

EXPLORING THE EXPERIENCES OF YOUTH WITH UNDIAGNOSED MENTAL
HEALTH CONCERNS WHO ARE STREAMED INTO ALTERNATIVE EDUCATION

**“WE CAN’T HELP YOU HERE”: EXPLORING THE EXPERIENCES OF YOUTH
WITH UNDIAGNOSED MENTAL HEALTH CONCERNS WHO ARE STREAMED
INTO ALTERNATIVE EDUCATION**

By: Laura Stothart, B.A., B.S.W.

A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Master of Social Work

MASTER OF SOCIAL WORK
(2018)

McMaster University
Hamilton, Ontario

TITLE: “We Can’t Help You Here”: Exploring the Experiences of
Youth with Undiagnosed Mental Health Concerns who are
Streamed into Alternative Education

AUTHOR: Laura Stothart, B.A., B.S.W.

SUPERVISOR: Dr. Ameil Joseph

NUMBER OF PAGES: i-vii, 1-133

ABSTRACT

Relying on the perspectives of critical disability studies and mad studies, this graduate thesis seeks to uncover the experiences of youth with undiagnosed mental health issues who have been streamed into alternative education. Guided by methodological principles of interpretive phenomenological analysis and arts-informed inquiry, the 5 participants in this study were invited to a focus group where they could engage in an arts-based activity, meant to provide the opportunity to reflect on their experience, build rapport with the researcher, express themselves through alternative means, and connect with peers who have shared experience. Participants were then invited to discuss their experiences with the topic in a one-on-one, semi-structured interview. This study reveals the ways in which the system of education, school communities, teachers, and social workers can support youth who are not diagnosed with a mental illness but still experience mental health challenges that impede on their school experience. Supported by mad studies, this study reveals how peer support has become the method of mental health response and treatment through which students feel is most effective. This study also challenges medical hegemony and the ways in which access to services is dependent on medical diagnoses. Finally, this study reminds stakeholders of the value of building trusting and empathic relationships between school staff and students. School communities and school boards are challenged to think about the structuring of their systems, and the ways in which they may present barriers to the success of all students regardless of ability and/or need.

ACKNOWLEDGEMENTS

First and foremost I would like to thank the participants in this study. Without their willingness to share their experiences this thesis would not have been possible. I hope they know their voices are valued and can make an impact.

I would like to thank my faculty supervisor Dr. Ameil Joseph. Through our conversations and the many book loans you offered from your office library, this thesis project was taken to new heights that I could not have imagined on my own. Thank you for your continual support and guidance.

Thank you to Saara Green who agreed to be my second reader. Saara had a great impact during my transition to graduate studies semester one, and I appreciate the positive and challenging environment she created in her classrooms.

Thank you to my loving and supportive family, without whom this would never be possible. I would like to particularly thank my mom who would drop anything anytime to help, and never failed to remind me “you can do this, you always do”. Thank you for believing in me on my most insecure and doubt-filled days. I would also like to thank my dad for his willingness to be informally interviewed and provide me with a teacher’s perspective that I kept in my mind throughout this thesis. Both of your love and support mean the world.

Finally I would like to thank my friends who remind me that side splitting laughter, rec sports leagues, and a few brews is the perfect recipe for stress relief. Thank you for understanding every time I had to say “I can’t, I am working on my thesis” and for always responding “you got this Laura, you’re so close!”. A special thanks goes to my cousin Alana who has been my biggest cheerleader since day one of undergrad when we moved into Hedden Hall together. Another huge thanks goes to my boyfriend Brian who has proof read countless essays, uses logic to talk me down when my emotions take over, and always answers yes to the question “can you put more coffee on?”. Thank you for your support and understanding through this entire year.

So once again, thank you to you all who have been in one way or another a part of this journey.

TABLE OF CONTENTS

Abstract.....	iii
Acknowledgments.....	iv
Chapter I: Introduction.....	1
Chapter II: Critical Review of the Literature.....	5
<i>2.1 Definition of Alternative School</i>	
<i>2.2 History of Alternative Schools</i>	
<i>2.3 Who Attends Alternative Schools? A Look at Demographic Statistics and Mental Health Issues as a Predictor of Alternative Education Enrollment</i>	
<i>2.4 Factors that Contribute to Students with Mental Health Issues Enrolling in Alternative Education</i>	
<i>2.5 How Student Disenfranchisement from Mainstream Education Contributes to the Development of an Othered or Stigmatized Identity</i>	
<i>2.6 How Future Research fits with Current Understandings</i>	
Chapter III: Theoretical Framework.....	25
<i>3.1 Critical Disability Studies</i>	
<i>3.2 Mad Studies</i>	
<i>3.3 The Intersection of Critical Disability and Mad Studies</i>	
<i>3.4 How Critical Disability and Mad Studies Align with my Research</i>	
Chapter IV: Methodology.....	33
<i>4.1 Interpretive Phenomenology as a Methodology</i>	
<i>4.2 Arts-Informed Inquiry as a Methodology</i>	

4.3 <i>Integrating Interpretive Phenomenology and Arts-Informed Inquiry</i>	
Chapter V: Methods.....	43
5.1 <i>Sampling and Recruitment</i>	
5.2 <i>Data Collection</i>	
5.3 <i>Data Analysis</i>	
5.4 <i>Ethical Considerations</i>	
Chapter VI: Findings.....	50
6.1 <i>Distrust of School Staff as a Barrier to Support and Services</i>	
6.2 <i>Internalized Independence Resulting in Resistance to Services</i>	
6.3 <i>Strongly Held Belief that School Staff are Unable to Help</i>	
6.4 <i>“You Can’t Get Services without Having a Diagnosis”</i>	
6.5 <i>Peer Support Works Best</i>	
6.6 <i>Alternative Schools as an Effective Means to an Ends</i>	
Chapter VII: Discussion and Analysis.....	76
7.1 <i>Individualization</i>	
7.2 <i>Risk of Disclosure and Systemic Stigma</i>	
7.3 <i>Alternative Schools as a Means to an Ends, but What Ends Exactly?</i>	
7.4 <i>What About Peer Support Does What for Youth?</i>	
7.5 <i>Medical Hegemony and Psychiatric Power</i>	
Chapter VIII: Implications.....	91
8.1 <i>Implications for the School Community</i>	
8.2 <i>Implications for the Field of Social Work</i>	

8.3 Implications for Research: Using Collage as Method

Chapter IX: Conclusion.....	97
References.....	100
Appendices.....	110

Appendix A: Letter of Information/Consent Focus Group

Appendix B: Letter of Information/Consent Interview

Appendix C: Focus Group Guide

Appendix D: Interview Guide

Appendix E: Confidentiality Agreement

Appendix F: Demographic Information Form

Appendix G: Recruitment Poster

Appendix H: Recruitment Email for Service Agencies

Appendix I: Community Mental Health Resources

Appendix J: Thank You Card Message

Appendix K: MREB Certificate of Ethics Clearance

Appendix L: MREB Certificate of Amendment Approval

Chapter I: Introduction

The prevalence of reported mental health issues among children and youth has increased in recent years (Findlay & Sutherland, 2014; Twenge, 2011). In the context of education, more and more students are experiencing mental health concerns significant enough to impede on their learning and overall school experience (Cornaglia, Crivellaro, & McNally, 2015; Wilkens & Williams, 2015). School staff including teachers, resource teachers, guidance counsellors, and administration are likely to encounter a student who is struggling with their mental health. In release of the federal budget for 2017 the Government of Canada reported that they would be partnering with the provinces to allocate more funding to mental health services, which includes distributing more funds to the education sector allowing more social work positions in both elementary and secondary schools (Government of Canada, 2017). As the rates of mental health issues rise among youth, it has become common practice for social work services to be available in schools (Findlay & Sutherland, 2014; Fraenholtz, S., Williford, A., & Mendenhall, A., 2015; Twenge, 2011). In line with the Canadian Association of Social Work (2005) core principles and values, the role of a school social worker is to work with marginalized and oppressed groups in effort to advance social justice, advocate on behalf of students and their needs, and to provide them with resources and supports necessary for their success and wellbeing.

From my practicum experience working in the Hamilton Wentworth Catholic District School Board I witnessed how services and supports for students are far more limited when the student does not have a mental health diagnosis, and how students who

chose to remain undiagnosed are often a highly marginalized and stigmatized group. Reports of mental health challenges from this group are often dismissed or unsubstantiated. Further, stigmatization and marginalization occurs when unwanted classroom behaviours are viewed as a product of deviance, rather than a result of mental health issues. From my observations, in situations where staff do not feel adequately prepared to respond to mental health issues among youth, or who lack a holistic understanding of the complexities of mental health, a youth's presenting mental health issue may be perceived as disruptive or deviant behaviour. Especially in those cases where a youth has not received a mental health diagnosis, school staff may feel they lack the adequate knowledge and resources to support said student and therefore suggest the student consider enrolling in alternative education where their needs will be better met. I am curious as to how this process increases separation of students with mental health concerns from those without, and what impact, if any, separation may have on a youth's development of self and life trajectory.

The purpose of this study is to examine the experiences of high school students with undiagnosed mental health issues who are streamed into alternative school systems due to lack of resources and support within the means of conventional schools. Through a qualitative analysis of interviews with 5 youth who identify with having undiagnosed mental health concerns while attending secondary school, I intend to uncover how alternative schools in Hamilton Ontario respond and meet, or do not meet, the needs of students with mental health concerns. I am also interested in role that social workers can, and do play, to facilitate the implementation of alternative approaches, support, resources

in conventional schools, thus minimizing the separation of students with mental health concerns. My official research questions are as follows: a) What are the experiences of students with undiagnosed mental health issues who are streamed into alternative school settings? b) How well are alternative schools responding to the needs of students with undiagnosed mental health issues? c) Can alternative approaches, support, resources, be implemented in conventional schools, and, how are social workers engaged in the facilitation of this process?

Carried throughout this thesis is the belief that youth have a meaningful part in shaping the future direction of mental health and education. Answering the research question “what are the experiences of students with undiagnosed mental health who are filtered in alternative school settings” is not attainable without hearing from the youth themselves. The data I have obtained is based in individual experiences (or shared experiences), from those who are most affected by policy and action, and those who feel they have something to contribute to the discussion. I would like to clarify that the data that is collected through individual testimony is nuanced, complex, and non-transparent. Individual testimonies share experiences that exist within structures of oppression and power relations.

When using an interpretive phenomenological approach there exists a fear participant’s voice may be seen at face value, ignoring the material effects of oppression and discrimination (Maiter and Joseph, 2016). This lack of critical structural analysis is precisely why my thesis will be using both the interpretive phenomenological analysis and critical approaches (discussed further in “Chapter III: Theoretical Framework” and

“Chapter IV: Methodology”). As Maiter and Joseph (2016) identify, researchers must “resist reliance on or accepting of analyses that take representations of voice as transparent and elude on an analysis of racism and other forms of discrimination” (p. 2). Therefore, an experience should never be seen as just that. Experiences must be unpacked, critiqued, and analyzed to gain further insight as to how systemic oppressions and social forces are at play.

As social workers with an interest social justice it remains crucial that we advocate for these individuals who can become a victim to gatekeeping processes and neoliberal structuring. It is my hope that this study will help education professionals, mental health workers, and social workers better understand student experiences, and that some of the recommendations provided will be considered and applied when shaping the future of secondary education, mental health response, and policy related to both mental health and education.

Chapter II: Critical Review of the Literature

In our current social context, mental health issues among children and youth are reported at higher rates (Findlay & Sutherland, 2014; Twenge, 2011). Youth mental health continues to be a concern of parents/guardians and educators, especially when mental health challenges have been reported to correlate with poor educational outcomes, school drop-out, and enrollment in alternative education (Cornaglia, Crivellaro, & McNally, 2015; Denny, Clark, Fleming & Wall, 2004; Johnson & Taliaferro, 2012; Wilkens & Williams, 2015). This research intends to uncover the experiences of youth with undiagnosed mental health issues who are streamed into alternative school settings. I also expect to determine if and how alternatives schools respond to the needs of students with undiagnosed mental health issues. Finally, I hope to answer whether or not alternative approaches, support, resources, be implemented in conventional schools, and, how are social workers engaged in the facilitation of this process.

The purpose of this chapter is to provide a review of the current literature as it pertains the streaming of students with mental health concerns into alternative school settings. Through this chapter I will first define alternative education using scholarly theorizations and will then provide a historical perspective of alternative education in Canada. I will then explore enrollment statistics, identifying mental health issues as a common characteristic among those who enroll in alternative education. I will then identify the factors that have contributed to students with mental health issues having greater difficulties in mainstream schools. I will argue that systemic and policy factors, in addition to personal prejudice, have each had a part to play in the exacerbation of the

problem. I will then explore how disenfranchisement from mainstream school and consequent enrollment in alternative school can lead to the development of a stigmatized, othered, and marginalized identity. Finally, I will conclude by providing an analysis of how the current literature aligns with the direction and aims of my future thesis research.

2.1 Definition of Alternative School

For the purposes of this literature review and the larger thesis it is beneficial to construct a definition of “alternative education” that will be used whenever this concept is referenced. Using Raywid’s (1994) understanding, alternative education is a system of education that is “designed to respond to students who are not optimally served by the mainstream program and consequently represents varying degrees of departure from standard school organization, programs, and environments” (p. 26). Characteristics of alternative schools include smaller class sizes, better teacher-student relations, instruction that focuses on skill development, self-paced, and individual learning plans (Henrich, 2005). Alternative schools are said to provide a supportive and non-traditional environment that is student-focused and aimed to equip the student with the skills and knowledge to promote future success.

2.2 History of Alternative Schools

Alternative education first emerged in the 1960s-1970s as the brainchild of the political left-thinkers who were dissatisfied with the rigidity of mainstream schooling, and sought a more progressive and democratic alternative system of education (Rothstein, 2017). Proponents of alternative education had been inspired by the early romantic influences of Rousseau and Dewey, who had both theorized the education standards of

their time. In his publication of *Emile* in 1792, Rousseau advocated for a naturalistic education where children were left to follow their curiosities and interests with minimal adult intervention (as cited in Rothstein, 2017). Similarly, Dewey wrote about a Progressive Education Movement that emphasized the uniqueness of the learner, and argued that education systems and pedagogies should be tailored to unique child needs, interests, and ways of learning (Rothstein, 2017).

Beyond philosophical influence, in the 1960s-1970s there were both personal and political factors that contributed to the mobilization of alternative education. In an analysis of the birth of alternative schooling, Rothstein (2017) and Azzarello (2017) state that the release of the Hall-Dennis Report *Living and Learning: The Report of the Provincial Committee on Aims and Objectives of Education* was a key factor for alternative education mobilization. The Hall-Dennis report reflected the progressive values of the 1960s, such as equitable education and child-centered focus, and presented a critique of current educational standards. The Hall-Dennis report advocated for more experiential learning, pedagogical choice, and a more human and democratic approach to discipline (Azzarello, 2017; Rothstein, 2017). On a personal level, many parents were dissatisfied with the education their children had received, arguing conventional education was too rigid and did not allow for more creative educational opportunities (Nash, 2017; Rothstein, 2017).

Many education scholars agree that alternative schools have since diverted from its progressive and democratic roots, and have shifted its overall focus to reflect punitive, rehabilitative, “fix and return” ideologies (Azzarello, 2017; Lerh & Lange, 2003;

McNulty & Roseboro, 2009; Raywid, 1994). In an analysis of the typologies of alternative education, Raywid (1994) argues that the image of alternative education has shifted as these schools are no longer seen as a viable alternative to mainstream education, but rather a default for students who are at-risk, deviant, and unsuccessful in mainstream schools. Similarly, McNulty & Roseboro (2009) say that alternative schools have diverted from their original democratic organization, and have since become a “placeholder for deviant or at-risk youth” perceived to fulfill a “fix it and send it back” service (p. 414). The service providing image of alternative schools that is problematic because it maintains a position of good intent, support, and benevolence but actually operates as a vehicle for social control (Foucault, 1978).

Azzarello (2017) argues that the neoliberal political influence prevailing over the past 20 years has contributed substantially to alternative education reform. Under neoliberal principles and the Harris Government of 1995, alternative education went from progressive critical schools to “conservative and hierarchical system where all aspects of education and schooling are to be measured, codified, and packaged”. The neoliberal influence described by Azzarello (2017) effected both alternative and mainstream schools, resulting in amalgamation of school boards, standardized testing, funding and staff cuts, larger class sizes, homogeneous curriculums, and emphasizing employability characteristic development over critical thinking skills.

Currently, scholars agree that there is no existing united front for alternative education and that philosophical positioning, mandates, and aims differ among school boards and individual alternative schools (Henrich, 2005; Lehr & Lange, 2003; Quinn,

Poirier, Faller, Gable, & Tonelson, 2006). Lehr and Lange (2003) argue that alternative education as a whole lacks governance and/or policies through which school operations would be guided. Further, Lehr and Lange (2003) argue alternative schools are not clearly defined and lack a clear value base, aim, and focus. As described by Raywid (1994) and Henrich (2005), alternative schools seem to serve multiple purposes within the larger system of education. Alternative schools can reflect popular innovations, where alternatives are sought by choice and school is more challenging and fulfilling for those in attendance (Raywid, 1994). Alternative schools can also reflect last-chance programs, where attendance is mandated and the program is aimed at behaviour modification rather than critical pedagogy (Raywid, 1994). Alternative schools can have a remedial focus, where students undergo academic, social, and/or emotional rehabilitation and attend under the assumption that they will eventually return to mainstream schooling (Raywid, 1994). Henrich (2005) expands on Raywid's (1994) aforementioned typologies and argues that alternative schools can reflect a student-focused perspective that emphasizes self-directed behaviour management, the development respectful school relationships, enables an adaptive curriculum, and provides another chance (as opposed to a last chance) for school success.

2.3 Who Attends Alternative Schools? A Look at Demographic Statistics and Mental Health Issues as a Predictor of Alternative Education Enrollment

Among the existing literature there is evidence to support that mental health issues are a common demographic characteristic among students enrolled in alternative education (Becker, 2010; Corgnalia et al., 2015; Denny et al., 2004; Fleming, Dixon, &

Merry, 2012). Further, literature on streaming has discussed the streaming of students based on class and race (Canfield et al., 2014; Shultz, 2017) and some scholars have hinted at the streaming of students based on mental health issues (Lehr & Lange, 2003). This section will use the literature to explore the two phenomena described, that is, the higher rates of enrollment in alternative education for students with mental health issues and the streaming of students into alternative education based on class and race.

In their review of alternative education in New Zealand, Denny et al., (2004) found that 35% of the girls and 21% of the boys in their study “had cut-off scores on Reynolds Adolescent Depression Scale that indicate a high likelihood of significant depression” (p. 143). Results of this study suggest that students enrolled in alternative education are in need of resources to prevent and/or treat mental health issues (Denny et al., 2004). Denny et al. (2004) argue that the high prevalence of mental health issues (especially depression) among students enrolled in alternative education require collaboration between communities, schools, and families, to provide the best care to this vulnerable group. I would agree with Denny et al. (2004) and would further argue that the collaboration they describe could also be utilized in the mainstream school system in effort to support the high numbers of youth experiencing mental health challenges.

The finding that depression was high amongst students enrolled in alternative education was supported by Fleming et al. (2012) who argue that this group of students are more likely to struggle with mental health issues than their peers in mainstream high schools. Fleming et al. (2012) further state that depression and other mental health issues may be unrecognized among both staff and students themselves in alternative schools

because either: a) they lack the knowledge to recognize the symptoms associated with the mental health issue, b) the student has multiple problems and another label (such as deviant) has been applied over a label such as depressed, and/or c) the student does not recognize the symptoms to be significant because they have always existed and have become the norm. Due to the prevalence of mental health issues among students enrolled in alternative schools, these institutions must be proactive and implement the necessary precautions, training, and resources for the schools and staff to respond accordingly to student needs (Denny et al., 2004; Fleming et al., 2012).

Untreated and unsupported mental health issues have also been found to result in poorer academic outcomes for youth (Cornaglia et al. 2015). Fletcher (2008) found a strong relationship between depression in high school and poorer educational attainment (as cited in Cornaglia et al., 2015). When students struggle to find success in school as a result of mental health challenges, they may drop-out of mainstream school and pursue alternative education in attempt to still achieve their academic goals in an environment that is more conducive to their mental health needs (Cornaglia et al., 2015). Lehr and Lange (2003) note that alternative schools have the potential to serve these populations through adequate mental health training of staff, flexible programming, the fostering of a caring and inclusive environment. While not specifically stated in the literature, some scholars (Henrich, 2005; Lehr and Lange, 2003; Quinn et al., 2006) have described the supportive environment that is found within alternative schools and it can be inferred that this supportive environment may be enticing for students with mental health challenges, thus offering an explanation as to why they are found to enroll at higher rates.

The streaming of students into specialized schools is a practice that has persisted for decades and continues to exist today, albeit in more covert and accepted ways.

Streaming occurs around the age of twelve, at which time students pursue middle school and are encouraged to select a stream or educational path (Shultz, 2017). Often it is the students in lower-income or racialized neighbourhoods that are the most likely to be targeted and encouraged to attend vocational schools and pursue a trade (Shultz, 2017). In addition, students described as “at-risk” or at “the end of the line” academically are also targeted to pursue vocational schooling. Shultz (2017) argues that the practice of streaming is a function meant to maintain class and race-based status quo.

Canfield (2014) similarly asserts that streaming is one of many tactics used by dominant groups to exert control over working-class and racialized communities. Canfield (2014) writes that “streaming is a form of institutionalized violence that works to convince many working-class and racialized students, as well as their parents, that they belong in dead-end programs with stunted curricula, which almost always lead to insecure, low-paid employment” (p. 361). Streaming was widely accepted in Toronto until the late 1980s at which time parents and progressive educators made efforts to de-stream; however, resistance to de-streaming was entrenched among privileged parents and educators (Shultz, 2017). The resistance of powerful groups made it incredibly difficult to de-stream the whole system and thus streaming practices are still seen today through academic and applied educational system (Shultz, 2017). Canfield (2014) explains that even though vocational schools have closed in Ontario, “children continue to be streamed according to the biased perceptions of their abilities into vocational,

general, and academic courses” (p. 238). Canfield argues that the “outcomes for less affluent, special needs, and racialized students remains substantially below average” when filtered through a streamed educational system. (p. 238).

