CAMPUS MENTAL HEALTH: IMPLICATIONS FOR INSTRUCTORS SUPPORTING STUDENTS

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ABSTRACT

The recent escalation in student suicides due to mental health problems has encouraged higher education institutions to not only modify their overall support structures, but to also (re)define the role of faculty and staff. Despite the increased attention given to student mental health in Canadian higher education institutions, little is known and understood about how instructors view their role as supporters or promoters of student mental health. The purpose of this study was to explore the role of college instructors in supporting students with mental health problems or illnesses. Participants were 42 instructors between the ages of 25 to 64 from Molize College in Toronto, Ontario. Qualitative ethnography was employed to gather data from participants, specifically through a survey questionnaire and interviews. A constructivist framework was adopted to analyze and understand the values, perceptions, meanings, and practices post-secondary instructors carry around notions of student mental health and intervention.

Findings revealed that instructors were generally aware of student mental health concerns in post-secondary institutions, but that greater awareness was still warranted, namely in the areas of instructor mental health and location of support services. Findings also demonstrated that most instructors evaluated their knowledge and confidence in relation to student mental health as poor, which was often credited to limited relevant professional development and training. Additionally, data indicated that instructors carried skepticism towards the role of some student support services departments, as well as towards their own role when supporting the mental health and well-being of students. On a final note, findings revealed that instructors commonly employed four practices to support the mental health and well-being of students: *conversation*, *referral*, *accommodations*, and *curricular inclusion and instruction*. Future studies are encouraged to acknowledge the narratives of instructors through ethnographic inquiry, to allow for greater insights into *their* awareness, knowledge/confidence, responsibilities, and practices when it comes to supporting the mental health and well-being of students in higher education settings. Incorporating the instructor may not be a panacea for the shortcomings of current mental health policies and practices in higher education settings, but it can certainly represent a colossal step in that direction.

KEYWORDS: *student mental health, higher education, instructors*

DEDICATION

To AJ. It's not just for "the piece of paper". It's for the independence, the liberation, and the thirst for inquiry. Be everything you can be my son – my support, you will always have.

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~

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TABLE OF CONTENTS

Abstract....ii
Dedication....iii
Acknowledgements....iv
Table of Contents....v
List of Tables....viii
List of Figures....ix
1 Introduction....1
1.1 Problem Statement....13
1.2 Purpose of Study....20
1.3 Significance of Study....21
1.4 Scope of Study....26
1.5 Limitations of Study....31
1.6 Theoretical Framework....33
1.7 Chapter Summaries....35

2 Literature Review....37
2.1 Definitions and Constructions surrounding Mental Health....39
2.2 Current Initiatives that Support the Mental Health and Well-Being of Students....50
2.2.1 Counselling....51
2.2.2 Accommodations....53
2.2.3 Programs....55
2.2.4 Information and event campaigns....60
2.2.5 Curricular inclusion and instruction....64
2.3 Working towards a Whole-School Approach in Supporting the Mental Health and Well-Being of Students....68
2.4 The Instructor's Role in Supporting the Mental Health and Well-Being of Students....75
2.5 Barriers in Understanding and Supporting the Mental Health and Well-Being of Students....83
2.5.1 Stigma and stereotypes....84
2.5.2 Underdeveloped policies and systems....87
2.5.3 Minimal opportunities for professional development and training....89
2.5.4 Issues with funding and time....92
2.6 Research Implications....96

3 Methodology....106
3.1 Study Context....107
3.2 Participants....111
3.3 Procedure....112

4 Situating the Post-Secondary Instructor in a Supportive Role for the Mental Health and Well-Being of Students....118
4.1 Instructors' Awareness of Student Mental Health....118

4.2 Instructors' Evaluation of their Knowledge and Confidence in relation to Student Mental Health……..122
4.3 Instructors' Beliefs surrounding Responsibilities in Supporting the Mental Health of Students……124
4.4 Instructors' Practices that Support the Mental Health and Well-Being of Students……..131

5 Analysis and Discussion……..140
5.1 Awareness of Student Mental Health……142
5.1.1 Commendable awareness of and response to mental health……..150
5.1.2 Concern for instructor mental health and the location of support services……..153
5.1.3 Concern for mental health stigma……..156
5.2 Knowledge/Confidence in Mental Health…….159
5.2.1 An overall poor evaluation of mental health knowledge/confidence……...164
5.2.2 Mental health training as a determinant of knowledge/confidence……...167
5.2.3 Issues with funding and time in relation to mental health training……...171
5.3 Responsibilities in Supporting the Mental Health and Well-Being of Students…….174
5.3.1 Ambiguities surrounding responsibilities over the mental health and well-being of students……...185
5.3.2 Mental health knowledge/confidence as a determinant of responsibilities……...188
5.3.3 Time as a determinant of responsibilities……..189
5.3.4 Obscure policies as a determinant of responsibilities……191
5.4 Practices that Support the Mental Health and Well-Being of Students…….194
5.4.1 Instructor practices: recognize, render, and redirect (RRR)……204
5.4.2 Positive practice features: quality instructor-student relationships and integration of information technology…...208
5.4.3 Unfavourable practice features: reactive responses and surveillance-based actions…….212
5.4.4 Challenges in practice employment: identification difficulties, time restrictions, and obscure policies……215
5.5 Implications for Research and Practice……..221
5.5.1 Supporting current practices…….222
5.5.2 Generating greater mental health awareness……..225
5.5.3 Encouraging mental health literacy……...227
5.5.4 Strengthening mental health knowledge and confidence…..228
5.5.5 Increasing opportunities for mental health training and professional development……230
5.5.6 Establishing essential resources: funding and time……...231

5.5.7 Developing and/or clarifying policies related to mental health……..235
5.5.8 Implementing whole-school approaches or systems of care…….237

6 Conclusions……..241

References……..244

Appendices
Appendix A: Survey Questionnaire…….267
Appendix B: Interview Schedule…….269
Appendix C: City of Toronto Ward Profiles……271
Appendix D: Post-Secondary Instructor Employment Designation Criteria……...289
Appendix E: Sample Evaluation Guides for Post-Secondary Student Transcript Grades and Academic Status……..293
Appendix F: Sample Post-Secondary Classroom, Assignment, and Exam Accommodations…….....295

LIST OF TABLES

Table 1: Examples of proposed and/or implemented mental health policies and practices in Canadian colleges and universities……10
Table 2: A comparison of the emancipatory and transformative disability frameworks……...49
Table 3: Summary of survey and interview participant demographic data……113
Table 4: Detailed breakdown of individual interview participant demographic data……..114

LIST OF FIGURES

Figure 1: Mental health positioned on a continuum.....39
Figure 2: An excerpt from a streamed preparatory program course outline/syllabus
in the School of Liberal Arts and Science at Molize College……..130

1. Introduction

Students are confronted with a number of transitions when making the move to post-secondary schooling, which can occur through institutions such as, colleges and universities (Canadian Alliance of Student Associations (CASA), 2014; Cavalheiro, Morgan, & Witten, 2012; Kadison & DiGeronimo, 2004; Kay, 2010; Kitzrow, 2003; Lunau, 2012; Ontario College Health Association, 2009; Sagan, 2012; Sharp, Hargrove, Johnson, & Deal, 2006; University of Manitoba's Campus Mental Health Strategy (UMCMHS), 2014). As a result of this move, college or university students can face the following: increased participation in some form of employment, often to finance education; extra pressure to succeed academically; fear of today's competitive job market; and prolonged periods of absence from family and close friends, especially if living on campus residences (CASA, 2014; Cavalheiro et al., 2012; Kadison & DiGeronimo, 2004; Lunau, 2012; Ontario College Health Association, 2009; Potvin-Boucher, Szumilas, Sheikh, & Kutcher, 2010; Sharp et al., 2006; UMCMHS, 2014). Additionally, students are commonly provided with greater independence and freedom towards their learning and social experiences while attending post-secondary schooling.

Looking at learning in particular, the Ontario College Health Association (2009) suggests that people attend college/university with the purpose of learning, but that the concept of, and experiences associated with, post-secondary school learning is profoundly different from that of secondary school or even the workforce. In college or university, student learning is more self-directed and autonomous, where content is read and lectured, rather than explicitly taught and recited (Cavalheiro et al., 2012; Kadison & DiGeronimo, 2004). Moreover, student success in such environments is measured by the quality of their work, which often reflects their capability of engaging in self-governed studying practices.

Although not always the case, students may experience difficulties managing the increase or transition in responsibilities and expectations of higher education, which can ultimately affect their mental health and well-being (Eells & Rando, 2010; Hanlon, 2012; Kadison & DiGeronimo, 2004; MacKean, 2011; Martin, 2010; Potvin-Boucher et al., 2010; Quinn, Wilson, MacIntyre, & Tinklin, 2009; UMCMHS, 2014). Put simply, in response to the pressures of post-secondary schooling, students can develop a mental health problem or illness; terms that are defined and explained more thoroughly in chapter two. According to Cavalheiro et al.'s (2012) investigation into the mental health of Canadian post-secondary school students, "…one in every five [students] experiences a mental health issue during their post-secondary school years" (p. 9). Put differently, "the most notable declines during college years are in the student's sense of psychological well-being" (Field, Elliot, & Korn, 2006, p. 105). Student mental health and well-being can be further compromised if or when coupled with additional life traumas and stresses, such as violence, poverty, neglect, abuse, illness/disability, or family discord. For some, mental health problems precede university/college attendance. For example, in reviewing preliminary findings from an unpublished study of student mental health at Cornell University, Lunau (2012) reported that 5% of students carry a previously diagnosed mental health problem or illness, which increased in severity while at university. It seems that student experiences while attending post-secondary schooling can prompt *or* exacerbate mental health challenges.

The stigma and discrimination associated with mental health and present within post-secondary institutions can further exacerbate mental health problems (CASA, 2014; Martin, 2010). A person with a mental health problem or illness may internalize this stigma and discrimination; oftentimes, resulting in more negative impacts than the problem or illness itself (Canadian Association of College and University Student Services (CACUSS) & Canadian

Mental Health Association (CMHA), 2014; CASA, 2014; Martin, 2010). More negative impacts are also likely to occur for marginalized populations who experience mental illness; enduring stigma not only for having a mental illness, but also for carrying an identity that deviates from "perceived norms" (Ministry of Training, Colleges and Universities, 2014). Individuals who endure social or systematic oppressions and exclusions related to their sexual orientation are an example of such populations. Mental health stigma/stereotypes and how marginalized populations are particularly affected are further discussed in chapter two. Regardless of origin or reason, a poor mental health status can impact student academic functioning, where a decrease in engagement and achievement, an increase in disruptive or maladaptive behaviour, or dropping out altogether are certainly possible (CACUSS & CMHA, 2014; CASA, 2014; Frado, 1993; Kitzrow, 2003; MacKean, 2011; Ontario College Health Association, 2009; Quinn et al., 2009; Santor, Short, & Ferguson, 2009). MacKean's (2011) environmental and literature scan of student mental health in Canada revealed that college and university students' academic performance is affected by factors associated with mental health problems, namely stress (38%), sleep (26%), and anxiety (26%).

Coping mechanisms can assist students in confronting adversity, reducing the degree of vulnerability, risk, and need, or preventing the development of mental health problems (Bal, Crombez, Van Oost, & Debourdeaudhuij, 2003). Coping can include finding security through interpersonal relationships, such as socializing with friends, or employing distraction techniques, such as concentrating on academic endeavours (Steiner, Erickson, Hernandez, & Pavelski, 2002). Within the health psychology research on populations facing mental health problems, coping mechanisms are usually divided between those that are "approach-based" – the subject faces the dilemma – and those that are "avoidance-based" – the subject evades everything related to the

dilemma (Steiner et al., 2002). Research has shown that individuals who employ approach-based coping mechanisms are more likely to experience less negative outcomes than those who execute avoidance-based coping strategies (Fraser & Pakenham, 2009). However, approach-based coping techniques are not always innately or easily practiced.

The encouragement and facilitation of approach-based coping mechanisms for students is dependent on the accessibility of support, ideally established through policies under a system of care; an organizational philosophy regarding collaborative support processes, that was initially introduced by Knitzner (1982) over thirty years ago, but has since been re-defined. Although some modifications and/or criticisms continue to evolve, below is a general description of this philosophy:

> A system of care is an adaptive network of structures, processes, and relationships grounded in system of care values and principles that provides [individuals] with serious emotional disturbance and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions. (Hodges, Ferreira, Israel, & Mazza, 2010, p. 6)

More recently, Schwean and Rodger (2013) have proposed a system of care model that draws from their work on children's mental health in Ontario schools. Following a brief definition of *systems of care* and description of *core values*, the model outlines eight principles that guide a mental health care system, including, but not limited to the following: the incorporation of public health frameworks; the facilitation of care management and conceptualization; the promotion of evidence-based practices; the consideration for cultural, racial, ethnic, and linguistic differences; and the use of technology (Schwen & Rodger, 2013).

School-based systems of care can draw from public health approaches or from relevant research outlets, such as those that focus on mental health protective/resilience approaches (Schwean and Rodger, 2013). Regardless of how systems are structured or informed, the promotion and accessibility of support through a system often relies on recognition that students can experience mental health problems and that more needs to be done to support this population. Moreover, it appears that promotion and accessibility can be dependent on efforts forwarded by the public and by other organizations or institutions that complement these efforts or facilitate their own. Schools can certainly be considered as a potential component of a system of care to support the mental health of students (Schwean & Rodger, 2013).

Although seemingly greater in international contexts, particularly the United States of America, the United Kingdom, and Australia, attention over student mental health has definitely increased in Canada over the last decade (CASA, 2014; Hanlon, 2012; MacKean, 2011; UMCMHS, 2014). For example, in 2005, the Government of Canada enacted the Accessibility for Ontarians with Disabilities Act (AODA), which intends to make Ontario structures and services, such as academic institutions and education, completely accessible by 2025 (Ministry of Economic Development, Employment and Infrastructure, 2015). Unfortunately, the growth in attention towards mental health is partially in response to the increased number of young adults who have committed suicide due to the impacts of mental illness (Hanlon, 2012; MacKean, 2011; UMCMHS, 2014). Queen's University student Jack Windeler who died by suicide due to mental health problems was a significant event that increased national concern over post-secondary student mental health; an event that led to the founding of The Jack Project in 2010, which attempts to raise greater awareness towards student mental health (Hanlon, 2012). As the President of Mount Allison University stated in a recent article published in *University*

Magazine, "often, it takes an event or crisis to push it (mental health) to the next level of priority" (Hanlon, 2012, p. 1). Such incidents have also prompted the media to report more frequently on mental health; for example, drawing greater attention to "high profile" people who disclose having a mental illness (MacKean, 2011). Increased concern over student mental health in Canada also appears evident when examining recent government and organization activities surrounding mental health and well-being; the most noteworthy ones developed by the Mental Health Commission of Canada (MHCC) formed in 2008. Specifically, in 2009, MHCC developed a document, *Toward recovery and well-being: A framework for mental health in Canada* that "sets out a vision containing seven broad goals for transforming mental health systems across Canada" (MacKean, 2011, p. 16). This document has been identified as "an important reference point for mental health policy and practice across the country" (MacKean, 2011, p. 16). Mental health policy and practice implementation across the country can also include the involvement of academic institutions.

Mental health policy and practice at the post-secondary level has been questioned and debated, which initially worked to keep this subject somewhat removed from the political and academic agendas associated with higher education (Hanlon, 2012; Lunau, 2012). Unlike their elementary and secondary school counterparts (K-12), post-secondary institutions are not entirely expected to "worry" about the mental health of students (Anderson-Butcher, 2006; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Lunau, 2012). With this understanding, the actions and behaviours of faculty and staff within higher education settings remain governed by an institutional framework that holds them as accountable for providing students with quality education and opportunities for economic development; not for supporting their mental health and well-being (Kadison & DiGeronimo, 2004; Lunau, 2012). This framework constructs student

mental health problems as issues that need to be primarily dealt with by other systems or institutions, such as families or communities (Anderson-Butcher, 2006; Burns & Hoagwood, 2002; Graham, Phelps, Maddison, & Fitzgerald, 2011). It represents students as independent, resilient, "adult-like", and not requiring support from an academic institution (Lesko, 2001). Furthermore, student confusion, obscurity, and stress are perceived as "normal" or expected when faced with the amorphous experience commonly attributed to post-secondary education (Tinklin, Riddell, & Wilson, 2005). Drawing from the above understandings, institutions may simply overlook or "dismiss" students with mental health problems (Graham et al., 2011; Grayson, 2006).

Evidence suggests that Canada is moving away from an industrial-age thinking of settings that are specialized in single affairs towards a more inclusive or "progressive" model of post-secondary schooling that places colleges and universities as central players in the provision of health-related services (Anderson-Butcher, 2006; Canadian Mental Health Association (CMHA), 2014a; CASA, 2014; Hanlon, 2012; MacKean, 2011; UMCMHS, 2014). It appears as though "the notion that mental health issues are irrelevant in what has traditionally been viewed as a strictly academic environment is, fortunately, on the wane" (Whitley, Smith, & Vaillancourt, 2012, p. 65). There is greater recognition that mental health is a dimension of higher education (CASA, 2014; CMHA, 2014a; Hanlon, 2012; MacKean, 2011). In a recent *Maclean's* article, Lunau (2012) cites an administrator at Queen's University who commented on the above-noted representation of higher education settings: "Our role is education and research, and to some degree, community service. That said, we do have a care and nurturing role over the young people that come to us" (p. 58). This understanding recognizes higher education settings as part of a broader system of care initiative, and thus, in part responsible for the mental health of

students, especially considering that mental health problems can contribute to educational hardships (or vice versa), and that most students are expected to spend a substantial amount of time in school (CACUSS & CMHA, 2014; CMHA, 2014a; Cornejo, 2010; Lightfoot & Bines, 2000; Ontario College Health Association, 2009; Santor et al., 2009; Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000).

Human Rights Legislation in Canadian provinces/territories requires that all public settings, including academic institutions, have a duty to treat individuals equally, which entails supporting those who have mental health concerns (Frado, 1993: Heyno, 2006; Jaycox, Morse, Tanielian, & Stein, 2006). As Martin (2010) promoted through her exploration of student mental health, stigma, and higher education settings, "…all people are to be provided with opportunities to reach their full potential, regardless of their disability" (p. 260). In accordance with AODA, post-secondary faculty and staff must be trained in accessible customer service, where the training includes topics such as, principles of accessibility and best practices for communicating and interacting with persons with disabilities (Ministry of Economic Development, Employment and Infrastructure, 2015). According to the Ontario College Health Association (2009), higher education settings are established infrastructures that are guided by Human Rights Legislation, typically "well-positioned to respond positively and adhere to mental health intervention" (p. 6). They can offer a proximal, familiar, informed, safe, and cost-effective environment for the provision of support (CASA, 2014; Field et al., 2006; Graham et al., 2011; Kadison & DiGeronimo, 2004; Leigh, Venn, & Kutcher, 2009). Support from Canada's public healthcare system is sometimes limited in accessibility, type, reliability, and quality. When public-based intervention is unattainable or untrustworthy, academic settings may become the only locations where students can, and are more likely to, successfully access support (Battalio & Stephens,

2005; CASA, 2014; Frado, 1993; Roeser & Midgely, 1997; Waller, Bresson, & Waller, 2006; Whitley, 2005).

In response to this increase in attention, national frameworks and strategies have been developed in the last six years to address mental health in general, as well as in academic settings, which include *Towards Recovery and Well-Being* (2009), *Changing Directions/Changing Lives* (2012), and *Mental Health: A Guide and Checklist for Presidents* (2012) (CACUSS & CMHA, 2014). Drawing from such national frameworks, many Canadian colleges and universities have demonstrated considerable commitment to the development of mental health policies and practices (CASA, 2014; Hanlon, 2012; MacKean, 2011; Ontario College Health Association, 2009; UMCMHS, 2014). According to a recent newsletter released by the Ministry of Training, Colleges and Universities (2014), "Ontario is strengthening mental health supports for post-secondary students by extending the Mental Health Innovation Fund…Ontario invests $9 million annually to support improved mental health services for post-secondary students, including up to $6 million each for the Mental Health Innovation Fund" (para. 1 & 5). Students are now better guided through post-secondary schooling if experiencing a mental health problem or illness (CMHA, 2014a; Hanlon, 2012; UMCMHS, 2014). Counselling and accommodation services are widely prevalent and accessible in most Ontario colleges and universities (MacKean, 2011; Martin, 2010; Ontario College Health Association, 2009). Additionally, several institutions even carry specialized academic programs that a) tailor academic pathways to suit the needs of students with a mental health problem or illness, and b) offer courses and certifications in mental health for interested students (Molize College, 2014a; Molize College, 2013; Seneca College, 2014; York University, 2014).

Partnerships with large organizations and corporations have also enabled colleges and universities to better promote student mental health, namely in the facilitation of programs and campaigns designed to increase mental health knowledge and awareness in higher education (CASA, 2014; Hanlon, 2012; MacKean, 2011). Two of the more pertinent school-corporate initiatives include, *Let's Talk Day* facilitated by Bell Canada and York University, as well as the Canadian-wide promotion of *Mental Health First Aid* facilitated by the collaborative efforts of Queen's University, the Jack Project, Kids Help Phone, and the Mental Health Commission of Canada (Hanlon, 2012; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Queen's University, 2014; Sagan, 2012; York University, 2013d). In addition to those highlighted above, Table 1 outlines other noteworthy examples of proposed and/or implemented mental health policies and practices across Canadian college and university institutions.

Table 1
Examples of proposed and/or implemented mental health policies and practices in Canadian colleges and universities

College or University	Policy or Practice
University of British Columbia	- Systemic approach to student mental health - Student led initiatives: Student Mental Health Awareness Club; Kaleidoscope – a student-led mental health group that supports students with mental health and addictions problems; and Healthy Minds at UBC
Queen's University	- Promotion of Mental Health First Aid training across Canadian post-secondary institutions in collaboration with the Jack Project, the Mental Health Commission of Canada, and Kids Help Phone
Fanshawe College	- Web-based resource for college students, *iCopeU*, in collaboration with Mind-Your-Mind – a not-for-profit youth mental health program
University of Toronto, Scarborough Campus	- Universal Design Approach implemented by Accessibility Services

Carleton University	-	Mental Health Framework focused on supporting students with mental health difficulties
Camosun College in Victoria	-	Specialized program for students who want to integrate back into an educational setting
Simon Fraser University	-	Student Mental Wellness: a student-led peer support program
Adapted from *Mental health and well-being in post-secondary education settings*, by G. MacKean, 2011, Retrieved December 17, 2014, from http://www.cacuss.ca/_Library/documents/Post_Sec_Final_Report_June6.pdf		

Considerable improvements in the mental health of students have already been documented in response to such recent developments (Hanlon, 2012; MacKean, 2011; Martin, 2010). Despite the overall marked improvements, however, intervention for students with a mental health problem or illness in Canadian higher education settings remain not yet accomplished, mature, or sustainable (CASA, 2014; Lunau, 2012; Martin, 2010). It appears that college and university institutions still struggle between accommodating students and holding the traditional notions surrounding academic integrity – "school for learning only" model (CASA, 2014; MacKean, 2011). Moreover, stigma and negative attitudes towards mental health have not ceased (CASA, 2014; Froese-Germain & Riel, 2012; Hanlon, 2012; Martin, 2010; Ontario College Health Association, 2009). Considering the increased attention towards post-secondary student mental health, little evidence shows how universities and colleges have moved encouraging efforts and initiatives into practice (MacKean, 2011). A number of challenges have been identified as contributory to the shortcomings surrounding student mental health in higher education settings, including, but not limited to, poor policy development, limited leadership and participation from individuals at all levels of the institution, untrained faculty and staff, lack of funding, and improper resourcing (CASA, 2014; CACUSS & CMHA, 2014; CMHA, 2014a;

Hanlon, 2012; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014). For example, although practices that support the mental health of students reflect better standards of equality, a reflection in equity is still lacking. Specifically, resources are sometimes inequitably distributed through the institution, which can affect the development or sustainability of practices that support the emotional well-being of students (CASA, 2014; MacKean, 2011).

Continuous efforts are being made to overcome existing barriers. The hope is for mental health policy and practice in Canadian academic settings to resonate with international trends and eventually be facilitated through a whole-school, systemic approach; one that encourages multi-purposeful, universal, and preventative strategies to essentially benefit the mental health and well-being of all school populations (Bond, 2010; CACUSS & CMHA, 2014; Ekornes, Hauge, & Lund, 2012; Hanlon, 2012; MacKean, 2011; Santor et al., 2009; Schonert-Reichel & Lawlor, 2010; UMCMHS, 2014). For example, collaboration between the Canadian Association of College and University Student Services and the Canadian Mental Health Association led to the production of a framework for post-secondary student mental health in 2014; a system-wide approach outlining key components for its development and implementation in Canadian colleges and universities. Furthermore, several of the initiatives outlined in Table 1 include whole-school ideologies, such as the University of British Columbia's *Triage System* or *Intervention Pyramid* (MacKean, 2011). Despite the increased consideration of student mental health and intervention in higher education settings, including recognition of the various barriers to be overcome and hopes for the future, there is one aspect that remains relatively underexplored: the views and roles of post-secondary instructors.

1.1 Problem Statement

The purpose of this study was to explore the perspectives and practices of college instructors in the support of students with mental health problems, or in the promotion of positive student well-being overall. To date, despite the increased attention given to student mental health in Canadian higher education institutions, little is known and understood about how instructors view their role as supporters or promoters of student mental health. Rather, current focus lay more in the development and implementation of wider mental health policies, practices, and holistic frameworks. A number of questions consequently ensue: Where do instructors fit in post-secondary mental health policies, practices, or holistic frameworks? How do instructors perceive student mental health and their potential role as "support providers"? What kind of initiatives do instructors employ to support students with mental health problems or to promote overall positive student well-being? What are the common personal or institutional issues and challenges that instructors face in relation to student mental health and intervention?

Of note, the term *professor* is also often used to identify those responsible for teaching/lecturing students at the post-secondary school level. The meaning of *instructor*, *professor*, *course director,* or any other term used to identify such individuals can vary institutionally, provincially, nationally, or internationally. For example, at the Canadian college level, the title of *instructor* may be given to those associated with a part-time employment status, while full-time faculty members may be designated as *professors*. Along with employment status, academic qualifications can also affect designation. In this case, for example, those who carry a doctorate degree can be given the title of *professor* regardless of their employment status. Conversely, in most Canadian university settings, *professor* or *course director* are more common designations. In these contexts, employment status or academic qualifications can also influence

or modify titles. For example, professors may carry preceding identifiers, such as *honorary*, *associate,* or *assistant*, depending on their status and qualifications. This study employed the term *instructor* to reflect the college study context; to ensure clarity/consistency; and to capture a greater pool of individuals.

Little insight into the relationship between instructors and student mental health is likely due to the discrepancies surrounding the role of educators in general when supporting the mental health of students. Elementary and secondary school teachers, who legally identified as practitioners of *in loco parentis* (via the Ontario College of Teachers, the Ontario Teachers Federation, and the Ministry of Education) seem to carry more pressure to abide by a positive health agenda (Kitchen & Dean, 2010; Lightfoot & Bines, 2000; Reupert & Mayberry, 2010; Schonert-Reichel & Lawlor, 2010; Wyn et al., 2000). Ontario elementary and secondary school boards have implemented a kind of "mental health focus strategy", whereby collaborative initiatives for schools to support the mental health and well-being of students are developed and implemented. For example, School Mental Health Assist (2014) "is a provincial team designed to help Ontario school boards to build capacity to support student mental health and well-being, through effective implementation of research-based programs and strategies" ("What We Do", para.1). With such board-wide strategies, practices that support the mental health of students are not simply dependent on individual teacher implementation.

Evidence suggests that Canadian elementary and secondary school teachers participate in the developed actions or initiatives associated with support for student mental health, such as *Healthy Minds, Bright Futures*, facilitated by the Alberta Teachers' Association and the Canadian Mental Health Association. Briefly, *Healthy Minds, Bright Futures* aims to increase awareness of student mental health and decrease the associated stigma (Alberta Teachers'

Association, 2014). The initiative includes a resource booklet for teachers to help them support students with mental health problems (Alberta Teachers' Association, 2014). The *Ontario-based Coalition for Children and Youth Mental Health* is another example of an elementary and secondary school level mental health initiative. Comprised of several education stakeholders, such as the Ontario Teacher's Federation and the Elementary Teachers' Federation of Ontario, this coalition is intended to foster emotional and social health by increasing mental health literacy and wellness, developing inter-ministerial and multi-sectoral approaches of support, implementing strategic policies, and building partnerships with families and communities (Froese-Germain & Riel, 2012; Leigh et al., 2009; Ontario School Boards' Association, 2014).

On the other hand, college or university instructors are dealing with a different kind of population, commonly comprised of older adolescents, young adults, adults, and sometimes seniors. At this level, instructors are represented as sharing a "less-engaged" relationship with their students; one that ordinarily develops through the formal and systematic rituals of post-secondary schooling, such as participating in lecture discussions or attending tutorials. This relationship does not assume that instructors are legally or ethically responsible for supporting students with non-academic concerns, or more specifically, students with mental health problems (Hanlon, 2012). They are not governed by a particular college of practices and guidelines that mandates this responsibility (Bower & Schwartz, 2010; Quinn et al., 2009). Put differently, the promotion of student well-being is not identified as a vital component in the functioning of post-secondary instructors. In this light, it seems that instructor quality is narrowly-defined by subject knowledge, student academic performance, or the ability to promote that which is encouraged by traditional models of schooling – esteemed education and opportunities for economic development – pushing the rest to "the sidelines". Most responsibilities related to student mental

health in college and university settings fall on mental health professionals, such as psychologists, psychiatrists, social workers, and/or school counsellors, who function through student support service departments, such as a counselling centre (Davidson & Locke, 2010; Kitzrow, 2003; MacKean, 2011; Molize College, 2013; Ontario College Health Association, 2009).

The recent escalation in student suicides due to mental health problems, many of which have become legal concerns, has encouraged higher education settings to not only modify its overall support structures, but to also (re)define the role of its faculty and staff (CACUSS & CMHA, 2014; CASA, 2014; Hanlon, 2012; Kay, 2010; Kitzrow, 2003; MacKean, 2011; UMCMHS, 2014). There has been "a shift in culture that recognizes that the entire post-secondary community is responsible for the mental health of its members" (CACUSS & CMHA, 2014, p. 10). Unfortunately, however, not much work on the role of teaching faculty in particular has been generated as a result. Kadison and DiGeronimo's (2004) book, *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It*, as well as Kay and Schwartz's (2010) edited compilation, *Mental Health Care in the College Community*, are two noteworthy sources that included the role of teaching faculty while considering student mental health in higher education settings. The above-noted literature, however, did not draw from Canadian contexts. In reference to colleges and universities in Canada, MacKean's (2011) literature and environmental scan of mental health and well-being in Canadian post-secondary settings is an exceptional study that offered some insight into the role of instructors as supporters and promoters of student mental health. Other Canadian-based resources that included components of the post-secondary instructor's role seemed to draw from government and organization policy/strategy documents or general media releases (CACUSS & CMHA, 2014;

CMHA, 2014; Cavalheiro et al., 2012; Hanlon, 2012; Lunau, 2012; UMCMHS, 2014). For example, CMHA's (2014) recent publication, *A Guide to College and University for Students with Psychiatric Disabilities*, is a noteworthy example of policy documents that highlight how instructors are considered.

Although noteworthy, work in the area of post-secondary student mental health seemed to have included only periodic or brief discussions of the role played by faculty and staff in relation to student mental health; a majority that have simply mentioned a need to consider this population in the future. In other words, explicit and comprehensive consideration of the instructor's role in relation to student mental health has not been taken up in any study to date, nationally or internationally. This study attempted to build from the examples of literature noted earlier, through its examination of the college instructor's role in promoting and supporting the mental health of students. With an explicit and comprehensive consideration for instructors, the study sought to extend existing knowledge of how mental health is taken up in Canadian higher education settings, or more specifically, how instructors understand and engage student mental health within the institution and particularly in their classrooms.

The perspectives and practices of instructors are integral to the development and sustainability of support for the mental health of students in higher education settings. How can the implementation of mental health policy and practice within colleges and universities be thoroughly engaged without considering the role of instructors, who are often depended upon to encourage such policy and practice? This question calls for a redefined understanding of the instructor, or of the educator more broadly. In addition to a deliverer of pedagogical instruction, the instructor or educator can be situated or imagined as a supplemental aide, key person, or "linchpin" in supporting the social and emotional needs of students or promoting positive student

well-being overall (Battalio & Stephens, 2005; Cornejo, 2010; Davidson & Locke, 2010; Paternite, 2004; Santor et al., 2009; Schonert-Reischel & Lawlor, 2010; Silverman & Glick, 2010). This understanding recognizes that addressing student mental health relies on instructors to deliver or drive such efforts. This suggestion does not imply that "…teachers bear responsibility for providing therapeutic interventions to their students with mental health problems; this is clearly not their role in the school system" (Whitley et al., 2012, p. 66). Whether working at the elementary, secondary, or post-secondary level, educators are not expected to carry expertise in mental health, educational psychology, or student well-being overall. Furthermore, unlike their elementary and secondary school counterparts, post-secondary instructors are not expected to hold a teaching degree or partake in any formal training regarding teaching, education, or student-instructor relationships.

With little direction, it is difficult to expect that instructors can or want to undertake responsibility over student well-being, or even know how to for that matter. Nonetheless, the opportunity for instructors to engage as promoters and supporters of student mental health can be seized; the unique or novel initiatives of support they practice can be acknowledged, valued, and utilized. Initiatives implemented by instructors can lead to enhanced practices in the development of ubiquitous approaches to intervention – a bottom-up approach. This approach entails that exemplary practices at the classroom level can develop into institution-wide, mandated mental health support strategies. Its counterpart, a top-down approach, situates institution administrators as those who hypothesize, examine, and implement strategies of support, intended to reach the classroom level for practice by instructors. Even through a top-down standpoint, instructors can play a vital role; that is, in communicating, promoting, or fostering the institutionally developed support practices.

Mobilizing instructor knowledge, efforts, and responsibility becomes imperative if they are to assume the role of supplemental aide, key person, or "linchpin" in supporting the social and emotional needs of college and university students. Delineating where and how exactly they can contribute to student mental health and well-being, as well as what is needed to encourage such contribution, is definitely warranted, especially when a whole-school approach or system of care is present (CACUSS & CMHA, 2014; Hanlon, 2012; UMCMHS, 2014). A strategically coordinated, integrated, and holistic response to student mental health can encourage the methodical development and facilitation of support initiatives by *all* parties in a given institution, including teaching faculty. Through such an approach, an overall school milieu that supports the mental health of students can be established. As MacKean (2011) put it, "if student mental health…remains viewed as the responsibility solely of student service professionals, a tremendous opportunity will have been missed to integrate mental health and well-being into academic structures, policies, and processes" (p. 8). Considering the possibility of instructors playing a fundamental role in supporting the mental health of students, whether or not working through an overarching system of care, it seems necessary to learn more about their perspectives towards mental health, as well as their potential as providers or extensions of support for students with mental health problems or illnesses.

In this study, college instructors were surveyed and interviewed regarding their understanding and support of student mental health. An ethnographic method of inquiry situated within a constructivist paradigm was assumed to capture the personal and shared meanings of instructors within higher education settings towards issues of mental health and intervention. The findings of this study revealed interplay between instructors' understanding of student mental health and the initiatives they practice to support students with mental health concerns. The

analysis and discussion signal a need to consider the instructor's perspectives and practices when addressing the mental health needs of post-secondary school students.

1.2 Purpose of Study

The purpose of this qualitative study was to examine the role of post-secondary instructors in relation to student mental health. The study uncovered the perspectives of instructors from Molize College (pseudonym), a post-secondary institution in Toronto, Ontario. Specifically, this study set out to document,

- Instructors' awareness of student mental health;
- Instructors' evaluation of their knowledge and confidence in relation to student mental health;
- Instructors' beliefs surrounding responsibilities in supporting the mental health of students; and
- Instructors' practices that support the mental health and well-being of students.

Firstly, the objective was to determine if and how instructors are aware of student mental health concerns. How aware are instructors when it comes to mental health at the post-secondary level? How often do instructors encounter students with a mental health problem or illness in their classrooms? Secondly, this study sought to uncover the knowledge and confidence instructors believe they carry in relation to student mental health. How do instructors evaluate their overall knowledge in mental health? How confident are instructors in supporting students with mental health problems? Thirdly, the study shed light on instructors' beliefs regarding responsibilities in the provision of support for student mental health. Who do instructors believe is responsible for supporting students? What, if any, responsibilities do instructors assume in the promotion of student well-being? Finally, the purpose of this research was to uncover the

approaches instructors practice that can support students with a mental health problem or illness, as well as encourage positive student well-being overall; practices that can work with or complement the wider, systematic-type initiatives facilitated in post-secondary institutions, as well as those that can be independently developed and implemented at the classroom level. Of note, the efficacy of support practices was not considered here, as the needs of all students in diverse contexts cannot be met by one explorative, cross-sectional study that focused on those who provide support (Greene, 2000; Santor et al., 2009).

