Good Kids, mad Schools

GOOD KIDS, MAD SCHOOLS:

AN ANALYSIS OF STRATEGIES TO IMPROVE ON STUDENT MENTAL HEALTH IN ONTARIO SECONDARY SCHOOLS

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ABSTRACT

The western world has long viewed 'mental illness' from a biomedical perspective; treating the brain the same way it treats physical issues, through diagnosis, medication and clinical intervention. We however tend to forget that a person is interdependent on her or his environment, and resultantly we frame the person as ill or weak rather than the environment as sick, or 'mad'. With this thesis I assess how mental health and 'mental illness' are being framed within secondary schools in the province of Ontario (Canada). I achieve this by analyzing mental health strategies using a theoretical lens developed from Critical Disability Theory and Mad Studies. Through use of a Critical Discourse Analysis (CDA) I analyzed a total of 4 mental health strategies from the federal government, the Ontario government and 2 Ontario school boards. My findings indicated that these mental health strategies generally subscribe to a medical or individualized understandings of mental health, and overlook the disabling influence that the school environment can have on the student. By minimizing the role of the social and physical environment on student mental health schools are reinforcing the dominant discourse, which is that distresses in mental health are the result of an individual deficit caused by a brain defect or personal weakness. This discourse has far reaching consequences that may contribute to many Ontario students not receiving the support they desire. I contend that social workers employed by school boards can be influential in challenging these dominant framings of mental health and carry forward the standpoint that the school environment and its social structures play a principal role in the mental health of students.

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It is a true wonder that I am in a position today to submit a Master's thesis. I've fallen short so many times in my academic career, and to still have the opportunity to complete this degree is a reflection of the privilege I've been gifted and the blessings that have been bestowed upon me. The truth is that I have achieved nothing without the guidance of others and have learned nothing without knowledge imparted by others. If this thesis is of a high quality, it is due to the guidance and support of others, but if it is substandard then it is product of my own ego and inability to apply the lessons taught to me throughout life

To the handful of you who read this thesis, thank you sincerely for taking the interest and time to do so. It was sincerely the most exerting undertaking I have attempted in my life and has pushed me further out of my comfort zone than I could have expected. I must warn that my viewpoints reflected in this thesis may have changed or evolved since I completed writing it. This is because I believe that the topic of mental health, especially from a social lens, is very complex and requires a significant amount of critical reflection and deliberation.

It's not often that I get to acknowledge people in my life so I will take full advantage. Dad, you sacrificed so much for me to complete this degree. Mom, you constantly challenge me. Neetu your support and belief in me is boundless. Bob, you're a dope bro-in-law. KSM, I looked to you for light when I felt darkness creeping into my mind. Bhaiya, for always being close despite our distance. Bhabie, you inspire me with your work ethic. Marisa, thank you for still loving me despite me not visiting you often enough. My Homies , I try to surround myself with great people, and you are proof. To the streets of Thorold, you raising me. To RR for reminding me to always laugh and smile. To Melenie, Angelica and CMHA for giving me my first breaks and the foundational experience to pursue social work as a career. To Dalhousie, McMaster University and the numerous professors who inspired me and guided me in my pursuit of knowledge and critical thinking. To Sheela, Vivekji and the various selfless spiritual masters who entered my life and kept me inspired to be better and do good. My Chinmaya family, you've given me more courage and confidence than I thought possible. To those who I am forgetting, forgive me, you deserved better.

To all the haters… What up now?!

Finally, to that all illuminating effulgence that is existence-consciousness-bliss (Sat-Chit-Ananda): the foundation that makes everything possible. I hope this thesis and line of work bring me ever closer to you.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

I believe that experiences are the greatest educators. I will therefore begin this thesis with 3 vignettes. I chose to illustrate these experiences here because it will give the reader a better understanding of my personal lens and why I was inspired to write an entire thesis on mental health discourse in secondary schools.

Executive Perspective

I have a history of volunteering as a public speaker for various mental health organizations that seek to educate young adults about mental health and challenge the stigma[1] associated with experiencing mental health difficulties. Some years back I spoke at a post-secondary school to a group of professors, school administrators and health workers about my own mental health distresses. The sole child and youth mental health organization – serving a community of over 500,000 people - in the region funded and coordinated the speaking event. At this particular speaking engagement, the Executive Director (E.D) of the organization chose to accompany me and give a short presentation about his ambitions as head of the organization. It was the first, and only, time I'd heard him speak to a public group. He spoke eloquently about the need for us to overcome stigma around 'mental illness'[2], much like society did with cancer in the mid 20th century. He spoke about the success of modern mental health treatment and how a good life can be lived by almost anyone who struggles with their mental health. However, he

[1] Rejection or discrimination against an individual because they are deemed "undesirable" (p. 179) based

[2] I will use single quotation marks to signal commonly used language that I find troubling or do not personally subscribe to, as a means of making it clear to the reader that these are the words of others.

then said "one day, I believe we'll find a cure for mental illness". He made this statement with conviction and everyone in the room accepted it with silent approval.

An Unlikely Source of Inspiration

Soon after Dave Chappelle left production in the middle of the 3rd season of "The Chappelle Show" – arguably the most watched television comedy series of all time - headlines from major news outlets reported that Dave had gone "crazy", had a "mental breakdown" and had started using illicit drugs such as a "crack cocaine" (Kaufman, 2015). None of these rumours were ever substantiated. The truth was, as Dave has detailed in interviews since, that the stresses and pressures of his environment were driving him to lose passion for his work and led to "psychological" distresses. After leaving the show, Chappelle moved to Africa for some time before spending a good part of a year at his farm in Ohio (Lipton, 2006).

The comments about Chappelle's mental status, as well as those about other prominent celebrities, upset him. He responded to such slanderous comments in multiple TV interviews, but none more memorable than on "Inside the Actor's Studio" (Lipton, 2006), where he stated: "The worst thing to call somebody is crazy, it's dismissive. I don't understand this person, so they're crazy. That's bullshit, these people are not crazy. They're strong people… *Maybe the environment is a little sick* [emphasis added]".

The Title

In 2012, a music album entitled "Good Kid, m.A.A.d. City" was released by celebrated artist, Grammy award winning musician and black-rights activist, Kendrick

Lamar. The acronym m.A.A.d. stood for "my angry adolescence divided", but also reflected the chaotic and dangerous state of the city he was raised in, Compton, California (Eells, 2015). On this highly candid and sincere album, Kendrick spoke about how his identity as a good, emotionally healthy, kid was compromised by the culture, social structures and feelings of powerlessness he grew up under. Negative experiences, such as being demeaned by police, made him angry and even hateful towards authority figures. He recalls feeling "depressed" and having thoughts of "self-hatred". He elaborated, "to be someone with a good heart, and to still be harassed as a kid . . . it took a toll on me. Soon you're just saying, 'Fuck everything'" (Eells, 2015). Experiences with inadequate social supports and negative treatment by government-backed authorities informed Kendrick, and the people of his city, that they are a problem and don't belong in normative society: "I mean it's evident that I'm irrelevant" (Campbell et al., 2015).

Making Sense of it All

As I unpacked the words of the ED, I came to realize that he was feeding into a social discourse at two levels: first, that 'mental illness' was an individual deficit, rooted in the biology of the human brain. Second, that it is undesired and serves no positive purpose to a person's life, and thus should be eliminated. The notion that people who experience significant distresses in mental health are suffering from an 'illness', which may – and should - eventually be 'cured' by western medicine, bothered me deeply. It simplified a topic that, I argue, is very complex. Kendrick and Dave offer alternative perspectives, where Kendrick identified his city as a 'mad' place and Dave saw his environment as 'sick', which resulted in each of them experiencing significant mental

health distresses. Kendrick and Dave pointed to the profound implications of discourse that informs the individual that they are a problem or labels them as 'sick': Kendrick expressed feeling 'irrelevant' and 'angry', and Dave adamantly vocalized, 'The worst thing to call somebody is crazy, it's dismissive'. Both Dave Chappelle and Kendrick Lamar gave light to the idea that mental and emotional suffering are tied to the environmental and social conditions we find ourselves in.

As a youth, being informed that I had an 'illness' by my doctor, because of the emotional difficulties I was experiencing, was distressing and made me feel defective. I felt most vulnerable when I was at school, as the school was where I spent the majority of my time outside of home, and where I established most of my social relationships. I recall feeling different from my peers and did not feel supported by the school because academics was always the priority and mental wellness was seldom discussed (even though it was clear to me that my academic performance was affected by my mental health). It is only now, in light of the reflections shared by Dave Chappelle and Kendrick Lamar that I consider how mental is tied to the environmental and social conditions we find ourselves in. My hope with this thesis is to build on a discourse that refocuses attention away from the student as the source of 'madness', and considers the school as a potential source of 'madness'. Inspired by Kendrick's album title, and his overall message, I titled my thesis: "Good Kids, mad Schools".

My research focuses on how mental health and 'mental illness' are framed and defined within secondary schools in the province of Ontario (Canada). I attempt to achieve this by analyzing – through the use of Critical Discourse Analysis (CDA) – mental health strategies that have been developed by federal and provincial governments,

as well as two Ontario school boards. As will be explained below, discourse is what gives meaning to a topic. Discourse is constructed through the language we use when discussing the topic or the practices we use to interact with the topic (Foucault, 1988). The discourses evident in these strategies provides insight into how such institutions perceive mental health: whether they see it as a medically-focused topic, located in the individual, or an environmental topic, located in the school structures and social environment, or some mix of the two. Such analysis is important because how such strategies frame mental health influence how schools, school personnel and, ultimately, students, understand mental health.

Up to this point in the thesis, the reader may have noted the attention given to mental health distresses in racialized individuals. Although this was largely unintentional, it does speak to the role that race, and other marginalized identities, such as gender, class and sexual orientation, have in influencing a person's sense of mental wellness. In addition to Kendrick's explicit references to racial oppression, Chappelle has also been vocal about how racial stereotypes contributed to his own mental health struggles, and stirred him enough to leave his show (Farley, 2005). Dr. Kwame McKenzie (as cited in James & Jones, 2013), of the Center for Addictions and Mental Health (CAMH), highlights the swollen rate of emotional trauma that racial minorities experience as a result of explicit or institutional racism. Similar barriers to wellness can be identified in other historically oppressed groups, but delving much further into this topic falls outside the scope of this Master's thesis due to restrictions in time and document space. The study of intersectional identities and mental health in students

deserves independent research of its own, and thus I will only touch on it briefly in this thesis in order to acknowledge its importance to the greater conversation.

A Note Regarding Language

It is appropriate here for me to contrast the terms 'mad' – note the lowercase m – and Mad – note the uppercase M - and also expand on other language used in this thesis. In addition to being a synonym for anger, the word 'mad' has taken on alternate meanings over time, such as "mentally ill", "insane" or being in a "frenzied mental state" (Oxford Dictionaries, 2016). I use the term 'mad' in my title to locate the source of illness in the environment and not in the individual. Conversely, the word Mad represents a movement of mental health survivors and activists who reclaimed the term as a way to take back the language that was used to oppress them for many years (LeFrançois, Menzies & Reaume, 2013). To be Mad-identified, an individual should embrace their identity as a Mad individual and not see it something that needs to be cured. Rather than trying to "fix" the individual, the Mad movement desires to "fix" the community's attitude "towards my difference and support me" (Reid & Poole, 2013, p. 210). The field of Mad Studies is an academic discipline through which Mad history and Mad theory have been collected and developed.

With regards to terminology used on the topic of mental health, terms such as 'mental disorders', 'mental illness', 'emotional difficulties', 'mental health difficulties', 'distresses in mental health'… etc. have all been used to refer to the same phenomenon by researchers, academics and advocates, based on their theoretical underpinnings (Beresford, 2002; Burstow, 2013; Gulliver, Griffiths & Christensen, 2010; Hunt &

Eisenberg, 2010; Lee, 2013; Meekosha & Shuttleworth, 2009; MindMattersAustralia, 2015; Mulvany, 2000). In this thesis I try to avoid any language that labels, stigmatizes or infers deficit in an individual. I ascribe to Beresford's (2002) perspective that the term 'mental illness' is "based on the deficit model… and conceptualizes their thoughts, emotions, perceptions and behaviours as wrong and defective" (p. 252). Therefore I avoid the terms 'mental illness', 'disorders', or any diagnostic terminology (for example, 'schizophrenic', 'bipolar', 'generalized anxiety… etc.) unless I am using the words of others or am using them to functionally describe something to the reader; for instance, 'he was diagnosed with 'depression''. As noted earlier I will put such terminology in single quotation marks, indicating that they are not my words.

I will typically use the term mental health throughout this thesis. Although some individuals may associate the term 'health' with a medical framing, I still use it because I personally don't associate it with the medical field. This is because the term health can be, and is, used to qualify a variety of topics that have no direct relation to the medical field – financial health, spiritual health, emotional health, social health. Health is a term I synonymize with wellbeing. Conversely, healthcare is a term I associate with medicine. Furthermore, health reflects a significantly more neutral meaning than does 'illness', which infers deficit or dysfunction. When using my own words to describe, what some refer to as, 'mental illness' or 'mental disorders', I use the terms *mental health difficulties*, *distresses in mental health*, *emotional struggles* or some variation of this language. I use these terms with the perspective that every individual has mental health and anyone is susceptible to experiencing difficulties with their emotions or mental health

given the right stressors and social context (Canadian Mental Health Association [CMHA], 2013).

The Research Questions

Over the last 5 years, the majority of Ontario school boards have released mental health strategies. These followed the Federal Government's release of the "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada'' mental health and addictions report (Kirby & Keon, 2006) and the release of the Ontario government's "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy" (OMHLTC, 2011). Each of these mental health strategies offers a window into how our political and educational institutions frame mental health and believe the solutions to addressing it are. The language they use, the interventions they propose, the research they access and the content they remain silent on create, reproduce and reinforce particular discourses about what mental health and 'mental illness' are.

As I will outline in the upcoming chapters, there are numerous and often combative theories and perspectives regarding what mental health is and how distresses in mental health occur. Similarly, the theories and perspectives utilized, and types of interventions recommended in mental health strategies developed by our political and educational institutions, can affect how secondary school students perceive mental health – in themselves and others - and influence whether or not a struggling student will reach out for support (CAMIMH, 2007; Corrigan, 2004).

To conduct this research I used a critical discourse analysis (CDA) as my methodology. According to Taylor (2004), CDA can be used to assess a document on its use of language, formatting, references, overall style, and a number of other factors. How these factors fit together in a policy or strategy document constructs a certain discourse on the topic; a discourse that may be novel and progressive, or may reflect, reproduce and strengthen existing discourses. I specifically used CDA to analyse mental health strategies that would impact secondary school students, and drew on texts developed at the federal, provincial (Ontario) and local (Toronto and Niagara) school board level to answer the following research questions:

Research Questions to be Addressed Through CDA:

- *How do federal, provincial, and local (school board) mental health strategies frame mental health and 'mental illness'?*
- *What discourses do these framings create or reinforce? Which ideas, theories and practices do they privilege and which do they maintain silence on?*
- *What are the possible implications of these discourses for secondary students who experience distresses in their mental health?*
- *How might these mental health strategies be improved by incorporating the theoretical perspectives of Mad Studies and Critical Disability Theory?*

Why Is This Important to Social Work?

