require medication to treat it. The decision to use medication depends on the scientific research about the best treatments for the condition and the wishes and comfort of the patient, family and provider. However, medications are often necessary for holistic treatment of someone with a mental illness. Medications should rarely, if ever, be provided without concurrent provision of psychotherapy or psycho-social supports. A useful way to think about this issue is to consider that based on the scientific evidence available, medications can be a necessary, but not sufficient treatment for young people who have a mental illness. Research on medications usually involves the use of placebo to take account of the placebo effect.

What is the purpose of using medication?

Medications are chemical messengers that help the brain reset its chemical processes. This reset helps the brain improve its functioning and should lead to decreases in the signs and symptoms of the illness and to improved functioning for the individual with the illness. This reset may also help decrease the likelihood that the illness will come back once a person is in remission.

In addition to the type of medicine that is used, the dose of the medicine is also important. For each illness a "total daily dose" has been determined through extensive research. This is the dose at which most people will receive the most benefit. However, some people may receive maximal benefit at daily amounts below that dose and some may need larger doses to obtain the maximal benefit.

Because medications act on many different parts of the brain, they may have both positive effects (called therapeutic effects) and negative effects (called side effects). For example, while a medicine may help the brain reset its control of mood, and thus improve Depression, the same medicine may also lead to unwanted effects such as headaches or weight gain. The use of any medication balances the relationship between positive therapeutic effects and negative side effects. Given that people have different genetic and environmental influences, different medications may impact them to different extents, even if both medications have been found to be helpful for treating their illness.

For more information on medication treatment, check out the Deeper Dive section of this module.

How will medications affect my student in school?

Some medications may have negative impacts on school performance such as sleepiness, agitation, cognitive "dulling" (i.e., making it hard for the student to think and concentrate). Other medications may have positive impacts on school performance, either by directly improving focus and concentration (like in someone with ADHD) or by improving the disorder and reducing the distraction from schoolwork (like in someone with Depression or Schizophrenia). How the medication will affect your student depends on the student, the type of mental illness and the specific medication that they are taking.

Psychotherapy

Are there effective treatments for people who have mental illness other than medications?

Yes. There are numerous psychosocial therapies (psychotherapy) that have been found to be effective on their own and in combination with medications to help people that have many different mental illnesses. Psychotherapy, also called talk therapy, helps people with mental illness problem-solve, learn and use healthy coping strategies and adaptively change their negative and harmful thoughts, emotions and behaviours. Similar to medications, psychotherapy works by changing the way brain chemistry works to modify different brain functions.

What is psychotherapy?

Effective psychotherapy or talk therapy is a combination of therapeutic technique, the personality and skills of the therapist and the patient's belief in the process and the provider (the placebo effect). Most psychotherapies require active participation by the patient and (just as different people respond differently to the same medicine), different people also respond differently to the same psychotherapy.

Psychological treatments can have side effects, just as medications can have side effects. Usually, psychological treatments provided in isolation are for mild forms of certain mental illnesses, like Anxiety Disorders and Depression. For more severe types of illness or more severe forms of these illnesses, psychotherapies are combined with medications to obtain better outcomes. Unlike medications, psychotherapies do not require repeat prescriptions once mastered, although increasing evidence suggests that regular "booster" treatments may have additional long-term benefit. Also unlike medicines, there is no "purity" with psychotherapy. That means that no two psychotherapists doing the same kind of psychotherapy will do it the same way with the same person. Making it extremely important to ensure that the therapist is skilled and the patient feels comfortable with the therapist.

There are many different types of psychotherapies. Most have not been properly evaluated to determine if they are safe or effective. Some, such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT), have. It is very important that there is good evidence for the safety and effectiveness of any psychotherapy your student is offered. As outlined above, there are well-established scientific and professional processes for determining which types of psychotherapy can be considered standard treatments.

Activity 5.2: Use this list to check out some available types of psychotherapy: https://en.wikipedia.org/wiki/List_of_psychotherapies. Were any therapies on that list new to you? Why do you think there are so many different therapies?

Activity 5.3: Now check out the psychotherapies listed below. For each one try to determine the following (you may want to read the section "Understanding Evidence" found below before you do this activity):

a) Is there good evidence that this is safe?
b) Is there good evidence that this is effective?
c) Is there good evidence that paying for this makes sense?

Type of Psychotherapy	Your Evaluation Responses
Attack Therapy	
Bioenergetic Analysis	
Daseinanalysis	
Holotropic Breathwork	
Nude Psychotherapy	

Question: Did what you read about each therapy provide you with enough valid scientific evidence to properly inform you? Why or why not?

Some teenagers who have a mental illness benefit from a combination of different evidence-based psychotherapeutic interventions. For others, a combination of medication and psychotherapy may be most effective. Psychotherapies often take time, effort and patience. Choosing the "best" treatment is based on personal preference, the interventions available and the scientific evidence to support their safety and effectiveness.

For more information about evidence-based psychotherapy, check out the Deeper Dive section of this module.

Treatment plans

Is psychotherapy or medication better for students?

Although this is a common question, it's an example of not clearly understanding how evidence is used to determine which treatment is best for each individual. As a general principle for all mental illnesses, both medication and an evidence-based psychotherapy should be considered. For many common mental illnesses such as Depression and Anxiety Disorders, particularly if they are mild in intensity, an evidence-based psychotherapy alone may be all that is needed. For more severe versions of these disorders, or for other disorders (such as Obsessive-Compulsive Disorder, Schizophrenia and Bipolar Disorder), psychotherapy is provided alongside medications. In every treatment situation, it is the scientific evidence, the patient's preference, the provider's prescription and the cost and availability of the treatment that determines what is chosen.

Another student in my school/class has a similar mental illness, does this mean they will have the same treatment?

Not necessarily. As we have previously discussed, treatments are specific to the individual. It is the PERSON who has a mental illness that is provided treatment. Your students may have different illnesses, and even if they have similar illnesses they may have different challenges and experience different outcomes. Remember, they are all different people with different families and school lives. Each person's illness is shaped by their unique genetic makeup and experiences. All people have their own strengths, challenges and needs. That is why all treatments need to be tailored to the specific individual.

During treatment

What should I expect when my student starts their treatment?

When a student in your classroom first starts their treatment, you should not expect to see an immediate change. Treatment can be difficult; it requires time and is not a "quick fix." Your student is learning new skills and new ways of thinking and looking at the world. Often, the way they currently think, feel and behave has developed over many years. As such, it will take more than a few weeks to change. That being said, there are some medication treatments, such as psychostimulants for ADHD, where the therapeutic impact may be seen almost immediately.

As your student progresses through treatment, it is important to link with their treatment team to find out how you can help in the classroom. Your student may require academic accommodations. Consult with your school administration if you're uncertain of your school's protocol for linking to health care providers. It is important to know that making academic accommodations isn't playing favourites or treating that student differently than other students; it's about giving that student the resources they need to successfully get through their treatment. However, try to make sure that the accommodations are designed to help, not harm. For example,

those that encourage avoidance can interfere with developing adaptive skills.

How does the school receive information about a student with a mental illness, updates on the student's progress, etc?

Most schools have different policies, regulations and procedures, which makes it difficult to give a specific response to this question. Included below is a general overview, but check with your school principal and/or guidance counselor for your school's specific policies.

Generally, your school receives information either from the student, from the student's parents or directly from the student's health care provider. In some cases, consent for sharing confidential health information will be made by your student alone. In other cases, your student's parents (or legal guardians) are the people who decide who can receive information and how the information will be sent out. Not all young people or parents will feel comfortable sharing that information with the school, especially if they're worried about stigma. Some parents will give permission to have their child's health care provider update the school directly with information, and sometimes you may be able to work directly with the health care provider to develop appropriate accommodations for your student. Usually, consent forms signed by the student alone or together with a parent (or legal guardian) are used to fulfill legal requirements for the sharing of confidential health information.

If the Mental Health Assessment was requested by the school and performed by a psychologist working for the school board, the school will often have a copy of the assessment results. However, if a Mental Health Assessment was facilitated through the parents or by the youth directly with a psychologist or psychiatrist in a hospital or private practice, it is the youth's or the parent/guardian's decision to share that information. Sometimes information about a student is not shared directly between the parent/health care provider and the student's teacher but rather between the parent/health care provider and the school principal, guidance counselor or learning resource teacher. In order to determine what the process is at your school, ask your school principal or guidance counselor.

Why do some parents share information while others leave teachers out of the loop?

Some parents may be more involved in your classroom than others, but that doesn't mean that less involved parents are less concerned with the wellbeing of their child. Your students' parents may work multiple jobs, be single parents, travel a lot for work or have to care for other children. Even if parents aren't reaching out to you, do your best to keep the lines of communication open.

Additionally, how, when and what information is shared is impacted by the stigma that surrounds mental illness. If a student in your class broke his or her ankle, sharing that information would happen quickly and easily. Although the process should be the same for a student with a mental illness, many times it is not. Stigma is best reduced with better mental health literacy.

What will my student be like during treatment?*

Some students will feel relief at being able to talk to a supportive third party, such as a teacher. Other students may feel vulnerable and want to avoid third-party discussions. All students react differently to treatment and there is no one-size-fits-all. Take the time to get to know your student and learn what they think and feel about you being involved.

Make sure that your guidance counselor and principal know that you want to be updated on your student's progress. Some schools require the guidance counselor to be the one to converse with the parents of a student. If this is consistent with the policies of your school, focus on how you can be a part of those meetings and/or how you can have your questions answered (e.g., giving the guidance counselor a list of your questions or ideas).

How can I help my student get the most out of their treatment?

- When appropriate, provide your student with up-to-date, best-in-class resources about their illness and its treatments. Check http://teenmentalhealth.org/ for accurate evidence-based information.
- Be part of the treatment team. Provide input on how your student is doing and discuss what kinds of interventions you may be able to put into place that would be helpful to promote recovery. For example, if a student in your class was diagnosed with insulin-dependent Diabetes or a peanut allergy, you would likely be informed. Your student would probably have permission to leave class and inject themselves with insulin in a private place if they needed it, and this would be a reasonable expectation. It is unlikely that a student would be required to stay in class to give themselves the injection in front of their fellow students. A student with a mental illness may require self-help strategies just like a student with diabetes does. Perhaps your student may need to leave class to collect themselves. Perhaps they would benefit from having a box on the corner of their desk where feelings can be written down instead of being held onto. Perhaps you pick your student's groups in class so no one is left out. If the first strategy you try doesn't work, try another – not every intervention will work the same for every student. For more on this check out: Deeper Dive: more on understanding treatment.
- Try not to nag your student if you think they are not putting in a full effort at school. Maybe their greatest accomplishment that day was walking in the front doors of the school – every day is different. Recognize your student's successes, however small they are, without patronizing them. At the same time, just because a student may be living with a mental illness does not mean that they are unable to work or play at the same pace as others. Keep the Diabetes example in mind. Just because a person has insulin-dependent diabetes does not mean that they can't climb a mountain! But make sure that you do not over-accommodate, as that can get in the way of your student developing the skills they need. For example, at some point a student needs to learn how to inject their own insulin.
- Don't hesitate to ask your school guidance counselor if they have any ideas about what you could do in your classroom to help, or if there are any extra resources you could use.
- Make sure not to single out your student or make it obvious to others that your student has a mental illness or mental health problem. It's your student's decision whether or not to tell their peers about their mental illness.
- Remember, while it is important for you as a teacher to know about treatments, it is not your role or competency to advise on what treatment should be used.

How can I tell if a treatment is working for my student?

The right treatment for your student is one that your student and their family have chosen based on best available evidence, that has been tailored to their individual needs and works for them. Many people need to try several different types of treatments (both medications and psychotherapies) before the right treatment or combination of treatments is found. Given that you spend so much time with your students, your observations can be very helpful to their health care providers in determining if a treatment is working or not.

Look for visible changes in your student, such as:

- A decrease in symptoms
- An increase in positive productive activity
- An increase in involvement in class activities
- An increase in your student's ability to talk about their problems/concerns (especially if your student is seeing a health care provider for psychotherapy)
- Improved grades
- An increase in social activity

Treatment for young people who have a mental illness may require the involvement of a treatment team. Traditionally that has been thought to be only made up of health providers such as doctors and nurses/ psychologists. Increasingly (especially if the student has a severe mental illness or is receiving complex treatments) the composition of the treatment team has widened to include all health and human services providers that are interacting with the student. This should also include key school personnel such as counselors, administrators and classroom teachers. The role of each of these individuals will differ from student to student but overall it is important for classroom teachers to be part of the treatment monitoring and treatment support team.

How long will it be before I see improvements in my student?

That depends on many factors, including: the type of mental illness, the severity of the illness, the types of treatment(s) being applied and your student's response to the treatments. Every person is different and how well and quickly treatment will work may vary. Remember that signs and symptoms may show improvement before functioning improves and that not all signs and symptoms will show the same improvement trajectory (for example: irritability may become better quickly while concentration problems may take longer to resolve). Because of the great variability in expected treatment responses there is no single time that can be given as an "average." That is why it is so important for the classroom teacher to be part of the treatment monitoring team. You will learn what the expected treatment response timelines are and you will be able to provide essential information to the health care providers as to what treatment goals are, or are not being met and when.

Remember that a person can have a mental illness, mental distress and a mental health problem at the same time. Just because your student has a mental illness (e.g., Depression) and is having a hard time this week, does not mean their difficulties are due to the illness. Maybe something has happened in their life (e.g., financial stress at home) that is causing problems. Don't jump to conclusions – take the time to find out.

Also, remember that the process of improvement is not a straight line. There are many bumps in the road to getting well.

Understanding evidence

Overview

Evidence is usually understood as proof that supports a claim or belief. In the clinical domain, evidence addresses the effectiveness, tolerability, safety and cost-effectiveness of interventions applied in the context of an illness to help a person get well and stay well. In the public health domain, evidence is the effectiveness, cost-effectiveness and safety of interventions that will create changes to the health of the population. Examples of interventions include, but are not limited to: educational programs, health promotion campaigns, health policies, environmental modifications (e.g., changing a classroom layout), medical interventions and psychological interventions.

In order to determine whether an intervention has sufficient evidence to be used, we look to the scientific literature, which includes peer-reviewed journals, books and government/institution-commissioned reports. As an educator, it is important for you to understand how to critically evaluate programs that are proposed for use in your school or your classroom.

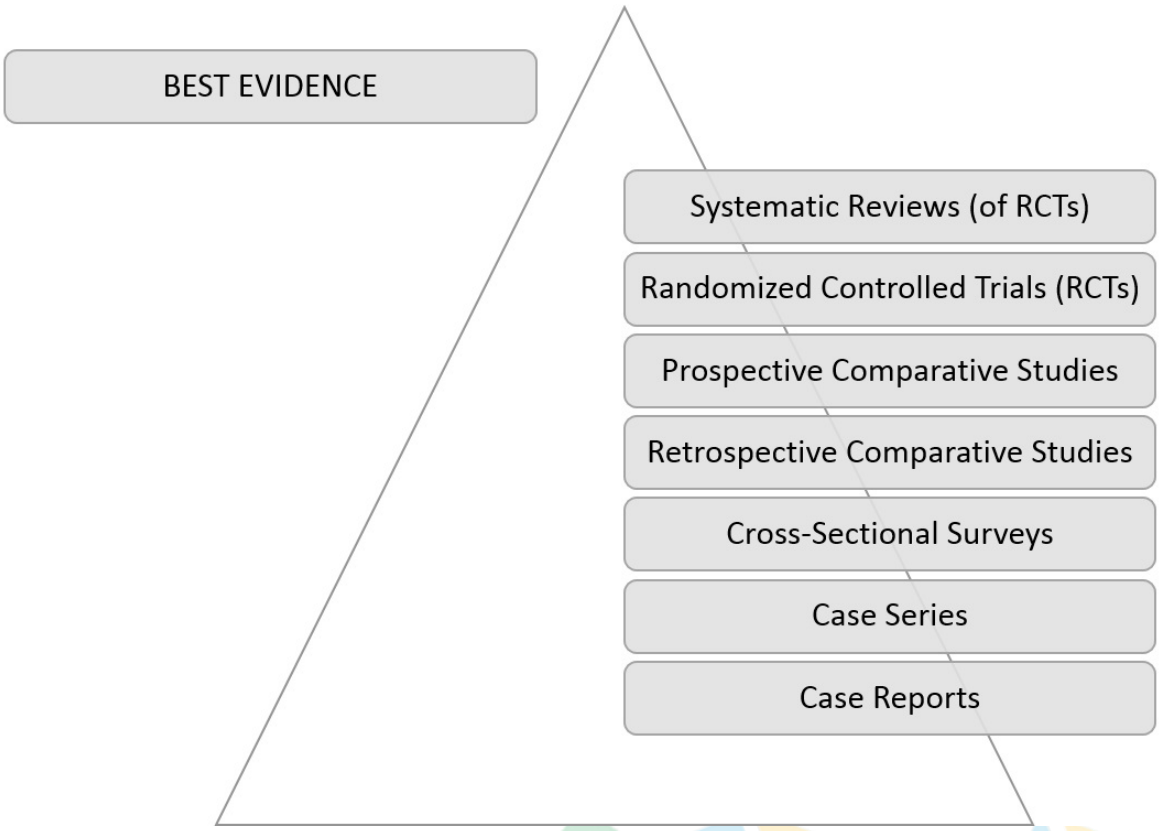
For more information on evaluating quality of research studies, check out Deeper Dive: How do we evaluate the quality of a research study?