1.3 Significance of Study

The current study represented a timely response to the increased number of students on campus who report or identify with a mental health problem (CACUSS & CMHA, 2014; CASA, 2014; Cavalheiro et al., 2012; Lunau, 2012; MacKean, 2011; Martin, 2010; UMCMHS, 2014). A recent article published in Canada's national magazine *Maclean's* indicated that "a quarter of university-age Canadians will experience a mental health problem, most often, anxiety or depression" (Lunau, 2012, para. 3). Provincially, MacKean (2011) noted that 4% of students from six post-secondary institutions in Ontario have a mental health problem or illness. In looking specifically at the context of Molize College, over the last couple of years, there has been a 41% increase in the number of students who reported as having a mental health problem or disability (Cavalheiro et al., 2012). Individuals are more likely to experience a mental health problem during late adolescence or young adulthood; age groups that coincide with post-secondary education (Adlaf, Gliksman, Demers, & Newton-Taylor, 2001; Cavalheiro et al., 2012; Frado, 1993; Lunau, 2012; Martin, 2010; UMCMHS, 2014; Waller et al., 2006). As discussed earlier, it is in college or university where "students with mental health problems are more likely to be identified, and may be more likely to be linked with appropriate services in a

timely manner" (Ontario College Health Association, 2009, p. 11). These students carry the right to partake in an education system that is not socially oppressive and that can support their mental health needs (CACUSS & CMHA, 2014). This study was significant because it focused on mental health at the college level; how the mental health needs of post-secondary students can be addressed. Although this study explored student mental health in one Canadian college setting, findings and discussions can be representative of other post-secondary institutions, including those at the university level.

This study appeared as the first of its kind to exclusively recognize instructors as potential key players in responding to the increased mental health needs of post-secondary students in Canada, which further contributed to its significance. For the most part, the role of instructors is only casually or partially considered (CACUSS & CMHA, 2014; CMHA, 2014a; UMCMHS, 2014). The powerful influence of instructors on the emotional well-being of students cannot be neglected (CACUSS & CMHA, 2014). Recognizing the supportive actions undertaken by instructors helps promote further reciprocity between health and education fields of study (Ontario College Health Association, 2009). Such recognition is also advised in order to develop a complete and comprehensive understanding of mental health care systems or whole-school approaches in higher education settings (Burns & Hoagwood, 2002; CACUSS & CMHA, 2014; Davidson & Locke, 2010; Field et al., 2006; Hanlon, 2012; MacKean, 2011; Patton, Glover, Bond, Godfrey, Di Pietro, & Bowers, 2000; UMCMHS, 2014).

An acknowledgement of support strategies facilitated by a college institution and its instructors was intended to benefit the well-being an academic experiences of students with mental health problems. For example, as MacKean (2011) outlined, supporting the well-being of college and university students' emotional health can increase graduation rates, or conversely

decrease drop-out rates. However, support for the mental health of students can also indirectly benefit other parties or domains. Firstly, the encouragement of positive mental health can support students without an identified mental illness (CACUSS & CMHA, 2014; Cornejo, 2010; Davidson & Locke, 2010; Tacker & Dobie, 2008). For example, an instructor may distribute resources on how to manage time in hopes of relieving some of the stresses students with a mental health problem can experience; a strategy that can help every student in the classroom (Kadison & DiGeronimo, 2004). Additionally, some students with mental health problems can affect the learning and well-being of other students (Kitzrow, 2003), and therefore, an instructor supporting students with mental health problems can indirectly support others in the classroom. Whatever the case may be, support facilitated by institutions and faculty can empower all students to actively participate in sustaining positive mental health, and thus, maintaining well-being throughout their lives (CACUSS & CMHA, 2014).

Secondly, the implementation and sustainability of mental health intervention can boost college or university credibility (Hanlon, 2012; Kadison & DiGeronimo, 2004; Ontario College Health Association, 2009). Kadison and DiGeronimo (2004) submit that systems of support

> ...directly influence the reputation and educational rankings of all colleges. Most specifically, they affect an institution's retention and graduation rates, both very important to the health and vitality of a college community – and to the bottom line. These rates are touted as an indicator of student satisfaction and are considered by students and parents when choosing colleges, and they are used in the formulas that select top-ranking colleges in the country and advertised in publications... (p. 162)

Alternatively, minimal efforts in addressing the mental health of students at the college or university level can lead to increased crises and potential suicides, which can damage an

institution's reputation (Hanlon, 2012). As a result, instructors and other educators who contribute to student mental health and well-being can essentially increase the respectability of efforts and healthcare frameworks practiced in post-secondary institutions.

Thirdly, society as a whole can benefit from intervention systems situated in academic institutions (Frado, 1993; Kadison & DiGeronimo, 2004; MacKean, 2011; Ontario College Health Association, 2009; Schwean & Rodger, 2013; Waller et al., 2006; Whitley et al., 2012). According to Waller et al.'s (2006) research on mental health in the classroom, schooling influences education, health, and well-being, all of which are necessary for an equitable and autonomous society to prevail. To elaborate, mental health intervention in post-secondary settings can enable "graduates to embark upon the next stages of their lives unencumbered by severe mental illness..." (Ontario College Health Association, 2009, p. 6). Embarking into the next stages of life can involve anything from pursuing additional education or vocational training, to obtaining full-time employment; potentially challenging tasks for mentally unhealthy individuals (CASA, 2014; Waller et al., 2006; Whitley et al., 2012). In many cases, untreated mental health problems lead to student drop out, where the potential of obtaining desired or well-paying employment is diminished (CASA, 2014; Kadison & DiGeronimo, 2004; Schwean & Rodger, 2013; Whitley et al., 2012). Mental health promotion and intervention in post-secondary settings can encourage gainful opportunities for all new graduates (UMCMHS, 2014). Increasing employability can help decrease dependence on employment insurance; a form of social assistance that can impact Canada's economy (CASA, 2014; MacKean, 2011; Schwean & Rodger, 2013; UMCMHS, 2014). While on the topic of social assistance and the economy, mental health promotion and intervention in post-secondary institutions can also help reduce hospitalization for individuals with mental health problems; another factor that can exhaust

national funds (MacKean, 2011; Schwean & Rodger, 2013). According to CASA (2014), the overall cost of mental illness, including employment insurance compensation and hospitalization, is over $50 billion per year. When considering all of the above, then, a negative ripple effect throughout all populations, communities, or economies is certainly possible when mental health interventions are under-explored and under-practiced. To this end, the current study can contribute to the present and future social or emotional welfare of society, particularly the functioning of individuals who face mental health problems.

On a final note, the current study was significant because it employed qualitative ethnography; a seemingly rare undertaking in this area of research. Quantitative measures, such as experiments, information/statistic systems, or close-ended survey questionnaires, are often used to investigate student mental health in post-secondary institutions, likely due to the medicalized/scientific/positivist lens through which topics of mental health and intervention are typically framed (Bal et al., 2003; Eichler & Schwartz, 2010; Hoefnagels, Meesters, & Simenon, 2007; Orel, Groves, & Shannon, 2003). Rather, this study used an open-ended survey questionnaire, interviews, and document review as methods of data collection. Qualitative ethnography enabled post-secondary instructors to share their perspectives regarding mental health and intervention, rather than solely relying on the quantitative data derived from "health experts" or an institution's mental health professionals operating through student support services departments. Put differently, this approach encouraged modes of inquiry that are exploratory – "what" and "where" questions – and explanatory – "why" and "how" questions (Morris, 2006). A methodological direction of this nature was rather unique, and thus, strengthened the significance of this study in the subject research area.

1.4 Scope of Study

In light of the public's increased attention of student mental health and the growing number of higher education students who identify as having a mental health problem or illness, this study sought to investigate the perspectives and practices of college instructors when it comes to the mental health of their students. Specifically, through a qualitative approach to inquiry, it examined instructors' overall awareness of student mental health at the post-secondary level; their evaluation of self- knowledge and confidence in mental health; their beliefs surrounding responsibilities in supporting students with mental health problems; and their employment of practices that support this population. Due to its focus on people, processes, and relationships, a qualitative avenue was useful to identify existing, emergent, and evolving patterns of meaning, or in this case, the meanings instructors carry towards mental health and intervention (Lincoln & Guba, 2000; Morris, 2006; Patton, 2002). Accordingly, a constructivist theoretical framework was employed to analyze and understand these meanings. Briefly, this framework posits that individuals develop personal constructs based on their experiences or encounters, and then make sense of phenomena through interpretation (Forster, 2008; Williamson, 2006). As such, the objective of a constructivist lens in this study was to acknowledge how instructors construct, perceive, interpret, and act in response to the phenomena of student mental health.

A Canadian college institution was the higher education context chosen in this study. According to Canadian stages or levels of formal education, post-secondary (higher or tertiary) schooling takes place within institutions such as, universities, colleges, academies, seminaries, or vocational/trade schools. Colleges are often more career-oriented than universities. Some Canadian colleges offer Bachelor degrees, but most primarily carry diploma and certificate

programs with a strong focus on the provision of practical training. Within the last decade, attendance in higher education through college institutions in particular has notably increased (Colleges Ontario, 2011; Molize College, 2014a). According to Ontario College statistics on student and graduate profiles, 57% of individuals interested in higher education attend college, whereas 43% attend university (Colleges Ontario, 2011). A college context was chosen for this study partially in response to the above-noted data. That said, however, study findings here can certainly be reflective of or applicable to different education contexts, including other college institutions, universities, or even some elementary or secondary schools. As such, *college* is often used interchangeably with *higher education setting*, *post-secondary institution*, *institution of higher learning*, or *post-secondary academic setting*.

Molize College was the particular institution chosen in this study. With approximately 27,000 full-time and 56,000 part-time students (about 5,300 of which graduate annually), this college stands as a distinguished, career-focused post-secondary institution in Ontario (Colleges Ontario, 2011; Molize College, 2014a). The information to follow in this paragraph and the next highlights some prominent characteristics of the college, as promoted through their general website (Molize College, 2014a). Molize has three campus locations, respectively situated in an urban, suburban, and rural community; the largest being its suburban, Central-North campus, which serves the majority of students and offers the most program options. Molize is known as a lively college environment that encourages students to "just hang around," rather than solely participating in "the academics" component of post-secondary schooling, even attracting engagement from surrounding community members. This encouragement or attraction likely stems from the following factors: a) the campus' close proximity to residential communities; b) the availability of multiple transportation services travelling to and from the campus; and c) the

wide variety of facilities and resources, such as athletics or child care services, accessible to both students and their families.

Molize College offers 170 full-time and 300 continuing education programs that include four-year baccalaureate degrees, two and three-year diplomas, and one and two-year certificates, some of which are in conjunction with partnering universities. The programs are offered through eight faculties, known as *Schools of Learning*, such as Applied Technology, Business, Health Sciences, and Liberal Arts and Science. According to Ontario College statistics on student and graduate profiles, the School of Business is often the most student-populated, with a 51.9% enrollment, followed by Applied Technology at 24.9% and Liberal Arts and Science at 18.6%. Each school carries a variety of departments that offer courses pertaining to a specified discipline and/or program. For example, most degree, diploma, and certificate programs through the School of Liberal Arts and Science offer courses in social sciences, such as economics, psychology, and communications; humanities, such as English, philosophy, or literature; introductory sciences, such as chemistry or anatomy; and introductory math, such as finite or calculus. Furthermore, ESL, technology, and preparation courses intended for students transferring to university are also provided. Of note, Molize College offers interdisciplinary studies through Liberal Arts and Science, whereby it welcomes students from every School of Learning to enroll in its courses.

Molize College carries a number of admirable features that can work to promote and support student mental health. Firstly, the college demonstrates an overall commitment to supporting the academic, social, and psychological needs of students. With respect to student emotional well-being in particular, in 2012, the institution implemented an official policy regarding student support and intervention:

> The College has the right and responsibility to address the behaviour of a student-of-concern in order to ensure the student is fit for academic life and/or to protect that student and/or other members of the College or local community from risks or significant impact posed by their behaviour, whether or not a violation under the Code of Student Conduct has occurred. (Molize College, 2013, para. 1)

The enactment of this policy appears to situate this particular institution and its members as fundamental actors in the facilitation and sustainability of student well-being. Secondly, like most other post-secondary institutions in Ontario, Molize College is equipped with student support services, such as the counselling centre or the student success and engagement centre (Molize College, 2015; Molize College, 2013). In addition to academics, these centres or departments address the more personal concerns of students, including mental health problems. If a student is faced with a tragic incident or some kind of loss, for example, they are welcome to take part in the Tragic Events Support Network (TESN) offered through the counselling services department (Molize College, 2013). Thirdly, Molize College offers a streamed preparatory department/program through its School of Liberal Arts and Science that provides additional avenues and guidance for students, for example, who are unsure of their academic and career plans or who come from "unconventional" or "challenging" backgrounds (in terms of education, family, well-being, etc.) (Molize College, 2014a).

Fourthly, the college's known lively environment that encourages students and community members to take advantage of campus facilities or to "just hang around" also works to promote positive mental health and well-being (Molize College, 2014a). Evidence suggests that it is important for post-secondary institutions to create supportive environments, or more specifically, physical spaces that foster student and community connections, and subsequently,

positive well-being; a particularly important endeavor for students commuting to campuses (Hanlon, 2012). Lastly, the college's recent school vision/mission statement included the following initiatives and accomplishments regarding student mental health: an increase in the number of mental health staff, such as psychologists; the encouragement of *Mental Health First Aid* training; and access to Ontario's Mental Health Innovation Fund to develop additional support initiatives (Cavalheiro et al., 2012; Ministry of Training, Colleges and Universities, 2014; Molize College, 2013).

Study participants were 42 instructors from the larger Central-North campus of Molize College, specifically part of the streamed preparatory department/program affiliated with the School of Liberal Arts and Science. Participants associated with the streamed preparatory program in particular were of interest because this program provides a representation of instructors with a wide exposure to various types of students and teaching subjects as it delivers classes/courses to students associated with other programs and schools at Molize College. This study gathered ethnographic data from participants during the school year of 2012-2013. Through qualitative ethnography, the study sought to bring instructor voices to the fore; to situate instructors not only as informants, but also as evaluators, who can examine and reflect upon their own and respective school practices (Hashimoto, Pillay, & Hudson, 2010; Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010; Kirby, Greaves, & Reid, 2006; Lunenburg & Irby, 2008).

The 42 instructors were surveyed through voluntary sampling. This method was chosen for a number of reasons: a) it invited only individuals who had the time to participate; thus, respecting the often heavy workloads and constraints of instructors; b) it pursued instructors who were enthused or invested in this area of interest, which not only enabled committed

participation, but allowed for individuals to truly become "a part of the research"; and c) as this study did not depend on a strictly defined target population, voluntary sampling encouraged a wide variety of instructor participants, which often results in more informed and fruitful study findings. Twenty-three of the 42 survey respondents were then interviewed. The semi-structured interviews were intended to amplify and enrich survey responses. Purposive, intensity sampling was used to gather interview participants; a method that encouraged a relatively unrestricted selection of participants who enabled an investigation of the topic at a variety of levels and through a variety of perspectives. As Lincoln and Guba (2004) submit, a purposive sampling technique allots room to explore a bountiful range of constructions, or in this case, of perspectives and practices towards student mental health. Several limitations likely affected the scope or breadth of this investigation, despite the parameters under which the study operated noted above.

1.5 Limitations of Study

A couple of methodological limitations impeded on this researcher's tenacious commitment to document the instructor's role in relation to student mental health. Firstly, this study was cross-sectional/synchronic, rather than longitudinal, which may have limited this researcher's ability to, for example, track the progress of certain practices, or compare the acute and long-term perspectives towards particular support initiatives within the given study context. Secondly, the participant sample was rather small in number and variation. More specifically, in addition to a relatively small sample size (due to a low survey return rate and interview participation), participants were part of *one* academic department/program, affiliated with *one* school of learning, on *one* campus, and of *one* college institution. Specifically, the academic department or program with which participants were affiliated is one that provides additional

avenues and guidance for students coming from “unconventional” or “challenging” backgrounds, in terms of education, family, well-being, etc. On the one hand, it seems essential to examine instructors’ perspectives and practices towards these students in particular, whose “unconventional” or “challenging” backgrounds can give rise to or exacerbate mental health problems. On the other hand, affiliation with this academic program may have influenced the number or diversity of post-secondary instructors’ perspectives and practices towards student mental health.

A third potential limitation drew from the age of college students. Although the population in higher education settings consists predominately of adolescents and young adults (Statistics Canada, 2006), some students are above this age range. Literature in this area of study reveals that mental health problems and illnesses can manifest differently depending on the age of an individual, and subsequently, different means of coping are likely employed (Cavalheiro et al., 2012; Kadison & DiGeronimo, 2004; Kay, 2010; Pederson & Revenson, 2005; Santor et al., 2009). This may not only influence the position of support providers, but also the quality, purpose, or facilitation of intervention. For example, the perspectives and practices of an instructor may differ when encountering a 19 year-old versus a 40 year-old student with a mental health problem. In this study, participants did not always refer to student ages in their responses, which limited this researcher’s ability to include this factor as an influential determinant in the way that instructors view or support the mental health of students.

When considering the above-noted limitations, it is important to understand that perspectives and practices can vary not only from instructor to instructor, department to department, or from institution to institution, but also from day to day. Intervention is considered fluid and temporal (Reupert & Mayberry, 2010), which can make it difficult to define practices

regardless of participant sample sizes and characteristics. Approaches of support can shift in as little as one academic year, as different implementers can incidentally or intentionally change their practices and delivery methods during implementation (Law & Shek, 2011; Reupert & Mayberry, 2010). Likewise, data collected through a constructivist approach is unique to place and time (Morris, 2006). The purpose of constructivist research is "...not to arrive at research findings that can be generalized to other settings, but rather to gather valid data about a problem or issue in its context" (Morris, 2006, p.197). Put in another way, although each post-secondary institution is different, the study "...captures a number of important issues, which are likely to exist elsewhere, and these findings have interesting implications for how [post-secondary institutions] should respond to the support needs of students with mental health problems" (Quinn et al., 2009, p. 415). The current study recognized the role of instructors as support providers by exploring, describing, and raising awareness of their evolving perspectives and practices towards student mental health, while keeping in mind that their reports represent a subjective phenomenon, different between contexts and not necessarily intended for replication or generalization. Overall, the findings were descriptive and heterogeneous in nature, providing a rich snapshot of a good portion of post-secondary instructors – their take on student mental health.

1.6 Theoretical Framework

This study employed a constructivist framework in an attempt to understand the values, perceptions, meanings, and practices instructors adopt around notions of student mental health and intervention (Greene, 2000; Guba & Lincoln, 1994; Lincoln & Guba, 2004; Lincoln & Guba, 2000; Morris, 2006; Williamson, 2006). Put simply, a constructivist paradigmatic lens submits that,

> [r]ealities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures), and dependent for their form and content on the individual persons or groups holding the constructions. (Guba & Lincoln, 1994, p. 110-111)

A constructivist approach recognizes the importance of contextualized perspectives. In relation to the current study, a contextualized perspective can represent the instructor's point of view towards student mental health within higher education settings. In other words, a constructivist approach is conscious of instructors' understanding as partially situated in, or influenced by, an institutional framework or system of care upheld by a post-secondary institution.

At the same time, however, multiplicity within the same space is certainly possible, despite any overarching influential ideologies. More specifically, topics surrounding mental health or social support carry an abundance of conceptions, conflictions, and connotations that draw from several cultural, political, and social influences (UMCMHS, 2014). A constructivist approach to research enables consideration of such multiple meanings and discourses. To elaborate, constructivism is represented by personal constructs, where "...people make sense of their world on an individual basis, that is, personally construct reality" (Williamson, 2006, p. 85), as well as shared constructs, where meanings reflect an inter-subjective blend of temporally-situated exchanges and processes among people (Schwandt, 2000; 1994). The current study employed a constructivist framework to analyze the rich data generated from surveys and interviews, or more specifically, the diversity in perspectives and practices of instructors towards student mental health. In addition to multiplicity, a constructivist paradigm also respects fluidity (Schwandt, 2000; Schwandt, 1994; Williamson, 2006). As such, depending on certain temporal

and contextual conditions, it is understood that the responses of instructors are subject to change, and thus, potentially subject to re-construction.

As the above paragraphs illustrate, the goal of inquiry through a constructivist lens is to understand, appreciate, and learn from the contextual knowledge of the "knower" or "actor" (Greene, 2000; Lincoln & Guba, 2000). Although commonly assigned to "health experts" or mental health professionals, the current study bestowed the instructor with the role of *actor* or *knower*; one who is frequently engaged and familiar with students. As Morris (2006) supported, it is imperative to recognize the voices of those in direct relation to the phenomenon under scrutiny. Constructivism gives this actor, the instructor, an opportunity to speak, or to offer an informed voice towards a pressing phenomenon – student mental health.

1.7 Chapter Summaries

The current study is presented in the following manner. Chapter Two is the *Literature Review*. This section reviews existing scholarship that, a) operationalizes the key terms, concepts, and ideologies involved in this area of research, such as *mental health* and *social support*; b) presents the status and goals of support for the mental health of students in higher education settings, highlighting the different approaches currently in practice and in progress; c) details the role instructors can play in promoting and supporting the mental health and well-being of students; and d) examines the current barriers that challenge student mental health and intervention in college and university contexts, those faced by both the institution and the instructor. The final part of this chapter outlines any pertinent research implications. Chapter Three features the *Methodology*, particularly describing the study context, and noting how participants were recruited and chosen, as well as how data were collected and analyzed.

Chapter Four presents the study's findings (*Situating the Post-Secondary Instructor in a Supportive Role for the Mental Health and Well-Being of Students*), taken up according to the study's research questions (Instructors' Awareness of Student Mental Health; Instructors' Evaluation of their Knowledge and Confidence in relation to Student Mental Health; Instructors' Beliefs surrounding Responsibilities in Supporting the Mental Health of Students; and Instructors' Practices that Support the Mental Health and Well-Being of Students. An analysis of findings is discussed in Chapter Five (*Analysis and Discussion*). Drawing from the findings and subsequent analyses/discussion, implications for research and practice are also explored in this chapter. The *Conclusions* (Chapter Six) summarize the outcomes of this study, ultimately to underline the importance of student mental health in higher education contexts and the value of instructors in supporting the subject population.

2. Literature Review

The learning and social experiences in higher education settings can impact the mental health and well-being of attending students, especially when a prior concern exists or when associated discrimination prevails. Although policies and practices to support this population are gradually coming about within the institution, they remain somewhat unclear and fragmented, especially when an overarching system of care is absent, coupled with other common institutional drawbacks, such as lack of funding and time. The role of teaching faculty in promoting and/or supporting students with a mental health problem or illness is equally unclear. Instructors can carry critical experiences and insights that may add to the composition of integrated interventions for student mental health concerns. That said, "teachers need the opportunity to approach the mental health needs of their students" (Roeser & Midgley, 1997, p. 131). This opportunity begins with an acknowledgement of the instructor's voice; their perspectives towards students with mental health problems and their role in supporting this population.

The literature review starts with a presentation and discussion of the various definitions/constructions affiliated with this topic of study (*Definitions and Constructions surrounding Mental Health*). The objective here was to highlight that the concept of mental health alone is entangled in a web of complex ideologies and interpretations, of which can work to complicate a student's well-being and experiences when having a mental health problem. Such ideologies and interpretations unfortunately prevail in academic settings. The way instructors conceptualize mental health is important to consider in understanding how they view their role in supporting the mental health and well-being of students.

The chapter then outlines the current initiatives facilitated in post-secondary institutions that can support students with mental health problems or illnesses (*Current Initiatives the Support the Mental Health and Well-Being of Students*). A review of these initiatives helped to outline what colleges and universities are doing to promote student mental health and provide intervention for students when necessary. This is followed by a discussion on whole-school, systemic approaches towards support for the mental health and well-being of students (*Working towards a Whole-School Approach in Supporting the Mental Health and Well-Being of Students*). It is important to note that colleges and universities are gradually establishing or solidifying mental health policies in hopes of sustaining support for the well-being of students through whole-school, systemic approaches. *The Instructor's Role in Supporting the Mental Health and Well-Being of Students* is then taken up. This section outlines where the efforts of instructors in supporting students with mental health problems are commonly present, and if not, where/how their inclusion can be imagined.

While considering the above, the review also identifies the eminent challenges faced by higher education settings, including its instructors, when it comes to student mental health and intervention (*Barriers in Understanding and Supporting the Mental Health and Well-Being of Students*). The goal here was to demonstrate that despite the efforts of instructors and other faculty/staff, individual and institutional barriers, such as limited time and funding, can affect perspectives and practices towards student mental health. Finally, any shortcomings, significant contributions, or additional considerations in relation to the research area are highlighted (R*esearch Implications*). Reviewing these implications helped to understand the general status of research and practice in the areas of post-secondary student mental health, including how and where this study can be contributory. Of note, due to nonexistent research that specifically

addresses the role of Canadian college and university instructors in supporting the mental health of students, the review occasionally drew from contexts outside of Ontario, Canada, including the United States of America, United Kingdom, European Union, Australia, as well as from other Canadian provinces, including British Columbia, Alberta, and Manitoba. Furthermore, some studies from K-12 educational contexts were also included, namely those that gathered data directly from educators. In these cases, this researcher highlighted the importance and value of studies that drew from non-Canadian or K-12 contexts; specifically, how they informed the context of this study. In other words, this researcher acknowledged how these studies helped to better understand or imagine the role of Canadian college and university instructors in supporting the mental health and well-being of students.

2.1 Definitions and Constructions surrounding Mental Health

Mental health has been best described when positioned on a continuum. A number of mental health continuums have been developed over the last ten years; a notable one introduced by CACUSS and CMHA (2014), based on Corey Keyes' conceptual work on student mental illness. Put briefly, this model "conceptualizes health and illness as separate continuums wherein a student with mental illness may flourish and conversely, someone without mental illness may languish with less than optimal health" (CACUSS & CMHA, 2014, p. 6). Through her work on *How can Educators be First Responders?* Bancroft (2012) also proposed a mental health continuum (see Figure 1).

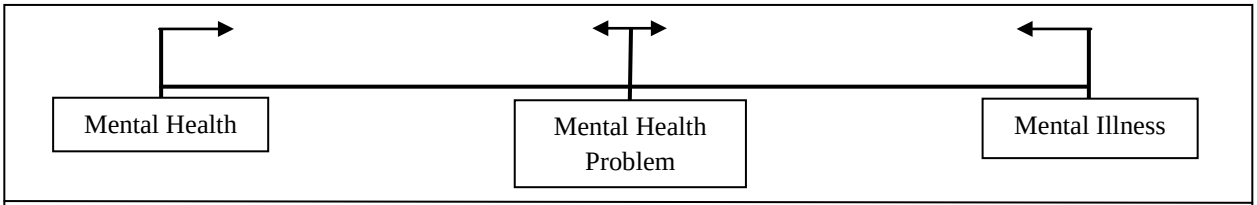

Figure 1. Mental health positioned on a continuum. Adapted from *How can Educators be First Responders?* (p. 10), by C. Bancroft, 2012, Presented at Being Proactive: Supporting Children and Youth Mental Health and Wellness in Schools and Communities Conference, Toronto, ON

This study adopted Bancroft's (2012) mental health continuum because it was founded on the understanding of "educators as first responders" in relation to student mental health. On one end of Bancroft's (2012) spectrum is *mental health,* which represents an individual with positive psychological well-being. Positive mental health "is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community" (World Health Organization, 2010, para. 3). On the opposite end is *mental illness,* often defined as "diagnosable disorders" (Weiten, 2004). Mental illnesses are "characterized by alterations in thinking, mood, and behaviour (or some combination thereof) associated with distress and/or impaired functioning" (Waller et al., 2006, p. 16). Put differently, people are usually identified as having a mental illness when their behaviour or personality becomes disorganized, unexpected, maladaptive, or extremely stressful (CACUSS & CMHA, 2014; CASA, 2014; MacKean, 2011; Ontario College Health Association, 2009; Weiten, 2004). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a widely referred to system providing a mental illness taxonomy (Santor et al., 2009; Weiten, 2004).

Mental health problems, which lies in the middle of the continuum, differs from mental illness (Bancroft, 2012; MacKean, 2011). It appears as though the term is often conflated with m*ental illness,* both typically used interchangeably with *psychological disorder* or *disability*. Mental health problems occur when an individual experiences signs that are similar to those of a mental illness, such as nervousness, sadness, or anger, but not "severe enough" to be diagnosed (Santor et al., 2009). Waller (2006) offers a definition of mental health problems in educational contexts: "...any emotional problem severe enough to result in a reduction in school, social, or academic performance" (p. 314). Moreover, those whose behaviour deviates from societal norms

and systemic constructions are commonly identified as having a mental health problem. In some cases, mental health problems are the grounds from which a mental illness evolves (McMillen, 2013). On a continuum, however, individuals can fluctuate between *mental health*, *mental health problems*, and *mental illness*, represented by the multi-directional arrows in Figure 1. This study used the terms *mental illness*, *mental health problems*, and more broadly, *mental health concerns* interchangeably, due to the fluctuating nature of mental health.

Initiatives of support can be useful in helping individuals sustain positive mental health, or maintain a position towards the left-hand side of the continuum noted earlier. Support, or oftentimes referred to more specifically as *social support*, can include emotional appraisal, the distribution of relevant education and information, and the provision of material aid and physical care (Reupert & Mayberry, 2007a; Shannon & Bourque, 2005; Thompson & Ontai, 2000). This study did not consider "the provision of material aid and physical care" in its exploration of support for the mental health of students in higher education settings. The review demonstrated a plethora of ways in which support can be advantageous for one's mental health. In their work on social support, developmental psychopathology, and social policy, Thompson and Ontai (2001) stated that social support "can contribute to restoring positive social skills, enhancing positive social motivation, and improving self-esteem...for a healthy psychological growth" (p. 659). For students in particular, support can benefit one's levels of academic engagement and achievement (Cornejo, 2010; Hoke, 2001; Jaycox, McCaffrey, Ocampo, Shelley, Blake, Peterson, Richmond, & Kub, 2006; Schwean & Rodger, 2013; Ontario College Health Association, 2009). Good academic engagement and performance can serve as a protective factor, which works to prevent the (re)evolution of negative experiences (MacKean, 2011).

Support for students' mental health can occur through both prevention/promotion and intervention strategies. *Mental health prevention/promotion* "encompasses efforts to enhance knowledge, skills, and attitudes in order to foster social and emotional development, a healthy lifestyle, and personal well-being" (Cornejo, 2010, p. 3). *Mental health intervention* refers to "…an activity, policy, practice, or service that is designed to result in some change in people or in the environment" (Davidson & Locke, 2010, p. 268). According to Graham et al. (2011), over the last ten years, stronger emphasis has been placed on "promotion" and "prevention" mental health strategies, rather than on "intervention", as the latter is commonly affiliated with discourses of "risk". Likewise, Martin (2010) suggested that "mental health services today are provided within a dominant paradigm of 'well-being' that has seen a shift from a 'disease model' in health to a 'wellness model'" (p. 262). Nonetheless, the facilitation, purpose, and outcomes of mental health prevention, promotion, and intervention are inter-dependent or similar in many ways, especially when part of a broader system of care. Moreover, the literature in this area of study continues to include discourses of intervention as much as prevention/promotion (Reupert & Mayberry, 2007a; Shannon & Bourque, 2005; Thompson & Ontai, 2000).

On another note, multiple strategies of prevention/promotion and intervention can be practiced at the same time, just as an individual can experience "multiple stressors" or a "cluster" of different mental health concerns (Burns, 2002; Davidson & Locke, 2010; Frado, 1993; Froese-Germain & Riel, 2012; Waller, 2006). To elaborate on the latter, though the exact cause of mental health problems or illnesses is unclear, a number of complex and interplaying biological factors, such as genetics, and environmental factors, such as the loss of a loved one, have been identified as contributory, which in many cases can occur collectively (Browne, Gafni, Roberts, Byrne, and Majumdar, 2004; Froese-Germain & Riel, 2012). That said, multiple stressors can

sometimes lead to multiple mental health problems or illnesses, or as Reupert and Mayberry (2010) suggest, *dual diagnoses*. According to Manion, Papadopoulos, and Short (2011), 45% of Canadian youth and adults experience more than one type of mental health concern at a time, which can warrant support through prevention, promotion, *and* intervention strategies.

Identifying the cause of mental health problems or illnesses can certainly be of value when considering higher education students in particular. To recall, the learning and social experiences of students while attending college or university can bring on or exacerbate mental health problems. For example, students may become overwhelmed with balancing their academic and employment obligations, which can *cause* stress and mental health concerns. The development of both intervention and prevention strategies tailored to resolve such causes would be of benefit. This does not entail that an identification of all causes and types of mental illnesses need to be disentangled when providing support. In fear of deviating from "the norm", individuals are usually more attracted to systems of support that do not necessarily depend on the identification of a problem (Hanlon, 2012). This study considered both prevention and intervention practices that can support students with a mental health problem or illness.

Aside from the more formal descriptions noted above, mental health, including any related terminologies and components, such as mental illness, mental health problems, social support, or intervention, is often (mis)understood through informal, mythical, socially-constructed, and/or cross-cultural representations and meanings (CASA, 2014; Centre for School Mental Health Assistance, 2002; Froese-Germain & Riel, 2012; Santor et al., 2009). Put differently, although an increase in the number of mental health interventions seems to indicate a positive shift in society's awareness or perceptions of this issue, individuals with a mental health problem or illness remain a group that is stigmatized (CASA, 2014; Cornejo 2010; Ontario

College Health Association, 2009; Potvin-Boucher et al., 2010; Reupert & Mayberry, 2007a/b; Santor et al., 2009; Sharp et al., 2006; Whitely, 2005). Drawing from Goffman's (1959; 1963) original definition, stigma is when particular individuals or groups are negatively represented and differentiated due to their deviance from "the norms" of society. It has also been defined as a mark of disapproval or label that brands populations with certain attributes or stereotypes, which can then lead to a number of disadvantages (Jacoby, 2005; Martin, 2010; Quinn et al., 2009).

In the context of this study, stigma can be characterized as "...society's negative response to people who have a mental illness" (Froese-Germain & Riel, 2012, p. 2). Social, political, economic, cultural, etc., environments are the determinants and mediators of such stigma (Davidson & Locke, 2010; Nastasi, Hitchcock, Burkholder, Varjas, Sarkar, & Jayasena, 2007; Waller et al., 2006). For example, media, such as Hollywood films or evening news reports, often produce and intensify mental health stigma (Ekornes et al., 2012; Lawson & Founts, 2004; Reupert & Mayberry, 2007b; Santor et al., 2006). A study that evaluated the representation of mental health in film determined that 85% of Walt Disney movies depict individuals with a mental health problem or illness as "crazy" or "nutty" (Lawson & Founts, 2004). Reupert and Mayberry (2007b) advised that media associates mental illness with violence and child abuse. The promotion of such representations through media is an unfortunate circumstance, considering that, a) media focus on mental health can encourage settings, such as schools, to talk more openly on this matter (Ekornes et al., 2012), and b) media has increased its documentation or "coverage" of mental health over the last decade (MacKean, 2011).

The stigmatized perceptions surrounding mental health draw from or are similar to those surrounding Individual and Medical/Rehabilitative Models of Disability (Oliver, 2009; Tinklin et al., 2005). In this case, individuals with a mental health problem or illness are defined as binary

oppositions to those without any mental health concerns. More specifically, a mental health problem or illness is situated as a "dilemma" within an individual, and as a result, this individual is perceived and described through a "disability language": tragic, lacking, non-functional, dangerous, dependent, impaired, violent, incapable, socially incompetent, unintelligent, and vulnerable/weak when faced with increased pressure (Aldridge & Becker, 2003; Cornejo, 2010; Martin, 2010; Oliver, 2009; Tinklin et al., 2005). Individuals with a mental illness or mental health problem are also commonly described through "medicalized or science-based language", whereby they are referred to as "diagnosed patients" who are "in need of treatment" (Anderson-Butcher, 2006; Cornejo, 2010; Eichler & Schwartz, 2010; Oliver, 2009; Shaw, 2003; Shaw & Ruckdeschel, 2002; Stone, Vespia, & Kanz, 2000; Wyn et al., 2000).