I see this issue as a social justice issue. As I will explore in the following sections of my thesis, the tactics we have used thus far to deal with mental health amongst students have not been effective at reducing the emotional struggle of students with mental health concerns (Lee, 2013). Similarly, the input and perspective of those who have been historically discriminated against by the psychiatric system are given marginal

status in the societal discourse on mental health (LeFrancois et al., 2013). As social workers, one of our primary responsibilities is to uphold social justice and advocate for those who have been marginalized.

As mental health awareness continues to gain momentum, social workers have an opportunity to be part of the political and ideological shifts in how mental health is perceived and addressed in the school system. Although it was not historically the case, many school boards in Ontario now employ social workers who are well positioned to influence change.

CHAPTER 2: THEORETICAL LENS

Mental Illness and the Medical Model

There is a historical practice of labelling and diagnosing individuals who experience significant distress in their mental health as having a psychiatric 'illness': this psychiatrization has become normalized, and is commonly seen as progressive because it falls under the umbrella of science and modern medicine (Starkman, 2013). This practice has fuelled a narrow (and ever narrowing) understanding of what is defined as normal, common or ordinary in our society. For example "children who were once understood as expressing sadness or low moods have been increasingly diagnosed with depressive disorders, whilst high energy, "uncontrollable" children have been increasingly diagnosed with a range of hyperactivity-related disorders" (LeFrançois et al., 2013, p. 7). The steadily increasing faith in medicine and trend of compartmentalizing certain behaviours using diagnostic labels runs the risk of limiting how we address mental health difficulties in individuals. This is especially pertinent for secondary schools students, because the onset of mental health struggles is highest amongst youth (Kessler et al., 2007). Labelling specific behaviours as undesirable frames the student as malfunctioning, rather than the environment, such as the school. It also puts faith in the competency of the psychiatric system, when it is known that only some psychiatric treatments are effective (Bracken et al., 2012).

To clarify, psychiatry, and the psychiatrization of 'abnormal' behaviour, is a reflection of the medical model's propensity to diagnose (LeFrançois et al., 2013). The medical model is based on an ideology that locates 'dysfunction' in the individual. It rarely considers social, economic, political or environmental factors in its diagnosis or

treatment. This can be problematic because the medical model - and the discourse it promotes – retains a privileged (dare I say, monopolistic) position in society today. Resultantly, other perspectives on the causes and treatment of 'dysfunction', specifically with regards to mental health, are not prominent in societal discourse. Although psychiatry has a repugnant history when it comes treating 'mental illness', it retains its position as the foremost authority on mental health because of the prominence of neoliberal ideologies (Carney, 2008). Neoliberalism, which seeks to promote a more economically efficient and independent society, endorses pharmacological interventions, and simple therapeutic interventions, such as Cognitive Behavioural Therapy (CBT). These interventions are cost effective and put the onus on the individual to adapt to the social structures rather than adapting the social structures to the individual (Teghtsoonian, 2009).

The medical model's focus on pharmacological interventions and temporary therapy, at the expense of addressing social and systemic barriers to wellness, runs counter to the desires of many service users (CAMIMH, 2007; Mulvany, 2000). Horwitz (2006) highlights how social and environmental factors, such as inequality, discrimination, school and workplace pressures, lifestyle choices or poverty, are key features to an individual's mental health and need to be given more consideration. In a chapter written by Geoffrey Nelson (2006) on "Mental Health Policy in Canada", he pointed out that policy had yet to catch up with research pointing to how oppression and other environmental barriers influence one's emotional health. Rather, Canadian policy largely remained rooted in "traditional" approaches to mental health - the "biomedical perspective" and "psychiatry" (p. 231).

The reason I highlight these points is not to debunk or devalue the capacities of the medical field; medical interventions have arguably been helpful to a number of individuals who struggle with emotional and psychological difficulties, including myself. The key issue I wish to highlight is the discourse that the medical model constructs of individuals as biologically and inherently defective (LeFrancois, Menzies & Reaume, 2013). It's been found that how we define or frame 'mental illness', its causes, and the capacity of individuals overcome it, dictate whether an individual will reach out for help (CAMIMH, 2007; Nelson, 2006). In general, people prefer "self- help, lay support and lifestyle interventions for mental disorders, and they are uncomfortable with medical and especially pharmacological, interventions" (CAMIMH, 2007,p. 12).

The Social Model and Critical Disability Theory

In the late 1970s and early 1980s, a shift in thinking started to develop in the study of disability (Meekosha & Shuttleworth, 2009). Specifically, in 1976, the Union of Physically Impaired Against Segregation (UPIAS) released a document titled, "The Fundamental Principles of Disability" (Oliver, 2013). This document, developed in the United Kingdom, "argued that we are not disabled by our impairments but by the disabling barriers we face in society" (Oliver, 2013, p. 1024). This document influenced disability activist and social work professor, Mike Oliver, to publish a book where the term Social Model of Disability (SMD) was coined as a direct response to the dominant individual model of disability. Mulvany (2000) explains the SMD in the following words: "The social approach to disability demands an identification and analysis of the social, political and economic conditions that restrict the life opportunities of those

suffering from an impairment" (p. 584).

The initial formulation of the SMD differentiated between 'impairment' and 'disability'. Impairment was thought to be the disease or defect that distinguished the individual from an able-bodied, or normative-minded individual, and a disability was considered to be a societal or environmental barrier, which prevented the individual from functioning as desired (Lester & Tritter, 2005). The implication of this model is that if you remove disability (societal barrier), which prevents an individual from functioning as desired, then the individual still has an 'impairment' but it no longer poses a problem for them.

Persistent criticism developed over time about the inclusion of the construct 'impairment', because it retained a focus on the individual's perceived shortcomings and stigmatized those who were accommodated for their disability (Meekosha & Shuttleworth, 2009; Mulvany, 2000). These critiques paved the way for the emergence of Critical Disability Theory, where the term 'impairment' was dropped, but 'disability' remained. Meekosha and Shuttleworth (2009) saw CDT as a "maturation" (p. 54) of SMD, where the basic tenets of SMD remained intact, but the impurities were sifted out. They also noted that the shift from SMD to CDT signified a severing of any relation to the medical model. It is important to note that involvement and reflective perspectives of those with lived experiences with disability catalyzed the growing embrace of CDT.

Critical Disability Theory "suggests that the very structure or organization of society itself may play a role in the epidemiology and etiology of mental illness" (Thoits, 2006, p. 119). Much like the SMD, CDT proposes that disability results from the way the world is physically, culturally, politically and socially structured. Where the SMD and

CDT diverge is in the added consideration of culture and power, and discourses that are constructed about those with disability (Sullivan, 2005). These added elements denote that features such as social attitudes and class/status also contribute to disabling barriers. Gilson and Depoy (2002) note that CDT considers the interaction between external factors, such as the environment and institutional structure, and internal factors, such as feelings of marginalization or powerlessness, as significant in creating "a disabling condition" (p. 239).

Teghsoonian (2009) directs our attention to research showing an interconnection between environmental factors such as "poverty, stress, fatigue and lack of control of one's environment" (p. 30) with depression. She, echoing Carney (2008), identifies that many of these factors are the result of policy driven by neoliberal ideology, which cut funding for social supports and public institutions, such as schools. An example where CDT ideology can be drawn upon in an analysis of schools is on the issue of class size. Class size is a key environmental factor that determines the performance and wellbeing of students (Froese-Germain, Riel & McGahey, 2002). Ontario teachers have repeatedly indicated that large class sizes decrease teachers' ability to meet the individual needs of students, and increases teachers' personal workload and stress (Brown & Rushowy, 2015). The question of class size was of such importance that secondary school board teachers almost went on strike over this issue this past year in Ontario (Brown & Rushowy, 2015).

Another example indicating the interconnection between mental wellness and the social environment can be seen in research looking at feelings of social connectedness in students and the likelihood that they will experience difficulties in mental health.

Generally speaking it has been found that individuals have good mental health when there is a "strong system of social integration that connected people to each other" (Horwitz, 2006, p. 10). Isolation on the other hand exacerbates one's sense of mental distress. Studies have found that students who feel connected to their peers and the school are significantly less likely to experience difficulties with their mental health in their later years (Bond et al., 2007; McLaughlin & Clarke, 2010; Shochet, Dadds, Ham, & Montague, 2006).

Also central to CDT is what Gilson and Depoy (2002) express as the diversity of the human body and mind. From this lens, there is therefore no 'normal' state of the human body or mind; normalcy is a social construct (Hirandandani, 2005). With regards to mental health, this means that different mental constitutions are simply an expression of diversity, and cannot be categorized as normal or 'abnormal'. Hirandandani (2005) suggests we challenge the idea of normalcy and the hierarchy it perpetuates; "A critical analysis of the discourse of normality and measurement, therefore, would serve to illuminate and expose power inequities" (p. 1). Meekosha and Shuttleworth (2009) build on this idea:

> How societies divide 'normal' and 'abnormal' bodies is central to the production and sustenance of what it means to be human in society. It defines access to nations and communities. It determines choice and participation in civic life. It determines what constitutes 'rational' men and women and who should have the right to be part of society and who should not (p. 65).

The Mad Movement and Mad Studies

Also gaining prominence, as an alternate perspective on mental health alongside CDT, is Mad Studies (MS). MS is an academic field founded on the exhaustive efforts of the Mad movement; an antipsychiatry movement composed primarily of "psychiatric survivors", but also "academics, journalists, and dissenting physicians" (LeFrancois et al., 2013). A key moment in the history of antipsychiatry came in 1961 when psychiatrist Thomas Szasz publicly called for a change to the "coercive methods" (LeFrancois et al., 2013, p. 5) the medical profession used when working with 'mentally ill' patients. He demanded structural change to the profession to reduce power disparities that existed between patients and psychiatrists, making each party "contractual equals" (p. 5). Organized grassroots groups, bearing the flag of antipsychiatry, started to form in the mid-1960s. From the 1960s to the 1970s, the anti-psychiatry movement gained momentum, carrying the message that "madness could only be understood and engaged existentially and through the eyes of those who live it" (LeFrançois et al., 2013, p. 5). The Mad movement planted roots in Canada in 1970-1971 under the umbrella of activists groups such as the Mental Patients Association. Any momentum gained by the Mad movement slowed significantly in the late 1970s and early 1980s as pharmacological corporations strengthened their partnership with the medical profession, and psychiatry reinforced its position as the dominant discourse in framing mental health. The Mad movement however has recently a seen a dynamic rejuvenation on a global level, which, as LeFrancois et al. (2013) express, "is unquestionably here to stay" (p. 8). Emerging from the messages and history of the Mad movement, and the stories of psychiatric survivors, came the academic field known as Mad Studies. Although still in its infancy,

Mad Studies has established programs in Ontario universities such as Ryerson University and York University, and a student led Mad Students Society at McMaster University.

Central to Mad studies is the need for acknowledgement of past injustices and acts of oppression conducted by the state (LeFrançois et al., 2013). Mad advocates believe that if the state can admit to the injustices it promoted in the past, it can be used as a stepping-stone to improve social attitudes towards mental illness. Social attitudes towards mental illness are obvious "barriers to the empowerment of mentally ill" (LeFrançois et al., 2013, p. 194). Poole et al. (2012) share an example of how the negative attitude of a social work professor disadvantaged potential students who experience mental health difficulties. This example touches on the often-cited myth that students who struggle with their mental health pose a risk to others. The professor in this case stated, "so you want us to let any old psychopath into our program?" (p. 27). Such attitudes are seen as historically grounded in the discriminatory and oppressive practices of traditional mental health practices. Mandating an educational curriculum in schools, which strongly incorporates the oppressive history of mental health treatment, could go a long way in preventing discriminatory attitudes in future generations (LeFrançois et al., 2013).

Building on this previous example, Mad Studies promotes that we take a critical look at the terminology and language used when speaking about mental health (Church, 2013). Certain words and terms are historically oppressive and perpetuate an inaccurate understanding of the mental health difficulties experienced by people in any society. As noted in the Introduction, the term 'Mad' is one such example of a reclaimed word that has historically been used to label anyone whose way of existing in the world did not fit

into what was designated as normative. Even psychiatric diagnoses, such as 'schizophrenia' or 'bipolar disorder', can be oppressive and not accurately capture the human elements of such individuals. Church (2013) suggests we "substitute medical and popular terms with more appropriate and less oppressive ones" (p. 188).

Also central to the Mad perspective are the celebrations of the "individual experiences of Madness and developing Mad culture" (Beckman & Davies, 2013, p. 66). In the case of the many students who avoid seeking help due to fear of isolation (Gulliver, Griffiths and Christensen, 2010), a school culture where Mad identity is promoted and celebrated would likely increase the number of students who reach out and feel supported. As far as I have found in my research such schools cultures do not sufficiently exist in Canada.

The Mad perspective calls for greater "mental health literacy" in society, especially in the media and core institutions, such as schools, which have a major impact on how society thinks about such issues (White & Pike, 2013, p. 248). Once again, there is an opportunity here for governments or school boards to establish policies and strategies that incorporate literacy initiatives. White and Pike (2013) however warn that literacy should challenge a dichotomous thinking of mental health. Students should be exposed to the idea that there can be "two or more legitimate and equal interpretations of mental health/illness or recovery operating at the same time" (p. 249). Much like the way CDT endorses that there is no 'normal' mental/emotional constitution; Mad Studies also rejects binary viewpoints of mental health.

Richard Ingram (as cited in LeFrancois et al., 2013) believes that MS owes a great deal of gratitude to "disability studies perspectives based on transformative

revaluation of the category of 'disability'" (p. 12). Although Mad Studies is distinct from the CDT, they have similar foundations of thought. Both perspectives resist the idea that mental health difficulties can be reduced to a biological flaw, and both try to shift society's perspective to understand mental health "within a social and economic context" (LeFrançois et al., 2013, p. 2). Mad Studies however was developed as a direct response to psychiatry by the community of people labelled 'mentally ill', whereas CDT was developed as a response to the disabling social and environmental barriers that exist in society.

How My Experience Informs my Lens

When I was told that I was suffering from a mental illness by my family doctor. I didn't question the source of my struggles, because the word 'illness' in my vocabulary meant that the issue existed inside me. It implied that I had a defect, and needed treatment. However, at the time, I wasn't aware of how my social and physical environment impacted my mental health.

Looking back, the school environment was the most influential environment I had in my life, even more influential than my home environment. School was the medium for my most important social relationships and it was the place where I gained or lost confidence through my participation in extra curricular activities. It was also where I found some key mentors. I cannot emphasize enough how my school experiences correlated with my personal sense of wellbeing. With that said, I believe that if the culture within my school system was more supportive, more inclusive and more accessible, then my mental health distresses could have been minimized.

I would like to recount a specific example of when I felt the school system failed to provide me adequate mental health support or offer a channel through which I felt comfortable reaching out and talking about my personal struggles. This situation occurred in my grade 12 year when my increasing 'anxiety' and bouts of 'depression' were affecting my ability to complete schoolwork to such a degree that I could not handle a standard 3-course workload. I approached my resource counsellor asking if I could drop one of my courses, citing personal responsibilities and extra curricular commitments as my reason. I informed her that I was registered for 4 courses the following semester, to assure her that I would be graduating on time. I knew full well that I was unable to handle 4 courses and I intended to manufacture another excuse when the time arrived next semester. The guidance counsellor informed me that in order to grant my request, she would need special permission from the vice principal or principal. After meeting with vice-principal and pleading with him, citing the earlier mentioned reasons, I was given permission to drop one of my 3 courses.