Similarly, understanding how we know certain interventions are likely to be effective can help you work more effectively with students undergoing those interventions. In this next section, we will review the key components that should be considered when determining if a program or intervention has sufficient evidence to be used.

The hierarchy of evidence

Evidence is hierarchical. Not all research studies are created equal (see Figure 5.3). Certain research studies are more prone to bias than others. That means that with some research studies, there is a chance that Intervention A appears effective for Problem A not because it works, but because something about the study or program made it look like it was working. Consequently, the results of studies that are more scientifically rigorous (and thus, at the top of the hierarchy) are more credible than the results of studies further down the hierarchy because they are less likely to report misleading or incorrect findings.

Fig. 5.3 Evidence Hierarchy



Correlation versus causation

A key difference to understand when critically evaluating research is between correlation and causation. Correlation means that two things are linked/connected/have a relationship. Correlation can only tell us that two things are linked – it cannot tell us which one thing caused the other to occur. For example, a study might find that having Depression is correlated with having fewer friends. This is a correlation so we only know that these two things are connected (that people who are Depressed are likely to have fewer friends than people who are not Depressed). It's possible that having fewer friends can increase risk for Depression – but it's also possible that having Depression can lead to fewer friends.

Causation on the other hand, is something that happens as a result of something else happening. There is an order – we know that A came before B and it led to (or caused) B to happen. For example, a study might find that getting hit really hard in the head leads to a traumatic brain injury. We know that A (getting hit in the head) happened before B (brain injury). Many studies are not able to determine causation; they can only tell if two things are correlated. Only very well-designed research studies can determine causation – what came first and

what led the second factor to happen. Be critical of studies that claim one thing caused another – make sure the research supports their statements.

Evidence-based medicine

Evidence-Based Medicine (EBM) refers to treatments or interventions that are developed using the best evidence available from research input from experienced providers, that abide by the wishes of patients (or students/families) and that are individualized to each person. The intention of EBM is to move away from popular 'recipes' for treatment (e.g., "This is what we've always done to treat Depression" regardless of the individual case, personal beliefs and quality of new research) and create an individual treatment plan for each person that is comprised of three distinct things:

1. The scientific evidence for or against an intervention or interventions
2. The expertise of the provider
3. The patient/student's choice

For more information check out Deeper Dive: other key terms

EBM is the gold standard for intervention decision-making because it requires the provider to use the best available evidence and to invite the patient into the decision-making process. It also requires the patient to be informed and involved in the process. For more on Evidence-Based Medicine, check out the information on the website: **http:www.teenmentalhealth.org/**

Evidence-based mental health promotion

Mental Health Promotion refers to the process by which we strengthen and enhance factors that contribute to good mental health. A key component of mental health promotion is its focus on strengths, rather than weaknesses. But not all programs marketed as mental health promotion are effective or beneficial. A celebrity endorsement or the fact that the program "sounds good" is not enough to justify its use. Further, the statement that strengthening protective factors will lead to better mental health should not be an assumption but should be based on good evidence that this indeed happens. To recommend the use of specific mental health promotion programs, the quality of evidence supporting the program must be considered and critically evaluated. Additionally, whether the program can be implemented as it was designed in its full and complete form is also a necessary consideration. This is called "fidelity".

Although every mental health promotion program should be examined independently for quality of evidence, there are a few common features found in programs that are more effective:

- Teaching positive mental health skills (this means coping skills, not positive emotions)
- Striking a balance between approaches that target high-risk individuals and those that target all students
- Starting young and continuing throughout schooling
- Long-term programs that are embedded throughout the school system
- Linking mental health interventions with academic learning
- Teacher education
- Working with and educating parents and the community

There is an international organization dedicated to trying to improve the quality of research. It's called the Cochrane Collaboration. Read more information about what it does and how to access its work.

Celebrity Endorsements

It is likely that celebrity endorsements of a particular product or program are inversely correlated to the scientific evidence behind it. That means, the more celebrity endorsement, the less the scientific evidence. For

example, the claims made by celebrities such as Gwyneth Paltrow, Tom Brady, Goldie Hawn, etc. should be approached with the greatest of skepticism. For an informative read about this issue check out “Is Gwyneth Paltrow Wrong About Everything?” by Timothy Caulfied and “America the Anxious: Why our Search for Happiness is Driving us Crazy and How to Find it for Real” by Ruth Whippman.

Activity 5.4: This has been a content heavy module and much of the information may have been new to you. Please go through the PowerPoint “What is Treatment?” to review.

Supplementary Resources

- Wong, M. L. (2002). Evidence-based health promotion: Applying it in practice. Journal of Academic Medicine, 31(5), 656-662. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12395656
- Müller-Riemenschneider, F., Bockelbrink, A., Reinhold, T., Rasch, A., Greiner, W., & Willich, S. N. (2008). Long-term effectiveness of behavioural interventions to prevent smoking among children and youth. Tobacco Control, 17(5), 301-302. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18522963

Self-Assessment

1. The purpose of treatment is to decrease the symptoms of the illness and prevent its causes.
2. Standard treatments are usually widely endorsed by well-known celebrities.
3. The most important challenge in treating a mental illness is to decide if a medicine or a psychotherapy should be used.
4. Advising students and parents about what treatment is best for their mental disorder is an important role a teacher can play.
5. The term “nocebo” means that a person has not experienced a placebo response.
6. Remission is a term used to describe the symptoms that have returned when a treatment is not working for a person.

Self-Assessment Answer Key

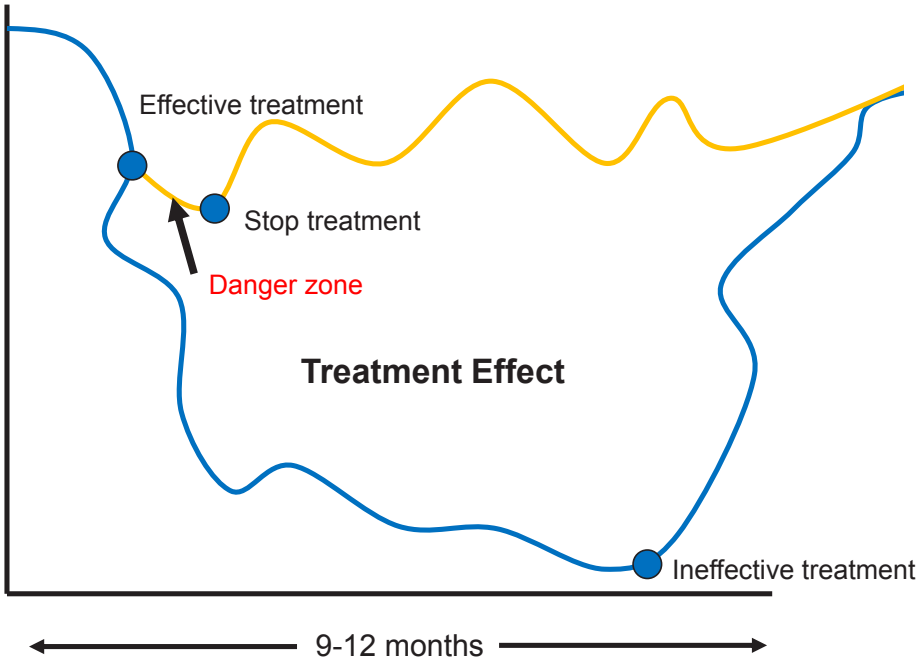
1) F 2) F 3) F 4) F 5) F 6) F

Module 5: Deeper Dive

More on what treatments are supposed to do

Sometimes, because of this time lag between the beginning of treatment and the onset of its effect, a person may not understand that the impact is not immediate and stop a treatment that will be effective before it has a chance to work. In the diagram below (Figure 5.1), the blue line represents the course of Depression without treatment. The orange line is the course of the same Depression with treatment. Treatment has begun at point #1 but positive results are not realized until point #2. The space between the two lines measures the impact of the treatment. But, if the person who is receiving the treatment does not know that response is expected to be delayed they may stop what would have been an effective intervention. That is why knowing what the expected therapeutic timeline will likely be is so important for a person receiving treatment.

Figure 5.1 How Treatment May Impact Illness Course



Key points

1. Symptoms can still worsen after treatment has begun, because it takes time for the treatment to start working.
2. Even as someone is getting better, they can have bad days or weeks.

Understanding categories of treatment

Although it is necessary to conduct scientific research to determine if treatments are effective, safe and tolerable, not all scientific research is of equal value and there is a clear and consistent hierarchy in research quality. It is very important that you know about these differences because many interventions are marketed as having scientific foundations that are either non-existent or known to be weak. This applies to biological treatments, psychological treatments and health/wellness programs.

Some treatments must meet rigorous standards to achieve regulatory approval for use. This approval is provided by a government agency such as Health Canada in Canada or the Food and Drug Administration in the United States of America, to ensure that they meet standards for effectiveness, safety and purity. Once treatments are regulated, they are closely controlled (available only through specific health providers) using

specific documented records (e.g., prescriptions) and subject to ongoing surveillance. Not all treatments that are provided are subject to regulatory approval. Here is a table showing which kinds of treatments commonly used to treat people who have a mental health problem or mental illness have regulatory approval in Canada and which do not. We have used the example of Depression but treatment for any illness (mental or non-mental) can be considered similarly.

Type of Treatment	Regulatory Approval by Health Canada
Prescription medicines	Yes
Over the counter medicines (any kind)	No
Psychotherapy (any kind)	No
Herbal remedies (any kind)	No
Electronic interventions (such as Apps)	No
Wellness therapies (any kind)	No

Treatment categories

Standard Treatment: This is a treatment that meets the standards of numerous credible professional organizations due to the substantial amount of scientific research that supports its use. Often standard treatments have received regulatory approval such as medicines approved by Health Canada. For standard treatments that have not undergone regulatory approval (such as for psychotherapies) reputable, professional bodies that have reviewed the scientific literature indicate this approval. For example: CBT is considered a standard treatment for Depression by the Canadian Psychiatric Association, the Canadian Psychological Association, the Canadian Academy of Child and Adolescent Psychiatry, the Canadian Pediatric Association, the Canadian Medical Association, the World Health Organization, etc. All credentialed and regulated mental health care providers are trained in the use of one or more of these standard treatments. Examples of standard treatments for Depression are SSRI medications and CBT.

Complementary Treatment: This is a treatment that has not met the standard of numerous credible professional organizations and/or received regulatory approval. These are provided in addition (to complement but not to replace) to standard treatments. They have some scientific evidence that they may enhance the effectiveness of the standard treatment or may add additional health benefits to the standard treatment. An example of this is adding vitamin D at a dose of 1000 IU daily to SSRI and CBT treatment of Depression.

Alternative Treatment: This is treatment for which there is insufficient evidence that, when used by itself, it is either safe or effective. Alternative treatments are not regulated, nor are they officially endorsed by credible professional organizations. They may be endorsed by celebrity health professionals (such as the TV host Dr. Oz and Dr. Phil), entertainment celebrities (such as Gwyneth Paltrow or Tom Cruise), organizations (such as Scientology) or so-called wellness gurus (such as Deepak Chopra). The marketing frenzy in the business of selling alternative treatments can lead to confusion for many. It is a “buyer beware” world with alternative treatments.

More on medications

What are medication interactions?

A medication interaction happens if someone is taking multiple medications that interact with one another. These interactions can happen in many different parts of the body, but mostly in the liver (the place that medications are metabolized) or in the brain itself (the place that the medications go to have their impact). Part of the role of your student’s doctor and pharmacist is to ensure that he or she is not taking any prescribed medications that will interact negatively with one another. However, prescribed medicines are not the only compounds that can interact with each other. Any medication or drug that is taken by a person can potentially

interact with any chemical compound. This means that some foods, over the counter compounds, herbal remedies, legal (such as alcohol and nicotine) and illegal (such as heroin) drugs can all potentially interact with medications. That is why it is so important to inform the doctor and pharmacist about all the different compounds that a person is taking.

The names of medications

Often the names used to describe medications can be confusing. There are both chemical class names and proprietary manufacturing names/trade names. For example, for the class of Serotonin Specific Reuptake Inhibitors (SSRIs) there can be many chemical names like Fluoxetine, Citalopram, Sertraline, etc. Each of these differ slightly from each other. Even more confusing, each of the chemical names also carries a trade name, such as Prozac (Fluoxetine); Celexa (Citalopram); Zoloft (Sertraline). Generic versions of medicines contain the same active ingredient but may differ in the types of inactive compounds used. The common designations applied to medicines can also be confusing. For example, although antidepressants are used to treat Depression they are also effective for treating Anxiety Disorders, some Sleep Disorders and even chronic pain. So, just because a medicine has the name of an illness in its description, it doesn't mean it is only to be used for that condition.

Can my student become addicted to his or her medication?

Addiction can happen with any type of chemical that induces craving. It impacts on specific brain circuits that drive the person to want and use the compound. Addiction to medications used to treat mental illness is rare. Addiction to commonly available compounds such as alcohol or nicotine is much more common.

Does the word "withdrawal" mean that someone is addicted to a medication?

Mostly not. Although withdrawal can refer to the negative effects of someone not taking a drug to which they are addicted, withdrawal most commonly happens to people who are not addicted, but are using a medication regularly and then suddenly stop using it. Withdrawal is the term used to describe the brain's reaction to the rapid and complete absence of that medication. This is why, if a patient is stopping their medication, they are advised to gradually decrease the use of the medicine over time. This usually decreases the risk of withdrawal.

More on psychotherapy

What is Interpersonal Psychotherapy?

Interpersonal Psychotherapy (IPT) is an evidence-based psychotherapy sometimes used in the treatment of Depression. IPT focuses on the relationships in someone's life, and aims to help the person improve their most important relationships. IPT helps identify areas in need of skill building to improve your student's relationships and through this process, decrease the symptoms they are experiencing. Over time, your student will learn to link changes in mood to events occurring in a relationship. They will then be able to communicate feelings and expectations to problem-solve the situation. The treatment length ranges from 12 to 16 sessions over 3 to 4 months between your student and their therapist.

What is Family Therapy?

There are many different varieties of family therapy and most of them have not received sufficient scientific research to justify their use as a stand-alone standard therapy for any mental illness. In all family therapies, the entire family or parts of the family are present and engaged to help solve problems.

Family Therapy is usually provided in addition to individualized psychotherapy (a standard evidence-based treatment for a specific mental disorder). It recognizes that the mental health of your student can affect their entire family, and your student's family can also affect their mental health. A family works as a unit, and the

members of a family respond to the 'pushes and pulls' of the relationships between people. Sometimes something like a mental illness in a family member causes the relationships between members of the family to change. Seeing a family therapist can be beneficial for identifying and addressing negative interaction processes within a family.

What is Group Therapy?