Evidence suggests that the stigmatization of individuals with a mental health problem or illness can increase if or when seeking support, including pharmacology-based interventions (Cornejo, 2010; Froese-Germain & Riel, 2012; Santor et al., 2009; Silverman & Glick, 2010: Waller et al., 2006). Intervention is represented as a form of "social assistance"; a term that has become inflated with many negative stereotypes. Accessing mental health intervention can be perceived as confirmation that societal norms have been transgressed; that a person is "unable" to independently overcome obstacles; or that a mental illness diagnosis has been established. In addition to accessing support, individuals with a mental health problem or illness may also experience increased stigma if they are associated with an ethno-cultural identity that does not "accept" mental illness. For example, a number of European and Asian cultures or religions regard mental health and intervention in a negative manner (Kadison & DiGeronimo, 2004; Larson & Lochman, 2011; Nastasi et al, 2007; Ontario College Health Association, 2009; Phippen, 2010; Santor et al., 2009). In such ethno-cultural groups, intervention for individuals

with a mental illness is considered intrusive or irrelevant (Nastasi et al, 2007). As the Ontario College Health Association (2009) submits, “differences in language and cultural norms may impede [immigrant students] from seeking and receiving support” (p. 6). In fact, disclosure of a mental health problem all together is often unwanted or disapproved by some ethno-cultural populations (Altschuler, Dale, & Sass-Booth, 1999). Consequently, individuals who are part of such ethno-cultural groups may experience greater stigma if they identify as having a mental illness.

On a similar note, some individuals experience intersecting stigmas; mental health stigma intersecting with other stigma-producing identifiers. For example, O’Hara’s (2014) work highlighted the blight of dual discrimination faced by black and minority ethnic populations who experience a mental illness. She specifically outlined concerns for young black men with a mental health problem who access care:

> Some groups, such as young black men, are much more likely than the wider population to be subject to sectioning under the Mental Health Act, to be held in seclusion on mental health units, to be physically restrained (in many instances causing death) and to face discrimination due to what campaigners have argued are misguided perceptions of "dangerousness" or propensity to violence. (O’Hara, 2013, para. 5)

CASA (2014) outlined similar concerns, but for Canadian Aboriginal groups. In addition to race and ethnicity, physical illness and disability are other examples of social identifiers that can produce stigma, which can also intersect with mental health stigma. For example, Anderson’s (2013) work revealed the dual stigma associated with mental ill health and HIV. HIV stigma stems from the misconceptions that are commonly held towards the disease (Anderson, 2013). Some of these misconceptions converge with discourses of sexuality; homosexuality “causing”

or “spreading” the virus, which introduces yet another social identifier that is vulnerable to stigma and that can intersect with mental health stigma. As a result, an individual with HIV or an individual who is gay may endure greater stigma if they also identify as having a mental health problem. Such “dual stigma” can be inevitable considering that “…there are higher rates of mental disorders in minority populations” (Nastasi et al., 2007, p. 164). Put differently, due to the stigma endured for being gay or black, for example, such individuals are likely to develop a mental health problem (Nastasi et al., 2007; Santor et al., 2009).

Unfortunately, the experiences of marginalized populations facing multiple stigmas can complicate their accessibility to support. Firstly, these individuals may be provided with low-quality and discriminatory-based support, if any at all, as O’Hara (2014) remarked in her discussion of young black males who access intervention. Secondly, the efficacy of interventions may be trumped by the stigma experienced (CASA, 2014). Lastly, in fear of discrimination of any kind, individuals who experience dual stigma often refuse accessing support all together (Anderson, 2013; CACUSS & CMHA, 2014; CASA, 2014; Nastasi et al., 2007).

Perspectives towards disability/illness communities have certainly shifted, predominately following Oliver’s (2009) introduction of the Social Model of Disability in the mid 1990’s. Through this model, persons with a disability, illness, or health problem are understood as restrained by societal barriers and not by themselves (Lunau, 2012; Oliver, 2009; Tinklin et al., 2005). Nonetheless, over the last decade, feminist and post-structural theorists have identified some shortcomings with the social model, which eventually gave rise to *critical disability studies* (Mertens, Sullivan, & Stace, 2011; Shakespeare & Watson, 2002). According to Shakespeare and Watson (2002), the social model “…claims that disabled people are an oppressed social group. It distinguishes between the impairments people have, and the oppression which they

experience. And most importantly, it defined "disability" as the social oppression, not the form of impairment" (p. 4). Put simply, the criticism of this model is its focus on binaries and lack of acknowledgement for the embodiment of impairment.

The objective, then, is to move from a kind of *emancipatory* framework of disability towards a more *transformative* one (Mertens et al., 2011); to go beyond the simplistic representative slogan of "disabled by society not by our bodies" (Shakespeare & Watson, 2002). A *transformative framework* submits the unsustainability of distinctions in disability communities; distinctions between impairment and disability or disabled and non-disabled. It includes a more in depth understanding of how (mental) illness is taken up when discussing disability (Shakespeare & Watson, 2002). More importantly, this framework entails an exploration of disability with an increased focus on social justice; a focus on how illness/disability intersects with other demographic diversities, such as gender, class, or race (Mertens et al., 2011). Mertens et al. (2011) offer a tabular comparison of the emancipatory/social and transformative disability frameworks (see Table 2). A societal trend towards open discussions and de-stigmatization of mental health has gradually ensued in response to this transformative shift in thinking (Hanlon, 2012). Despite these shifts in ideologies, however, previous models or paradigms of disability, especially individual and medical/rehabilitative ones, continue to dominate the public's understanding of health. According to CASA's (2014) evaluation of the Canadian federal government's response to mental health, "Canadians still greatly fear the idea of mental illness, and discrimination persists to this day" (p. 20). In sum, individuals with mental health problems or illnesses remain stigmatized (CASA, 2014; Lunau, 2012; Ontario College Health Association, 2009; Potvin-

Boucher et al., 2010; Reupert & Mayberry, 2007a/b; Santor et al., 2009; Sharp et al., 2006; Tussing & Valentine, 2001; Whitely, 2005).

Table 2
A comparison of the emancipatory and transformative disability frameworks

	Emancipatory	Transformative
Focus	Focuses exclusively on disability as the central focus.	Focuses on dimensions of diversity associated with differential access to power and privilege, including disability, gender, race/ethnicity, social class, sexual orientation, and other contextually important dimensions of diversity.
Role of Researcher/Participants	Assumes participants are "conscious of their situation and ready to take leadership" (Sullivan, 2009, p.77).	Team approach; partnerships are formed; capacity building undertaken as necessary.
Model of Research	Participatory action research; interpretive approaches.	Multiple and mixed methods; culturally respectful; supportive of diverse needs.
Tone	Sets up "us" against "them" tone.	Acknowledges the need to work together to challenge oppressive structures.

Adapted from "Disability communities: Transformative research for social justice", by D.M. Mertens et al., 2011, In N. Denzin & Y. Lincoln (Eds.), *The Sage Handbook of Qualitative Research 4th Edition* (p. 231). Los Angeles: SAGE Publications.

Some researchers have suggested that schools carry less mental health stigma than "the public" (Burns & Hoagwood, 2002; Heyno, 2006; Lunau, 2012; Reupert & Mayberry, 2010). Through her discussion on mentoring for students with mental health problems, Heyno (2006) suggested that education systems are settings where stigma is deconstructed. As Lunau (2012) illustrated in her discussion on the mental health of "today's students", there is less stigma associated with accessing support in college and university settings. For the most part, however, it has been documented that mental health stigma persists even within academic institutions (Brener, Weist, & Adelman, 2007; CASA, 2014; CMHA, 2014a; Froese-Germain & Riel, 2012;

Lunau, 2012; Ontario College Health Association, 2009; Potvin-Boucher et al., 2010; Sharp et al., 2006; Whitley, 2005). For example, Sharp and colleagues' (2006) evaluation of mental health education in post-secondary institutions revealed that a popular mode of informing educators of mental health is media, which, as demonstrated earlier, is commonly riddled with derogatory, biased, and stereotypical descriptors of mental health problems and illnesses.

Mental health discrimination or stigma is often institutionalized, embedded deeply into the organization, policies, and practices of higher education settings and those who function within (CACUSS & CMHA, 2014; CASA, 2014; Martin, 2010). Unfortunately, "the prevalence of stigma in society makes it hard to fight stigma in schools" (Ekornes et al., 2012, p. 305). It has been argued that an institution's insufficient acknowledgement of this population alone can indicate the presence of mental health stigma and stereotypes (Froese-Germain & Riel, 2012). Without consideration for a transformative framework of disability, issues of stigma and stereotype that can exacerbate student mental health problems remain undisclosed or unaddressed in the public and schools (Hanlon, 2012; Tinklin et al., 2005).

2.2 Current Initiatives that Support the Mental Health and Well-Being of Students

Initiatives of support in higher education settings for students with mental health problems have certainly come a long way, both in quantity and quality. As Eells and Rando (2010) suggest,

> Institutions of Higher Education (IHEs) are recognizing with greater clarity that they cannot educate the minds of their students without attending to the health of those minds. As this shift unfolds, mental health services are increasingly being seen as serving an essential function in the mission of IHEs. (p. 43)

Currently, support offered in post-secondary institutions can include an array of practices, all seeming to share a similar objective: "...to further growth and development for the individual, by teaching new skills and bolstering the individual's ability to confront obstacles and challenges..." (Silverman & Glick, 2010, p. 159). The following paragraphs document the individual *and* collective, formal *and* informal initiatives commonly offered in higher education settings to support those with an (un)indentified mental health problem or illness, as well as encourage positive well-being for all student populations. This section thoroughly discusses the distinct features of each initiative, including through what or whom the given initiative is facilitated. As a reminder, reviewed studies sometimes drew from college and university contexts outside of Ontario, Canada, and occasionally from K-12 school settings to compensate for the paucity in academic research that has closely examined student mental health and intervention in Canadian higher education settings. Interest in such "other" studies lay in the incorporation of data that were transferrable and that helped inform this study. In other words, this researcher clarified how data drawn from other studies can work to inform the perspectives and practices upheld in Canadian post-secondary institutions.

2.2.1 Counselling. The review represented counselling as the most common practice exercised in post-secondary institutions to support the mental health of students (Cavalheiro et al., 2012; Eichler & Schwartz, 2010; Kadison & DiGeronimo, 2004; Kitzrow, 2003; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Ontario College Health Association, 2009; Sharp et al., 2006; Silverman & Glick, 2010). Counselling is often described as a service that consists of multiple, one-to-one or group, in person or phone psychotherapy sessions between a mental health professional and student(s), with the expectation that support recipients learn how to manage the impacts of their mental health problem(s) (CACUSS &

CMHA, 2014; Kitzrow, 2003; Ontario College Health Association, 2009). This approach is commonly offered to all students through an institution's health or counselling services department. The core figures in the provision of counselling are psychologists and/or psychiatrists, who both carry expertise in diverse psychotherapeutic approaches, such as Cognitive Behavioural Therapy and Dialectical Behavioural Therapy; the latter also carrying qualifications in supplementing counselling with a pharmacology component if/when necessary (Cavalheiro et al., 2012; Eichler & Schwartz, 2010; MacKean, 2011; Ontario College Health Association, 2009). Although evidence suggests that students seek therapeutic counselling themselves (Cavalheiro et al., 2012), in some cases, students are made aware of and referred to these services by faculty and staff (Frado, 1993; Kitzrow, 1993; Quinn et al., 2009; Sharp et al., 2006). Due to their knowledge of students who require academic accommodations, disability service department personnel are known to often refer students to counselling (Heyno, 2006).

In an attempt to "modernize" this traditional practice, counselling has begun to include practices that are not solely based on the provision of psychotherapy (Brener et al., 2007; Eells & Rando, 2010; Kitzrow, 2003). Also with the hope of modernizing counselling services, some post-secondary institutions include a web-based component to this type of support (CACUSS & CMHA, 2014; Cavalheiro et al., 2012; Hanlon, 2012; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014). Through their research on the growing concerns of mental illness on Canadian campuses, Cavalheiro et al. (2012) advised that Molize College has recently implemented *E-Counselling*; giving students the opportunity to safely, comfortably, and anonymously engage in psychotherapy. Queen's University has similarly put in place a mental health support website to help counsel all post-secondary students in Ontario (Ministry of Training, Colleges and Universities, 2014). Web-based counselling can also occur between

students, otherwise known as peer counselling. Fanshawe College's *iCopeU* is an example of an online space/portal that enables this kind of support (MacKean, 2011). Likewise, Mount Allison University implemented an online tutorial, *Student Health 101*, and an online forum, *Beautiful Minds*, which provide students with opportunities to reach out to others who similarly experience mental health problems; the forum being moderated by counselling staff (Hanlon, 2012). Additionally, students can engage in "self-counselling". For example, an institution's counselling services department website can include a "self-counselling" section where students with a mental health problem can access "psychotherapeutic" strategies (Molize College, 2013). Alternatively, the website can redirect students to other online "self-counselling" resources, such as *Mental Health 101*, currently promoted throughout many post-secondary institutions in Canada (Hanlon, 2012).

2.2.2 Accommodations. The review revealed the facilitation of accommodations as another practice in post-secondary institutions that recognizes students' rights and supports their mental health and well-being (Bower & Schwartz, 2010; CMHA, 2014a; Frado, 1993; MacKean, 2011; Martin, 2010; Quinn et al., 2009; Ontario College Health Association, 2009). Accommodations can be simply defined as "an arrangement that is put in place to support a student with a disability" (CMHA, 2014a, p. 28). Through their examination of legal and ethical issues in relation to college mental health, Bower and Schwartz (2010) defined accommodations as "modifications to policies, procedures, and rules that are designed to provide students who have disabilities with an equal opportunity to meet academic and technical standards so that they remain and succeed in school" (p. 132). Of note, the standards of an institution's evaluation process are not modified when accommodations are provided; rather, the objective is to offer tools to assist students in meeting those set standards (CMHA, 2014a; Ontario College Health

Association, 2009). The Ontario College Health Association (2009) outlined that in order to "formally guarantee" students who have a mental health problem or illness with accommodations, a mental health professional has to identify an individual as having a concern and generate a letter thereafter; a sometimes lengthy process to complete. In this letter, the following confidential information is often outlined: relevant medical history; how the student's condition might affect his/her performance; current medication intake and how that medication might affect the student; and specific accommodations required as a result of the condition and its effects (CMHA, 2014a).

Most accommodations are organized or arranged by an institution's accessibility or disability services department (CMHA, 2014a). Students who provide documentation identifying a mental health problem or illness are registered with the department, whose staff then, in consultation with the given student, issues a "disability document" (CMHA, 2014a). This document, a) acknowledges that the student is formally registered with the disability services department, b) demonstrates how the disability affects the student academically, and c) indicates what accommodations need to be implemented in order to support the student, namely their academic engagement and performance (CMHA, 2014a). According to CMHA (2014a), "some institutions do not include specific accommodation requests in the letter, and suggest that [students] decide on them one-on-one with each instructor, based on the course set-up" (p. 29). Additionally, some documents partially disclose the student's identified concern, or in this case, his/her particular mental health problem or illness *only* when given permission by the student through written consent (CMHA, 2014a). Of the different practices in place to support the mental health and well-being of post-secondary students, accommodations seem most reflective of Individual/Medical Models of Disability. To be eligible for accommodations, a student must

obtain a disability document, which relies upon a "medical expert" to make a formal diagnosis of a mental health problem or illness. This process seeks to uncover a "dilemma" within a student; to deem a student as "non-functional", "lacking", "incompetent", or "in need" of accommodations (Anderson-Butcher, 2006; Cornejo, 2010; Eichler & Schwartz, 2010; Oliver, 2009; Shaw, 2003; Shaw & Ruckdeschel, 2002; Stone, Vespia, & Kanz, 2000; Wyn et al., 2000).

Accommodations can include a variety of services, including, but not limited to, extra time on the completion of exams; testing environments with minimal distraction; reduced number of courses per semester; in-class note-takers; access to assistive technology, such as online lecture notes; and occasional breaks during class lectures (Bower & Schwartz, 2010; CMHA, 2014a; Frado, 1993; Kearney & Bates, 2005; MacKean, 2011; Martin, 2010; Ontario College Health Association, 2009; Quinn et al., 2009; Silverman & Glick, 2010). In their guide to college and university for students with psychiatric disabilities, CMHA (2014a) included a detailed tabular representation of accommodations typically offered in post-secondary institutions (see appendix F). The table identifies the potential problems students experience in response to their illness or medication, and the subsequent classroom, assignment, and exam accommodations that can support the identified problems.

2.2.3 Programs. In addition to counselling and accommodations, students with mental health problems or illnesses can also obtain assistance through participation in support programs (CACUSS & CMHA, 2014; Frado, 1993; Jaycox et al., 2006b; Molize College, 2013; Tussing & Valentine, 2001). *Mentorship programs* were the most commonly identified in the literature (Brener et al., 2007; Cavalheiro et al., 2012; Frado, 1993; Heyno, 2006; Kadison & DiGeronimo, 2004; Lunau, 2012; Quinn et al., 2009). Mentorship programs usually initiate during an institution's admissions process or at the beginning of each academic year, where students can be

mentored or assisted by a team of support providers (Anderson-Butcher, 2006; Cavalheiro et al., 2012; Frado, 1993; Heyno, 2006). Alternatively, students can be assigned an individual "buddy" or academic coach for support, often a volunteer student as opposed to a team (Kadison & DiGeronimo, 2004; Lunau, 2012; Quinn et al., 2009). Whether a team of professionals or a volunteer student, assistance can be given in completing documentation, planning course schedules, locating classrooms/departments, providing emotional support, managing time and tasks, and accessing further support services (Cavalheiro et al., 2012; Frado, 1993; Heyno, 2006; Kadison & DiGeronimo, 2004; Lunau, 2012; Quinn et al., 2009).

Some student mentorship programs simply hold support sessions (Heyno, 2006). As an alternative to the sometimes stigmatized practice of psychotherapeutic counselling, these sessions provide students with the opportunity to have random, informal discussions with a mental health professional, volunteer student, or support team on an "as needed" basis (Heyno, 2006). These sessions can help students with settling into a post-secondary institution, establishing friendships, managing study commitments, or accessing any other kind of support offered at an institution (Heyno, 2006). Examples of current Ontario-based student mentorship programs include, *Bounce Back* at Carleton University (Lunau, 2012); *Peer Mentoring* through the Student Success Program at York University (2013b); *M^2 Peer Mentoring Program* at Queen's University (Supporting Student Success, 2014); and *FYE: First Year Experience* at Molize College (2013).

Although not always appearing as such on the surface, *extra-curricular programs*, such as sports teams, student councils, and glee committees, can also support the mental health of students, and thus, are worthy of brief consideration (Anderson-Butcher, 2006; Bibou-Nakou, 2004; Patton et al., 2000). Extra-curricular programs are essentially developed to promote an

engaged and well-rounded student population, and are in their own way predicated on notions of well-being. Competence and recognition in "common" school activities can help protect or safeguard individuals from mental health distress (Bibou-Nakou, 2004). Put differently, student engagement in all aspects of school life, including sports teams and school counsels, can be a means for students to better cope with mental health problems (Reupert & Mayberry, 2007a). Specifically, extra-curricular activities can help students in the following ways: provide entertaining experiences; foster encouragement, happiness, collectivity, and life skills; temporarily distract students from their concerns and indentured circumstances; and provide support without disclosure of a concern/crisis (Anderson-Butcher, 2006; Bibou-Nakou, 2004; Patton et al., 2000).

Other than those indicated above, most programs of support are unique to individual higher education settings, and thus, are often difficult to capture through research. In some cases, researchers have proposed unique mental health programs for future consideration and implementation. For example, Tussing and Valentine (2001) introduced a *Bibliotherapy Program* as a way to support students with mental health problems, particularly those facing the impacts of parental mental illness. A bibliotherapy program "involves the usage of literature to assist individuals in understanding and treating their problems" (p. 457), combined with occasional guidance from a mental health professional, such as a social worker or psychologist. They looked specifically at the benefits of students engaging in books with fictitious storylines concerning parental mental illness. Similarly, CACUSS and CMHA (2014) proposed the facilitation of mental health symposiums, forums, and dialogues within colleges and universities. They suggested that the objective of such programs is to increase openness when it comes to

mental health, which can subsequently decrease associated stigma and fear (CACUSS & CMHA, 2014).

Programs can be developed by student support services departments within institutions, such as Molize College's (2015) Student Success and Engagement Department. However, some can also be suggested, developed, organized, and/or facilitated by students (CACUSS & CMHA, 2014; Kadison & DiGeronimo, 2004; Molize College, 2013; Siggins, 2010; Silverman & Glick, 2010). Student suggestions regarding programs can be made, for example, through the Student Satisfaction Survey, part of the Key Performance Indicators (KPI) evaluation process. Put simply, in the context of education, KPI measure how well Ontario post-secondary institutions meet the needs of students and the marketplace (Molize College, 2013). The Student Satisfaction Survey is a key element of the KPI. Post-secondary, full-time students who have completed at least one semester of academic study are eligible to complete this survey, ideally every six months. As mentioned earlier, the types of programs and how they are exercised vary between institutions, in that they are often specially developed by various parties based on the needs within a given population (CACUSS & CMHA, 2014; MacKean, 2011; Molize College, 2013).

Like with counselling, efforts are being made to include "the web" or information technologies in the provision of support programs (CACUSS & CMHA, 2014; Hanlon, 2012; Kadison & DiGeronimo, 2004; Lunau, 2012; Santor et al., 2009; Thompson & Ontai, 2000). An institution's counselling or disability services departments can list and describe the programs offered on their webpage (CACUSS & CMHA, 2014; Kadison & DiGeronimo, 2004). In other words, the web makes it easier for students to become familiar with or navigate through mental health content associated with the institution (CACUSS & CMHA, 2014; Hanlon, 2012). There are also some public-based websites, such as campusblues.com or trappedminds.org, which can

help students find programs offered on their particular campus (Kadison & DiGeronimo, 2004). Similar to counselling, a web-based component can offer students a comfortable, easily-accessible, or in some cases, anonymous avenue to participation in programs.

Some college and university support programs are in partnership with or are supplemented by community resources (Centre for School Mental Health Assistance, 2002; Davidson & Locke, 2010; Eells & Rando, 2010; Field et al., 2006; Hanlon, 2012; Heyno, 2006; Patton et al., 2000; Santor et al., 2009; Silverman & Glick, 2010). Programs that collaborate with community resources, such as a mental health agency, are often referred to as providing *linked* or *wraparound* services (Anderson-Butcher, 2006; Brener et al., 2007; Burns, 2002; Davidson & Locke, 2010). The overall objective of wraparound or linked services is to offer student support through connected and complementary school- and community- based resources (Burns, 2002). The literature suggested that programs developed through linked services help build a circle of trusting relationships; target individual and exact needs; promote increased specialization for support/resources; enable the sharing of support knowledge and responsibilities, which reduces time constraint issues; and lastly, help find additional network possibilities if needed (CACUSS & CMHA, 2014; CMHA, 2014a; Ontario College Health Association, 2009). Institutions can develop partnerships with public healthcare systems, medical authorities, community health providers, or with private mental health initiatives. Public and private parties that develop partnerships with post-secondary institutions to address student mental health include Child and Youth Mental Health Information Network, Canadian Mental Health Association, Ministry of Training, Colleges and Universities, Kids Help Phone, Public Health Agency of Canada, Youth Assisting Youth, the Centre for Addiction and Mental Health, and The Jack Project (Hanlon, 2012). For example, Ryerson University is in partnership with the Barbra Schlifer

Commemorative Clinic to develop support programs for Muslim women who experience mental health problems as a result of family violence (Hanlon, 2012). Other examples of programs that develop from college and university partnerships with external parties were listed in Table 1 (MacKean, 2011). Indeed there are also programs offered strictly through community settings (not linked to an academic institution) that can support the mental health of students. These are either funded by governments and/or non-profit organizations, or are provided through the private healthcare sector. An examination of strictly community-based programs extends beyond the confines of this study's focus.

2.2.4 Information and event campaigns. Support for the mental health and well-being of students can also occur through information and event campaigning (Frado, 1993; Hanlon, 2012; Jaycox et al., 2006b; Molize College, 2013; Tussing & Valentine, 2001). Often less formal and structured than programs, campaigns seek to reach communities, or more specifically, to build or increase (de-stigmatized) mental health support initiatives, rather than to provide direct support (Clarke, Coombs, & Waltonet, 2003; CMHA, 2013; Davar, 2010; Field et al., 2006; Frado, 1993; Kitzrow, 2003; Lightfoot & Bines, 2000; Lunau, 2012). They attempt to create a "culture of openness" towards mental health in higher education settings (Quinn et al., 2009). Mental health information and event campaigning can occur in different forms; one being the simple distribution of information material, such as books, brochures, bookmarks, and posters (Field et al., 2006; Frado, 1993; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Ontario College Health Association, 2009; Sharp et al., 2006; Stone & Archer, 2000). For example, Potvin-Boucher et al. (2010) introduced *Transitions: Student Reality Check*, an information resource designed to increase mental health education and support in higher education settings. The objective is to circulate information to students, such as who to contact when facing mental

health problems or how to identify mental health problems in others. Specifically, *Transitions* material "...consists of two parts, a larger broad version and a condensed pocket-sized passport version" (p. 725). The larger version is to be carried by an institution's counselling services department, available to students if requested. The passport version is supposed to be distributed to first year students, for example, during orientations. Potvin-Boucher et al. (2010) determined that although a counselling services department is best suited for the dissemination of *Transitions* material, other individuals or groups, such as student-based organizations, can prove equally able to assume this responsibility. *Transitions: Student Reality Check* "is currently used in 25 postsecondary institutions and community organizations across Canada" (p. 726). Similarly, the Canadian Mental Health Association (2014a) developed *A Guide to College and University for Students with Psychiatric Disabilities*. In this guide, students can access information on how to effectively mediate through post-secondary education when having a mental health problem or illness. The guide is presented in a "step-by-step" structure, highlighting important components for consideration, such as *choosing a program, applying for admission,* and *getting support services*. This resource can be available through some college and university bookstores or libraries, as well as online.

The dissemination of information through distributed reading material is sometimes considered unsuccessful and unproductive (Kadison & DiGeronimo, 2004; Santor et al., 2009). As a result, many mental health campaigns supplement the information with an event; one being conferences, such as George Brown College's annual mental health conference; last year's entitled, *Post-Secondary Student Success: Fostering Mental Health and Wellness on Campus* (Supporting Student Success, 2014). In addition to conferences, COPE, a student-facilitated organization at McMaster University in Hamilton, Ontario, hosts an annual *Move for Mental*

Health Marathon to encourage collective and active participation in student mental health (Lunau, 2012).

Molize College (2015) recently launched an *IWill Campaign* to increase mental health awareness. The campaign "focuses on providing students with resources to build self-awareness and connect them with helpful tools to promote mental health. [Campaign organizers] will be handing out self-care kits and facilitating short depression/anxiety/stress screens for students" (Molize College, 2015, para. 1 & 3). Likewise, Kadison and Di Geronimo (2004) recommended holding annual mental health fair events, where in addition to the promotion of mental health information, the provision of onsite mental health screenings to identify issues with college students' emotional and cognitive well-being can also take place. Practiced at York University, *Active Minds* is another example of a mental health information and event campaign:

> Modeled on the U.S. organization based in Washington D.C., *Active Minds* at York seeks to promote a dialogue about mental health at York by holding events such as movie screenings, panel discussions, and mental health awareness weeks. The organization works to increase students' awareness of mental health issues, provide information and resources regarding mental health and mental illness, encourage students to seek help as soon as it is needed, and serve as liaison between students and mental health services. (York University, 2013c, para. 3).

In many cases, information and event campaigns, such as *Active Minds* and *Move for Mental Health Marathon*, draw from a *Mental Health Awareness Week* adopted by a number of Canadian post-secondary institutions to promote different mental health events and information outlets. For example, York University launches an annual two-week *Mental Health Awareness Campaign*, developed in 2012 (York University, 2013c; 2013d). The campaign initiates with a

conference that informs participants on how to reach out to individuals in need, including a piece on "self-care skills" (Sagan, 2012). In addition to the distribution of supportive pamphlets, the campaign also features a *Let's Talk Day* facilitated by Bell Canada, "to raise awareness around Mental Health and work toward decreasing the stigma associated with mental illness" (York University, 2013d, para. 1). McMaster University and the University of British Columbia also hold a mental health awareness week "…to promote positive mental health for all campus members through everything from healthy food choices, physical activity, and inclusion" (Hanlon, 2012, p. 2). Through mental health week(s), institutions can extensively and exclusively introduce, promote, and employ multiple support initiatives.

Like with programs, information and even campaigns can be developed and facilitated by student support services departments or by students. Furthermore, efforts are also being made to include "the web" in the promotion of mental health information and event campaigning (CACUSS & CMHA, 2014; Hanlon, 2012; Kadison & DiGeronimo, 2004; Lunau, 2012; Molize College, 2015; Santor et al., 2009; Thompson & Ontai, 2000). For example, the Canadian Mental Health Association's (2014a) *Guide to College and University for Students with Psychiatric Disabilities* is available to students online. As mentioned earlier, public-based websites, such as campusblues.com or trappedminds.org, can help students find campaigns held at their particular campus (Kadison & DiGeronimo, 2004). Social networking sites in particular are also used to supplement campaigns (CACUSS & CMHA, 2014; Kadison & DiGeronimo, 2004; Lunau, 2012; Molize College, 2015). Online social networking can occur through popular sites such as, Facebook©, Twitter©, YouTube©, Skype©, Instagram©, and blog pages. For example, York University promoted their *Let's Talk Day* through Facebook, while Molize College (*IWill Campaign*) and George Brown College (*Storify of My Tweets)* used Twitter for people to access

the contents of their mental health events (Molize College, 2015; Supporting Student Success, 2014).

Many campaigns collaborate with community resources, namely government or non-government organizations and corporations (Centre for School Mental Health Assistance, 2002; Davidson & Locke, 2010; Eells & Rando, 2010; Field et al., 2006; Hanlon, 2012; Heyno, 2006; Patton et al., 2000; Santor et al., 2009; Silverman & Glick, 2010). Some of the more "high-profile" Canadian organizations and corporations that campaign with post-secondary institutions for student mental health include Bell Canada, Great West Life, the Centre for Addiction and Mental Health, the Canadian Mental Health Association, and the Ministry of Training, Colleges and Universities (MacKean, 2011). A number of information and event campaigns have evolved from college and university collaborations with the above-noted organizations/corporations, such as *Let's Talk Day* facilitated by Bell Canada and York University, or *ICopeU* facilitated by Fanshawe College and Mind-Your-Mind (MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Queen's University, 2014; Sagan, 2012; York University, 2013d). Table 1 lists other examples of campaigns that were developed through collaborative efforts between post-secondary institutions and community organizations/corporations.

2.2.5 Curricular inclusion and instruction. Unlike counselling, accommodations, programs, or campaigns, curricular inclusion and instruction is a practice that focuses more on the general promotion of mental health (Anderson-Butcher, 2006; CACUSS & CMHA, 2014; Han & Weiss, 2005; Patton et al., 2000; Sharp et al., 2006; Waller et al., 2006). More specifically, the objective of promoting student mental health through curricular content and tasks is to "enhance knowledge about mental health, change attitudes in both students and teachers, and decrease the stigma associated with mental disorders" (Froese-Germain & Riel,

2012, p. 6). Delivery is just as important as content and tasks, and therefore, the application of particular instructional techniques and processes that can support the mental health and well-being of students was also considered in this review.

Some post-secondary institutions carry academic programs and courses that address or promote student well-being in some way (CACUSS & CMHA, 2014; Canadian-Universities.net, 2014; Kadison & DiGeronimo, 2004; Molize College, 2014a; Seneca College, 2014; York University, 2014). Canadian-Universities.net (2014) lists the mental health certificate, bachelor, masters, and doctorate programs and affiliated courses offered across Canadian universities. For example, York University (2014) offers a *Fundamentals of Learning* academic program to support students at risk of academic probation or withdrawal. Specifically, this program,

> …consists of various academic and personal development components, and is grounded in current theory and practice related to student success, human development, and retention. [Some of the topics it covers includes] time management; reading, note-taking and exam techniques; critical thinking, researching, and writing essays; memory and concentration; the university system; issues of procrastination and motivation…and personal issues such as self-esteem, managing emotions, and confidence. The program runs through the Fall/Winter term and comprises of weekly lectures, weekly tutorials, and bi-weekly individualized learning sessions. (York University, 2014, para. 2-4)

Similarly, as described in earlier chapters, Molize College's (2013) School of Liberal Arts and Science carries the streamed preparatory program to provide students, including those who come from challenging backgrounds, with extra assistance. This program offers first-year preparatory courses intended to guide students throughout their academic careers by providing a number of strategies to enhance their academic capabilities and overall emotional well-being. Likewise,

Seneca College (2014) offers a *Mental Health Intervention Certificate* program. This one-year certificate "…prepares front line service providers or recent graduates…who wish to obtain a specialization in mental health intervention to better support individuals and families in their mental health and well-being" (para. 1). The courses provided through this stream introduce topics such as, crisis management, family dynamics, and exploring prevention. Although designed to "assist individuals assisting others", the program is noted to indirectly support student well-being by virtue of participation (Seneca College, 2014).

Aside from academic programs, institutions can facilitate individual, general elective courses that carry a student mental health and well-being focus (Kadison & DiGeronimo, 2004). For example, at the University of Maryland, first-year students are offered the opportunity to enrol in general, credit-worthy courses designed to help with issues that pertain to mental health, namely time management and stress avoidance (Kadison & DiGeronimo, 2004). An evaluation of this initiative demonstrated that "86 percent of the students who took the course returned for their sophomore year, compared with 69 percent of a comparable group who did not take the course" (Kadison & DiGeronimo, 2004, p. 178). Unfortunately, not all institutions are able or willing to fit any kind of academic program or courses surrounding mental health (Law & Shek, 2011). Higher education settings are divided into different faculties, departments, or schools of learning, each promoting a particular discipline and focus. Those that welcome an engagement with the specificities or complexities surrounding mental health represent optimal venues for the evolution of academic programs and courses that include a mental health and well-being focus.

Considering the challenges of developing entire programs or courses, the addition of mental health curriculum within existing programs/courses presents as a feasible alternative (Anderson-Butcher, 2006; CACUSS & CMHA, 2014; Cornejo, 2010; Patton et al., 2000; Sharp

et al., 2006; Tacker & Dobie, 2008; Waller, 2006). In some cases, information regarding student support services available at an institution is added to course syllabi or outlines (York University, 2013a). In other cases, mental health curriculum can be included more deeply. As part of their systemic approach to post-secondary student mental health, CACUSS and CMHA (2014) indicated that mental health curriculum and pedagogy can be encouraged through any lesson facilitated or task assigned in the classroom. As Tacker and Dobie (2008) proposed for implementation in secondary schools, *MasterMind* is an example of adding mental health curriculum through units. The six-week unit combines instruction and written exercises with individual and group discussions and activities that cover a variety of topics, such as types of mental health issues and school resources of support (Tacker & Dobie, 2008).

Mental health curriculum can also be facilitated through individual lessons, which may work more easily in post-secondary classrooms. Working in a higher education context and with an interest in mental health education and helping students seek support, Sharp and colleagues (2006) proposed and evaluated a psycho-educational intervention strategy for curricular inclusion in college course lesson plans. The strategy involved the facilitation of a one-hour, in-class lecture, where first year college students were given a lesson on the accessibility of support resources, the psychological disorders prevalent in college populations, the efficacy of treatments, and the role of conventional mental health professionals. When tested with 123 college students, those who partook in the lecture developed a more informed understanding towards mental health problems and intervention, according to the results of two Likert-type scales and a survey questionnaire that were completed following the lecture. Sharp et al. (2006) suggested that if one hour seems too condensed, three forty-minute lessons divided according to

prevailing mental health themes, such as myths/stigma or interventions options, can be created instead.

In addition to the facilitation of mental health content or tasks, or when the facilitation of mental health content or tasks through lessons/units is not at all possible, the literature revealed that the promotion of certain instructional or delivery techniques can also help support the mental health and well-being of students (Han & Weiss, 2005; Kearney & Bates, 2005; Kitzrow, 2003; Martin, 2010; Maryland School Mental Health Alliance, 2011; Patton et al., 2000). For example, through her exploration on the mental health needs of college students, Kitzrow (2003) recommended using a guest lecturer, often obtainable from student support services departments within institutions, to inform students of mental health issues and intervention practices. This technique allows for the topic of mental health to be addressed in a forthright and detailed fashion.

2.3 Working towards a Whole-School Approach in Supporting the Mental Health and Well-Being of Students

Despite the initiatives listed above, the review determined that support for the mental health and well-being of students remains somewhat fragmented and uncoordinated (Anderson-Butcher, 2006; Kadison & DiGeronimo, 2004; Lunau, 2012; MacKean, 2011; Ontario College Health Association, 2009; Quinn et al., 2009; Roeser and Midgley, 1997; Waller et al., 2006). Specifically, initiatives offered at the post-secondary level still appear as isolated entities developed and facilitated to support “target populations”. In response to this drawback, the current objective of subject theorists and practitioners is to move towards an understanding of support that does not target a particular population or concern, but rather focuses on the exposition of multi-purposeful, universal, prevention, and intervention processes (strengths-

based) that can essentially benefit the well-being of all student populations (Bond, 2010; CACUSS & CMHA, 2014; Ekornes et al., 2012; MacKean, 2011; Santor et al., 2009; Schonert-Reichel & Lawlor, 2010). A whole-school approach towards student mental health is warranted.