Lehr and Lange (2003) also speak to streaming in their review of alternative education. They argue that enrollment in alternative education continues to be a result of students being pushed out of schools, or what they call “forced choice” (p. 61). Lehr and Lange (2003) make the argument that schools have the tendency to encourage students with higher needs to attend alternative education as a way to avoid addressing systemic issues of accommodation for the needs of all students. Sager (1999; as cited in McNulty & Roseboror, 2009) echoes this argument and implies that instead of implementing inclusive practices in schools, “policy removes students from schools and places them in alternative settings where they receive separate and unequal education out of the mainstream educational experience” (p. 414). Both Lerh and Lange (2003) and Sager (1999; as cited in McNutly & Roseboro, 2009) indicate that there is a systemic issue in mainstream schools. It appears that without changes being made to the system, schools will continue to be a place where students with needs outside of the norm are not fostered to reach their full potential.

Gorney and Ysseldyke (1993) suggest that students with emotional or behavioural issues are most susceptible to streaming, indicating that this group is attending “alternative programs at much higher proportions than traditional public schools” (as cited in Lehr & Lange, 2003, p. 61). While the term mental health is not specifically used here, it can be inferred that “emotional and behavioural issues” may indeed be connected

to mental health issues, and this could support the argument being made that students with mental health issues are being filtered into alternative school settings as a result of inadequate systems in mainstream schools. Lehr and Lange (2003) conclude by stating that:

Alternative schools have the potential to provide successful school experiences for those youth who are most disenfranchised within traditional schools. And yet establishing alternative schools and programs should not take attention away from the necessary reforms that must occur in traditional public schools in order to better serve all students. Alternative school educators are challenged to provide quality programs that can serve as models for educating students who are at risk for school failure. (p. 64)

I agree with Lehr and Lange (2003) and intend to further explore what it is schools can be doing to better serve all students, ensuring the most marginalized and vulnerable groups are receiving the resources they need in an equitable school environment.

2.4 Factors that Contribute to Students with Mental Health Issues Enrolling in

Alternative Education

In the previous section the literature was used to identify that mental health issues are a common characteristic among those students who attend alternative education. In this section I will explore some of the key factors that may have an impact on this phenomenon. While some scholars have argued that it is personal characteristics or life choices that lead a youth attend alternative education (Fuller & Sabatino, 1996; as cited in Quinn et al., 2006), others suggest there are many factors external to the individual that have contributed to students with mental health issues having greater difficulties in mainstream schools. The following section will explore how personal prejudice, policy, and systemic factors that have each had a part to play in the exacerbation of the problem.

The Perception of Undiagnosed Mental Health as Deviance

In their study Spratt, Shucksmith, Philip, and Watson, (2010) explored the perceived relationship between mental health issues and deviance. Spratt et al. examined the referral process of students to in-school mental health services. The findings of Spratt et al. (2010) suggest that there is a significant amount of stigma associated with accessing in-school mental health services. The students that were interviewed in their study expressed the belief that the disruptive pupils are those most likely to be referred to social work services by teachers who are ill-equipped to respond to the students' needs. When asked what role the school social worker plays, one student responded "the bad people go and speak to her, the really extreme cases, the ones who have behavioural problems — the ones who bully people, folk who don't work in class" (Spratt et al., 2010, p. 489). This comment is rich with assumptions and reflects how disruptive behaviour and a deviant label is somehow attached to mental health issues.

Becker (2010) in their ethnographic study provides a similar analysis of the relationship between deviance, mental health issues, and disability. Becker (2010) argues that there are two primary classifications of students that are perpetuated within alternative education institutions: a) students who have problems, and b) students who are problems. Students who have problems are said to be those with mental health and/or intellectual disabilities. Students who are problems are seen as those who are deviant, trouble-causing, and disruptive (Becker, 2010). Becker argues that often these classifications are not always clear-cut, and at times mental health difficulties are associated with deviant behaviours. Mintz (2000) states that:

Truancy, substance use, disruptive classroom behaviour, academic failure, fighting, arrest, pregnancy, learning disabilities, and mental health needs are problems that can land a student in alternative education. The majority of youth are suffering from academic, social, legal, economic, or mental problems. They are failing, disengaged, and in many cases “bad”. (as cited in Becker, 2010, p. 61)

This quote highlights how mental health challenges and learning disabilities are perceived to be “problems that can land a student in alternative education” and are often grouped with perceptions of deviance (Mintz, 2000; as cited in Becker, 2010, p. 61). Students and teachers in this study stated how they often didn’t know which category they belonged, demonstrating this value laden association between mental health issues and deviance (Becker, 2010).

The relationship between mental health issues and deviance is further perpetuated in the training of teachers, which emphasizes discipline as opposed to empathic understanding (Frauenholtz, Williford, & Mendenhall, 2015). In a study assessing school employees ability to respond to mental health needs of students, many teachers reported having difficulties seeing beyond behaviour, and had troubles realizing how mental health can be implicated (Frauenholtz et al., 2015). Further, the teachers struggled to recognize indicators that a student may be experiencing mental health concerns, and felt inadequate to intervene in situations where mental health issues were identified.

In response to Frauenholtz et al. (2015), Cooper (2004) offers insights as to why teachers may struggle to empathize with their students and look beyond behaviour. Cooper (2004) argues that this instinct to address and mitigate behaviour is a result of the structuring and constraints of the education system itself. Cooper (2004) states that most teachers enter the field with a genuine interest and care for their students, however, the

environment in which they work suppresses these instincts and encourages teachers to focus their efforts on behaviour management and academic achievement. Cooper (2004) also recognizes how current social and economic conditions, such as neoliberalism and austerity, have resulted in constraints on student-teacher empathy. Factors such as large class sizes, over-filled curriculum, and government policies that stress standardized testing and competitive performance, have all contributed to lowered empathic interactions between teachers and students (Azzarello, 2017; Connell, 2013; Cooper, 2004).

Inadequate Application of the Accessibility for Ontarians with Disabilities Act

The purpose of the Accessibility for Ontarians with Disabilities Act (2005) was to develop, implement, and enforce universal accessibility standards for Ontarians with disabilities, removing barriers and ensuring their full participation in society (Marquis et al., 2012). In line with current understandings, the AODA (2005) defines disability as physical, mental impairment, learning disability, mental disorder, and/or a workplace injury resulting in impairment or disability (Government of Ontario, 2005). In their article Marquis et al. (2012) discuss the information and communications standard that was enacted as a part of the Integrated Accessibility Standard Regulation of 2011. This standard specifically addresses issues of accessibility in education and mandates the removal of barriers around information and communication (Maron, 2014). In line with this legislation, schools are expected to respond to the mental health needs of students and remove any barriers that may impact their ability to learn. Unfortunately as the legislation

stands, it is unable to prevent the discretion that is used when the people with power decide who gets accommodated and how.

Maron (2014) argues that the AODA (2005) has been ineffective due to inadequate enforcement, the lack of complaint procedures, and unclear guidelines around the creation of an accessible environment. The vague application of the policy has contributed to the problem of students with undiagnosed mental health issues experiencing barriers and remaining unsupported (Flaherty and Roussy, 2014; Maron, 2014). In the context of education, the “open-to-interpretation” application of the AODA allows attitudinal barriers to persist where individuals with power are able to approve or deny accommodations. Contributing to this discussion of disability related policy and its application, Vick (2012) explains how episodic disability is often not recognized in the context of ODSP, due the inherent tendency of humans to only see the binary (i.e. well/unwell) when we assess a person’s health status. This means that the way in which current disability policy is written and enforced continues to neglect people with episodic disability compared to those who are chronically disabled (Vick, 2012).

Mental Health Resourcing within Education

Another significant factor that has contributed to the filtering of students with undiagnosed mental health into alternative education is the general lack of mental health literacy among school staff. According to Kutcher, Bagnell, and Yifeng (2015) mental health literacy includes four “interrelated components: (1) understanding how to optimize and maintain good mental health, (2) understanding mental disorders and their treatment, (3) decreasing stigma, and (4) enhancing help seeking efficacy” (p. 234). Based on

frequency of interaction, schools and school employees are in the ideal position to recognize and support students who may be struggling with their mental health; however, the literature suggests that frontline employees in education do not feel comfortable doing so (Frauenholtz et al., 2015). In their study on assessing school employee's abilities to respond to student mental health needs, Frauenholtz et al. (2015) found a general trend where staff feel do not feel comfortable recognizing and intervening with issues of child and youth mental health, and feel that their mental health training has been inadequate. Further, it was found that even when mental health services exist they are not accessed or used appropriately because frontline employees such as teachers lack the ability to recognize and refer their students to those services (Frauenholtz et al., 2015).

Kutcher et al. (2015) argue that schools are the ideal platform through which mental health literacy promotion can be implemented. Mendenhall and Frauenholtz (2013) agree with Kutcher et al. (2015) that schools are the ideal platform for mental health literacy promotion, and further argues that social workers should have a central role in programs of this kind. Mendenhall and Frauenholtz (2013) argue that social worker's value base, mission statement, and knowledge and experience in the mental health field make them ideal candidates to lead this endeavor.

There are many studies that have proven that mental health literacy programs have positive outcomes, such as increased general knowledge of mental health, decreased stigma and discriminatory attitudes, and has resulted in an increase help-seeking for those who require support around their mental health (Solerno, 2016; Patalay et al., 2017; Kutcher et al., 2015). As documented by Solerno (2016), Patalay et al. (2017), Kutcher et

al. (2015), increased mental health literacy among students, teachers, and administration may result in better outcomes with students who experience mental health challenges that impact their learning and school experience. In their article assessing re-integration of students with emotional and behavioural disorders, Wilkens and Williams (2015) state that it is a collective responsibility among school staff to remove any present barriers and provide flexible programming, a personalized approach to care, and additional supports and services to the youth to enable their success upon reintegration.

2.5 How Student Disenfranchisement from Mainstream Education Contributes to the Development of an Othered or Stigmatized Identity

While alternative education can indeed be a positive experience in a young person's life, there is considerable evidence that speaks how students in alternative schools bring with them an othered and stigmatized identity as a result of being marginalized within their mainstream school (Kim & Taylor, 2008; Loutzenheiser, 2002; McNulty & Roseboro, 2009). Further, it has been argued that within alternative settings these othered and stigmatized identities become solidified and engrained in the student's self-image (McNulty & Roseboro, 2009). In this section I will use the literature to explore how involvement in alternative education and prior negative experiences in mainstream schooling has resulted in the othering, stigmatization, and marginalization of both students and teachers.

In their article, Loutzenheiser (2002) looks at the experiences of young women who have become disconnected from their conventional school and opted to attend alternative education. The students in the study reported that they became disconnected

from their school of origin over time as a result of “teacher actions, school culture, and pedagogies that ‘othered’ them” (Loutzenheiser, 2002, p. 446). For example, students felt that there was an existing pedagogy of “if you get it [class material] you get it, if you don’t you don’t” (Loutzenheiser, 2002, p. 448). Students felt they were neglected assistance and that their teachers showed no interest in getting to know them individuals, leaving them feeling invisible and irrelevant in school.

Silencing was a common theme amongst the literature, where students felt their voices were not heard nor welcomed in their schools. Loutzenheiser (2002) explains how the students in their study recognized how life traumas affected their school experience, health, and mental health; however, the students did not feel that school staff acknowledged nor responded to the impact of trauma. One student described how the school refused to address her trauma, preferring the student to seek help or treatment outside of the school environment (Loutzenheiser, 2002). Many students’ achievement declined as a result of unresolved trauma and negatively impacted mental health, yet the school was unwilling to help them. One student explained that she could not speak to the teachers at her school “because instead of helping or listening, they would probably say that [she] has lots of problems at home and would try to get [her] to see a doctor” (p. 451). This “we can’t help you here” mentality reinforced difference and reminded the students in the study that school was not a place where they could turn for help.

Further, the students in the study described how they were instructed to not discuss their experiences of trauma, thus contributing to their silencing (Loutzenheiser, 2002). The students recognized they had different experiences than their peers, and felt

the school “highlighted their otherness by denying them spaces to talk about these different life experiences and traumas” (Loutzenheiser, 2002, p. 451). Silencing, as Fine (1991) argues, is not only about “who can and cannot speak, it is also about what can and cannot be spoken” (p. 4; as cited in Loutzenheiser, 2002). The silencing of select topics around trauma inadvertently silences and others those who have direct experiences with these topics.

In their analysis of alternative education and identity development, McNulty and Roseboro (2009) write that students felt stigmatized when they enrolled in alternative schooling and perceived that they subsequently adopted a deviant identity. Further, Kim and Taylor (2008) noted that the students in their study perceived alternative education to be a “dumping ground” for problem students and deviants (p. 211). In McNulty and Roseboro’s (2009) study, students recognized how those enrolled in alternative schools “are perceived as deviant, and since deviancy presents a specific set of connotations, it represents ‘stigma’ as an identifying marker” (p. 145). In response to Raywid’s (1999) argument that alternative schools can serve to normalize, McNulty and Roseboro (2009) make the argument that alternative schools will never be a normalizing space for students because “they reinforce stigmatized identities, and serve to incubate stigmatized students in a collective of others who share their stigma” (p. 418).

The feeling of marginalization was further enforced in the poorer quality of education/training that students and teachers felt was provided to them within alternative education settings (Henrich, 2005; Kim and Taylor, 2008; Sakayi, 2009). In their study on educational inequality and inequity, Kim and Taylor (2008) found that students held

greater aspirations to attend university and that this opportunity was not fostered in the alternative education system. In addition, the teachers in alternative education felt marginalized from their mainstream counterparts in that they were not provided opportunities for career advancement or professional development (Kim and Taylor, 2008). These findings are significant and show that both students and teachers feel marginalized from upward social and professional mobility within alternative education.

2.6 How Future Research fits with Current Understandings

The purpose of my study is to further examine the phenomenon of the filtering of students with undiagnosed mental health concerns into alternative school settings. The literature tells us that mental health has been identified as a characteristic of many students enrolled in alternative education (Denny et al., 2004; Johnson & Taliaferro, 2012; Wilkens & Williams, 2015). We also see that students with poorer mental health are more likely to drop out of mainstream education for various reasons including inadequate support and resources in mainstream school (Cornaglia et al., 2015). The literature has shown that many of these youth than find themselves enrolling in or being referred to alternative education in effort to achieve goals of graduating (Lehr & Lange, 2003; Loutzenheiser, 2002; Quinn et al., 2006). Finally, we have seen how streaming of youth based on class and race has been identified and challenged within Canadian education in the last 40 years (Canfield et al., 2014; Lehr & Lange, 2003; Shultz, 2017). The literature has offered some insights into why students with mental health difficulties may be more likely to enroll in alternative education, identifying personal prejudice, systemic failures, and poor application of policy as contributing factors. After reviewing

existing literature, I am unable to find anything to date has explored the phenomenon of the filtering of students into alternative school settings due to mental health challenges in mainstream school. My research intends to address this gap in the literature.

Chapter III: Theoretical Framework

Whether it is realized or not, how we engage with our social world is dependent on the epistemological position, at which we are each uniquely located. Schwandt (2001) defines epistemology as “the study of the nature of knowledge and justification” (p. 71). Our epistemological frame has us consider what lens we use when we interact with a topic, what assumptions we automatically make about our social world, and based on our assumptions, where knowledge or evidence can be located (personal communication, 2018). The purpose of this chapter is to explore the theoretical/epistemological frames that have shaped and guided the methodology, methods, and analysis throughout my research. Specifically, this chapter will provide an overview of both critical disability and mad studies and explain how these theories have shaped my own epistemology as it pertains to the research.

3.1 Critical Disability Studies

Disability studies first emerged as a body of knowledge and understanding in the 1970's, aligning with many social rights and activist movements of this time, and has since continued to expand into the 21st century (Meekosha & Shuttleworth, 2009). French Gilson and DePoy (2002) define disability as the “interplay of diverse human conditions with environmental barriers that prevent full community inclusion” (p. 153). In its early stages, disability studies was largely informed by a social model of disability. Through a social model of disability it is argued that disability is not a condition of an individual, but rather a consequence of the physical and social barriers that prevented disabled people from full inclusion in society (French Gilson & DePoy, 2002).

Eventually, it became evident that the social model of disability was not fully capable of addressing the oppression and marginalization of disabled people (Shildrick, 2012). Disability scholars have argued that there is a need for both an investigation into the phenomenological experience of disabled peoples, in addition to, a critical analysis of the psychosocial realities that maintain existing power structures, and the norms that disable people who experience embodiment differently (Meekosha & Shuttleworth, 2009; Shildrick, 2012). From this, thinking critical disability studies (CDS) emerged in the last decade encouraging disability advocates, activists, scholars, and allies to expand on prior understandings of disability that centered around binary thinking (i.e. able/disabled, social model/medical model) and begin to think more critically about power, history, normative structures, and self-implication in issues of oppression (Beresford, 2000; Meekosha & Shuttleworth, 2009; Shildrick, 2012).

There are several factors that separate critical disability studies from a social model of disability. To begin, critical disability studies requires individuals to ask themselves how they are uniquely implicated in maintaining oppressive and marginalizing power structures (Meekosha & Shuttleworth, 2009; Shildrick, 2012). Critical disability studies recognizes that no matter how we are embodied, or what status we may hold, we are all implicated in the maintenance of power and oppression (Shildrick, 2012). Once individual implication is recognized, critical disability studies would unpack this and have us “rethink the relations between disabled and non-disabled designations, both ethically and ontologically” (Shildrick, 2012, p. 30). In line with other

critical theories, CDS asserts that through constant questioning, asking why rather than how, a “world of new potential” can be found (Shildrick, 2012, p. 31).

Critical disability studies also argues that the maintenance of oppression is further achieved through the social construction of normalcy and normative assumptions (Freud, 1999; Shildrick, 2012). Freud (1999) speaks to the social construction of normalcy and argues that “normalcy is a value-based concept, which heavily depends on socio political economic context that does not exist outside of that particular context” (p. 333). Critical disability studies would then understand disability as a social construct that has been developed around perpetuating beliefs about what is “normal” and what is “deviant” as it pertains to bodies and embodiment. CDS would then expect individuals to ask themselves how they are complicit in perpetuating the values and beliefs that discriminate against disabled people based on what is constructed as the “norm”.

Critical disability studies is also recognizable by its desire to disrupt binary understandings of disability (Meekosha & Shuttleworth, 2009). When disability studies first emerged there was a dominant social vs. medical model discourse. Similarly, narratives of able bodied vs. disabled continued to circulate (Meekosha & Shuttleworth, 2009). Critical disability studies asks us to see beyond the binary and consider intersectionality, that is, how disability and oppression is uniquely experienced by individuals due to interlocking systems of oppression (Meekosha & Shuttleworth, 2009). Further, critical disability studies recognizes how disability may be fluidly experienced by individuals (Vick, 2012). Vick (2012) discusses the concept of episodic disability where a person could experience both periods of ability and periods of disability. Episodic

disability and/or a fluid understanding of disability is inclusive to mental illness where individuals may not identify as chronically disabled, but rather periodically disabled (Vick, 2012).

Critical disability studies is also characterized by its concern to address not only the physical/material conditions that result in disabling environments, but the “underlying attitudes, values, and subconscious prejudices and fears that ground a persistent, albeit often unspoken, intolerance” (Shildrick, 2012, p. 35). Critical disability scholars agree that addressing the physical conditions of disability is only half the battle, recognizing that real social justice cannot be achieved without changing the attitudes and preconceived beliefs around disability and embodiment (Flaherty and Roussy, 2014; Maron, 2014; Marquis et al., 2012; Shildrick, 2012).

Critical disability studies is further distinguishable by its concern with power and resistance. This component of critical disability studies is heavily influenced by the works of Foucault (1978), who conceptualizes biopower as the procedures and practices that result in the governance of human bodies (as cited in Meekosha & Shuttleworth, 2009). Meekosha and Shuttleworth (2009) state Foucault’s “radical defamiliarization of modern institutions and practices as caring and benevolent” is crucial in revealing the “technologies and procedures that classify, normalise, and manage anomalous bodies” (p. 57). Foucault further exposes how attempts to “measure, predict, and manage” phenomenon pertaining to human life (such as death and reproduction) has been deliberate in the maintenance of power and control over subjugated groups (as cited in Meekosha & Shuttleworth, 2009, p. 57).

3.2 Mad Studies

Mad studies first appeared in the 1960s during the anti-psychiatry and mental patient liberation movements that mobilized in response to the violence that was endured by people with mental illnesses who were involuntarily held in psychiatric institutions (Menzies, LeFrancois, & Reaume, 2013). “Madness” became a reclaimed word, used to self-identify and as a means of entry to the field of organized psychiatry (Menzies et al., 2013). Menzies et al. (2013) explains how “madness” became a critical alternative to the terms mental illness or mental disorder, both of which are labels that are given and automatically applied regardless of how the individual identifies. People who identify as mad resist pathologizing labels that have been degrading and biologically reductionist.

Just as Foucault had an influence over critical disability studies, he similarly influenced mad studies through his conceptualizations of biopower and resistance (Menzies et al., 2013). Foucault’s ideas inspired mad studies to think about power maintenance by dominant groups and how it can be mobilized to serve subjugated groups. According to Foucault (1991) reclaiming the word madness is a practice of “strategic reversibility of power” through the medium of language and discourse (as cited by Menzies et al., 2013, p 10). This practice has been similarly seen in the LGBTQ2+ communities through the reclamation of the term queer. The madness discourse is said to “invert the language of oppression...restoring dignity and pride to difference” and autonomy for peoples with mental illnesses (Menzies et al., 2013, p. 10). Foucault (1991) has also inspired mad studies to embody a critical pedagogy, which is concerned with

disseminating a counter-knowledge or subjugated knowledge as a way to contest assumed truths that are perpetuated by dominant groups (as cited in Menzies et al, 2013).