Group Therapy is a format for psychotherapy in which there is one therapist and a number of participants who are experiencing similar life challenges or have a similar mental illness. It is usually based on an evidence-based psychotherapy, such as CBT or IPT. Group Therapy can be beneficial for teens because the other participants in the group are usually a similar age and experiencing similar challenges. For some, this can be a positive social support and may help teens realize they are not alone. For others, it is less appealing. It may also be more cost effective than individual psychotherapy because one therapist can help multiple people simultaneously.

Motivational Interviewing

This is a type of treatment that may be especially useful for young people as it is action oriented. Unlike traditional non-directive psychotherapies, motivational interviewing encourages direct engagement between the therapist and the patient to encourage the patient to make positive changes in their lives that will then result in better mental health outcomes. This type of therapy is also often applied to help young people who are experiencing substance abuse.

What is Cognitive Behavioural Therapy (CBT?)

Cognitive Behavioural Therapy (CBT) is a type of psychotherapy that has been widely studied and is considered to be an effective treatment for a number of mental illnesses as well as for mental health problems, including Depression, Obsessive-Compulsive Disorder and most Anxiety Disorders. CBT teaches people how to change their distorted thinking patterns and unhealthy behaviours. CBT is usually considered a "short-term treatment" by psychologists, meaning that your student will usually see their therapist anywhere from 6 to 20 times over a period of 12 – 16 weeks. Many people think therapy is like in the movies, where someone lies down on a couch and tells their therapist memories from childhood. CBT isn't like that because it focuses on teaching specific skills to teens and their families. CBT explores how your student's thoughts, emotions and behaviours are interconnected and how change in one area can lead to changes in other areas (e.g., changing a thought can change the emotion experienced, which can then result in changes in behaviour). In CBT, the therapist will collaborate with your student to help them learn specific skills they can use for the rest of their life. CBT helps your student identify what is known as "dysfunctional thinking" (when you think something that isn't correct) and helps them examine the truth and usefulness of those thoughts. CBT can be done with or without parents present, as well as in a group setting with other teenagers. Recently, online versions of CBT have begun to be researched.

Does CBT have homework?

CBT usually includes "homework," because the skills being taught are skills that need to be practiced. In the beginning, your student will be asked to simply observe their thoughts in certain situations and write them down. In later sessions, homework will involve recognizing how those thoughts are influencing emotions and subsequently behaviour, and critically examining the accuracy of those thoughts. This helps your student achieve the main goal of CBT which is, in essence, to become their own therapist because they have the skills to examine and regulate their own thoughts, emotions and behaviours.

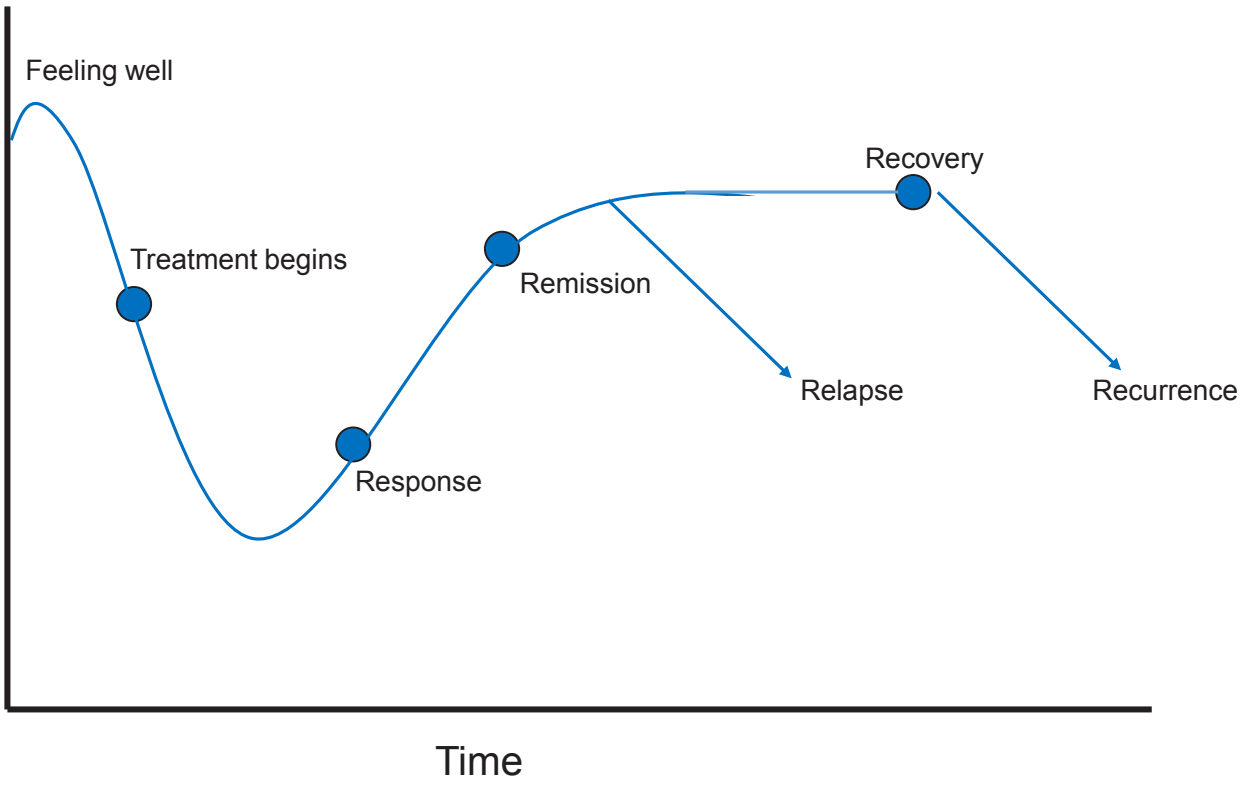
What is Computerized Cognitive Behavioural Therapy (cCBT)?

Computerized Cognitive Behavioural Therapy (cCBT) is a relatively new format of CBT that involves the use of different computerized modules to teach students coping strategies and help them learn about their mental illness. At this time, the research into the effectiveness of this form of CBT is only beginning, and results have been mixed so far. Much more scientifically rigorous study is needed before this type of therapy can be recommended as a treatment on its own.

More on understanding the course of treatment

What does it mean when my student is in remission, has had a relapse or has had a recurrence? Treatment generally follows a process that we call the 5 R's of Treatment. (See Figure 5.2). Your student's health care provider may use the following terms to describe how they are progressing in treatment. Most teens will experience periods 1 through 3, but not all will experience periods 4 and 5. Whether they experience each stage once, twice or multiple times is not an indication of how committed they are to treatment. Treatment is different for every person.

Figure 5.2 Impact of Treatment over Time



Response: Treatments are provided and the signs and symptoms of the illness begin to improve. Functioning also begins to improve.

Remission: Most of the signs and symptoms have shown substantial improvement and functioning can be back to (or almost back to) usual.

Recovery: The degree of recovery can vary from person to person. For many people, this means that for a relatively long period of time (about one year), the signs and symptoms of the illness have gone away or mostly gone away and that they have returned to usual or mostly usual functioning. For others, who perhaps

may have a more severe illness or who may not be experiencing the same response to treatments, the signs and symptoms of the illness continue to show improvement and functioning has improved. Some residual features or challenges with functioning may remain, but the person is able to progress with their life and be as well as they can be.

Relapse: Some or all of the signs and symptoms of the illness return and functioning worsens while the patient is still getting better and before they have recovered. This can occur because the illness has entered a more severe phase, the treatment has stopped being as effective as it initially was, the person has stopped all or part of their treatment or an additional negative impact has occurred (such as a severe life stressor or drug use).

Recurrence: Some or all of the signs and symptoms of the illness return and functioning worsens after they have recovered. This can occur because the illness has entered a more severe phase, the treatment has stopped being as effective as it initially was, the person has stopped all or part of their treatment or an additional negative impact has occurred (such as a severe life stressor or drug use).

How do we evaluate the quality of a research study

It is not very common that a classroom teacher would have the time to critically evaluate the quality of research that is used to support which mental health and wellness related interventions are being proposed for use in the school. However, it is important that each classroom teacher ask the following questions whenever an intervention is proposed.

If you are an administrator who is choosing what to implement in your school or jurisdictional area, these are questions (in addition to the others asked – such as cost, benefit, time, etc.) that you should make sure you ask before making your choice:

1. What is the scientific research evidence behind this intervention and what kind of quality does that evidence have?
2. Is the intervention a “product” (that is, provided by a vendor making money from the application of the intervention). If so, has the evidence mentioned in question 1 been created by the vendor, by individuals who support the vendor or the vendor’s ideas or by independent investigators?
3. Are there other things that could be applied that are less costly and equally effective? If so, why are we choosing to use the one that has been suggested? For example, vigorous daily exercise and application of easy to use deep breathing techniques may be as good or better for stress reduction than many of the marketed stress reduction programs. They are also cheaper, and daily exercise has additional multiple health benefits.

What kind of study is it?

What is the study design? (e.g., Is it a case study? An RCT?) Where does it fit on the evidence hierarchy? Is the design likely to provide strong evidence or weak evidence? Remember, randomized clinical trials (RCTs) and systematic reviews provide the best evidence if the quality of the study is high. Was the intervention compared to a placebo?

Do the study authors discuss statistical and clinical significance?

The authors of research studies always discuss statistical significance – that is, whether the observed result (e.g., that people who received the intervention improved more than people who did not receive the intervention) is probably real or whether that result could have occurred by chance. However, clinical/practical

significance is another concept altogether. Clinical/practical significance refers to whether the observed result will make any real difference in the lives of patients/participants.

Did they follow up with participants after the end of the study?

We want to know more than just whether people improved at the end of the study period. For some studies, the study period is not very long – it may be a matter of hours or weeks. We also need to know whether those improvements lasted over time. For that reason, the effects of prevention efforts should last throughout the time period of highest risk, whereas the effects of treatments should last at least two years. If a study doesn't indicate that participants have been followed up with a later date, check for newer studies by the authors that describe longer-term follow-up. If none exist, then the results of the study should be interpreted with caution.

Have any other studies found similar results?

Have the findings been replicated by other researchers? A new, well-designed study that is consistent with previous high-quality studies is more convincing than one that is not. This is especially true if the second study was conducted by researchers who are not connected to the original researchers, and thus more likely to be unbiased. If the new study is the first of its kind, more research will be needed to confirm the result. Further, when authors report on controversial topics, they should include a discussion of the "other side" of the argument in their paper.

How many people participated in the study?

Generally, the larger the number of participants in a well-designed and well-conducted study, the more confidence we can have in the results (although this is not always true). Also check how many people dropped out of the study ("withdrew" or were "lost to follow up", etc). High dropout rates can weaken the results. Attrition is another word for withdrawing from a study.

How did the researcher decide who would be in the different groups they tested?

Studies are more convincing when they use a process called random assignment, where participants are randomly assigned to different treatment groups/program conditions instead of either choosing the group themselves, being assigned to a group by a subjective researcher or having a pre-existing condition that places them in a specific group. Of course, there are times when random assignment is not possible (e.g., randomly assigning a group of people to have Diabetes and a group of people to not have Diabetes), but when it is possible, it provides much stronger research evidence.

How well-designed is the study?

Do the authors provide details about the intervention or program they are testing? They should provide enough detail that you could theoretically replicate their procedure. Do they provide enough scientific background that it's clear to you why an intervention or program is necessary and why this particular intervention or program is a logical choice? Do they talk about what they expect to find (i.e., their hypotheses) and how they intend to measure those findings (i.e., their outcome measures)? Do the measures they are using seem likely to provide the kind of answers required by their hypotheses?

Do the author's interpretations of the results make sense?

In the Discussion section of each paper, the authors will discuss their interpretation of the results they found. Do their conclusions seem logical? Are they making assumptions that the results do not support? Remember that all good studies will provide not only an interpretation of their findings but also a description of the study's limitations or problems in the Discussion section. All studies have weaknesses, and papers that do not address those weaknesses are concerning.

Also consider:

Was the study conducted on animals or humans?

Research conducted on humans is more likely to apply to your students than research conducted on animals.

Does the study include people like your students?

Check to see if the study participants were similar to your students in age, sex, SES, geographic region, cultural background, diagnoses and health concerns. The results of studies that were conducted on people who are very different from your students may not apply to them.

Is the study published in a peer-reviewed journal?

In peer-reviewed journals, an independent panel of experts reviews every article before it can be accepted for publication. For this reason, research that is published on a website or in a brochure is less believable than research that is published in a peer-reviewed medical journal. But just because a study was published in a peer-reviewed journal does not mean it is of high quality or of good design.

Who conducted the study? When and where?

Check to see that at least one of the authors is an expert in the field, and that the authors are affiliated with reputable universities, hospitals or research institutions. Be wary of authors without any clear affiliations. Look for studies that were done within the last 5 years. Research done in the 1990s may not have the same quality as research done today due to scientific advances.

Who funded the study?

Knowing who paid for the study and what stood to be lost or gained from the results is very important. People or organizations that fund studies sometimes stand to make or lose money from positive or negative study results.

For more information on evaluating research studies for application in schools, check out the CESMH project at: http://teenmentalhealth.org/care/educators/cesmh/

The Facts: Evidence Hierarchy (the strength of the research design)

The type of research study that has been done provides varying degrees of comfort as to the validity of its findings. The following list provides us with the level of hierarchy used to evaluate the strength of the research design. In addition, we need to know the quality of the study. It is both the strength of the design and the quality of the study that are important.

1. A case report

- A case report is a report about one patient.
- A case series is a report about several patients.
- Case reports and case series usually are about patients who reacted very strongly to a treatment, a pattern that a health care provider has noticed, or something unusual and novel. They are not always scientifically based, but they usually bring attention to something that was unexpected. Most research starts with case studies, but they do not have the level of scientific rigor required for use in making treatment plans or for application in schools.

2. A cross sectional study

A cross sectional study is when researchers look at one or more health problems in a group of people at any one time. These people are similar in some ways (age, gender and area where they live), but different in others. For instance, the surveys that Canadians complete every few years contain a section about health. That is Health Canada's way of finding information about the health of a population, which is considered to be a cross-sectional study. With cross-sectional studies, we might learn that children who watch more TV are more likely to be obese, but we cannot say that TV watching leads to obesity. This is because we only asked about TV watching at one specific point and it may be coincidental that TV watching and obesity co-occurred at this juncture. There may be many other factors that contribute to the child's obesity.

3. A retrospective comparative study

A retrospective comparative study is when researchers look back in time to figure out what may have caused a specific health problem in a group. There are usually two groups: those who have the specific health problem and those who do not. These studies are usually used to determine what factors predict who develops or does not develop a particular health problem. One problem with retrospective comparative studies is that our memories are not as good as we often believe them to be, so asking people to recall events and behaviours that happened in the past may not be an accurate reflection of what actually happened.

4. A prospective comparative study

A prospective comparative study is when researchers look forward in time and follow at least two groups that differ in some way to see if they will develop a specific health problem later in life. For example, following children of parents who smoke and children of parents who do not smoke over the course of a number of years to see if either group of children develops specific health problems. Because researchers are following these children over time, rather than asking them (or their parents) to recall specific behaviours, information from these studies is much more likely to be trusted.

5. A randomized controlled trial (RCT)

A randomized controlled trial (RCT) is when the participants of the study are randomly sorted into groups that receive different treatments or conditions. Researchers then follow these groups and observe what happens. Study participants are randomized because it ensures that the groups are basically equal at the beginning of the treatment – so any differences the researchers find between groups cannot be the result of differences that existed between participants before the study began. A double-blind RCT provides stronger evidence than an RCT that was not double-blind.

6. A high quality systematic review of best quality research

A systematic review is when researchers compile data from multiple other studies (usually RCTs) to determine best practice models and patterns. Systemic Reviews are the gold standard for determining the best course of treatment. They review and summarize the best quality research that exists – allowing for health care providers and other key decision makers to make informed treatment and program decisions. But even here we need to think critically. These reviews are only as good as the quality of the review, the independence of the authors and the quality of the research studies that were reviewed. If systematic reviews include poor quality research studies, they will also be of poor quality and can provide misleading conclusions.