Looking back, I see this experience as a personal victory where I manipulated the school structures to make it more manageable and less anxiety triggering. This allowed me to maintain a high overall average and get a scholarship for university. Had this accommodation not been granted, my grades and self-confidence would have suffered drastically. However, I believe that the stresses I experienced, and the manipulation of the school structures, would not have been necessary had the schools utilized mental health strategies that were informed by Mad Studies and Critical Disability Studies.

I want to believe that current school systems have changed since my experiences 15 years ago, but recent experiences inform me otherwise. As part of a recently

developed program called Talking About Mental Illness (TAMI) I make regular visits to secondary schools in the Niagara Region to speak about my personal trials with mental health. I have noticed that anti-stigma and mental health awareness campaigns are increasingly abundant, and students are much more willing to speak about their experiences. However I have witnessed that the questions being asked and conversations being had amongst students and teachers are medically and diagnostically driven. Many conversations revolve around the importance of accepting a mental health diagnosis, accepting psychiatric help and not being opposed to taking medication. Very few discussions consider social structures, school culture or the environment, and how they affect the experiences of student mental health. It is only now, as I begin to assess how rooted my mental health difficulties are in my environment that I see the value of schools changing their culture to become more community oriented, more mental health literate and more accommodating to the emotional needs of all students.

Applying Theory to My Analysis

In conducting an analysis of the federal, provincial and local mental strategies, I determined that I would draw upon CDT and Mad Studies to guide my analysis.

Informed by CDT, I analyzed policy from the perspective that a supportive, isolation-minimizing environment in the school is a key form of prevention for the mental health struggles of students in schools. Similarly, I attempted to challenge the notion that there exists a normative state of being or thinking, and thus looked at mental health struggles as forms of diversity. This means that individuals who struggle with

their mental health are not dysfunctional, but rather require different structures, supports or accommodations from the ones they currently have (Beresford, 2002)

Informed by the Mad Studies lens, I analyzed policy from the perspective that the experiences and accomplishments of those with mental health struggles should be celebrated and they should be provided a supportive forum to discuss their experiences. Additionally, I considered the need for greater attention to be given to mental health literacy, which focuses on alternative frameworks of mental health, apart from the dominant medical discourse. Similarly, the use of oppressive language needed to be challenged and replaced with language that is less stigmatizing.

CHAPTER 3: LITERATURE REVIEW

The western world has long approached mental health distresses from a biomedical perspective (medical model); treating the brain the same way it treats other parts of the body, through diagnosis, medication and clinical interventions (Beresford, 2002). Given western medicine's success at treating many physical health ailments, it is perhaps understandable that society believes an individual's mental health can be treated primarily through medical methodologies. Nevertheless, this view promotes the ideology that there is something inherently deficient in the human brain when it struggles psychologically. When we think about this critically, there are obvious problems with comparing an organ as complex and unknown as the brain to that of the heart or liver or lungs. Additionally, according to Wipond (2013), science lacks the kinds of accurate medical instrumentation to test the healthy operation of the brain that we have for other organs in the body.

Given how plastic the brain is, and how frequently it changes, it cannot be divorced from an individual's environmental, social, or historical experiences (Sale, Berardi & Maffei, 2014). The brain - and ultimately the mental composition of an individual – will change based on its interactions and experiences with the environment. Seeming to reflect a CDT and MS lens, the World Health Organization (WHO) (Herrman, Saxena, Moodie, 2005) endorses that we rethink, and reframe, how we understand 'mental illness', to no longer look at it as primarily a biological 'deficiency', but as something that is strongly tied to our social structures and environment.

Artificial constructions of what is 'normal' and 'abnormal' typically lead us to assign particular behaviours or thought processes with a psychiatric label or diagnosis,

when, from a another perspective, these behaviours and thought processes could just be an alternative way of thinking and acting in the socially rigid domain in which the person finds themselves (Horwitz, 2013). As I have noted in the previous chapter, in recent decades a number of alternate perspectives on mental health have gained support. Although no single alternative perspective appears to be inline to usurp the medical model, these perspectives have gained momentum through the hard work of psychiatric survivors, activists and researchers. Many who advocate against the medical perspective are motivated by the stigma and discrimination that it endorses by framing mental illness as an individual deficit (Poole et al., 2012).

Why Focus On School Policy and Strategy?

Patton et al. (2000) indicate that diagnosable distresses in mental health typically commence in childhood and adolescence, because this juncture of life is a time of major social, biological, emotional and environmental change – or stress - for an individual. As a result, many researchers declare that it is vital to address mental health policy in schools, where adolescents spend the majority of their time outside the home (Adelman & Taylor, 1999; Brown et al., 2004: Patton et al., 2000; Waddell et al., 2005; Wells, Barlow and Stewart-Brown, 2003). Studies have found that a student's mental wellness has proven to be a key factor in that student's ability to learn and be taught (Adelman & Taylor, 1999/2006; Brown et al., 2004; Lendrum, Humphrey & Wigglesworth, 2013; Patel & Sexena, 2014; Waddell et al., 2005; Wells et al, 2003: Wyn et al, 2000). School systems on the other hand have traditionally resisted the notion that caring for students' mental health is part of their responsibility, reasoning that their role is solely to educate

(Wyn et al., 2000). Adelman and Taylor (2006) admit that schools are not in the "business" (p. 297) of health, and therefore allocate only limited resources to mental health. Yet, with the increased mental health needs of students, and evidence that poor mental health affects a student's ability to learn, Wells, Barlow and Stewart-Brown (2003) argue that schools should make student mental health part of their institutional responsibility, and therefore policy (and strategy) should follow suit.

"Children's mental health has not received the public policy attention that is warranted by recent epidemiologic data. To address the neglect of children's mental health, a new national strategy is urgently needed" (Waddell, McEwan, Shepherd, Offord & Hua, 2005, p. 226). Studies conducted in Canada indicate that as few as 25% of all students in need of mental health support actually receive it, and that average waits times in Ontario are close to six months (Kutcher, Hampton & Wilson, 2010; Waddell et al., 2005a). This inefficiency, on a national and provincial level, is an indicator that our efforts and methods to address mental health in students have been inadequate or inappropriate, and thus need to be rectified. Closing that 75% gap by simply offering more services will likely not suffice as a key reason that many youth don't seek targeted help is because common interventions, such a medical treatment and psychotherapy, frame them as abnormal and potentially isolate them from peers (Hunt & Eisenberg, 2010; Waddell et al., 2005a). It may be time for a different direction in how schools address mental health in students.

Aligned with a CDT perspective on schools, Adelman and Taylor's (2006) research shows that environmental factors in school, such as "poor quality schools", "inappropriate peer models", "violence" or "negative encounters with peers" (p. 298), can

lead to increased stress and emotional distress in youth, whereas their behavioural and emotional responses to such environmental stressors are often being labelled as the result of a 'mental illness'. By giving students a 'mental illness' label, the responsibility for a student's wellness shifts from the school (and the government who funds the school), onto the individual student (who now has the responsibility of securing support) and the medical field. Mad Studies, and the antipsychiatry groundwork it is founded on, might look at the practice of diagnosing students as a purposeful tactic pushed forward by pharmaceutical companies to increase sales of psychiatric medication (Moncrieff, 2008). Mulvany (2000) notes that in some cases individuals, including youth, benefit from clinical treatment to alleviate symptoms that arise from stress, but in many cases an adjustment in the environment, circumstances and social attitude would be more effective (Mancini, Hardiman & Lawson, 2005).

The Trouble with Mental Health Policies of the Past

As earlier mentioned, with this thesis I assessed some of the most recent mental health strategies at the National (Canada), Provincial (Ontario), and local (school board) levels. Prior to the conception of these strategies, a number of other mental health policies/strategies were constructed in Canada but none (at least at the national and provincial level) were able to adequately address the sizable mental health needs of the population (Nelson 2006/2013). Some of the issues with previous mental health policies in Canada, according to Nelson (2013), were that they empowered medical practices but failed to empower services users, they focused too heavily on adult populations and they were often not informed by research.

Nelson (2006/2013) indicates that mental heath policies have traditionally supported initiatives that used a top down, medicalized approach. Even with the reallocation of resources from hospital-based institutions to the community, many community supports "retained the character of the institutional paradigm" (p. 236). Ontario policies did attempt to fund consumer survivor initiatives, however such mental health policies continued to empower professionals over service users.

The majority of mental health policies and strategies in Canada have been directed at adults (Kutcher et al., 2010; Nelson, 2006/2013). As of 2010, only 4 provinces had a child and adolescent mental health strategy, one of which was Ontario. However, the limited scope of each of these strategies and their lack of adherence to research likely led to a struggle to meet the needs of youth with mental health difficulties (Kutcher et al., 2010; Nelson, 2013; Waddell et al., 2005b).

In 2005(a), Waddell et al. found that Canadian school policy was not inline with up-to-date research evidence, and, in fact, school strategies dealing with certain youth populations may cause more harm to student mental health than benefit. They note, for instance, that strategies to deal with violent youth often frame such students as deviant, labelling them as having behaviour problems rather than considering the possibility that they were victims of difficult environments, and required specific types of support and encouragement from the school system. Waddell et al. (2005a) interviewed policy makers to understand why there was a disconnection between research and policy and why expert opinion was not translating into school mental health strategies. What they found was that policy makers were influenced by a number of stakeholders, of which expert research was only one of many. Public opinion and media portrayals/framings

were amongst the most effective voices in influencing the construction of policy. They also found that policy makers did not utilize any sophisticated methodology to develop policy, but simply "obtained most of the information internally and informally" (p. 1649).

Calls to Build Better Policies and Strategies

According to a number of researchers the majority of school strategies and policies that do exist emphasize short-term, narrowly focused interventions (Adelman & Taylor, 2006; Beresford, 2002; Browne et al., 2004). Such strategies and policies are not comprehensive, and often only a small number of students who need support receive it. Adelman and Taylor (2006) advocate for school policy to support "a full continuum of prevention and corrective programs that are integrated with each other and with instruction" (p. 150).

Some researchers call for mental health strategies to move away from deficit-based conceptions of student mental health, which single out specific segments of the student population, and labels them as divergent from the norm (Hui & Stickley, 2007; Teghtsoonian, 2009). In Teghtsoonian's (2005) surveying of mental health policy documents out of British Columbia, she identifies that "each document directs our attention to the individual with depression rather than to the broader socio-political environment – including current public policy choices – that might be understood as contributing to the high rates of depression among members of the public." (p. 31).

Finally, Kutcher et al. (2010), recognizing the lack of research backing policy, argued that youth mental health policy, starting at a national level, needs to be developed with the input of mental health experts who utilize up-to-date research and perspectives

of service users. They suggested the government employ an independent body such as the Mental Health Commission of Canada (MHCC), to develop and construct such policy. They MHCC has since constructed their own 'Child and Youth Mental Health Framework', known as 'Evergreen', which they hope "could be used by governments, institutions and organizations across Canada to assist with the development of mental health policies, plans, programs and services" (Kitcher & McLuckie, 2010, p. 4).

Gaps in Literature

Throughout my literature search, I could find only 3 studies - by Teghtsoonian, (2009), Hui and Stickley (2007), and Goldman and Grob (2006) - that looked at how mental health policy, or lack thereof, generates discourse or is influenced by it. Goldman & Grob (2006) note, "mental health policy is shaped fundamentally by the definition of mental illness associated with the policy" (p. 737). I therefore argue that we must pay greater attention to the definitions of 'mental illness' we use in our policies and how those policies influence public discourse. For example, if school policy reflects a medical definition of mental illness, students, and in many cases their parents and teachers, may be led to see mental health as bio-medically driven and individually focused. Furthermore, researchers Hui and Stickley (2007) assert, language and "subtle inferences" (p. 416) found in policy can influence services user involvement, such as youth avoiding reaching out for help to evade being labeled with a 'mental illness'. Thus, a focus on language use in policy at the school level is particularly important when we remember that mental health difficulties generally develop between in adolescence and youth adulthood (Waddell et al., 2005a).

In my literature search I was also unable to find any publicly available research that analyzed Canada's or Ontario's most recent mental health strategies or any of the newer school board strategies in Ontario. I would like my thesis research to begin to fill this gap. I want to assess how these policies frame mental health because, as I hope is clear, how they do so will have an effect on how the public (particularly) understands mental health and on the societal discussions we have on the topic. For example, in an analytical review of Canada's mental health policies – none of which I looked at in this thesis - done in 2010, Kutcher et al. champion the notion that the Canadian mental health system and the lack of strong policy is to blame for poor mental health outcomes in youth. They identified, for instance, that many high-profile cases of mentally unwell youth involved with the justice system unfairly painted the youth as a dangerous or unstable.

Although specific research in this area is sparse, this gap provides the opportunity for my research to contribute to an area of mental health that is little understood.

An Example to Build Off Of

I want to present the example of an initiative out of Australia known as MindMatters. Wyn et al. (2005) provide an in-depth analysis of this Australian mental health initiative, which has become a national strategy due to its successful outcomes (Principals Australia Institute, 2016). This initiative aligns closely with Critical Disability Theory and Mad Studies perspectives, because its primary focus is on tailoring the school's social and physical environments to improve student wellness. The initiative uses a "whole school approach" (p. 594) by retrofitting the school system to make it more

supportive and collaborative, preparing teachers to better support the emotional needs of the children, and restructuring the classroom so the students can be more engaged. According to the MindMatters initiative, "mental health is our ability to respond to challenges" (MindMattersAustralia, 2015). This definition is simple but it also has some discursive elements that can be noted. The definition uses 'our' to denote that mental health and mental health difficulties belong to everyone, because everyone faces 'challenges'. When we dig more into the philosophy behind MindMatters, we find that it does not use medicalized terminologies such as 'mental illness' or 'disorder' in any instance when describing student experiences. In fact, it indicates that while illness terminology, such a "depression" and "anxiety", may be useful "from a clinical point of view" it can mislead students to believe that some people can have mental health difficulties and others do not (MindMattersAustralia, 2015). MindMatters advocates that clinical terminology be left out the schools. They point to "poor mental health", as being the result of environmental factors such as "low socioeconomic status" or "chronic illness", and "mental wellness" being influenced by social factors, such as a sense of belonging (MindMattersAustralia, 2015). "Treatment of ill health and disease is missing the most important point if the social causes of ill health are not addressed" (Wyn et al., 2005, p. 599).

The MindMatters approach offers three fundamental questions for schools to ask in order to construct a "health promoting school environment" (Wyn et al, 2005, p. 595):

> "(1) How can we promote a safe and supportive environment in which all students can maximize their learning?;

(2) How can we remain accessible to their needs?;

(3) How can we assist our students to develop their ability to cope with challenge and stress?" (p. 596).

The initiative recognizes that because anyone is susceptible to mental health difficulties, the priority should be on constructing healthy environments. According to the MindMatters (n.d) official website, the initiative has over "1,403 participating schools" and is supported by the Australian Government Department of Health.