A whole-school or holistic approach towards support for the mental health of students goes beyond a modified combination of individual initiatives. Rather, it involves "multiple strategies that have a unifying purpose and reflect a common set of values... to create a protective environment that promotes mental health and well-being" (MindMatters, 2010, para. 1). Put differently, "*whole-school approach* includes consideration of elements such as the school organization and ethos, provision of services, partnerships with outside agencies and professional development of teachers, as well as classroom focused activities" (Kidger et al., 2010, p. 921). Holistic approaches place the entire campus as responsible for encouraging the mental health of its community; creating a campus climate grounded in social equity for all students; and promoting the values and voices of students (CACUSS & CMHA, 2014).

Whole-school approaches essentially draw from an institution's overarching mental health system of care (Schwean & Rodger, 2013; UMCMHS, 2014). Networking between multiple parties offered through a system of care is often necessary for the success of whole-school approaches; to ensure continuous, synchronized, and sustainable partnerships within the institution for the promotion and support of student mental health (Hanlon, 2012; UMCMHS, 2014). *Relationships* are the core of systems of care: "the effectiveness of any one component is related to the availability and effectiveness of the others. Success is entirely dependent on attaining balance between the components…and the enmeshment of services in a coherent, well-coordinated system (Schwean & Rodger, 2013, p. 144). Of note, a whole-school approach or system towards support for the mental health and well-being of students does not entail that

cases where acute, targeted attention is necessary are overlooked. As Martin (2010) cautioned, the recent promotion of overarching wellness models and systems can also represent another means of stigmatization for students diagnosed with severe mental illnesses, deeming them as "unworthy of social investment" (p. 263). The intention of whole-approaches or systems of care is, rather, to promote support that reflects the fluid or web-like nature of mental health, respecting the needs of individuals who fall anywhere on the continuum (Schwean & Rodger, 2013).

A whole-school approach or system of care in supporting the mental health and well-being of students not only draws together initiatives of intervention, but also invites a conversation on student academic growth in general, or more specifically, on how mental health promotion and support supplements or complements student engagement and performance, as student learning partially relies on maintaining or enhancing their emotional and social capacities (Adelman & Taylor, 2000; Bibou-Nakou, 2004; CACUSS & CMHA, 2014; Clarke, et al., 2003; Cornejo 2010; Field et al., 2006; Kadison & DiGeronimo, 2004; Patton et al., 2000; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). For example, a founding principle of the University of Manitoba's whole-school approach to mental health is that, aside from leading an emotionally-healthy life, "mental health is essential to a person's *academic* and job success…" (p. 5). Similar to mental health, academic engagement and performance needs to be developed, fostered, and sustained. Considering the inter-dependency between mental health and academics (as indicated above and detailed earlier), it is possible that interventions intended to support the mental health of students likely align in several ways with those intended for academic growth, and vice versa. As Patton and colleagues (2000) suggest, support initiatives, especially those offered in academic settings, "need to be seen as complementary and bringing benefits in

educational achievement as well as promoting well-being" (p. 592). This kind of synergy encourages a comprehensive, integrated approach to address barriers to learning and enhance academic and personal well-being. This is why an ideal whole-school design to student mental health promotes "strengths-based" and "recovery-approach" discourses (CACUSS & CMHA, 2014; MacKean, 2011). In other words, the focus is on strengthening and recovering a student's life in the academic and civic community (MacKean, 2011). Greater insights into the relationship between health and academic promotion can lead to the development of multi-purposeful interventions, aimed at benefiting *overall* student well-being (Browne et al., 2004).

Within the last five years, whole-school approaches or systems of care intended for or situated in higher education settings have increased in number and diversity (CACUSS & CMHA, 2014; Davidson & Locke, 2010; Field et al., 2006; Hanlon, 2012; Martin, 2010; MacKean, 2011; UMCMHS, 2014). Current approaches seem to draw from or complement national frameworks and strategies that were developed to address mental health in Canada, including *Towards Recovery and Well-Being* (2009), *Changing Directions/Changing Lives* (2012), and *Mental Health: A Guide and Checklist for Presidents* (2012) (CACUSS & CMHA, 2014). To date, there is a dearth of research that has evaluated post-secondary mental health systems of care, which is likely due to the limited number of institutions that actually promote such systems (Schwean & Rodger, 2013). Nonetheless, the few studies "…focusing on the effectiveness of systems of care suggest that overall, they provide high quality, more appropriate, and cost-effective care realized through an expanded array of services…" (Schwean & Rodger, 2013, p. 145). It has been suggested that once school-based whole-school approaches or systems of care are established, "wraparound" services can then be initiated, which aim to incorporate

other “institutions”, such as families and community agencies, when supporting student mental health (Schwean & Rodger, 2013).

To recall, Table 1 included some Canadian college and university mental health initiatives that are practiced through a whole-school ideology; a notable one being the University of British Columbia’s mental health *Triage System* or *Intervention Pyramid* (MacKean, 2011). This system divides support strategies according to three populations: 1) All students; 2) Students wanting/needing skill development; and 3) Students needing professional intervention/care, or students with more complex and serious concerns (Hanlon, 2012). Strategies are then outlined and connected to parts of the triage system. For example, one strategy is to increase mental health awareness, which is connected to numbers one and two, or in other words, to all students and students wanting/needing skill development (Hanlon, 2012). A number of Canadian post-secondary institutions, such as the University of Guelph and Carleton University, have used the *Triage System* as a model in developing their own holistic approach.

The University of Manitoba has also recently implemented a noteworthy campus mental health strategy or whole-school approach to reinforce their *Success through Wellness Mission* (UMCMHS, 2014). Specifically, the strategy “outlines a holistic and inclusive approach to promoting the mental health and wellness of the entire University community, as well as supporting the individual needs of faculty, staff, and students with mental health problems and illnesses” (UMCMHS, 2014, p. 4). The approach is comprised of six components, each identifying an objective: 1) A Committed Community – review of campus health-related profile, policies, and procedures; 2) A Caring Community – engagement of faculty and staff in promoting positive mental health; 3) A Healthy Community – build awareness of mental health; 4) A Responsive Environment – educate faculty, staff, and students to respond to mental health

issues; 5) A Supportive Community – increase mental health service accessibility and efficacy; and 6) A Resourceful Community – build awareness of the signs and appropriate responses for crisis/suicide situations (UMCMHS, 2014).

In 2014, a collaborative effort between the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA) led to the production of *Post-Secondary Student Mental Health: Guide to a Systemic Approach* "to support the creation of campus communities that are deeply conducive to transformative learning and mental well-being through a systemic approach to student mental health in colleges and universities in Canada" (p. 5). Similar to the University of Manitoba's approach, this guide also consists of key components intended to govern student mental health strategy development and generate "supported students": 1) Institutional Structure: Organization, Planning and Policy; 2) Supportive, Inclusive Campus Climate and Environment; 3) Mental Health Awareness; 4) Community Capacity to Early Indications of Student Concern; 5) Self-Management Competencies and Coping Skills; 6) Accessible Mental Health Services; and 7) Crisis Management. The framework adds that steps one through three can support all students; steps four and five can support students with concerns about coping; and that the final two steps can support students with mental health concerns in particular (CACUSS & CMHA, 2014). CACUSS and CMHA (2014) concluded that this whole-school approach represents broad strategies for support development, from which individual institutions can remodel and tune to meet the mental health needs of their particular campus population.

Although not at the implementation stage, Davidson and Locke (2010) recommended an approach entitled, *Thinking and Planning Strategically*, for campus faculty and staff in British post-secondary institutions to follow when developing or implementing interventions for

students with a mental health problem. The model highlights seven interdependent steps. The first three steps of *Thinking and Planning Strategically* encourage an assessment of context, outlining any priority problems, long-range goals, and relevant research material. The following three components suggest the development of a plan to establish interventions and evaluation procedures based on the findings from steps one to three. The final action is to implement the decided interventions in classrooms, and thereafter, make any accommodations following evaluation stages.

ADAPT – Action for Depression Awareness, Prevention, and Treatment is an approach intended to help counselling and disability services departments in American higher education settings develop interventions for students, primarily for those who experience depression (Field et al., 2006). As Field and colleagues (2006) described, the first step is for college counselling or disability services departments to complete a needs assessment, for example, to determine the college's position in terms of mental health intervention. This process is undertaken by collecting data from students, faculty, staff, and sometimes parents through instruments, such as survey/feedback questionnaires. The second step is to generate strategies of support based on the gathered data, and determine how they will be implemented or executed. Field et al. (2006) made note of some intriguing support ideas, such as instructors in the faculty of Fine Arts applying a mental health theme to play/drama performances. With support for the mental health and well-being of students becoming an increased concern in higher education settings, it is expected that more whole-school approaches, like the ones described above, will be developed, implemented, and documented in the near future.

2.4 The Instructor's Role in Supporting the Mental Health and Well-Being of Students

As detailed above, support for the mental health and well-being of students in higher education settings is gradually working its way in becoming part of an overarching whole-school approach and system of care; one that includes participation from all faculty and staff (CACUSS & CMHA, 2014; Hanlon, 2012; UMCMHS, 2014). Despite this objective, little is known about the role of instructors in supporting the mental health of students, especially in Canadian higher education settings (CACUSS & CMHA, 2014; MacKean, 2011; UMCMHS, 2014). Disagreement persists between what post-secondary instructors are *expected to do* versus what they *can do* in light of increased institutional efforts of addressing student mental health. In response to such disagreement, few expectations are formally placed upon instructors regarding support for the mental health of students, which can make planning and implementing ways for instructors to engage in support more challenging. As mentioned earlier, no known researcher has yet to exclusively acknowledge the role of Canadian college and university instructors in supporting students with mental health problems or illnesses. Of the few Canadian works that have included this component, most are either dated or not scholarly/peer-reviewed (CACUSS & CMHA, 2014; CASA, 2014; CMHA 2014a; Cavalheiro et al., 2012; Frado, 1993; Hanlon, 2012; Lunau, 2012). In other cases, literature often drew data from non-Canadian contexts or just partially included the instructor's role in the investigation (Heyno, 2006; Kadison & DiGeronimo, 2004; Kay & Schwartz, 2010; MacKean, 2011; Martin, 2010; Quinn et al., 2009; Sharp et al., 2006; UMCMHS, 2014).

Faculty and staff, including instructors, are being called upon to undertake a more assertive and supplementary role in supporting student mental health, despite the rather independent nature of their employment (CACUSS & CMHA, 2014; UMCMHS, 2014). The

benefits of including instructors as individuals in higher education settings who can support the mental health and well-being of students are certainly recognizable. Firstly, compared to a clinical setting, support within academic institutions is often most successful when practiced in *authentic* settings, such as in the classroom by an instructor (Han & Weiss, 2005; Klem & Connell, 2004; Larson & Lochman, 2011; Roeser & Midgley, 1997). Secondly, mental health problems are likely to first appear in the classroom and be recognized by instructors (Cornejo, 2010; Graham et al., 2011; Quinn et al., 2009; Tacker & Dobie, 2008; Waller et al., 2006; Whitley et al., 2012). As Whitley and colleagues (2012) proposed, "teachers and other school personnel are often the first to observe behaviours that indicate either the development or worsening of mental health problems" (p. 58). Thirdly, "...fewer than half of college students in need of mental health services actually seek them out" (Sharp et al., 2006, p. 419), but if and when they do, students prefer seeking support from a non-professional in classroom settings, such as a peer or instructor (Anderson-Butcher, 2006; Frado, 1993; Klem & Connell, 2004; Sharp et al., 2006; Silverman & Glick, 2010). As Kidger et al. (2010) summarized when referring to secondary school educators,

> teachers might vicariously be called upon to educate about mental health and emotional well-being within the classroom, identify and refer on pupils with mental or emotional problems, provide support to pupils themselves…and act as role models in the fostering of positive mental and emotional health. (p. 922)

Post-secondary instructors can experience a similar "vicarious calling", especially when coupled with increased student suicides and reports of college and university students with mental health problems (Cavalheiro et al., 2012; UMCMHS, 2014). That said, the perspectives and practices of K-12 educators can certainly help inform or encourage the role of college and university

instructors. As MacKean (2011) implied in reference to post-secondary mental health, good learning can be shared across institutions or academic contexts.

Considering the push to include instructors in college and university mental health policies and practices, the following questions demand attention: What exactly does the instructor's role entail, or rather, how can this role be imagined? What does it mean for instructors to become a supplemental aide, key person, or "linchpin" in supporting the social and emotional needs of students or promoting positive student well-being overall? Where do instructors fit when it comes to mental health in schools, whether in relation to the promotion of individual initiatives or as part of a wider system of care/whole-school approach? As Silverman and Glick (2010) summarized,

> because these non-mental health professionals (post-secondary education instructors) are often the first point of contact, they need to be prepared, willing, and able to assist students in distress by inquiring about the circumstances surrounding a crisis presentation, making an initial assessment of relative risk, and presenting mental health services as a viable and trusted intervention. (p. 160)

Ideally, then, the want is for post-secondary instructors to become a kind of "first-line responder" when supporting the mental health and well-being of students (CACUSS & CMHA, 2014; Eichler & Schwartz, 2010; Kitzrow, 2003; Quinn et al., 2009; Schonert-Reischel & Lawlor, 2010; Sharp et al., 2006; Silverman & Glick, 2010; UMCMHS, 2014). A review of the literature revealed that in this role, instructors can undertake certain supportive actions; actions that this researcher has summarized and designated as *Recognize*, *Render*, and/or *Redirect* (RRR). Through their interactions with students, more often than a mental health professional or any other post-secondary school staff member, classroom instructors can carry greater opportunities

to *recognize* when students are experiencing a challenge or stressful situation, especially in cases where students' academic engagement or performance is affected as a result of a mental health problem (CACUSS & CMHA, 2014; Clarke et al., 2003; Schonert-Reischel & Lawlor, 2010; Waller, 2006; UMCMHS, 2014). Of note, recognizing a potential mental health concern is not the same as "diagnosing" (Eichler & Schwartz, 2010). Rather, the process of recognizing is more synonymous to "screening"; identifying the possibility that a student's well-being is of concern in some way (Eichler & Schwartz, 2010).

As first-line responders, instructors can also *render* preliminary initiatives of support in their classrooms; to assist students with an identified mental health problem, as well as those without (CACUSS & CMHA, 2014; Cornejo, 2010; Han & Weiss, 2005; Quinn et al., 2009; Silverman & Glick, 2010; UMCMHS, 2014). Such initiatives can include facilitating accommodations or incorporating mental health topics into lesson plans (CACUSS & CMHA, 2014; CMHA, 2014; Frado, 1993; MacKean, 2011; Martin, 2010; Ontario College Health Association, 2009; Quinn et al., 2009). Finally, a first-line response can also entail that instructors *redirect* identified students to known alternative/additional means of support within the institution, such as making a referral to counselling services (CACUSS & CMHA, 2014; Frado, 1993; Quinn et al., 2009; Silverman & Glick, 2010; UMCMHS, 2014).

Instructors' response in supporting the mental health of students can certainly vary. For example, they may *render* support without a need to *redirect*. The actions they undertake typically depend on the type of support that is necessary, which is discussed more thoroughly in the paragraphs below. For counselling, a classroom instructor is noted as one who commonly refers students to such services (Cornejo, 2010; Frado, 1993; Froese-Germain & Riel, 2012; Quinn et al., 2009; Silverman & Glick, 2010; Waller et al., 2006). It has often been suggested

that instructors' initial response is to redirect a student to counselling services upon recognizing a potential mental health concern (Waller et al., 2006; Quinn et al., 2009; Silverman & Glick, 2010).

The instructor's role in the provision of accommodations is also definitely noteworthy. As noted in earlier paragraphs, academic accommodations rely heavily on the negotiation of expectations, actions, and commitments set out in the classroom (Frado, 1993; Kearney & Bates, 2005; Quinn et al., 2009; Reupert & Mayberry, 2007a). Therefore, instructors can render a number of strategies to accommodate student learning; in some cases, even if an "official document" has not been issued. Expanding on the general services previously mentioned and looking more closely at the role of instructors in relation to accommodations, researchers have noted that instructors can compartmentalize excessive assignments/projects into more accommodating and feasible tasks, allow greater time for task completion in general, or recognize if or when entire class schedules need to be negotiated to better suit the personal and academic needs of some students (CMHA, 2014a; Kearney & Bates, 2005; Reupert & Mayberry, 2007a). Along with altering deadlines or course workloads, the review also revealed that instructors can provide students with materials, such as textbooks and reading lists, ahead of time, in attempt to relieve the pressures associated with the beginning of academic semesters (Frado, 1993; Quinn et al., 2009).

Instructors can also accommodate students by way of altering the physical classroom space; for example, seating identified students near doors to exit for breaks or allowing access to beverages/foods if needed (Anderson, Klassen, & Georgiou, 2007; Frado, 1993; Quinn et al., 2009; Silverman & Glick, 2010). Silverman and Glick (2010), who discussed crisis interventions on college campuses, as well as Quinn et al. (2009), who investigated the viewpoints of post-

secondary school students with a mental illness, uncovered that students with mental health problems actually prefer establishing classroom exit procedures, adding that these spatial arrangements should be accompanied by supplementary information, such as when to re-enter the classroom. In addition to providing classroom accommodations, instructors can redirect students to locations or centres where additional accommodations are accessible (UMCMHS, 2014). For example, instructors can place exams in the test centre where students complete testing with the following types of assistance: access to a computer or other assistive technologies; lengthened time to complete exams; and isolated testing rooms (CMHA, 2014a). If instructors recognize that an unidentified student may benefit from formal accommodations, they can redirect or refer the student to student support services, from where students can be identified and recommended for accommodations (Heyno, 2006; Ontario College Health Association, 2009).

Like accommodations, curricular inclusion and instruction appears as an accessible and practical avenue for instructors to play a role in supporting the mental health of students. Instructors affiliated with academic programs and courses that address or promote student well-being in some way often carry many opportunities to integrate mental health into curriculum (CACUSS & CMHA, 2014; Canadian-Universities.net, 2014; Kadison & DiGeronimo, 2004; Molize College, 2014a; Seneca College, 2014; York University, 2014). The addition of mental health curriculum within "regular" courses is also possible (Anderson-Butcher, 2006; CACUSS & CMHA, 2014; Cornejo, 2010; Patton et al., 2000; Sharp et al., 2006; Tacker & Dobie, 2008; Waller, 2006). Considering student mental health and well-being within the content, tasks, and delivery of courses can occur in several ways: facilitating lectures that speak to a variety of topics related to mental health and well-being; assigning tasks that encourage critique, reflection,

problem-solving, and collectivity; promoting organization, routine, and structure; and ensuring open channels of communication between instructors and students (Kitzrow, 2003; Martin, 2010; Patton et al., 2000; Quinn et al., 2009; Sharp et al., 2006).

The potential challenges of incorporating mental health into all curriculums bring to light the importance of curricular delivery in particular. Delivering curriculum does not always rely on the flexibility of a course subject area. Furthermore, it is through delivery where the role, importance, and potential of the instructor seem imperative. Therefore, instructors can consider some delivery techniques that can support student well-being, such as using motivational phrases (e.g., "try to stay positive" or "I am here to help you"); pointing out the positive elements of students' academic work; or encouraging simple stress-release strategies, such as concentrated breathing or meditation (Han & Weiss, 2005; Kearney & Bates, 2005; Maryland School Mental Health Alliance, 2011; Reupert & Mayberry, 2007a).

Of note, mental health curriculum can be integrated into courses that may seem more rigid or less accommodating to "other" curricular content/tasks, such as Math or Science. According to Askew, Rhodes, Brown, William, and Johnson's (1997) report on effective teachers of numeracy, Math can be taught in a "connected manner" to increase student engagement and understanding. Put simply, Math concepts can draw from everyday life situations, such as investigating different life challenges (e.g., anxiety) and resolutions (e.g., counselling) while studying "problem solving" (Askew et al., 1997). The inclusion of mental health curriculum, then, seems doable, possible, and practical in various course subjects. Curricular inclusion and instruction can generate opportunities for instructors to *recognize* students in need, and to subsequently take further action, whether that action includes *rendering* more support in the classroom or *redirecting* to external intervention.

Unlike counselling, accommodations, or curricular inclusion and instruction, the instructor's role in the development, implementation, or provision of programs and information/event campaigns is not as obvious, and thus, has not really been taken up in related literature. Nonetheless, an instructor's participation in such efforts can certainly be imagined. Firstly, instructors can (re)direct students identified as experiencing a mental health problem or illness in the classroom to campus programs and information/event campaigns, as in many cases, students are not aware of, nor do they often seek, more unique, specialized, or sometimes discreet types of support, such as some programs and campaigns (Sharp et al., 2006). Considering the frequent use of course web-based learning management systems in higher education settings, such as Blackboard©, WebCT©, or Moodle©, it seems feasible for instructors to "post" links for students to easily access information on campus program or campaign initiatives. Secondly, instructors can make suggestions to related departments or staff members on what kind of programs and campaigns can be implemented (Molize College, 2013). That said, they are also likely eligible for participation in most programs and campaigns.

As first-line responders, it appears that instructors can carry a central place in implementing or facilitating a number of initiatives available in higher education settings to support the mental health of students, whether this entails *recognizing* a concern, *rendering* a type of support, or *redirecting* a student elsewhere for further intervention. Along with individual interventions, instructors can carry an equally important role when looking at support through a system of care framework (CACUSS & CMHA, 2014; UMCMHS, 2014). Many whole-school approaches towards student mental health rely on the execution of certain strategies in the classroom. For example, to recall from Davidson and Locke's (2010) *Thinking and Planning Strategically*, the final step of their recommended whole-school approach is to implement mental

health interventions in the classroom; thus, necessitating participation from instructors. Likewise, several components of the University of Manitoba's whole-school approach relied upon the efforts of instructors, or more specifically, instructors creating a campus climate that promotes positive mental health ("A Caring Community"); instructors responding to early signs of mental health issues ("A Responsive Community"); and instructors providing accessibility to support services ("A Supportive Community") (UMCMHS, 2014). Looking more broadly, whole-school approaches stand in need for "…teachers' participation in the interdisciplinary planning, advocacy, and monitoring of their students" (Waller et al., 2006, p. 11). After all, whole school approaches are defined as requiring *all* parties to function properly; thus, calling upon the instructor's presence. To reiterate, instructors are well-situated in higher education settings to offer a number of supportive practices (*recognize*, *render*, and/or *redirect*) for students with mental health problems.

2.5 Barriers in Understanding and Supporting the Mental Health and Well-Being of Students

Implementing individual or whole-school approaches in support of student mental health and well-being does not come without facing barriers. A review of the literature revealed a number of challenges in relation to how student mental health is understood and supported in higher education settings; challenges that can particularly affect instructors' ability to *recognize*, *render*, or *redirect*. Stigma and stereotypes, underdeveloped policies and systems, minimal professional development and training opportunities, and issues with funding and time were noted as some of the more common challenges associated with understanding and supporting the mental health of students (Brener et al., 2007; Cornejo, 2010; Han & Weiss, 2003; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Law & Shek, 2011; Patton et al., 2000; Reupert & Mayberry,

2010; Tinklin et al., 2005; UMCMHS, 2014). The paragraphs below provide additional details of each identified barrier, including an indication of how each one can impact an institution's, or more specifically, an instructor's understanding and support of students' mental health and well-being.

2.5.1 Stigma and stereotypes. As detailed earlier in the chapter, academic institutions are commonly represented as safe, discrimination-free locations where the barrier of stigma is deconstructed, discussed, and challenged (Burns & Hoagwood, 2002; Heyno, 2006; Leigh et al., 2009; Lunau, 2012). However, the literature review revealed that stigma related to mental health is still evident in these settings, despite occasional moments of resistance (Bibou-Nakou, 2004; CASA, 2014; CMHA, 2014a; Han & Weiss, 2005; Heyno; 2006; Martin, 2010; Quinn et al., 2009; Sharp et al., 2006). As Bond (2010) suggested in her review of service delivery systems for students, "at the foundation of all [intervention] policies lie assumptions about young people" (p. 8). Mental health stigma and stereotypes in higher education settings can present a number of challenges. Stigma, usually accompanied by underlying bureaucratic reasons, such as annual academic institution credibility ratings, can encourage institutions and their respective faculty/staff to under-report cases of students with mental health problems (Bibou-Nakou, 2004; Kitzrow, 2003). In other cases, the mental health problems of students are not exactly under-reported, but rather minimized. For example, even if a student is identified as having a mental health problem or illness, institutions can ultimately decide that the identified student does not "qualify" for formal or additional intervention (Waller et al., 2006). As a result, if "student need" is not sufficiently represented, then limited efforts can be exercised to build mental health awareness or implement intervention strategies (Froese-Germain & Riel, 2012; Whitley, 2005).

Mental health stigma can also lead to issues with identification (CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; Ekornes et al., 2012; Kitzrow, 2003; Quinn et al., 2009; Tinklin et al., 2005; Ulman, 2006). In some cases, it can lead instructors to assume that certain actions and attitudes of students are representative of a mental health problem. Looking specifically at college mental health, Kitzrow (2003) advised that the identification of student populations with a mental illness is sometimes based on perceptions of what mental health problems are known to look like, or more specifically, on socially-constructed, stereotypical representations of mental health, rather than on direct evidence. Although not in explicit reference to mental health stigma, Ulman (2006) submitted the idea of *folk psychology perspective* or *pop psychology*; whereby teachers make (socially constructed) assumptions about the origins and prevalence of student behaviours. As a result of these assumptions, students become described by their behavioural attributes, such as "student *x* is disruptive"; attributes that educational theorist Skinner defined as *explanatory fictions* (Ulman, 2006, p. 34). Such socially-constructed assumptions can lead to an identification of a mental health problem that is not actually there (Kitzrow, 2003). In other cases, instructors may feel threatened by mental health problems or illnesses due to associated stigma and stereotypes, which can prevent them from identifying students with these concerns all together (Altschuler et al., 1999). Ekornes et al. (2012) discussed the implications of teachers carrying medical and pathological connotations of mental health. They suggested that with this understanding, "…many teachers tend to link 'mental health' only to pupils with some kind of defined condition or diagnosis" (Ekornes et al., 2012, p. 289). This likely occurs when mental health is not viewed as part of a continuum, leaving those "undiagnosed" with minimal support.

On a final note, student disclosure of a mental health problem can also be affected by stigma (Brener et al., 2007; CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; Cornejo, 2010; Hanlon, 2012; Potvin-Boucher et al., 2010; Quinn et al., 2009; Sharp et al., 2006; Whitley, 2005; Wyn et al., 2000). More specifically, individuals with a mental health problem or illness can experience *self-stigma*, where they internalize the negative attitudes upheld and expressed by society, and in turn, may refrain from accessing support (CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; Froese-Germain & Riel, 2012). According to Quinn et al.'s (2009) research on students' experience of mental health support within higher education settings, "...one of the manifestations of stigma is to be found in the reluctance of students to disclose their mental health problems" (p. 406). Stigma prevents Canadian youth from accessing mental health intervention, even when resources are accessible (CACUSS & CMHA, 2014; CMHA, 2014a; Hanlon, 2012). At times, students may solely fear the "disability label" that can materialize in relation to stigma (CASA, 2014; Frado, 1993; Quinn et al., 2009; Tinklin et al., 2005). The "disability label" can make students believe that their academic and professional careers are in jeopardy (CASA, 2014). Conversely, students with mental health problems may not view themselves as "disabled", considering the physical nature often associated with the term "disability", as sometimes insinuated through Individual/Medical Models of Disability (Frado, 1993; Quinn et al., 2009; Waller et al., 2006). As a result, they may believe that support offered through student *disability* services, for example, is not intended for them, and thus, do not bother disclosing (Quinn et al., 2009). Of note, the above-noted drawbacks for individuals who experience mental health stigma are often further intensified if they also experience stigma in response to marginalized identifiers associated with race/ethnicity, gender, sexuality, etc., or if they are part of ethno-cultural groups that do not "accept" mental health problems (Anderson,

2013; Nastasi et al, 2007; O'Hara, 2013; Ontario College Health Association, 2009; Santor et al., 2009). To recall, "intersecting stigmas" were discussed earlier in the review.

2.5.2 Underdeveloped policies and systems. Unfortunately, although there are signs that "health and education agendas are converging" (Patton et al., 2000, p. 588), and that society wants to address mental health more closely, substantial evidence of institutionalized, coordinated, and sustainable mental health policies in post-secondary school settings have yet to ensue. In response to the increased attention given to student mental health in higher education settings, some policies have certainly been developed (CACUSS & CMHA, 2014; CASA, 2014; Hanlon, 2012; MacKean, 2011). As CASA (2014) determined, "many PSE (post-secondary education) institutions [in Canada] are now equipped with an internal mental health policy to direct their students toward available services, resources, and delivery mechanisms" (p. 17). However, many of these policies are outdated; they continue to reflect a philosophy of "weeding out" students with mental health problems in the institution (MacKean, 2011). Put differently, mental health policies and procedures do not always align with an institution's current goals related to student wellness (Hanlon, 2012). Even when developed, mental health policies are not always cohesive or fully implemented, which may suggest that faculty and staff are not entirely or effectively practicing these policies (CASA, 2014; Hanlon, 2012; MacKean, 2011). Underdeveloped or rudimentary policies can mean that an overarching system of care is lacking, and consequently, institutions are not undertaking a whole-school approach in supporting the mental health and well-being of students (Burns & Hoagwood, 2002; Burns, 2002; CACUSS & CMHA, 2014; Davidson & Locke, 2010; Field et al., 2006; Hanlon, 2012; Kitzrow, 2003; Patton et al., 2000; Siggins, 2010; Statham, 2004; Wyn et al., 2000). Consequently, there is a need for comprehensive mental health care systems (Schwean & Rodger, 2013). As noted earlier, holistic

approaches depend upon sustainable, cohesive, and systemic policy development (CACUSS & CMHA, 2014; Hanlon, 2012).

The shortcomings of current mental health policies can lead to a number of drawbacks when it comes to supporting students with a mental health problem or illness. Firstly, initiatives of support remain unclear, fragmented, and moderately-regulated, typically offered on a random, discreet, or "as needed" basis (CASA, 2014; Froese-Germain & Riel, 2012; Ontario College Health Association, 2009; Patton et al., 2000; Silverman & Glick, 2010). Secondly, without established and communicated mental health policies or systems, faculty and staff are likely uninformed of an institution's "response protocols" when encountering students with mental health problems (CACUSS & CMHA, 2014; CASA, 2014; Hanlon, 2012; Larson & Lochman, 2011; Reupert & Mayberry 2007b). Thirdly, faculty and staff may be unsure of their ethical or legal responsibilities when addressing students' mental health (Bower & Schwartz, 2010; CACUSS & CMHA, 2014; CASA, 2014; Eells & Rando, 2010; Hanlon, 2012; Kay, 2012; Kitzrow, 2003; Martin, 2010). Faculty and staff accountabilities over the emotional well-being of students are often poorly planned and communicated within the institution's structural organization, or put differently, the institution is not typically organized or structured to engage faculty and staff in asserting responsibility when supporting students with a mental health problem or illness (CACUSS & CMHA, 2014). Building stronger policies, ideally through systems of care, can be a difficult task to accomplish when considering all of the components that are often involved. More specifically, policy or system development can rely upon strategic planning, legislation changes, strong fiscal structures, infrastructure-related support, cultural and linguistic competence, informed decision-making processes, technology use, outcomes assessments, information exchange, and implementation fidelity (Schwean & Rodger, 2013).

2.5.3 Minimal opportunities for professional development and training. Professional development and training in the areas of mental health has been documented as advantageous for all faculty and staff within an institution, but especially for teaching faculty who are in frequent contact with students (CACUSS & CMHA, 2014; Kitzrow, 2003; Ministry of Training, Colleges and Universities, 2014; MacKean, 2011; Silverman & Glick, 2010; UMCMHS, 2014). Training and professional development can occur through multiple avenues; one being through formal group seminars. *Mental Health First Aid* was indicated as one of a few impressive and recurring training seminars currently executed in many Ontario post-secondary institutions (Hanlon, 2012; MHCC, 2011; Ministry of Training, Colleges and Universities, 2014; Whitley et al., 2012). Led by MHCC (2011), this training "improves mental health literacy, and provides the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague" (para. 3). It is intended to teach faculty, namely instructors, how to respond to issues concerning student mental health in advance of professional support provision (MHCC, 2011). The training occurs through two avenues: a) a representative from a post-secondary institution, likely a faculty member affiliated with a student support services department, partakes in the three to five day course held at a community or academic location by a *Mental Health First Aid* professional, and then once certified, facilitates a similar training seminar to faculty at his/her institution; or b) faculty members can take it upon themselves to partake in the course (MHCC, 2011).

In addition to group seminars, researchers have also recommended "one-on-one" training (Cornejo, 2010; Santor et al., 2009). For example, mental health professionals can coach instructors on how to address student mental health concerns in the classroom (Santor et al., 2009). Furthermore, researchers have also suggested self-training through online resources

(Centre for School Mental Health Assistance, 2002; Martin, 2010; Santor et al., 2009). The Mental Health Commission of Canada (2015) and the Centre for Addiction and Mental Health (2012) are examples of organizations that offer online education/information resources for "self-training".

Although increasing in number, little evidence suggests that colleges and universities promote evolved, continual, and relevant professional development and training opportunities (Anderson et al., 2007; Brener et al., 2007; CACUSS & CMHA, 2014; Cavalheiro et al., 2012; Centre for School Mental Health Assistance, 2002; Davar, 2010; Kitzrow, 2003; Silverman & Glick, 2010). Few professional development and training opportunities in mental health has been attributed to issues with funding, described further in an upcoming section titled, *issues with funding and time* (Burns & Hoagwood, 2002; Cavalheiro et al., 2012; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kadison & DiGeronimo, 2004; Kitzrow, 2003). As a result, mental health knowledge mobilization can be challenged. In other words, limited mental health training and professional development can result in instructors holding poor mental health knowledge or feeling ill-prepared in addressing students with mental health problems or illnesses (UMCMHS, 2014).

The review demonstrated that limitations are present even in the existing or growing professional development and training initiatives regarding support for student well-being. Studies revealed that most initiatives related to student support do not often focus enough on mental health; preference is given to learning disabilities or "physical" health concerns (Frado, 1993; Reupert & Mayberry, 2007). When mental health *is* considered, diversity in the information or topics covered is rare; preference is given to "teaching the theory", rather than, for example, offering "how-to" exercises when encountering a student with a mental health

problem (Frado, 1993; Kearney & Bates, 2005; Lightfoot & Bines, 2000; Silverman & Glick, 2010; Stone et al., 2000). Without adequate professional development and training in the areas of mental health, it would appear difficult for faculty and staff to understand students with a mental health problem or illness; to identify a student with a mental health problem or illness; to assume the responsibility in supporting the mental health and well-being of students; or to avoid practices that may disservice those with a mental health problem or illness (CACUSS & CMHA, 2014; Frado, 1993; Greenberg, Weissberg, O'Brien, Zins, Fredricks, Resnik, et al., 2003; Molize College, 2013; Silverman & Glick, 2010; Stone et al., 2000; Waller et al., 2006).

Another challenge to consider is the limited expectations on instructors to partake in opportunities of professional development, whether or not student mental health is considered. In other words, even when/if exceptional training opportunities are established, dissemination or acquisition of mental health education is not assured. As discussed in chapter 1, post-secondary school instruction does not require that instructors carry a teaching degree or engage in *any* kind of training; their employment status, duties, and sometimes even remuneration may not depend on it (Bower & Schwartz, 2010; Hanlon, 2012; Quinn et al., 2009). Mental health professional development and training, then, is situated as voluntary or optional, whereby instructors who are willing or interested are those who participate. Consequently, this frames the challenge of making mental health professional development and training a useful resource, and thus, of positioning instructors as informed promoters and supporters of student mental health. Nevertheless, the role/use of mental health professional development and training would likely change if, a) student mental health continues to be a pressing concern in Canadian higher education settings; b) greater awareness of students with mental health problems and associated support initiatives ensues; and c) support for the mental health of students becomes forwarded

through a wider institutional agenda or system of care that includes the role of instructors. For example, integrating professional development and training as a component of a whole-school approach can work to encourage instructor participation in such opportunities; to mobilize their knowledge and efforts in becoming supporters of students with mental health concerns. In sum, limited participation in mental health training and professional development can challenge the instructor's role in knowing how to support the emotional well-being of students.