How to use best available evidence to choose mental health related programs marketed to schools

Education administrators can find it difficult to evaluate if a program being marketed to schools shows the quality and quantity of best available evidence to support its implementation. Before spending significant

amounts of money on programs of uncertain value, it may be useful to obtain a third party independent evaluation of what you are considering. Asking that the information be summarized and put into a best evidence-based summary using a framework such as the OJP can be an eye-opening experience. For example, here is an evidence summary provided to a Provincial Ministry/Department of Education regarding two commonly applied mindfulness programs. It combines critical analysis of the scientific information with the use of the OJP framework.

Other key terms

Placebo: A placebo is something that looks, tastes or feels like what the researchers are attempting to study, but is not actually an effective treatment/intervention. For example, if a researcher is studying the effect of a medication, those receiving the placebo would usually be given a sugar pill that has no medication in it. Sometimes the act of taking a pill can make people feel better – even if the pill only contains an inert substance. In a psychological intervention a placebo can include things such as relaxing, reading a book, playing video games, etc. Placebos are used to make sure that the treatment group improves because of the actual treatment, not because the act of getting treatment makes them hopeful.

Nocebo: A nocebo is the opposite of a placebo. It is an inert substance that causes side-effects to happen in the person taking it. Sometimes in research, evaluating the impact of medicines on an illness, the “placebo” is also the “nocebo.” That is why when you look at lists of side effects in clinical research you can find that many people who took the “sugar pill” reported adverse effects that they ascribed to the pill (eg: side effects).

Double-Blind: When neither the researcher nor the participant is aware of who has received the placebo in a study. This reduces bias. Expecting someone to improve because you know they are receiving treatment can sometimes cause improvements, often because the researcher has unintentionally behaved differently toward the individuals receiving treatment. Because no one knows who is receiving the treatment and who is receiving the placebo in a double-blind study, both groups have the same expectation that they might improve, so any actual differences between the groups are much more likely to be the result of the intervention.

Module 6

Seeking Help & Providing Support

This module builds on what you learned in Module 5, “What is Treatment for a Mental Disorder and How do we Know What is Likely to Work?” and will provide you with various strategies you can use to help students by providing them with best available evidence-based resources. These include: how to identify and refer students at risk of mental illness, how to talk to students about your concerns and encourage them to seek help, how to adjust academic expectations for students, how to help student build relationships necessary to provide support and how to establish appropriate interactions with parents when addressing mental health and mental illness.

What can a classroom teacher do?

Having a mental illness is not uncommon. One in five young people will experience a mental illness. However, only about 1/3 of those who could benefit from treatment receive it, in spite of the fact that there are many effective treatments available, and effective treatments provided early in the course of an illness can have a substantial positive short and long-term impact. In Canada, there are barriers to obtaining rapid access to effective mental health care. These include: stigma against mental illness, lack of mental health care in primary health care, lack of mental health literacy in teachers, students and families and insufficient availability of specialty youth mental health care in the health care system.

Learning objectives

Upon completion of this module, you will be able to:

- be familiar with some of the resources for accessing mental health care for young people
- know what to do if you are concerned that a student is likely to have a mental health problem or a mental illness
- realize when and how to talk to parents about your concerns related to the possibility that your student has a mental health problem or mental disorder

Overview

How do we decide if what a person is experiencing is outside the range of the normal ups and downs we all go through? When is it time to seek assistance from health providers for a mental disorder? Seeking help and finding support for mental health problems or mental illness can be a tricky business. You may want to review the module “Introduction and Background.” From the outside, it’s often not clear when a mental health care intervention is necessary, and people who are experiencing a mental illness may themselves not always be aware of what’s going on or can be reluctant to come forward. Additionally, there is often confusion between treatments for a young person living with a mental illness and support for a young person suffering from a mental health problem. Indeed, sometimes interventions that are designed for treatment of a person with a mental illness are applied to support those who have a mental health problem, and vice versa.

To further complicate things, there can be a demand to treat challenges that are not mental illnesses or even mental health problems, perhaps because of confusion about what constitutes a mental illness and what is just an expected life challenge that happens to have negative emotional, cognitive or behavioural components. Not only is this confusing, but applying treatments designed for mental illnesses to the normally expected negative aspects of life can be needlessly expensive, expose young people to risks from treatment (such as side effects of medications) and can tie up mental health care resources (such as psychiatrists, psychologists, etc.) that should be primarily focused on treatments for youth who have a mental illness. On the other hand, providing supports more appropriate for youth who have a mental health problem (such as being bullied, grief, divorce of

their parents, etc.) for young people who have a mental illness often will not be an effective way to treat those who are experiencing a mental illness. Simply put, the intervention must match and meet the need.

One of the barriers to young people seeking help for a mental illness is the confusion between a mental illness and the negative emotions or cognitions that can be challenging (and even get in the way of good functioning at school, at home or socially) but are not due to a mental illness. This is why mental health literacy is so important. We need to learn the difference between illnesses that require treatment and problems that require support. For example: having a low-grade fever, a cough and a sore throat does not mean that you need to go to your family doctor or the emergency room. However, if you have pneumonia, you should. You may want to review the module “Introduction and Background” to clarify this point.

Rapid access to effective, best evidence-based intervention is important and increases the chances of getting well and staying well. Being able to rapidly access effective support if experiencing a mental health problem is also important.

Activity 6.1: Think about how our education and health care systems are set up. Do they help or hinder rapid access to effective treatment for young people who have a mental illness, or rapid access to effective support for young people who have a mental health problem? In the chart below, make a note of some of the challenges and what you think could be a solution.

Challenge	Possible Solution
Example: Young people often live a long distance from a health care provider	Example: Place health care providers into schools (e.g. school based youth centre)

Activity 6.2: For the following chart, use your best judgment to determine which care providers would be best suited to provide support for each type of mental health care need.

Check out Deeper Dive: What Do Health Providers Do? for more information.

Situation	Possible Provider
Depression	
Psychosis	
Parental Divorce	
Exam Stress	
Attention Deficit Hyperactivity Disorder	
Chronic Medical Illness (e.g. Multiple Sclerosis) with substantial coping challenges	
Obsessive Compulsive Disorder	
Excessive Alcohol Use	

In the table above, one of the examples in the Type of Problem column is not a mental health problem or a mental disorder. It is an example of mental distress.

- Which example is it?
- Who did you think would be best suited to address this type of problem?
- For each of the domains in the Situation column above, what do you think the role of the classroom teacher should be in addressing that issue?

The classroom teacher's role

The role of a classroom teacher is to identify students who may be experiencing a mental health problem or mental disorder, engage the appropriate student supports within the school to help with assessment/referral, participate as a member of the help providing team if the student is receiving mental health care and provide ongoing support to the student. The role of a teacher is NOT to diagnose or treat students who have a mental health problem or mental disorder.

What students have said about their teachers in relation to their experience with a mental illness, mental health problem and mental distress:

"I am lucky to have had a teacher who recognized that what I was going through was not just being a teenager and helped me get treatment for my Depression."

"If only my teachers had been able to see that I was having a mental illness and not just acting strange. I think I would have been able to get the treatments I needed much earlier."

"My teacher was a great support to me when I was not well. Her help made it much easier to get back to school and to handle the pressures there."

"My gym teacher realized that something was wrong in my life, my parents were divorcing, and took me to see the counselor in the school. Discussing my problems with the counselor and getting support from him were really helpful during that time."

"I was always stressed out when I had to write an exam. Math was the worst. Lucky for me my grade 10 math teacher gave me some really good study tips, taught me how to do some deep-breathing when I felt stressed and encouraged me to work hard. What I learned from her also helped me to learn how to write all my exams!"

Activity 6.3: Review the PowerPoint "Who Can Help With What"

What can a teacher do to help?

Remember: Most negative emotions, negative cognitions and behavioural challenges are not due to a mental illness. It is important, however, to be able to differentiate those behaviours that are more likely to signify that a mental health problem or a mental illness may be present from those that do not.

You have a feeling that something is "not quite right" about the way a student is behaving. You're concerned about them, but you're not sure if it might be a reflection of a serious problem or mental illness, or if their moodiness, irritability and withdrawn behaviour is just part of being a teenager. Could drugs be involved? Is there difficulty at home? Do you think you might need a professional opinion to decide if there is a serious problem?

The chances are that most students will be exhibiting mental distress and not a mental health problem or mental illness. That means that a compassionate ear, usual support and perhaps some helpful suggestions are all that are needed. However, if your student is facing a mental health problem, then additional support and counseling may be very helpful to them. Likewise, if your student is dealing with a mental illness (including Substance Use Disorder), then professional treatment is what is needed. Being able to differentiate amongst these needs is important but not always easy.

Here is a list of some signs of concern that may occur at home, at school or in the workplace. These can seem like they come out of nowhere or they may occur in the context of common and expected stressors (for example: conflict with peers, failure at an important goal, etc.). They can be challenging and may cause distress in the student, their friends, teachers or their parents but are often within the expected norm. Always consider the following in evaluating what you see:

1. is this unusual for the student?
2. is this intense or severe?
3. is this persistent?
4. is this causing difficulties in functioning?

Remember: Consider these as concerning if you observe a marked, persistent and relatively rapid change from usual behaviours and emotions.

Signs of Concern

1. Peers and other students remarking that the student is not themselves

2. Decreased participation in or withdrawal from usual school activities (such as clubs or sports teams)
3. Worsening grades and poorer classroom participation, may show decreased motivation with school work
4. Peer drift (moving from a high to a low functioning peer group)
5. Parents, guardians or other teachers reporting specific concerns
6. Decreased school attendance or frequently late when previously not the case
7. Physical or other indications of the use of alcohol or drugs during the school day
8. Social isolation
9. Reporting of suicidal ideation, self-harm or a suicide attempt

As you can see from the above list, there is no single type of behaviour or emotion that signals a student may have a mental health problem or a mental disorder. Instead, there are many different signs, and most of these are not a specific behaviour or emotional state, but are demonstrations of functional impairment (e.g., persistent academic, social or interpersonal problems). Sometimes these challenges arise in the absence of a significant life stressor or in conjunction with a life stressor that is well below the expected level of severity to elicit such a response. If this is the case, then consideration should be given to a potential mental illness. If there is a preceding substantial life stressor (such as a death in the family), then consideration should be given to the presence of a mental health problem. In either case, the appropriate next step is support and referral to the most appropriate professional within the school setting to conduct an assessment and evaluation.

Additional signs that a student may be struggling with mental health problems or a mental illness may include the following:

- Behaviours or emotional states that are not age-appropriate
- Behaviours or emotional states that are much more disturbing or intense than those of their peers

Consider three things if you are concerned that one of your students may be struggling with a mental health problem or a mental illness:

- **Frequency:** how often does the student exhibit the signs of concern?
- **Duration**: how long do the signs of concern last?
- **Intensity**: how severe are the signs and symptoms?
- **Functional Impairment:** how do these interfere in the students functions? (academic, social, etc.)

Understanding the frequency, duration and intensity of the Signs of Concern will help to determine the potential severity of the problem and is also important information for a mental health professional to know if the student is referred for further assessment.

Even with these factors well known, it may still be difficult to determine what degree of risk a student has for having a mental health problem or mental illness. In this case, talking to the most appropriate professional within the school setting about your concerns (such as: counselor, school psychologist, social worker, etc.) and instituting a period of watchful waiting with specific “check-in” times for the student is a reasonable strategy. Remember that this watchful waiting approach is determined after you have discussed the situation with the most appropriate professional in the school setting. This is not a decision you make on your own. You both have put that process into place and you must agree what you are watching for and upon regular communication times when you can report on what is happening with the student.

During this period of watchful waiting it may be useful to obtain inputs from other teachers and for a designated school representative to obtain further information from the student’s parents or guardians.

How, when and to whom do I refer a student who I think needs help from a mental health care provider?

Most schools have policies and procedures about referring students for mental health care, either to family doctors, psychologists or specialty mental health services. They also usually have policies and procedures for how and when parents are contacted. There is great variability from one school to another with regards to these policies and procedures. As such, we cannot describe how your specific referral pathway works. However, we can provide you with a set of questions that you can ask to help clarify what you need to do. Remember, you are bound to follow the policies and procedures of your school. If you do not know what they are, make sure you find out.

Ask yourself and members of your school staff:

- Who is the right person for me to be talking to about a student with a potential mental health problem or a mental illness?
- Who else at the school needs to know and why?
  - Do they know?
  - Is there documentation that I need to complete?
- What about parents or legal guardians?
  - Have they been contacted?
  - How do we go about contacting them?
  - Who is responsible for parental contact?
- What about consent for information?
- Who can send and receive information?
- How am I going to support the student during the in-school assessment and potential referral process?

How do I do what I think is best for my student without breaking their trust?

The answer for this question may differ student to student. Confidentiality is important but has its limits. Your student may want you to keep the information they share from their parents, peers and even from other teachers or administrators in the school. It's important that your student understands that although you will not share the information they tell you with their peers, you cannot promise to keep it a secret from school professionals and those who may need to know – especially if your student or others are at risk for harm. It is important to address the issue of confidentiality from the first time you talk to your student so that they understand that there are limits to confidentiality and what those limits are, prior to telling you something that you cannot keep secret. Tell your student upfront what you can keep private and what you cannot. It's much better to have a student know this before they tell you something, rather than after.

Similarly, parents may want confidentiality from their teen's school administrators, peers and teachers (or even from each other) when discussing concerns about their child. Cultural norms and personal or family expectations may impact discussion.

Other considerations:

- What are the legal parameters in your jurisdiction (for example: reporting of abuse and age of majority for health care decision making)?
- What are the regulatory frameworks, policies and guidelines of your professional and licensing bodies?
- How will you help maintain your student's privacy if you use electronic interactions such as email, texting, etc.?

Talking with a student about your concerns

Before discussion with your student, share your concerns with the most appropriate student services provider. Together, decide on a plan of action.

1. Find a time to chat with the student in a private (but not isolated) location.
2. Share your concern using open ended questions such as:
    - "I've noticed things seem to be especially hard for you recently" or "can you tell me how things are going?"
3. Gently and respectfully point out those signs that have raised your concern. Ask them to help you understand what is happening as they see it. Tell them what they share with you will be confidential unless you think what is happening will cause harm to themselves or others.
4. Try to understand what your student tells you, but avoid using the words "I know how you feel" to express understanding. Try not to downplay their feelings by putting a positive spin on things.
    - Using the words "I know how you feel" or "I understand" will probably never soothe your student and may make them feel worse. In reality, you don't know how your student feels – only they do. Saying "I know how you feel" can make your student feel like you're downplaying their emotions or feel even more alone when they realize that you actually don't know exactly how they feel.
5. If a student comes to you, one of the best things you can do as a teacher is to listen.
    - Be open, understanding and supportive
    - Avoid labeling what your student is going through or judging
    - After the conversation, write down important points that you want to remember and ask yourself if professional help may be needed
    - Bring your concerns to the most appropriate student service provider in your school

Check out the Deeper Dive section for tips on talking with kids in tough situations.

Talking with parents about your concerns

Before meeting with parents, make sure you have discussed the situation with your school's student services staff and you have a clear idea as to what your role is. If appropriate, have the student services staff join you.

Here are some tips for connecting with your student's parents:

1. When you make contact, initiate at a reasonable time. A telephone call is usually preferred to email.
2. When meeting with your student's parents, use their names, not Mom and Dad.
3. Share your Signs Of Concern. Be specific about your observations and do not make interpretations or suggest treatments.
4. Have the conversations at a time and place that respects confidentiality (e.g., when you both have the time to commit to it, and if possible, not during school hours).
5. Work proactively. Don't wait until report card time, parent/teacher meetings or when a crisis erupts.
6. Use accessible language. Avoid using acronyms and "teacher speak".
7. Develop a connection and remember cultural differences.
8. Try to understand what the parent may be going through:
    - Put yourself in the parents' shoes – it's never easy to hear that your child is having a tough time or is struggling.
    - Remember that mental disorders can be stigmatizing for parents as well.
    - Parents see children in a different context and truly may not know about the difficulties that you see within the school setting.
    - Parents may have had negative experiences with schools or health providers that impact how they relate to you.