CHAPTER 4: CDA RESEARCH DESIGN

Choosing a Methodology

In making a choice of methodology, I kept in mind the goals I hoped to achieve with my research. Firstly, I wanted to look at mental health policy or strategy[3], because they are what guide the development of local programs and interventions. Secondly, I wanted to focus on language and discourse because, much like I cited earlier referring to the writings of Goldman and Grob (2006) and Hui and Stickley (2007), I believe that how we define and frame mental health will affect how we understand and interact with it. Lastly, I wanted to conduct research that could contribute to social change, or at least add to the breadth of research that uses Critical Disability Theory and Mad Studies, because both fields of study left a significant impression on me during my of course work in McMaster University's Masters of Social Work (MSW) program. With the guidance of a number of academic advisors[4] I concluded that a Critical Discourse Analysis (CDA) was the best method to achieve these goals.

Neuman (1997) indicated that if one is interested in challenging and changing social relations then a critical methodology is the correct choice. Fairclough (2001) reinforced this idea, arguing that a primary benefit to using CDA with policy is its

[3] It was difficult for me to locate a definite distinction between policy and strategy; in fact, a number of definitions I reviewed appeared to have conflicting and unclear descriptions of the terms. Nonetheless, reflecting on what I have seen in literature I have come to understand policy as a defined course of action adopted by an organization or body, designed to address a specific circumstance or situation. Whereas, I understand strategy as a plan of action designed to address an identified concern. With this thesis, I ultimately I chose to analyze strategies because I found that they are more easily accessible online, have received more media attention, and many school boards in Ontario recently released strategies to address student mental health.

[4] Dr. Rachel Zhou (McMaster social policy professor), Dr. Jennifer M. Poole (Director of Ryerson's School of Social Work), Dr. Stephanie Baker Collins (McMaster social work professor) and Dr. Ann Fudge Schormans (my thesis supervisor)

"commitment to progressive social change" (p. 230). Taylor (2004) concured, noting "it allows a detailed investigation of the relationship of language to other social processes, and of how language works within power relations" (p. 437). As Fiske and Browne (2006) remind us, policies are inherently unequal because of the unequal power of those who develop them. As such, if policies are immersed in dominant ideologies, critical discourse analysis can balance out the power disparity through critical feedback on the policy.

The focus of CDA is on discourse. I would like to define the term "discourse" using the insights of French philosopher, Michael Foucault. Foucault saw discourse as more than a "linguistic concept" composed of "speech and writing" (Hall, 2001, p. 72). Discourse is the combination/configuration of language used when describing a topic, as well as the practices used to interact with that topic. From Foucault's perspective, a thing or topic has no intrinsic meaning in itself, but the "discourse… constructs the topic" (p. 72), or more simply, it constructs knowledge of a topic. In Foucault's opinion, "nothing has any meaning outside of discourse" (1972, as cited in Hall, 2001, p. 73). For instance, topics like mental health, or "madness" (Foucault, 2013, p. 188), are given meaning and understood by the discourse – language and practice - ascribed to them.

Foucault pays particular attention to issues of power, and warns that social systems and institutions can govern discourse by promoting specific knowledge of a topic at the expense of other – equally applicable - knowledge (Hook, 2007). The use of such regulating discourse "rules out, limits and restricts other ways of talking, of conducting one's self in relation to the topic or constructing knowledge about it" (Hall, 2001, p. 72). Therefore, if discourse is not carefully assessed or critiqued, we may be left with an

incomplete, or invalid, understanding of the topic. For example, Fairclough (2010) identified how CDA and neo-liberalism evolved over the same period. The neo-liberal lobby has used a great deal of rhetoric and very particular discourse to push forward its perspective, and CDA was developed as a tool for researchers and advocates to critique those perspectives with other valid perspectives.

Discourse has the capacity to marginalize and act as a form of social control if not carefully reviewed: critical assessment of discourse and the introduction of new discourse can be a tool to remedy existing forms of harmful discourse (van Dijk, 2008b). Fairclough (1989) contends, "people internalize what is socially produced and made available to them" (p. 24). Therefore, there is a need to be mindful of the discourses that influence our perception of society and ourselves. "Discourse analysis aims to remind readers that in using language, producing texts, and drawing on discourses, researchers and the research community are part and parcel of the constructive effects of discourse (Phillips & Hardy, 2002, p. 2).

Critical discourse analysis is utilized in a number of different research fields, including linguistics, political science and others, but it has been most widely adopted in sociology and social work (Hui & Stickley, 2007). "An interest in a particular theoretical or substantive topic, a desire to look at a familiar topic in a new way, or an interest in social construction are among the important reasons that warrant the adoption of discourse analysis" (Phillips & Hardy, 2002, p. 59). CDA however is not a methodology with a defined system of application; it allows for a great a deal of flexibility and tailoring (Poole, 2007; Kendal & Wodak, 2007). Fairclough (2010) and Poole (2007)

emphasize that there are numerous ways one can go about designing a CDA, and new researchers can take a novel approach with their research design.

In designing my Critical Discourse Analysis[5] I turned primarily to the writings of Fairclough (2003; 2010; & as cited in Taylor, 2004) to guide the process. Using these sources I identified some specific features which can be found in texts that contribute to, produce or reinforce discourse. Some of these features were easier to identify than others, but I attempted to identify each feature to the best of my ability in the documents I assessed. The features are listed here:

- **Organization of the entire text**:
  - How it is structured?
  - What narrative does it promote? What tone does it take on?
- **The style of the text:**
  - How it chooses to bold, italicize and position certain sentences, words and ideas
  - The use of graphics, images and quotes
- **Social Events**
  - What social circumstances or events does the text arise under?
  - How are such social events represented? Whose perspective of the social events are highlighted and whose are not?
- **Intertextuality**
  - Which external texts and voices are included in this text, and which are left out?
- **Assumptions**
  - What do the assumptions tell us about the values/perspectives of the text?
- **Language**

[5] At this juncture, I wish to acknowledge Dr. Jennifer M. Poole for personally sending me her 2007 PHD dissertation, which I used to guide the design of my Critical Discourse Analysis (CDA). Additionally, I must credit McMaster Social Work PHD graduate, Yahya El-Lahib, whose thesis I reviewed to further inform my CDA design. The work of both authors introduced me to the various writings of Fairclough, Jager, Wodak, Meyer and Foucault, all of whom I cite throughout my research design and findings.

  - What specific words are chosen? What alternatives could have been used?
  - What phrases, terms, metaphors or clichés are used?
  - How does the text combine sentences and utilize grammar to promote a specific voice and emphasize specific points while minimizing others
- **Evidence**
  - Which academic and research evidence is utilized?
  - Is there justification for the specific evidence utilized over other possible evidence?
- **Audience**
  - Which audience is the text aimed at? How does it address the audience? Why does it address the audience in that manner?

I considered, too, Faircough's (2010) warning that not all discourse analysis is critical, and to be critical it must have the following elements:

1. It is not just analysis of discourse (or more concretely texts), it is part of some form of systematic transdisciplinary analysis of relations between discourses and other forms of social process.
2. It is not just general commentary on discourse; it includes some form of systematic analysis of text.
3. It is not descriptive, it is also normative. It addresses social wrongs in their discursive aspects and possible ways of righting or maintaining them. (pp.10-11)

I attempted to accomplish these elements by specifically looking at strategy documents that have direct influence on school systems and the perspectives of youth. I used the features listed above to dissect the strategies, and ultimately I recommended ways to improve them using the ideologies of MS and CDT.

It should be noted that my purpose in using CDA was political. With regards to conducting a CDA, Fairclough (2013) declared, "the crucial point… is that critique assesses what exists, what might exist and what should exist based on a coherent set of values" (p. 7). I saw it as my responsibility to challenge the dominant discourse of mental health, and bring recognition to marginalized discourses of mental health. This is why I chose to assess the documents using the lenses of Critical Disability Theory and Mad Studies. From my perspective, both of these lenses integrate a value system that prioritizes the needs, desires and concerns of those with lived experience above all else. These values align with my personal values.

The Process and Design

I went about conducting my analysis of 4 selected strategy documents – I indicate the importance of these specific documents below - in multiple phases. First, I read over each document without doing any specific analysis. By doing this, I was able to narrow which sections of the documents my analysis would focus on; this ended up being only necessary for the Federal government's mental health report because of its length. I then reviewed the documents again, this time assessing each document using Fairclough's features (listed above) to identify the discourses that the documents constructed and reinforced. With the identified discourses, I categorized them into 2 groups, based on if they supported a CDT/Mad perspective of mental health, or alternatively, if they supported a medicalized/individualized perspective of mental health. Afterward I reviewed my notes and further narrowed or expanded on the discourse I identified prior.

Lastly, I attempted a comparison between the documents to identify any significant similarities or differences that existed between them.

The Documents

The 'Out of the Shadows at Last' Report

On October 7, 2004, in the Canadian Senate, it was motioned that The Standing Senate Committee on Social Affairs, Science and Technology be sanctioned to study and report on the state of "mental health and mental illness" (Kirby & Keon, 2006, p. xiii) in Canada. The senate then debated the topic, before eventually approving the motion to go forward with the report. This report, which includes a large number of recommendations/strategies for how to address the subject, was completed in May 2006, under the guidance of Senate Chair, Michael J.K. Kirby, and Deputy Chair, Wilbert Joseph Keon. The report was intended to act as a foundation for a new wave of mental health changes to be adopted throughout Canada (Kirby & Keon, 2006).

As far as my research yielded, this was the first comprehensive report and strategy on mental health that was sanctioned and produced under the Federal government. Though there have been federal strategies and reports released since then, such as the Mental Health Commission of Canada's "Changing Directions, Changing Lives" strategy, the 'Out of the Shadows at Last' report was the precursor to numerous provincial strategies, including Ontario's, and subsequently, many school-board, strategies. It is for this reason that I chose to assess this text first.

The report spans approximately 300 densely packed pages. Performing a Critical Discourse Analysis on the entirety of the report would have been an immense task that

would not have been possible for a Masters level thesis. I therefore focused on sections of the report that I believed would adequately capture discourse related to youth, students, schools, and those with lived experience. The sections I chose are as follows: the "Forward", "Chapter 1: Voices of People Living with Mental Illness", "Chapter 3: Vision and Principles", and "Chapter 6: Children and Youth".

The 'Open Minds, Healthy Minds' Report

The provincial "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy"[6] was developed to address child and youth mental health, and had a budget of 257 million dollars. The first phase of the strategy – one of three phases to be released - targeting child and youth populations, was released in June of 2011. Much like the Federal report was a precursor to this strategy, this strategy acted as a precursor to the various school board mental health strategies that have been released since (People for Education, 2012). I therefore analyzed this strategy second, before I analyzed the local (Ontario school board) strategies.

Toronto District School Board

The first school board strategy I assessed was Toronto District School Board's (TDSB) "Healthy Schools, Healthy Relationships: Children and Youth Mental Health and Wellbeing" strategy. The TDSB is the single largest school board in Canada, comprised of 116 secondary schools, and serving over 75,000 students (TDSB, 2004c). I therefore thought it especially important to assess this strategy because more students will be affected by this strategy than any other in Ontario. The strategy spans over 22 pages

[6] From here on will be referred to as 'Open Minds, Healthy Minds'

in length and is densely packed with research, statistics and specific details regarding their plan of action. Published in 2014, it is publically available on the TDSB website.

Niagara Catholic District School Board

The final strategy I assessed was the Niagara Catholic District School Board's (NCDSB) "Mental Health and Addictions Strategy". It would be appropriate here for me to clarify that in Ontario there are 2 primary school boards operating across the province: the Public and Catholic school boards. I chose this strategy because I was born, raised and have the majority of my work experience in the Niagara region, and I wanted to look at a Catholic school board because the TDSB is part of the public school system.

The creation of the strategy was initiated in 2013, when the NCDSB hired a Mental Health Lead to develop the strategy (NCDSB, n.d.). It was completed and approved by Niagara Catholic's Board of Trustees in March of 2015. The strategy was part of the school board's "Vision 2020 Strategic Plan" to improve student achievement and wellbeing. It is in the process of being implemented in Catholic schools across Niagara.

CHAPTER 5: FINDINGS AND DISCUSSION

Canada's 'Out of the Shadows At Last' Report

Setting the Scene

One of textual features requiring attention in CDA, as suggested by Fairclough (listed above), is 'social events', which calls for an examination of the social context that a document arises under. Similarly, Phillips and Hardy (2002) state the importance of making "reference to the social context in which the texts are found and the discourse are produced" (p. 5). I therefore want to begin by considering the circumstances that led to the creation of the Federal government's 'Out of the Shadows at Last' report. Although it is difficult to pinpoint a specific event or motivation that led to the proposal of the federal report – the report itself does not discuss this - groups such as the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), which is "composed of healthcare providers and organizations representing people with mental illness and their families and caregivers" (CAMIMH, 2007), called for a national strategy for many years (Torgerson, 2006). It is also believed that the Romanow Report (a noteworthy report on Canadian healthcare, produced in 2002 by New Democratic Party politician Roy Romanow (Hall, 2016)), which criticized the government's handling of mental health, further persuaded the senate to take action (Torgerson, 2006).

In a study by Torgerson (2006) on the federal report (one of very few academic commentaries on the report I could find), she indicated that the professional bodies, or "actors", with "very strong influence" (rated as 4 or 5 out of 5, on an 'influence' scale) on the report were the Federal Government, The Canadian Psychological Association, The Canadian Pediatric Association, The Canadian Psychiatric Association, and The College

of Family Physicians of Canada. Although she does not specify how or why they had a very strong influence, the title of each of these organizations reveals a direct link to the government or the medical system. Groups with moderate influence (rated a 3 out of 5 on the 5 point 'influence' scale) on the report included The Canadian Mental Health Association, The Canadian Alliance on Mental Illness and Mental Health, and The Mood Disorders Society of Canada; each of which align more closely with the social services and public advocacy sectors. Anti-Psychiatry, Psychiatric-Survivor and Mad groups were not included in the construction of the report.

Mad activists and members of anti-psychiatry movements have called for significant changes to mental health systems, specifically in schools, for many years (LeFrancois et al, 2013; Morrow, 2013; Warme, 2013). They may not have conducted much formal research to spell out the need for change, but they cited personal stories and experiences as evidence to their call for action. These groups, especially the Mad movement, advocated for a complete overhaul of how mental health was framed; minimizing the role of psychiatry, diagnosis and unneeded pharmaceutical treatment, and recognition of the role that psychiatry played in a tumultuous history of mistreatment towards those who experienced mental health difficulties (LeFrancois et al., 2013). Not having such groups' perspectives incorporated in this report, to me, indicates that the government chose to ignore the knowledge base of Mad Studies; the lived experience and knowledge of Mad-identified people. It is therefore important we take note of the preference given to actors such as those from the medical field, to influence the development of this national mental health report by the Senate of Canada.