For the purposes of this chapter, I will draw from Ingram's (2008) definition of mad studies as the "project of inquiry, knowledge production, and political action devoted to the critique and transcendence of psy-centered ways of thinking, behaving, relating, and being" (as cited in Menzies et al., 2013, p. 13). Mad studies is positioned in opposition to psy-centered practices, while simultaneously recognizing and validating the experiences of those who have come into contact with psy-centered systems (Menzies et al., 2013). Further, Menzies et al. (2013) explain how mad studies is primarily sourced, at its core, through the lived experiences of those people who have been directly influenced by psychiatric systems. Menzies et al. (2013) also states how mad studies recognizes and is cognizant of relations of sameness and differences, utilizing an intersectional lens in its analysis (Menzies, et al., 2013). Finally, mad studies is devoted to a greater restructuring of the mental health industry (Menzies et al., 2013). Mad studies scholars argue there are multiple spaces where this restructuring can occur, including the institution of education (Jones & Browne, 2012; Menzies et al., 2013).

3.3 The Intersection of Critical Disability and Mad Studies

There has been some debate as to whether or not there is a place for mad studies within the realm of critical disability studies (Beresford, 2000). Beresford (2000) explains how some disability scholars have thoughtfully argued for their separation, wanting mad studies and critical disability studies to be uniquely distinguishable; however, Beresford

(2000) rebuts that difference still exists within both disciplines, therefore, difference should not necessarily mean grounds for separation. Beresford (2002), and Jones and Browne (2012) advocate for the alignment of CDS and mad studies based on a few key reasons. To begin, Beresford (2002) says that both psychiatric system survivors and disabled people lumped together in a system which uses externally imposed definitions and categories that have ramifications on policies, legislation, and administration systems that rely on a medically defined model of disability. Second, Beresford (2000) argues that there are significant overlaps between both groups in regards to intersecting identities and experience. By this he means that many psychiatric system survivors identify with other disabilities and vice versa (disabled people identifying with mental illness). Third, Jones and Browne (2012) and Joseph (2015) state that critical disability studies provides a platform or entry point for mad studies to critically take up issues of oppression, violence at the hands of biomedical psychiatry, eurocentrism, and discrimination. Finally, Beresford (2000) argues that both disabled people and psychiatric system survivors are exposed to marginalization and oppression within our society. Based on the commonality of experience and shared social justice goals, it is understandable as to why it is advocated for both critical disability and mad studies to coexist and collaborate on disability debate and action.

3.4 How Critical Disability and Mad Studies Align with My Research

It is imperative for the purpose of this thesis that both lenses be used. Both critical disability and mad studies align well with my research topic, challenging the assumption that mental illness is a problem to be fixed and examining how power structures,

dominant discourses, institutions, language, and behaviours keep people with mental illnesses marginalized and powerless, while those deemed mentally fit maintain power. The application of critical disability and mad studies to the institution of education allows me to deconstruct the current educational environment, critiquing the ways that schools are structured to oppress students with mental illness and advance the students deemed mentally fit. Further, in using both critical disability and mad studies throughout the research process, there exists the potential to raise critical consciousness among participants, and foster emancipation through the exposure of new knowledge or way of understanding previous experiences. Finally, both critical disability and mad studies demonstrate a commitment to social change. Using these theories in my research I intend to discover what change is needed to remove barriers for folks with mental health issues and challenge sanist thoughts and/or actions. Using this methodology it is crucial that the criticism of institutions does not remain just that; transformative social action must also occur.

Chapter IV: Methodology

Mason (2002) describes methodology as the strategy by which you go about answering your research questions and solving the intellectual puzzle that has been established in the research design. For the purposes of this thesis research both aspects of interpretive phenomenological analysis and an arts-informed process were used with intent to guide the research process. This chapter will describe how both interpretive phenomenological analysis and an arts-informed process were used, why they were compelling for this specific thesis, and how they work collaboratively to answer the research questions identified in the introduction chapter.

4.1 Interpretive Phenomenological Analysis as a Methodology

Informed by interpretive social science and the belief that knowledge exists within human experience, I chose phenomenology as my primary methodological positioning guiding the research process. According to Petty, Thomson, and Stew (2012), phenomenology originated in Germany in the early 20th century. Rooted in psychology and philosophy disciplines, phenomenology is most commonly associated with the works of Heidegger, Gadamer, Satre, Husserl and Merleau-Ponty (Petty et al., 2012). Phenomenology seeks to understand the essence of a given phenomenon through the unique experiences of individuals (Petty et al., 2012; Pringle, Drummond, McLafferty, & Hendry, 2011; Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013).

Under phenomenology two variants exist, that is, descriptive and interpretive (or hermeneutic) phenomenology (Petty et al., 2012; Tuohy et al., 2013). The former is

concerned with describing a phenomenon in general terms and characteristics to arrive at conclusions. In contrast, the latter is concerned with the description, understanding, and interpretation of an individual's experience in order to arrive at conclusions about the given phenomenon (Tuohy et al., 2013). Consistent with the beliefs of both critical disability and mad studies, interpretive phenomenological analysis (IPA) became the methodological approach most fitting for the research project given its emphasis on the experience of individuals and co-constructive meaning making (Pringle et al., 2011; Tuohy et al., 2013). Critical disability, mad studies, and IPA all value the lived experience of individuals and posit that individual testimony can reveal the essence of a phenomenon.

Interpretive phenomenological analysis was also appealing for the research process in that it recognizes how both the researcher and the participant bring with them their own values, beliefs, and experiences to their arrived interpretations of phenomenon (Tuohy et al., 2013). Traditional phenomenology encourages a practice called bracketing, which was not followed by this researcher (Petty et al., 2012). Bracketing is a practice whereby it is expected that the researcher 'bracket' (put away) their own feelings, thoughts, biases around the phenomenon, in order to deepen their understanding and avoid reproducing a narrow and pre-described conclusion (Petty et al., 2012). In my research I resisted this component of traditional phenomenology and more closely followed IPA, which allows and even encourages the researcher to reflect on their positioning within the research and how it may influence possible outcomes (Gadamer, 2004; Petty et al., 2013).

Researcher reflexivity is similarly supported in the works of Gadamer (2004) who speaks to this practice through his horizon metaphor. Gadamer (2004) explains how each individual brings with them a unique horizon of understanding, that is, the vantage point at which they view phenomenon. The horizon is shaped by a confluence of historical, cultural, and social contexts (Gadamer, 2004). Horizons can also be reshaped, expanded, and/or new horizons can be acquired based on the interactions we have with others as we try to understand the horizon they bring in that moment (Gadamer, 2004). Throughout the semi-structured interviews with participants I was highly cognizant of how my values, beliefs, and past experience with the education system and social work's position within it would contribute to the arrived at understandings between myself and the participant. Through open dialogue the participant and I were able to reach a shared understanding of their experience.

In their overview of interpretive phenomenological analysis, Tuohy et al. (2013) speak to the four existential themes identified in the works of Merleau-Ponty that are used by phenomenologists to reflect on the ways individuals can experience the world; lived space, lived time, lived body, and lived human relations. Among these existential themes, both lived space and lived human relations influenced the inquiry and analysis phases of the research project. Mackey (2005) states that through a 'lived space' lens a person's reality is grounded in the space they most frequently occupy; further, these spaces are uniquely "felt" by the occupant and will differ depending on the environment (as cited in Tuohy et al., 2013, p. 19). A lived space analysis was compelling for my research because I was interested in the experiences of youth with undiagnosed mental

health concerns in both alternative and mainstream settings. The lived space analysis was applicable to my research in that it considers how a youth's understanding of the world is significantly shaped by their school environment. Alternatively, Van Manen (1990) states that the lived human relation theme is interested in how people communally experience the world with those around them (as cited in Tuohy et al., 2013). Tuohy et al. (2013) further explain that the way an individual experiences the world is shaped by the reciprocal influence people have on one another. The lived human relation theme was helpful for my research in that it spoke to the ways the interpersonal relationships youth may develop either at home, at school, or with social welfare systems, may influence how they make sense of their experience and the world around them.

4.2 Arts-Informed Process as a Methodology

There are many ways a researcher can gather data or information pertaining the topic being studied. Traditionally, qualitative data collection has been accessed through three primary forms: focus groups, one-on-one interviews, and survey responses (Mason, 2002). Arts-informed methodologies provide an alternative approach to research and expression. The idea that information can be conveyed outside of verbal expression aligns with Langer's (1953) seminal philosophy of art, which states that art presents a unique opportunity to express that which words at times cannot (as cited in Chilton & Scotti, 2014). Beyond accessing information, Hervey (2004) explains that arts-based research can be utilized in all phases of the research project to include initial design, data collection, and dissemination (as cited in Chilton & Scotti, 2014). For this project an arts-

informed process was enticing for its potential to enhance the research experience for participants.

One of the most commonly agreed upon benefits of arts-informed inquiry is its potential to access information that would not otherwise be accessed through traditional qualitative inquiry (i.e. interviews and focus groups). Mann and Warr (2017) make the comment that art can be a more accessible way of expressing abstract thoughts or complex emotions that are often difficult to verbally communicate. Further, Kusenbach (2003) and Prosser & Loxley (2008) argue that when partaking in research with youth an expanded methodology to include arts-informed inquiry can be useful for times when the youth has not had the opportunity to critically reflect on their past experiences, and/or feels unable to narrate (or name) said experiences (as cited in Mann & Warr, 2017).

Arts-informed process was also used in consideration with its fit with critical disability and mad studies. Through her project Boydell (2011) demonstrates how arts-informed methods can be appropriately aligned with the values and aims of critical disability and mad studies. Interested in the collaboration between arts, inquiry, lived experience, and creative dissemination, Boydell (2011) used dance to portray individuals' experience of psychosis and their unique pathways to mental health care. This project highlights how art can be used to disseminate the meaningful stories of individuals, thus promoting horizontal pedagogy and knowledge translation of those with lived experience to wider audiences (Boydell, 2011). Valuing the knowledge that stems from the experience of individuals is a crucial element of critical disability and mad studies, and is similarly supported through arts based research methods (Menzies et al., 2013).

How Art (Collage) was used to Enhance the Research Process

I was initially drawn to use of art as it provided an alternative way of expression for participants. I knew from experience working with children and youth that verbal communication is not always an effective way of conveying one's thoughts and feelings; therefore, I felt art may be a useful communicative aid for some participants. As many scholars have noted (Leavy, 2014; Chilton & Scotti, 2014; Sinding, Paton, & Warren, 2014) art is an effective way to explore topics that may be sensitive or difficult to verbalize. While I recognize that arts-informed methods are helpful in data elicitation and analysis, I was more interested in exploring how the process of engaging in an art activity could enhance the overall project and participant experience.

An arts-based activity within a focus group setting was included into the research design due to the benefits I felt were inherent in the *process* of creating art rather than the *product* itself. To begin, I felt that participating in an arts-based activity among a group of youth with shared experiences would organically result in group solidarity and empathic understanding between peers. It was my hope that an arts-based activity would facilitate natural conversation throughout the process of creation, and that in this time participants may find comfort or support through the recognition that others share their experience. Further, it was my hope that through the creative process the participants will have an opportunity to reflect on their experiences so that when the time came for them to participate in the semi-structured interview they would feel more comfortable expressing themselves having already had the time to self-reflect. I felt the mixed methods aspect of this study created a more collaborative and comfortable experience for the participants. In

the initial research design phase of the project I felt discomfort with the ethics of traditional qualitative interviewing. The idea of meeting a youth once in an interview setting and asking them a series of personal questions felt intrusive and non-genuine. From my experience of working with youth I have learned the importance of building rapport, especially when a natural power imbalance exists within those relationships. I felt that the two-phase mixed-method approach to the study allowed rapport and familiarity to be built between the participant and the researcher, which would hopefully result in more comfort for the participant as they entered the interview process.

For the purposes of this study I was also drawn to collage for its consistency with photo manipulation, deconstruction, and reconstruction. This arts-based method aligns with critical disability studies in that it provides a medium through which individuals can present meaningful critique of given standards and societal norms that are perpetuated through visual representations (Shildrick, 2012). Inspired by empowering outcomes of Fudge Schormans' (2010) *photo changers* project it was my hopes that collage creation would similarly result in an empowering experience for participants, as they use the deconstruction and reconstruction of visuals to express their realities and lived experiences. As exhibited by Fudge Schormans' (2010) project, I feel that there is something very powerful about the physical manipulation of dominant images to create a new image that is representative of a person's reality. Further, I feel there is potential for empowerment in having the participant create a piece of art that they can then keep post research project. There is no exact way of knowing the possible outcomes of artistic

engagement; however, as Leavy (2014) states the alternative possibilities that emerge from the unknown is part of what makes art so impactful.

Reflections

The decision to use collage as a method of inquiry in my research was intentional, made with careful consideration of the possible benefits and associated risks. Through my review of existing literature on arts-informed research and collage as a method I am content with my choice to include an art component in my research project, and feel it was appropriate given the research context. Reflecting on the use of an arts-informed process I see that art was an effective tool for some of the participants but not all. Some participants were drawn to the art activity and had no difficulties finding images that they felt represented their experience, while others struggled to express themselves visually and felt more comfortable in the one-on-one interview setting. As I observed the participants engage with one another, it was interesting to see them talk about their mental health challenges, and begin to recognize that others in the room had similar stories, emotions, and/or thoughts on the issue. The arts-informed focus group was unique in that it provide a comfortable and informal setting for the youth to engage with one another and take up meaningful conversations about mental health.

Throughout this chapter I have spoken to how it was my intention to use an arts-informed process to benefit the participants; however, I was later reminded of the fact that the researcher is not objective in this process and that any choice in research design has its own set of implications. Further, I was challenge to think about what I (as the

researcher) may have gained from an art-informed process. As I reflect on the outcome of the collage activity I recognize that there was information that arose from the group that may have impacted the interviews, shaping my thinking and the questions that were asked. This project has revealed to me the innovative and accessible ways that art and images can be used as a means of knowledge translation with others. I feel as though for this project the art was effective in building solidarity within the group, building rapport between the researcher and participants, and eliciting initial data that would be explored further in the one-on-one interviews.

4.3 Integrating Phenomenology and an Arts-Informed Process

The integration of an arts-informed process and interpretive phenomenological analysis was a decision that I feel enhance the overall research process. In my belief, supported by Pringle et al. (2011), these methodologies are both compatible and complementary for a qualitative research project. Pringle et al. (2011) state that interpretative phenomenological analysis leaves space for creativity and flexibility in data collection. Willig (2001) argues that IPA allows “more room for creativity and freedom” than other approaches because the participant narratives can be shared through multiple creative avenues (as cited in Pringle et al., 2011, p. 22).

Further, the arts-based activity was effective in generating what Leavy (2014) refers to as researcher-participant empathic engagement. This empathic understanding is critical in an interpretive phenomenological analysis as the researcher attempts to grasp the meanings that the participant has attached to their experience. Engagement with art

allows the viewer to “imaginatively enter (or come close to)” someone’s lived experience and foster greater empathic responses (Sinding, Paton, & Warren, 2014, p. 193). Using art as a method to more closely see another person’s worldview aligns with phenomenological task to understand someone’s reality through the experiences they choose to share.

Beyond building empathy and understanding, using both an arts-informed process and an interpretive phenomenological analysis enables multiple avenues of expression for the participants (Sinding, Paton, & Warren, 2014). Offering alternatives of expression reflects the theoretical underpinnings of critical disability studies that challenges us to recognize the equal validity in the different ways of being embodied and expressing our embodiment (Boydell, 2011; Sinding, Paton, & Warren, 2014; Shildrick, 2012). By using both interpretive phenomenological analysis and arts-informed methods the participants had the option to express themselves in a way that was comfortable for them, whether that be through visual art or verbal expression. In this project art was used to disrupt traditional notions of knowledge and knowledge production, allowing individuals to express themselves in ways outside the norm. Used in collaboration, interpretive phenomenology and arts-based research methods provide greater opportunity for the participant to share their experience with a given phenomenon, and enables the researcher to more closely understand the participant’s worldviews.

Chapter V: Methods

5.1 Sampling and Recruitment

In line with my proposed research questions I was interested in collecting a small sample of youth between the ages of 16-22. There was no specific gender requirement for this study. Participants were local to Hamilton Ontario and were either currently enrolled in conventional secondary education, enrolled in alternative education, or a recent secondary school graduate of either school system which includes students who have earned a High School Equivalency Certificate. Participants must have experienced mental health concerns (as defined by the participant) significant enough to have impacted their school experience. The criteria of “mental health concern” remained fairly open ended to not restrict students who-self identify with various mental health issues. In addition, participants had to have experience with being streamed into and/or encouraged to enroll in alternative education.

Undiagnosed/Diagnosed Criteria

Based on the proposed research question(s) it was appropriate to exclude participants who had a diagnosis for their mental health concern while in school. The study is interested in those students who have experienced gatekeeping of mental health services and pressure to attend alternative education due to their lack of a mental health diagnosis. It is assumed that students with a mental health diagnosis more easily access accommodations within conventional schools. This assumption is based on the researcher’s experience and observations within practice. Therefore, students with a medical or psychiatric diagnosis were excluded from this study. However, when

participants reached out to me stating their interest in the project there were some who stated that while they did not have a diagnosis during their time in school, they have since sought a diagnosis or a diagnosis was given to them in their final years of secondary school. It was decided that these participants would be included in the study because they would still be able to provide meaningful data that reflected the research question(s), speaking to their experiences prior to be diagnosed.

Participants were recruited through various methods. I began recruitment by reaching out to agencies in Hamilton who focused on providing youth mental health services. With permission from the agency staff I displayed a recruitment poster (see “Appendix G: Recruitment Poster”) that I personally created on a public website design program called Canva at their agency. I then displayed my poster in various public spaces that were close to the secondary schools in Hamilton, targeting spaces that were frequently visited by students (i.e. pizzerias, coffee shops, sandwich shops, convenience stores, and bus shelters). I also used my personal Facebook page and Instagram profile to share the poster. The posts were set as “public” allowing friends and family to circulate the poster if they so desired. Finally, I was given permission to visit one of the agencies I initially contacted and advertise my study in person at their site. Permission to visit the site was given by the executive director of this agency and an ethics amendment certificate (see “Appendix L: Ethics Amendment Certificate”) was also granted to recruit through this means.

5.2 Data Collection

Both a focus group and one-on-one interviews were used to collect the data. The interviews and focus group were designed using sample guides that were made available to graduate students on McMaster University's website (see "Appendix C: Focus Group Guide" and "Appendix D: Interview Guide"). Influenced by arts-informed inquiry, the focus group was centered on a collaging activity. The participants received three questions/statements from which they chose one question to be the motivation or prompt for the art they created. The participants then had the opportunity to discuss what they created with the group, however, it was not mandatory. I then asked follow up questions to generate larger group discussion. The participants were given the option to either keep their creation or leave it with the researcher. All but one participant kept their art. The interviews were semi-structured, meaning I had prepared a set of open-ended questions (see "Appendix D: Interview Guide") but asked further questions that organically fit with the dialogue. Both the interviews and the focus group were audio recorded to make a detailed analysis possible and ensure data accuracy. Consistent with interpretive phenomenological analysis, I did not take any handwritten notes as this may have interfered with the fostering of natural dialogue (Balls, 2009).

5.3 Data Analysis

The first step for data analysis was to transcribe verbatim all audio-recordings from the focus group and interviews. In order to achieve authenticity and remain true to the participants' voices I avoided altering the transcripts as much as possible (Balls, 2009). The only time the transcriptions were altered was when a participant used names

or places that may have made them identifiable to the reader. This was to ensure participant confidentiality was maintained.

Consistent with my epistemological and methodological orientations, I then conducted interpretive reading of the transcripts that Mason (2002) says involves “reading through or beyond the data in some way” to arrive at your own interpretations of the data and identify emerging themes (p. 149). Using a computer software program called Quirkos I began the process of coding, which Miles and Huberman (1994) defined as “tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study” (as cited in DeCuir-Gunby, Marshall, & McCulloch, 2011). I assigned data driven codes (those that emerge from the raw data itself) to the transcripts to identify the themes (DeCuir-Gunby et al., 2011). Through Quirkos I was able to visually display the themes to see which were most significant. After identifying several themes and sub-themes based on repetition, significance, metaphor, and language, I collapsed the data to identify the themes that were most significant and engaged in axial coding that attempts to determine if the themes were at all interrelated in some way (DeCuir-Gunby et al., 2011). Consistent with what was written into the research design and ethics application, I chose to not provide an analysis of the physical art creations; however, the discussion that followed the art activity was recorded, transcribed, and coded, following the data analysis process outlined above.

5.4 Ethical Considerations

This study was reviewed by the McMaster Research Ethics Board (MREB). After some minor and major revisions to my application, I received ethics clearance to conduct

the study. All participants were aware and were reminded that they could always contact the MREB directly if they required further information or had any outstanding questions. This section will provide an overview of the ethical considerations pertaining to consent, confidentiality, management of risks, possible benefits, and dissemination of knowledge to participants.

Consent

For the purposes of this study consent was documented through the letter of information/consent form(s) provided to the participants prior to the study and signed at the time of study. Prior to conducting the focus group and interview, I reviewed the letter of information and consent form(s) with the participants, sought confirmation of understanding, and gave them the space to ask questions or seek further clarification. I also reminded the participant of their right to withdraw from the study penalty free, up until July 1st, 2018 at which time data analysis and writing was underway. The participant then signed two copies, one of which they kept and the other I maintained for my records. For the purposes of this study, the decision was made to waive that parental consent. I recognized that the participants in my study are minors and that there are special considerations when a minor is involved in research without parental consent. I felt that privacy was essential to the study and that the lack of parental awareness may increase privacy for participants. In this study consent was only be obtained from the participants themselves (following regulations of consent as per TCPS2).

Confidentiality

Every effort was made to protect the participants' identities and privacy. I did not use their names or include any information that would allow them to be identified in data analysis. Participants were reminded of the limits of confidentiality, where as an academic researcher I have a duty to report if it is disclosed or suspected that the participant intends to harm themselves or cause harm to another person. As a safety measure I have asked the participants to provide a parent/guardian or another trusted adult emergency contact number to be used in those cases where confidentiality legally needs to be breached. Further, participants were reminded that is possible someone could be identified by the stories they choose to tell, and to consider this when deciding what to answer. Finally, in attempt to protect focus group confidentiality, all members read and signed a confidentiality agreement (see "Appendix E: Confidentiality Agreement") which outlined the direct terms of participant confidentiality.