2.5.4 Issues with funding and time. A review of the literature revealed that funding and time can also challenge the development, implementation, and/or facilitation of mental health interventions (CACUSS & CMHA, 2014; CASA, 2014; Cavalheiro et al., 2012; CMHA 2014; Kadison & DiGeronimo, 2004; Kitzrow, 2003; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Ontario College Health Association, 2009). Funding is essentially required to support most initiatives of support in relation to mental health. For example, the provision of counselling relies considerably upon funding, namely to employ an appropriate number of qualified mental health professionals; that is, appropriate for the number of student caseloads in particular (CASA. 2014; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Ontario College Health Association, 2009). Currently, "North American data shows that there is a ratio of one counsellor for every 1,600 students" (CASA, 2014, p. 25). To offer another example, resources are also necessary to run most programs and campaigns; from hiring program/campaign facilitators to printing information/advertisement materials (Browne et al., 2004; Cavalheiro et al., 2012; Kadison & DiGeronimo, 2004). The implementation of training and professional development also requires financial resources (Brener et al., 2007; Browne et al., 2004; Burns & Hoagwood, 2002; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kadison & DiGeronimo, 2004; Kitzrow, 2003).

Funding for student support in post-secondary institutions has definitely increased in the last decade (CASA, 2014; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014). In Ontario, the most notable increase stems from the Mental Health Innovation Fund ($6 million annually), which is provided to post-secondary institutions by the Ministry of Training, Colleges and Universities for the development and strengthening of mental health support initiatives (Ministry of Training, Colleges and Universities, 2014). Put simply, the Ministry uses this fund to support mental health projects initiated by academic institutions (Ministry of Training, Colleges and Universities, 2014). To date, the mental health innovation fund has supported 32 projects, which have led to improved access to better quality mental health services in post-secondary institutions (Ministry of Training, Colleges and Universities, 2014). Moreover, increased academic-corporate collaboration has also worked to fund post-secondary mental health policy and practice development (MacKean, 2011). For example, York University receives support and funding through their collaboration with Bell Canada for the facilitation of the Mental Health Awareness Campaign, featuring *Let's Talk Day* (Sagan, 2012; York University, 2013d). According to the Ontario College Health Association (2009),

> college and university accessibility services (accommodations), for example, are funded by the Access Fund for Students with Disabilities Fund (ASED) and allocated funding by the Ministry of Training, Colleges and Universities according to institutional enrollment numbers. They also received funds based on the number of students using their services and the number of students with certain targeted disabilities. (p. 16)

Although such funding avenues are ongoing, more is necessary to meet the increased demands and requirements in supporting the mental health of students (Ontario College Health Association, 2009). Resource competition has been reported as high in college and university

settings (Ministry of Training, Colleges and Universities, 2014). According to Kitzrow (2003), "the increased demand for services without a corresponding increase in resources is a major challenge and concern for 63% of campus counselling centres surveyed" (p. 170). Compared to other nations, "Canada spends considerably less on mental health…with just 7% of its health care dollars; in comparison [for example] New Zealand and the United Kingdom spend 10-11% of their overall healthcare package on mental health" (CASA, 2014, p. 24). It appears that other than some federal and provincial funds, sponsorships, or donations, the acquisition of funds for support development continues to be a challenge (Brener et al., 2007; Burns & Hoagwood, 2002; CASA, 2014; Cavalheiro et al., 2012; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kitzrow, 2003; Lunau, 2012; Ontario College Health Association, 2009).

Existing funding intended to support the well-being of students is also questionable, in that it can be piecemeal and/or improperly allocated (Brener et al., 2007; Burns & Hoagwood, 2002; CASA, 2014; Cavalheiro et al., 2012; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kitzrow, 2003; Lunau, 2012; MacKean, 2011; Ontario College Health Association, 2009). School-based mental health services often derive from multiple, inconsistent streams, which can give way to fragmented and marginalized support systems (Brener et al., 2007). For example, fragmented funding was identified as a factor in relation to the few experienced counselling psychologists allocated at Ryerson University and the University of Toronto (Lunau, 2012). It has also been noted as a reason for the increase in student mental health problems that go unaddressed (Quinn et al., 2009). Furthermore, differing support systems between larger and smaller post-secondary institutions can be largely due to fragmented funding, whereby the former typically has increased availability of resources than the latter (Stone et al., 2000). Existing funding can also be improperly distributed within an institution (CASA, 2014;

MacKean, 2011; Schonert-Reischel & Lawlor, 2010). According to CASA's (2014) investigation of the Canadian federal government's response to mental health, "…the way that current funds are allocated seems to be problematic" (p. 24). In some cases, funding is reduced from interventions to be given elsewhere; to "more important areas" within the institution (Kadison & DiGeronimo, 2004). Even when appropriate funding is received to better support the well-being of students, prevention-based strategies are given little priority (Schonert-Reischel & Lawlor, 2010).

In addition to funding, researchers have identified *time* as an often unavailable, yet necessary asset in relation to understanding and supporting the mental health of students (Anderson-Butcher, 2006; Anderson et al., 2007; Jaycox, McCaffrey, Ocampo, Shelley, Blake, Peterson, Richmond, & Kub, 2006; Patton et al., 2000; Reupert & Mayberry, 2010; Schonert-Reischel & Lawlor, 2010; Wyn et al., 2000). Lack of time was noted as a barrier for educators more broadly, whether working through the primary, secondary, or post-secondary school level (Cornejo, 2010; Graham et al., 2011; Han & Weiss, 2005; Kidger et al., 2010; Tinklin et al., 2005). Participation in training and professional development can be difficult to accomplish when additional time is unavailable (Cornejo, 2010; Graham et al., 2011; Han & Weiss, 2005; Kidger et al., 2010; Tinklin et al., 2005). Furthermore, limited time can also affect the employment of some support practices, including, but not limited to, integrating mental health into subject curriculums, becoming familiar with campus interventions for referral, and making note of students with mental health problems (Anderson-Butcher, 2006; Cornejo, 2010; Graham et al., 2011; Han & Weiss, 2005; Kidger et al., 2010; Patton et al., 2000; Tinklin et al., 2005). Like with professional development and training, it is possible that additional funding and time can be established if student mental health continues to generate attention within higher

education institutions and if instructors become recognized as key facilitators of positive student well-being.

2.6 Research Implications

The review suggested that in the last twenty years, there is a clear momentum and engagement to drive forward greater and enhanced mental health support service provision at the post-secondary education level (CACUSS & CMHA, 2014; CMHA, 2014a; Clarke et al., 2003; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Ontario College Health Association, 2009). This drive has given way to a considerable growth in the literature on college and university student mental health. In particular, the number and diversity of mental health policies and practices noted confirms that this topic is becoming a priority for relevant theorists and practitioners (CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; Kay & Schwartz, 2010; Kadison & DiGeronimo, 2004; MacKean, 2011; Martin, 2010; Ontario College Health Association, 2009; Quinn et al., 2009; Sharp et al., 2006). Additionally, researchers in this area of study have also demonstrated an understanding of the existing barriers that (im)mobilize mental health policy and practice within academic settings (Anderson et al., 2007; Brener et al., 2007; CACUSS & CMHA, 2014; Cavalheiro et al., 2012; Cornejo, 2010; Han & Weiss, 2005; Ontario College Health Association, 2009; Reupert & Mayberry, 2007a; Santor et al., 2009: Statham, 2004; Stone et al., 2000; UMCMHS, 2014). A continued interest in this area can encourage researchers to establish strategies on how to overcome the immobilizing elements, or conversely, foster the mobilizing ones.

Despite the contributory advancements of existing scholarship, several shortcomings were inevitably apparent. First and foremost, there was a paucity of scholarly research that investigated student mental health at the Canadian post-secondary level, as similarly recognized

in MacKean (2011) and CASA (2014). MacKean's (2011) literature and environmental scan of mental health and well-being in Canadian post-secondary settings appeared as the only known recent publication that closely examined student mental health in Canadian post-secondary institutions. Frado's (1993) *Learning Diversity: Accommodations in Colleges and Universities for Students with Mental Illness* appeared as another publication that closely examined post-secondary student mental health in Canada. However, her work was published more than twenty years ago; much has changed with respect to mental health since then. Other Canadian-based resources that explored mental health at the college and university level seemed to draw from government and organization policy/strategy documents, as well as media releases (CASA, 2014; CMHA, 2014 a/b; Cavalheiro et al., 2012; Lunau, 2012; Ontario College Health Association, 2009). CMHA's (2014a) recent publication, *A Guide to College and University for Students with Psychiatric Disabilities*, as well as CACUSS and CMHA's (2014) *Post-Secondary Student Mental Health: Guide to a Systemic Approach*, are two noteworthy examples of policy documents that discussed mental health in Canadian post-secondary institutions. Hanlon's (2012) article "State of Mind: Addressing mental health issues on university campuses" in *University Manager* magazine, as well as Lunau's (2012) article "Mental health: the broken generation" in *Maclean's* magazine are examples of media releases concerning the topic at hand. Greater scholarly studies that draw from Canadian contexts are certainly warranted.

As introduced in the *Problem Statement*, another major drawback of the literature in this area of study was the lack of national work on the role of post-secondary instructors in understanding and supporting the mental health of students. In other words, none have echoed the purpose of this study: to recognize instructors as potential key players in responding to the mental health needs of post-secondary students in Canada. International studies seemed to have

more frequently acknowledged the instructor's role in this regard. Among the several, Kadison and DiGeronimo's (2004) book, *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It*, as well as Kay and Schwartz's (2010) edited compilation, *Mental Health Care in the College Community*, are two noteworthy international sources that commented on the role of teaching faculty while considering student mental health in higher education settings. In particular, Silverman and Glick's (2010) piece in Kay and Schwartz's (2010) compilation looked more closely at the role of post-secondary educators, placing them as first line crisis responders and making suggestions on how they can address student mental health in the classroom. Although noteworthy, most international studies included only periodic or brief discussions of the roles faculty and staff play in relation to student mental health. In other cases, studies simply mentioned a need to consider this population in the future.

As similarly noted in CASA (2014), educator roles in relation to student mental health were more exclusively taken up in the literature that drew from elementary and secondary school contexts; three recent Canadian examples being Froese-Germain and Riel's (2012) text, *Understanding Teacher Perspectives on Student Mental Health: Findings from a National Survey*; Schonert-Reischel and Lawlor's (2010) article, "The effects of a mindfulness-based education program on pre- and early adolescents' well-being and social and emotional competence"; and Whitley et al.'s (2012) article, "Promoting mental health literacy among educators: critical in school-based prevention and intervention". Considering their elemental presence in the daily practices of higher education institutions, post-secondary instructors can represent core and supplemental support providers for students with a mental health problem or illness, like educators in elementary and secondary school contexts.

Several drawbacks were also noted with how studies documented and presented practices that support the mental and well-being of students, whether or not these practices were represented as employed by instructors in Canadian post-secondary institutions. Firstly, many studies presented initiatives as supportive of students with specific, identified, or "diagnosable" mental illnesses, such as depression, anxiety, and bipolar disorder (Cornejo, 2010; Davidson & Locke, 2010; Kay & Schwartz, 2010; Patton et al., 2000; Weisz, Sandler, Durlak, & Anton, 2005). This can be due to the prominence of quantitative, scientific studies that promote medically-defined categories of illness, rather than acknowledge mental health as part of a continuum. Mental illnesses can be stigmatized as more "threatening" than mental health problems, which perhaps may encourage researchers to explore intervention possibilities that are primarily applicable to the former. Whatever the reason may be, the dominating focus on diagnosed mental illnesses can leave a large number of students with mental health problems without recognition or support. That said, even in the literature that focused on specific, identified, or "diagnosable" mental illnesses, it seems that a handful of the more "popular" illnesses were covered; some common ones being, depression, anxiety, schizophrenia, and bipolar disorder (Cornejo, 2010; Davidson & Locke, 2010; Kay & Schwartz, 2010; Patton et al., 2000; Weisz, Sandler, Durlak, & Anton, 2005). Eating disorders, for example, can also be a component of mental illness, sometimes comorbid with depression or substance abuse, but these were rarely mentioned in the literature when reviewed. Again, a large number of students with a mental health problem or illness can go unrecognized when focus is on particular diagnosed concerns.

Secondly, research seemed overwhelmingly invested in assessing intervention outcomes; if and/or how recipients benefit from support (Reupert & Mayberry, 2010; Saunders, Evans, &

Joshi, 2005; Sharp et al., 2006; Stone et al., 2000). This was most notable in the quantitatively-designed, evaluation-based studies. There are two potential shortcomings in examining intervention outcomes: a) intervention outcomes can be situational or temporal, which would make a determination in efficacy difficult to accomplish, and b) with evaluation studies focusing primarily on the individuals *receiving* support, the experiences or outcomes of those *promoting*/*providing* support, such as classroom instructors, can be ignored (Han & Weiss, 2005). Indeed, an inquisition into intervention outcomes for post-secondary school students is fundamental (Davidson & Locke, 2010). However, considering the prematurity of many post-secondary mental health intervention systems, it seems necessary for researchers to first, or sometimes exclusively, concentrate on the intricate actions taken and conflict-laden realities experienced *before* and *during* the implementation of support (Munro & Bloor, 2010). Moreover, if and when outcomes are taken into consideration, the breadth of investigation can include the experiences and outcomes of multiple parties; those receiving *and* those providing support.

In turning to methodological limitations, a review of the literature confirmed that quantitative inquiry dominates this area of study (Alkin, 2004; Munro & Bloor, 2010; Sharp et al., 2006; Shaw, 2003; Shaw & Ruckdeschel, 2002; Tolma, Cheney, Troup, & Hann, 2009). In other words, qualitative exploration is a rare undertaking in studies that examine student mental health. Positivist paradigms and frameworks often prevail in quantitative research, leaving little room for social constructivist epistemology (Gephart, 1999; Gergen, 2013). As a result, "discussions of personal experience, deeply held values, spiritual concern, political ideology, and aesthetic taste, for example, are simply irrelevant to the demands of the science qua science" (Gergen, 2013, p. 37). Put simply, subjective, ethnographic accounts of individuals outside the scientific research community are often unwelcomed. In relation to this area of study, the

perspectives of individuals affiliated with post-secondary schooling, including, but not limited to, teaching faculty, mental health professionals, and staff/administration, were under-represented in the literature that examined student mental health in higher education settings. Rather, studies generated data through experimental methods and standardized measurements carried out by university or hospital faculty researchers, indicating a dependency on the knowledge of professionals and institutions outside the field of education (Bibou-Nakou, 2004; Maryland School Mental Health Alliance, 2011). This was not surprising when considering the medicalized/scientific lens through which mental health topics are usually viewed and investigated.

Quantitative research that excludes the voices of individuals operating within academic settings has given way to several shortcomings in this area of study; one being a gap between theory and practice (Cornejo, 2010; Jaycox et al., 2006b; Reupert & Mayberry, 2010; Santor et al., 2009; Tinklin et al., 2005). Specifically, it seems difficult to understand practices that support the mental health and well-being of students in post-secondary institutions when data are taken from external contexts. How can knowledge regarding student mental health and intervention in higher education settings represent continuous, expansive, and multiple realities without the collection and analysis of subjective data from individuals directly associated with these environments, such as mental health professionals, instructors, or students with a mental health problem or illness? Along similar lines, how interventions are described versus how they are delivered remains uncertain when quantitative measures and “expert” voices are promoted (Foster-Fishman & Droege, 2010). The voices of post-secondary school mental health professionals and/or instructors were rarely brought into conversation, rendering the capacity and readiness of higher education settings in facilitating interventions unclear. Faculty

unpreparedness would appear as a common occurrence considering the continuous gaps between theory and practice. According to Burns (2002), an interruption between system development and system delivery occurs because researchers place emphasis on the continuous development of new and innovative intervention ideas without investigating their level of execution. A qualitative approach to inquiry can help bridge the gap between development and delivery. Moreover, it offers the opportunity of using delivery as a means of informing development (Gergen, 2013).

Another shortcoming that came about in response to dominating positivist-based knowledge was a limited acknowledgment of the social, political, cultural, etc., factors or constructions that can influence mental health in higher education settings. The guide to a systemic approach towards post-secondary student mental health developed by CACUSS and CMHA (2014) was a noteworthy source that explicitly discussed the impacts of contextual factors, such as politics, culture, and socio-economic organization, on student well-being and whole-school approaches of support. Otherwise, these components or constructions were only briefly taken up in the few works that proposed or investigated whole-school approaches and systems of care (CACUSS & CMHA, 2014; Hanlon, 2012; UMCMHS, 2014). The social, political, cultural, etc., complexities that underlie other areas in relation to student mental health in higher education settings warrant greater consideration; for example, another area can include mental health stigma (CACUSS & CMHA, 2014; CMHA, 2014a). How is mental health stigma present within institutions? Is it through the language of academic documents or in the vocabulary used by faculty and staff? What factors might be encouraging this stigma? According to Shaw and Ruckdeschel (2002), the moral and political dimensions of particular circumstances and settings can be effectively revealed through the qualitative approach of detailed contextual

analysis. As Lunenburg and Irby (2008) suggested, qualitative research "...emphasizes understanding by closely examining people's words, actions, and records" (p. 89). More specifically, the process of qualitative inquiry works to uncover the individual and shared/systemic meanings or constructions held within certain environments (Denzin & Lincoln, 2000). Capturing the ethnographic chronicles of post-secondary instructors can lead to a better understanding of the intricate and sometimes discreet conceptions surrounding mental health, such as stigma, that can influence practices of support.

On a positive note, recent scholarly inquiry is experiencing "a shift from an empiricist to a constructionist view of science… [where] age-old concepts of validity, accuracy, and objectivity demand continuous reflection, and new concerns with such issues as responsibility, transparency, and relativity begin to invite debate" (Gergen, 2013, p. 42, 37). Put differently, more health-related studies have adopted methodologies rooted in qualitative inquiry. The literature review definitely revealed some studies that assumed a qualitative outlook, whereby descriptive narratives and informed discussions about mental health were shared (Browne et al., 2004; Corbin, 2005; Kearney & Bates, 2005; Jaycox et al., 2006b). The voices of students with mental health problems, including those who attend college and university, have been more frequently captured in response to this methodological shift (CACUSS & CMHA, 2014; CMHA, 2014; Martin, 2010). With respect to educators, however, the viewpoints of K-12 teachers were mainly represented (Anderson et al., 2007; Bibou-Nakou, 2004; CASA, 2014; Cornejo, 2010; Froese-Germain & Riel, 2012; Kidger et al., 2010). That said, the voices of post-secondary instructors were still limited, and even when highlighted sometimes, data was often "quantified" or drew from American contexts. The narratives of post-secondary administrators or mental health professionals were more often captured. In these cases, rather than the assumption of a

completely pluralistic posture, researchers seemingly returned to “commanding foundations” of quantitative inquiry, with the objective of including voices that promote rational, evidence-based data to establish pre-eminence (Gergen, 2013).

A substantive bulk of qualitative research that represents the viewpoints of Canadian post-secondary instructors in relation to student mental health seems necessary. Those “in situ” are quintessential in determining or reporting on the everyday functions within a particular context, or in other words, on the mental health policies and practices in post-secondary institutions. Hashimoto et al. (2010) suggest that, “to initiate [policies or practices] into an education system, capacity development of human resources, systems, and institutions at *all* levels is required (emphasis added)” (p. 104). The classroom is certainly a level of interest. In many cases, instructors can initiate support for students more often than mental health professionals due to their constant presence in the classroom, which can give them multiple opportunities to assess the needs of students, and thereafter, exercise relevant practices of support (Han & Weiss, 2005; Schonert-Reichel & Lawlor, 2010). Additionally, limiting the voices of “experts” or “professionals” can encourage support practices that are less prescriptive, formulaic, or scientific in nature. Put differently, an assortment of voices can contribute to more holistic and inclusive approaches towards student mental health in post-secondary schools (Siggins, 2010). This can be seen, for example, through the several intervention applications and coalitions within Ontario elementary and secondary classrooms that resulted from a consideration of teacher perspectives (Froese-Germain & Riel, 2012).

Along with the “missing voices” of classroom instructors, the literature review revealed that several qualitative studies have also excluded or vaguely included guiding theoretical models or frameworks (Burns & Hoagwood, 2002; Schonert-Reichl & Lawlor, 2010; Stone et

al., 2000). In some cases, the grounding of theory is considered unneeded when exploring human practices through a qualitative research methodology (Abraham, 2008). However, every topic of study can be conceived through multiple foci or "ways of knowing", which may necessitate researchers to establish a primary guiding lens or theoretical framework. The explicit identification of a theoretical framework is particularly important in this area of research, as mental health is typically approached and understood through a medicalized perspective. Therefore, without an indication otherwise, it can be assumed that studies in this area are guided by scientific models or frameworks. As such, research on mental health, even that which engages in qualitative, explorative inquiry, may continue to represent conventional or narrow understandings in this area of study.

Drawing from a college institution situated in Toronto, Ontario, this study attempted to add to the currently small number of studies that have closely investigated student mental health at the post-secondary education level in Canada. Specifically, it sought to recognize the role of instructors in supporting the mental health and well-being of students; an undertaking not known to have yet been completed. Contrary to the quantitative, evaluation-based methodologies more commonly assumed in health-education research, this study examined the perspectives and practices of post-secondary instructors through a qualitative, constructivist lens. It situated instructor voices on the forefront. Doing so helped this study draw closer attention to the sometimes discreet and complex factors that influence mental health policy and practice in higher education settings; factors that can remain silenced or unnoticed, for example, when the ethnographies of post-secondary instructors are ignored.

3. Methodology

This study adopted a qualitative research design in its exploration of instructor perspectives and practices towards student mental health in higher education settings. Specifically, the study employed qualitative ethnography to understand student mental health in higher education settings from the viewpoint of school instructors; individuals that are directly involved in the experiences of students. As Tedlock submitted (2000), "...by entering into the firsthand interactions with people in their everyday lives, ethnographers can reach a better understanding of the beliefs, motivations, and behaviours of their subjects..." (p. 470). Moreover, with an interest in authentic, local contexts, qualitative ethnography helped reveal and challenge (un)common constructions, such as myths, biases, and silences, associated with this topic; to develop an understanding of *what* or *how* people are thinking and acting within academic communities in regards to mental health and intervention (Emerson, Fretz, & Shaw, 1995; Katz, 2001; Lunenburg & Irby, 2008; Spradley, 1979). In sum, the objective of qualitative ethnography in the areas of health and education is not necessarily to chronicle random conventions, resolve a particular problem, or provide a definitive solution, but rather to outline and critique complex networks within certain environments (Shaw, 2003), or in the case of this study, the role of higher education instructors in supporting the students with a mental health problem or illness and promoting positive student well-being overall.

The study objectives and overall design reflected the position of this researcher as both an outsider and insider. As part of the teaching faculty at Molize College, this researcher is socially-situated within the study context, and as a result, carries personal, institutional, cultural, etc., perspectives that reflect her position as an instructor *and* researcher. As a socially-situated researcher, qualitative engagement with the topic is simultaneously influenced by collected and

analyzed participant data, as well as real-life, evolving experiences within the field. A detailed explanation of the methodology and overall study design employed is presented in this chapter. The chapter is organized into three components: *Study Context*, *Participants*, and *Procedure*.

3.1 Study Context

An overview of Molize College was provided in chapter 1, *Scope of Study*. This section identifies additional demographic data of the college, as well as some composition details of its students, neighbouring community, and teaching faculty. It was already noted that the Central-North Campus, which served as the context for this study, carries the majority of students and offers the most academic program options. Specifically, this campus is home to more than 19,000 full-time students (Molize College, 2014a). Aside from the 1000 students "on residence" (situated both on and off campus), most students commute to the institution from neighbouring communities. As such, the campus' student demographics align closely to that of its surroundings. Diversities in ethnicity, culture, language, family, household/dwelling, education, and income are evident in the national demographic data of Molize College's surrounding community. The Central-North campus is nestled in a community with a population of 61, 315 people, whereby 66.4% of the population consists of first generation migrants (City of Toronto Ward Profiles Census, 2011; City of Toronto Ward Profiles National Household Survey, 2011). The more common ethno-cultural groups in this population are East Indian (23.4%), followed by Jamaican (6.2%), Canadian (4.6%), and Italian (4.2%) (City of Toronto Ward Profiles National Household Survey, 2011).

About 52% of families residing in the campus' surrounding neighbourhood are couples with children, followed by about 22% of couples without children and 25% lone-parents (City of Toronto Ward Profiles Census, 2011). Education certificates, diplomas, and degrees are held by

74.4% of this community's population, close to the City's average of 82.5% (City of Toronto Ward Profiles National Household Survey, 2011). With respect to individual income, habitants earn an average of $27,332 per year, compared to the City's average of $44,517 (City of Toronto Ward Profiles National Household Survey, 2011). Low average incomes can be the reason why the area contains the largest concentrations of rented and subsidized housing in the City (City of Toronto Ward Profiles Census, 2011; City of Toronto Ward Profiles National Household Survey, 2011). Appendix C provides additional demographic data of Molize College's community.

Teaching faculty at Molize College, namely at the Central-North Campus, is comprised of demographically-varied (in age, gender, teaching experience, etc.) instructors employed as full-time, part-time, partial-load, or sessional. These designations mediate instructor course loads, teaching hours, compensation/benefits, and job security/stability/seniority. Full-time faculty workload can include instruction or classroom teaching; professional development; service to students, such as program coordinating; service to the college, such as curriculum development; and/or service to the community (Molize College Human Resources Associate, personal communication, November 20, 2014; University of Toronto, 2014). Full-time instructors are also encouraged to assume "other" responsibilities, such as participation in annual convocations/graduations, committees, and conferences, as well as advising students (Molize College Human Resources Associate, personal communication, November 20, 2014; University of Toronto, 2014). Of note, instructional time for full-time faculty usually varies depending on an instructor's assumption of other duties.

Part-time post-secondary instruction entails teaching up to and including 6 hours per week on a contract basis (Algonquin College, 2014; Molize College Human Resources Associate, personal communication, November 20, 2014). Also driven by semester contracts,

partial-load instructors teach more than 6 and up to and including 12 hours per week (Algonquin College, 2014; Molize College Human Resources Associate, personal communication, November 20, 2014). Lastly, sessional instructors teach more than 12 hours weekly; however, they are restricted to 10 months of service in a 24 month rolling period, from which they are re-hired (when applicable) as either partial-load or part-time (Algonquin College, 2014; Molize College Human Resources Associate, personal communication, November 20, 2014). Unlike full-time, the last three designations do not require instructors to partake in other academic activities, yet many may volunteer to do so if looking to broaden career opportunities (Algonquin College, 2014; University of Toronto, 2014; Molize College Human Resources Associate, personal communication, November 20, 2014). Appendix D provides more details on full-time, partial-load, part-time, and sessional instructor course loads, teaching hours, compensation/benefits, and job security/seniority.

The qualifications expected of post-secondary instructors can vary between institutions, between faculties/departments within the same institution, or even sometimes between instructors within the same faculty/department. Oftentimes, qualifications are linked to employment designation. At Molize College, namely in the School of Liberal Arts and Science, a full-time employment designation may require that an individual holds a doctorate degree in a given field (Molize College Human Resources Associate, personal communication, November 20, 2014). Partial-load employment sometimes encourages possession of a doctorate as well, or at least, evidence that an individual is enrolled in a doctoral program (Molize College Human Resources Associate, personal communication, November 20, 2014). Otherwise, partial-load employees commonly require a Master's degree in a given field (Molize College Human Resources Associate, personal communication, November 20, 2014). With respect to part-time

and sessional instructors, a Master's degree in a given field may be encouraged, but if the type of instruction requires "practical experience", then exceptions can be made (Molize College Human Resources Associate, personal communication, November 20, 2014). In this case, an instructor can carry a Bachelor's degree or years of relevant workforce experience instead (Molize College Human Resources Associate, personal communication, November 20, 2014). Although employment designation can define qualifications, as implied earlier, variation is still possible, which can be due to the shift in credential expectations of college instructional positions over the last decade, as well as today's competitive job market in the areas of teaching (Molize College Human Resources Associate, personal communication, November 20, 2014).

Despite the variations in employment designation or academic credentials, instructors at Molize College seem to share one primary function: teaching. Instruction or teaching includes the development and/or preparation of courses and associated material, the delivery of course content, and the evaluation of submitted work with the provision of relevant feedback. Appendix E provides sample college evaluation guides that determine student transcript grades and academic status (Molize College, 2014c; Molize College, 2014d). For the most part, these teaching processes require some understanding of students in the classroom; some sense of familiarity in the overall nature of students, perhaps of their academic strengths, weaknesses, efforts, and goals. At this time, instructors can access student data through class/roster lists that include academic status and contact information (Molize College, 2014e). The institution has recently implemented an online software, *SunGard Higher Education Banner*, where instructors can access detailed student academic information, including their standings in each course, as well as in their program overall (Molize College, 2011). Instructors may also be provided with a disability document of students identified with an illness/disability, which specifies relevant

accommodations (Molize College, 2013). Other identifying information and demographics, such as a student's academic standing upon entrance, is not volunteered by the institution. Aside from student disclosures, instructors can sometimes access additional student information from Program Coordinators if requested/needed; however, student confidentiality/privacy policies can limit such access at times, especially when it concerns student mental health.

3.2 Participants

Study participants were 42 instructors between the ages of 25 to 64 from the Central-North campus of Molize College, specifically from the streamed preparatory department/program part of the School of Liberal Arts and Science. To recall, this program provided a representation of instructors with wide exposure to various types of students and teaching subjects, as it delivers classes/courses to students associated with other departments, programs, and sometimes schools at Molize College, as was detailed in chapter 1, *Scope of Study*. The 42 survey participants and 23 interview participants generally varied in *teaching subjects* and *teaching experience*. In the latter, however, only 3 of the 42 survey participants carried more than 21 years of teaching experience, and of the 23 interview respondents, none carried greater than 20 years of teaching experience. Less variation was noted with *employment designation*. Of the 42 survey participants, 22 were full-time and 20 were partial-load. Moreover, 11 of the 23 interview participants were full-time and 12 were partial-load. Neither survey nor interview participants included instructors designated as sessional or part-time. This was somewhat anticipated considering the fewer expectations placed upon part-time and sessional instructors compared to full-time or partial-load, namely in terms of "teaching time" and participation in academic engagements.

Participant *gender* variation was also narrow. Specifically, of the 42 survey participants, 29 were female, whereas 13 were male. Of the 23 interview respondents, only 8 were male, compared to 15 female. Like *employment designation*, the uneven *gender* composition was not an unconventional or unsuspected outcome, considering that females have been identified as often more willing to partake in research studies, especially those relating to health and support (Fontana & Fray, 2005; Malacrida, 2009a; 2009b). Of note, information regarding *teaching subjects*, *teaching experience,* and *employment designation* may have drawn from participants' affiliation with other Schools of Learning at Molize College or other institutions of higher learning. Table 3 provides a summary of survey and interview participant demographic data. Additionally, Table 4 offers a detailed breakdown of individual interview participant demographic data.

Voluntary sampling was the technique employed to gather the 42 survey participants. Conversely, purposive, intensity sampling was the technique used to identify and gather data from the 23 interview participants. Overall, chosen participants were instructors who satisfied the criteria to yield information that was rich and pertinent to the characteristics of the study (Lunenburg & Irby, 2008; Williamson, 2006). In accordance with the York University Human Participants Research Protocol, informed by the Tri-Counsel Policy Statement (TCPS), all human subjects in this study provided informed consent to collect data.

3.3 Procedure

Data were collected through a survey questionnaire (see appendix A), interviews (see appendix B), and document review. A brief description of the study and survey questionnaire was advertised to 200 instructors via a recruitment letter placed in their school mailboxes. Following the description, a web link to the survey questionnaire was provided for those who

were willing to participate. This process was completed twice over a period of 6 months to encourage/increase participation in survey completion. The cross-sectional survey consisted of both closed and open-ended questions/statements developed by this researcher. The first part of the survey consisted of demographic questions that sought to identify participant indicators such as, gender, years of teaching experience, and teaching subjects. The questions that followed corresponded to the study's research questions. Forty-two participants completed the survey questionnaire out of the 200 distributed; a return rate of 21%.

Table 3
Summary of survey and interview participant demographic data

Variable	Number of Survey Participants (N=42)	Number of Interview Participants (N=23)
Gender		
Male	13	8
Female	29	15
Age		
25 – 34 years	8	5
35 – 44 years	16	8
45 – 54 years	11	6
55 – 64 years	7	4
65+ years	0	0
Teaching Subjects		
Social Sciences		
Law	3	2
Communications (Business)	5	3
Histories/Geographies	4	3
Psychology	6	4
Sociology	7	5
Linguistics (Composition/ESL)	8	6
Humanities		
English/Literature	9	7
Maths	9	6
Sciences (Physical/Environmental)	7	6
Preparatory Courses	6	4
Teaching Experience		
0 – 1 year	8	7
2 – 5 years	9	6
6 – 10 years	9	3
11 – 15 years	7	5
16 – 20 years	6	2
21 – 25 years	3	0

+25 years	0	0
Employment Designation		
Full-Time	22	11
Partial-Load	20	12
Sessional	0	0
Part-Time	0	0

Table 4
Detailed breakdown of individual interview participant demographic data

Participant Pseudonym	Gender	Age (range in yrs.)	Teaching Subjects	Teaching Experience (range in yrs.)	Employment Designation
Abrianna	Female	35–44	• Psychology • English/Literature	2–5	Partial-Load
Aida	Female	35–44	• English/Literature • Linguistics (Composition)	2–5	Full-Time
Benito	Male	25–34	• Maths • Sciences	11–15	Full-Time
Caprice	Female	35–44	• Sociology • Linguistics (Composition)	0–1	Partial-Load
Domenico	Male	55–64	• Psychology • Sciences	16–20	Full-Time
Damiano	Male	45–54	• English/Literature • Linguistics (ESL)	2–5	Partial-Load
Emiliano	Male	25–34	• Maths • Sciences • Communications (Business)	11–15	Full-Time
Ercole	Male	35–44	• Law • Preparatory Course	6–10	Full-Time
Frederico	Male	35–44	• Linguistics (Composition/ESL)	2–5	Full-Time
Jolie	Female	45–54	• English/Literature • Law	0–1	Partial-Load
Jamma	Female	25–34	• Sociology • Preparatory Course	0–1	Partial-Load

Juliano	Male	25–34	• Maths • Histories/Geographies	0–1	Partial-Load
Kara	Female	45–54	• English/Literature	16–20	Full-Time
Lissandra	Female	35–44	• Sciences • Psychology	2–5	Full-Time
Liliana	Female	45–54	• Sociology • Linguistics (Composition)	6–10	Full-Time
Participant Pseudonym	Gender	Age (range in yrs.)	Teaching Subjects	Teaching Experience (range in yrs.)	Employment Designation
Marina	Female	55–64	• Maths • Sciences	0–1	Partial-Load
Mia	Female	25–34	• Maths • Communications (Business)	2–5	Partial-Load
Montrelle	Female	55–64	• Sociology • English/Literature	11–15	Partial-Load
Romia	Female	35–44	• Histories/Geographies • Preparatory Course	11–15	Full-Time
Tazia	Female	55–64	• English/Literature • Linguistics (ESL)	0–1	Partial-Load
Umberto	Male	45–54	• Maths • Sciences • Communications (Business)	11–15	Full-Time
Valentina	Female	35–44	• Sociology • Histories/Geographies	6–10	Partial-Load
Zaira	Female	45–54	• Psychology • Preparatory Course	0–1	Partial-Load
Note. N=23					

A request to participate in a follow-up interview was included in the recruitment letter, as well as at the end of the survey questionnaire. In this request, the specificities of the interview process were communicated, including an indication of the time commitment required of

participants, as well as the opportunity to peruse interview questions in advance. Of the 42 survey respondents, 25 were interested in a follow-up interview; a response rate of 60%. Interested participants contacted this researcher via email. Of the 25 interested, 23 participants were purposefully selected to partake in the interview. Two of the 25 interested participants were not chosen to participate in the interview for specific reasons: one participant completed only the demographic questions in the survey questionnaire, and the other was only able to commit to a one-time, 10-15 minute interview with a request to address only the first three questions outlined in the interview schedule. Twenty-three, 25-60 minute interviews were conducted in person at Molize College. Interviews were semi-structured, or in other words, questions were predetermined, but broadly-scoped in relation to the research questions. They were partly inspired by the strategies for conducting constructivist-based studies discussed in Morris (2006) and the survey questionnaire developed by Cornejo (2010) for her investigation of teacher perceptions on mental health promotion.

A collection of documentation occurred concurrently with the interviews. Participants presented this researcher with documents during the interview process. The documents presented corresponded to what was reportedly used or referred to by participants. These included information brochures or pamphlets from the institution's counselling or disability services departments, as well as course syllabi/outlines. The types of documentation or "nonhuman" data sources presented reflect the authentic individual and joint constructions held towards student mental health and intervention (Morris, 2006). Multiple methods of data collection were employed to increase triangulation, which is particularly important for this area of study. Research related to post-secondary student mental health, especially the role of instructors in supporting the mental health and well-being of students, is in its infancy, and therefore, it seemed

necessary to provide multiple sources of data collection that can generate more and diverse findings.