Understanding the Vision and Intent of the Report

The creation of this report was stimulated by a contingent of senators in the Senate of Canada. In the motion to develop a report, it was stated, "the Committee shall be authorized to *examine issues concerning mental health and mental illness*" [emphasis added] (Kirby and Keon, 2006, p. xiii). The terminology used here is important to note, because it reveals the stated purpose of the report, and conceivably acted as a guide for how the report was constructed. The motion uses the term 'mental illness' – as opposed to just mental health – which is an indication that the committee sees mental health and 'mental illness' as two distinct states of being, much like the medical system does when it labels some individuals as having a disability and others not.

The framing of mental health as a medical topic can further be seen in the Forward to the report. The authors organize the text in such a way that positions psychiatry as the authority on mental health by beginning the Forward with reference to a study about "*psychiatric* services in Canada" [emphasis added] (p. xvii). By essentially beginning the report with an item related to 'psychiatric services', there is a clear partiality for the medical perspective on the topic. Although this may seem insignificant, one should consider why they did not begin this section with the voice of someone with lived experience or the words of a social worker or activist. The framing of mental health as a medical topic can also be seen at a number of intervals in the Forward. For instance the authors highlight how this topic is personal to many committee members, making note of "*mental illness* in our families… *schizophrenia… anorexia… depression*" [emphasis added] (p. xvii): the use of medical and diagnostic terminology is a further

indication of the pathological and diagnostic perspective from which they view this subject.

Finally, in Chapter 3, titled Vision and Principles, the report begins to more explicitly articulate the philosophy that guides the many recommendations it makes. The report states, "In the Committee's view, what is needed is a genuine *system that puts people living with mental illness at its center*, with a clear focus on their ability to *recover"* [emphasis added] (p. 37). Using the term "mental illness" as part of the vision of the committee reinforces the discourse that it is a medical issue. Also noteworthy is the use of the term 'recover', and it's implication that individuals with varied states of mental health need – and want – to 'recover' to a presumably 'healthy' state of mind. Dr. Kim Hopper (2007) identified that the term 'recovery' "remains hostage to a rhetoric of suffering" (p. 876). She expands on this by noting how 'recovery' presumes the existence of a "damaged" (and "undamaged") (p. 877) state of mental health that one needs to be freed from. This perspective conflicts with the perspectives of Mad Studies and Critical Disability Studies, who champion that no single state of mental health is right or wrong, there is simply 'diversity' (Gilson & Depoy, 2002; White & Pike, 2013). This is another example of Fairclough's feature, 'language', and how specific words are used to construct discourse.

The Report's Use of Storying

In Chapter 1 of the report, titled 'Voices of People Living with Mental Illness', the committee utilizes personal stories from Canadian citizens who are impacted by "mental illness" (Kirby and Keon, 2006, p. 1), to demonstrate how the mental health

system has been insufficient for the needs of the population. The committee received over 2000 stories from citizens across Canada. Utilizing commentaries of individuals with lived experiences is something that Mad Studies sees as significant to its philosophy (Poole & Ward, 2013), however, the chosen stories utilized by the authors supports a medical discourse and positions psychiatry as the leading form of support for mental health. The authors begin the chapter citing the story of a woman named Helen Forristall, who exclaims, **"***my doctor told me I had a sick brain just like someone would have a sick heart*" [emphasis added] (Kirby and Keon, 2006, p. 1). Helen elaborates on how she "had to beg my GP to have an appointment with a psychiatrist" (p. 1). Although Helen doesn't accept the systemic mistreatment she's received, she does relate the nature of her struggle to a physical illness. Her story ends with the statement: "I would do anything to have breast cancer instead of mental illness" (p. 2). To me, this story acts as a precedent for the remainder of the chapter as it outlines the story of an individual who has struggled mightily but still accepts her illness label and desires further psychiatric supports to assist in cure and recovery. Of the 2000 plus stories reviewed by the authors, they organize the text in a way that highlights a poignant story that frames the topic from a medical perspective and reinforces an illness discourse of mental health.

Children and Youth

Chapter 6 of the report focuses on 'Children and Youth'. Similar to what we've seen thus far in the report, this section also uses medicalized and pathologizing language to describe the issues faced by children and youth. It notes that there are "1.2 million Canadians who live with anxiety, attention deficit, depression, addiction and other

disorders" (p. 135). This cited statistic, possibly accurate from an empirical perspective, reflects a medical interpretation of mental health. As indicated by LeFrancois et al. (2013), many youth once seen as eliciting a range of different behaviours are being diagnosed with a 'mental illnesses'. Therefore the use of this statistic would likely not be seen as evidence from a Mad or CDT lens. Furthermore, the idea of 'mental illness' as a "*chemical imbalance* [emphasis added]" (p. 140) is included in one of the authors' citations: the idea of mental distresses as the result of 'chemical imbalances' has been generally discredited and implies that there is a 'normal' chemical balance in the brain (Kemp, Lickel & Deacon, 2014). The authors' choice of words and evidence here again frame mental health a biological and medical topic. The report also makes the argument that **"***When symptoms of distress or illness first appear* [emphasis added] in a child or young person, regardless of age, family caregivers, health professionals and educators should intervene immediately*"* (p. 136). This statement is worth noting for two reasons. Firstly, the use of the term 'symptom' is a medical term, which implies that there are exclusive indicators of a 'mental illness' that are not present in healthy individuals. Secondly, rather than offering education, building mental health literacy, developing programs that improve the mental health of all youth or making supports easily available, the authors suggest 'immediate' intervention, as though all youth who subjectively present any 'symptoms' are in crisis.

In section 6.3, the report seeks to address the "shortage of … mental health professionals" (p. 148) available to youth. They however place emphasis on the shortage of child psychiatrists and delays in children and youths' access to psychiatric services. They later add, "shortages of *other* [emphasis added] mental health professionals… must

also be addressed" (p 148). The authors clearly organize this section in a way that places psychiatry as more legitimate or important than other mental health professionals, such as social workers or psychologists. Interestingly, of the 21 professionals cited in this chapter, 12 were either doctors or medical professionals; a decision that further frames the medical field as the experts on the subject of mental health. Perhaps not surprisingly, many of their observations and recommendations are rooted in a psychiatric perspective on mental health. For example, when Dr. Nasreen Roberts is quoted in section 6.3, 'Shortage of Child and Adolescent Mental Health Professionals', her words focus on the shortage of child psychiatrists and the "800,000 kids across Canada" with "severe" disorders (p. 148).

In section 6.4, 'Inclusion of Youth and Family Caregivers in Treatment', the authors cite the importance of considering youth and family as "collaborators" (p. 152) in the design and decisions regarding treatment. Such consideration falls within the framework of Mad studies, which promotes that individuals who have experiences with mental health distresses should be the ones whose voices are given the most weight (Church, 2013). However, this recommendation is buried deep within section 6 of the report, and is less than half a page in length (compared to section 6.3, which is almost 5 pages in length). I feel this gives the impression to the reader that it is not as important as the numerous preceding sections that stress the importance of medical professionals and interventions. Additionally, at the end of this section, where the committee makes recommendations based on the research, nowhere is it noted that youth and families be involved in the decision making process. It only suggested that family members be offered support – via family therapy – and training on how to work with their struggling

youth. There is a disconnection between the committee's earlier stated beliefs and their actual recommendations.

Glimpses of Non-Medical Perspectives

In section 1.3, the report covers "What are Individuals with Mental Illness Asking For?" (p. 6). This section gives attention to how social and economic factors, such as poverty and inadequate housing, are contributors to poor mental health in individuals. Once again, in section 3.1.3, "The Mental and Physical Dimensions of Illness" (p. 40), the authors assert, "it is extremely important to stress the significance of… social determinants of health" (p. 41). This focus on social determinants of health certainly aligns better with CDT and Mad lenses of mental health because of the focus on environmental and social factors, rather than individual factors. Unfortunately, neither section is thoroughly developed or elaborated on by the authors nor do we find mention of social determinants of health in the other sections of the report I assessed.

In section 3.1.2, "Some question of language" (p. 38), the authors touch on the need for a potentially broader approach to mental health than is in place. They include the following statement from an individual with lived experience, named Jocelyn Green:

> "The formal mental health system is still *too hierarchal and pathology-based* [emphasis added]. Yes, obviously, there are severe, legitimate mental illnesses that need treatment and medication, but I think *we often fail to factor in the systemic roots of many mental health problems, such as poverty, abuse, discrimination, the lack of child care and affordable housing* [emphasis added]. I

> think if a lot of those issues were addressed, certainly a lot of the people that are coming through our formal systems would not need to be there" (p. 39-40).

This quote poignantly hits on ideologies that are promoted by CDT and Mad perspectives, such as the need to consider power structures, systemic inadequacies and the pathologization of mental health. From my perspective, the ideologies presented in this quote could justify the production of an entire chapter, or even a separate report. However, the authors do not elaborate on the quotation, and immediately move forward to a new topic on language. The authors' decision to only devote 3 sentences (not even their own words) seems to suggest that they wanted to included this alternate perspective of mental health to pacify any advocates or groups that called for such perspectives to be acknowledged. Furthermore, the authors may have anticipated various mental health groups and professionals, with a range of perspectives, as audiences of the report, and thus might have thought the inclusion of this quote – like the stories of people with lived experience – would satisfy those groups.

In section 3.2, the committee emphasizes their commitment to building a mental health system on the basis of recovery principles: "The Committee believes that recovery must be placed at the center of mental health reform" (p. 42). Building on this perspective, they note that recovery emphasizes a shift away from 'illness' and a focus on 'wellness'. As I noted earlier, this is not necessarily true of 'recovery' rhetoric, which informs service users that they are unhealthy or "damaged" (Hopper, 2007, p. 877). Additionally, the report goes on to define recovery as a "way of living a satisfying, hopeful, and productive life *even with limitations caused by the illness* [emphasis added]; for others, recovery means the reduction or complete remission of *symptoms related to*

mental illness [emphasis added]*"* (p. 42). We see again the report's attempt to bring in non-pathologizing perspectives – with a focus on 'wellness' rather than illness – but it quickly reverts back a pathologizing framing of mental health. The words 'limitations caused by the illness' are in direct contradiction to a critical disability perspective, which focuses on the disabling environment and social structures.

Overview and Implications

Upon analysis of the federal government's 'Out of the Shadows' report, there is an observable framing of mental health as a medical or psychiatric matter. There are some recommendations made, and thoughts shared, that align with non-medical perspectives, but there is a continuous reversion back to the medical perspective. Almost all of the recommendations offered in the report target individuals who have identified 'symptoms' or a 'diagnosis', which reflects an assumption that 'symptoms' are always detectable and that individuals see the psychiatric system as the most competent when it comes to addressing mental health struggles. No strategies are offered for individuals who do not seek help because they prefer not to be given a diagnosis or medical intervention. All the recommendations are treatment or intervention oriented, and apart from improving mental health education more broadly (section 1.4), no references are made to how an environment, such as the school, or social structures can be addressed.

The report does acknowledge that mental health policy and strategy for children and youth should use school as a medium to reach such groups. They recommend that teachers be given training to support youth who may be struggling with their mental health, but the focus on such training is on identifying mental health issues and

connecting students with professionals outside of the school, and not on how to construct a classroom culture or environment that promotes mental health. Similarly, the committee does not make recommendations on how school structures could be changed to become more supportive, for instance, through reduced classroom sizes which, as outlined earlier in this thesis, is important for the emotional health of both students and teachers (Brown & Rushowy, 2015; Froese-Germain, et al. 2002).

Apart from a few references made to social determinants of health, there is a general silence on how the individual is influenced by the environment. The idea that an environment can be disabling is seldom explored and this helps reinforce the dominant discourse that mental health is caused by a biological deficit and is to be addressed at the individual level by medical professionals and interventions.

Ontario's 'Open Minds, Healthy Minds' Strategy

Setting the Scene

The background and context of Ontario's 'Open Minds, Healthy Minds' strategy is difficult to pinpoint. The strategy itself does not provide a background for how or why it was constructed at this particular juncture of time, and it does not include a reference page or footnotes that indicate from where it extracted its information or recommendations. Similarly, on the Ontario Ministry of Health and Long Term Care (OMHLT) – the body that funded and conducted the report – website (2015b), which is where the report can be found, there is no reference made to the background of the report. Nonetheless, the OMHLT itself is a health care focused department, and this should be an indicator of the medical lens it will likely approach this report from. Upon further

digging, I was able to locate a short review of the strategy, produced by Jason Guriel (2013) of the Centre for Addictions and Mental Health (CAMH), where it is indicated that the report is a response to "recommendations from the Ministry Advisory Group for Ontario's mental health strategy" (p. 1), which was composed of "experts from the field, service providers and people with lived experience" (OMHLTC, 2010). This raises the question: why doesn't the strategy explicitly state how it came to be or where its source material emerged from. Considering that the audience of the report is likely to be the public, news sources, and school professionals, it is certainly possible that the government wished to take credit for the material presented in the report as a way of appearing competent on mental health topics. Not including references in a document would not be acceptable from an academic lens, and of the four reports assessed in this strategy, this was the only one to not provide at least some references.

Sticking to the Status Quo

In the Introduction section of this provincial level report, the authors outline how this mental health strategy is intended to be a "*comprehensive approach* to *transforming* the mental health system" (Minds, 2011, p. 4). Specifically for child and youth mental health, they declare an intention to reduce wait times and increase access to services, improve early intervention supports, and close service gaps. Counter to their earlier stated desire to 'transform' the mental health system, they later assert that they don't intend to alter the existing mental health system or the way services are offered, but only make the existing system more efficient and effective. We see conflicting discourses present here. Firstly, they create the impression for the reader that this shift will be

transformational, which I interpret as language use designed to satisfy those who are unsatisfied with the current mental health system. Secondly, the assertion that the current mental heath system only needs fortification reinforces the discourse that the medical approach to mental health, which Ontario's system is largely built on, is still the best approach to the subject.

Many of the goals and objectives outlined in the strategy suggest an alignment with Mad and CDT ideologies, and even support discourse that is counter to the medical model, however the practical methods that the strategy proposes to achieve these objectives and goals is simply by reinforcing traditional methods. One of the first goals outlined in the strategy is to "create healthy, resilient, inclusive communities" (p. 12). Within this goal the authors highlight the importance of social determinants of health such as "education, employment, income and housing" (p. 12) and the need to "build healthy communities that promote mental health" (p. 12). To achieve these targets they propose "reducing stigma and discrimination" (p. 12). When they detail how to reduce stigma and discrimination they simply propose implementing "*more* [emphasis added] mental health promotion and anti-stigma practices" (p. 12), and making services more culturally competent. Additionally, to achieve their objective of "creating community hubs for activities and services" (which is a novel and important idea), the only recommendation suggested is to "incorporate mental health and addiction supports throughout the communities in which people live…" (p. 13). Both of these recommendations, which are vaguely described, focus only on adjusting or building on existing programs and services, rather than actually 'building healthy communities'. It's hard to see how any of the recommendations offered truly address their stated goal of

building healthy or inclusive communities, or it may be that the strategy does not provide enough detail. Also there is no evidence provided in the strategy that supports that these methods are adequate to achieve the state goals and objectives.