Risks and Benefits

The risks to participating in the study were moderate. There is the potential for social and/or psychological risks by participating in the study. The participant may feel uncomfortable, nervous, and/or uneasy about disclosing personal information, or they may be worried about how others will respond to what they say. Further, I cannot guarantee that what was said in the focus group will not be repeated outside of the group, which may lead the participant to feel betrayed or exposed. It is also possible discussing/reflecting on our mental health may elicit an emotional response. In attempt to provide the participants with support in the event that they felt triggered, a list of local

and accessible mental health resources was provided and the participants were encouraged seek them out if they felt it was needed.

The participants were given two \$20.00 gift cards of their choice to either Limeridge Mall, Starbucks, Tim Horton's, or Chapters/Indigo for their participation in the study. I also provided the participants with two HSR bus tickets to reimburse and travel expenses, and offered coffee, water, and small snacks at the time of the focus group and interviews. A thank you card was distributed at the end of the interview with the second honorarium enclosed (see "Appendix J: Thank-you Card Message"). While there was no direct benefit from participating in this study (besides the honorariums), it was my hope that the participant felt their voice is heard and valued in shaping the future of secondary education, mental health response, and policy related to both mental health and education. Further, it is my hope that this thesis may be shared with professionals in the field of education, and that some of the recommendations provided (by the participants) will be considered and applied, in attempt to reduce shame, stigma, separation, or undue hardship that a student struggling with their mental health in school may feel.

Dissemination to Participants

In effort to minimize researcher parachuting and notable power imbalances (cite), I wanted to ensure the participant could receive a summary of the study's results if they so desired. Participants had the option to indicate on the consent form that they would like a summary of the study's results in the form of an infographic. I felt an infographic aligned with my methodology and provided a fun and accessible way for the youth to receive the information.

Chapter VI: Findings

Relying on perspectives from mad studies and critical disability theory I have arrived at several key findings which I feel provide genuine insight into research topic. These being: distrust of school staff as a barrier for support and services, internalized independence resulting in resistance to services, genuine belief that school staff are unable to support student mental health, realization that services are unattainable without a label or diagnosis, belief that alternative education has been a means to an ends, and consensus that peer support is the most effective mental health resource for this cohort. These findings illuminate the experiences of youth with undiagnosed mental health concerns within the institution of both mainstream and alternative education, and through participant's suggestions provide meaningful direction for social change.

6.1 Distrust of School Staff as a Barrier for Support and Services

Common among most participants was a distrust of school staff resulting in a barrier for accessing in-school support and services. Due to their frequency of interaction with youth, it would be assumed that school staff could be a valuable source of support around their mental health and/or could be helpful in directing students to other mental health resources; however, consistent with what was found in the literature review this is assumption is not reflective of our reality. As I interviewed the participants it became apparent that they did not feel they could trust school staff for various reasons.

To begin, the participants reported negative past experiences with school staff that had discouraged them from seeking support in the future. Participant two discussed his encounter with a school social worker, stating “there were social workers [at my school],

but they weren't really social workers, y'know (laughing). They were...terrible. If that's what you want to call social worker". Participant two did not explain what he meant by "terrible", however, he continued to explain his perception of what a good social worker should be and how his past experience with social workers had not met his expectations, saying:

A social worker should make time for you, check in. All the social workers I ever got... they didn't do any of that. I had to go check in with them. It's like what do I look like to you? Like I'm the one with the mental illness, and yet I have to come to you? Nah, forget that. I never really spoke to them either, I just... you know what, I am in this world alone now, screw you guys, I can do it by myself.

My interpretation of this statement is that his encounter with the social worker left him feeling neglected and unimportant. This encounter reinforced his perception that he is "alone" and has to manage his mental health independently. Further, the dissonance between what he felt was the social worker's role, and their sub-par fulfillment of the role, left him feeling as though he were better off to "do it by [himself]".

This finding was echoed by participant five who stated that his "vice principals are pretty bad and everyone at [his school] are just bad and lazy". He further explained that his school "[has] a learning resource team" but felt they were "obsolete and kind of busy". While participant five did not elaborate on what he meant by "bad" it appears that like participant one, participant five also felt neglected and that the staff would not make the time for him.

Participants in the study also described the negative experience of being labeled deviant and being "paced under suspicion" and/or surveilled by school staff after disclosing their mental health issues or having an encounter with the mental health

system. Both participant one and participant three explained how their depression prevented them from attending class at times, and continued to explain how teachers responded to their absences in a disciplinary manner. When I asked participant one how her teachers responded to her absences she explained:

I got in trouble, and they didn't really understand why [I was missing school]. Like even when I would tell em why, like I was depressed and was not going to come to school, I got in trouble still for it. And that just makes me feel worse.

Participant one's statement describes a lack of empathy and understanding demonstrated by her teachers. It appears that the behaviour of missing school (resulting from mental health challenges) was treated in disciplinary means by school staff. The response she received discouraged her from disclosing her mental health to her teachers and resulted in a newfound resentment for school staff.

Participant one further described how after she had an encounter with the mental health system, school staff began to "baby her" and had an educator assistant (EA) "sit in" on all her classes. She recalled:

As soon as a told them [about my mental health] they began to baby me around everywhere. Like they had someone come to class with me, like a sit in, a teacher. Like my EA teacher. Ya fricken, every class someone from there was with me. Like why? It'd be so embarrassing man! It's like a full classroom and you just have a random teacher sitting beside you.

Participant one's statement explains how the surveillance that was place upon her, without her consent or consideration, resulted in her feeling embarrassed and singled out. This experience only heightened her resentment of her teachers and distrust of school staff. This surveillance was also brought up in participant five's interview. He explained that "people smoke for a lot of reasons" but as soon as school staff are aware that you

smoke “you are put on a suspicion list”. Participant five seems to feel that engaging in smoking results in those students being labelled suspicious and worthy of surveillance by school staff. It appears that both participant one and five felt surveilled at one point in time, and this perception resulted in greater distrust of school staff and lessened the likelihood that they would ever use school staff as a resource for their mental health concerns.

Participants in the study also explained how they found it difficult to build rapport and relationships with school staff, resulting in a lack of mutual trust. Many participants commented on how the majority of their teachers failed to take an interest in them and get to know them on an individual level. In our interview, participant five described a time where he experienced a “rush of emotions” in class and said it “may have been a breakdown”. When asked whether or not his teachers noticed his state, he said that they did not, and he felt it was due to their lack of relationship and inability to pick up on his “cues”. Participant five later explained that he felt if the breakdown were to occur in one of his tech classes, the teachers would have noticed his emotional state and provided him with support. He explained that:

In tech I am very social with my teachers, we converse, like I’ll stay at lunch and just talk to them. Whereas in math class or English class it’s kinda weird, they don’t really pay attention to you. So maybe if it [the breakdown] happened in one of those classes, somebody might have noticed.

Participant five’s statement emphasizes the importance of taking an interest in the lives of your students and taking the time to converse with them on an individual level. His account reminds us that the first step in helping a student is building a personalized relationship with them.

Finally, participants in the study reported a serious lack of trust in the concept of confidentiality. When the participants were asked if they had ever met with a school social worker to get support for their mental health challenges, many reported an extreme disbelief that confidentiality was legitimate in those spaces. This disbelief that confidentiality would be maintained acted as a significant deterrent from reaching out for help. Participant five explained how he had been referred to speak to guidance or talk to an adult but felt that it was not a safe nor confidential space to do so. He said:

Obviously they say speak to an adult or you know go to guidance, but in terms of confidentiality... it's not confidential. I can tell you for a fact it's not confidential. If I were to tell them about my drug use, which I feel like, I don't use drugs anymore, but when I did... it went right to the vice principals.

This fear that any information disclosed would become privy to the vice principals was echoed by participant one who explained that she “had her IEP teacher but I only felt comfortable talking about a few things [with her], cus [she] knew all [the IEP teacher] would do was run to the principle”. Confidentiality breaches appear to be the main reason why students are not trusting of school staff, and this belief continues to prevent youth from seeking support when it may be needed. When asked what the biggest barrier was to accessing in-school mental health support, participant five was quick to say “confidentiality, ya that's really [the biggest barrier]”. This finding illuminates a major flaw in our social service sector, a flaw that should and could be easily addressed by social workers and their employers.

6.2 Internalized Independence Resulting in Resistance to Services

Stories of Internalized Independence

One of the greatest commonalities amongst all participant interviews and the focus group was the belief that mental health was something that each individual had to manage on their own. I have interpreted this finding as *internalized independence*. By this I mean that each participant had come to understand mental health and illness as a phenomenon existing on an individual level. Further, participants were quick to state that they were the sole ones responsible for managing their mental health. When asked if he ever sought out support for his mental health challenges from anyone in his life, participant four said he did not “need help from nobody” and that he “[was] just coping with it the best way [he could]”.

Participant four’s belief that his mental health challenges are to be dealt with independently was also revealed during the collaging activity. His art included an image of a golden star that was located in the centre of his collage. When asked what the star represented participant four said:

The star represents who you are, because like you... the sky’s the limit, only you are stopping you from completing your mental health. Only you can stand in the way of the path you want to create.

The symbolism behind the star confirms participant four’s belief that he is solely responsible for his mental health outcomes. While his sentiment is positive and demonstrates resiliency and a drive for attaining one’s goals, it also represents the prevailing message that mental health is a product of individual shortcomings, which requires individual change and action to correct.

The term independence is used because I feel it accurately represents the sense of pride or capability that each participant felt they had acquired by dealing with their mental health on their own. Participant two described the independence he felt and attributed to the fact that he never felt supported by his family. When reflecting on his past, participant two explained:

I've been independent since I was fourteen. I went out on my own, independent, and I'm doing it all by myself. If I want help, I'll go seek my own help. Like look how good I'm doing so far.

Participant two clearly felt that because his family had not supported him in the way he would have wanted, he learned to take care of himself. From his past experience he became more independent, and took pride in the fact that he was able to manage life challenges on his own.

Participant two continued to describe his internalized independence recalling a time where he had been referred to services through the youth criminal justice system. He explained how his probation officer said “you know there are some supports that could help you with mental illnesses, and we can come up with the funding”. His response to this offer is an excellent example of what I have labeled internalized independence:

I don't know if it's just me and it being like a pride thing or something, but I looked at this lady and I'm straight up said: no, I'm not talking money from nobody, not even you guys, and I know you guys are the government but still I don't do that.

This statement is so powerful in that it exposes the sense of independence this participant felt that was integral to his identity. He later explained how this pride and sense of independence may have been an outcome of how he was raised. He explained that “[he] was told at home that if I did tell anyone [about his social/emotional/familial issues]

then... [he] would get disciplined obviously... and would get in really big trouble”. It appears that participant two’s family had a large influence over him, shaping his outlook on how people are to go about managing social and emotional issues.

Poor Experiences with Mental Health Systems

Participants in the study also explained how they had previous poor experiences with the mental health system resulting in their belief that they were better off managing their mental health on their own. Participant five described his experience in an anxiety group that was regulated by a nearby children’s hospital. He explained:

I would go to this program called “No Fear” which is for kids with anxiety, and half the stuff was so corny and so cheesy. It was like, the game of life you know what I mean, like it would show you different outcomes for what you did or how you behave, how other people will react. A lot of those kids needed it. Obviously I have anxiety, but it wasn’t that extreme for me. I mean, you don’t want to go to the programs, you don’t, it’s not a fun experience.

Participant five’s recollection of his experience in the anxiety group was highly negative. Based on my interpretation of his statement he found the group to be not helpful, disengaging, and not a good fit given his perception of his own circumstance.

Through his testimonies, participant five explained further why he remained critical of the psychiatric system and the services offered within it (i.e. anxiety group). Participant five was particularly vocal with his negative experience of being diagnosed as a child. He explained that he felt he had been misdiagnosed resulting in his distrust of the system. He explained:

Like the social worker would tell my parents ‘oh your kid has trouble focusing’ and then like based off my behavior from like kindergarten.... like I would write things in my textbook like ‘miss you dad’, like sad stuff, or like I’d draw pictures of my parents fighting, you know? But my aunt would tell me like, “you’re just a

regular kid going through something, I don't know why they would treat you like this. Like you seem pretty normal to me".

Participant five describes how his low mood (due to his parents' recent divorce) and difficulties focusing were flagged by school social workers as an indicator of mental illness, and because of these behaviours he was referred to psychiatry to be diagnosed. He later recalled an encounter with a doctor, he stated:

I guess one time I like freaked out, I was really upset. And the doctor was like 'wow you're very mature for freaking out, kids your age would accept it [medication] and just take it'. I remember thinking that was kind of weird. He was trying to make me feel good, you know what I mean, for fighting it, when like it's [medication] is causing me so much distress... I am fighting with my mom at home, I feel like shit a school, you know. It was really weird, really odd... like maybe he was just trying to help me in the moment, right, but I thought it was a weird thing to do.

Participant five explained how he never identified with the diagnosis he was given and how he feels to this day he was misdiagnosed.

It can be inferred that participant five's experience of being diagnosed at a young age may have influenced his resistance to the anxiety group. He never felt that diagnosis was accurate and had a great distrust of psychiatric professionals as a result of this poor experience. Participant five did not identify with the anxiety group's need as noted by his statement "a lot of those kids needed it" and "obviously I have anxiety but it is not that extreme for me". Participant five was quick to create a division between himself and the others who were referred to this group. It is my interpretation that his rejection of the anxiety group may be in part due to his poor past experience with the psychiatric system.

Participant two similarly described his negative experience with various mental health systems. He explained how the time constraints and demands had been overwhelming for him, and was not helpful at that stage of his life. He stated:

Like the more people rush me, I'm going to get even more overwhelmed. Like what's the point of that. Like you're trying to help me be less upset, yet you're coming to me with certain times to be at certain places and what not, and knowing fully I can't [meet] at that time, putting stress on stress. It makes no sense carrying more weight on my shoulders, when I can just do it myself.

Participant two's statement identifies how the rigid structure of our mental health systems is not accommodating of the diverse lifestyles of youth, especially with regard to those who are marginalized or transient. It appears that the system participant two was referred was not helpful, and exacerbated his stress and the mental health issues he identified with. These negative experiences described by both participant two and five provides a partial explanation why they were unlikely to seek support and resources from others regarding mental health and wellbeing.

Systemic Barriers

School based mental health systems were also found to be inadequate based on participant responses. Participant five described the inadequacy of the mental health services and systems operating within his school. He explained how he felt "system is broken and it's too outdated". He further explained that in his opinion, based on the "amount of students who need one-on-one help, or like need support, there's not enough learning resource teachers and social workers. So it's a "little too late when they get to you". Participant five's statement leads me to believe that earlier intervention and support is needed in order for student to be adequately assisted. In addition, his statement

identifies that the number of staff in social, emotional, and educational support roles is insufficient given the growing demand of students who require those services.

Negative experiences with mental health systems, systemic barriers to support, and an internalized belief in independence led participants to be what mental health professionals have termed “resistant”, to using mental health services. The term resistance often carries a negative connotation in the field of social work as it is used to describe a person’s resistance to accepting/accessing services. However, in my interviews with the youth, it appeared that the participants made the conscious and personal choice to opt out of traditional or medical interventions that are typically recommended by “professionals” in a psy-centered and/or medical model understanding of mental health. For most participants this was because their past experiences of mental health services were unhelpful or inappropriate for their specific needs.

For example, participant five shared how he refused to accept help from the resource team at his school. He explained how his past experiences with resource teams had been ineffective and how he never felt his opinion or voice was validated in those settings. When referring to his high school resource team he stated:

I was kind of pissed off and didn’t want anything to do with them. I just kind of ignored them. Like they would try to talk to me, frisk me, and I kinda like, tell them to go away. Like I don’t want it.

Participant five’s negative past encounters with resource teams and mental health services left him feeling very frustrated, and resulted in his choice to refuse those services being offered to him. The findings suggest that poor past experiences with mental health systems, systemic barriers to support, family influence, and identity formation have led to

participants internalizing mental health as an issue of the individual. Social, cultural, and economic factors that may have influenced this finding will be further discussed in “Chapter VII: Discussion and Analysis”.

6.3 Strongly Held Belief that School Staff are Unable to Help

When asked what they thought school staff could do better to support student mental health and wellbeing, consistently all participants initially responded “there’s nothing they can do to help”. The belief that school staff are unable to help was strongly held among all six participants. When participant two was asked the question he initially laughed and retorted with “what kind of a question is that?”. He later continued and said:

What could they really do for me though? Like that’s the question (laughing). Like what can the teachers really do? What can the principles really do? What can anybody in the school really do? All they can really do is call a doctor.

His response demonstrates the belief that school staff are ill equipped and unable to provide mental health support. Further, participant two’s response demonstrates perceptions about mental health and treatment that are strongly rooted in the medical model. As I interpret it, the participants statement “all the can really do is call a doctor” is representative of his core belief that mental illness can only be treated through medical means, and that school staff are not in a position to help given they do not work in a medical field. After further discussion and questioning with participant two he suggested that “[school staff] could have public health nurses available”. His primary suggestion for how school staff could help support student mental health was to refer to medical professionals and to have medical services available in school. This finding demonstrates a lack of holistic thinking around mental health and wellbeing, and speaks to specific

socialization and social constructs. This finding will be elaborated on in “Chapter VII: Discussion and Analysis” where I will unpack the belief and commitment to the medical model.

Participant five similarly explained how he was unable to see how school staff could be of use to him with regards to mental health and wellbeing. He described how in his opinion there is “nothing [school staff] can do about it” and that he “[doesn’t] really know what help they could give [him] because the advice [he is] looking for, [he doesn’t] think it can be answered”. Participant four also described disbelief that school staff could do anything to help. He explained that “there’s really nothing, like when someone is feeling depressed there is really nothing you can do except pretty much, be by their side”. It appears that participant four perceives mental illness as something to be endured, and all anyone can do is sit beside and wait for the storm to pass (so to speak). As I interpret this statement, I feel it demonstrates a disempowerment narrative, where mental illness is perceived as having power over the individual as opposed to the individual having power over the mental illness.

Another common response I heard from participants was that mental health was not part of the job description for teacher and other school staff. Many participants felt that mental health wellbeing promotion was not a responsibility of school staff, therefore, they are not prepared nor able to provide any services or support as it pertains to mental health. As participant one explained:

Well in that school [public], I had an IE teacher at that point but they don’t really... they aren’t there for that reason [mental health], they’re more there for your learning disability. Like she would help me with it [mental health] but there’s only so much they can do, cus there’s no set person there [at school] as a mental

health worker or something, back when I was in high school anyways... maybe it's different now.

Participant one's response demonstrates that some teachers will try to support student mental health, but because it is not within their scope of practice or expertise, there is little they can do to provide meaningful assistance. This finding is revealing of the fact that students do not feel school staff are capable of supporting student mental health, despite the frequency and quality of interactions school staff have with youth on a daily basis.

6.4 “You Can’t Get Services without Having a Diagnosis”

When asked what they thought the connection was between having diagnosed mental illness and accessing services, many participants were quick to answer that the diagnosis was necessary condition of receiving services, resources, and support. Further, the thought that someone could access services for their mental health concerns without having a medical diagnosis was inconceivable for many participants. Participant two was even confused by the question and struggled to respond because he perceived the answer to be very cut and dry. As he bluntly put it “you can’t get services without a diagnosis (laughing), like what kind of a question is that?”. Participants were unable to see how living diagnosis free may be a choice for some, and how this choice might not necessarily negate them needing or wanting support around their mental health.

Conversely, based on their varying experiences with/without diagnoses, participants were also able to identify the significant link between having a diagnosis and accessing services. Participant one described her experience prior and post diagnosis, as she recalled:

Well when I didn't have the labels, I wasn't getting the help so I was like I'm not even going to ask for help cus they aren't going to give it to me. The only reason they gave it [help/support] to me was after I came back from the hospital, that psycho place, they [the doctors] told the school. So it's not like I asked them. So it just made me feel like I have to have that label in order to get help, so I'm not even going to bother.

Participant one's statement alludes to the fact that prior to being diagnosed, she was unsuccessful accessing services. She later explained how "people who are supposed to care, only care if there's a label, and if there's not a label they don't believe you". As participant one stated "it makes us not even want to talk to them". Participant one needed help prior to diagnosis, but without the "label" services not provided to her and her experience was not validated. This experience left her feeling very rejected and ignored, and deterred her from seeking help in the future. Based on her experience with the mental health system participant one was quick to see how having a label and a medical professional's validation were necessary conditions for accessing services and being provided accommodations from school staff.

After identifying the significant relationship between having a diagnosis and accessing services, participants were provided the opportunity to further share their thoughts on the mental health system. Responses were fairly divided. Some disagreed with this system, believing that access should not be so dependent on a medical label. Participant two explained that "you can go seek help even if you're not diagnosed, just to find out if you should be...even if you're not diagnosed, or you shouldn't be diagnosed with anything, you should be able to get help regardless".

Similarly, participant one argued:

I don't agree with it, but I feel like you have to have a label to get anything... like a job, school, work, anything! If you don't have a label they don't care. Like it shouldn't be like that. Like if you know you have issues with it [mental health], then you should be able to go talk to somebody and get accommodations... instead of getting a fricken label on you.

Both participant one and two explained how if the individual is able to recognize that they may need help, accommodations, support, or resources for their mental health concern they should be able to access such despite not having a diagnosis. Further, if the individual is successful in accessing services, this should not mean they must then follow up with a doctor to receive a diagnosis.

Other participants advocated for earlier identification/diagnoses under the justification that you will receive help and support more quickly after being diagnosed. Participant five explained how he felt the system had misdiagnosed him, and that he wanted to be re-diagnosed in order to access the services and supports that were more linked to his mental health needs as a teenager. He explained:

One time I was mad at the learning resource and I was just like, 'well re-diagnose me then!' and they were like 'that'll take like four years, there is a waiting list'. So I have been trying to be re-diagnosed but it's just like, I'll be in collage pretty soon so it's not worth it.

His frustrations stem from what he felt was a misdiagnosis and being given supports and services that did not accurately reflect his needs. By the time this was recognized and verbalized, the participant felt the process of being re-diagnosed would be too lengthy and would result in further frustrations. Participant two also recognized how earlier diagnosis enables access resources and support in a more timely manner, thus avoiding someone living with their mental health issue unsupported. He explained that "if you don't want to go get checked you might just break down one day, and beat yourself up for it, and regret

it”. As I interpret it, based on participant two’s experience he felt that a diagnosis should be sought out if it was in the best interest for the person’s mental health and wellbeing, and would result in immediate access to services. Based on participant response, it appears that without a diagnosis, it is very challenging to receive mental health support within the education system that reflects the needs of youth.