Qualitative analysis of the data followed the collection process. Analysis included a constant comparison and classification method; a detailed assessment and categorization of information following each phase of the data collection process (Kirby et al., 2006; Lunenburg & Irby, 2008; Morris, 2006; Williamson, 2006). Participant responses from the survey questionnaires were compared, and any similarities, differences, and/or relationships were noted. Following a word for word transcription, the same process was employed with the interview-generated data. The method used to analyze or interpret material data embodied "...context definition, the construction of patterned similarities and differences, and the use of relevant culture theory" (Hodder, 2000, p. 714). In other words, documentation was evaluated according to how it paralleled the understandings represented through the context, the literature, as well as the other methods of data collection.

After a detailed comparison between all methods of collection was completed, data were divided, coded, and given particular headings. These headings were then organized into themed categories that reflected the objectives of this study. Subsequently, themes were presented and discussed in relation to the existing rhetoric through which this topic is couched. As Morris (2006) proposed, the intention of constructivist data analysis is to offer themes, or "units" of information that represent individual and shared meanings, rather than to establish a definitive theory towards a particular topic. In other words, the analysis assumed in this study involved the interplay, dissection, and synthesis of data gathered from the subjective accounts of college instructors concerning their perspectives and practices towards support for the mental health and well-being of students.

4. Situating the Post-Secondary Instructor in a Supportive Role for the Mental Health and Well-Being of Students

This study explored the perspectives of 42 instructors towards their role as promoters and/or supporters of student mental health in post-secondary institutions. Results revealed a complex interplay between instructors' understandings of student mental health and the role they play in supporting students with a mental health problem or illness. It is recognized that although each post-secondary institution is different, this study captured several meaningful insights in relation to student mental health that are likely pertinent elsewhere. The objective of this chapter is to present the findings collected from the survey questionnaires, interviews, and documents review. Findings are presented according to the themes of this study's research objectives:

1. Instructors' awareness of student mental health;
2. Instructors' evaluation of their knowledge and confidence in relation to student mental health;
3. Instructors' beliefs surrounding responsibilities in supporting the mental health of students; and
4. Instructors' practices that support the mental health and well-being of students.

Of note, quoted data were documented in their original form. Furthermore, to maintain confidentiality, this study used pseudonyms when presenting data.

4.1 Instructors' Awareness of Student Mental Health

Survey and interview responses demonstrated that mental health is a growing concern in today's post-secondary institutions; one that has generated awareness among teaching faculty. For example, in response to the survey question that asked instructors if and how they first engage students with a mental health problem, Umberto wrote, "[Instructors] deal with about 150

students per semester, so over the course of the year, there are tons of students who have mental health issues that we engage". Moreover, often prompted by the question *what does student mental health mean to you?* 14 of 23 interview participants reported an understanding that student mental health can be compromised by a compilation of factors, including, but not limited to, academic pressures, family dysfunction, relationship issues, economic dilemmas, and/or employment obligations. As Liliana mentioned, "there is a 'bigger picture' to consider here. It's not just academics that make kids go crazy – it's everything like family or work, and so everything needs to be taken into account". Whatever the cause, 12 of the 14 interview subjects who identified a compilation of factors recognized that an individual's schooling experiences can be affected when dealing with a mental health problem/illness, or more specifically, that students who experience any kind of mental health concern are unable to successfully engage in the learning process: "It is difficult to be engaged when you are depressed...dropping out of school all together is usually the better option for students with mental health issues. They need to be treated first" (Jamma). Likewise, Montrelle claimed, "I usually end up telling a student with a mental illness that this is not the right time for them to be in school, or to at least downgrade to part-time status...they should do this until they are better at being a student".

Survey and interview participants identified that their level of awareness drew from their encounters with students who identify as having a mental health problem or illness. Specifically, 30 of 42 survey participants reported "occasionally" and "frequently" encountering a student with some kind of mental health concern. Ten of 23 interview participants determined that in addition to their personal encounters with students who identify as having a mental health problem or illness, their awareness drew from Molize College's overall consideration of students' mental health and well-being. Instructors particularly referenced the streamed

preparatory program and its affiliated courses, namely when responding to interview questions that inquired about the institution's strengths, weaknesses, and distinguishing characteristics:

> It appears as though [the streamed preparatory program] is very aware of students with mental health problems – closely following them, tracking their progress, their grades...particularly through the program's main [preparatory] course, where mandatory one-on-one appointments [between instructors and students] bring forth multiple opportunities to recognize student need. (Ercole)

Romia made note of the school's current mission statements, or more specifically, the "vision" of greater input into supporting students through college programs: "...[the streamed preparatory program] really takes this vision seriously because they ensure that for [preparatory] courses only those with enthusiasm are selected. When you find the right people, it works". Another interview participant, Frederico, presented a recent issue of the college's seasonal magazine publication that featured an article about student mental health in higher education settings to further support his recognition of the institution's efforts in acknowledging or raising awareness towards this concern.

Despite an overall level of satisfaction, survey and interview participants suggested that more awareness can be generated. When asked to discuss the extent to which they feel pleased or dissatisfied with current student support structures in higher education settings, 11 of 23 interview participants referenced a need for greater awareness in some way, such as Tazia, who remarked that "awareness is never finite...there is definitely room for improvement". Five of the 11 interview participants who reported a need for greater awareness identified that greater recognition regarding instructor mental health was necessary in particular: "I am stressed with work, family, life in general, but I don't tell the admin that I have a mental health problem

because I am not sure how they would respond to it. Do they even offer anything for us the instructor?" (Marina). Greater awareness in relation to the location of support services, such as the college's counselling or disability services departments, was also suggested, appearing in 6 of 42 survey responses. For example, when asked to discuss his knowledge of support initiatives offered at the college, Damiano expressed that, "the college offers students counselling, but I am not sure where that is accessed". Likewise, 5 interview participants shared their discontent with the limited awareness surrounding the location of Molize's student support services. For example, in response to the question *what new directions, career options, enhanced perceptions, or improved skills have you acquired in response to this study topic?* Caprice noted, "you know how I found out about the counselling services department? One year I taught a course further from the 'main area' of campus and I stumbled upon it on my way from my car to the classroom! I have learned that there is probably more out there…more than what I pass along the way".

In sum, the findings demonstrated that instructors were well-aware of student mental health concerns in post-secondary institutions, and that this awareness drew from their encounters with students who have a mental health problem or illness, as well as from the institution's acknowledgement of and responses to this population, such as the streamed preparatory program, the preparatory courses, the institution's mission statement, or the college's magazine article on student mental health. Furthermore, instructors were aware that student mental health can be compromised by a compilation of factors, and that their academic standings or endeavours can be subsequently jeopardized. Nonetheless, instructors encouraged greater awareness in general, with a particular focus on two areas: instructor mental health and location of support services.

4.2 Instructors' Evaluation of their Knowledge and Confidence in relation to Student Mental Health

Thirty of 42 survey participants evaluated the quality of and confidence in their mental health knowledge as "below average" or "extremely poor". Similar findings surfaced in 16 of 23 interview responses. For example, when asked to discuss the challenges she faces in facilitating or implementing support, Aida stated the following: "I don't have training to know about mental health issues. I am not a psychologist, nor did I study it, so everything that I think or do in relation to students with mental health problems is technically 'unprofessional' and 'unsatisfactory' in a way". Likewise, Lissandra noted, "I do not have the exact resources or information background to help [a student with a mental health problem], and yes that makes me feel awful at times... I want coaching and guidance in learning how to support, but it takes more money to run training". As suggested above, limited mental health training and professional development, due to funding issues, presented as a reason why instructors reported carrying little knowledge and confidence in the area.

Although few in number, some survey responses demonstrated that instructors *do* carry mental health knowledge/confidence: 6 as "average", 4 as "above average", and 2 as "excellent". Similarly, feeling knowledgeable and confident in student mental health was expressed in 5 interview responses. As Benito reported with assertion, "I definitely think I have what it takes to address this population as an educator". Likewise, Domenico stated,

> I have made sure to learn and be educated about this stuff. I actually even participated in *Mental Health First Aid*, which I think really boosted my morale and know-how with mental health. It is a great initiative, which unfortunately not everyone accesses because

of time…we do not have the extra time to do training, especially in addition to all of the duties we already have…it's just too much for some.

As suggested above, instructors can feel knowledgeable and confident in mental health, especially if they participated in some kind of training and professional development. Interestingly, 2 interview participants expressed not feeling satisfied with or confident in their abilities to understand and support the mental health of students, despite their assertions of carrying some kind of knowledge in the area. As Valentina claimed, "even though I studied psychology and sociology in school where we talked about mental health a lot, I don't think I can provide those students [with a mental health concern] the best support".

In sum, the data revealed that for the most part, instructors believed they do not carry substantial knowledge or confidence to understand and support the mental health of students. Limited training and professional development in the areas of mental health and support provision was revealed as a common reason why instructors were unsatisfied with their knowledge and confidence. Participant reports demonstrated that although interested in developing their knowledge base, many do not have the additional time to engage in training and professional development. Instructors who believed that they *do* carry knowledge and confidence in relation to student mental health were modest in number. Participation in training and professional development was accredited for the knowledge and confidence carried by those few. Interestingly, the study's findings also indicated that some instructors believed they carry ample knowledge in relation to student mental health, but then seemed to lack confidence at the same time.

4.3 Instructors' Beliefs surrounding Responsibilities in Supporting the Mental Health of Students

Survey and interview respondents appeared skeptical or uncertain when asked to comment on the responsibilities within post-secondary institutions in relation to promoting and supporting the mental health of students. Thirteen of 42 survey participants expressed uncertainty surrounding the responsibilities of some student support services departments in particular. For example, when responding to the survey question that asked where or who instructors contact for assistance in supporting students with mental health problems, Emiliano disclosed, "I usually don't bother with the counselling people because I am not sure if all they do is actually counsel…can they do more for students?". Seven of 23 interview participants acknowledged similar uncertainties, namely when responding to the questions intended to elicit how instructors support students and the challenges that are faced along the way. As Mia noted,

> There is a discrepancy with what counselling services or disability services or special needs services in general advertise they do versus what they actually provide. The big example would be the career counselling aspect. I have had a lot of students go down to counselling because of their careers because it says on their pamphlet that they do academic, personal, and career counselling [*participant presented pamphlet*]. But when they go there, they are sent to a career services place somewhere else. And then in some cases, students have told me that when they seek personal counselling, they are sometimes referred to community resources. There should be clearer policies of exactly through whom mental health services are accessible.

In addition to instructor confusions regarding *what* is practiced through some student support services departments, skepticism also lay in *how* these services can be practiced, appearing in 5 of the 7 interview responses where uncertainty with services departments was expressed:

> I think the counselling services department is a bit of a problem...I had one student who was really challenging. She constantly wanted to meet with me and discuss her severe problems at home. At the same time, she came to class and did well overall. One day, she came to class crying, when I finally said, 'you need to seek counselling'. I knew she probably wouldn't go on her own, so I went down with her. We arrived and I said to the lady at the desk, 'we need to see someone', to which she responded, 'well, is it an emergency?' I said, 'Yes! This student is here and is crying!' The lady turned to the student and asked, 'well is it really an emergency? You realize that if you go and see the counsellor and then if someone else comes in a real emergency, they will not be able to see someone because you are in there'. I was very alarmed by this response and insisted that she see someone – are they not responsible for *every* case? I wondered if the student would have just walked away if I wasn't there to push. What is considered an emergency anyways? Was that a pre-assessment procedure that the department follows before a student can access counselling? I sure hope not. Frankly, after that experience, I am not quite sure what they do, or how they do it. (Kara)

As Mia and Kara suggested above, instructors identified that their uncertainties surrounding the roles and practices of mental health professionals often drew from limited development or communication of policies in this regard.

Dichotomous viewpoints were observed when instructors were asked, in both the survey and interview, to respond to their *own* responsibilities in relation to student mental health, or

more specifically, to the following statement: *Teaching faculty members are in part responsible for the mental health and overall well-being of students.* Twenty-four of 42 survey participants and 13 of 23 interview participants indicated that they are not partially responsible for the mental health and overall well-being of students; often deferring this responsibility to who they identified as "professionals" within the college, such as psychologists/psychiatrists, counsellors, disability department staff, and/or program coordinators. For example, in the survey, Caprice noted, "I should not be worrying about student mental health though. That is for professionals, a counsellor, advocate, or program coordinator, who have the knowledge and time to care for students who have these troubles". Likewise, an interview respondent claimed that "it's not part of an educator's job description to know how to support student mental health. It is not highlighted anywhere in our job duties...Our duty and our time is to be concentrated on just doing our 'regular' job, rather than supporting" (Juliano). Of note, 22 of the 24 survey respondents and 10 of the 13 interview participants who reported that instructors are not partially responsible for the mental health and well-being of students did state that instructors of preparatory courses were exempt from this understanding: "[Preparatory course] teachers are different. They are obliged to help when [they] see a student struggling with mental health issues. After all, the course is all about supporting students" (Zaira).

Interestingly, although very few in number, 3 survey responses and 1 interview response suggested that schools in general should not carry any responsibility in supporting the mental health and well-being of students, let alone instructors. For example, Romia reported during the interview that "after reading this student's poetry, it brought me to tears it was so dark... I was thinking, 'a psych-based institution is the place that can really help you, not us, not here'". Likewise, Tazia noted in the survey that "students need to be able to help themselves or get

support from their loved ones whatever the problem may be. They need to learn how to cope...". As suggested in the above-noted narratives, other than ensuring an overall safe, positive, and equitable environment, instructors reported only being responsible for "the academics"; anything involved in the process of teaching. These instructors often noted limited mental health knowledge and time as reasons why they believed supporting the mental health of students was outside their scope of duty. Additionally, they reported that their resistance in supporting students with mental health problems or illnesses also drew from the unspecified roles of instructors in policies that take up student mental health.

On the other hand, 17 of 42 survey respondents and 10 of 23 interview participants classified instructors as partially responsible in supporting the mental health of students, as Abrianna expressed in her interview narrative: "We should be expected to support student mental health concerns as mentors, as educators. It's like helping an elderly woman who has fallen – you should not have to be told to help her...you just take the time to do it". These participants identified instructors as "daily witnesses" of students who experience distress. For example, Umberto disclosed that "instructors are the only ones really that notice or can anticipate when something is impeding on a student's success in the classroom, or in other cases, when the classroom is exacerbating something being experienced by a student". As witnesses of distress, instructors became noted as initial points of contact, as demonstrated in the following interview narrative:

> We are their primary advocates in colleges; their number one "go-to" person; their first response. So, I should be responsible and able to support them first, as the leader in the classroom, rather than saying, *I don't know* or *I'll go check*. Deferring this responsibility

undermines my professionalism a bit...undermines my leadership in the classroom. (Valentina)

As primary witnesses and points of contact, these participants determined that instructors *are* responsible for facilitating support initiatives in some way. Through the survey, Liliana documented that "it's part of our job to address these issues thoroughly...it is a given, not added duty. We need to make the time to put in place the supports necessary for those students, at least while in the classroom...". Instructors of preparatory courses were often noted as "more responsible", due to their frequent encounters with students who identify as having a mental health problem or illness.

The 17 survey respondents and 10 interview respondents who identified instructors as partially responsible in supporting the mental health of students all acknowledged in some way that when student mental health concerns cannot be resolved through interventions at the classroom level or through "first-response" actions, then instructors can direct students elsewhere within the institution to access appropriate "second-line" support. Like Domenico reported in the survey, "it is good to be informed to recognize these issues...to be an educated mediator and know where to refer". Put differently by Jolie during the interview, "I think that when [a student] tells someone, like their professor, that professor should be able to at least say, 'you should definitely go and talk to *blank* as they will help you with whatever support you require'".

Despite the survey and interview respondents who asserted supporting the mental health and well-being of students in some way, uncertainty in terms of responsibilities was expressed, represented in 9 of the 10 interview responses where "partial responsibility" was asserted. When asked to discuss the steps instructors would take following the scenario of a student who disclosed a mental health problem, Kara responded,

> I think there should be guidelines that tell you, 'if you come across a student with a mental illness, you should do this or that'. We should also be able to access some kind of documentation about the student, like an OSR [Ontario Student Record] but for mental health. I am not sure though if all this is possible or even exists.

As another interview participant passionately described,

> I wish someone would just tell me what I can do or what others can do, rather than having to search it up myself and find nothing... Tell me how much I can skew the grades. Maybe tell me what my flexibility isn't, such as not allowing a student to pass if 50% of the work is incomplete regardless of the issue they are experiencing. Define what I can and cannot do. Like how do I know if I cross the line when I implement *x* or *y*; if I, for example, escort a student down to the counselling department... I would love a sheet of paper that lists the services that I can connect with or where I can tell students to go for help. (Ercole)

One study subject presented this researcher with a course outline/syllabus affiliated with the School of Liberal Arts and Science's streamed preparatory program at Molize College (see Figure 2), which he accompanied with the following narrative:

> Look at this part in particular [*participant pointing to the section entitled, "Late Assignments"*]...'after one week, the assignment will not be accepted', so at first when I started I did not accept anything after this time if I did not have a note or prior warning. In speaking with a colleague after she told me she spoke with admin, who said we *can* allow late submissions even without the indicated advisories...we have to 'play it by ear' depending on the situation, like a mental illness. (Benito)

LATE ASSIGNMENTS

Students are expected to submit assignments on time. Late assignments will be penalized by 5% per day and will receive no commentary from the professor. After one week, the assignment will not be accepted and will receive a grade of zero. Anyone unable to submit an assignment on time due to **exceptional circumstances** must

- Discuss the circumstances and possible options with the professor before the date of the assignment;
- Provide appropriate documentation to verify the reason for the absence

Figure 2. An excerpt from a streamed preparatory program course outline/syllabus in the School of Liberal Arts and Science at Molize College.

He concluded that documentation such as the one he presented complicates his understanding of instructors' responsibilities in supporting students. All of the above examples seem to indicate that instructors who assume partial responsibility in supporting the mental health of students can be unsure of the policies and procedures involved in providing certain kinds of support or in accessing student mental health documentation.

In sum, participant discussions illustrated that instructors carried uncertainties, discrepancies, or differences in their beliefs of who is responsible for student mental health in higher education settings. Firstly, it was determined that instructors were skeptical towards the general responsibilities of student support services departments or mental health professionals, including the quality of some of their practices. Secondly, with respect to instructor accountability, the data illustrated that some instructors believed they are predominately responsible for teaching, or in other words, for developing and facilitating lectures/lessons, evaluating assignments/tests, and implementing accommodations when necessary – placing school-based psychologists, counsellors, or program coordinators as those responsible for student mental health. In this light, only certain instructors, namely those who teach preparatory courses designed to support students were identified as responsible for addressing students with a mental health problem or illness.

On the other hand, the data demonstrated that some instructors prioritized mental health as much as academics, representing instructors as "first-line responders" and/or "educated mediators", especially in circumstances where the number of students with mental health problems can be elevated, like in the preparatory courses affiliated with specialized preparatory academic departments or programs. However, it was noted that these instructors were uncertain of their responsibilities when supporting the mental health of students. Furthermore, the findings revealed that some instructors believed student mental health is completely beyond the scope of higher education; reserved for settings/professionals outside of the institution. The data demonstrated that instructors' uncertainties or discrepancies surrounding responsibility over the mental health of students stemmed from, a) evaluations of their knowledge, confidence, and time, and b) reports of nonexistent or unclear policies in relation to the expectations of student support services departments, mental health professionals, and instructors when promoting/implementing support, as well as in relation to legal and ethical processes associated with student mental health in higher education.

4.4 Instructors' Practices that Support the Mental Health and Well-Being of Students

Survey and interview participants described an array of practices that they employ to support the mental health and well-being of students in higher education settings. The order in which the practices are discussed below complements the organization of this study's survey and interview questions and does not necessarily reflect the order or frequency in which participants would employ them. When asked questions intended to determine the practices instructors employ to support students with a mental health problem or illness, 28 of 42 survey participants and 16 of 23 interview participants suggested that instructors would initially engage students in an informal discussion, referred to in this study as the *conversation*. Of the above-noted 28 and

16, 23 survey participants and 11 interview participants respectively reported using conversation as a way to acknowledge and discuss a mental health concern with a student, particularly if instructors experience difficulty in identifying students with mental health problems when not "formally" indicated through a disability document. As Aida remarked during the interview,

> I learn that students have a problem mainly through the disability forms completed by the disability services department. The students usually present you with this form, but in some cases, they misplace the document, or forget, or not know to provide it to their teachers. Even when we have these documents, there is often more going on that what it says…this remains private. So, as an alternative, I ask a student to see me personally to initiate a discussion if I saw that their mental health was interfering with their ability to succeed. I strive to build a closer connection with these students so I can continue talking with them and learning to identify their troubles.

Moreover, 3 survey respondents and 5 interview participants documented using conversation to determine if students are interested in accessing intervention, and if so, to highlight the practices of support available and of interest to them, as Lissandra indicated during the interview: "I met with [a student] for a conversation about how I can help, but she didn't want help, so I didn't offer any. Students have a right to 'pass' you know, but just in case, I watched her in case it got worse". Marina similarly outlined during the interview using conversation to highlight practices of support on campus, noting that students are not always aware of support initiatives, especially those not often identified as supporting one's mental health:

> …talking to students about what the college can do to help is important because they may not know. They may not even realize that "formal" support may not be necessary...I had

> one student whose emotional well-being improved after I told her to join the basketball team. From then on, I advise any student in distress of this "simple" option.

Conversations facilitated by instructors were noted to take place in person, but on occasion, in writing, such as through email or course web-based learning management systems. Five of the 16 interview participants who indicated using conversation reported doing so via email, such as Lissandra, who recalled an email from a student disclosing that her mother had endured a brain aneurysm, and as a result, was struggling with her emotional well-being and academic tasks/expectations. In response to a similar email message, Domenico remarked, "a lot of students know that people think about mental health negatively, and so they keep it to themselves. I mean there is definitely a danger of bias and labeling when disclosing, which means not many students take the chance of writing such emails for us to make an identification".

In addition to the conversation, 35 of 42 survey respondents and 19 of 23 interview participants suggested that instructors typically refer students to student support services departments, such as the counselling or disability centre, as a means of supporting students with a mental health problem or illness; termed in this study as the *referral*. As one interview respondent expressed, "I am here to instruct Math, and so when these [mental health] issues arise in any way...we refer this stuff directly out to professionals" (Juliano). Similarly, when asked to make note of the strategies instructors use to support students with mental health problems, Jolie responded in the survey as follows:

> I would try and get them to go see counselling services or the program coordinator who have dealt with these students in the past and more frequently obviously... someone they

> can talk to that might be able to provide more ongoing and better help than I could give...to give support that goes beyond the classroom.

The referral was noted as commonly occurring after an instructor has identified a student with a mental health concern, which similar to when employing the conversation, was reported as sometimes difficult to accomplish. Specifically, instructors referring students to student support services departments *following* identification was suggested in 17 of the 19 interview participants who claimed employing the referral. For example, Frederico indicated during the interview that "depending on what happens after we discuss their circumstances and I realize something is wrong, I would refer them on, [but] it's tough to recognize the signs of distress sometimes when you don't know much".

Forty of 42 survey participants and all 23 interview participants identified the facilitation of *accommodations* as another practice employed to support the mental health and well-being of students, which were said to be determined by disability documents. To recall, instructors are accountable for implementing any accommodations as highlighted in a student's disability document, which they are supposed to receive at the beginning of each semester. Of note, 26 of the above-noted 40 survey respondents and 13 of the above-noted 23 interview participants reported implementing accommodations even when identification through a disability document was not established. As Lissandra expressed during the interview,

> I consider myself very flexible and accommodating to all students, identified or not. I ask students to communicate with me when he or she needs more time on an assignment and I will allot them more time. There was one time a student told me her parents were fighting often; leaving her to act as a kind of buffer... she wasn't able to finish the

assignment due to the stresses of the situation. I told her to hand it in at a later date and I kept this in mind for the rest of the assignment deadlines of the semester.

The types of accommodations instructors employ were identified in 26 survey responses and 22 interview responses, which included the following: extending assignment/test deadlines; altering assignment/test objectives; providing isolated testing environments; and enabling access to course material through multiple avenues, such as course web-based learning management systems. For example, when asked the interview question *how exactly do you implement this strategy in the classroom?* Montrelle concluded,

> I can offer them more time, rather than just take an incomplete. I can put a test in the Test Centre which is quieter and gives them more time to complete. I can even change an assignment's objectives a little bit. Other than this, we really do not have much direction on what else we can do.

Making adjustments to classroom spaces was another type of accommodation reported; albeit, identified by only 2 interview participants who determined employing accommodations. For example, Benito recounted that he would ensure the desks in one of his classrooms were separated to accommodate a student who disclosed feeling anxious when sitting too closely to peers. Like with the conversation, course web-based learning management systems were often identified as useful when employing accommodations, specifically reported in 9 interview responses. For example, Umberto claimed he accommodates students who miss class by posting lecture materials online.

Twenty-one of 42 survey respondents and 13 of 23 interview participants reported structuring components of courses in a way that can support the mental health and well-being of students, specifically by integrating mental health into course content, tasks, and delivery;

termed in this study as *curricular inclusion and instruction*. Preparatory courses were identified in 6 of the 21 above-noted survey responses and 12 of the 13 above-noted interview narratives as those that exemplify the inclusion of mental health curriculum. As one survey respondent wrote, "the [preparatory course] in [the streamed preparatory program] is designed to help students learn how to be students; how to cope with life in general, [examining] issues such as stress and dealing with disappointments in life" (Ercole).

When the 13 interview participants who reported employing *curricular inclusion and instruction* were asked exactly *how* they incorporate mental health content and tasks into their courses or in courses other than those affiliated with specialized preparatory academic programs (e.g., *Tell me more about the goals of curricular inclusion)*, they suggested adding mental health topics through research, writing, reading, and/or discussion activities. For example, Zaira claimed that "...for a final term paper in one of my classes, I add a mental health topic as an essay option…for them to research and write about". To offer another example, Jamma described her inclusion of mental health into a discussion activity:

> We have discussions about conflict management styles. Some people are 'sharks' whereas some people are 'teddy bears', 'turtles', or 'owls'... In doing this exercise, we end up opening up discussions about *why aren't you a shark? What is keeping you from being a shark?* What can come out of this is *well, my family needs me all the time, which adds stress and reduces my engagement in school*. Exercises such as these allow me to see who has problems so I can keep an eye on them.

Course web-based learning management systems were again highlighted as instrumental when incorporating mental health into research, writing, reading, and/or discussion activities, as reported in 7 of the 13 interview responses that described curricular inclusion and instruction.

For example, Kara stated, “I use the course website to post information pamphlets or brochures so that students can read about and reflect on this issue...sometimes I build something to teach from this information as well”.

Along with course content and tasks, instructors reported implementing certain strategies in their methods of instruction/delivery or in the general organization of their course to promote mental health and well-being, as outlined in 5 survey responses and 6 interview responses. A noteworthy strategy mentioned by a participant during the interview, specifically following the question *what has helped you facilitate the implementation of support for students with mental health problems?* was the invitation of a guest lecturer who introduces and discusses issues surrounding mental health: “I have a counsellor come in at the start of the semester to introduce themselves and the department... I then have them run a workshop with the students on stress management” (Umberto). This particular strategy represents the inclusion of mental health through multiple avenues – course content, tasks, *and* delivery. Instructors “setting meeting hours” was another noteworthy instructional strategy intended to benefit the mental health and well-being of students, as identified in Damiano’s interview narrative:

> Meeting hours create opportunities for us teachers to support students both academically and personally. However, it is crucial that we have routine, set meeting hours, and if wanted, also by appointment... which can take place in my office or even virtually through [the course web-based learning management system]. Set hours give students the impression that we take these moments seriously...that their concerns are part of the course in a way. ‘By appointment only’ appears more distant...it places the student as ‘support-seeker’...it removes ‘student support’ from being a component of the course.

The promotion of strict guidelines and structure represented a final instructional strategy highlighted in the findings. For example, study participant Liliana remarked that she "always set[s] firm and static protocols for [her] students at the start of school…by sticking to [her] routine lectures and power points. In doing this, it is easier to determine who is falling off the grid and needs support".

Some participants expressed reservations using *curricular inclusion and instruction* to support the mental health of students, pointing to the rigid structure of certain courses as the reason. Of the 13 interview participants who reported employing *curricular inclusion and instruction*, 5 indicated carrying such reservations at times. For example, Emiliano claimed, "I can see how and where teachers can add mental health, like in my Communications class, but not my Math or Science. [Math and Science] are not those kinds of subjects where this can be done". Interestingly, however, some participants (3) challenged such reservations while discussing how they integrate mental health in their course curriculum. As Marina highlighted,

> The first two [Math] quizzes I do with students are divided into the quiz and then a reflection piece on how they studied versus how they did. On one of these reflections, I learned of a student who had a death in the family due to illness. This kind of task can be implemented in classes where some think they do not apply, like I did in Math...In my Math class, I also include a peer evaluation component which provides lots of opportunity to open up personal discussions and perhaps uncover problems. It's funny because people do not see how Math skills can help them in general, or in this case, mental health. Math teaches problem solving and logic, and with these skills, people become better problem solvers...leading to less mental health distress.

Likewise, Benito also seemingly challenged the viewpoint of certain course structures as not conducive to a mental health curriculum:

> These things don't really fit into anyone's curriculum, but only on the surface. Time to include is the real concern...Are we going to get any more time to fit this into curriculum? No. [Mental health] needs to be part of an overall teaching strategy for student success that is infused in every subject; in the content; in all classrooms.

Although course rigidity was challenged, Benito's narrative presented time constraints as a potential factor the can affect or limit instructors' consideration of mental health in curriculum content, tasks, and delivery; a factor that was also identified in 8 of the 13 interview participants who reported using curricular inclusion and instruction.

In sum, the findings revealed that instructors generally employed four practices to support students with a mental health problem or illness, and to promote positive student well-being overall. The *conversation* appeared as the initial practice of support instructors employed, intended to confirm identification of a mental health concern; to determine if an identified student wants support; to explain available and suitable intervention options within the institution; and lastly, to understand what practices are of interest to a student. The findings demonstrated that instructors also employed the *referral*; referring students specifically to student support services departments, such as the counselling centre. Additionally, the data highlighted that instructors facilitated *accommodations*, such as assignment due date extensions, isolated testing environments, and alternative test-taking dates, in support of students with mental health problems, even when formal documentation was not indicated. Lastly, instructors included mental health in their course curriculum, through content, tasks, and delivery (*curricular inclusion and instruction*) as a means of promoting student well-being.

5. Analysis and Discussion

The purpose of this study was to explore the potential role of post-secondary instructors in supporting students with mental health problems and illnesses by uncovering their level of mental health awareness; their evaluation of personal knowledge and confidence in mental health and related topics; their beliefs surrounding the responsibilities of supporting students with mental health problems or illnesses; and their employment of practices that support this population. Briefly, this study's findings revealed that instructors were generally aware of student mental health concerns in post-secondary institutions, but that greater awareness was still warranted, namely in the areas of instructor mental health and location of support services. Findings also demonstrated that most instructors evaluated their knowledge and confidence in relation to student mental health as poor, which was often accredited to limited opportunities to participate in relevant professional development and training. Limited mental health training for faculty and staff was often noted as due to poor funding and resource allocation, as well as minimal time for instructors to participate in relevant professional development initiatives.

In turning to responsibility, the data indicated that instructors carried some skepticism towards the role of student support services departments, such as the counselling or disability centre, in supporting the mental health of students, including the quality of practices employed by individuals associated with these services. Furthermore, although most instructors believed that they were not "in part" responsible for promoting/supporting the mental health of students, a good portion believed otherwise. Nonetheless, those who reportedly assumed partial responsibility in supporting the mental health and well-being of students demonstrated uncertainty in their responsibilities; uncertainties that were often determined to draw from a number of factors, including, but not limited to, nonexistent or unclear policies in relation to

instructors providing support for students. On a final note, findings demonstrated that instructors employed four practices that can support the mental health and well-being of students: *conversation*, *referral*, *accommodations*, and *curricular inclusion and instruction*. Some positive features of the above-noted practices were revealed, including, but not limited to, instructors supplementing initiatives with technology. Unfavourable practice features were also suggested, such as instructors experiencing difficulties identifying students with mental health problems.

The paragraphs to follow provide an analysis and discussion of this study's findings in order of the research questions and themes revealed. Findings were first analyzed in light of data drawn from other relevant studies to determine how the ideas in this study converged or diverged with the subject research area. Due to limited, qualitative studies that closely examined the perspectives and practices of college and university instructors towards student mental health in Canada, findings were often exclusive or unique to this study. Consequently, an analysis of findings in reference to "other relevant studies" sometimes included those that drew from non-Canadian contexts, as well as from K-12 school settings when the "educator's voice" was centered. In these cases, it was ensured that applicability or relevancy in relation to this study was clearly indicated. Following an analysis in relation to existing literature, ideas were then discussed more broadly in relation to prevailing concepts and themes that surround this research area. Furthermore, the principal theoretical and practical implications of the findings and analyses were explored, ultimately outlining suggestions for moving forward in the facilitation of a comprehensive student mental health support system that considers the role of post-secondary instructors. How can college or university instructors, as well as post-secondary institutions in general, better respond to the mental health needs of students?

5.1 Awareness of Student Mental Health

Study data revealed that instructors carried general awareness of post-secondary student mental health. Thirty of 42 (71%) survey respondents noted that encounters with students who have a mental health problem or illness contributed to their awareness, while 10 of 23 (43%) interview participants reported that the institution's positive response to mental health increased their mental health awareness. These findings were rather unique, which is likely due to the limited number of studies that focused on the role of post-secondary instructors in relation to student mental health or that gathered data directly from instructors. In other words, with little consideration for instructors, it can be difficult to confirm whether or not they encounter students with mental health problems or recognize the institution's response to this population. Nonetheless, even though not drawing from the perspectives of instructors, studies have still reported on mental health awareness in post-secondary institutions more broadly, but drew conclusions that seem to diverge from current study findings.

Other researchers in this area of study have suggested that post-secondary faculty and staff are *not* well-aware when it comes to student mental health in general (CACUSS & CMHA, 2014; Martin, 2005; Mowbray & Megivern, 1999; Quinn et al., 2009; Sharp et al., 2006). For the most part, literature that explored post-secondary student mental health communicated a need to increase the general mental health awareness of faculty and staff (CACUSS & CMHA, 2014; Hanlon, 2012; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Lunau, 2012; MacKean, 2011; Martin, 2010; Quinn et al., 2009; Tinklin et al., 2005; UMCMHS, 2014). For example, a key element identified in the systemic mental health guide developed by CACUSS and CMHA (2014) was increasing initiatives that improve the mental health awareness of faculty and staff. Likewise, through interviews with higher education students who have a mental illness, Quinn et

al. (2009) concluded that, “in addition to student awareness, the need to address the lack of awareness amongst academic staff emerges from this study” (p. 416). Specifically, they determined that several instructors seemed unaware of students with mental health problems; unaware of how these students are generally received or supported (Quinn et al., 2009). Also drawing from the reports of students with a mental health problem or illness, Tinklin et al. (2005) revealed “…a lack of awareness and understanding on the part of staff member[s]” (p. 509). In particular, the student case studies demonstrated that instructors sometimes took no account of the mental health difficulties experienced by students (Tinklin et al., 2005).

Although post-secondary instructors were often represented as lacking in student mental health awareness, it was suggested that faculty and staff can still be aware of the impacts of mental illness and how learning can be affected as a result (Lunau, 2012; MacKean, 2011; Martin, 2010; Quinn et al., 2009; UMCMHS, 2014). This suggestion supports current study findings, as 14 of 23 (61%) interview participants recognized that student mental health problems arise from a compilation of factors; 12 (86%) of which acknowledged the subsequent impacts on schooling. Following his environmental and literature scan of mental health in Canadian higher education settings, MacKean (2011) determined that faculty and staff can identify issues with academic engagement and performance in students who experience a mental illness or health problem, as was similarly indicated by study participant Jamma, who stressed that “it is difficult to be engaged when [students] are depressed”, or by study participant Liliana, who suggested that “there is a ‘bigger picture’ to consider here. It’s not just academics…”.