Guiding Goals

The authors outline four goals they will use to guide any recommendations that direct the policy and programs they recommend in the strategy. The first goal, to "improve mental health and *wellbeing for all Ontarians*" [emphasis added], supports a discourse that suggests that all individuals can struggle with their mental health, and all individuals have the capacity for wellbeing. This aligns with a CDT lens because it suggests that there exists a diversity of mental/emotional constitutions, not just 'healthy' and 'ill', or 'normal' and 'abnormal'. The second goal, to "Create *healthy, resilient, inclusive communities*" [emphasis added], contains some conflicting discourses. The notion that healthy and inclusive communities are a key stimulus of mental health supports a CDT and Mad lens. Yet the inclusion of the construct of 'resilience' suggests that an individual's lack of resilience is what potentially led to their experiences of mental health distresses. It reinforces an individualizing discourse, stemming from neoliberal ideologies, as it takes the responsibility off of the government and places it on the individual to prevent/recover from mental health struggles. The 2 goals that follow align closely with an individualized and medicalized perspective on mental health. The first of these goals, "Identifying mental health and addiction problems early and intervene" frames mental health distress as something that requires intervention, and suggests that 'mental health problems' can objectively be defined. It also carries the

assumption that early detection/intervention techniques are what are needed to improve mental health in the population. This goal supports a scientific understanding of mental health. The final goal, "Provide timely, high quality, integrated, person-directed *health and other human services*" [emphasis added], again positions the healthcare field as the foremost form of support, ahead of 'other' supports.

Treating Mental Illness like Physical Illness

In the section titled "Open Minds, Healthy Minds" (p. 4), the Ontario government begins to more clearly articulate the framing and assumptions that underlie how it views mental health. To begin, they assert that Canadians reach out to "our health system" (p. 5) when physically ill, and assert, "it's time to take the same approach to mental health" (p. 5). They very firmly fortify a discourse supporting that mental health is a healthcare topic and that the health care system is best suited to address mental health distresses. The authors go on to note that medical "treatments" (p. 5) have made significant advancements over the decade, but do not specify what such 'treatments' are, or why they are better than before. The notable lack of evidence here can mislead the reader/audience into thinking that science is moving closer to a 'cure' for 'mental illness'. It conveniently overlooks antipsychiatry evidence that the psychiatric system can do more harm that good, or the CDT perspective that 'mental illness' is a disability created by the social and environmental composition of our society. Even the insinuation that mental health and physical health are comparative topics suggests to the reader that healthcare system should be utilized for support with mental health.

A further indication of how the strategy links mental health to physical health is its stated alignment with the "Excellent Care for All initiative" (p. 6). This initiative, which is an evidence-based healthcare delivery model initiated by the OMHLTC – the same government body that conducted this mental health strategy -, was designed for use in hospitals and healthcare settings, and refers to mental health service users as "patients" (OMHLC, 2015a). Seeing as most mental health services are now offered in community settings, there is an assumption here that this model can be effectively used in the community. It also clearly reinforces the discourse that mental health is a healthcare concern and once again positions the medical field as the foremost authority on the subject.

Putting the Onus on the Individual

To achieve their stated goal to improve mental health and wellbeing for all Ontarians the strategy proposes "improving mental health literacy" (p. 10). The strategy defines 'mental health literacy' with individualizing ideology. For instance, it recommends that people be taught the skills "*they need to improve their* mental health and the *factors that put them at risk* – such as *stress, a loss, or lack of self-esteem* [emphasis added]" (p. 10). The use of the term 'their mental health' suggests that mental health is an individual concern that a person has direct control over. Furthermore the mention of 'they need to improve… factors that put them at risk again suggests that these 'factors' are in the individual's control and are self imposed. It completely removes the government or society as the cause or influence of these 'factors'. Additionally, none of

the factors mentioned that 'put them at risk' are environmental, structural or social risk factors, such a marginalization, poverty or unsupportive social cultures.

3 Year Plan- Child and Youth

In the final section of the strategy, the authors outline a scheme to address child and youth mental health, which is the priority for the first phase of the 10 year mental health strategy (phase 2 was released in 2014 and the final phase will be released in the coming years). They emphasize three goals, which they believe will drastically improve youth mental health: "providing fast access to high quality service", "Identifying and intervening… early", and "Closing critical service gaps" (p. 7-8). What's apparent in each of these strategic points is that they are only applicable to those youth who reach out for help voluntarily or have been identified as having a mental health concern and referred for service. This is noteworthy because it ignores the portion of students that do not reach out for help because they do not desire the interventions that are commonly offered (Leahy, 2015; Mulvany, 2000; Waddell et al., 2005b). Once again, none of these goals attend to the environmental or social structures in schools as a way to improve the mental health of all students, such as creating an inclusive environment, which was one of the original goals of the strategy.

The second stated goal, improving early identification and intervention techniques, is intended to offer support to students before their mental health distress does "too much harm" (p. 22). Much like we saw earlier, the discourse supported here is that early identification is possible, and that students, who are identified, will be receptive to medicalized supports. However, evidence shows that early identification is difficult,

and students are commonly not receptive to support (Leahy, 2015), especially when the support is medical or psychiatric in nature (Waddell et al., 2005b; CAMIMH, 2007).

The final goal, "Closing critical service gaps…" (p. 23), attends to how to serve vulnerable and hard to reach youth. The first suggestion offered is expanding telepsychiatry services, which are used to connect youth to a psychiatrist or medical professional when they don't have access to one. This suggestion was also made in the federal report and similarly positions psychiatry, and the expansion of its reach, as a primary strategy to reaching more youth.

What is as important as the content included in this section is that which is absent from it. There is no suggestion of including youth, especially those with lived experience with mental health difficulties, in the execution of the strategy. This specific feature is central to Mad Studies. For instance, they cite the need to implement a service known as "Working together for Kids' Mental Health" (p. 22), where agencies, school staff, and healthcare collaborate on how to better assess children and youth. Seeing as youth arguably have the deepest understanding of what life circumstance and social structures in schools disable them and cause the most emotional distress, it is of concern that they are not given a voice here: not providing youth the power to drive change, it reinforces a power structure that informs them that they do not possess valuable knowledge, nor are they capable of working with others towards change. Professionals, including healthcare professionals are positioned as knowing what is best.

Overview and Implications

The Ontario 'Open Minds, Healthy Minds' strategy choses to reinforce the already dominant discourse of mental health: the perspective that mental health is a

medical concern and is best suited to be addressed by the healthcare field. Many of the strategies it recommends look to build individual resilience and coping skills, citing these as the key reasons that individuals succumb to mental health difficulties. Apart from some mention of reducing poverty and addressing housing, no responsibility is owned by the Ontario government for policies or social structures that, in failing to adequately address poverty and lack of affordable and safe housing, may contribute to mental health distress in individuals. The strategy does identify schools as an important location to address mental health difficulties in students, but does not explore how school environments or social structures can be improved to support emotional needs of students.

The report utilizes a great deal of language that would however suggest a critical focus on improving social structures and environments to support good mental health. For instance they mention the need for 'healthy', 'positive', and 'inclusive environments', but offer scant information and irrelevant methods to achieve these. Additionally, the lack of any evidence or research to fortify its recommendations suggests that they may not have been thoroughly researched or academically validated. The implications for schools that use this strategy to guide their own mental health strategies is that they may employ interventions that are not backed by evidence and will thus continue to frame mental health difficulties as a personal deficit caused by, for instance, a student's lack of resilience or personal ability to cope. Lastly, the strategy does not offer a voice to students. Resultantly, students will be bystanders in identifying what is causing their emotional distress and determining what interventions should be used to address it.

Toronto District School Board Strategy

Setting the Scene

The TDSB's mental health strategy was sparked by a 2011-2012 student and parent census (Toronto District School Board [TDSB], 2014b), which revealed that over 70 percent of secondary school students worried about their future, and over one third reported feeling "nervous" or "anxious" most of the time. In addition, the census found that more than 20 percent of TDSB students reported "feeling down" the majority of the time (Fox, 2014). There are a couple of features to note about the discourse that is promoted with the use of this census. Firstly, the census provided students with a confidential and direct medium through which they could self-report emotions. Although this method may not be perfect, I would argue that this aligns with the tenets of Mad Studies, because students are given a voice and opportunity influence change. This especially appears to be a step forward when compared to the federal and provincial recommendations of 'identifying' (singling out) students who present 'symptoms' and then 'intervening'. Secondly, the language used in the census is significant because instead of asking students to self identify with medical diagnoses such as 'depression' or 'anxiety', the census uses descriptive terms, such as "feeling down" or "nervous", which are emotions that every student can potentially relate to.

Setting the Stage

The title of the report, 'Children and Youth *Mental Health and Wellbeing* [emphasis added]**:** Healthy Schools, Healthy Relationships', is unique when compared to the previously assessed government documents because of its emphasis on health and

'wellbeing', as opposed to 'illness'. The focus on wellbeing continues in the Introduction, where Director of Education (DE) Donna Quan, provides the purpose and significance of the TDSB strategy. In this Introduction she states, "mental health and well-being impacts everyone and belongs to each of us" (TDSB, 2014a, p. 3). Her statement frames mental health as something that implicates all of society, which challenges the notion that it is an individual, deficit-based, subject. It suggests that everyone experiences states of mental health and anyone is capable of experiencing wellbeing: it does not imply that some of us experience mental health and others 'mental illness'. Also noteworthy is the subtitle of the report, 'Healthy Schools Healthy Relationships', which Mrs. Quan expands on: "creating Healthy Schools Healthy Relationships will help *create a culture* [emphasis added] where mental health and well-being is integrated into every aspect of our students' school experience" (p. 1). The emphasis on 'creating healthy schools' and creating 'a culture' aligns closely with the tenets of CDT because it acknowledges the interconnection between the person and environment. Moreso, Mrs. Quan's specific choice of language infers that the school environment and culture are the most significant factors in the mental health of students.

Mrs. Quan was likely aware that this report would be publicly published and that school board employees would be exposed to the report, especially since local new sources would be covering its release. It is thus noteworthy that her words reinforce a discourse which locates schools as central to the mental health of students. This is significant because traditionally schools resisted the idea that they were anything beyond educators (Adelman & Taylor, 2006). She is explicitly informing school workers, and the public, that schools' impact on students goes beyond their academic education.

Within the strategy's "Mission, Vision and Commitments" (MVC) (TDSB, 2014a, p. 5) we can identify additional language and ideology that supports MS and CDT discourses. In this section, the report identifies students as "key stakeholders" that "shapes our understanding" (p. 5) of how to address mental health. These thoughts support both a Mad and CDT lens because they give power to the voices of those who have personal experience. Much like Mrs. Quan stated in the Introduction, this section of the report asserts a need to construct a "board-wide culture… where mental health and well-being is integrated into every aspect of each student's school experience" (p. 5.). They add to this need for a supportive culture, and a CDT discourse, by stating that student mental health is "a shared responsibility" (p. 5). Mrs. Quan appears to be framing student mental health as something that is interconnected with the school environment. Her words openly challenge the neoliberal and medical perspective that 'mental illness' is an individual issue.

Definitions of Mental Health and 'Mental Illness'

As we move into the actual strategy, we see that it is rich in research and information from a variety of sources. Some of the cited research promotes illness or disorder-based framing of mental health, while other citations promote more of a wellness framing of mental health. The report cites a document from UNICEF, which uses medical terminology: "*Early signs of mental disorders* frequently appear in adolescence yet they are often *undiagnosed or go untreated*" [emphasis added] (TDSB, 2014a, p. 2). However they also cite the WHO definition of mental health, which is wellness-oriented, stating that mental health is a "state of *well-being in which every*

individual realizes his or her potential, can cope with the normal stresses of life, *can work fruitfully*, and is able to make contributions to his or her community" [emphasis added] (p. 2). Although the 'wellness' framing does appear to be prominent, it must be noted that the WHO's definition does contain elements of individualizing discourse, which appear to stem from neoliberal ideologies. For instance the emphases on 'work' and 'contribution' reflect the neoliberal subscriptions to a capitalistic society where everyone adds to society economically. Furthermore, the subtle implication of the WHO's definition is that everyone's goal should be to work and if you aren't working then you aren't achieving your 'potential'.

Achieving Its Goals

After presenting their research and outlining their mission, vision and commitments, the authors articulate how they will implement the strategy over the first 3 years of its implementation. The report features four specific objectives that will be used to achieve the goal of "creating mentally health schools" (p. 11). The first objective, "Providing Quality Services and Programs", is to be achieved by increasing professional development for staff. The second objective of creating "A Caring School Culture and Healthy Physical Environment" will be effected by establishing wellness teams that will oversee increasing library resources and opportunities for all students to engage in extracurricular activities. The third objective is to develop "A Supportive Social Environment" by reducing mental health stigma within the school environment. The last objective, the development of "Parent and Community Partnerships" with the school, will be accomplished by increasing communication between the home and school. These

objectives, once again, reflect the priorities of CDT because of their focus on the physical environment, school culture, integration of the community, and inclusion of students in the delivery process. However the practical methods used to execute the strategy do not align with such a lens in my opinion. I expand on this below.

High Quality Services and Programs: To achieve the goal of introducing 'High Quality Services and Programs' to the school, the strategy specifies that training will be mandated to all staff on the "Foundations of Mental Health" (p. 13) – an online course – and other modules on "*anxiety, depression…*" [emphasis added]. The details of a 'Foundations of Mental Health' training are not provided, nor any evidence of its efficacy, so it's difficult to assess the training. However, the strategy's focus on 'anxiety' and 'depression' indicate that the trainings have at least some tie to diagnostic or medical understandings of mental health, which could influence how teachers and staff come to understand mental health.

A Caring School Culture and Healthy Physical Environment: The TDSB strategy outlines a plan to establish "Mental Health Teams" (p. 15) that oversee and facilitate changes to create a 'caring school culture' and build a more 'healthy physical environment'. These teams would look to establish more school clubs, provide learning sessions "for staff and parents" (p. 13), and create spaces for student to engage in healthy lifestyle activities. It indicates that these mental health teams "*may* [emphasis added] include… students" (p. 15). This non-commitment to including students directly conflicts with the strategy's stated mission that students would be "key stakeholders"

whose "voice shapes our understanding of how we ensure mental health is a priority" (p. 5). A MS lens would demand that those with lived experience and those most affected – in this case, students - should be the central voice in any changes or interventions (Church, 2013). Not incorporating students validates an existing discourse that students are not as capable as adults (parents and educators) to make important decisions regarding their own health and wellbeing.

A Supportive Social Environment: The TDSB report states that it will utilize anti-stigma programs as the primary tool to create a 'supportive social environment'. The assumption here is that targeting stigma will create this desired environment, which evidence does not support. Recent work by Poole et al. (2012), who represent Mad Studies, make the case that just addressing stigma is "too limiting" (p. 21), because it does not address actual discrimination faced by those with 'mental illness'. Poole et al. (2012) a suggest a shift in focus from reducing stigma to curbing any form of 'discrimination' directed at the psychological composition of an individual; such forms of discrimination are referred to as "sanism" (p. 20). Chamberlin (1990) notes that sanism exists as societal beliefs that individuals with a diagnosis are "(i)ncompetent, not able to do things for themselves, constantly in need of supervision and assistance, unpredictable, violent and irrational" (p. 2). Therefore, unless the anti-stigma initiatives address sanism in the school system, the goal of building a 'supportive social environment' will likely not be realized. Therefore, the TDSB's approach may not be informed enough to achieve its goal.