6.5 Peer Support Works Best

After initially struggling to imagine what support for mental health would look like, participants were eventually able to name peer support as the preferred method. Peer Support Canada (2018) defines peer support as “emotional and practical support between two people who share a common experience, such as a mental health challenge or illness”. Further, someone in a peer support role shares in the experience of the person seeking assistance and is trained as to how to effectively provide support to this person (Peer Support Canada, 2018). While participants were not using the term “peer support” in the same way that it is used in many grassroots mental health organizations, what they described as the most helpful to them was a friend or acquaintance who they trust, who will provide an empathic response, and/or someone who shares their experience or has had a similar experience.

The concept of peer-support was first mentioned in the focus group when the participants were invited to engage in a discussion about their collages. When it was participant four’s turn to share his collage, he identified several images that he chose to include, explaining their symbolic significance. He eventually pointed to an image of a table with two empty shares, with a caption that read “table for two”. He explained that

“[he] chose this picture because when [he’s] in a low state [he] want[s] to be with close friends”. When the group was asked to identify anything that stood out to them from each other’s art, participant two said he liked the “table for two image” explaining how he felt he could relate to the image, because it reminded him of the importance of having a “small circle” of friends that he could “rely on”. I then asked participant two how the people in his “circle” responded to his mental health issues he said how “[they] responded positively, they would assess the situation and try to get [him] to forget about it and help [him] move on to better things”. Both participants identified how having a few close friends, whom they could rely on and feel comfortable turning to for support had been helpful for them as they attempted to manage their mental health issues.

The concept of peer-support was further explored with the participants in their one-on-one interviews. In my interview with participant five, he was very clear that he would only feel comfortable seeking support from someone who he trusted, and that the trust would stem from knowing that the person shares his experience. Participant five explained that “[he] would have to trust, not trust but [they] would have to have similar experiences for [him] to actually accept [their] advice, like [they] would have to be alike”. Participant five’s response demonstrates how trust and understanding is built on a foundation of shared experience. Participant four similarly explained how he would generally not disclose his mental health status to most people, and that he only really felt comfortable doing so if he knew that they could relate based on shared experience. He said “I don’t really tell people, or [I’ll] ask them if they have also heard voices”. For participant four it would require knowing the person he went to for support shared his

experience for him to feel comfortable disclosing his mental health status and to accept support or advice.

Participants also explained how for them peer support could be talking to a close friend or someone they trust. Consistently participants described how a close friend would be the first to hear about the mental health difficulties they were experiencing. Participant two described one friend in particular who he had known for a very long time, and who he felt he had a mutual support system with. He stated:

I just need like moral support, it's all I really go for. Like I'll go rant, I'll go to somebody I really trust I'll just rant to them. My friend that I really trust, he lives up the mountain. I pretty much grew up with him. Cus he's the only guy I this world that I swear to god, that I trust - that's not my blood.

For participant two this friend who knew him very well and had been there during other challenging times in his life, was the one person he felt confident going to for support. Participant five similarly described how he would only feel comfortable going to someone who he knew would genuinely care based on a developed relationship. He stated “I wouldn't really feel comfortable telling anybody unless it was a close friend of mine, someone who's invested in me”. As I interpret it, participant five's use of the word “invested” is describing a person who has genuine care and concern, and someone who will stay with them through the process and the outcome. Both participant's accounts tell us that peers or close friends will always be the first responders to the mental health challenges young people experience.

Participants also explained how their peers are able to help by providing an empathic response and then offering guidance. When asked what the best thing a person can do to support you and your mental health, participant five answered “I would like to

be acknowledged, but not babied...being acknowledged is different than being babied...and then I would like to be challenged on my thinking”. Participant five described how validation was helpful but further explained how he would not want to be babied. He explained how he would appreciate talking through his experiences in a critical way, hearing advice that he had not heard before, and/or thinking about his experience through a new lens or way of understanding.

Participant three and participant one differed from participant five in that they wanted support in its purest form. When asked what is the best thing a persona can do to support you and your mental health, participant three answered “just that they support me, that’s basically it. I’m just looking for support”. When asked to describe support further, participant three explained how they wanted that person to support their choices, actions, thoughts, and feelings. When asked the same question, participant one explained how “people need to be more friendly, understanding, and open minded” and that she would like to be “respected, believed, and heard”. To these participants, support was about being empathetic, nonjudgmental, and validating of their experiences and choices.

Finally, in our discussion around peer support participant five described how his school had begun student-run mental health and wellbeing initiatives. When initially asked what mental health services look like in his school he was only able to report on those that were run by students. Further, he described how social media had been used as a platform to spread awareness about mental health and offer that peer support service. He explained:

I know there are a lot of [school] Instagram pages run by students, like Westmount Spark and like all these different things. Ya but like nobody uses

them, you know what I mean, cus they aren't that cool... actually maybe people do, and I know that there are a few programs and stuff.

It appears that peer perceptions of what is “cool” or “not cool” still persists, but participant five was quick to correct himself and explain that he really is not sure how often these services are utilized due to their private and more confidential nature. Whether or not student run initiatives are being used to their full potential, this finding is interesting because it highlights a trend in schools where peer support and student-run mental health services are becoming more recognized and utilized among youth in schools.

6.6 Alternative Schools as an Effective Means to an Ends

In this study all participants had either attended or currently attend alternative education. In an effort to explore the research question “how do alternative schools meet the needs of students with mental health issues” I asked the participants to describe the impact that alternative schooling had had on their lives. Almost all participants shared how alternative education for them had been an effective means to an ends, meaning that alternative school provided them the opportunity to achieve the goals that they had set for themselves.

When discussing their experience in alternative education settings, participants in the study felt that these schools serve a meaningful purpose of helping students achieve their goals of earning credits, graduating, and developing skills. Many participants emphasized how alternative education was not that different from “mainstream” schooling in that it was a place where curriculum was taught, credits were earned, and

students graduated with plans for entering a pathway of some kind (college, university, workplace, or apprenticeship). As participant two explained:

I didn't go for changes, whatever changes it made, I don't really care about cus at the end of the day it [alternative school] is just making me smarter. Alright like it's a school, it's just like mainstream, you're just in a smaller class. Getting the education and the credits that I need to graduate, to get me where I want to go afterwards, that's it that's the way I look at.

Participant two explained that although the structure may be different, the objective is the same: educate the students and help them achieve their goals. For him alternative education did not change him as a person, it just enabled him to work towards the goals he had set out for himself, in an environment that was more conducive to his learning and social needs.

Participant one similarly described how alternative school has provided her with the opportunity to improve her English and attend college. During the focus group, participant one included the words “achieve” and “success” in her collage, explaining how she felt she had achieved better grades and felt she was going to succeed this year in school. In her interview, participant one reiterated how in alternative school “[she] got to work on [her] English and [she's] finally going to college, so [she] guessed that's a good thing”. She then later said “I think if I didn't go to alternative education, I probably wouldn't be going to collage right now.” As previously described, participant one had a particularly challenging time in mainstream school and it seems that alternative education provided her the opportunity to accomplish the goal of improving her English mark so she could be accepted to a collage program that was of interest to her.

Almost all of the participants felt that their alternative education path had helped them get one step closer to achieving their future academic and career goals. Participant one has been accepted to the law secretary program at a nearby collage, participant two aspires to become a nurse, participant three aspires to become a paramedic, participant four would like to attend culinary school to become a chef, and participant five aspires to be an audio engineer. Participants had a clear understanding of their goals and recognized how alternative schooling had fit with their achievement of their goals.

Participants also commented how their goals were more achievable because there was less distractions in alternative schools. The participants described how drama, gossip, and the immaturity of their peers had all been distracting for them in mainstream schools, and that alternative schools significantly minimized those which interfered with goal attainment. Participant two stated how “in public school there was just so much drama and gossip” and questioned “how [he was] supposed to learn anything with [that] around him”. Participant five explained how in his alternative school “everybody is in their own bubble, and that is kind of how you have to be because it is so self-paced and independent, like you are there to do work”. Consistently it appears that alternative schools provide a more practical experience for students and has helped them achieve their goals.

Participant one further explained how the judgment and bullying she experienced in her mainstream school had negatively impacted her mental health and resulted in her struggling academically, socially, and emotionally. She explained how:

In public school people judge you for the littlest things. They’ll pick on you for the littlest thing, and if your mental health is already not great it’s hard. But in

alternative school there's only like twelve people in the class, it's not that big of a space for people to judge you, cus they're all there for the same reasons because they don't want to go to the regular school. So I like that better, I can I feel like I can focus on my work and actually do it.

As I interpret it, participant one felt safer in the alternative setting and therefore could better focus on her schooling. This finding was echoed by participant two who stated how in alternative school he did not “have to deal with people's bull crap in the classroom, y'know, throwing spitballs around and whatnot” he felt he “[could] actually get work done”. It appears that school drama, bullying, and immaturity was a significant distraction for participants and that alternative settings provided a space where the participants were enabled to focus on their education. While this finding was significant, it is important to note that it was not consistent among all participants. Participant three had experienced bullying and drama in their alternative school, to the extent that they withdrew from school entirely. In addition, while participant five recognize that alternative school was an education-focused spaced that minimize distractions and fostered independence, he was quick to critique it in that he felt he was not provided the same social experiences of that of his peers in mainstream schools. As he described it “academically it's great, socially it's terrible”. While participant five did not expand on what he meant by “terrible”, his testimony indicates that he felt somewhat isolated from his peers, and did not feel he was given adequate opportunities to make social connections.

Finally, participants also reported that their alternative school was effective due to better student-teacher relationships within these settings. Participant two described how he felt his “voice was actually heard” in his alternative school, and that the teachers made

the time to explain difficult concepts within the curriculum to their students. Further, the participants explained how teachers were sensitive to the unique needs of students, and were more willing to make the time to accommodate those needs. As participant one explained:

I feel like [in alternative school] I'm actually a somebody, cus you get more attention, that you normally wouldn't get in public school cus there's not, it doesn't have to do with the teachers, there are more people more students. You don't get the more one-on-one time that you would need, or that certain people would need, if they have anxiety or whatever.

As I interpret it, participant one's statement "I'm actually a somebody" indicates that in alternative education settings she feels valued and that her teachers have taken an interest in knowing the unique person she is. Furthermore, by knowing and recognizing the individuality of their students, teachers in alternative schools are better able to accommodate and support students' mental health needs. Participants were quick to attribute better student-teacher relationships to the structure of alternative schools that enables smaller class sizes and more one-on-one interaction.

It was also found that the participants were more likely to discuss their mental health issues with their teachers in alternative settings. The comfort students felt discussing socioemotional issues with their teachers was attributed to the smaller class sizes and one-on-one interaction time. Participant one explained:

Since there's fewer people I have more access to the teacher, to be able to talk to them, whether I was sad or even about school. I always have someone to talk to. In the alternative school there are always two teachers there so if I ever need to talk there is a backroom there where they will come and talk to me. Like sometimes, the teacher will notice I'm upset and come talk to me, or I'll go to them and ask to talk to them.

Participant one describes how the accessibility of her teachers made her more comfortable confiding in them when she felt it was needed. Further, participant one described how the teachers take notice of her and are able to recognize when she may be in need of support. This is strikingly different to the finding discussed earlier where the participants described a lack of trust in their public school teachers and a resistance to accept school based mental health services.

Chapter VII: Discussion and Analysis

The purpose of this chapter is to take a deeper look at the findings and provide and analysis of the themes and concepts that have emerged from the data. These themes will then be considered when revisiting the primary research question: “what has been the experience of youth with undiagnosed mental health issues in school settings?”.

7.1 Individualization

As discussed in “Chapter VI: Findings” a significant finding was that youth struggling with their mental health preferred to manage it on their own without help from others. I had called this internalized independence, however, it is important to more critically engage with how the independence is internalized, and what cultural, social, political, and economic factors have influenced youth to feel that mental health is a problem of the individual.

When looking at how mental health is internalized as an individual problem neoliberalism cannot be ignored. Esposito and Perez (2014) define neoliberalism as a the “vision and order of the world in which all aspects of social, cultural, and economic life are shaped by market rationality” being the evaluation of all actions and behaviours based on what is acceptable or desirable to the free market (p. 416). Neoliberalism encourages individuals to change their behaviours, attitudes, and actions to align with the market demand, to be a functioning and contributing member of a capitalist society (Esposito & Perez, 2014). Not doing so is considered to reflect a personal deviance or pathology.

In a neoliberal society, mental illness is heavily medicalized and seen as a problem of the individual, ignoring the social, cultural, and economic implications that

negatively impact mental health (Esposito & Perez, 2014; Lewis, 2013). Individuals are seen as “self-contained agents” and they are pathologized for their thoughts and behaviours that deviate from the expected norm, that is, fulfillment through success in the marketplace. The neoliberal society places the expectation on individuals that in order to compete and “come out on top” they must assume “personal responsibility for their own problems” (Esposito & Perez, 2014, p. 422). Blaming personal problems on social, cultural, or economic factors is seen as an excuse for problems that lie with the individual. The individual then must be solely responsible for overcoming the pathology they might have (Esposito & Perez, 2014; Lewis, 2013).

This message that the individual is responsible for solving their own problems is taught to us early on and is heavily reinforced. In an individualistic society self-reliance is viewed as a positive and admirable quality (Esposito & Perez, 2014). In contrast, in a collectivist society the individual is encouraged to connect with their family and community to overcome challenges, recognizing how this promotes social solidarity and positive mental health (Kirmayer, Simpson, & Cargo, 2003; Manitowbi & Maar, 2018). However, as explained by Manitowbi & Maar (2018) collectivism and the promotion of community interconnectedness is one of the many cultural underpinnings of Indigenous communities that has been erased at the hand of colonialism. A history of colonialism and the growth of neoliberalism has shaped how individuals are taught to manage issues such as mental illness. When looking at how the youth in this study have internalized their independence and self-reliance we cannot forget how this stems from a confluence of historical, cultural, and political factors that promote a neoliberal hegemony.

Critical disability scholars have also spoken to the problematic nature of individualization and how it reinforces oppression. CDS asks us to consider how we are complicit in the maintenance of oppression (Meekosha & Shuttleworth, 2009; Shildrick, 2012). Individualization is one way in which individuals become subdued to oppressive nature of psychiatry and the ways in which bodies are controlled to ensure hierarchies of power (Foucault, 1978; Meekosha & Shuttleworth, 2009). The individual is taught to think that mental illness exists within the person, rather than looking at how social determinants of health such as poverty, homelessness, or unresolved trauma may impact a person's mental health and wellbeing, and how these social issues could be addressed at the systems or policy level. The individualization of mental illness becomes the norm and through this social construction oppression is maintained (Freud, 1999; Shildrick, 2012).

7.2 Risk of Disclosure and Systemic Stigma

Earlier it was reported that students in this study did not feel comfortable disclosing their mental health status to school staff because they perceived school staff to be not trustworthy. Participants had developed this perception due to poor past experiences with the system, doubts that social worker services were indeed confidential, and difficulties building relationships with school staff. While these are all valid reasons to distrust school staff, another factor must be considered: stigma.

Goffman (1963) was one of the first social theorist to write about stigma in his book titled *Stigma: Notes on the Management of Spoiled Identity*. Goffman (1963) states that “stigma is equivalent to an undesired differentness” (as cited in Brown, 2013, p. 147). However, what is deemed desirable or undesirable is contingent on the social and cultural

context at that given time (Brown, 2013). Further, it is the powerful or dominant groups that determine what is desired or undesired, thus what is stigmatized reflects the values and judgments of the dominant groups. Brown refers to stigma as a “powerful and pernicious social tool” used to make specific people feel inferior and result in downward social mobility. It is possible that someone who has been stigmatized can have a personal awakening or develop a critical conscious, discovering that “the responsibility for being stigmatized does not lie with the person themselves” (Brown, 2013, p. 153).

Jorm et al. (2012) argue that stigma is something placed on a person to mark them out as defective, degenerated, or...dangerous” (as cited in Large & Ryan, 2012, p. 1099). A main reason why mental illness has become stigmatized in society is the belief in dangerousness and/or the perceived risk mental illness poses to society (Large & Ryan, 2012). Large and Ryan (2012) posit that belief in dangerousness has been the most damaging of the prejudices that are held against people with mental illness. This belief has been further perpetuated by pop culture film, television shows, and media coverage of the few incidents, “1 in 10 000” to be exact, where a homicide is committed during first-episode psychosis (Large and Ryan, 2012, p. 1099). It is important to remember that these messages that perpetuate the belief in dangerousness are not missed by younger generations.

While no participant directly named stigma as an operating force, I feel it enriches to discussion to consider how socially constructed stigma associated with mental illness may work to deter youth from disclosing to school staff. As participant one described, once she disclosed her mental health status to her school she was “babied” and was

heavily surveilled by a “sit-in teacher” who followed her to all her classes. Participant one described how embarrassing this process was for her, and I can infer the process made her feel outed as different. Based on Brown (2013) and Large and Ryan’s (2012) analysis of stigma I feel that participant one’s experience may have reinforced an undesired difference. Further, the surveillance that was enforced over her perpetuated the belief in the dangerousness of mental illness, which may have left her feeling stigmatized in her school environment. This experience to me demonstrates why the fear of being stigmatized is valid and why it may deter students from seeking help from school staff.

7.3 Alternative Schools as a Means to an Ends, but what Ends Exactly?

In “Chapter II: Critical Review of the Literature” it was identified that while alternative education can indeed be a positive experience in a young person’s life, there is considerable evidence that speaks how students in alternative schools bring with them an othered and stigmatized identity as a result of being marginalized within their mainstream school (Kim & Taylor, 2008; Loutzenheiser, 2002; McNulty & Roseboro, 2009).

Students in the study were quick to acknowledge how their attending an alternative school had helped them take the necessary steps toward achieving their life goals. I am glad to hear that students feel adequately supported in alternative school settings, however, this is a fairly one dimensional and non-critical analysis of the alternative school experience. A discussion of what is possibly lost or risked by attending an alternative school would enrich the overall analysis.

Contributing to the prior discussion around stigma, McNulty and Roseboro (2009) wrote that students felt stigmatized when they enrolled in alternative schooling and

perceived that they subsequently adopted a deviant identity. Further, Kim and Taylor (2008) noted that the students in their study perceived alternative education to be a “dumping ground” for problem students and deviants (p. 211). The “dumping ground” reference is similarly discussed by Brown (2013) who speaks to how social exile is experienced by those who are stigmatized. Brown (2013) explains how stigmatized people are often not encouraged to develop or grow or to have aspirations to be successful.

As noted in “Chapter II: Critical Review of the Literature”, some students in alternative education feel as though they are not being fostered to their full potential (Sayaki, 2001). In Sakayi’s (2001) study students felt that the mediocre education they were receiving in alternative settings was disrespectful to them as individuals and had done a disservice to them by not preparing them for future success. The findings of Kim and Taylor (2008) and Sayaki (2001) support the arguments made by Kelly (1993) that students in alternative education were treated as second-class citizens, and that the system perpetuates social, political, economic, and educational inequalities.

In attempt to achieve educational equity, Lehr and Lange (2003) and Sakayi (2001) assert that alternative schools must maintain high expectations of their students and must hold their instruction and curriculum delivery to the same standard. Kim and Taylor (2008) assert that without systemic change “the [alternative] school will serve merely as a tool to reproduce the ideologies of the dominant social groups and the hierarchy of the class structure rather than promote social change, equality, and equity” (p. 217). While it appears that the participants in my study were indeed encouraged to

pursue their dreams whilst in alternative education, it does not negate the possibility that other youth who attend alternative schools may feel socially exiled or discouraged from upward social mobility.

Participant five was the only participant who was critical of his alternative school experience saying “academically it’s great, socially it’s terrible”. From my conversation with participant five it appeared that he always felt his difference was reinforced in an alternative school setting, and that he was not afforded the same social opportunities as that of his peers in mainstream settings. It appears that participant five greatly sought the “normal teenager experience” but did not feel this was fostered in his alternative school. In response to Raywid’s (1999) argument that alternative schools can serve to normalize, McNulty and Roseboro (2009) make the argument that alternative schools will never be a normalizing space for students because “they reinforce stigmatized identities, and serve to incubate stigmatized students in a collective of others who share their stigma” (p. 418). I feel participant five’s experience may be more closely aligned with the literature that argues how students attending alternative schools bring with them an othered and stigmatized identity as a result of being marginalized within their mainstream school (Kim & Taylor, 2008; Loutzenheiser, 2002; McNulty & Roseboro, 2009).

7.4 What about Peer Support Does What for Youth?

In my discussions with the participants it was evident that peer support was the preferred method of treatment for youth who struggle with their mental health. Peer support is defined as “emotional and practical support between two people who share a common experience, such as a mental health challenge or illness” (Peer Support Canada,

2018). A Peer Supporter has “lived through that similar experience and is trained to support others” and inspire hope (Peer Support Canada, 2018). A key feature of peer support is enhanced social support and social networks, in addition to, an emphasis on positive change and/or increased ability to cope (Peer Support Canada, 2018). Peer support also stems from mad studies and a resistance to pys-centered treatment due to historical violence and mistreatment at the hands of the psychiatric system (Lewis, 2013). Lewis (2013) explains how mad pride activists have been successful in their efforts to promote and legitimize peer support and peer-run alternatives, however, it is challenge when the opposition located within the pharmaceutical industry is powerful and profitable.

In this discussion I want to unpack what it is about peer support that is so appealing for today’s youth. Hardiman et al. (2005) state that a common characteristic among peer support advocates and users is a shared negative experience with the mental health system. While the participants in my study are relatively young and received diagnoses for their mental health issues later in life, some reported initial contact with the mental health system at a young age; specifically, some were diagnosed with Attention Deficit Hyperactivity Disorder as a child. Menzies et al. (2013) argue that the labelling of children with psychiatric disorders is blatantly connected to social control over their thoughts and behaviour. Children that were once perceived as badly behaved or high energy are increasingly diagnosed with ADHD or conduct disorders (Menzies et al., 2013). Similarly, children who have low moods or emotional outbursts are diagnosed with depressive disorders.