- Parents may have a mental disorder that may also impact how they relate to you.
- Don't expect immediate agreement and immediate results.

9. Be helpful:
   - Provide the parents with advice about where they can seek credible information about mental health and mental illnesses. (such as: http://www.teenmentalhealth.org/; http://www.keltymentalhealth.ca/; www.nimh.nih.gov/index.shtml)
   - Establish a contact plan for future discussions.

What else can I do to help my student?

One of the best ways you can help your student is to reduce stigma in your classroom. A great way to do this is to watch what kind of language you use around your students and others. What we say and how we say things reflects our beliefs and the way we view people. People living with mental illness or addictions (including your student) are often put-down, discouraged, demoralized and marginalized. Don't let your student feel that way in your classroom where you control the environment. By choosing the words that you use, you can fight stigma in your classroom and help your student feel safe and supported.

Here are some tips:

- Put the person before the illness. The illness is not the most important aspect of the person. (e.g., Don't say "Mark is bipolar". Say "Mark has Bipolar Disorder).
- Avoid defining the person by their behaviour.
- Avoid using blame statements.
- Avoid sensationalizing mental illness or overcompensating.
- Emphasize a person's abilities instead of their limitations.

Activity 6.4:

Scenario: Because teachers spend a great amount of time with young people and have a large reference sample, they can sometimes notice a problem before it is noticed at home. It can be challenging to tell a parent about your observations, just as it can be challenging for parents to hear that their child is struggling with a possible mental health problem or a mental illness. If you are concerned, please first share those concerns with the most appropriate student services provider in your school (for example: a counselor or a social worker). After that discussion you can develop a plan for the best way forward.

Here is an example of how you could raise this issue with your school counselor about a student (aged 13) who is concerning you:

Mary is very creative and I think that she is capable of completing her work in class and doing well on her assignment. But she is not very productive. Actually, she is doing almost no work in class and not completing her homework either. I have tried various techniques to motivate her but nothing seems to make a difference. I don't know what is getting in the way of her motivation and her ability to complete her work and am concerned that she is already beginning to fall behind. I wonder if any other teachers have noticed similar patterns? Do you have any advice for me regarding talking to her parents about these concerns?

If the plan includes you (as the teacher) talking to your student's parents, there are some tips that have been suggested above that you should consider.

Here is an example of how you could raise this issue with Mary's parents:

Mary is a very creative person and has the ability to do really well in my class. However, I have noticed that she is having difficulties being motivated and does not complete her work in class or her homework. I'm wondering if you have noticed any of this at home?

Think about how you will advance the conversation if:

- the parents agree with your observation
- disagree with your observation
- become hostile
- begin to express frustration about their parenting or the situation they find themselves in
- disclose information that makes you concerned about potential harm to your student

Write down and reflect on what you could do in each of these situations.

Remember: Do not diagnose. Describe what you see, don't interpret what you see. Say, "Johnny seems to be having much more difficulty than other students sitting still and keeping focused on his school work." Don't say, "Johnny has ADHD." Say, "Michelle seems to be unhappy and exhausted at school." Don't say, "Michelle seems to be Depressed."

Supporting students with Mental Illness at school

What special challenges can school present to a student with mental illness?

For all students, each school year usually brings a new teacher and new workload. But for students with mental illness, these changes can be more challenging. Dealing with new teachers, new classmates and more demanding work can be a difficult adjustment. You can ease your students' transition by scanning their permanent files at the beginning of the year. Although this is important for all students, for a student with mental illness it is essential. Knowing what is in those files could prepare you for behaviours and emotional challenges that you may see in your classroom. Depending on whether or not the student has already been assessed or diagnosed, and if the results have been sent to the school, it is possible that their permanent file may not contain any information about a mental illness. Talking to the student's former teachers may give you some insight into what is going on with your student and ideas for accommodations that might be beneficial.

How will treatment for a mental illness affect a student at school?

Treatment for mental illness could have a very positive effect on your student's cognition, emotions and behaviours. With treatment, your student may become better able to manage their behaviours/emotions, become more social with peers, exhibit more appropriate in-class and in-school behaviours and report more enjoyment from being in school. Some treatments may have side effects that show negative impacts on cognition and ability to stay alert. It's important for teachers to know if this is the case.

Will a mental illness affect my student's attendance and ability to do school work?

An unidentified, ineffectively treated or untreated mental illness can affect a student's emotional state, behaviours, cognition and may even affect whether or not the student stays in school. There are a number of possible accommodations you can make to help your student increase probability of success. However, make sure that your accommodations do not have a negative impact such as reinforcing avoidance or limiting the development of necessary skills.

Your student may also miss class due to treatment appointments or "bad" days. Although your student will often attempt to make healthcare appointments during times that will not conflict with school, it may not always be possible. Try not to fault your student for missing class to be at an appointment with their therapist. The

work your student does in therapy will not only help them manage their symptoms but also improve their ability to do school work. Give your students additional opportunities to get the information they missed from class.

Sometimes, the medication that the student is taking will have a positive impact on their ability to do academic work. However, sometimes the side effects from certain medications can impede their capacity to work to the best of their ability. If you observe that medication side effects may be having a negative impact on your student's functioning, you should raise those concerns with the student's health care provider.

In the classroom

How can I encourage my student to become an effective self-advocate?

A self-advocate is someone who is capable of speaking up for themselves and for what they need. Encouraging your students to become self-advocates is important because it helps them take more control of their responsibilities in treatment for their mental illness. You can encourage your student to become a more effective self-advocate by helping them become more mental health literate. Steps include:

1. Using the name of the mental illness when talking with your student
   - Using the correct name creates a starting point for helping your student vocalize what they may need in a given situation.
2. Helping your student learn about their needs, how to express those needs clearly and how to differentiate needs from wants
3. Providing them with resources designed to help them better understand their illness and how to navigate the relationship with their health care provider.
   - Give them the appropriate resources pertaining to their mental illness from reliable sources.
   - Give them the "Communicating with Your Health Care Provider: What Every Person Should Ask" resource.
   - Give them the "Evidence Based Medicine" resource: http://teenmentalhealth.org/product/evidence-based-medicine-youth/

Can the student work with others?

Many students with a mental illness will have no significant problems working with other students. At times, it may be beneficial for you to create groups yourself when group work is necessary so that you can subtly pair certain students together. You may find that a student with a mental illness may work best with certain members of your class, so putting that student in a position to succeed will help increase their comfort in a group setting. Some students with a mental illness are apprehensive about working with other people. If this is the case, it may be a good idea to start off with groups of two or three students instead of groups of five or six.

How will this illness impact my student's relationships with their peers? With me?

In a perfect world, being diagnosed with a mental illness would not impact your student's relationships with their family or friends. However, mental illness is still stigmatized. Start with yourself, and encourage other teachers and staff in your school to carefully look at their behaviour and how it could be interpreted by someone else. You are an important role model and if you approach mental illness without stigma, students in your class may start to learn from you.

Is a student with a mental illness more likely to get bullied?

The stigma attached to mental illness can result in negative consequences for students, including bullying. Bullying does not "cause" a mental illness but some types of mental illnesses (such as Anxiety Disorders) are

associated with higher rates of victimization from bullying. Bullies tend to pick on the most vulnerable population in a school, and students with a mental illness are often part of that population. To help decrease the chances that a student will be bullied, you, your fellow teachers and your school can limit the ways that a bully could target other students.

Review your school policies on bullying and target structural areas of the school that could enable bullying behaviour such as hallway corners, school courtyards, etc. Then, attempt to minimize the occurrence of these spaces being taken advantage of by changing walking routes or standing posts for the teacher on duty. You can also talk about bullying in your classroom. Some students may bully others on purpose, whereas others may not realize the impact they're having on their fellow students. Awareness is key. Talk about the importance of sticking up for others. The bystander effect can be helpful. Check out this video to learn more: https://www.youtube.com/watch?v=ruBqetaMd5g

How can I help my student feel welcomed, safe and supported in my classroom?

Treat your student as a person, not as a mental illness. Although it's important to recognize that their mental illness may impact their experience in the classroom and to make accommodations where necessary, remember that they are still a teenager and that they will often act as any other teenager does. Not all of their behaviours can be attributed to their illness. They are still their own person. Don't single your student out in front of others and do your best to ensure that they are included in group activities. Educate yourself about mental illness and make it clear to your student that you are there for support should they need it.

How can I support my student after they have been diagnosed?

There are many ways in which you can support your student directly. Here are a few ideas:

- Be friendly but not a friend
- Establish confidentiality and clear limits of confidentiality
- Help identify the most important problems occurring at school
- Help develop and apply practical solutions to those problems
- Schedule brief face-to-face "check-in" visits but try not to schedule them during class hours. Avoid making it obvious to other students that you're setting "special" time aside for them only.
- Support and monitor evidence-based health enhancing activities (eg,. exercise, sufficient sleep, etc.)
- Work collaboratively with family/parents, guidance counsellor and school administration to solve common educational problems

Academic support

What is an academic accommodation and will my student require one?

Some students with mental illness may require accommodations in order to benefit from your teaching to the same extent as the rest of your students. An accommodation is something that removes a barrier to participation and learning for that particular student. An accommodation is not about giving your student the answers. Rather, it's about providing your student with equal access to the content and activities that you do in class. Also, you must make sure that the accommodation is helpful and not harmful to your student. For example, accommodations that support the avoidance of expected school activities or that prevent the student from learning the skills they need to overcome the challenges they face can have negative consequences in the long run.

Perhaps your student has an Anxiety Disorder, and instead of completing all 5 assignments they have in that week, they complete 2 or 3 each week but work towards completing all assignments over a period of a few months by receiving therapeutic interventions designed to help them address the anxiety. The key issue here is

that you do not support avoidance of the assignment completion but make assignment completion part of the goal of therapeutic improvement. Perhaps your student has ADHD, and instead of seating them next to the door where they might get distracted by the movement of people, you seat your student in an area of the class that has less traffic. The following are some examples of accommodations you could use in your classroom during tests and with assignments. Make sure that the accommodation is being used as a step towards success and not becoming a barrier to success. Remember that persistent avoidance of an expected task can result in the student developing learned helplessness.

Classroom

- Preferential seating near the door to allow leaving class for breaks or away from the door to minimize distractions
- Beverages (water only) permitted in class
- Prearranged or frequent breaks
- Voice recorder use
- Notetaker or photocopy of another student's notes
- Predictable or routine schedules

During tests

- Exams in alternate format (e.g., from multiple choice to essay or oral, presentation, role-play or portfolio)
- Use of assistive computer software
- Extended time for test taking
- Exam in a separate, quiet and non-distracting room
- Increased frequency of exams (multiple little exams versus one big exam)

Assignments

- Substitute assignments in specific circumstances
- Advance notice of assignments
- Permission to submit handwritten assignments rather than typed (or vice versa)
- Written assignments in lieu of oral presentations or vice versa
- Assignments completed in dramatic formats (e.g., demonstration, role-play and sculpture)
- Extended time to complete assignments

Resources for you and your students

If you are unsure about resources available in your community, ask your school guidance counselor, principal or resource teacher. You can also consult the following online resources for more information:

1. TeenMentalHealth.org www.teenmentalhealth.org
- Developed by the Sun Life Financial Chair in Adolescent Mental Health Team, this site has evidence-based information about teen mental health that is straightforward, easy to understand and meets the needs of teachers, health providers, youth and parents.

2. Caring for Kids www.caringforkids.cps.ca
- Developed by the Canadian Paediatric Society, this site has health information for parents about a number of child and teen health issues

3. Kelty Mental Health Resource Centre www.keltymentalhealth.ca
- Developed by the Kelty Foundation and based in British Columbia, this site provides mental health and substance use information for children, youth and families.

How can I support myself while helping my student?

While you support your student, you should also remember to support yourself. It can be confusing trying to understand different people's roles and how to avoid overstepping boundaries. To avoid this confusion, establish a plan with your administration, the student, the student's parents and the student's other teachers. A pre-established plan keeps people from stepping on each other's toes and ensures that the student receives the best support possible. Try some of the questions below when establishing a plan:

- What is my role, and the school's role, in helping students?
- What are my limits?
- Do I have the support of my administration?
- Are they in the loop?
- Am I a collaborator in the treatment process?
- Is it appropriate for me to be a collaborator in the treatment process?
- How can I become a collaborator in the treatment process?
- Who is my "go-to person" if I have a concern about the mental health of a student in the school/ treatment setting?
- What documentation do I keep and how do I keep it?
- What is the crisis plan for this student?
- How can I address confidentiality?
- What is the role of the parents?
- Is there a single point-of-contact in the school for parents? For instance, will the parents contact you as a teacher directly, and then you will relay information? Or do they contact someone else who then passes information on to you? Do you always speak with a certain parent or guardian or does it not matter which parent you speak with?
- What is our monitoring plan?
- Who are we monitoring? What are we monitoring? Where and when are we monitoring?

Activity 6.5: Review the PowerPoint "How Can I Be More Helpful."

Self-Assessment

1. Most negative emotions that students have are the result of a mental health problem or a mental illness.
2. When speaking to parents, it is important to share with them what you think the diagnosis may be.
3. If you are concerned that a student may have a mental disorder, your first step should be to speak to the most appropriate student service provider in your school.
4. Confidentiality takes precedent over all scenarios that can arise following a conversation between a teacher and a student.
5. Evidence-based student wellness enhancing activities include: supplements, vitamins and wellness water.
6. Academic accommodation should be a process to achieve a goal of success rather than a goal in and of itself.

Self-Assessment Answer Key
1) F 2) F 3) T 4) F 5) F 6) F

Module 6: Deeper Dive

What do health providers do?

Family Doctor/General Practitioner

Medical doctors (MD) do not specialize in mental health care but are trained in diagnosis and treatment of all illnesses for people of all ages. They are certified by the College of Family Physicians of Canada and regulated by the physician licensing organizations in the province in which they practice. Some family doctors have substantial amounts of experience in providing treatments for mental illnesses and some do not. Mostly family doctors provide care to people who have a mild to moderate or relatively uncomplicated mental illness. They also recognize when the illness is severe or the situation is complex and initiate referrals to mental health specialists, such as psychiatrists or clinical psychologists for additional help. It's perfectly acceptable to ask a family doctor how much experience they have in treating mental disorders and ask for a referral to a mental health specialist if necessary. An initial appointment with a family doctor/GP will often be approximately 15 minutes. If a diagnosis of a mental illness is considered, the family doctor will usually schedule one or two follow-up appointments of longer duration to clarify the diagnosis and discuss treatment options.

Psychiatrist

Medical doctors who specialize in the diagnosis and treatment of mental illness. A psychiatrist is the most skilled of all of the specialist mental health care providers and is expert in diagnosis and the application of a wide variety of evidence-based treatments. They are certified by the Royal College of Physicians and Surgeons of Canada and regulated by the physician licensing body in the province in which they practice. Psychiatrists ideally are only used to provide care to patients who have the most complex or severe mental disorders. They also provide consultation and advice to other health (such as family doctors) or mental health (such as nurses, clinical psychologists) providers. Often the psychiatrist will lead or be a part of a mental health care treatment team. An initial appointment with a psychiatrist will be approximately one to two hours in length and usually the family (or at least the parents) will be seen as well as the young person. In order to see a psychiatrist, a student will likely need a referral from a family doctor/GP.

Clinical Psychologist

Mental health professionals who have obtained an advanced degree (usually a PhD) in clinical psychology, indicating advanced training and expertise in human behaviour and psychological health. Clinical psychologists specialize in the assessment and evidence-based psychotherapeutic treatment (e.g., talk therapy) of mental illness. They are not medical doctors, so they do not prescribe medication or provide any biological treatments. Often, a clinical psychologist and psychiatrist will work together to jointly treat a patient who needs both medication and psychotherapy. Some psychologists practice with a degree in Counseling Psychology or School Psychology but their ability to practice is more limited (e.g., a school psychologist works exclusively in the school system). An initial appointment with a clinical psychologist is about 1 hour in length, but occasionally can be longer. Psychologists are licensed through the province in which they practice. For more information on locating a psychologist in your area visit http://www.cpa.ca/public/findingapsychologist

Social Worker, Mental Health Counselor (School Counselor, Family Counselor)

The above are all health professionals who use counseling and various types of psychotherapies to help people function in their environment, improve their relationships with others and solve personal and family mental health problems. They usually have a specific area of practice in which they focus. They can provide counseling or psychotherapy services for individuals, couples, families, students and children, depending on their skill sets and areas of interest. Initial appointment times can vary from 15 minutes to an hour, depending on the setting where the provider works and the mental health condition that is the focus of care.