Overview and Implications

The TDSB strategy utilizes language that aligns with CDT and MS perspectives by framing mental health as something that affects everyone and is rooted in social, structural and environmental factors. The DE, Mrs. Quan, firmly establishes a social lens of mental health, citing the need for a wellness culture, whole school approaches to mental health, and including students in the construction and delivery of interventions. These are indications that the TDSB does not subscribe to the illness, deficit-based and individualized discourse of mental health. However, this lens of mental health begins to loosen the deeper the strategy is delved into. There is a disconnection between the language used in the earlier part of the strategy and the actual plans and interventions proposed by the strategy. For example, the school planned to offer training to staff that appears, at least in part, to be influenced by a psychiatric lens and diagnostic terminology. Another example is that the strategy does not definitively offer opportunities for students, especially those with lived experience, to be involved in the design and intervention delivery processes in schools. Finally, the selected method for creating healthy school environments - addressing 'stigma' - is not sufficiently backed by research evidence. Although the strategy itself frames mental health as socially/environmentally influenced through its use of language, this will likely have little impact on how students understand mental health, because the practical methods outlined in the strategy do not support this framing.

Niagara Catholic District School Board Strategy

Setting the Scene

I was unable to locate or identify any information on what led to the development of Niagara Catholic District School Board's (NCDSB) mental health strategy. Neither the strategy itself, nor the NCDSB website present any background on the development of the strategy, or what social context it arose under. What is also perplexing is that I also could not locate any news coverage of the strategy. One thing that is clear, which I expand on later, is that the strategy was influenced by Ontario's mental health strategy as it references content directly from the provincial strategy. Prior to completing this CDA, I expected to see evidence of the federal strategy's influence on the provincial strategy, and the provincial strategy's influence on the school board strategies, however this was the first (and only) explicit connection I've seen made between the 4 strategies I have assessed. This suggests that there may be a disconnect in the influence that higher levels of government have on the lower levels with regards to mental health.

Inclusive Culture

The strategy begins with a "Message from the Director of Education" (NCDSB, 2015, p. 1). The Director, John Crocco, speaks about the importance of having a school community where there is a "sense of belonging" (p. 1). He expresses a desire for schools to be a "community" where the "suffering" of one student is the responsibility of everyone. This message is similar to what we saw in the Introduction to the TDSB strategy. It aligns with both the CDT and MS perspectives in that it promotes an inclusive social culture, where 'community' trumps 'individualism'.

Defining Mental Health

The strategy references a number of research papers in an attempt to define mental health and 'mental illness'. The definitions used centre around the mental health "continuum" (p. 3), which categorizes different degrees of mental health distress: "well-being", "emotional problems" and "mental illness" (p. 2). Although the 'continuum' does not subscribe to a binary ('healthy' or 'ill') lens of mental health, it does utilize a hierarchical medical framing, as it informs individuals that they have a 'mental illness' if their emotional distresses become significant beyond a certain point – if they deviate too far from the more desired 'well-being'.

Open Minds, Healthy Minds

The NCDSB strategy dedicates an entire page to discussing Ontario's 'Open Minds, Healthy Minds' mental health and addictions strategy. This page centres on one specific excerpt from the Ontario strategy, which supports an individualizing and neoliberal discourse of mental health: "People who feel good about themselves and their lives are *more productive and less likely to take sick days*. Ontarians must know how to manage stress and enjoy *work-life balance*. They need constructive ways to deal with negative emotions such as anger, sadness, fear and grief" [emphasis added] (p. 3). The excerpt uses specific language, such as a 'more productive' and 'work-life balance' to highlight the importance of contributing to the economy and features the importance of not taking sick days. Similarly, the excerpt indicates that 'Ontarians' need to learn how to manage the various stresses and circumstances that present themselves in life. Behind this excerpt is the notion that any failure to maintain one's mental health is because they lacked the ability to manage their emotions. It ignores the stress inducing structures of

society, schools and the workplace, which contribute to an individual's compromised mental health.

Also striking is placement of an employment-focused excerpt in a school mental health strategy. It suggests that the role of the school is to produce an effective workforce that contributes to the economy, and in order to do this, individual students need to be taught how to deal with difficult emotions. It's significant to see how the neoliberal ideologies and discourse presented in the provincial strategy have filtered into a local school board strategy. This may serve as evidence of how discourse used at upper (government) levels impacts discourse at the lower (local) levels.

Tier One of the Strategy

The NCDSB strategy uses a 3-tier approach to implement its mental health goals. The first tier, "Promotion" (NCDSB, 2015, p. 6), aims to bring awareness of mental health topics to schools in the region. For this first tier, lesson plans are to be rolled out in grade 9 religion classes. The potential lesson plans include: "Mental Health and *Mental Illness*", "The Stigma of *Mental Illness*", "The Triple A: *Anxious About Anxiety*", "Letting Go of *Anxiety*" and "*Self Care Kits* and *How to Cope*" [emphasis added] (p. 6). There is an overriding trend of focusing on medical and illness discourses, rather than wellness. None of the lesson plans listed suggest a focus on strengthening school culture or building more accepting environments for students. Similarly, the lesson on 'self care' and 'coping' suggests that students are personally responsible for maintaining their mental health, and that experiences of emotional distress are the result of the student not engaging in enough self care or effective coping mechanisms.

Tier One also outlines a number of other programs. Some are faith based, others are focused on life skills and physical education, and some are aimed at parents. Of the 10+ programs listed, only one targets the environment or "school climate" (p. 9): the "Safe and Accepting School Teams". This program looks to reduce bullying by providing schools with survey information from students, teachers and parents. There is a very obvious minimizing here of the role that school structures, environment or culture play in a student's mental health. Conversely individual-focused interventions are predominant.

Tier Two of the Strategy

The second tier of the NCDSB strategy is titled "Prevention" (p. 10). As you read this section it become apparent that the NCDSB equates 'prevention' with early identification and intervention. In constructs a discourse that the seed of 'mental illness' inherently exists in certain students, and all that needs to be done to 'prevent' distress in students is to utilize "identification/screening tools" (p. 10) that can be used to locate students with specific "mental health needs" (p. 10), and then connect them to services. These 'identification/screening tools' are in the form of "questionnaires" and "surveys" (p. 10), such as "Child and Education Needs and Strengths". Each of these surveys focus on "identifying students with potential health needs" (p. 10), but do not try to determine why students do not reach out for help in the first place, or how to create an environment where students feel comfortable reaching out.

Tier Three of the Strategy

The final 'Tier' of the NCDSB strategy is titled "Intervention" (p. 12). This section begins with information on how "social workers" will be involved in mental health intervention. Although this is the only strategy to have explicitly identified the role that social workers can play, it draws out the role of social workers out in a very medical and clinical manner. For instance it notes how social workers will work with students "whose *clinical* presentation is appropriate for *treatment* in schools" and offer "*clinica***l** crisis intervention", "provide psycho-social assessments and develop *treatment* plans" [emphasis added] (p. 12). It later notes how "Mental Health and Addictions Nurses" will "consult with school staff regarding a *mental health diagnosis*" [emphasis added] (p. 12). Each of these interventions, including their descriptions, support a medical lens of mental health, and situates the medical model as the primary mode of intervention when it comes to mental health distresses. It also defines social workers as clinical interventionists who operate from a healthcare perspective.

There is only one program/intervention outlined by NCDSB that aligns with a MS and CDT lens. This program, developed by the Niagara Region Public Health Department is known as Youth Net. This program is a "mental health promotion and early intervention program run by youth for youth", which creates forums for youth "to discuss their opinions on mental health, the issues they face and how they deal with these issues" (p. 14). This program promotes the creation of a safe environment, developed and facilitated by students, allowing for the open discussion on mental health.

Overview and Implications

This strategy, similar to that of the TDSB, initially speaks of the importance of addressing culture, climate and environment in schools to support the mental health of

students, but once analyzed, the fingerprints of a medical and individualizing perspectives are readily observable. The strategy defines mental health using the 'mental health continuum', which implies that significant distress in mental health constitutes a medical 'illness', and denotes that this position on the continuum is undesirable and non-normative. Though there are some thoughts on how to address bullying culture in schools, there is almost no focus on how to change the school culture, structures or environment to improve mental health outcomes for students. The majority of the ideologies shared in the strategy focus on building the individual's capacity to overcome mental health difficulties, or identifying individuals who may be susceptible to, or may be experiencing 'mental illness'. Additionally there is strong use of clinical and illness language, which frames mental health as a medical issue, and positions the medical profession as an authority on the topic. The implication of the way the NCDSB frames mental health is that students will likely see their emotional struggles as deficits or products of their own lack of coping skills or efforts. Students will be uninformed of how the environment, institutional structures or school culture play a role in their mental health struggles, and will be referred to social workers who, under the terms of this strategy, must necessarily reinforce medicalized assumptions

Research Questions

At this point it is beneficial to revisit the original 'research questions' and discuss them in the framework of what was found when analyzing the mental health strategies.

RQ1: *How do federal, provincial, and local (school board) mental health strategies frame mental health and mental illness?*

The federal government's strategy positions psychiatry and medicine as the highest authority on mental health. It frames mental health as, primarily, a medical issue that should be tackled by targeting specific individuals who have been identified or diagnosed as 'mentally ill'. The provincial strategy endorses the idea that the traditional medicalized system of working with mental health just needs to be fortified with more resources. Although this strategy uses very little pathologizing language, it likens 'mental illness' to physical illness, and frames 'mental illness' as a individual concern that is exacerbated by that individual's lack of resilience, distancing itself from any responsibility in the mental health of the population. The TDSB strategy utilizes language that critically frames mental health as something that can affect anyone and is tied to social and environmental factors. However, the practical interventions it purposes approach mental health as an individual concern, and offer few specific plans to improve social or environmental features in schools. Lastly, the NCDSB strategy mentions the impact of social and environment factors as contributors to mental health difficulties in students, but it uses a great deal of clinical terminology and, like the national strategy, positions the medical field as the authority on mental health. It too frames the individual as the source, and solution, of mental health difficulties, much like the provincial strategy does.

My analysis yielded that a medicalized and individualized framing of mental health is dominant in each strategy - with arguably the exception of the TDSB strategy. The primary focus of each strategy – again, with some exceptions - is that the individual

is responsible for their distresses in mental health. There is very little onus taken by the government bodies or school boards to improve the physical or social environments that may impact the wellbeing of students. This is the case, I believe, for two reasons. Firstly, the general public have been told for a long time that mental health distresses are a medical matter, or more recently, the result of a deficiency in coping skills or resiliency (Howell & Voronka, 2012). Secondly (this relates to the first reason), there would be significant costs associated with governments or school boards having to make amendments to the school environment necessary to realize significant change. For instance, decreasing class sizes would require the hiring of more teachers and in some cases building more classrooms in schools (Biddle & Berlinder, 2014). This is just one of a number of possible physical and social amendments that could be made to improve student mental health; there would presumably be a cost associated with any other identified amendment. The neoliberal framework, which our society increasingly subscribes to, suggests that the more efficient method to improving mental health is by making it the responsibility of individual (Teghtsoonian, 2009), and thus, whether intentionally or not, the neoliberal rhetoric of individual responsibility has garnered additional support from each of the strategies.

It should be made clear that in each strategy there are hints of ideology that present mental health distresses as more than a medical or individual subject. This was particularly evident in the TDSB strategy. Each strategy however ultimately reverts back to the traditional (medicalizing and individualizing) lens of mental health. It may be the case that we are seeing a slight shift in social understanding of mental health, but apparently not enough for policy makers and educators to fully buy into. Even the

Canadian Psychological Association, who ultimately supported the 'Out of the Shadows at Last' report, expressed "concern that it might be interpreted through the traditional view of mental health which is focused on the medicine centric system, publicly funded services, 'illness care' rather than prevention and promotion" (Torgerson, 2006).

RQ2: *What social discourses do these framings create or reinforce? Which ideas and theories do they privilege and which do they maintain silence on?*

The way these strategies frame mental health generally reinforces the discourse that mental health difficulties are the result of a sick or dysfunctional individual, as opposed to a sick or dysfunctional environment. The influence of the medical model is clearly visible in each of the mental health strategies assessed where with the exception of the TDSB strategy, we see psychiatry and healthcare positioned as the authority on the subject. By positioning the medical system in this way, there is a privileging of the 'illness' discourse of mental health. In addition, the majority of interventions and programs presented in the strategies intervene at the individual level, where the person is targeted, rather than at the environmental or social level, where the school system is targeted. For instance, each of the strategies recommends trying to identify youth who may be already be exhibiting 'symptoms' or may be at risk of developing 'symptoms' of mental health difficulties. When interventions are designed to target individuals or specific populations, they are reinforcing a discourse that mental health difficulties are issues that select individuals experience, and ignore the perspective that anyone can be affected based on their social circumstances (CMHA, 2013). Similarly, research has shown that early identification and screening techniques, which are built on a Euro-

western understanding of mental illness, have not been effective at predicting 'mental illness' in racial groups, and in fact certain 'symptoms' identified using early intervention tools "run the risk of medicalizing appropriate social struggle and distress" (Chakraborty & McKenzie, 2002). Therefore the use of these normative screening tools may unsuitably stigmatize racialized individuals and members of other oppressed groups as more likely to be 'mentally ill' or unstable.

As important as the content included in these strategies is the content that is absent: there were no direct references made to MS, CDT or anti-psychiatry movements or perspectives in any of the strategies. The voices of those with lived experience of mental health distress were entirely absent from each of the strategies except for the federal strategy. However in the case of the federal strategy, such voices were given prime position in the report primarily if they supported a medical perspective on mental health, whereas those voices that challenged the medical perspective were generally absent or subjugated to less prominent sections of the report. In each report, social determinants of health or the need for a healthy school culture/environment are highlighted, but they are given significantly less focus and allocated fewer resources than interventions that target the individual. Therefore, discourse that purports school environments and social structures to be potentially disabling to students, are marginalized. Similarly, the Mad Studies philosophy - that differences in mental health should be celebrated and embraced - is missing from all of the strategies: instead mental health difficulties are presented as something that should treated or cured. I was also unable to locate any acknowledgement of, or reference to, the historically oppressive role of psychiatry and medicine towards those with 'mental illness'. As noted in my literature

review, Mad advocates believe that if the state admitted to historical injustices of the past, it could be used as a stepping-stone to improve current social attitudes towards 'mental illness' (LeFrançois et al., 2013).

I found that the federal strategy endorsed a medical discourse more strongly than any of the other strategies. This could be the product of the federal strategy being the oldest of the 4 strategies, and thus most influenced by traditional thought. Nevertheless scholarship in MS, CDT and Anti-Psychiatry perspectives were prevalent at the time of the strategy's conception, in 2006. Therefore, much like Torgerson (2006) showed, the alignment with medical thought was likely the result of the authors turning most heavily to medical professionals and groups when developing the strategy. Of the 4 strategies, the TDSB strategy reared the most discourse on mental health being tied to social and environmental structures. In this strategy, the idea of developing a healthy school culture is emphasized on numerous occasions and it also stressed the importance of empowering students to lead change. A review of the strategy's Appendix and references shows that minimal influences on the report were from medical organizations or group; apart from the WHO, none of the listed resources were medically based. However, many of the resources were government based. This may explain the individualizing discourse that was promoted by this strategy, as government ideology (at least as is demonstrated in the government strategy) is notably motivated by neoliberalism.