The processes of being diagnosed at a young age is heavily invasive, emotionally and mentally exhausting, and impacts an individual's self-esteem. As participant five vocalized, he had a highly negative experience with the system where his emotional reaction to his parents' divorce and difficulties focusing in school resulted in his referral to psychiatric services. Participant five explained how he never identified with the diagnosis he was given and how he feels to this day he was misdiagnosed. Further, this misdiagnosis resulted in great frustrations between him and the resource team at his school, where his expectations of need differed from theirs. Participant five expressed feeling very depressed in his teenage years but did not intend to seek a diagnosis. Based on this information I can interpret that his negative experience with the psychiatric system has greatly deterred him from ever engaging with this system again, and may partly influence his preference for a peer support method.

Peer support has been further theorized to be successful because of the social support that is provided in those settings (Solomon, 2004). Social support as defined by Sarason, Levine, and Basham (1983) is the “availability among people on whom we can rely: people who let us know that they care about, value, and love us” and those who are willing to provide us with support for our social and emotional needs (as cited in Solomon, 2004, p. 394). Research suggests that supportive relationships act as a buffer for life stressors and consequent mental distress (Solomon, 2004). Based on the findings of this research I feel that social support is the key reason why participants performed peer support. The participants vocalized wanting to work through their mental health

issues with someone they trusted, who listened to them, validated their experience, cared for them, and would help them take the necessary next steps.

Experiential knowledge is further theorized to be a factor that has led to the success of peer support (Solomon, 2004). Borkman (1990) defines experiential knowledge the “specialized information and perspectives that people obtain from living through the experience of having a mental illness” (as cited in Solomon, 2004, p. 394). This information tends to be more pragmatic and useful for the person on the receiving end and is likely to provide comfort knowing the knowledge is grounded in lived experience (Solomon, 2004). Participants four and five both described how they would prefer to get help from someone “who gets it” or someone who “has been there before” because the advice they sought could only be given from someone with the lived experience. As I interpret it, living with a mental illness can be very intimidating and can induce stress. Seeking support then from someone who has lived through that specific mental health challenge decreases the fear and anxiety that the individual receiving support may be feeling, and it may be comforting to know that the advice that is given is grounded in actual experience.

There is immense literature that advocates for the use of peer support and further provides evidence for its success (Beresford & Hopton, 2000; Campbell, 2005; Patalay et al., 2017; Peer Support Canada, 2018; Solomon, 2004). In study of graduate student-led mental health literacy program called *OpenMinds*, Patalay et al. (2017) advocate for peer-driven mental health literacy programing, arguing that secondary students are more engaged and more likely to respond to those with whom they can relate. Patalay’s (2017)

study reminds us that there are ways that mental health literacy can be promoted in high school settings using effective peer-driven initiatives.

Despite the prominent peer-support narrative, some participants did say they appreciated a diagnosis that was both accurate and resulted in accessing appropriate care. It appears a tension exists between accessing the mental health system and choosing to forgo the system, opting for peer-support or other holistic initiatives. I can only infer that this may be due to system wide inconsistencies and contradictions (such as misdiagnoses, systemic barriers, etc.) that have left users feeling emotionally exhausted and confused.

Peer-support appears to provide a reliable and accessible response to the mental health needs of youth. Participant responses indicate that past negative experiences with psychiatric system, enhanced social support found in peer support programs, and perceived trust in experiential knowledge may explain why youth are saying “peer support works best”. In “Chapter VIII: Implications for Practice” I will further discuss how school communities and social workers can facilitate peer support or peer-run initiatives that are said to result in better mental health outcomes for youth (Beresford & Hopton, 2000; Campbell, 2005; Patalay et al., 2017; Peer Support Canada, 2018; Solomon, 2004).

7.5 Medical Hegemony and Psychiatric Power

When asked what they thought the connection was between having a diagnosis and accessing services, all participants were able to recognize the significant role of the medical model and how services become dependent on diagnoses. Participants felt that medical intervention and diagnoses was not just the preferred option, but the only option.

This tendency to see the science/medicine field as the source of correct and objective knowledge is known as medical hegemony (Conrad, 1979). Medical hegemony or medical social control is the undoubted acceptance of the medical perspective and the dominant definition of certain phenomena, and the tendency to use medicine to regulate, eliminate, or control undesirable attitudes, habits, and behaviours to ensure complicit normativity (Conrad, 1979).

Medical dominance is prominent in the realm of mental health and has been used for decades as an agent of social control (Esposito and Perez, 2014). Psychiatry has been deemed the preferred (or only) option for treatment, and psychiatric medicine is has been proclaimed to be the answer for living a “normal life” (Elder-Woodward, 2014; Esposito and Perez, 2014). It is important to note that normal in a neoliberal society is equated with being successful in the free market and contributing to our capitalist society (Elder-Woodward, 2014; Esposito and Perez, 2014). In their article on neoliberalism and the commodification of mental health Esposito and Perez (2014) explain:

Constructs are promoted as medical facts, mental disorders become viewed as conditions that are divorced from social, economic, and political contingencies and are turned into pathologies that can be diagnosed and treated through allegedly value-free traditions and methods of science/medicine. (p. 415)

Esposito and Perez (2014) are eluding to how a social construct becomes medicalized and promoted as a value-free and/or objective truth, when in reality there are many social, political and economic reasons for medicalization.

In a medically dominant society mental illness has been proclaimed to be rooted in chemical imbalances and/or genetic determinism, and that psychiatric drugs as the treatment of choice (Lewis, 2013). This belief is deterministic and does not consider how

a person's social, emotional, economic, or environmental realities can influence mental health. Mad pride activists have campaigned against the American Psychiatric Association (APA) asking for evidence that proves these claims. In 2003 the APA finally admitted that "brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathological lesions or genetic abnormalities that in and of themselves serve as a reliable predictive biomarkers of a given mental disorder" (as cited in Lewis, 2013). While this was a small success for mad pride activists, they are still in an uphill battle against superpower dominant group whose main ally is the incredibly profitable and very influential, pharmaceutical industry (Lewis, 2013).

As was discussed in "Chapter II: Critical Review of the Literature" the biomedical model and psychiatric power has primary control over mental health service delivery in institutions. Due to their hierarchical positioning in schools, administration (principals, vice principals, etc.) carry immense power and are able to decide who gets accommodated and how. Based on my own observations in these settings, administration will rationalize their decision based on whose disability claim is most validated by a medical professional. If a student reports struggling with their mental health and would benefit from accommodations, they then must provide medical verification from a family doctor or psychiatrist. Verification from a school social worker is often not enough to be validated. Vick (2012) argues that in order to access aid a person must be considered chronically unwell by a medical professional. Medical professionals have been deemed the acceptable expert who can acts a gatekeeper of social control and enable access to accommodations (Conrad, 1979, p. 5). Vick (2012) further explains how mental health is

often not always legitimized as a disability due to its episodic and invisible nature, and thus impacts how aid is given. Medical hegemony persists and can become a systemic barrier for many young people experiencing poor mental health who have not been diagnosed.

It should also be discussed how referrals to psychiatry are done so as a way of controlling undesirable behaviour. Conrad (1979) argues that psychotherapy and psychiatry is an agent of social control and a supporter of the status quo. Based on my observations, if a youth is “acting out” in class they will be referred to social work services. When it is disclosed that mental health is implicated, students are quick to be referred to psychiatric services to receive a diagnosis. While it is true that psychiatric services could be of use to some students and that they have autonomy over their course of treatment, it should also be considered how psychiatry is used for social control and in attempt to diminish undesirable behaviours. Menzies et al. (2013) and Lewis (2013) argue that psychiatry is often offered as the “quick fix” for behaviours that disrupt social norms. Undesirable behaviours are pathologized and viewed as an abnormality that can be corrected through medical means (Lewis, 2013). Due to prevailing medical hegemony, it is rarely considered that “undesirable” behaviour, attitude, or distress could be a result of social exclusion, isolation, or lack of opportunity that may be perpetuated in the individual’s immediate environment (Lewis, 2013). Critical disability and mad studies reminds us to remain critical of given norms or accepted truths. Challenging these dominant forces “requires more than a movement towards demedicalization, it requires an

ideological opposition against the basic assumptions and institutional practices that shape our lives” (Esposito and Perez, 2013, p. 425).

Chapter VIII: Implications for Practice

This research has revealed key implications for the larger school community and the field of social work. Through my conversations with youth it has become evident that the way in which school communities and social workers support the mental health of students is taking new direction. It is our choice as to whether we are resistant to change or whether we listen to the voices of young people, who are the most affected and most implicated in this process, and make the necessary strides for change.

8.1 Implications for the School Community

Positive Student-Teacher Relationships

My discussion with the youth in this study revealed that positive student teacher relationships do make a difference for youth mental health. Phillippo and Stone (2013) state that “teachers stand in a unique position to boost student achievement by providing a range of supports across different types of interactions with their students” (p. 371). Therefore, the larger school community must create an environment that fosters the development of organic student-teacher relationships. Some of the most meaningful student-teacher relationships come from the time spent together in extracurricular activities (Phillippo & Stone, 2013). Whether it be in a sport, music group, theatre production, club, or student government. These spaces outside of the classroom allow teachers to see the emotional and social sides of their students, and connect with them in a way that is much harder to achieve within the restrictions of a classroom. It is recognized that not all teachers can take the time away from their busy lives to take on an extracurricular role, however, if it was supported by school administration, school boards,

and/or policy makers (either financially, resourced, provided space, enable flexible time of operations, provided guidance etc.) then teachers and other school staff may be more opt to take on these roles.

Positive student teacher relationships can also be achieved by developing students' critical thinking skills and facilitating meaningful conversations in classrooms when possible (i.e. English, drama, humanities, civics, law, social studies). By allowing students to voice their opinions and contribute to meaningful conversation, teachers will be exposed to unique philosophical, epistemological, and value bases of their students (Phillippo & Stone, 2013). This is further enabled when class sizes remain low and students feel comfortable voicing their thoughts and feelings in class (Loutzenheiser, 2002; Phillippo & Stone, 2013). As Loutzenheiser (2002) explains, smaller class sizes and student to teacher ratios allows teachers to spend more one-on-one or small group time with their students, and develop those meaningful relationships. Supporting teachers to take on extracurricular roles and creating classroom environments that open up critical discussion where student voices are heard and valued, are just two examples of how school communities can do more to foster those organic and meaningful student-teacher relationships shown to contribute to overall better student mental health.

Peer-Support

My conversations with youth further revealed that peer-support is the preferred and best route for supporting youth mental health. This trend is often met with hesitation by school staff due to the fear that high school students are not socially or emotionally prepared to deal with severe mental health disclosures. The reality is that high school

students are the first line responders to their peers' mental health disclosures, regardless of their social or emotional preparedness. Rather than being fearful of liability issues, school communities can lean into this trend and begin to train and support students who are taking on this role. Peer-support training should be available to youth, policy makers should include basic mental health first aid and/or "SafeTALK" training (LivingWorks, 2016) into the mandatory health curriculum, and youth taking on this role should be supervised and meet regularly with someone who is able to provide them with support and guidance.

Fostering Independence Safely

After hearing from students who lived with mental health issues throughout their time in high school, it is evident that students feel they are able to care for their mental health independently. As discussed in "Chapter VII: Analysis and Discussion" this internalized independence is highly influenced by a confluence of complex cultural, social, political and historical factors, therefore, it is unlikely these perceptions will change overnight. That being said, if students are insisting they can do it on their own we must ensure the school community make mental health information, resources, and services readily available and accessible. These young people are resilient and resourceful. Schools should acknowledge this and provide an environment that foster these qualities and empowers youth to care for themselves. However, this fostering of independence should not negate from challenging neoliberalism and its influence over our current mental health system. The school community should take any opportunities that are presented to explain how the personal experience is politically implicated and explore

how the perception of mental health being a problem of the individual feeds the neoliberal agenda (Esposito & Perez, 2014).

Finally, the school community should continue to provide accommodations when student mental health challenges interfere with their academic experience. Teachers especially have so much power to support youth who are struggling. Teachers should be willing to listen to the needs of their students, avoid making assumptions about what is helpful and simply ask what accommodation would be the most effective, and follow through by providing the academic accommodations that will give the student the best chance at success. Lastly, accommodations should be given in the least intrusive way. Students want to be heard and respected. When a student discloses a mental health issue, believe them and validate their experience. Remember that the school community has immense power and can greatly impact these students in a positive way.

8.2 Implications for the Field of Social Work

Mendenhall and Frauenholtz (2013) said that social workers are in the ideal position to spearhead mental health initiatives in their schools. Mendenhall and Frauenholtz (2013) argue that social worker's value base, mission statement, and knowledge and experience in the mental health field make them ideal candidates to lead endeavors of this kind. I would agree and argue that social workers are in a unique position where they are able to engage with students in meaningful ways, exposing them to social justice issues and what it means to help others. If peer support is the future for supporting youth mental health in schools, social work should have a large role to play in the development of a peer support program. This would include training of students,

overseeing the program, adapting and improving constantly, and remaining available to students to provide that supervision and support.

Another huge implication for social work is client-worker confidentiality. After my discussions with youth it was highly evident that many of them are not willing to engage with youth because they fear that whatever is disclosed will be reported to either the school administration, their teachers, or their parent/guardian. These fears are rooted in past experience with social work where they felt betrayed when something they disclosed to their social worker in confidence was later share with someone else. The Canadian Association of Social Workers (2005) Code of Ethics states:

Social workers demonstrate respect for the trust and confidence placed in them by clients, communities and other professionals by protecting the privacy of client information and respecting the client's right to control when or whether this information will be shared with third parties. Social workers only disclose confidential information to other parties (including family members) with the informed consent of clients, clients' legally authorized representatives, when required by law or court order... or when disclosure is necessary to prevent serious, foreseeable and imminent harm to a client or others. (p. 7)

Social workers who are not practicing confidentiality must revisit this code and hold themselves accountable to practice confidentiality in an ethical way. Anyone who encounters a social worker should be reminded of the limit of confidentiality, and should be given the opportunity to seek clarification when needed. Further, it is recognized that some host settings (such as a school board) may try to override CASW Code of Ethics (2005) with their own internal policies that encourage social workers to share client information with other involved parties. If host setting has policy around this, social workers should be protected to advocate for ethical client-worker confidentiality, and policy should be rewritten to respect what is expected of social workers registered with

the College. Confidentiality breaches are a huge barrier for many students, but is a barrier that can be easily removed.

Social workers are also encouraged to take the time to make their presence known within their schools. It used to be that school social workers were expected to be discrete, however, by encourage discreteness social work becomes perceived as a service that is somehow shameful to be using. This discreteness only further perpetuates stigma around accessing services. Social workers should be encouraged to be visible in their schools, check in with students regularly, and build those organic relationships. Social workers may even be involved in the larger school community through various initiatives and/or extracurricular activities. Through this, students may become more comfortable and trusting of their school social worker, and may be more likely to seek help when it is needed.

Finally, social workers with an interest in social justice should be critical of the ways in which medical hegemony influences their practice. Social workers should consider how their practice is shaped policies that are written to prioritize psy-centered ways of thinking. Social workers should also consider how much of their practice is guided by the social construct of normalcy, and what it would mean to disrupt normalcy in practice. Social workers can look to critical disability and mad studies, which both provide compelling counter positions to medical hegemony and its control over and historic oppression of people with disabilities, to inform the implementation of a critical and anti-oppressive practice.

Chapter IX: Conclusion

Through the qualitative interviewing with youth who identify with having undiagnosed mental health concerns while attending mainstream and alternative schools, I have discovered how this phenomenon is uniquely experienced by this cohort and what students in this position would like to see changed in their school systems to better support their wellbeing and personal aspirations. Participants in this study voiced how poor relationships with school staff and general distrust in helping professionals has resulted in an internalized independence, where they feel mental health management has become their sole responsibility. Participants were not inclined to seek support from school staff or social work services, opting to manage their mental health on their own. That being said, participants recognized how positive student-teacher relationships can benefit their social, emotional, and academic wellbeing, and in instances where a positive student-teacher relationship was reported, were more likely to disclose their mental health status and seek support. Further, participants voiced how trusting relationships with their peers and peer support like interactions can be helpful to maintain positive mental health. Finally, participants noted that their enrollment in alternative school had been effective means to an ends, being that these smaller settings, flexible programming, and positive student-teacher relationships had been effective in helping them achieve their goals.

This thesis presented a critical analysis of the data, and argued how cultural, social, political, and economic factors may be implicated in the shaping of the participants' responses and perspectives. Namely, the influence of neoliberalism, medical hegemony, capitalism, and stigma on participants' perceptions of mental health and

mental health treatment. Most significantly, this discussion highlighted how individualism and personal pathology has been ingrained in our society and has constructed mental health as an individual problem, to be solved by the individual themselves. This social construct completely disregards how our environments, political, cultural, social, and economic contexts shape our mental health and wellbeing; further, it negates how families, friends, and communities can collectively work together to improve an individual's mental health and wellbeing.

After listening to the youth in this study and engaging with the relevant literature I have discussed the varying implications for school communities, policy makers, and the field of social work. School communities and policy makers are encouraged to support the development student-teacher relationships that the potential to support positive student mental health. School communities are also encouraged to lean into the peer support trend and ensure the school environment makes mental health services, resources, and support visible and accessible to their students. Social workers who work with this population are reminded of the importance of client confidentiality and should recognize how breaches in confidentiality can greatly deter students from seeking support for their mental health and other social/emotional challenges. In addition, host settings (such as educational institutions) that enact policy that overrides client-worker confidentiality should be revisited and rewritten, recognizing the importance of worker-client confidentiality and its limitations that are ethically considered to protect the privacy and safety of the client.

This study is limited by the time, budget, ethical considerations, and resources impacted the scope of this study. Future research could expand on this project, by following up with students in the Greater Toronto Area across varying school boards and alternative school settings. The small sample size also limits the diversity of voices that are represented; however, the sample was relatively diverse given its small size. This study represented voices from different racial, gender, socioeconomic status, and sexual orientations. In future projects it would be beneficial to expand on this sample gather data from youth with varying identities and intersectional experiences to ensure accurate representation of the population. Finally, this thesis focused on the experience of youth with undiagnosed mental health in school settings; what is absent then is the voices of school staff who are also uniquely implicated in student mental health and wellbeing. Future research would benefit from listening to teachers, guidance counsellors, social workers, and administration to try to uncover their unique experience and role in supporting student mental health (both diagnosed and undiagnosed) in school settings.

References

- Azzarello, L. (2017). Reverberations of neo-liberal policies: The slow dilution of secondary alternative schooling in the Toronto District School Board. In Bascia, N., Sokolov Fine, E. Levin, M. (Eds.), *Alternative Schooling and Student Engagement: Canadian Stores of Democracy within Bureaucracy* (55-70). Toronto, ON: Macmillan.
- Balls, P. (2009). Phenomenology in nursing research: methodology, interviewing and transcribing. *Nursing Times*, 105(32), 30–33.
- Becker, S. (2010). Badder than “just a bunch of SPEDs”: Alternative schooling and student resistance to special education rhetoric. *Journal of Contemporary Ethnography*, 39(1), 60–86.
- Beresford, P. (2000). What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability & Society*, 15(1), 167-172.
- Beresford, P. & Hopton, J. (2000). The future of critical psychiatry. *Critical Social Policy*, 26(1), 57-73.
- Broome, J. (2015). Using hip-hop music to enhance critical discussions on postmodern art. *Art Education*, 68(5), 34-39.
- Brown, L. C. (2013). Stigma: An enigma demystified. In L. J. Davis (Eds.), *Disability Studies Reader* (117-131). New York, NY: Routledge.
- Campbell, J. (2005). Effectiveness findings of the COSP multisite research initiative. *Grading the evidence for consumer driven services*. UIC NRTC webcast. Chicago, IL.

- Canadian Association of Social Workers. (2005). *Code of Ethics*. Retrieved from <https://www.casw-acts.ca/en/Code-of-Ethics>
- Canfield, D., Curtis, B., Galabuzi, G. E., Gaymes San Vicente, A., Livingstone, D., & Smaller, H (2014). Restacking the deck: Streaming by class, race and gender in Ontario schools. *Our Schools/Ourselves*, 23(2). Ottawa: Canadian Centre for Policy Alternatives.
- Chilton, G., & Scotti, V. (2014). Snipping, gluing, writing: The properties of collage as an arts-based research practice in art therapy. *Art Therapy*, 31(4), 163-171.
- Connell, R. (2013). The neoliberal cascade and education: An essay on the market agenda and its consequences. *Critical Studies in Education*, 54(2), 99-112.
- Conrad, P. (1979). Types of medical social control. *Sociology of Health and Illness*, 1(1), 1-12.
- Cooper, B. (2004). Empathy, interaction and caring: Teachers' roles in a constrained environment. *Pastoral Care in Education*, 22(3), 12-21.
- Cornaglia, F., Crivellaro, E., & McNally, S. (2015). Mental health and education decisions. *Labour Economics*, 33(Complete), 1-12.
- DeCuir-Gunby, J., Marshall, P., & McCulloch, A. (2011). Developing and Using a Codebook for the Analysis of Interview Data. *Field Methods* 23(2), 136-15.
- Denny, S. J., Clark, T. C., Fleming, T., & Wall, M. (2004). Emotional resilience: Risk and protective factors for depression among alternative education students in New Zealand. *American Journal of Orthopsychiatry*, 74(2), 137–149.