Mental Health Nurse (Psychiatric Nurse)

Nurses who have specialized training in mental health/psychiatric nursing and work in a variety of clinical settings, including hospitals and community clinics. A mental health nurse works with individuals, families, groups and communities. They assess mental health care needs and develop a nursing diagnosis and a plan for evidence-based nursing care. Mental health nurses implement, evaluate and continually revise that plan with their patients. The Canadian Nurses Association holds examinations in Psychiatric Mental Health (PMH) Nursing. Registered nurses who successfully complete the exam are considered certified in PMH Nursing and use the credentials CPMHN(C).

Therapist

For the sake of consistency in this document, we will use the word 'therapist' to refer to psychologists, psychiatrists, social workers, mental health counselors and medical doctors who perform evidence-based psychotherapy. However, the term therapist does not designate a particular professional category and anyone who wants to call themselves a therapist can do so without legal implications. This means that someone who may have taken a 2-day course (or have no training whatsoever) could be calling themselves a therapist, and what "therapy" they are providing may not meet standards for evidence. In comparison, a clinical psychologist, who also performs evidence-based therapy has anywhere from 6 to 10 years of formal training and clinical experience. Therapists, as referred to in this curriculum, belong to well-established professional organizations, are regulated and licensed professionals and provide evidence-based interventions. However, many people who describe themselves as therapists sell interventions based on little or no credible scientific evidence and are not certified by any credible professional organization nor subject to provincial regulations or legal requirements. If searching for a therapist, make sure to check the therapist's qualifications. It is completely within the patient or client's rights to ask the therapist about their training and credentials and verify that you are comfortable with their experience.

Can all of the above health care providers correctly diagnose my student's Mental Illness?

Only medical doctors and clinical psychologists can make a diagnosis of a mental illness because it is an act protected by law. It is very important that you, as a teacher, never attempt to diagnose a student in your class with a mental illness. Write down the signs you notice and tell your school's student services provider (e.g., school psychologist, counselor or social worker) about your concerns. Develop and apply a go-forward plan as described earlier in this module.

Talking with kids in tough situations

1. Get to know your students and keep your eyes and ears open.
2. Know about your school safety plan and have a safety plan with your student. Where do they go when they feel like they might not be able to handle the situation? Who do they need to talk to?
3. Know who is coming into your class. Organize transition meetings between grades, teacher to teacher.
4. Document, document, document for both your own information and for the teacher next year. Keep daily and weekly logs.
5. Be aware of non-verbal skills that will help a child de-escalate, including the tone and cadence of your voice (don't be a drill sergeant). Remember that authority doesn't have to be loud. Be calm.
6. In the moment with an angry student, your heart is in your throat. How do you get grounded?
   - Visualization: remember that we are in a classroom, in a school, in this town, in this province.
   - Empathy: recognize their behaviour is telling you what they cannot say in words.
   - Breathing: just keep breathing. Use the deep breathing techniques you have learned.

- Assess the situation for danger to yourself or others. Problem solve: what is the most important thing to do; how am I going to do that?

7. Taking care of the class when something or someone is threatening their safety (for example, a student fight in the classroom):
   - Take action immediately.
   - Break the line of sight between the students who are fighting and the other students.
   - Take the rest of the class to a safe place – this may be out into the hallway.
   - Follow school crisis procedures.
8. Care for the class when one student is in distress (which may be turned inward or outward):
   - Have a quick activity always ready. For example, “make a list of everything that is in your desk and see how accurate you are.”
   - Escort the student out of classroom and to a safe place, calling for help if necessary.
9. Don’t put yourself in harm’s way:
   - Meet with students in an area that is private but with public prominence.
   - If you think that the situation is beyond your control, get help.

What are best available evidence-based health enhancing activities that are beneficial for my student?

These health-enhancing activities are beneficial for all your students, not just those with mental illness.

Consider incorporating them into your lessons and classroom.

1. Exercise
   - 30 minutes of vigorous exercise daily, including running, biking, climbing stairs or playing a sport. If this exercise can be done outside in fresh air and sunlight, even better!
   - 20-40 minutes of light to moderate activity, such as walking.
2. Sleep
   - Teenagers need approximately 9-10 hours of sleep a night. This means NO electronics in the bedroom and a good understanding of positive sleep hygiene (check out: http://teenmentalhealth.org/toolbox/healthy-sleeping/)
3. Organization and consistent daily routine
   - Keeping track of assignments, due dates and activities and regularly following a routine are great ways for your students to feel more control over their own lives.
4. Positive social contact
   - Joining school clubs or organizations.
   - Becoming a volunteer.
5. Healthy nutrition
   - Regular meals.
   - Healthy snacks (light sugar intake).
   - Grazing (eating small amounts of healthy food over the course of a day) is good.
   - Let your student bring fruit, nuts or crackers into your class (depending on whether or not your school is nut-free). A snack that is easy to clean up if it spills.
6. Music and movement
   - Improves mood and moderates the stress response. Music education has profound positive impact on brain growth and development. Check this out: https://www.youtube.com/watch?v=2h9I2yzKQcU
7. Bright light
   - Natural light affects our moods. Encourage your students to spend time outside during breaks and

keep the blinds open in your classroom to let light in.

8. Learn to properly manage use of legal drugs and alcohol – this can include avoiding them altogether (for example: nicotine/alcohol/cannabis).
    - You can share this evidence-based self-care wellness enhancing diary with your students and encourage them to use it daily: http://teenmentalhealth.org/toolbox/taking-charge-health-daily-checklist/
    - Try a two-week period of implementing this diary in your classroom. You can try it too.

Module 7

Caring for Students and Ourselves

Understanding Stress and Resilience for teachers and students

Now that you have improved your understanding of the four components of mental health literacy, you can engage in this module, which provides you with an up-to-date understanding of the stress response and how to use it to achieve and maintain good mental health for yourself and – by extension – your students.

Learning objectives

Upon completion of this module, you will be able to:

1. Better understand the various types of stress and the usual stress response
2. Understand how successful adaptation to positive and tolerable stressors is the key to resilience
3. Demonstrate understanding of contextual factors that underlie the stress response, resilience and teacher burnout
4. Apply this knowledge to better understand how to help create a healthy classroom environment
5. Develop a better understanding of how to apply this knowledge in their chosen career

Guiding Principles for Strategies

Throughout this module you will find activities and strategies designed to encourage both self-reflection and skill development for you and your students.

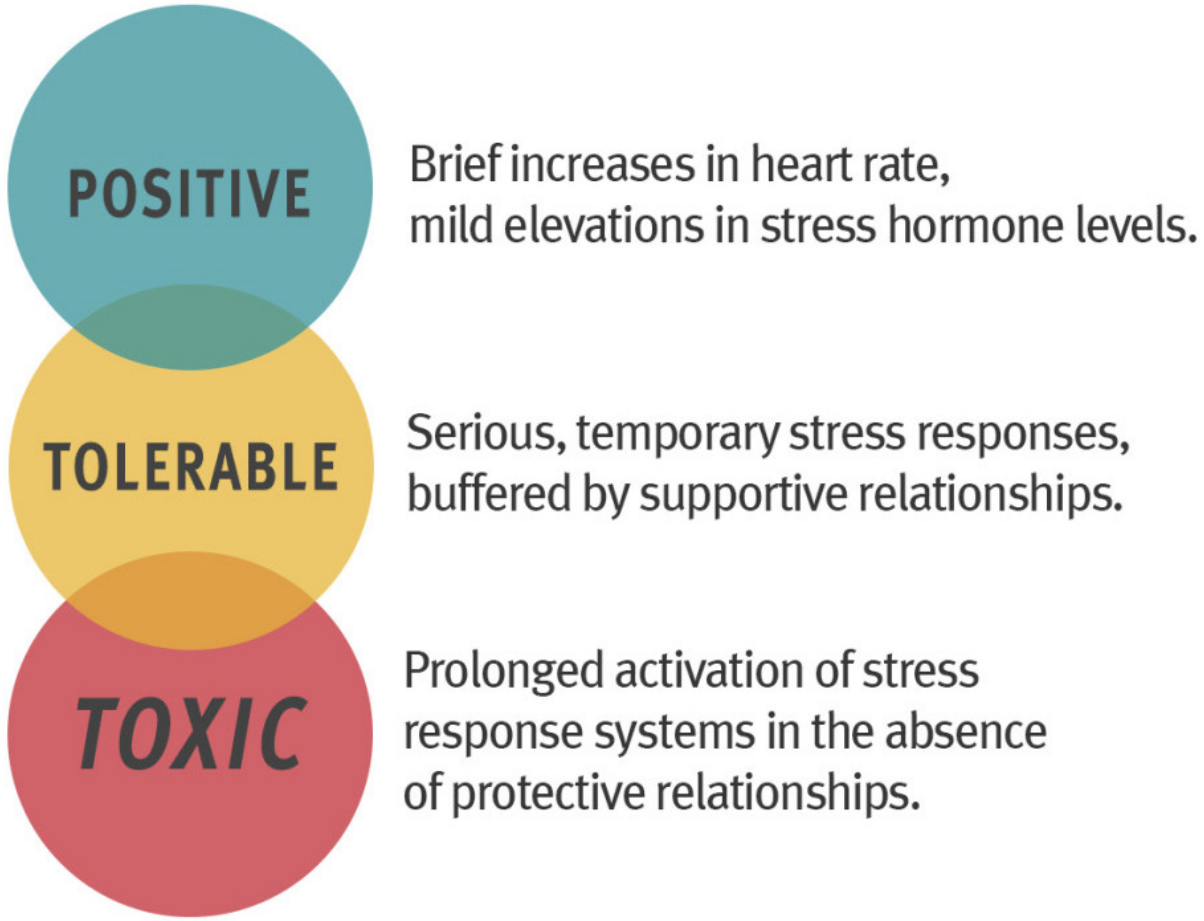
Understanding Stress

Stress is a subjectively experienced physiological reaction to an environmental stressor, which is a challenge or opportunity that disrupts our existing equilibrium (also known as homeostasis). This reaction is based on the brain signaling function (see the module, “Human Brain Development) and alerts us not only to life-threatening danger (where we can experience the “fight or flight” response), but also to numerous life challenges and opportunities (including what is called the “excite and delight” response). It is a fundamental error to consider the stress response to always be of the fight or flight variety. Indeed, unless we live in circumstances such as conflict zones, poverty or experience severe and persistent traumas (such as abuse or neglect) our stress response is not of the fight or flight variety. In these situations, the stress response can be so severe or prolonged that for some (but not all) people, it can lead to negative health outcomes.

Most daily stress is not fight or flight, but a signal that we need to change something in our environment. If we do that successfully, the stress response goes away and we are said to have adapted. Then we remember successful adaptations and apply these to new challenges, demonstrating we have learned a new skill. Successive successful adaptations bring multiple new skills which leads to resilience. So, most daily stress is normal, adaptive and can be health promoting.

The Harvard Centre for the Developing Child has created a useful table which illustrates differences in types of stress (See Figure 7.1):

Fig. 7.1 Undestanding the Types of Stress



Note: even with toxic stress, there are protective factors that help mitigate potential negative impacts. These factors can be both biological (some people are more "stress-resistant" by nature) or environmental (particularly the presence of a caring, trusted person – such as a parent, grandparent, spouse, partner, friend, etc.)

Activity 7.1: Watch Kelly McGonigal's TED Talk about stress: https://www.youtube.com/watch?v=RcGyVTAoXEU

What did you think about her presentation? How does it line up with your knowledge and experience? For many people, the idea that stress is helpful runs counter to what they believe. Why do you think so many people believe that to be the case? What do schools do to perpetuate that belief? Can that belief be harmful in other ways besides leading to early death? How?

How does this scientific understanding of the different types of stress, the importance of positive stress for normal growth and adaptation, the realization that even many highly stressful events are tolerable and do not necessarily cause us long-term problems and the knowledge that even with toxic stress, the presence of supportive and responsive relationships can often overcome the negative impacts of toxic stress, compare to commonly cited descriptions of stress? For example, check this out:

With all the reports coming in on the high stress levels our children are under we began to investigate what some of the common culprits might be and were surprised by what we found…. -- e.g., kids' sleep, eating, exercise and leisure activities, or their environment -- might be adding considerably to their stress load. (Huffpost Living Canada, September, 2015)

What do you think of this comment? Do you think there is some confusion between positive and toxic stress here? Is eating the same as abuse? Is exercise and leisure the same as poverty and neglect? What impact does this confusion have on the marketing of products from the stress-free or wellness industry? How do the scientists at the Harvard Center for the Developing Child explain the impact of toxic stress? Is this the type of stress that most students are under? What kinds of things could a school setting do to assist youth under toxic stress and how is that different than addressing usual positive or tolerable stress?

For more on this check out the Deeper Dive: Critically thinking about the "stress free" and "wellness industries".

Activity 7.2: What category of stress response would the following usually fit into? For each stressor listed below, determine if it's more likely to be positive, tolerable or toxic for you. Do you think that most of the people you know would categorize these as you have done?

- Having an argument with your parents
- Failing an exam
- Being turned down when asking for a date
- Taking an examination
- Being fired from your part-time job
- Death of a friend
- Losing a twenty dollar bill
- Not making the school soccer team
- Death of a parent
- Writing a report
- Being made fun of at school
- Losing your wallet

Different people interpret and experience a similar stressor in different ways. What may cause little notice for one person may seem intense to another. Therefore, it is important to keep in mind two different but related considerations when thinking about the stress response:

1. How would this stressor be experienced by most people?
2. How is this stressor being experienced by this person?

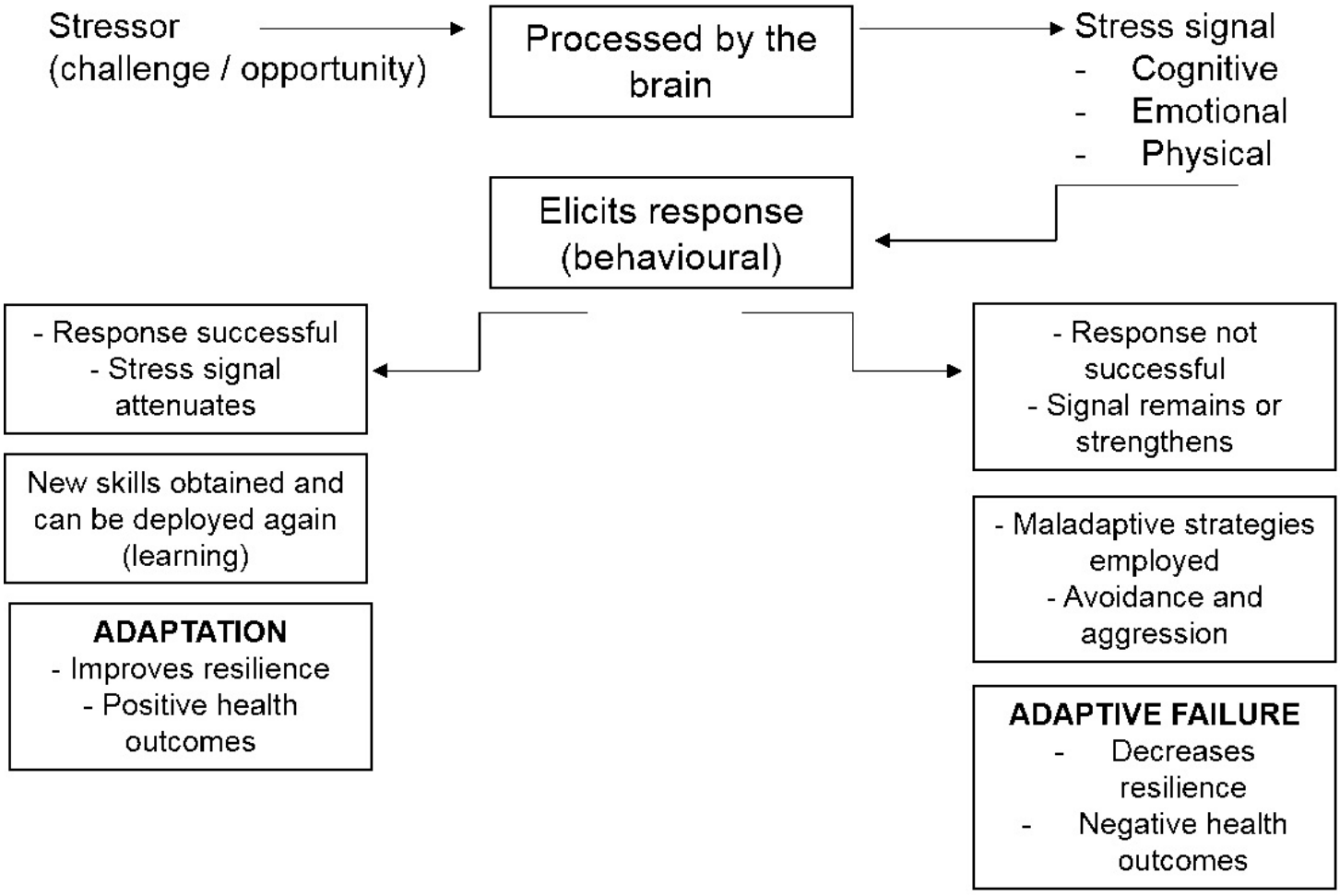
What factors can influence a person's response to a stressor. Here are some to consider:

1. Their genetic makeup
2. Their environment (many different components such as social, interpersonal, financial, etc.)
3. Their perception or understanding of the stress signal
4. Their expectations
5. Their existing coping mechanisms
6. The nature and severity of the stressor

As we can see, understanding and successfully identifying the stress response can be challenging. There is no "one size fits all" approach. However, if we have a better understanding of what the stress response is, what purpose it serves and how we can use it to help our students and others succeed, we can apply that understanding to the different needs and circumstances of each of our students.