RQ3: *What are the possible implications of these discourses for secondary students who struggle with their mental health?*

Fairclough (1989) pronounced, "people internalize what is socially produced and made available to them" (p. 24). Therefore if our policies and strategies continue to frame mental health as a medical and individual matter then students will continue to perceive mental health difficulties, in themselves and others, as 'deficits', 'abnormalities' or personal problems, rather than considering how social structures and the environment influence mental health. Consequently, as Horwitz (2006) stated, "those who fail to realize their goals will tend to blame themselves, rather than the cultural values that emphasize success or the structural conditions that place limits on how many people can actually reach such high levels of accomplishment" (p. 12). Therefore, individualized framings of mental health may feed into self-blame for those students whose mental health difficulties significantly affect their academic success. As it is, the majority of youth do not reach out for mental health support, and research shows that many of them are averse to seeking help that may label them or isolate them from their peers (Gulliver, Griffiths & Christensen, 2010). Self-blame, which assuredly adds to the distress of students already struggling with their mental health, will continue to be an prevalent as long as neoliberal ideologies and medicalized discourse maintain their dominant positions in society.

The federal and Ontario government strategies put their faith in the current mental system, and indicate a need to bolster it, rather than revamp it. The existing literature suggests that simply fortifying supports and services is not likely to make up for the massive need that exists, because as few as 25% of students deemed appropriate for mental health support actually receive it (Kutcher, Hampton & Wilson, 2010). This isn't simply the product of insufficient resources; many students avoid any clinical or

institution-based support even if available (Waddell et al., 2005a; CAMIMH, 2007). Therefore, I believe, an ideological shift in how we frame and perceive mental health is needed. I will explore this idea further when addressing the next research question.

RQ4: *How might these mental health strategies be improved by using the theoretical perspectives of Mad Studies and/or Critical Disability Theory?*

I would like to make three recommendations, based on the insights of MS and CDT, which I believe would improve the assessed mental health strategies. Firstly, I would recommend that strategies prioritize *identifying and adjusting disabling factors in the school system, with the direct help of students*. Secondly, I recommend an organized approach to *challenging the generally accepted belief that a medical approach to mental health is the most effective.* Lastly, I recommend that *diagnosing/diagnosis be kept out of the school system*. It may be noted that the second and third recommendations are derivatives of the first recommendation, however the reason I categorize them separately is because they are recommendations that I believe are long-term goals, which may be difficult to impact immediately. These recommendations are not intended to be sequential and should be worked in concert with one another to achieve the most effective outcome in the long term. I believe that social workers, especially those positioned in schools, are important to the realizations of these recommendations. Below, I provide actionable items that might be used to accomplish each of these recommendations. Since these recommendations are inspired by MS and CDT ideologies, they are not novel recommendations that I can take credit for.

1. Identify and adjust disabling factors in the school system, with the direct help of students

A critical disability theoretical lens, which focuses on the disabling factors in our environment, would suggest that we consider what in the school system is contributing to distresses in a student's mental health, and make changes to the environment accordingly. In accordance with an MS and CDT philosophy, those who are most affected by such barriers should have an indispensible influence in changing them (Meekosha & Shuttleworth, 2009; Russo & Beresford, 2015). Therefore, the inclusion of students, especially those with lived experience, is essential to determining and acting on disabling factors in the school system. Bearing this in mind, I would offer the following actionable items to improve on the existing mental health strategies:

- Implement and support student-driven mental health or wellness committees to determine how the school's social and physical environment can be amended for the better mental health of students.
- Conduct research into what students believe are the aspects of school environments and related social structures that cause them the most psychological stress and emotional distress. The previously mentioned committees may be appropriate to conduct this research.
- Determine which of the identified causes are most feasible to act on, determine a course of action and begin the change process.
- Advocate to municipal and provincial governments to increase funding for structural and environmental changes to schools, citing the benefits this would

offer students and the potential reduction of burden on community mental health systems.

Social workers who are employed by schools and are educated in community building and research processes can offer their skills to aid in the development (and, if necessary, facilitation) of mental health or wellness committees, as well as to support students to conduct comprehensive research on disabling factors in schools. In addition, social workers can guide the process of advocating to government organizations for additional funding, or applying for grants and other endowments that may help the committees reach their goals.

2. Challenge the generally accepted belief that a medical approach to mental health is the most effective.

Bearing in mind Fairclough's (1989) earlier caution about the internalization of discourse, the pathological perspective of mental health may be so ingrained in our social DNA (deliberate ironic use of terminology) that policy makers and educators may not think to entertain alternative perspectives of mental health. Society may believe that scientific knowledge of mental health is more robust than it really is, because of the many advancements made in physical health (Wipond, 2013). Therefore, like psychiatric survivor groups and antipsychiatry activists argue, the medical approach to mental health should be challenged as the most competent form of support or treatment (LeFrancois et al., 2013). I would offer the following recommendations to improve on the existing mental health strategies:

- Introduce alternative theories and perspectives on mental health –such as Critical Disability Theory and Mad Studies- to policy makers, educators and students
- Bring awareness to policy makers and educators of the limits of science and the medicine when it comes to mental health
- Future social work research might consider studying whether policy makers, who construct such strategies and reports, and educators charged with evaluating their use in the school system, are aware of these alternate perspectives of mental health

Alternative theories and perspectives on mental health, such as CDT and MS, can be found in social work literature, and in some cases, such as was my experience at McMaster University, these perspectives are explored in the classroom. Social work academics and researchers have an opportunity to assist in the achievement of the above recommendations by working closely with policy makers to assure that alternate perspectives of mental health are given more attention and the limits of the medical approach to mental health are better understood. Furthermore, for social workers that operate in schools – particularly if they are involved in staff and teacher education/training -, these perspectives can incrementally be introduced into the school system through new or ongoing mental health awareness campaigns and the inclusion of such perspectives in mental health curriculum.

3. Keep diagnosis and labelling outside of the school system.

The use of diagnosis has been shown to segregate some community members from others, potentially creating an in-group/out-group division amongst students

(Corrigan, 2007). Such a dichotomy may cause students to deny their emotional struggles and avoid reaching out for support. If the psychiatric field believes that diagnosis helps with treatment, than it can be utilized in medical circles, however, it potentially does more harm than good when applied in school environments. The MindMatters initiative, run out of schools in Australia, argues that a whole-school approach to mental health is most appropriate for the school setting. It further argues that diagnoses are only beneficial for clinical purposes and since school workers are not clinical professionals they need not use clinical terminology (MindMatters Australia, 2015). This approach promotes supporting students based on how they are feeling rather than their supposed or assigned diagnosis. It also avoids labelling students or indicating to them that their distresses are not normal. Furthermore, as MS suggests, differences in mental health, including significant struggles, can also be celebrated as part of human diversity, and the development of culture where mental health difficulties are openly talked about should be encouraged (Beckman & Davies, 2013). Therefore, I would offer the following recommendations to improve on the mental health strategies:

- Eliminate any programs or interventions that utilize diagnoses or labels that position certain students as outside of the norm.
- Utilize school-based interventions that target the entire student population, as opposed to only targeting specific students
- Adjust school curriculum that is grounded in diagnosis-based knowledge. Instead, the scholastic knowledge of MS and CDT should be introduced into mental health curriculum, and students should be taught that society is constructed in a specific way that benefits some individuals and potentially disables others.

- Construct a culture where distresses in mental health are openly voiced. This may be achieved by encouraging pride in the exceptional and gifted ways that all individuals, especially those who struggle with their mental health, interact with and look at the world (deBie, 2014).
- In cases where the distress of a student requires more support than teachers and school staff can offer, designated school workers (e.g., Social workers) can work with the student and family to determine and support access to community based mental health supports would be most helpful.

Social workers, who are often experienced in group facilitation and planning, may further be involved here by facilitating the introduction and implementation of whole-school programs such as the MindMatters initiative (discussed above). Moreover, they can be instrumental in promoting a celebratory culture and creating space for students to discuss the experiences with mental health struggles.

Limitations

There are numerous limitations to this research given that it is my first time at embarking on such a venture. There are however three identifiable limitations that I would like to highlight. The first limitation regards the subjective nature of a Critical Discourse Analysis (CDA), and how another researcher could extract different results than the ones I concluded (Fairclough, 2010; Poole, 2007). The second limitation regards not having much background information on how the strategies were constructed or who the authors were that created them. The final limitation regards the lack of breadth of my

research, as the time limits and scope of a master's level research project meant that I was only able to assess four strategies, and do so in a more limited way.

Earlier I cited three criteria that Fairclough (2010) declared make a CDA critical. Because my research uses a methodical analysis of institutional documents with the hope of addressing harmful discourses that affects student mental health as a means of working towards change, I believe my CDA would be categorized as critical. However, my research is likely limited by the subjective nature of conducting a CDA (Fairclough, 2010; Poole, 2007). The combination of designing a CDA and it being my first attempt at academic research may have further limited the strength of my research process. I tried to offset this limitation by being transparent about my personal lens and theoretical perspective, and how these influenced my interpretations of the strategies. Ultimately however, because there is a no objective way to interpret these strategies this in itself limits my research from being generalized.

Much like van Dijk (2008) has asserted, CDA "is crucially interested in the social conditions of discourse" (p. vii), the systematic process by which policies are developed, who was involved in their development, and how they went about collecting resources. This information would have helped me better understand how and why the policy makers came to their conclusions and wrote the policy the way they did. This however was not possible given the scope of my thesis. It would have required personal interviews with those involved in developing these policies and/or a more in-depth investigation into the development of each of the policies; neither of which was something I could do with the time and resources I had available to me. This might be an interesting possibility for future research.

Once again, due to limited time, I was only able to assess four mental health strategies, and of those, only two were school board strategies. This is not a large enough sample size to draw any major conclusions, nor can I generalize my results across all Ontario school boards. My research then provides only a small window into how mental health is framed by school board strategies. Additionally, it was difficult to draw many conclusions between how school board strategies were influence by the federal and provincial strategies. The NCDSB made references to the provincial Open Minds, Healthy Minds strategy, but how much the NCDSB looked to the provincial or federal strategies to develop its own strategy was difficult to conclude. I would like to think that there is some connection between the government strategies and school board strategies, because that would indicate that the government strategies served their purpose of informing local reform, but I have very little evidence to substantiate such a belief. This again may be a key opportunity for future research.

As noted in the Introduction, the scope of this thesis did not allow me to thoroughly investigate the critical role that race, Eurocentrism or historical oppression impacted the mental health of students, nor how the strategies accounted for these factors. Not attending to Eurocentric ideologies and approaches to mental health may further marginalize minority groups, who may have different experiences and worldviews than are espoused in such approaches (Joseph, 2015). This too requires further exploration and research, especially in Canadian secondary schools, which are structured according Eurocentric thought (Berger, 2009).

CHAPTER 6: CONCLUSION

A Personal Reflection on Changing the Discourse

When I initiated my research and brainstorming for this thesis, I felt my passion for the subject would carry me through any trials I encountered along the way. I have worked in the mental health field for 6 plus years, have completed many courses on the subject during my first undergraduate degree in psychology, and, most importantly, have a wealth of personal experience navigating the mental health system since my diagnosis as an adolescent. As a result, I fully expected this thesis process to be smooth and even accelerated. Conversely, the process has been filled with self-doubt, second-guessing, and general tentativeness. It has been one of the most emotionally tumultuous endeavours I have ever undertaken.

This is a topic that I believed I had complete understanding of. It gave me confidence when clients, colleagues and friends looked to me for knowledge on mental health. Now I am coming to believe that what I once called knowledge was rooted in ignorance; fed to me by a dominant discourse that exists in academia and general society. I am still piecing together the new perspective of mental health that I have detailed in this thesis, and being in a place of uncertainty is highly distressing.

It has struck me how demanding it is to truly challenge the dominant perspective that is present in society and in one's own psyche. I regularly wonder whether it is dominant for a reason, and whether my newfound perspective is a moment of fascination before I realize the dominant perspective was right to begin with. Some readers may have sensed my ambivalence in the Methodology and Findings of this thesis. Reflecting back, it may have been the case that the arduous process of espousing a new (to me)

theoretical framework hindered the strength of my CDA. Had my belief in and understanding of CDT and MS perspectives been more firmly rooted I reckon that my critical assessment of the documents would have been more thorough and critical. It was particularly uncomfortable challenging the perspectives held by powerful, and supposedly informed, organizations, such as the Canadian Psychological Association, the Mood Disorder's Society of Canada and the Canadian Mental Health Association (an organization I work for), who viewed the federal government's 'Out of the Shadows' report favourably (Torgerson, 2006).

I am temporary lifted from my distress when I remember those from the Mad and Critical Disability communities, who have fought vigilantly for many years to carve out a place for their viewpoints in academia and society. Many individuals from these communities have experienced immense sorrow, anger and discrimination, which I will never fully comprehend. It therefore becomes a privilege if I can contribute to strengthening a discourse of mental health that they initiated. I can only hope that my research achieves this.

Mad Kids or mad Schools?

This research has bolstered arguments that the complex interconnections between the environment and person that exist in society is ignored or underappreciated far too often. We veer more towards looking at individuals as being independent from the environments in which they live. By doing this we subtly perpetuate a discourse that those who emotionally struggle to live well have some form of psychological deficit.

This perpetuated perspective has long-term and deep-seated ramifications that we need to consider.

I cannot definitively claim that schools, their cultures, social structures or environments, are a source of mental health struggles of students. I do however believe that a strong relationship between them exists and needs to be better acknowledged, especially in government policies and educational strategies that seek to address the issue. Utilizing the results of my research I might conclude that only insignificant attention, in policies and strategies, is paid to recognizing this relationship and adjusting school environments and social structures to make them less mentally distressing to youth, as well as to faculty. The onus put directly on individual students and faculty will not lead to a mentally healthy society in the long run. I conclude that our approach and understanding of mental health requires a significant adjustment.

Nor can I make efficacy-supported recommendations for how schools need to be restructured or improved to meet the mental health needs of student, however the message our current approach to mental health sends to students is incomplete and likely leads to fewer students receiving the help they need. Schools can be a source of distress but they also have the capacity to positively influence the emotional wellbeing of youth because of how they are positioned in their lives. Richard Goldbloom, a professor of paediatrics, sees the school as a youth's "natural habitat. For 6-8 hours a day, it is where they are, it is where their parents often come and it is where you can deal with the problem…" (cited in Kirby & Keon, 2006, p. 138).

Moving forward, we need to focus less on the supposed 'inherent' madness that is perceived in students and begin studying ways that Ontario schools may be mad. What I

mean by this – referring back to Dave Chappelle and Kendrick Lamar – is that we need to consider how our schools' social and physical environments are 'sick' or 'mad', and thus cause, or influence, the mental health distresses that students continue to experience. A focus can then be shifted to how to change this so that schools can become a source of support versus distress. I contend that this begins at the level of policy/strategy, which is what structures school environments, curriculum and practices, and are what school board personnel look to for guidance on topics such as mental health. Dominant social discourse can lead us to not consider alternate perspectives of mental health, but we have been treading in the same harmful ideological waters for far too long, and the mental health of our students demands this to change.

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