- Elder-Woodward, J. (2014). "Living well" vs neoliberal social welfare. *Ethics & Social Welfare*, 18(3), 306-313.
- Esposito, L., and Perez, F. M. (2014). Neoliberalism and the Commodification of Mental Health. *Humanity & Society*, 38(4), 414-442.
- Findlay, L. & Sutherland, A. (2014). "Professional and informal mental health support reported by Canadians aged 15 to 24". *Health Reports*, 25(12), 3-11. December. Statistics Canada, Catalogue no. 82-003-X.
- Flaherty, M. and Roussy, A. (2014). A Failed game changer: Post-secondary education and the Accessibility for Ontarians with Disabilities Act. *Education Law Journal* 24(1).
- Fleming, T., Dixon, R., & Merry, S. (2012). 'It's mean!' The views of young people alienated from mainstream education on depression, help seeking and computerised therapy. *Advances in Mental Health*, 10(2), 195–203.
- Frauenholtz, S., Williford, A., & Mendenhall, A. (2015). Assessing school employees' abilities to respond to children's mental health needs: Implications for school social work. *School Social Work Journal*, 39(2), 46-62.
- French Gilson, S. & DePoy, E. (2002). Theoretical approaches to disability content in social work education. *Journal of Social Work Education*, 38(1), 153-165.
- Freud, S. (1999). The social construction of normality. *Families in Society: The Journal of Contemporary Social Services*, 80(4), 333-339.
- Fudge Schormans, A. (2010). Epilogues and prefaces: Research and social work and people with intellectual disabilities. *Australian Social work*, 63(1), 51-66.

- Gadamer, H. (2004). The extension of the question of truth to understanding in human the sciences. In Weinsheimer, J. & Marshall, D. G. (Eds.), *Truth and Method* (299-306). New York, NY: Continuum International Publishing Group.
- Goffman, E. (1963). *Stigma: Notes on managing spoiled identity*. New York, NY: Simon and Schuster.
- Government of Canada. (2017). *Budget 2017: Building a Strong Middle Class*. Retrieved from <https://www.budget.gc.ca/2017/docs/plan/toc-tdm-en.html>
- Government of Ontario. (2005). *Accessibility of Ontarians with Disabilities Act*. Retrieved from <https://www.ontario.ca/laws/statute/05a11>
- Grassau, P. (2009). Resilience and “turning it out”: How the arts engage with relational and structural aspects of oppression. *Canadian Social Work Review*, 26(2), 249–265.
- Hardiman, E. R., Theriot, M. T., & Hodges, J. Q. (2005). Evidence-based practice in mental health: Implications and challenges for consumer-run programs. *Best Practices in Mental Health*, 1(1), 105-122.
- Henrich, R. (2005). Expansion of an alternative school typology. *Journal of At-Risk Issues*, 11(1), 25-37.
- Johnson, K. E., & Taliaferro, L. A. (2012). Health behaviors and mental health of students attending alternative high schools: A review of the research literature. *Journal for Specialists in Pediatric Nursing*, 17(2), 79-97.

- Jones, N. & R, Browne. (2012). The absence of psychiatric C/S/X perspectives In academic discourse: consequences and implications. *Disability Studies Quarterly*, 33(1), np.
- Joseph, A. J. (2015). The necessity of an attention to Eurocentrism and colonial technologies: An addition to critical mental health literature. *Disability & Society*, 30(7), 1021-1041.
- Kelly, D. M. (1993). Last chance high: How girls and boys drop in and out of alternative schools. New Haven, CT: Yale University Press.
- Kim, J. and Taylor, K. (2008). Rethinking alternative education to break the cycle of educational inequality and inequity. *The Journal of Educational Research*, 101(4), 207-219.
- Kirmayer, L., Simpson, C., and Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, 11(15), 15-23.
- Kutcher, S., Bagnell, A., & Yifeng, W. (2015). Mental health literacy in secondary schools: A Canadian Approach. *Child and Adolescence Psychiatric Clinics*, 24(2), 233-244.
- Large, M., & Ryan, C.J. (2012). Sanism, stigma and the belief in dangerousness. *Australian & New Zealand Journal of Psychiatry*, 46(11), 1099–1103.
- Leavy, P. (2014). *Method Meets Art: Arts-Based Research Practice* (2nd Ed.). New York, NY: Guilford Publications. Retrieved from <https://ebookcentral.proquest.com>

- Lehr, C. A., & Lange, C. M. (2003). Alternative schools serving students with and without disabilities: What are the current issues and challenges? *Preventing School Failure: Alternative Education for Children and Youth*, 47(2), 59-65.
- Lewis, B. (2013). A Mad Fight: Psychiatry and Disability Activism. In L. J. Davis (Eds.), *Disability Studies Reader* (117-131). New York, NY: Routledge.
- LivingWorks. (2016). *SafeTALK Half-Day Training*. Retrieved from <https://www.livingworks.net/programs/safetalk/>
- Loutzenheiser, L. (2002). Being Seen and Heard: Listening to Young Women in Alternative Schools. *Anthropology & Education Quarterly*, 33(4), 441-464.
- Maiter, S. & Joseph, A. (2016). Researching racism: The colour of face value, challenges, and opportunities. *British Journal of Social Work*. 47(3), 755-772.
- Manitowabi, D. and Maar, M. (2018). “We stopped sharing when we became civilized”: A Model of Colonialism as a Determinant of Indigenous Health in Canada. *Journal of Indigenous Social Development*, 7(1), 1-19.
- Mann, R. & Warr, D. (2017). Using metaphor and montage to analyse and synthesise diverse qualitative data: exploring the local worlds of ‘early school leavers’. *International Journal of Social Research Methodology*, 20(6), 547-558.
- Maron, M. (2014). Second legislature review of the Accessibility for Ontarians with Disabilities Act, 2005.
- Marquis, E., Jung, B., Fudge-Schormans, A. Vajoczki, S., Wilton, R., Baptiste, S., and Joshi, A. (2012). Creating, Resisting or Neglecting Change: Exploring the

- Complexities of Accessible Education for Students with Disabilities. *Canadian Journal for the Scholarship of Teaching and Learning* 3(2).
- Mason, J. (2002). *Qualitative Researching*, 2nd Edition. London: Sage Publications.
- McNulty, C. P., & Roseboro, D. L. (2009). “I’m not really that bad”: Alternative school students, stigma, and identity politics. *Equity & Excellence in Education*, 42(4), 412-427.
- Meekosha, H. & Shuttleworth, R. What’s so ‘critical’ about critical disability studies? *Australian Journal of Human Rights*, 15(1), 47-76.
- Mendenhall, A. N., & Frauenholtz, S. (2013). Mental health literacy: Social work's role in improving public mental health. *Social Work*, 58(4), 365-368.
- Menzies, R., LeFrançois, B.A., & Reaume, G. (2013). Introducing mad studies. In *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto, ON: Canadian Scholars’ Press Inc.
- Nash, C. (2017). From the release of the Hall–Dennis Report to the founding of Alpha II Alternative School: My personal journey. In Bascia, N., Sokolov Fine, E. Levin, M. (Eds.), *Alternative Schooling and Student Engagement: Canadian Stores of Democracy within Bureaucracy* (107-118). Toronto, ON: Palgrave Macmillan.
- Patalay, P., Annis, J., Sharpe, H., Newman, R., Main, D., Ragunathan, T., Parkes, M. & Clarke, K. (2017). A pre-post evaluation of OpenMinds: A sustainable, peer-led mental health literacy programme in universities and secondary schools. *Prevention Science*, 18(8), 995-1005.

- Peer Support Canada. (2018). *About Peer Support Canada*. Retrieved from <http://peersupportcanada.ca/>
- Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy*, 17(5), 378-384.
- Phillippo, K. L., & Stone, S. (2013). Teacher role breadth and its relationship to student-teacher support. *High School Journal*, 96(4), 358-379.
- Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse Researcher*, 18(3), 20-24.
- Quinn, M. M., Poirier, J. M., Faller, S. E., Gable, R. A., & Tonelson, S. W. (2006). An examination of school climate in effective alternative programs. *Preventing School Failure: Alternative Education for Children and Youth*, 51(1), 11-17.
- Raywid, M. A. (1994). Alternative schools: The state of the art. *Educational Leadership*, 52(1), 26-31.
- Raywid, M. A. (1999). History and issues of alternative schools. *The Education Digest*, 64(9), 47-51.
- Rothstein, H. (2017). Public to private: Alternative schools in Ontario 1965-1975. In Bascia, N., Sokolov Fine, E. Levin, M. (Eds.), *Alternative Schooling and Student Engagement: Canadian Stores of Democracy within Bureaucracy* (71-94). Toronto, ON: Palgrave Macmillan.

- Sakayi, D. R. (2001). Intellectual indignation: Getting at the roots of student resistance in an alternative high school program. *Education, 122*(2), 414-422.
- Salerno, J. P. (2016). Effectiveness of universal School-Based mental health awareness programs among youth in the United States: A systematic review. *Journal of School Health, 86*(12), 922-931.
- Schwandt, T. (2001). Dictionary of qualitative inquiry (2nd Ed.). Thousand Oaks, CA: Sage.
- Shildrick, M. (2012). Critical disability studies: Rethinking the conventions for the age of postmodernity. In Watson, N., Roustone, A., & Thomas, C. (Eds.) *Routledge Handbook of Disability Studies*. Abingdon: Routledge.
- Shultz, K. (2017). Resistance: Student activism, SEED alternative school, and the struggle against Streaming. In Bascia, N., Sokolov Fine, E. Levin, M. (Eds.), *Alternative Schooling and Student Engagement: Canadian Stories of Democracy within Bureaucracy* (227-244). Toronto, ON: Palgrave Macmillan.
- Sinding, C., Paton, C., & Warren, R. (2014). Social Work and the arts: Images at the intersection. *Qualitative Social Work 13*(2), 187-202.
- Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.
- Spratt, J., Shucksmith, J., Philip, K., & Watson, C. (2010). ‘The bad people go and speak to her’: Young People’s choice and agency when accessing mental health support in school. *Children & Society, 24*(6), 483-494.

- Taylor, S. (2016). *SExT: Sex Education by Theatre*. [Play]. Toronto, ON: Toronto Fringe Festival and Summerworks.
- Tuohy, D., Cooney, A., Dowling, M., Murphy, K., & Sixsmith, J. (2013). An overview of interpretive phenomenology as a research methodology. *Nurse Researcher*, 20(6), 17-20.
- Twenge, J. M. (2011). Generational differences in mental health: Are children and adolescents suffering more, or less? *American Journal of Orthopsychiatry*, 81(4), 469-472.
- Vick, A. (2012). Theorizing Episodic Disabilities; The case for embodied politics. *Canadian Social Work Review* 29(1), 41-60.
- Wilkins, J. and Williams, L. (2015). Re-engaging school dropouts with emotional and behavioral disorders. *The Phi Delta Kappan*, 96(4), 52-56.



APPENDIX A:
LETTER OF INFORMATION/CONSENT FORM FOCUS GROUP

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed
Mental Health Concerns who are Streamed into Alternative Education

Student Investigator:

Laura Stothart
Masters Candidate, School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 869-0704
E-mail: stothalj@mcmaster.ca

Faculty Research Supervisor:

Dr. Ameil Joseph
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23792
E-mail: ameilj@mcmaster.ca

What am I trying to discover?

You are invited to participate in a study that explores the experiences of high school students with undiagnosed mental health issues who are encouraged to attend alternative schools due to the lack of resources and support within their traditional school. I am doing this research for the thesis component of my Masters of Social Work education. I am hoping to hear from students who have sought in-school support for their mental health and to discover what they experienced and how school staff responded to their needs. I intend to further uncover how alternative schools respond and meet the needs of students with mental health concerns and how social workers can facilitate the implementation of alternative approaches, support, and resources in conventional schools to minimize the current trend to place students with mental health needs into alternative schools.

What will happen during the study?

In the study you will be asked to attend one focus group lasting approximately one hour. The focus group will be held in a private/secure space, in a public location, where the participants feel most comfortable and your confidentiality can be protected, such as a public library or local community centre (i.e. Hamilton Public Library, Hamilton YMCA, etc.).

In the focus group, you will join approximately 5 other youth aged 16-22 who identify with having experienced mental health concerns but have not received a medical diagnosis, who have something to say about their school experience and how they have/have not been supported by school staff. In the focus group you will be invited to participate in a collaging activity, which is intended to help you reflect on your school experiences and prepare you for the follow up

interview (See Appendix B: Letter of Information/Consent Form One-to-One Interview). In the activity you will be given three questions, from which you will pick one to be the inspiration or guiding thought for the collage that you will create from various media samples. You will then have the opportunity to discuss the art with the group if you are comfortable and hear from others in the group who choose to share. With your permission, I would like to audio record the discussion, take some hand written notes, and photograph the art.

The three questions/statements from which you can choose one to respond to through your art will be:

- 1. What can school employees do to better support you and your mental health concerns?**
- 2. When I disclose my mental health status to my teachers and/or other school employees I feel/have experienced _____.**
- 3. What has attending alternative education been like for you?**

Are there any risks to doing this study?

The risks to participating in this study are moderate. You may feel uncomfortable, nervous, and/or uneasy about disclosing personal information, or you may be worried about how others will respond to what you say. Remember that you do not need to answer questions that you do not want to answer or that make you feel uncomfortable. There are also social risks because I cannot guarantee that what was said in the focus group will not be repeated outside of the group, which may lead you to feel betrayed or exposed. You should also be aware that sometimes discussing/reflecting on our mental health can produce an emotional response. In attempt to provide you with support in the event that you feel triggered, I will be giving everyone a list of local and accessible mental health resources that can offer you extra support if needed.

Other actions I will take to protect your privacy/minimize risks are outlined below:

- I will explain my duty to report/limits of confidentiality as an academic researcher
- All group members will review and sign a confidentiality agreement which will state that nothing shared in group be discussed/repeated outside of the group setting
- Group rules of respect will be collaboratively discussed and agreed upon at the beginning of the focus group

What are the benefits to doing this study?

While the study may not benefit you directly, participating in this study allows you to share your experience and have your voice heard. It is possible that your contributions will be used when shaping the future of secondary education, mental health response, and policy related to both mental health and education. Further, it is my hope that this study will help education professionals better understand student experiences, and that some of the recommendations you provide will be considered and applied, in attempt to reduce the shame, stigma, isolation, or undue hardship that future students struggling with their mental health in school may experience.

Payment or Reimbursement

To compensate you for your time and energy invested in the project I will be offering two \$20 gift certificates to either Tim-Hortons, Starbucks, Chapters/Indigo, or the Limeridge Mall. One gift certificate of \$20 will be given after the focus group and another gift certificate of \$20 will be given after the one-on-one interview. Withdrawal from the study will not result in withdrawal of the compensation. I will also provide you with coffee, tea, water, and small shared snacks during the focus group. To reimburse you for any travel costs, you will be given 2 HSR bus tickets.

Who will know what I said or did in the study?

Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell.

I will undertake measures to safeguard the confidentiality of the discussion. I will ask the other members of the focus group to keep what you say confidential, but I cannot guarantee that they will do so. Please keep this in mind in deciding what to share.

The information/data you provide will be kept in a locked desk/cabinet, to which only I and the research supervisor Ameil Joseph will have access. Information kept on a computer will be protected by a password. Audio files saved to my cellular device will also be password protected. Once the study has been completed, the data will be destroyed.

b) Legally Required Disclosure:

I will protect your confidentiality and privacy as outlined above. However, as an academic researcher I have a duty to report if it is disclosed or suspected that you intend to harm yourself or cause harm to another person. On the consent page I have asked you to provide a parent/guardian or another trusted adult emergency contact number. This contact will be used in the case of disclosed intent to harm yourself or others or if an emergency occurs. Also, legally I must report disclosed or suspected child abuse to Children's Aid Society for anyone under the age of 16, and may choose to report suspected child abuse or neglect to anyone under the age of 18.

What if I change my mind about being in the study?

Your participation in this study is completely voluntary. If you decide you want to stop being in the focus group have the right to stop responding or leave at any time. However, remember that it will not be possible for you to pull out your data from the flow of the conversation because of the interconnected nature of the group discussion where one person's comments can stimulate the sharing of comments made by others in the group. If you later decide after participating in the focus group that you would no longer like your responses to be included in the final product, you may withdraw up until July 1st, 2018, which is when I expect to be finishing the first draft of my thesis. If you chose to withdraw prior to July 1st, 2018 no consequences will be applied. Withdrawal will also have no impact on any relationship established with the student researcher, faculty supervisor, McMaster University, or any affiliated service organization(s). In the case of withdrawal, all hard copy data will be shredded, all audio files will be erased, and any digital files will be deleted.

How do I find out what was learned in this study?

I expect to have this study completed by approximately **end of August 2018**. If you would like to receive an infographic which briefly summarizes the results, you may indicate it on this form and it will be sent to you through email or traditional mail.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Laura Stothart
Masters Candidate, School of Social Work
McMaster University
Hamilton, Ontario, Canada
Email: stothalj@mcmaster.ca
Phone: 905-869-0704

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Laura Stothart and Dr. Ameil Joseph of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand the limits of confidentiality and that the parent/guardian or another trusted adult contact provided below may be used in the case of a health related emergency, disclosed harm to self or others, and/or apparent participant distress..
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until **July 1*, 2018**.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____ Date: _____

Name of Participant (Printed): _____

Emergency Contact

Parental/Guardian or Trusted

Adult*: _____

Telephone*: _____

*required for participation in study

1. I agree that the focus group can be audio recorded.

☐ Yes

☐ No

2. I agree to have my collage be photographed (only to be seen by the student researcher).

☐ Yes

☐ No

3. ☐ Yes, I would like to receive the infographic of the study's results.

Please send them to me at this email address _____

Or to this mailing address: _____

☐ No, I do not want to receive a summary of the study's results.



APPENDIX B:
LETTER OF INFORMATION/CONSENT FORM INTERVIEW

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed
Mental Health Concerns who are Streamed into Alternative Education

Student Investigator:
Laura Stothart
Masters Candidate, School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 869-0704
E-mail: stothalj@mcmaster.ca

Faculty Research Supervisor:
Dr. Ameil Joseph
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23792
E-mail: ameilj@mcmaster.ca

What am I trying to discover?

You are invited to participate in a study that explores the experiences of high school students with undiagnosed mental health issues who are encouraged to attend alternative schools due to the lack of resources and support within their traditional school. I am doing this research for the thesis component of my Masters of Social Work education. I am hoping to hear from students who have sought in-school support for their mental health to discover what they experienced and how school staff responded to their needs. I intend to further uncover how alternative schools respond and meet the needs of students with mental health concerns and how social workers can facilitate the implementation of alternative approaches, support, and resources in conventional schools to minimize the current trend to place students with mental health needs into alternative schools.

What will happen during the study?

In the study you will be asked to attend 1 one-on-one interview approximately 30-60 min. The interview will be held in a private/secure space, in a public location where the participants feel most comfortable and your confidentiality can be protected, such as a public library or local community centre (i.e. Hamilton Public Library, Hamilton YMCA, etc.).

In this phase of the study you will meet with the student researcher one-on-one to further discuss your experiences with having mental health issues, having not received a diagnosis, and seeking support and services within your school. I will ask you to explain times when you felt you were supported and times when you felt you were not, resulting in a poor outcome. I will also ask you to describe the times when you disclosed your mental health concerns to school staff and how staff responded to your disclosure. I will also be interested in hearing from you as to what

systems, policies, supports, resources etc. you would ideally like to see in your school, which may help you and your peers succeed. Finally, if you have attended alternative education, I will ask you to speak to your experiences in that system and identify the differences between the alternative school and the school you attended initially. With your permission, I would like to take some hand written notes and audio record the discussion.

Some of the questions you can expect to be asked to share your responses to are:

- **What do mental health support services look like in your school?**
- **Are you comfortable disclosing your mental health concerns to your teachers? Why or why not?**
- **What has been your experience when trying to access academic accommodations? (I.e. writing exams in separate rooms, extensions, alternative assignments, etc.)**
- **What practice/policy would you like to see applied in your school that would help you be successful?**
- **Has school staff ever suggested you attend alternative education? If yes, what were your thoughts/feelings with this suggestion?**
- **If you have attended an alternative school program, what has been your experience in this setting? How is it different from the school you initially attended?**

Are there any risks to doing this study?

The risks to participating in this study are moderate. You may feel uncomfortable, nervous, and/or uneasy about disclosing personal information. Remember that you do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You should also be aware that sometimes discussing/reflecting on our mental health can trigger an emotional response. In attempt to provide you with support in the event that you feel triggered, I will be giving you a list of local and accessible mental health resources that can offer you extra support if needed.

Other actions I will take to protect your privacy/minimize risks are outlined below:

- I will explain my duty to report/limits of confidentiality as an academic researcher
- When the time comes to report the findings no identifiable characteristics will be used, however, remember sometimes we are identifiable by the stories we share. Please keep this in mind when deciding what to share.

What are the benefits to doing this study?

While the study may not benefit you directly, participating in this study allows you to share your experience and have your voice heard. It is possible that your contributions will be used when shaping the future of secondary education, mental health response, and policy related to both mental health and education. Further, it is my hope that this study will help education professionals better understand student experiences, and that some of the recommendations you provide will be considered and applied, in attempt to reduce the shame, stigma, isolation, or undue hardship that future students struggling with their mental health in school may experience.

Payment or Reimbursement

To compensate you for your time and energy invested in the project I will be offering two \$20 gift certificates to either Tim-Hortons, Starbucks, Chapters/Indigo, or the Limeridge Mall. One gift certificate of \$20 will be given after the focus group and another gift certificate of \$20 will be given after the one-on-one interview. Withdrawal from the study at any time will not result in withdrawal of either gift certificate(s). I will also provide you with coffee, tea, water, and small shared snacks during the interview. To reimburse you for any travel costs, you will be given 2 HSR bus tickets.

Who will know what I said or did in the study?

Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell.

The information/data you provide will be kept in a locked desk/cabinet to which only I and the research supervisor Ameil Joseph will have access. Information kept on a computer will be protected by a password. Audio files saved to my cellular device will also be password protected. Once the study has been completed, the data will be destroyed.

b) Legally Required Disclosure:

I will protect your confidentiality and privacy as outlined above. However, as an academic researcher I have a duty to report if it is disclosed or suspected that you intend to harm yourself or cause harm to another person. On the consent page I have asked you to provide a parent/guardian or another trust adult emergency contact number. This contact will be used in the case of disclosed intent to harm yourself or others or if an emergency occurs. Also, legally I must report disclosed or suspected child abuse to Children's Aid Society for anyone under the age of 16, and may choose to report suspected child abuse or neglect to anyone under the age of 18.

What if I change my mind about being in the study?