Consider the following diagram, Figure 7.2

Fig. 7.2 The Stress Response Pathway

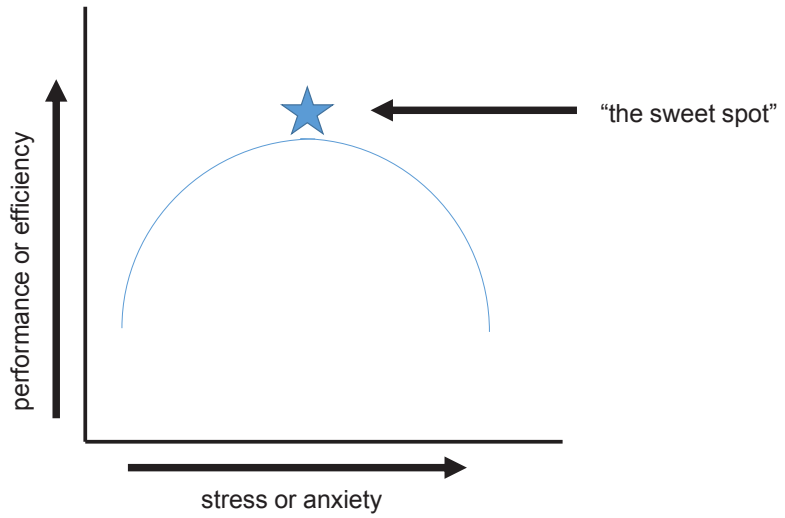


Key Points

The stress response is a signal (cognitive, emotional or physical) that the person needs to address a challenge or opportunity in their environment. Its purpose is to alert us that adaptation is necessary. Successful adaptation leads to resolution of the stress response and the learning of a new skill that can be applied in the future. This is how resilience is built.

Another important consideration is that some degree of stress is necessary for performing well. Originally suggested by Yerkes and Dodson (1908) this relationship is often graphically portrayed as seen in Figure 7.3.

Fig. 7.3 The Relationship Between Stress Intensity and Performance



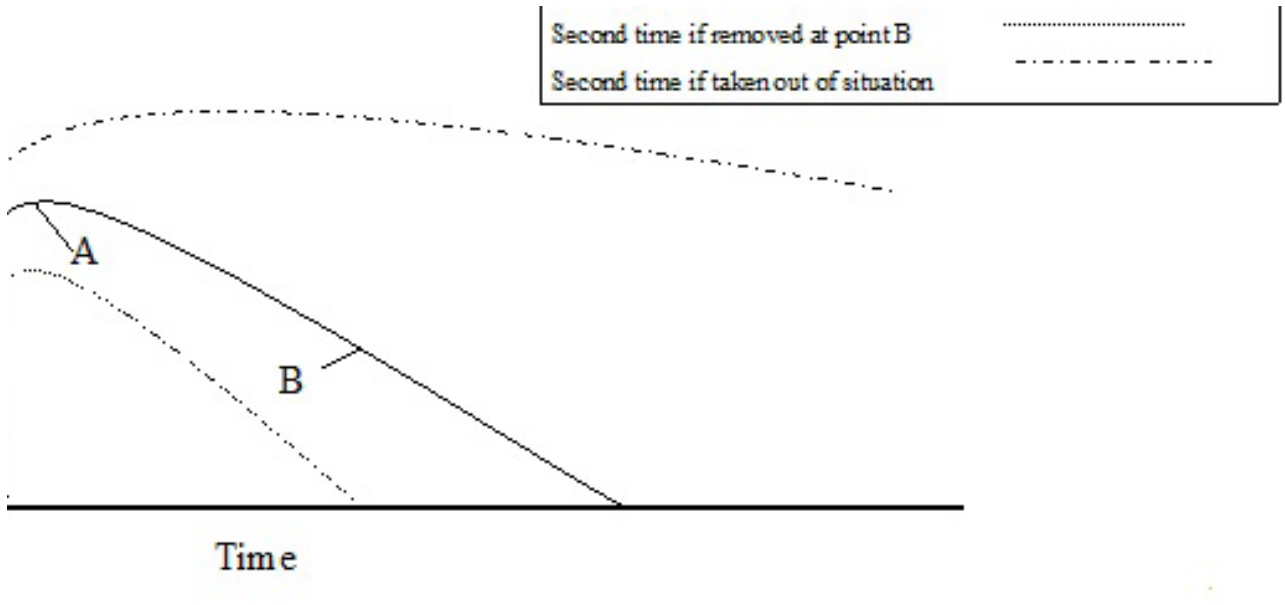
Activity 7.3: Listen to an explanation of this relationship and consider the following questions: If low arousal is related to poor performance, how can a teacher address this in their classroom? If high arousal is related to poor performance, how can a teacher address this in their classroom? How can people learn to find their optimal point of best performance? Why is there so much attention paid to reducing stress instead of helping people learn how to find their "sweet spot"?

The stress response curve

When faced with a stressor (challenge, opportunity, threat, etc.) your brain and body initiates the stress response. This stress response is usually proportional to the stressor. For example, the stress response to misplacing your keys is less intense than the stress response to losing your wallet or being in a car accident. But the experience of the stress response is not only a product of the stressor, but also includes factors previously described in Activity 7.2. It is possible for a person to increase the intensity of their response to any stressor by how they think about it and how they learn to manage it. So, just as we can learn to use the stress response in a helpful way and decrease our experience of it (learning how to find our sweet spot), we can create increased experience of a stress response to a specific stressor and so generate a more intense response, resulting in maladaptive outcomes.

Activity 7.4: Study the normal stress response curve (Figure 7.4). Consider, how does avoidance worsen the experience of everyday stress? How does managing stress successfully (which includes not avoiding the stressor) help moderate the stress response in the future? How can you use this knowledge to help students learn to better manage their stress response in the interest of building their resilience? (see the section on Managing the Stress Response Below).

Fig. 7.4 The Impact of Avoidance on the Stress Response



When can "stress" have negative impacts?

Chronic, persistent and severe stress (often called Toxic Stress) can have many negative impacts, including poor health (like mental health) and decreased capacity to be successful in the school environment. Additionally an excessive stress response to usual and expected stressors can impair a person's ability to learn. In a classroom setting this can include: reduced sustained attention, poorer comprehension and difficulties with short-term memory and sequencing.

The impact of toxic stress is increased in these situations that some of your students may be experiencing:

1. Poverty
2. Abuse
3. Neglect
4. Parental mental illness
5. Substance abuse
6. Violence

Additionally, if a person has a mental illness, usual and expected daily stressors can be experienced with greater intensity. The person may have greater difficulty in bringing their coping capacity into play. Thus, for students experiencing chronic stress or those who have a mental illness, additional supports may be necessary. However, those supports should be put into place with the purpose of helping the student develop their capacity to better cope and become successful. Interventions should be growth-promoting, not avoidance-supporting. The presence of a caring and consistent adult is fundamental, and teachers can play an important role in the lives of some students by being one of these adults.

Activity 7.5: Review the PowerPoint "Caring for Students and Ourselves: Understanding the Stress Response". Reflect on what you have learned about the stress response so far. How can what you have learned help you be a better teacher? How can you apply what you have learned in your own life?

Managing the Stress Response

Our challenge is to help our students (and ourselves) learn how to better manage our stress response: not by avoiding stressors and not by focusing solely on stress response reduction, but by building skills and coping strategies that help us use the normal stress response for our growth and development. Management of the stress response is a learning process. This is often also a process of trial and error. If the strategy works, we use it again. If it does not, we don't. This process means that we will not always be successful the first time we try out a strategy. We learn as much (or more) from our failures as from our successes.

And, over time, these successful strategies are remembered, enhanced and increased. Taken together, they build our adaptive capacity and we become more and more resilient. Thus, protecting people from the normal and expected adversities of life is resilience depleting, not resilience building. Similarly, solving everyday problems for someone instead of encouraging them to learn how to do that without your doing it for them can be adaptation negating instead of adaptation promoting. Helping young people develop skills that they can use to then solve their problems (academic, social and interpersonal) is a good example of how teachers can help their students grow into competent adults.

Managing the stress response falls into two broad categories: techniques used by the individual and interventions that modify the environment.

Individual stress management techniques

These also fall into two broad categories: general self-care and dealing with the stress response. They should be used simultaneously. Remember, the purpose of learning how to manage stress is neither to avoid it nor to only focus on reducing its intensity. It is learning how to find and use the "sweet spot." It's as Dr. McGonigal said in the video you watched in Activity 7.1, making stress your friend instead of your enemy.

General Self-Care

Everyone has learned techniques that help them manage stress, improve their mood, optimize their performance, enjoy life more, etc. There are a number that are common for many people but all are not equally effective for everyone. Additionally, within each of the techniques there are sub-techniques and some people will prefer those to others. For example: exercise is one of the techniques. Some people will prefer going for a run outdoors while others will prefer playing a racquet sport and others will go to the gym, etc. One of the enjoyable challenges of life is to seek out new and different activities that you can try out to see which are most to your liking and which are most helpful to you. An important consideration is that some of these techniques provide additional health benefits (for example: running improves heart health, dancing enhances social interaction as well as improving muscle tone and heart health, choral singing improves academic outcomes in addition to enhancing social interaction, etc.).

These strategies fall into numerous categories, and there are numerous techniques within each category. For some of the techniques there is robust evidence of positive health impacts. For others, less evidence exists. What is important is choosing from a number of these strategies and applying those chosen techniques daily for a number of times per week. Yes, getting and staying healthy is hard work!

Strategy Categories

- Exercise (includes: vigorous – reaching a sustained 80% of maximum cardiac output; moderate – walking at a pace that talking is comfortable; general movement – standing or walking frequently during the day; sports; yoga; etc.).
- Sleep (9 – 10 hours for adolescents and 7-8 hours for adults – keep interruptions as few as possible,

this usually means no cell phones in the bedroom and stopping screen time at least ½ hour before going to bed). You can check out this resource for some helpful suggestions.

- Healthy eating (eating a balanced diet and following published food guidelines – such as Canada's Food Guide – and avoiding fad diets).
- Positive social experiences (includes with friends and family).
- Making music (includes singing or playing an instrument).
- Helping others (includes volunteering, being part of a team, etc.).

Activity 7.6: For each of the Strategy Categories (from the previous page) identify one activity that you routinely engage in (at least twice a week). If there are gaps in your list, fill them in with an activity that you would like to try out and go for it! You may also want to check out the resource, "Stress Management: Enhance your well-being by reducing stress and building resilience."

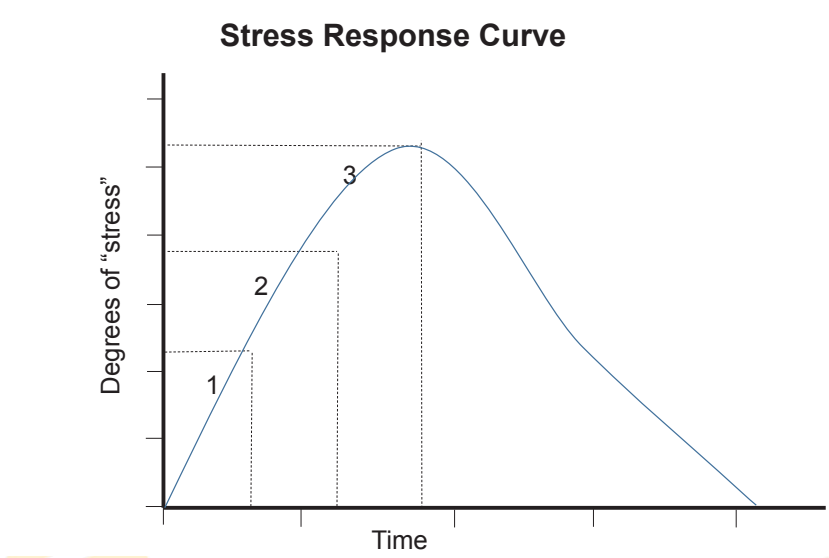
Category	Activity I Engage In
Exercise	
Sleep	
Healthy Eating	
Positive Social Experience	
Making Music	
Helping Others	

Dealing with the stress response

The good news is that there are a number of very simple techniques that you can learn to help you manage the normal stress response. The even better news is that you can learn to do this without paying a lot of money for a course or buying apps that have no evidence that they are helpful. Save your money.

Have a look at the Figure 7.5 below (Managing Your Stress Response). Read through each of the steps below. Match where those steps are on the curve.

Fig. 7.5 Managing your stress response



Step One

Focus on what you are thinking when you feel the stress response.

In fancy terms, this is called cognitive attribution. That means, what you interpret the stress signal to be. If you recall the McGonigal video, this is the difference between thinking that the stress signal is "bad" or "negative" and thinking that what you are experiencing is a cue to alert you that there is a challenge or opportunity in your environment that you need to deal with. When you think that the signal is negative or harmful, your physiology and behaviour differ from when you interpret that same signal as a challenge or opportunity, or as courage instead of fear.

Some students, for various reasons, will have developed negative cognitive attributions to the stress signal. These are commonly called "faulty logic" which is a pattern of thinking which focuses on the negative and spirals from one negative thought to another. When people apply faulty logic they can get trapped into a negative feedback loop where the negative thoughts accentuate the stress response. Here are some common "faulty logic" examples: "I can't possibly learn everything in the course before the exam, I am going to fail"; "I can't do this presentation because my friends will think that I am stupid"; "Everything is going wrong, nothing will ever work out for me." If such faulty logic cognitions have become ingrained, they will often need to be addressed by counseling or psychotherapy techniques as part of the stress management process.

Step Two

Determine what the stress signal is alerting you to and figure out how to address it effectively.