Although literature in this area of research represented higher education faculty and staff as lacking in mental health awareness, the institution overall was described as gradually becoming more aware of and responding more positively to student mental health, as 11 of 23

(48%) interview participants also revealed in this study (CACUSS & CMHA, 2014; Hanlon, 2012; MacKean, 2011). For example, MacKean's (2011) literature and environmental scan of post-secondary mental health highlighted that the efforts of colleges and universities in supporting students with mental health problems and illnesses has generated greater awareness towards this subject. Specifically, he determined that the current promotion of mental health whole-school approaches or holistic frameworks has contributed greatly to increasing and sustaining such awareness (MacKean, 2011). In addressing mental health issues on Canadian university campuses, Hanlon (2012) similarly determined that systemic approaches towards student mental health, like the University of British Columbia's *Triage System*, are excellent tools that have promoted mental health awareness.

Also focusing on a whole-school approach, CACUSS and CMHA (2014) included mental health awareness as one of the seven integral components in their guide to post-secondary mental health. They indicated that the way an institution structures, organizes, or plans their mental health policies and practices can work to reinforce values and behaviours surrounding student mental health (CACUSS & CMHA, 2014). In other words, poor structure in this regard can limit faculty and staff's mental awareness and encourage unwanted values and behaviours, which can subsequently impact the mental health of students, and in turn, their learning (CACUSS & CMHA, 2014). Similar to all of the above-noted examples, study participants, such as Ercole, Frederico, and Romia, described how their mental health awareness drew from the institution, or more specifically, from the institution's streamed preparatory department/program, preparatory courses, and mission statement. In addition to policies, practices, or whole-school approaches, an institution's positive response towards mental health through advertisements has also been noted in other work as contributory in raising mental health awareness, as it did for study participant

Frederico, for example, when he referred to the student mental health article published in Molize College's seasonal magazine (Cavalheiro et al., 2012; Frado, 1993; Kadison & DiGeronimo, 2004; Santor et al., 2009). Frado's (1993) investigation of how Canadian post-secondary students with mental illnesses are accommodated demonstrated that increasing the number and diversity of mental health advertisements within post-secondary institutions can generate greater awareness, or specifically, more comfort with student mental health.

On the other hand, literature that focused on K-12 school contexts and/or that gathered data directly from teachers revealed that educators *can* carry awareness when it comes to student mental health, drawing from both their encounters with students and the institution's response (Ekornes et al., 2012; Froese-Germain & Riel, 2012; Graham et al., 2011; Roeser & Midgley, 1997; Whitley et al., 2012). Teachers surveyed in Froese-Germain and Riel's (2012) Canadian study, which evaluated the perspectives of teachers towards child and youth mental health, agreed that "…a number of mental health-related problems were considered to be a pressing concern in their schools" (p. 11). Guided by similar research objectives, Graham et al.'s (2011) study revealed that Australian K-12 teachers are well-aware of the problems students face in relation to their mental health. According to survey responses, 40% of teachers believed that their school viewed student mental health and emotional well-being as important: "…the school was supportive, proactive, had good policies and processes in place or worked well as a team" (Graham et al., 2011, p. 489). Likewise, in proposing "teachers as mental health promoters", Ekornes and colleagues (2012) determined that 80% of teachers carried awareness and understanding of student mental health, which they noted drew mainly from their interactions with pupils who have a mental health concern, as study participant Umberto similarly revealed when he stated that "…over the course of the year, there are tons of students who have mental

health issues that we engage". It is possible that detailed accounts of mental health awareness would have been documented more often in studies that focused on post-secondary institutions as well if the roles and perspectives of instructors were considered.

Despite the commendable amount of mental health awareness study participants shared, 11 of 23 (48%) interview participants reported a need for more. Specifically, 5 of the above-noted 11 (45%) interview participants suggested that greater awareness surrounding instructor mental health is warranted, while 6 of 42 (14%) survey respondents and 5 of the above-noted 11 (45%) interview participants indicated that greater awareness surrounding location of support services is necessary. Due to the limited number of researchers who have explored student mental health from the standpoint of post-secondary instructors, instructors' want for greater awareness regarding their mental health and the location of support services has not been really captured elsewhere. Although not gathered directly from the reports of post-secondary instructors, however, some other works have included concerns over post-secondary instructor mental health and the location of support services, which seem to support this study's findings (Brener et al., 2007; CACUSS & CMHA, 2014; Eells & Rando, 2010; Frado, 1993; Graham et al., 2011; Kidger et al., 2010; Patton et al., 2000; Quinn et al., 2009; Stone et al., 2000; UMCMHS, 2014).

Looking first at instructor mental health, the University of Manitoba demonstrated considerable interest in what they called *workplace mental health*, through their mental health strategy to promote success through wellness (UMCMHS, 2014). They determined that 40% of the university's faculty and staff reported experiencing a mental health problem or illness, which led to some individuals taking a leave of absence – short and long term disability leave (UMCMHS, 2014). From this understanding, the university established that little attention is

drawn to the mental health of post-secondary faculty and staff, as implied in study participant Marina's narrative: ""I am stressed with work, family, life in general…Do they (the institution) even offer anything for us the instructor?". Similarly, in their promotion of a guide to a systemic student mental health approach, CACUSS and CMHA (2014) outlined that "this framework does not focus directly on improving the mental health of staff, faculty, and students' personal networks…" (p. 5). Nonetheless, they suggested that greater efforts are necessary in developing support for faculty and staff mental health when considering that communal, organizational, and environmental conditions surrounding students can affect their well-being (CACUSS & CMHA, 2014).

Educator mental health was more explicitly recognized in the literature that drew from international K-12 contexts, as data was often gathered directly from teachers. Drawing from Australian K-12 contexts, Graham et al. (2011) uncovered that "…an overwhelming theme voiced by teachers through their open responses related to their own mental well-being" (p. 491). Likewise, in reference to British high school settings, interviews with teachers in Kidger et al.'s (2010) study revealed "…a general consensus that formal support systems to help teachers cope with emotional distress did not exist, with some participants discussing a dominant culture among school staff that works against them seeking help or support" (p. 929). To recall, study participant Marina similarly suggested the possibility of a negative administrative reaction in response to faculty disclosing a personal mental health concern. Again, it is likely that increased insight into the roles and perspectives of higher education instructors would have revealed more explicit accounts of instructors' concern over their mental health, as it did in those that documented the viewpoints of K-12 educators, as well as in this study.

In turning to the location of support services, Frado's (1993) evaluation of accommodations for students with mental illnesses in Canadian colleges and universities revealed that faculty, staff, and students are often confused regarding the whereabouts of mental health support services due to minimal efforts in raising the profile of special needs and disability offices. It seems that not much has changed since Frado's (1993) observations in the early nineties. CMHA's (2014a) guide for university and college students with psychiatric disabilities also indicated that students are often unsure of where support services are located, particularly the disability department where accommodations are often accessed. While investigating what constitutes effective college mental health service, Eells and Rando (2010) identified some limitations with the location of support services. They determined that 66.5% of mental health support clinics are too often situated in a discreet setting on campus or integrated within a general student affairs or services building, making it somewhat difficult for individuals to locate (Eells & Rando, 2010). This resembles study participant Caprice's experience of "stumbling" upon the counselling services department while walking far away from the main campus area.

In addition to the areas in need of greater awareness that study participants specifically identified, it appears as though greater awareness of mental health stigma and stereotype is also warranted. Although not explicitly recognized by participants, accounts of mental health stigma/stereotype were revealed in 7 of 23 (30%) interview narratives, specifically during discussions on mental health awareness that focused on instructors' encounters with students who have a mental health problem or illness, and their recognition of the institution's response to this population. The presence of mental health stigma and stereotype in higher education settings, whether carried by the instructor or the institution more generally, is definitely not a

finding unique to this study (CACUSS & CMHA, 2014; CASA, 2014; Frado, 1993; Kitzrow, 2003; Potvin-Boucher et al., 2010; Sharp et al., 2006). In addressing the mental health needs of today's college students, Kitzrow (2003) concluded that post-secondary school campuses can hold negative perceptions about mental health problems, as was reflected in the some of the discourses of study participants, such as when Liliana referred to students with a mental illness as "crazy". In their promotion of mental health literacy through an information resource, *Transitions: Student Reality Check*, Potvin-Boucher et al. (2010) recognized colleges and universities as sites where students can experience feelings of isolation and stigma if dealing with a mental health concern. Likewise, according to Frado (1993),

> some faculty and staff at colleges and universities question the appropriateness of having students with psychiatric disabilities enrolling in their institutions. Teachers are concerned about strange or disruptive behavior, the effects of medication on academic performance, safety issues for classmates and the inability of the student with a mental illness to deal with academic pressure. (p. 6)

She concluded that the above remarks reflect instructor-held mental health stigma and stereotypes; conventional misconceptions of students with a mental health problem or illness (Frado, 1993). Despite the more than twenty year gap between Frado's (1993) study and this one, study participants shared similar remarks, such as Montrelle or Jamma, who both recommended that students with a mental health problem or illness should "drop out of school all together" or "at least downgrade to part-time status".

Some researchers have made note of institutional- and instructor- held mental health stigma by evaluating the perspectives of post-secondary students who have a mental health problem or illness (Martin, 2010; Quinn et al., 2009; Sharp et al., 2006; Tinklin et al., 2005).

Through their evaluation of how students with a mental health concern experience higher education in the United Kingdom, Quinn et al. (2009) concluded that "students appeared afraid of the stigma attached to mental health difficulties and feared that it would be seen as a sign of weakness…" (p. 410). Students interviewed in Martin's (2010) study were also concerned that instructors' (mis)understandings of mental health would result in stigma and discrimination. As one participant claimed, "I don't want the staff to treat or view me any differently" (Martin, 2010, p. 265). Likewise, drawing from case studies of students with a mental health problem or illness, Tinklin et al. (2005) determined that the culture of higher education does not allow for students to openly admit or discuss mental health due to associated stigma/stereotype, as well as prevailing traditional/medical beliefs surrounding mental health difficulties, as implied in study participant Jamma's narrative, for example, when she recommended that students with a mental illness "need to be *treated* first" (emphasis added). Specifically, students in Tinklin et al.'s (2005) study revealed that they experienced stigma and alienation, especially when seeking support through campus services.

5.1.1 Commendable awareness of and response to mental health. Findings suggest that post-secondary institutions can respond positively to the mental health needs of students. Specifically, data demonstrated that this response, coupled with encountering students with mental health problems or illnesses, can contribute to instructors' awareness of mental health. Working within a socio-ecological framework (inspired by Bronfenbrenner, 1979; 2005), Ekornes et al.'s (2012) evaluation of teachers as mental health promoters revealed that educator perspectives towards mental health are greatly influenced by context, at the individual, organizational, and societal level. In looking at a societal level, the topic of mental health has been given increased attention by the general public over the last decade (CACUSS & CMHA,

2014; CASA, 2014; CMHA, 2014; Cavalheiro et al., 2012; Hanlon, 2012; Kadison & DiGeronimo, 2004; Martin, 2010; UMCMHS, 2014). According to Martin (2010), who examined mental health in higher education, "the severity and high levels of disability associated with mental illness have led to increased global efforts to address mental health problems…" (p. 259). This attention has inevitably percolated into the education system; the organizational or institutional level (Ekornes et al., 2012; Waller, 2006). Consequently, as was detailed in the *Introduction*, higher education settings have begun to recognize their importance in fostering student mental health and well-being (CACUSS & CMHA, 2014; CASA, 2014; Cavalheiro et al., 2012; CMHA, 2014; Field et al., 2006; Hanlon, 2012; Kadison & DiGeronimo, 2004; Kay & Schwartz, 2010; MacKean, 2011; UMCMHS, 2014).

Colleges and universities in Ontario appear to recognize the importance of mental health, and have demonstrated considerable commitment in positively responding to the mental health needs of students, which includes drawing greater awareness in this regard (CASA, 2014; CMHA, 2014 a/b; Cavalheiro et al. 2012; Hanlon, 2012; Lunau, 2012; MacKean, 2011; Ontario College Health Association, 2009). In response to increased societal and institutional awareness, "it would be impossible [for educators in particular] not to [be aware], given the impact that these mental health challenges have on learning and overall functioning" (Whitley et al., 2012, p. 58). In other words, it is unlikely that instructors or educators in general can ignore the emotional health concerns of students. That said, greater consideration of the instructor's perspective in this research area would likely reveal a larger number of college and university instructors as carriers of mental health awareness.

It is unsurprising that participants in this study demonstrated overall awareness of mental health in higher education settings. Some characteristics of the study sample may have

contributed to the large number of instructors who reported ample mental health awareness. Firstly, to recall, the streamed preparatory department/program from which participants were gathered is one that can provide additional avenues and guidance for students coming from "unconventional" or "challenging" backgrounds in terms of education, family, well-being, etc. As a result, it is likely that, a) the subject academic program and associated school of learning more broadly responds frequently and positively to student mental health concerns, and b) instructors often encounter students with a mental health problem or illness; all of which may have increased instructors' awareness of mental health, compared to, for example, instructors affiliated with other departments or schools of learning. Secondly, *teaching subject* may have also contributed to instructor reports of mental health awareness. Specifically, 6 of 42 (14%) survey respondents and 4 of 23 (17%) interview participants were instructors of preparatory courses founded in student success and well-being. As such, it can be expected that instructors who teach or have taught these types of courses, such as Ercole, Jamma, and Romia, frequently encounter students with a mental health problem or illness or are more familiar with how the institution responds to this population.

A third demographic feature of consideration is *employment designation*. To recall, 22 of 42 (54%) survey respondents and 11 of 23 (48%) interview participants were employed as full-time. Furthermore, 20 of 42 (48%) survey respondents and 12 of 23 (52%) interview participants were employed as partial-load. None were employed as part-time or sessional. Full-time and partial-load designations, especially the former, place instructors at the institution more regularly, either teaching courses, meeting with students, or participating in other academic/administrative activities. Such frequent attendance and participation can increase instructors' recognition of an institution's mental health policies and practices, or of students

who have a mental health problem or illness; all of which can improve mental health awareness. If data were gathered from part-time or sessional teaching faculty, less mental health awareness may have been reported. In considering all of the demographic variables listed above, it would have been rather unsettling if participants in this study reported little awareness of student mental health.

5.1.2 Concern for instructor mental health and the location of support services.

Findings suggest that despite many colleges and universities recognizing the importance of mental health and demonstrating considerable commitment in drawing awareness to this issue, "awareness is never finite" (Tazia). It seems that instructors can carry limited awareness in relation to support for their own mental health and the location of student support services. Concern for workplace mental health in the context of higher education is gradually becoming a priority (CACUSS & Centre for Mindfulness Studies, 2014; CMHA, 2014; UMCMHS, 2014). For example, the University of Manitoba included support for the mental health of instructors as part of their overall mental health strategy, specifically through professional development and training.

Alternatively, a number of organizations have been developed to support the mental health of employers and employees, such as post-secondary faculty and staff, including the Centre for Mindfulness Studies (2014) that offers relevant social programs, diverse therapies, and education courses. Little evidence suggests, however, that these efforts are well-known or widely practiced (UMCMHS, 2014). Post-secondary faculty and staff seem unsure of how an institution responds to their mental health (UMCMHS, 2014). Limited awareness of instructor mental health can be surprising and problematic: "student mental health and workplace mental health are inextricably linked for a few reasons…there is a direct relationship between faculty

and staff mental health and wellness and the level of service provided to students" (UMCMHS, 2014, p. 4). Put differently, when the mental health of instructors is in jeopardy, their ability to support students with mental health problems can be challenged (CACUSS & CMHA, 2014; Kidger et al., 2010). In addition to increasing one's ability to provide support, *all* individuals are entitled to a personal mentally-healthy experience, particularly while taking part in public institutions (Martin, 2010; Ontario College Health Association, 2009). The considerations noted above clearly signal a need for greater awareness in this regard.

Confusion regarding the location of student support services also seems to be of concern. Knowing where student support services departments, such as the counselling or disability centre, are located is definitely important for students with a mental health problem or illness who are interested in accessing support (CMHA, 2014a). It seems equally necessary for instructors to know where these support services are located, in order for these individuals to guide students towards support. How can an instructor refer a student to counselling services, for example, if they are unsure where this type of support is located/accessible? Unfortunately, support services for students are often dispersed throughout the institution, operating through different types of departments (MacKean, 2011). Moreover, these departments are sometimes situated in isolated campus locations (MacKean, 2011). Faculty, staff, and student awareness of support service locations is understandably limited when the placement of these areas does not coincide with where faculty, staff, and students tend to populate (MacKean, 2011). In this way, instructors in particular are less likely to know about these locations, and more likely to simply "stumble upon" them. In sum, greater awareness seems necessary when it comes to the mental health of instructors and the location of student support services departments on campus.

Without increased awareness overall, disengagement between what is needed and what is actually provided will persist in relation to school mental health (Froese-Germain & Riel, 2012).

Although participants identified that greater awareness was necessary in the above-noted areas in particular, it is possible that some were "unaware" of other mental health components as well. Put differently, something *may* be said about instructor "unawareness" by pointing out areas where instructors did not report awareness. For example, instructors did not reference any mental health literature resources, such as CMHA's (2014a) *Guide to College and University for Students with Psychiatric Disabilities*, that they may potentially advise students to access. At the same time, however, participants not reporting awareness of something does not necessarily entail that they were unaware of that something. Mental health policies, resources, and practices are still not "fixed" within post-secondary institutions, which can make it difficult for faculty and staff to be aware of them (Canadian Alliance of Student Associations, 2014; CMHA, 2014a). What *can* be said is that mental health awareness overall is an ongoing process in post-secondary institutions; to grow and never be completed (Cavalheiro et al., 2012; Froese-Germain & Riel, 2012; Graham et al., 2011; Isreal et al., 1995; Quinn et al., 2009).

Employment designation and *teaching experience* were two demographic variables of the participant sample that may have contributed to instructors' concerns over their own mental health and the location of support services. To recall from Table 3, 20 of 42 (48%) survey respondents and 12 of 23 (52%) interview participants were employed as partial-load. Furthermore, 17 of 42 (40%) survey respondents and 13 of 23 (57%) interview participants carried only 0-5 years of teaching experience. Participants employed as partial-load and with 5 years or less in teaching experience, such as Tazia, Marina, Damiano, and Caprice, were those who more often expressed a need for greater awareness in the areas of instructor mental health

and the location of student support services. Perhaps with full-time employment, which places the instructor at the institution more frequently, as well as added years of teaching experience, instructors can become more familiar with how their own mental health is taken up by the institution or where mental health support services are located within the institution. Of note, instructors who taught preparatory courses, which accounted for 6 of the 42 (14%) survey respondents and 4 of the 23 (17%) interview participants, did not demonstrate concerns over their own mental health or the location of support services, regardless of employment designation or teaching experience. This can be due to these instructors' carrying greater familiarity in how mental health is addressed at the institution.

5.1.3 Concern for mental health stigma. Findings suggest that mental health stigma persists in higher education settings, whether or not explicitly acknowledged by a subject institution or its affiliated faculty/staff. Conventional attitudes towards mental health can influence one's understanding and awareness of this topic (CASA, 2014; Ekornes et al., 2012; Hoefnagles et al., 2007; Kitzrow, 2003; Martin, 2010). As detailed in the *Literature Review*, individuals with a mental health problem or illness are commonly represented as lacking, non-functional, dangerous, "crazy", and in need of "medical treatment" (Aldridge & Becker, 2003; Anderson-Butcher, 2006; Cornejo, 2010; Eichler & Schwartz, 2010; Frado, 1993; Martin, 2010; Oliver, 2009; Tinklin et al., 2005; Wyn et al., 2000). Returning to Ekornes et al.'s (2012) notion of contextual influences, educators' perspectives are partially influenced by society, which often promotes the above-noted representations of mental health; media as the typical informant. Unfortunately, these perspectives can become (un)intentionally communicated; perpetuation of mental health *il*literacy. Mental health stigma or illiteracy can be noted in the vocabulary used by institutions or instructors to describe students with a mental health problem or illness, and in the

opinions and decisions forwarded by institutions or instructors when addressing this population; hence some study participants' description of students with a mental health problem or illness as "crazy" or "unable to successfully engage in the learning process" (Liliana and Jamma). It may also surface in discourses between instructors and students, or through institutional mental health policy documentation.

Whether in the opinions of instructors on how to "deal" with students who have a mental health problem or in the mental health policies of institutions, negative conceptions surrounding mental health – stigma/stereotypes – represent a perceptual barrier in higher education settings. As Kidger et al. (2010) expressed, "…a construction, far from being supportive, is more likely to be disempowering" (p. 921). This construction or perceptual barrier is one that gives rise to a challenging paradox: stigma surfaces when mental health awareness and mental health literacy is limited; however, stigma is often that which "silences" mental health, and thus, limits awareness or literacy. As Cavalheiro et al. (2012) noted, the mental health problems of students in college settings are "a well-kept secret" due to stigma. Consequently, "the way the concept of mental health is defined and understood has concrete and serious consequences for people in need of help" (Ekornes et al., 2012; p. 304). In other words, in limiting mental health awareness, associated stigma and illiteracy can cause serious inequities and disadvantages for students with mental health concerns, in addition to the social, political, cultural, and economic disempowerment they can experience in general (Froese-Germain & Riel, 2012; Martin, 2010).

Instructor-held mental health stigma/illiteracy in particular can lead to a number of challenges or structural barriers for students with mental health problems: a) it can prevent students from disclosing a mental health concern to their classroom instructors (CACUSS & CMHA, 2014; CASA, 2014; Cornejo, 2010; Frado, 1993; Hanlon, 2012; Potvin-Boucher et al.,

2010; Quinn et al., 2009; Sharp et al., 2006; Whitley, 2005; Wyn et al., 2000); b) it can prevent instructors from effectively identifying students with a mental health problem or illness, as those who maintain a more conventional understanding of mental health, for example, may wrongly link the actions and attitudes of students to a mental illness (CASA, 2014; Quinn et al., 2009; Tinklin et al., 2005); and c) in promoting "medicalized" support for students with mental health problems or illnesses, stigma can limit the implementation of instructor-facilitated interventions (Cornejo, 2010; Frado, 1993; Shaw, 2003; Shaw & Ruckdeschel, 2002; Stone et al., 2000; Wyn et al., 2000). Likely in response to recent legal altercations regarding mental health problems and student suicides, post-secondary institutions and their respective faculty have become challenged to abandon any actions of oblivion; to tackle issues of stigma; to increase mental health literacy; and to raise greater awareness of mental health overall (CACUSS & CMHA, 2014; CASA, 2014; Hanlon, 2012; Kitzrow, 2003; Sharp et al., 2006; UMCMHS, 2014).

Interestingly, mental health stigma seemed impervious to participant demographic variables. In other words, participants' age, gender, employment designation, teaching subjects, etc., did not seem to determine whether or not mental health stigma or stereotype was present in their discourses. Mental health stigma and stereotypes can "unintentionally" or "unknowingly" surface in study participant discourses, regardless of demographic influences. To explain, instructors made no explicit reference to mental health stigma/stereotypes while discussing their awareness of mental health in higher education settings, or during any discussion for that matter. In other words, although this researcher uncovered mental health stigma following an analysis of the language/vocabulary participants employed, they did not refer to personally- or institutionally- held stigma. For example, instructors did not refer to mental health

stigma/stereotype as a potential reason why awareness of instructor mental health is limited, or why instructors are resilient in disclosing their mental health problems to administrators.

The absence of explicit reference to mental health stigma/stereotypes does not necessarily entail that it does not occur implicitly, or that study participants believed stigma does not exist at their institution. Rather, it may indicate that instructors were somewhat unsure, uneasy, or uncertain with the notion of mental health stigma/stereotype. Ekornes et al. (2012) uncovered that teachers are reluctant in using terms associated with mental health, and that overall, they often demonstrate a poorly developed vocabulary when speaking about mental health. Similarly, Altschuler et al. (2007) insinuated that teachers are sometimes uncertain of how mental health is taken up by a school's culture; if mental health is stigmatized. Likewise, Martin (2010) determined that university staff are often unclear if what they think and practice is actually discriminatory or simply their personal perceptions of what is discriminatory. CMHA (2014b) advised that the word *stigma* is often poorly defined and carries many misconceptions; typically conflated with terms such as, discrimination or prejudice. Misconceptions, uneasiness, or uncertainties associated with the word can prevent individuals from using the word, or worse, acknowledging its existence; its subsequent impacts; or its manifestations through language. Considering all of the above, then, mental health stigma/stereotype can easily surface in the discourses of instructors, as it did in this study, even if "unknown" or never explicitly referenced.

5.2 Knowledge/Confidence in Student Mental Health

Study data revealed that 30 of 42 (71%) survey respondents and 16 of 23 (70%) interview participants evaluated their knowledge and confidence in mental health as "below average" and "extremely poor". Like with mental health awareness, findings on instructor knowledge/confidence were uncommon, which again was likely due to the limited number of

studies that focused on the role of instructors in relation to student mental health or that gathered data directly from instructors. In other words, with little consideration for post-secondary instructors, it can be difficult to understand how they specifically evaluate their knowledge and confidence in relation to mental health. Nonetheless, even though not drawing from the perspectives of instructors, some studies have reported more broadly on the mental health knowledge/confidence of faculty and staff in higher education settings and have come to conclusions that support this study's findings.

Researchers in this area of study have determined that faculty and staff within post-secondary institutions do not carry ample knowledge/confidence in relation to mental health (CACUSS & CMHA, 2014; Field et al., 2006; Hanlon, 2012; MacKean, 2011; Martin, 2005; Mowbray & Megivern, 1999; Quinn et al., 2009; Sharp et al., 2006; Tinklin et al., 2005; UMCMHS, 2014). Sharp and colleagues' (2006) look into classroom-based strategies to support student mental health discovered that non-professionals, including educators, feel ill-prepared and generally lack in knowledge when it comes to issues of psychological distress, such as how to identify signs of mental health problems or where to make a referral. Field et al (2006) similarly determined that instructors' discomforts in supporting students with mental health problems are partially due to their lack of understanding in this area, as revealed in the discourses of study participants, such as Lissandra, who noted "feeling awful" for not carrying the knowledge necessary to support student well-being. Likewise, drawing from the reports of post-secondary students, Tinklin et al. (2005) revealed that instructors often misjudge or misunderstand the nature and outcomes of student mental health difficulties due to their lack of knowledge in this area. Research that investigated whole-school approaches to student mental health, such as those presented in CACUSS and CMHA (2014) or UMCMHS (2014), often

advocated for the mobilization and enhancement of faculty and staff members' mental health knowledge with the implication that their current state of comprehension in this regard is poor.

Studies that focused on K-12 school settings included more detailed accounts of poor mental health knowledge and confidence (Altschuler et al., 1999; Cohall, Cohall, Dye, Dini, Vaughan, & Coots, 2007; Graham et al., 2011; Han & Weiss, 2005; Kidger et al., 2010; Waller et al., 2006). In their study on teacher and adolescent responses towards mental health, Cohall and colleagues (2007) determined that teachers felt uncomfortable addressing issues related to adolescent psychosocial problems. Likewise, findings from Graham et al.'s (2011) study revealed that most teachers believe they are poorly equipped in terms of knowledge and confidence to contribute to or enhance student mental health in the classroom: "teachers feel totally inadequate in terms of knowledge, fearful of the unknown" (p. 490). Study participants expressed similar feelings, such as Aida, who believed that due to limited mental health knowledge, her efforts in supporting student well-being are "unprofessional" and "unsatisfactory". It is possible that increased insight into the roles and perspectives of higher education instructors would have revealed more detailed accounts of poor mental health knowledge/confidence, as it did in those that documented the viewpoints of K-12 educators, as well as in this study.

Poor instructor knowledge and confidence in mental health was also taken up in this area of research when studies examined mental health professional development and training. Specifically, researchers have identified minimal training and professional development as a reason why instructors are not knowledgeable, confident, or comfortable in addressing student mental health, as was revealed when this study's findings were analyzed (Davar, 2010; Hanlon, 2012; Kitzrow, 2003; Silverman & Glick, 2010; UMCMHS, 2014). In proposing a whole-school

approach to mental health, UMCMHS (2014) recognized that post-secondary instructors are often ill-prepared in addressing student mental health when they have not been appropriately trained in this regard. Similar to study participant Lissandra's comment, that "it takes money to run training", the University of Manitoba highlighted a need to forward greater resources in the mental health training of faculty and staff (UMCMHS, 2014). Likewise, through their respective studies, Kitzrow (2003) and Silverman and Glick (2010) recommended that greater training of faculty and staff can be essential in building mental health education and reducing mental health stigma.

Studies that focused on K-12 school settings captured a more detailed representation of how educators may link their poor mental health knowledge and confidence to limited mental health professional development and training (Bibou-Nakou, 2004; Clarke et al., 2003; Froese-Germain & Riel, 2012; Kidger et al., 2010; Leigh et al., 2009; Waller, 2006). Over two-thirds of teachers in Froese-Germain and Riel's (2012) study reported that they had not received knowledge acquisition or skills training, which they believed limited their preparedness in addressing students with mental health problems. In Altschuler et al.'s (1999) study, which examined educators' views on supporting students through a psychological lens, "teachers stressed the need for support to feel confident about responding appropriately" to students who are distressed due to parental issues (p. 29). Case study examples revealed that without direct training, teachers remain anxious and lack confidence when supporting this population (Altschuler et al., 1999). As study participant Domenico suggested, "we do not have the extra time to do training…", other researchers have also documented that teachers lack time to participate in relevant training even when accessible (Bibou-Nakou, 2004; Froese-Germain & Riel, 2012; Kidger et al., 2010; Waller, 2006). For example, drawing from interviews with

secondary school staff on their views of supporting student emotional health and well-being, Kidger et al. (2010) determined that teachers lack time to attend to everything that is needed when supporting student well-being, including increasing one's comprehension and understanding of emotional health through training. It is possible that such detailed connections between poor mental health knowledge and limited training would have also been revealed in studies that focused on post-secondary institutions if the roles and perspectives of instructors were more often considered.

Despite the overwhelming number of poor evaluations of mental health knowledge/confidence, 12 of 42 (29%) survey respondents, as well as 5 of 23 (22%) interview participants *did* evaluate their mental health knowledge as "average", "above average", or "excellent". Unfortunately, the above findings were generally unsupported in this area of study. Positive evaluations of mental health knowledge and confidence were only noted in some studies that focused on K-12 school settings (Cornejo, 2010; Graham et al., 2011; Reupert & Mayberry, 2010). For example, teachers in Graham et al.'s (2011) work felt very confident (34%) or quite confident (37%) in implementing mental health supports for students, as study participant Benito similarly demonstrated when he stated, "I definitely think I have what it takes to address this population…". Likewise, Cornejo's (2010) research into the attitudes of teachers toward their role as mental health promoters uncovered that teachers carry some kind of expertise in supporting students, and thus, can feel confident when addressing students with mental health problems. Reupert and Mayberry's (2010) evaluation of Australian student support projects also revealed that teachers carried ample knowledge about mental health issues. Participation in mental health training and professional development was often documented as that which contributed to positive evaluations in mental health knowledge and confidence (Clarke et al.,

2003; Kidger et al., 2010; Waller et al., 2006). To recall, study participant Domenico also associated his mental health knowledge/confidence with participation in training: "I actually even participated in *Mental Health First Aid,* which I think really boosted my morale and know-how with mental health". It is likely that increased consideration of the instructor's roles and perspectives in relation to post-secondary mental health would have revealed greater occurrences of instructors carrying mental health knowledge and confidence.

Of note, 2 interview participants evaluated their knowledge positively, but then reported lacking confidence, specifically when supporting students with mental health problems. To this researcher's knowledge, beliefs of carrying knowledge, but lacking confidence in relation to student mental health is a finding yet to be reported in any other study, whether drawing from K-12 or post-secondary school settings. This outcome may be partially due to the limited number of qualitative studies that use ethnographic techniques in this field of research, which "…provide opportunities for researchers to try to elicit the perceptions, meanings, and experiences of participants and provide rich descriptions of them" (Williamson, 2006, p. 89). In other words, with little inquiry through qualitative ethnography, understanding the intricacies of or relationship between knowledge and confidence can be difficult.

5.2.1 An overall poor evaluation of mental health knowledge/confidence. Findings suggest that an instructor's response to student mental health can depend on their perceived efficacy in this area, or more specifically, their knowledge and confidence in mental health. Unfortunately, most instructors reported that they did not feel efficacious in promoting or supporting the mental health of students. Although not drawing from the reports of post-secondary instructors, other studies appear to confirm that instructors do not carry ample knowledge and confidence in relation to student mental health (CACUSS & CMHA, 2014; Field

et al., 2006; Hanlon, 2012; MacKean, 2011; Martin, 2005; Mowbray & Megivern, 1999; Quinn et al., 2009; Sharp et al., 2006; Tinklin et al., 2005; UMCMHS, 2014). Even though college and university teaching faculty have increased their awareness of student mental health, it seems that they are limited in related knowledge, which can consequently decrease their confidence in addressing students with a mental health problem or illness. It is understood that post-secondary instructors are not expected to carry specialized knowledge in mental health. That said, with little mental health knowledge or confidence, it seems impractical to expect that instructors can or will naturally assume a supportive role when it comes to student mental health, or that instructors can be easily included into whole-school approaches of support (UMCMHS, 2014). However, to respond to the increased demands placed on post-secondary institutions to better address student mental health, the mobilization of faculty and staff mental health knowledge seems important.

Although teaching faculty are not generally expected to carry mental health knowledge/confidence, it is still surprising that 30 of 42 (71%) survey respondents and 16 of 23 (70%) interview participants evaluated their knowledge and confidence in mental health poorly when taking into consideration the streamed preparatory department/program with which they are affiliated. To explain, in sometimes working with students from "unconventional" or "challenging" backgrounds, including those that may have a mental health problem or illness, it is possible that instructors have acquired some knowledge/confidence on emotional well-being. However, this was generally not the case with study participants. *Teaching experience* is a demographic variable that may have contributed to participants' evaluation of their mental health knowledge/confidence as poor. It is undoubtable that diverse experiences and understandings are gained as instructors increase their years in teaching. In this case, perhaps more years of teaching experience is necessary to acquire ample and relevant knowledge/confidence in student mental

health and well-being. However, a majority of study participants did not carry many years of experience. To recall from Table 3, 17 of 42 (40%) survey respondents and 13 of 23 (57%) interview participants carried only 0-5 years of teaching experience. As a result, it is possible that limited years in teaching experience contributed to some study participants' poor evaluation of mental health knowledge/confidence.

Other researchers have confirmed the above-noted possibility. For example, Quinn et al.'s (2009) research on mental health in higher education revealed that greater teaching experience would better faculty's response to students with mental health needs. Likewise, in support of experiential knowledge, a participant in Ekornes et al.'s (2012) study on Norwegian K-12 teachers as mental health promoters mentioned the following: "the more years you work, the more competence [in mental health] you get. You see things and feel that there *is* something" (p. 296). Instructors' satisfaction in their understanding of students with mental health problems or illnesses can strengthen as they gain practical experience with this population.

At the same time and although fewer in number, it seems important to note that 12 of 42 (29%) survey respondents, as well as 5 of 23 (22%) interview participants *did* evaluate their mental health knowledge as "average", "above average", or "excellent". In carting greater opportunities to encounter students in "troubled" circumstances, the experiences gained teaching in the subject academic department/program can likely account for the few instructors who reported that they carried ample mental health knowledge/confidence, compared to other related studies where such reports were scarce. Like with most participants' poor evaluations of mental health knowledge/confidence, *teaching experience* may have also contributed to some participants' positive evaluations of their mental health knowledge/confidence. In other words, instructors who evaluated their mental health knowledge/confidence as "average", "above

average", or "excellent" were often those who carried more than 5 years of teaching experience, such as Benito or Domenico. Other than program affiliation or teaching experience, *teaching subjects* may have also contributed to participants' evaluation of mental health knowledge as "average", "above average", or "excellent". Specifically, such evaluations sometimes came from those, such as Ercole, Romia, and Zaira, who teach/taught preparatory courses where student mental health and well-being can take up a larger component of the curriculum.

5.2.2 Mental health training as a determinant of knowledge/confidence. Findings suggest that participation in mental health training can mediate an instructor's perceived knowledge and confidence in the area of mental health. Specifically, it appears that participation in related professional development can increase instructors' understanding and preparedness when addressing student mental health concerns. Training and professional development has been identified as fundamental when referring to student mental health: "…sufficient training of key staff is critical to improving school-based mental health and social services" (Brener et al., 2007, p. 498). Training and professional development is particularly beneficial for the development of knowledge and confidence in faculty and staff (CACUSS & CMHA, 2014; Kitzrow, 2003; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; UMCMHS, 2014). For example, instructors can better identify signs of mental health problems and execute relevant strategies of support as a result of training and professional development (Frado, 1993; Hanlon, 2012; Leigh et al., 2009; Silverman & Glick, 2010; Stone et al., 2000). Stone et al.'s (2000) insights into mental health care on college campuses led to the conclusion that advanced training generated a staff who felt prepared and well-educated. Particularly, they determined that training on "the basics" of the DSM can enable instructors to better identify mental health problems in students (Stone et al., 2000). Waller's (2006) text, which explored

many aspects of children and adolescent mental health in schools, is a useful training resource that compliments Stone et al.'s (2000) suggestions, as it outlines a simplified version of the DSM.