Your participation in this study is completely voluntary. If you decide you no longer want to be interviewed you have the right to leave whenever you feel. If you later decide after participating in the interview that you do not want your responses to be included in the final product, you may withdraw up until July 1st, 2018, which is when I expect to be finishing the first draft of my thesis. If you chose to withdraw prior to July 1st, 2018 no consequences will be applied. Withdrawal will also have no impact on any relationship established with the student researcher, faculty supervisor, McMaster University, or any affiliated service organization(s). In the case of withdrawal all hard copy data will be shredded, all audio files will be erased, and any digital files will be deleted.

How do I find out what was learned in this study?

I expect to have this study completed by approximately end of August 2018. If you would like to receive an infographic which briefly summarizes the results, you may indicate it on this form and it will be sent to you through email or traditional mail.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Laura Stothart
Masters Candidate, School of Social Work
McMaster University
Hamilton, Ontario, Canada
Email: stothalj@mcmaster.ca
Phone: 905-869-0704

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Laura Stothart and Dr. Ameil Joseph of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand the limits of confidentiality and that the parent/guardian or another trusted adult contact provided below may be used in the case of a health related emergency, disclosed harm to self or others, and/or apparent participant distress.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until **July 1st, 2018**.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____ Date: _____

Name of Participant (Printed): _____

Emergency Contact

Parental/Guardian or Trusted

Adult*: _____

Telephone*: _____

*required for participation in study

1. I agree that the interview can be audio recorded.

☐ Yes

☐ No

2. ☐ Yes, I would like to receive the infographic of the study's results.

Please send them to me at this email address _____

Or to this mailing address: _____

☐ No, I do not want to receive a summary of the study's results.

APPENDIX C:
FOCUS GROUP GUIDE

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed
Mental Health Concerns who are Streamed into Alternative Education

Researcher: Laura Stothart

***NOTE: TEXT WRITTEN IN ITALICIZED BOLD CAPITAL LETTERS CONSTITUTES ADDITIONAL
REMINDERS MEANT TO GUIDE THE FOCUS GROUP FACILITATOR ONLY.***

***[THE COMPLETION OF THE INTRODUCTORY SECTION OF THE FOCUS GROUP
SHOULD TAKE APPROXIMATELY 10-15 MINUTES]***

I. INTRODUCTION AND INSTRUCTIONS:

Hello, my name is Laura Stothart. Thank you for agreeing to participate in this focus group meeting. Just to remind everyone, I’m looking at the experiences of high school students with undiagnosed mental health concerns who feel they have been streamed into and/or encouraged to attend alternative education, as a result of their school’s inability to support student mental health needs. In this focus group you will be asked to participate in an arts-based activity which is meant to inspire group discussion around this topic and help you reflect on your experiences before participation in the second component of this study, the one-on-one interview.

What is a focus group?

A focus group is an interactive group discussion where we can gain several perspectives about a topic and members of the group can think about and comment on what others have said in the group. In a minute, we will all introduce ourselves – first names only. But first, I would like to walk you through the consent form that is in front of you.

***[FOR FACILITATOR: REVIEW INFORMED CONSENT FORM AND ANSWER ANY
QUESTIONS ABOUT IT. COLLECT SIGNED CONSENT FORMS AND ENSURE THAT
PARTICIPANTS HAVE A COPY OF THE LETTER OF INFORMATION TO TAKE WITH
THEM (IF APPROPRIATE FOR THE TOPIC AND GROUP).***

Ground Rules: [READ ALOUD] – before we begin our discussion, I want to spend a few moments setting ground rules for this group. The purpose of ground rules is to make people feel safe in this setting. The ground rules for today are:

- Everyone’s views are welcomed and important.
- Negative or disrespectful comments are not welcome in this space.
- Anything heard in the room should stay in the room.

- All voices are to be heard, so I may step in if too many people are speaking at once or to make sure that everyone has a chance to speak.
- I may also step in if I feel the conversation is straying off topic.
- I will be respectful of your time, you can expect this session to last 1 hour

Confidentiality: [READ ALOUD] – Also it is important we review confidentiality before we begin the focus group conversation. Confidentiality means that:

- The information which we will collect today will be connected to you as a group.
- We will not identify quotes or ideas with *any one person* of this group. Because of the nature of small communities or groups, it is possible that people could link participants in this room to quotes in the report. This is why we need to talk about confidentiality.
- We *are* assuming that when we learn about one another's views, they remain confidential. In a small community (group) like this, people are identifiable to some degree by their views and opinions.
- Having said this and having made these requests, you know that we cannot guarantee that the request will be honoured by everyone in the room.
- So we are asking you to make only those comments that you would be comfortable making in a public setting; and to hold back making comments that you would not say publicly.
- If you want to stop being in the focus group you can leave or stay and simply stop talking, but it will not be possible for you to pull out your data from the flow of the conversation because of the interconnected nature of the group discussion where one person's comments can stimulate the sharing of comments made by others in the group.
- I will now ask you to sign a confidentiality agreement, this is meant to benefit everyone in the room and keep members accountable

[FOR FACILITATOR: READ THE CONFIDENTIALITY AGREEMENT – HAVE ALL MEMBERS SIGN AND KEEP A COPY]

Use of Tape Recorder

- As you will recall, this focus group discussion will be recorded to increase accuracy and to reduce the chance of misinterpreting what anyone says.
- All tapes and transcripts will be kept stored in a locked space and digital files will be password protected by the researcher.
- Names will be removed from transcripts. Participants will have coded numbers attached to their name which only I will know.
- Only I and my thesis supervisor will have access to transcripts (with your personal names removed) of this focus group.
- I'll also ask that when using abbreviations or acronyms, you say the full name at least once to aid transcription.

[AT THIS POINT, GROUP MEMBERS CAN QUICKLY INTRODUCE THEMSELVES – remind them that it is 'first names only'.]

[HAND OUT ANY MATERIALS THAT THE PARTICIPANTS WILL NEED DURING THE FOCUS GROUP INCLUDING COLLAGE CANVAS, SCISSORS, GLUE, MEDIA SOURCES.]

II. COLLAGE

- We will now participate in the arts-based activity central to this focus group
- Today I will ask you to create your own collage [***DOUBLE CHECK GROUP IS FAMILIAR WITH THIS MEDIUM***]
- Please use one of the three questions/statements provided as the inspiration for your collage
- Your collage is meant to visually answer the question you chose to respond to
- The questions/statements are:
 - **What can school employees do to better support you and your mental health concerns?**
 - **When I disclose my mental health status to my teachers and/or other school employees I feel/have experienced _____.**
 - **What has attending alternative education been like for you?**
- Help yourself to any of the media sources seen in front of you
- You will have 20 minutes to create your collage
- After the 20 minutes we will have 30 minutes to discuss your art (if you choose) and there will be a few follow up questions to generate more discussion

III. GROUP QUESTIONS

[OPEN UP DISCUSSION FOR GENERAL RESPONSES OF PARTICIPANTS TO EACH QUESTION.]

- **Interview questions:**
 - If you are comfortable, please tell the group about your art and what it means to you.
 - What was this process like for everyone?
 - When collaging what memory was most vivid for you?
 - When collaging which images in the media stood out to you most? Why?
 - When the group had the chance to share their art, was there anything someone said that was meaningful for you or that you connected with?
 - How has this process shaped your thinking around the topic?
 - Is there anything we forgot or is there something important that we should know about your experience with this topic?

III. WRAP-UP:

- I would just like to remind everyone that what was said in the room today, stay in the room
- **Discuss next phase (one-on-one interviews):**
 - You are now each individually invited to our one-on-one interview where you will have more time to discuss this topic privately
 - You should know our scheduled interview time, if you don't remember or have not yet scheduled an interview time please check in with me on your way out
- Thank participants

APPENDIX D: **INTERVIEW GUIDE**

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed Mental Health Concerns who are Streamed into Alternative Education

Researcher: Laura Stothart

NOTE: TEXT WRITTEN IN ITALICIZED BOLD CAPITAL LETTERS CONSTITUTES ADDITIONAL REMINDERS MEANT TO GUIDE THE FOCUS GROUP FACILITATOR ONLY.

[THE COMPLETION OF THE INTRODUCTORY SECTION OF THE INTERVIEW SHOULD TAKE APPROXIMATELY 10-15 MINUTES]

I. INTRODUCTION AND INSTRUCTIONS:

Hello, again. In case you forgot my name is Laura Stothart. Thank you for agreeing to participate in this one-on-one interview. Just to remind you, I’m looking at the experiences of high school students with undiagnosed mental health concerns who feel they have been streamed into and/or encouraged to attend alternative education, as a result of their school’s inability to support student mental health needs. This interview will take approximately 30-60 minutes. In the given time I will ask 21-27 questions about your experiences. Remember, I do not have a right to your answers. You do not need to answer anything you do not want to, do not know the answers to, or feel uncomfortable answering.

[FOR FACILITATOR: REVIEW INFORMED CONSENT FORM AND ANSWER ANY QUESTIONS ABOUT IT. COLLECT SIGNED CONSENT FORMS AND ENSURE THAT PARTICIPANTS HAVE A COPY OF THE LETTER OF INFORMATION TO TAKE WITH THEM.]

Confidentiality: [READ ALOUD] – Also it is important we review confidentiality before we begin the conversation. Confidentiality means that:

- Anything you say today will be kept confidential
- Only myself and the research supervisor Ameil Joseph will have access to your responses
- When answering please remember the **limits of confidentiality** that were noted in “Appendix B: Letter of Information and Consent Form Interview”
- The information which we will collect today will not be connected to you by name. When your statements are used in the final product they will be connected to a pseudonym or number.
- I will make every effort to protect your confidentiality, however, we are sometimes identifiable by the stories we tell
- If you want to stop the interview you can you can leave at any time

Use of Tape Recorder

- As you will recall, this discussion will be recorded to increase accuracy and to reduce the chance of misinterpreting what is said.

- All tapes and transcripts will be kept stored in a locked space and digital files will be password protected by the researcher.
- Names will be removed from transcripts. Participants will have coded numbers attached to their name which only I will know.
- Only I and my thesis supervisor Ameil Joseph will have access to the transcripts (with your personal names removed) of this interview.

[OFFER REFRESHMENTS TO PARTICIPANT]

II. INTERVIEW

Information about the interview: Interview questions will be open ended, meaning not yes/no questions. Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that ...?*”), to get more information (“*Please tell me more?*”), or to learn what you think or feel about something (“*Why do you think that is...?*”).

SECTION 1: About the participant

1. **Describe the climate of your school? *[IF NEEDED DEFINE CLIMATE]* (Climate meaning, supportive/not supportive, connected/disconnected, community focus/individual focus, etc.)**

SECTION 2: Exploring mental health

1. If you are comfortable, please tell me about the mental health issue you experience.
2. **Have you ever felt comfortable disclosing your mental health status to your teachers or other school staff? If yes, what has been their response?**
3. When disclosing your mental health status to someone, what do you think is going through their mind? What assumptions or conclusions do you think they make?
4. **When disclosing your mental health to someone, what is the ideal response you would like to get?**
5. **Tell me about your choice to live with this mental health concern diagnosis-free.**
6. Has there ever been a time where you felt pushed to receive a diagnosis for your mental health issue? If yes, what was this experience like for you?

SECTION 3: Accessing in-school services

1. **What do mental health services look like in your school?**
2. **What has been your experience when trying to access academic accommodations? (i.e. extensions, writing exams in a separate room, alternative assignments, etc.)**
3. **What do you think the relationship is between having a medical diagnoses and accessing in-school services, accommodations, etc.?**
4. **Are there any barriers exist that may prevent you from seeking or receiving services (attitudinal, physical, psychological/emotional, etc.)?**
5. **Have you been encouraged to attend alternative education, if yes, what was this experience like for you?**
6. **In a perfect world, how would you like to be supported and/or accommodated in school?**

SECTION 4: Experience in alternative education (if applicable)

1. Why do you think someone might suggest you enroll in alternative education? What might they gain from this suggestion?
2. **What does being a student enrolled in alternative education mean to you?**
3. **How has attending alternative education impacted your life?**
4. **How does alternative education compare to conventional schooling?**

SECTION 5: Closing remarks

1. Is there anything else you would like me to know?

III. WRAP-UP:

- Thank participants [*HAND OUT THANK YOU CARD WITH HONOURARIUM ENCLOSED*]
- [*DISTRIBUTE “APPENDIX I: COMMUNITY MENTAL HEALTH RESOURCES”*]
 - Encourage participant to seek help in the case that anything has been challenging for them

Appendix E:
CONFIDENTIALITY AGREEMENT (FOCUS GROUP)

Researcher: Laura Stothart

Purpose: This form is intended to further ensure confidentiality of data obtained during the course of this research study. All parties involved in this research, including focus group members, will be asked to read the following statement and sign their names indicating that they agree to comply.

I hereby affirm:

- I will not communicate anything that was said within the group, outside of the group setting.
- I understand communication includes online communication and social media.
- I will protect the information and the integrity of the study.
- I will not to not talk about material relating to this study or interview with anyone outside of my fellow focus group members and the researcher(s).
- I understand the researcher's legally bound limits of confidentiality, as described in the "Appendix A: Letter of Information and Consent Form Focus Group".

Name (Participant): _____

Signature (Participant): _____

Date: _____

Researcher Signature (Witness): _____

Appendix F:
DEMOGRAPHIC INFORMATION FORM


**DO NOT include your
name on this form**

INSTRUCTIONS: Please fill in as comfortable. This is intended to provide us with some basic background information about you.

1. I gender identify as:
[] _____
[] Prefer not to say
2. I'm (check one):
[] between the ages of 15-16
[] between the ages of 17-18
[] between the ages of 18-20
3. The mental health issue(s) I identify with is/are:
[] _____
[] prefer not to say
4. How would you describe your race and ethnicity?
[] _____
[] Prefer not to say
5. How would you describe your sexual orientation?
[] _____
[] Prefer not to say
6. What is your current or most recent level of education?
[] Grade 9
[] Grade 10
[] Grade 11
[] Grade 12
[] Grade 12+
[] High school graduate
[] High school degree or equivalent (i.e. GED)
[] Prefer not to say
7. I have attended/attend:
[] Public school (conventional)
[] Catholic school (conventional)
[] Private school
[] Alternative school

Please turn over this brief information sheet and leave it on the table when you leave. Thanks.

Appendix G: RECRUITMENT POSTER



Participants Needed for Research

This study is looking to hear from high school students who have been streamed into and/or encouraged to attend alternative education due to their mental health needs

Participant Requirements:

- Between the ages 16-20
- Identifies with having mental health concerns that impact school experience - excludes learning disability or other cognitive disabilities
- Has not received a diagnosis for identified mental health concern(s)
- Has experienced being streamed into and/or encouraged to attend alternative education


Your involvement will include participating in **1 focus group** with an arts-based activity (60 min) and **1 one-on-one interview** (60 min) where you will be asked to share your experience with this topic.

For your time you will be **compensated with two \$20 gift cards** to your choice of Starbucks, Tim Hortons, Chapters/Indigo or Limeridge Mall.

For more information about the study or to volunteer to participate, please contact:

Laura Stothart
Masters Candidate, School of Social Work
McMaster University, Hamilton, ON.
stothalj@mcmaster.ca

This study has been reviewed by, and received ethics clearance from the McMaster Research Ethics Board



Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

Laura Stothart
McMaster University
stothalj@mcmaster.ca

APPENDIX H:
RECRUITMENT EMAIL FOR SERVICE AGENCIES

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed
Mental Health Concerns who are Streamed into Alternative Education

Researcher: Laura Stothart

E-mail Subject line: McMaster Study – An Analysis of the Filtering of Students with
Undiagnosed Mental Health Concerns into Alternative School Settings

Hello,

My name is Laura Stothart and I am a Masters Candidate at the School of Social Work, McMaster University. This program requires me to conduct original research that will be used for my final thesis, under the supervision of Dr. Ameil Joseph. The purpose of my research is to examine the experiences of high school students with undiagnosed mental health issues who are filtered into alternative school systems due to lack of resources and support within the means of conventional schools. I intend to uncover how alternative schools respond and meet the needs of students with mental health concerns and how social workers can facilitate the implementation of alternative approaches, support, resources in conventional schools, thus minimizing the separatism of students with mental health concerns.

I am writing to you today in the hopes that you may display my recruitment poster in your agency on my behalf. I have attached the letter of information/consent forms related to this study. These explain in further detail the purpose, process, risks, and benefits of the study. The recruitment poster is also attached below.

I understand the nature of your service agency and the vulnerability of the populations with whom you work. Participation in this study is completely voluntary. If a potential participant is interested they can contact me directly through email at stothalj@mcmaster.ca. This study has been reviewed and cleared by the McMaster Research Ethics Board. I have taken every precaution to minimize risk to participants. While there is no direct benefit from participating in this study (besides a small honourarium), it is my hope that the participant feels their voice is heard and valued in shaping the future of secondary education, mental health response, and policy related to both mental health and education.

If you any have concerns or questions about the rights of participants or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administration, Development and Support
E-mail: ethicsoffice@mcmaster.ca

Thank you in advance for your time and consideration. I look forward to hearing from you.

Appendix I:
Community Mental Health Resources

Youth Wellness Centre (ages 17-25)

38 James St S, Hamilton, ON L8P 4W6

(905) 522-1155 ext. 31725

<http://reachouthamilton.ca/>

Provides counselling, support and navigation services for young people aged 17 to 25. This service is covered by OHIP and confidential.

Kids Help Phone Canada (ages 20 and under)

1-800-668-6868

<http://www.kidshelpphone.ca/Teens/Home.aspx>

Call to speak to a counsellor (anonymous, free, confidential, and professional).

Hours of operation: 24/7

COAST (Crisis Outreach and Support Team)

St Joseph's Healthcare

50 Charlton Ave E, Hamilton, ON L8N 4A6

905-972-8338

www.coasthamilton.ca

Mobile crisis team of child and youth crisis workers connected to a variety of mental health and social service agencies and able to help those who have a serious mental illness and are in a crisis situation. This service also includes staff from police services.

McMaster Children's Hospital, Child and Youth Mental Health Program

Ron Joyce Children's Health Centre

325 Wellington St N, Hamilton ON, L8L 0A4

905-521-2100 ext. 776211

www.mcmasterchildrensmentalhealth.ca/

Provides outpatient, inpatient, day hospital and emergency mental health services for children, youth and families dealing with mental health concerns.

SACHA (Sexual Assault Centre Hamilton)

75 MacNab St S, Hamilton, ON L8P 3C1

24/7 Support Line: 905-525-4162; Business Line: (905) 525-4573

<http://sacha.ca/>

SACHA supports survivors of sexual assault. Provides counselling (ages 16 and older), 24/7 support line (no age restriction), and advocacy.

Lynwood Charlton Centre (ages 18 and under)

Main Office

526 Upper Paradise Rd, Hamilton ON, L9C 5E3

905-389-1361

www.lynwoodcharlton.ca

Accredited children's mental health centre offering services to children and youth (all genders) with emotional and behavioural struggles and their families.

APPENDIX J:
THANK YOU CARD MESSAGE

“We Can’t Help You Here”: Exploring the Experiences of Youth with Undiagnosed
Mental Health Concerns who are Streamed into Alternative Education

Researcher: Laura Stothart



Dear _____,

I would like to thank you for your time and energy invested in the project. The project would not be possible without you and the stories you have shared. Know that your voice is important and what you have shared can make a difference. Please accept this honourarium as compensation for all you have done. I wish you all the best in your future endeavors!

Sincerely,

Laura Stothart

APPENDIX K:**MREB CERTIFICATE OF ETHICAL CLEARANCE**

		McMaster University Research Ethics Board (MREB) c/o Research Office for Administrative Development and Support, MREB Secretariat, GH-305, e-mail: ethicsoffice@mcmaster.ca	
CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH			
Application Status: New <input checked="" type="checkbox"/> Addendum <input type="checkbox"/> Project Number: 2018 041			
TITLE OF RESEARCH PROJECT:			
We Can't Help You Here: An Analysis of the Filtering of Students with Undiagnosed Mental Health Concerns into Alternative School Settings			
Faculty Investigator(s)/ Supervisor(s)	Dept./Address	Phone	E-Mail
A. Joseph	Social Work	x23792	ameilj@mcmaster.ca
Co-Investigators/ Students	Dept./Address	Phone	E-Mail
L. Stothart	Social Work	9058690704	stothalj@mcmaster.ca
The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB: <input type="checkbox"/> The application protocol is cleared as presented without questions or requests for modification. <input checked="" type="checkbox"/> The application protocol is cleared as revised without questions or requests for modification. <input type="checkbox"/> The application protocol is cleared subject to clarification and/or modification as appended or identified below:			
COMMENTS AND CONDITIONS: Ongoing clearance is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and cleared before any alterations are made to the research.			
Reporting Frequency:	Annual: Apr-03-2019		Other:
Date: Apr-03-2018		Vice Chair, Dr. S. Watt 	

APPENDIX L:**MREB CERTIFICATE OF AMMENDMENT APPROVAL**

		McMaster University Research Ethics Board (MREB) c/o Research Office for Administrative Development and Support, MREB Secretariat, GH-305, e-mail: ethicsoffice@mcmaster.ca	
CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH			
Application Status: New <input type="checkbox"/> Addendum <input checked="" type="checkbox"/> Project Number: 2018 041			
TITLE OF RESEARCH PROJECT: We Can't Help You Here: An Analysis of the Filtering of Students with Undiagnosed Mental Health Concerns into Alternative School Settings			
Faculty Investigator(s)/ Supervisor(s)	Dept./Address	Phone	E-Mail
A. Joseph	Social Work	x23792	ameilj@mcmaster.ca
Co-Investigators/ Students	Dept./Address	Phone	E-Mail
L. Stothart	Social Work	9058690704	stothalj@mcmaster.ca
The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB: <input checked="" type="checkbox"/> The application protocol is cleared as presented without questions or requests for modification. <input type="checkbox"/> The application protocol is cleared as revised without questions or requests for modification. <input type="checkbox"/> The application protocol is cleared subject to clarification and/or modification as appended or identified below.			
COMMENTS AND CONDITIONS: Ongoing clearance is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and cleared before any alterations are made to the research.			
Addendum 1 (received May-16-2018, approved May-16-2018) 11. Participants Involved in Study 12. Recruitment Process			
Reporting Frequency:	Annual: Apr-03-2019		Other:
Date: Apr-03-2018		Vice Chair, Dr. S. Watt <i>Laura Stothart</i>	