As we have reviewed above, the stress signal is telling you that there is something happening that you need to pay attention to. It can be as mundane as feeling cold and putting on a sweater or more challenging such as allocating additional study time (and not going out with your friends) to prepare for an examination that you will be writing soon. Regardless of the situation that is causing the stress response, you need to determine what is the challenge or opportunity and then figure out how you are going to successfully address it or problem solve. This can include asking others for advice and help, checking out Professor Google, using what worked previously in a similar situation, coming up with your own innovative ideas, etc. When you apply your presumed solutions, if they work, the stress signal will modulate and you will now have another skill to use in

the future or to share with others.

Step Three

If necessary, apply specific techniques to modify the intensity of the stress response.

Sometimes the stress signal will be so intense that it is difficult to get into the “sweet spot.” In those cases, applying a number of other techniques can be helpful. These include: seeking support from others, direct modulation and cognitive reframing. Since seeking out the support of others is self-explanatory, we will address the other two techniques.

Direct modulation

We can decrease the stress signal in two different ways by applying two different but related techniques. The first engages the activity of the parasympathetic nervous system to decrease hyperarousal, and the second engages the brain’s pre-frontal cortex to decrease hyperarousal. It is useful to use these techniques simultaneously.

The first is controlled breathing (also known as box breathing). It decreases sympathetic system arousal and thus helps modulate the intensity of the stress signal. This is a technique that elite combat troops use to help them during times of extreme stress. It is easy to learn and with practice you can apply it in almost any stressful situation without others even knowing you are doing so.

Activity 7.7 - Control Breathing: Go to the Gear Patrol site and scroll down the page to the blue button. Follow the instructions you find there. Practice this technique for the next three minutes, even if you know how to do this. Then set up a practice schedule for yourself for the next week. Try to practice this technique 3-5 times per day, for about 3-5 minutes each time. Practice makes perfect!

Activity 7.8 - Hand Muscle Relaxation: This is a type of body relaxation technique that focuses your attention (using the pre-frontal cortex of your brain) on an unobtrusive activity that you can learn to do and apply in a way that others will not know you are doing it. First take one hand and clench a fist tightly. Focus your attention on the clenched fist and the sensations in your muscles. Gradually (over about 20-30 seconds) relax your fist, as you keep focused on the sensations in your muscles. When you have fully relaxed your hand and kept it that way for 30 seconds, repeat.

Practice the hand muscle relaxation technique now. Take yourself through three cycles of clench to relax. Then set up a practice schedule for yourself for the next week. Try to practice this technique 3-5 times per day, for about 3-5 minutes each time. For more information on muscle relaxation check out this resource “How to do progressive muscle relaxation.”

What do you think would be the outcome if you taught students these exercises and had them practice for 3-5 minutes every day?

Activity 7.9: Now review the above material by going through the PowerPoint presentation “Managing My Stress Response”. Reflect on how what you have learned can be used to help you with your stress response. Reflect on how you can use what you have learned to help your students better manage their own stress response. What impact may our cultural infatuation with removing stress from life have? For example, just Google stress-free schools, stress-free life, stress-free relationships). What impact will interpreting being well as only having positive emotions have on our student’s ability to manage normal and expected stress?

Did you notice that in this entire section we did not use the phrase “stress reduction” and “strategies to reduce stress”? That is because our task is not stress reduction, it is stress management. Learning how to use the

normal stress signal to help us find our “sweet spot.”

Modifying the environment

Your students will also be reacting to the environment in your classroom and in the rest of the school. How can you and your colleagues help establish an environment that promotes resilience and helps students develop the skills they need to grow into healthy adults? Remember this is not creating a stress-free environment, it is creating a space where people can respect each other, celebrate their diversity, disagree and debate and learn the skills they need. Part of this means learning to manage stress, not being protected from it. First, is it important to understand what your students bring to the classroom, and also important to understand what you bring to the classroom.

Stress, your students and you

Knowing about your students, who they are and what they do is important. Here are some considerations regarding your students and their lives.

What kinds of stressors do students commonly bring to the classroom?

- Missing their parents/family/pets.
- Worried/anxious about a test that day.
- They’ve had a bad night, or a difficult morning because of an argument with a parent.
- Had a conflict with a good friend earlier today.
- Living in poverty or in a violent neighborhood.
- Hungry/tired.
- Failing an exam.
- Over-scheduled (e.g. teams, lessons or part-time jobs).
- Parental conflict (non-violent or violent) in the home.
- Being bullied.
- Health problems (themselves or their family).
- Worried about getting into the college of their choice.
- Mental illnesses such as Anxiety Disorders, Depression or ADHD.

Are these stressors positive, tolerable or toxic? Are these stressors chronic? What is the difference in these stressors? Should a teacher react in the same way to every one of these stressors?

And, we need to remember that we as teachers also bring stressors into the classroom.

What do you bring to the classroom?

- Missing your friends/family/pets.
- Test or performance Anxiety (teaching evaluations, being ‘the teacher’).
- You’ve had a bad night or a difficult morning.
- Had a conflict with a good friend.
- Hungry or tired.
- Failing at a job promotion interview.
- Over-scheduled (e.g. social life, sports teams or part-time jobs).
- Conflict at home with your children or partner.
- Bullying with peers, colleagues, staff or administration.
- Health problems (yours or your family).
- Worries about getting a job after graduation.
- Mental illnesses such as Anxiety Disorders, Depression or ADHD.

Understanding where our students are coming from and being aware of our own situations might help us become better educators, mentors and role models. Which of the above stressors would be considered to be positive, which are tolerable and which may be toxic or chronic? How would you deal with these different kinds of stressors?

Do you think that what you have learned about managing the stress response in this module can be helpful to you personally?

Activity 7.10: Review the PowerPoint presentation "Creating a Mentally Healthy Classroom." After you have finished, reflect on what you have learned. How has this reflected what your classroom experience has been so far? How is stress management different from stress reduction?

And what about teachers?

Teachers also have to deal with their own stress response. Hopefully, you can use what you have learned so far in your own life. In addition, there are some other things to consider as you prepare for your career.

Talking about teachers and their challenges

As in any profession, teachers face numerous challenges in their workplace – the school. One of the hallmarks of a professional is that the person has developed through their training and with the support of their peers, the competencies needed to effectively discharge their responsibilities. However, as well prepared as any professional may be, there are situations that arise that challenge those competencies and create a stress response that may need to be modulated.

Teachers realize that as they grow and develop in their profession, they will encounter many situations that will tax their skills and create stress. Most will be positive stress and will be used to drive successful adaptation. It is therefore very important to remember that competency development is an ongoing process and that all professionals learn as they go along. Living the life of a professional is living a life of continuous learning.

There will be times, however, when the situation may be experienced as overwhelming. Sometimes the word "burnout" is used to describe how people feel, think and act when that happens. Teachers are not immune to burnout. But, there are a number of strategies that teachers can apply to help modulate the stress response challenges that can occur. We call those strategies "teaching wisdom."

Activity 7.11: Review the PowerPoint presentation "Stress & Self-Care." When you are finished, reflect on what you have learned. How can you apply this learning now and in the future?

Supplementary resources

- McGonigal, K. (2015). The upside of stress. New York: Random House.
- Whippman, R. (2016). America the anxious. Oxford: St. Martins Press.
- Harvard Medical School. (2017). Feeling okay about feeling bad is good for your mental health. Harvard Health Publishing. Retrieved from https://www.health.harvard.edu/blog/feeling-okay-about-feeling-bad-is-good-for-your-mental-health-2017091412398
- Poulin, M. J., et al. (2013). Giving to others and the association between stress and mortality. American Journal of Public Health, 103(9), 1649-55.

Self-Assessment

1. Three categories of stress are: positive, tolerable and toxic, with toxic affecting most Canadian students.
2. Successful resolution of the challenge or opportunity that is driving the stress response often results in decrease of the experience of stress
3. People usually perform their best when they are in a stress-free environment.
4. Avoidance of stress is a useful strategy for learning how to adapt.
5. Public sharing and free-form daily activities can be classroom strategies designed to help students manage their stress response.
6. Having a mentor is one strategy that a new teacher could use to help them better adjust to the challenges of their new career.

Self-Assessment Answer Key

1) F 2) T 3) F 4) F 5) F 6) T

Module 7: Deeper Dive

Critically thinking about the "stress free" and "wellness" industries

Over the last decade or so, there has arisen a huge and profitable industry promoting life that is "stress free" or marketing the concept of "wellness/wellbeing." Your students are being exposed to these sophisticated marketing messages daily – and are being encouraged to understand normal, everyday and necessary for adaptation experiences of positive stress as toxic. Similarly they are being bombarded with "wellness/wellbeing" with the message that a healthy life is one that is completely filled with positive experiences and that the presence of negative emotions is a signal of illness. There are plenty of products of dubious or non-existent value that promise to provide stress relief or create wellness – at a price of course. The positive impacts of these products on health are not known and are likely minimal, if any. The negative impacts of these approaches are also not known but might be found in the increasing attention to mental malaise that currently characterizes media reports about the mental health of young people.

One of the important roles that a teacher can have on helping address mental health outcomes for young people is to help them understand the delusion that this "stress-free" and "wellness" marketing is. And, to help them focus their energies on those things that they can do for which good scientific evidence of health outcomes exists: exercise, sleep, nutrition, social engagement; etc.

Understanding what is meant by positive mental health

There is a tendency to promote the concept "positive mental health" which then leads to the obvious correlate "negative mental health." Right away it is clear that such a contrast makes no sense (one example of this is the "flourishing/languishing" model so popular in schools today. For example, as Keyes (2002) himself noted, this model "defined mental health as a syndrome of positive feelings and positive functioning in life." Positive mental health has commonly been defined as made up of positive emotions with negative emotions considered to be a sign of poor mental health. Nothing could be farther from the truth. In fact, negative emotions are often (if not usually) a sign of good mental health. If a person's best friend dies and they do not feel sad, unhappy, despondent, etc., we would be concerned about them. Clearly in this situation negative emotions are a sign of good mental health. Indeed, most negative emotions play an important role in our mental health. Without them we would not be able to form good relationships, decide on our life trajectories or learn how to deal with the demands of our environments. Teaching students that mental health is all about positive feelings is not only silly, it may also have negative consequences. If young people believe that life must be comprised of only positive feelings, when negative emotions arise they may label them as a sign of illness or avoid using them to help themselves adapt to life's challenges and opportunities.

Wellness and Wellbeing

These words are used in daily language and have become ingrained into cultural discourse – to the point that we often do not think critically about what they mean. Initially these were constructs that brought attention to the importance of social determinants of health (such as poverty, inequality, etc.) and encouraged individuals, communities and societies to focus on these important domains as valid and helpful targets for health interventions. Later they became terms used to encourage focus on healthy eating, exercise and the importance of supportive social relationships. Today, these words are used by product producers and vendors to focus on self-actualization, to the detriment of a focus on those social determinants of health that require difficult political, civic, legal and financial decisions to be made. Your students will likely not appreciate that the term "wellness" was created to help change the social order so that more people could enjoy being healthy. They likely think that if they purchase a specific product that will make them happy, and that this is the goal of health.

Activity DD 7.1: Take a minute and Google these terms: "stress-free life", "stress-free relationship", "stress-

free schools." What do you think of what you have found? Can you apply your critical thinking to understand what is being "sold"? Now Google some of these terms: "wellness water", "wellness underwear", "wellness pet food", "wellness cannabis." What do you think of what you have found? How does what students can find on Google relate to the wellness programs being rolled out in schools? Do you think there may be confusion? How can you as a teacher become part of the solution to addressing this confusion?
You may find reading these recent articles and books that have addressed this issue of positive mental health, wellness and happiness as components of self-awareness or self-actualization and the impact of this activity on health of interest.

Books

Davies, W. (2015). The happiness industry: how government and big business sold us happiness and well-being. London: Verso

Whippman, R. (2012, September 22). America the anxious. New York Times. Retrieved from http://opinionator.blogs.nytimes.com/2012/09/22/america-the-anxious/

Wellness Marketing Advice

Murrow, J.L. & Welch, J. (1997). Improving marketing strategies for wellness. Marketing Health Services, 17(2), 30-38.

Krom, K. (2016). Health and wellness is the next trillion dollar industry. Women's Marketing. Retrieved on Nov. 30, 2017 from: http://www.womensmarketing.com/blog/2014/11/health-and-wellness-market/

Critical thinking about positive mental health theories

Miller, A. (2008). A critique of positive psychology—or 'The New Science of Happiness.' Journal of Philosophy of Education, 42, 591–608.

Negative emotions and their importance for health:

Ford, B. Q., Lam, P., John, O. P., & Mauss, I. B. (2017). The Psychological Health Benefits of Accepting Negative Emotions and Thoughts: Laboratory, Diary, and Longitudinal Evidence. Journal of Personality and Social Psychology. Advance online publication. http://dx.doi.org/10.1037/pspp0000157

Rodrigez, T. (2013). Negative emotions are key to well-being. Scientific American. Retrieved on Nov. 30, 2017 from: https://www.scientificamerican.com/article/negative-emotions-key-well-being/

Shpancer, N. (2010). Emotional acceptance: why feeling bad is good. Psychology Today. Retrieved on Nov. 30, 2017 from: https://www.psychologytoday.com/blog/insight-therapy/201009/emotional-acceptance-why-feeling-bad-is-good

Topor, D.R. Feeling okay about feeling bad is good for your mental health. Harvard Health Publishing, Harvard Medical School. Retrieved on Nov. 30, 2017 from: https://www.health.harvard.edu/blog/feeling-okay-about-feeling-bad-is-good-for-your-mental-health-2017091412398

Here is a critical thinking piece recently written by Dr. Yifeng Wei, one of the developers of this pre-service mental health literacy curriculum that provides a nice summary for thoughtful consideration. What do you think about this short overview? Do you agree or disagree? Why?

Critically thinking about school-based wellbeing and wellness approaches

The importance of applying effective and useful mental health promoting interventions in schools may be challenging in the current cultural climate that has made emotional positivity a virtue while brandishing normal negative emotions as either signs of ill-health or reasons for ill-health. In the school setting, the focus on positive emotions as being consistent with good mental health, and negative emotions as indicative of poor mental health has developed concurrently with the growth of the positive psychology phenomenon. This construct has been widely accepted and generally applied in schools implementing wellbeing approaches, such as flourishing mental health, without due consideration to its lack of rigorous controlled empirical support, nor with little or no analysis of potential negative impacts.

This construct ignores the reality that an individual can have a mental illness and negative feelings (for example, sadness and/or disappointment) that result not from the illness but are a healthy and positive response to a negative life event (for example: doing poorly on an examination or a job interview). Further it ignores the reality that negative emotions arising in appropriate response to a negative environmental impact (such as failing an examination, having an argument with a friend, etc.) are usually a signal of good mental health.

Additionally, even if the construct was untarnished by these concerns, available Canadian data shows that about ¾ of Canadians are flourishing. The recent Positive Mental Health Surveillance Indicator Framework conducted by the Public Health Agency of Canada (PHAC) demonstrates similar results in young people (2017). This then raises the uncomfortable question – if the great majority of Canadian youth are mentally well, why are schools applying universal interventions focusing on positive emotional states instead of targeting the needs of youth who may need additional support? Perhaps this reflects a social-cultural shift away from addressing the social determinants of health to providing life enhancements to those who are already doing well.

This confusion has been more recently amplified with the increasing use of another construct now popular in the school setting that blends with the positive psychology framework described above, that being wellbeing or wellness. While initially focused on proactively addressing the many different components that support the development and deployment of a healthy lifestyle in which environmental factors known to increase poor health outcomes are a focus for intervention, the wellness concept has gradually shifted away from these considerations of social determinants of health to focus on individual self-actualization.

Additionally, despite decades of wellness theory activity and many thousands of learned articles, it is difficult to find consensus on what the terms ‘wellbeing’ or ‘wellness’ actually mean. They are used as synonyms, and show up repeatedly in school publications, policy documents, and even in the titles of some roles that educators play. Schools using these terms need to be very aware of what students may think that they mean. Schools using these terms also need to be very aware of not promoting self-actualization over those best evidence-based activities that lead to healthy lifestyles. Schools need to encourage clear use of language and critical thinking – these are skills that will have a lifelong impact on how students evaluate what they see, hear and are prompted to purchase.