In addition to "building" knowledge, training can also help to "modify" certain understandings in relation to mental health (Frado, 1993; Kearney & Bates, 2005; Molize College, 2013; Silverman & Glick, 2010). For example, common supportive phrases that are often viewed as beneficial, such as "everything is going to be okay", can actually work to simplify or downplay an experience (Centre for School Mental Health Assistance, 2002, p. 7). The counselling services department at Molize College (2013) outlined a number of recommendations on "what not to practice" through their online, self-training resource:

> [D]o not avoid the situation or pretend nothing is wrong; avoid using unhelpful comments like "pull yourself together"; [and] try not to humour the student by pretending to agree that there isn't a problem if it is clear there is one, [as] the student may not always identify that they have a problem or may not want to acknowledge it. ("Approaching the Student", para. 1-8)

Training as a means to "modify" certain knowledge can also pertain to stigma and stereotypes (CASA, 2014; Froese-Germain and Riel, 2012; Hanlon, 2012; Heyno, 2006; Ontario College Health Association, 2009; Potvin-Boucher et al., 2010). Advocating for increased mental health literacy for post-secondary students, Potvin-Boucher et al. (2010) suggested that the promotion of information resources through training, for example, is effective at de-stigmatizing mental illness. Educators are often identified as a target group in need of anti-stigma and anti-discrimination programs (Reupert & Mayberry, 2007b). Teachers who participated in *MindMatters* (an Australian whole-school approach towards mental health) disclosed that they

"…feel a lot more comfortable with the whole notion now [by] getting some precise information about the different types of illnesses" (Wyn et al., 2000, p. 599). Participation in Canada's training program, *Mental Health First Aid*, has been similarly identified as helpful in reducing stigma at the higher education level (CASA, 2014).

In addition to improving mental health knowledge/confidence, increased training in supporting the mental health and well-being of students can also help alleviate instructor "burnout" (Cornejo, 2010). After all, the overwhelming feelings instructors can experience in response to student emotional difficulties can be partially due to their sense of efficacy, or a lack thereof (Roeser & Midgely, 1997). Adequate training on student mental health can increase knowledge and confidence or sense of efficacy, which can help reduce some of the pressures associated with supporting students in the classroom (Cornejo, 2010). Ironically, however, reducing instructor burnout associated with supporting students through participation in training often requires instructors to find additional time; an issue that can also contribute to burnout, which is described in greater detail in paragraphs to come.

Other than MHCC's (2011) *Mental Health First Aid*, few formal and relevant mental health training and professional development opportunities are currently executed for faculty and staff in Ontario post-secondary institutions (CASA, 2014; MacKean, 2011; Mental Health Commission of Canada, 2011; UMCMHS, 2014). This is likely the reason why study participants, such as Benito or Domenico, did not reference any training initiatives other than *Mental Health First Aid*. Indeed, some institutions may carry their own mental health training opportunities. For example, inspired by MHCC's (2011) *Mental Health First Aid* training, "[The University of] Guelph has developed its own… version that ranges from a one-hour session for faculty, focusing on warning signs and how to refer, to a full-day training…" (Hanlon, 2012, p.

4). However, not being nationally disseminated, such training initiatives often remain discreet, informal, and inconsistent. On another note, several of the few that exist may limit their breadth of focus on mental health (Frado, 1993; Kearney & Bates, 2005; Lightfoot & Bines, 2000; Molize College, 2013; Silverman & Glick, 2010; Stone et al., 2000). It has been reported that little is addressed and subsequently gained through formal educational training on mental health (Ekornes et al., 2012). As Whitley et al. (2012) suggested, mental health training is often provided through "one-off" workshops that communicate general facts about mental illnesses.

It was somewhat surprising that the subject streamed preparatory department/program was not represented as developing, offering, or promoting a greater number of training initiatives to improve instructor knowledge/confidence in mental health, especially for instructors of preparatory courses. With so few training initiatives, it can be anticipated that instructors would evaluate their mental health knowledge/confidence as poor, or that mental health stigma/stereotype would emerge in their discourses. *Teaching experience* is a demographic variable that may have played a role in instructors' acquisition of mental health knowledge/confidence through participation in relevant training. To explain, despite awareness of student mental health in general, it is possible that instructors' familiarity with any existing mental health training initiatives, such as *Mental Health First Aid*, and their subsequent participation to improve mental health knowledge/confidence, depends on greater years of experience teaching within an institution. This may help explain why study participants who carried more than 5 years of teaching experience, such as Benito or Domenico, reported participating in training more than those with fewer years in teaching experience. Unfortunately, 17 of 42 (40%) survey respondents and 13 of 23 (57%) interview participants carried only 0-5

years of teaching experience, which can mean that instructors were less likely to know of or participate in mental health professional development initiatives.

Another challenge to consider here is the limited expectations of post-secondary teaching faculty to partake in opportunities of professional development in the first place, regardless of program affiliation or teaching experience. In other words, even when/if exceptional training opportunities are established or recognized, dissemination or acquisition of mental health education is not assured as post-secondary school instruction does not technically require that instructors engage in training. That said, unless presented as mandatory or strongly encouraged through an overarching whole-school approach/system of care framework, mental health professional development and training becomes situated as voluntary or optional, whereby willing or interested instructors are those who likely participate. Consequently, individuals who participate are more likely to carry increased knowledge and confidence in relation to student mental health. Furthermore, these individuals are also more likely to continue such participation and increase their knowledge/confidence as they may come to recognize how and why student mental health is important.

5.2.3 Issues with funding and time in relation to mental health training. Findings suggest that limited time and funding are potential reasons why most universities and colleges offer few training and professional development opportunities in the areas of student mental health. Without funding, the development of any initiatives intended to support student mental health seems inconceivable (Brener et al., 2007; Browne et al., 2004; Burns & Hoagwood, 2002; CASA, 2014; Cavalheiro et al., 2012; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Ontario College Health Association, 2009). Some post-secondary institutions, such as Molize College and George Brown College, have been

fortunate enough to receive financial support through Ontario's Mental Health Innovation Fund, which has fueled the implementation of training and professional development (Cavalheiro et al., 2012; Ministry of Training, Colleges and Universities, 2014; Supporting Student Success, 2014). Accessing the funds to develop, implement, or improve campus-based training is a challenging task when resource cutbacks continue to plague education systems (Brener et al., 2007; Burns & Hoagwood, 2002; CASA, 2014; Cavalheiro et al., 2012; Eells & Rando, 2010; Froese-Germain & Riel, 2012; Kitzrow, 2003; Lunau, 2012; Ontario College Health Association, 2009). Moreover, even if accessed, funding allocated exclusively to resourcing mental health professional development and training does not always take place (MacKean, 2011). Little evidence suggests that funds are pulled from other areas when resources for mental health are in need, such as training for faculty and staff (CASA, 2014). To compensate for limited or poorly distributed funding for professional development in mental health, most universities and colleges, including Molize, offer online, self-training resources for instructors to access (Centre for School Mental Health Assistance, 2002; Children's Mental Health Ontario, 2011; Martin, 2010; Molize College, 2013; Santor et al., 2009).

Difficulties in finding the time to participate in any existing mental health training, whether in-person or online, can also be experienced (Cornejo, 2010; Graham et al., 2011; Han & Weiss, 2005; Kidger et al., 2010; Tinklin et al., 2005). Post-secondary instructors, or educators in general, undoubtedly face demanding workloads (Patton et al., 2000; Wyn et al., 2000). According to Patton et al. (2000), "more and more is being expected of schools…[and] in turn, teachers' work has intensified. Not only are they working with young people whose needs are complex and diverse, but also the demands, expectations, and workloads of teachers have increased" (p. 590-91). Consequently, time restrictions can limit instructors' ability to engage in

student mental health, including participation in relevant training. Most in-person training and professional development opportunities, such as *Mental Health First Aid,* are offered only one or two times in each academic year (Molize College, 2013), restricting instructors' ability to easily participate. Participation in training and professional development can present as an additional "burden", potentially contributing to burnout (Cornejo, 2010; Graham et al., 2011; Kidger et al., 2010). Specifically, instructors can be at a higher risk for stress and burnout when dealing with disruptive student behaviours, such as those that can result from mental health problems (Evers, Tomic, & Brouwers, 2004). When reaching the point of burnout, they may invest less effort in their employment, which includes participation in any kind of professional development (Han & Weiss, 2005).

It was unsurprising that funding presented as an issue in the development of training initiatives to increase instructor mental health knowledge/confidence. Limited funding is a possible reason as to why the streamed preparatory program in particular, which prides itself in supporting student success and well-being, was represented as unable to develop, offer, or promote many relevant professional development initiatives; why study participants, such as Lissandra, believed that there are few initiatives developed to help "coach" or "guide" instructors on how to support student well-being. Furthermore, it was also expected that limited time presented as a barrier for some instructors to participate in existing mental health training. *Employment designation* may have determined whether or not instructors reported having the time to participate in training. Although professional development at the post-secondary level is an option offered to all faculty and staff, full-time instructors are actually allotted time to participate in such initiatives (Algonquin College, 2014; University of Toronto, 2014). On the other hand, partial-load instructors are not, which means that reserving additional time for

participation in training is completely voluntary. To recall, 22 of 42 (54%) survey respondents and 11 of 23 (48%) interview participants were employed as full-time, while 20 of 42 (48%) survey respondents and 12 of 23 (52%) interview participants were employed as partial-load. With approximately half of the participant sample employed as partial-load, the few accounts of participation in mental health professional development and training can be anticipated.

Once more, the limited expectations placed on post-secondary teaching faculty to partake in opportunities of professional development can be a concern, which in this case, is regardless of employment designation. In other words, even when additional time is allocated for full-time instructors to participate in training, or even if additional time were given to partial-load, part-time, or sessional instructors to participate in training, dissemination or acquisition of mental health education cannot be assured as post-secondary school instruction does not formally require that instructors engage in any professional development. In their current state, training initiatives remain primarily occupied by instructors who take advantage of or can generate additional time for participation in this regard. Those few who do participate are more likely to improve their knowledge and confidence in relation to student mental health.

5.3 Responsibilities in Supporting the Mental Health and Well-Being of Students

Study data revealed that 13 of 42 (31%) survey respondents and 7 of 23 (30%) interview participants shared confusions regarding the responsibilities and practices of student support services departments, or more specifically, of the individuals who operate within these departments. Such confusions presented as a unique finding in this research area, which again, is likely due to the few studies that have explored the perspectives of post-secondary instructors in relation to student mental health. Nonetheless, some researchers have more broadly documented similar confusions surrounding the responsibilities and/or practices of student support services

departments in post-secondary institutions (CACUSS & CMHA, 2014; CMHA, 2014a; Frado, 1993; Hanlon, 2012; MacKean, 2011; Kitzrow, 2003). Frado's (1993) evaluation of Canadian college and university student mental health accommodations exposed general ambiguity with respect to the responsibilities of mental health departments and personnel when handling student psychiatric concerns. Over twenty years later, evidence still suggests that ambiguity prevails regarding the responsibilities of mental health professionals or student support services departments in general, as study participant Mia expressed when she outlined the discrepancies between counselling, disability, and special needs services. MacKean's (2011) recent evaluation of mental health in Canadian post-secondary institutions also revealed that students and faculty can be unclear of where or through whom mental health services are provided, which they determined is likely due to institutions "lumping" together student services in general.

CMHA (2014a) noted that the development of their guide for students with psychiatric disabilities was partially influenced by student uncertainties of who can help them and how while attending college and university. The Association revealed that without a clear understanding of who can offer support and how, students may refrain from disclosing a concern, and therefore, remain unidentified and unsupported (CMHA, 2014a). A similar objective was noted in the systemic guide for post-secondary mental health in Canada developed by CACUSS and CMHA (2014). Specifically, potential shortcomings of the services offered by mental health professionals were implied, such as undefined or isolated service provision, practice inconsistencies, and dated initiatives (CACUSS & CMHA, 2014).

Drawing directly from the reports of post-secondary students with a mental health problem or illness, Martin (2010) referred to a student's interactions with a counsellor as a way to question the quality of practices employed by counselling service departments in particular.

As a participant in her study claimed, “I found the consultation very disappointing…I nearly cried when the lady I saw demanded to know how depression could impact on my studies. The experience was really undermining” (Martin, 2010, p. 269). To recall, study participant Kara reported a similar experience, who was also unimpressed with the way one of her students was treated while at the counselling services department. Kitzrow (2003) also revealed some issues with the quality of practices associated with counselling service departments during her review of college mental health. Specifically, she indicated that counselling centres often promote varied and informal procedures when conducting assessments, planning long-term interventions, or ensuring follow-up visitations (Kitzrow, 2003).

Studies that focused on K-12 school settings provided more detailed information on educators experiencing confusion over the responsibilities and practices of mental health professionals and student support services overall (Anderson et al., 2007; Bibou-Nakou, 2004; Brener et al., 2007). Through their examination of Australian K-12 teachers’ opinions regarding school psychologists, Anderson et al. (2007) determined that teachers are unclear of the role psychologists play in supporting students, specifically when practicing inclusivity. They expressed uncertainty in how student assessments and consultations provided by psychologists work to support students (Anderson et al., 2007). Bibou-Nakou (2004) drew similar conclusions, as her focus group discussions with primary school teachers in Greece revealed that 22% of teachers were unclear about what to expect from “other” school-based mental health professionals when it comes to student support. Perhaps increased insight into the roles and perspectives of higher education instructors would have revealed more detailed accounts of instructor confusions regarding the responsibilities and practices of student support services

departments and their affiliated professionals, as it did in those that documented the viewpoints of K-12 educators, as well as in this study.

Study data also revealed confusions or ambiguity surrounding the responsibilities of instructors in relation to student mental health. On the one hand, 24 of 42 (57%) survey respondents and 13 of 23 (57%) interview participants determined that instructors are *not* partially responsible in promoting or supporting student mental health, placing this responsibility rather on mental health professionals or student support services departments in general. Indeed, 22 of the 24 (92%) survey respondents and 10 of the 13 (77%) interview participants noted above exempted instructors of preparatory courses from this perception, as they outlined that these courses typically require instructors to address student well-being in some way. Furthermore, it is worthwhile noting that 4 of 42 (1%) study participants indicated that the institution in general should not carry responsibility over the mental health of students, let alone instructors or mental health professionals. On the other hand, 17 of 42 (40%) survey respondents and 10 of 23 (43%) interview participants indicated that instructors *are* partially responsible in promoting or supporting the mental health of students, often identifying themselves as "first-line responders" and/or "educated mediators" when encountering students with a mental health problem or illness.

Due to limited investigation into student mental health from the instructor's perspective, little is known about how instructors view their responsibilities in this regard. In other words, the dichotomy in relation to instructor responsibilities as revealed in this study cannot be confirmed by other findings in this area of research. However, discussions regarding instructor responsibilities more broadly were still noted. Interestingly, these discussions also reflected somewhat of a dichotomy; that is, a representation of post-secondary instructors who either

assume some responsibility in supporting the mental health and well-being of students or who defer this responsibility elsewhere.

Most studies determined that post-secondary instructors *do not* often assume responsibility in supporting students with mental health problems or illnesses, typically placing the onus on mental health professionals or student support services departments instead, which supported the responses of 57% survey and interview participants respectively (Frado, 1993; Kadison & DiGeronimo, 2004; Kitzrow, 1993; MacKean, 2011; Mowbray & Megivern, 1999; Quinn et al., 2009; Sharp et al., 2006; Stone et al., 2000). Reports from post-secondary students with a mental illness in Quinn et al.'s (2009) study demonstrated that instructors rarely assume a role in supporting the mental health and well-being of students, as study participant Juliano implied through his interview response: "It is not highlighted anywhere in our job duties...Our duty and time is to be concerned with just doing our 'regular' job, rather than supporting". Likewise, Kadison and DiGeronimo's (2004) exploration of mental health in American colleges revealed that post-secondary instructors do not assume responsibility in supporting the mental health of students, pointing to ethical/legal restrictions as a potential reason. MacKean's (2011) environmental and literature review of student mental health and well-being in Canadian higher education settings outlined that researchers and institutions focus considerably greater on the role of mental health professionals, representing these individuals as the primary and sometimes only support providers for students with mental health problems, rather than instructors. As such, the responsibilities instructors may carry in relation to student mental health and how these can be improved are often undocumented or unknown (MacKean, 2011).

In drawing more often from teacher perspectives, studies that have investigated mental health in K-12 contexts provide greater detail of educators not assuming any responsibility when

it comes to student mental health (Anderson-Butcher, 2006; Kidger et al., 2010; Froese-Germain & Riel, 2012; Graham et al., 2011). Through her examination of the educator's role in identifying and supporting students with mental health problems, Anderson-Butcher (2006) noted that most American K-12 teachers believe their jobs involve just teaching, rather than "case managing" student mental health needs, as similarly revealed by study participant Caprice, who noted "I should not be worrying about student mental health…". Likewise, interviews with British high school teachers in Kidger et al.'s (2012) study demonstrated that "…most [teacher participants] felt that their teaching colleagues…were reluctant to take an interest in the emotional health of their pupils" (p. 926). Responsibility over student mental health was often noted to be deferred to others within the institution (Anderson et al., 2007; Froese-Germain & Riel, 2012; Graham et al., 2011). In Graham et al.'s (2011) study, Australian K-12 teachers directly nominated school-based mental health professionals as supporters of student mental health:

> Teachers moved between recognizing that mental health issues arose in the everyday context of teaching, yet looked primarily to the outside 'experts' to assist them with the issues. A dominant view appeared to be that it is counsellors and specialist support services that are best placed to support mental health-related issues for students. (p. 492)

Seeking "outside expert support" somewhat corresponds to the responses of some study participants, such as Zaira, who indicated that preparatory course instructors assume responsibility over student well-being due to the specialized nature of these courses. Perhaps, increased insight into the roles and perspectives of higher education instructors would have revealed more explicit accounts of instructors not assuming any responsibility over the mental

health and well-being of students, as it did in those that documented the viewpoints of K-12 educators, as well as in this study.

Although not very often, student mental health has also been identified in other studies as not part of an academic institution's responsibility whatsoever, whether at the primary, secondary, or post-secondary level; a finding that paralleled the responses of 3 survey participants and 1 interview participant (Burns & Hoagwood, 2002; Clarke et al., 2003; Field et al., 2006; Frado, 1993; Froese-Germain & Riel, 2012; Graham et al., 2011; Lawson, Quinn, Hardiman, & Miller, 2006; Quinn et al., 2009; Stone et al., 2000). Due to the often piecemeal nature of counselling services in higher education settings, such as the limited number of available therapy sessions, several researchers have determined that "some counselling" is often more disadvantageous than none at all, and thus, suggested that referral to a party outside of school is the better option for students with a mental illness (Frado, 1993; Stone et al., 2000). Although they encouraged the consideration of mental health as an opportunity for expanding the boundaries of school improvement, Lawson and colleagues (2006) demonstrated that it is often thought that "mental health problems are not the school's responsibility; they belong to families and community agencies, [as] schools don't cause mental health problems, and [therefore] teachers are not implicated in their development and maintenance" (p. 295). Likewise, through their proposal of a psychology and school nurse partnership model to address adolescent mental health, Clarke et al. (2003) suggested that even when receiving intervention, students are ultimately responsible for their own mental health; responsible for measuring and monitoring their well-being, as study participant Tazia similarly demonstrated: "Students need to be able to help themselves or get support from their loved ones…"

In response to the increased attention towards mental health in higher education settings, literature that places instructors as partially responsible for student mental health is certainly growing, even though qualitative data gathered from instructors is scarce. Confirming the responses of 17 of 42 (40%) survey respondents and 10 of 23 (43%) interview participants, other works have also identified instructors as "first-line responders" and "educated mediators", or in other words, as partially responsible in supporting the mental health of students (CACUSS & CMHA, 2014; Eichler & Schwartz, 2010; Kitzrow, 2003; Quinn et al., 2009; Schonert-Reischel & Lawlor, 2010; Sharp et al., 2006; Silverman & Glick, 2010; UMCMHS, 2014). Teaching faculty appeared to carry an important role in the systemic guide to post-secondary mental health in Canada proposed by CACUSS and CAMHA (2014). The guide outlined that teaching faculty is partially responsible in maintaining and enhancing student mental health, or more specifically, that the institution carries "built in accountabilities for staff and faculty to support student mental health" (CACUSS &CMHA, 2014, p. 8). Likewise, Kitzrow's (2003) evaluation of mental health in American colleges revealed that rather than being the sole responsibility of counselling centres, mental health is an important concern for everyone in higher education settings, including teaching faculty, as study participant Abrianna suggested: "we should be expected to support student mental health concerns as mentors, as educators…".

Quinn et al. (2009) remarked that post-secondary instructors represent "the first port of call" for students seeking mental health support, who if necessary, can "signpost" to additional, specialized help, as study participant Domenico implied: "It is good to be informed to recognize these issues, and then to know where to refer". Within their mental health strategy document, the University of Manitoba indicated that instructors are at the forefront in ensuring that post-secondary institutions reflect a committed, caring, responsive, supportive, and resourceful

community when it comes to mental health (UMCMHS, 2014). Specifically, it was outlined that instructors can respond to the mental health needs of students by increasing/extending mental health support initiatives (UMCMHS, 2014). Silverman and Glick (2010) similarly highlighted the responsibilities of instructors in their examination of mental health care in British college communities. They determined that instructors are able to assist students with a mental health problem or illness by communicating with a student when a concern is presented, assessing the ways that a student can be supported, and facilitating appropriate intervention, whether that entails employing initiatives at the classroom level or redirecting students to other campus-based support (Silverman & Glick, 2010).

Studies that focused on K-12 school contexts have similarly identified educators that assume partial responsibility over student mental health, and in these cases, data drew from the reports of educators (Han & Weiss, 2005; Leigh et al., 2009; Schonert-Reischel & Lawlor, 2010; Waller et al., 2006). Drawing from an evaluation of American K-12 school health program implementation, Han and Weiss (2005) demonstrated that teachers are ultimately responsible in delivering support in the classroom, or as study participant Valentina suggested, “I should be responsible and able to support them first as the leader in the classroom…”. Through their discussion on American K-12 teacher roles in fostering student mental health, Waller and colleagues (2006) acknowledged the educator as the primary source of support in schools, in that they can recognize students with a potential problem, refer students to support services, and ultimately participate in the monitoring of their students’ well-being. Schonert-Reischel and Lawlor (2010) made similar acknowledgements when reporting on how Canadian K-12 educators can be responsible for supporting the mental health of students. Specifically, through their evaluation of *Mindfulness-Based Education* in support of adolescent well-being, Schonert-

Reischel and Lawlor (2010) revealed that teachers assume the responsibility of implementing components of this wider school program 75% of the time. Perhaps increased insight into the roles and perspectives of higher education instructors would have revealed more explicit accounts of instructors assuming responsibility over the mental health and well-being of students, as it did in those that documented the viewpoints of K-12 educators, as well as in this study; albeit with the understanding that greater ethical and legal expectations surrounding responsibility and student support are placed upon K-12 teachers compared to their college and university counterparts.

Study data revealed that 9 of the 10 (90%) interview participants who reported assuming partial responsibility in supporting the mental health of students indicated that they were uncertain of what responsibilities they *can* or *should* assume, as Benito noted when he identified his initial confusions in handling students who submit late assignments when/if experiencing a mental health concern. Similar uncertainty has been documented in this research area (Eells & Rando, 2010; Field et al., 2006; Hanlon, 2014; Kadison & DiGeronimo, 2004). Through interviews with post-secondary institution administrators and some affiliated professors for the publication of her article on university mental health in *University Magazine*, Hanlon (2012) concluded that instructors carry uncertainties surrounding their responsibilities in supporting students with mental health problems. As a professor at Queen's University reported, "we need to know our responsibilities and what we should and should not be doing" (Hanlon, 2012, p. 4). In promoting a widespread mental health model for use in post-secondary institutions, Field et al. (2006) determined that faculty can be uncomfortable if unsure of their responsibilities in supporting students. According to Eells and Rando (2010), there is some confusion in Institutions of Higher Education (IHE) on how to handle cases where student mental health is of

concern. Specifically, IHE circles (faculty and staff) can carry "confusion with what laws apply to the records of students receiving mental health services" (Eells & Rando, 2010, p. 51). Likewise, Kadison and DiGeronimo (2004) identified that in response to limited ethical and legal protocols, instructors in American colleges can hold little understanding towards their roles and responsibilities over student mental health. Study participants, such as Kara, Benito, and Ercole, demonstrated similar concerns with what to do and how to do it when addressing students' mental health, and as a result, they often outlined the need for guidelines.

Educator uncertainty regarding their responsibilities in supporting the mental health of students has been captured more often in studies that drew data from K-12 contexts. According to Whitley et al.'s (2012) literature review, most Canadian K-12 educators are unclear of their overall responsibilities in the prevention, identification, and intervention of mental health difficulties in students. Australian K-12 teachers in Graham and colleagues' (2011) work also expressed conflict in determining what to do as a mental health support provider. Their narratives demonstrated uncertainty in what it is that teachers do to support student mental health, versus what it is that others are responsible for instead (Graham et al., 2011). Drawing from one of their case studies in British primary school settings, Altschuler et al. (1999) recounted a story where a teacher was ambivalent about supporting a student whose mother was dying: "The teacher found herself unsure of where to draw the boundary" (p. 28). Through another case study, Altschuler and colleagues (1999) revealed that some teachers even refrain from supporting students due to the fear of becoming too emotionally involved. These experiences speak to those of study participant Ercole, as he stated "…how do I know if I cross the line…" when supporting students with mental health problems. It is possible that increased insight into the roles and perspectives of higher education instructors would have revealed richer

understandings of the uncertainties they carry when assuming responsibility over the mental health of students, as it did in those that documented the viewpoints of K-12 educators, as well as in this study.

5.3.1 Ambiguities surrounding responsibilities over the mental health and well-being of students. Findings suggest that a collective agreement regarding who is responsible for the mental health and well-being of university and college students is certainly lacking. Specifically, participants seemed to question the responsibilities and practices of student support services departments and their affiliated professionals. Furthermore, competing viewpoints were observed regarding instructor responsibilities in supporting the mental health of students; some believed instructors *are* partially responsible, whereas others believed they *are not*. It was anticipated that confusions prevail surrounding the responsibilities and practices of mental health professionals or of student support services departments more generally. Shifting viewpoints regarding the "newfound" role of post-secondary institutions in supporting the mental health of students likely contributes to the undefined or unclear responsibilities of student support services departments, or more specifically, of mental health professionals (Eells & Rando, 2010; Kitzrow, 2003). To explain, although traditionally represented as core mental health care providers, even at the higher education level, mental health professionals and their responsibilities have been redefined over the last two decades, and will likely continue to be as mental health penetrates further into campus culture (CASA, 2014; MacKean, 2011). In response to such shifts, the responsibilities of mental health professionals in higher education settings in supporting the mental health of students can remain unclear, under-developed, or unauthorized.

Departments or professionals offering support for students, whether or not for mental health concerns, are often unique to hosting institutions; to their particular structural or

administrative arrangements and operations (Eells & Rando, 2010). For example, psychologists and social workers are typically responsible for supporting students with mental health problems, but in some institutions, this is reserved for counsellors, while psychologists/social workers assume more administrative-like duties (Brener et al., 2007). In many cases, few psychologists are hired due to financial constraints, which can mean heavier workloads and increased delegation of duties to other staff (Kitzrow, 2003). When staff members, such as psychologists or social workers, take on too many responsibilities, the quality of their practices can be challenged (CASA, 2014). In considering all of the above, understanding who can support students with mental health problems, and how, can be difficult. In addition to "what they do" or "how they do it", other aspects surrounding the efforts of mental health professionals or student support services departments also lack in clarity, such as if their services align with student and community needs or with wider mental health policies and systems (CACUSS & CMHA, 2014).

It is similarly unsurprising that instructors can carry uncertainties regarding their own responsibilities over the emotional well-being of students. More so than those of mental health professionals or student support services departments, instructors' responsibilities have been poorly defined, clarified, or communicated, whether through relevant theory/research or in practice at the institution level. As detailed in the *Problem Statement*, instructors are often governed by an institutional framework that holds them accountable for providing students with quality education and opportunities for economic development; not for supporting the mental health of students (Kadison & DiGeronimo, 2004; Lunau, 2012). Conversely, a more inclusive perspective situates post-secondary instructors as part of a broader institutional mental health care initiative or system (CACUSS & CMHA, 2014; CASA, 2014; MacKean, 2011; Ontario College Health Association, 2009; UMCMHS, 2014). With increased attention towards post-

secondary student mental health over the last ten years, the more inclusive perspective is gradually overcoming the traditional one.

Nonetheless, Canadian colleges and universities continue to demonstrate some tension between the two ways of thinking noted in the above paragraph. This tension can work to complicate teaching faculty's understanding and/or assumption of responsibilities over the well-being of students, even if or when they are affiliated with a department or academic program that is sensitive to student well-being. As a result, instructors who may carry a more "traditional" perspective, for example, are likely to situate themselves as predominately responsible for governing and nurturing academics, and thus, potentially place the responsibility of supporting the mental health of students on school-based mental health professionals or parties located outside of the institution (Kadison & DiGeronimo, 2004; Lunau, 2012; MacKean, 2011). On the other hand, if holding an inclusive perspective, instructors may be more receptive in assuming some responsibility over the mental health of students even if unclear of what such responsibility entails (Ontario College Health Association, 2009). In sum, conflicting or shifting perspectives towards the expectations of post-secondary institutions, student support services departments, mental health professionals, or instructors in relation to student mental health can determine whether or not instructors assume any responsibility in supporting the mental health of students, as well as what is involved if assumed (CACUSS & CMHA, 2014; Eells & Rando, 2010; Frado, 1993; Stone et al., 2000).

Participant demographic variables did not seemingly contribute to instructors' ambiguity surrounding responsibility in supporting the mental health of students, whether in relation to their own responsibilities or to those of mental health professionals and the institution in general. For example, the *teaching experience*, *employment designation*, or *teaching subjects* of instructors

who deferred responsibility in supporting students were not any similar to or different from the *teaching experience*, *employment designation*, or *teaching subjects* of instructors who assumed some responsibility. Little influence of demographics here is likely due to the dichotomous or ambiguous perceptions held towards faculty and staff responsibilities in supporting the mental health and well-being of students. That said, however, *teaching subjects* did play a role in one way. Specifically, regardless of how they characterized their own responsibilities or those of other staff members, participants claimed that instructors who teach/taught preparatory courses do carry partial responsibility in supporting the well-being of students, considering that such courses are designed to somewhat promote and support student mental health and well-being.

5.3.2 Mental health knowledge/confidence as a determinant of responsibilities.

Findings suggest that ambiguities and uncertainties regarding the responsibility of faculty and staff in supporting the mental health of students can draw from a number of determinants, working separately from or in combination with one another. The mental health knowledge/confidence of instructors appears as one potential determinant. Post-secondary faculty and staff undertaking any responsibility in supporting students with mental health problems, whether or not identified through policy, can depend on the quantity or quality of related knowledge they carry (UMCMHS, 2014). Consequently, instructors who feel knowledgeable/confident may also feel partially responsible in supporting the mental health of students. In cases where instructors assume some responsibility, or take on the role of "first-line responder" or "educated mediator", they may still feel uncertain with what such responsibility entails when carrying limited knowledge/confidence in mental health. On the other hand, instructors who feel that they lack knowledge/confidence may defer responsibility to someone who they believe carries greater knowledge/confidence, such as mental health professionals

operating through counseling services departments, as study participant Caprice noted: "[Support for student mental health] is for professionals, a counsellor, advocate, or program coordinator, who have the knowledge…". Unlike instructors, mental health professionals are generally expected to carry knowledge/confidence in mental health. As such, it is understood that some instructors defer responsibility to mental health professionals, even if instructors may carry uncertainties in the responsibilities and practices of these professionals.

As previously noted, instructors do not often perceive themselves as knowledgeable or confident in relation to student mental health, which may discourage them from assuming any responsibility in supporting students with a mental health problem or illness. That said, even if instructor responsibilities were to be clearly outlined and designated, ambiguity and uncertainty can still prevail if their mental health knowledge/confidence is not sufficient. Unfortunately, with limited opportunities for participation in mental health professional development and training, it is likely that instructors will continue feeling unprepared, and therefore, will continue carrying varied beliefs surrounding the responsibilities of faculty and staff over the emotional well-being of students. To recall, instructor *teaching experience* and *teaching subject* were determined as influential to their amount/quality of mental health knowledge/confidence. A more detailed analysis and discussion of instructors' knowledge/confidence in relation to student mental health was held earlier in this chapter.

5.3.3 Time as a determinant of responsibilities. Findings suggest that instructor ambiguity surrounding responsibility in supporting the mental health of students in higher education settings can also stem from concerns with time. Instructors, or educators in general, may refrain from supporting students with mental health problems if responsibility in this regard is considered too time-consuming (Anderson-Butcher, 2006; Anderson et al., 2007; Kidger et al.,

2010; Patton et al., 2000; Reupert & Mayberry, 2010; Schonert-Reischel & Lawlor, 2010). As study participant Juliano reported, “our time is to be concentrated on doing our ‘regular’ job…”. Instructors may be concerned that assuming any additional responsibilities at the institution, such as supporting the emotional well-being of students, will increase their stress levels or contribute to burnout (Cornejo, 2010; Graham et al., 2011; Kidger et al., 2010). In such cases, deferral of this responsibility to other parties can be expected, who instructors may consider are given the time to address student mental health. As implied earlier, however, counseling and/or disability services departments can similarly struggle in finding the time to support the mental health of students, often due to resource cutbacks, which can sometimes affect the quality of their practices (CACUSS & CMHA, 2014; CMHA, 2014a; Frado, 1993; Hanlon, 2012; MacKean, 2011; Kitzrow, 2003).

On the other hand, instructors may believe that assuming responsibility over the well-being of students does not necessarily require additional time; that concern for student mental health can be part of daily instructional time and routines (Eichler & Schwartz, 2010; Kitzrow, 2003; Quinn et al., 2009; Schonert-Reischel & Lawlor, 2010; Sharp et al., 2006; Silverman & Glick, 2010). In this case, the fundamental component in supporting the mental health of students is not the designation of *additional* tasks to the responsibilities of instructors, or educators more broadly, but rather of complementary or commonplace ones (Waller et al., 2006). As study participant Liliana remarked, “it (supporting students) is a given, not added duty”. However, understanding how to make responsibility over the well-being of students complement or fuse with the other “regular” responsibilities of instructors may still take time. Improving instructor knowledge is likely needed to acquire this understanding, which then necessitates greater training or professional development; another aspect that requires time. In other words, it

may take time to attain what is needed to become a "first-line responder/educated mediator" when addressing student mental health and assuming or understanding the associated responsibilities. It was outlined earlier that instructor *employment designation* can influence their time in participating in mental health training. Interestingly, whether instructors were full-time or partial-load did not seem to influence their perspectives on time with respect to their assumption of responsibility over the well-being of students or what this responsibility entails. It appears as though not any demographic variable influenced instructors' beliefs surrounding time in relation to responsibility. In sum, with little clarity on how instructors or mental health professionals are responsible for the mental health of students, understanding if or how much additional time is necessary from these individuals can be a challenge.

5.3.4 Obscure policies as a determinant of responsibilities. Findings suggest that the uncertainties and ambiguities held by instructors can draw from nonexistent/unclear policies in higher education settings that define the accountabilities or responsibilities of faculty and staff; if or how student mental health is supposed to be addressed by individuals in higher education settings. Defining accountability and responsibility specifically entails an understanding of the legal and ethical guidelines associated with supporting students who have a mental health problem or illness. As outlined in the *Problem Statement*, faculty and staff, especially instructors, are not ethically/legally responsible for supporting the mental health of students. According to Hanlon's (2012) exploration of mental health issues in Canadian universities, "although from a legal perspective the university is not held to the same provision of service standards as medical facilities, members of the university who belong to certain professional groups may be held accountable by their accrediting bodies when responding to mental health issues" (p. 2). This understanding does not make it clear whether or not, or when, faculty and staff are accountable

for the mental health and well-being of students. Without clarity in this regard, it seems difficult to determine who is responsible in addressing the mental health needs of students, and how. More specifically, it appears difficult for instructors to know if and how they, as well as mental health professionals, assume responsibility in supporting the mental health of students. Put differently, when faculty and staff responsibilities are unclear or poorly articulated through policy, ambiguity can evolve; hence, the discrepancies between what is versus what is not legally or ethically appropriate when supporting the well-being of students that was often revealed in the discourses of study participants, such as Emiliano, Mia, Kara, Benito, and Ercole.

Lack of clarity in the policies that determine student privacy/confidentiality can also complicate faculty and staff's beliefs surrounding accountability and responsibility over students' mental health. Many professional ethical and legal guidelines state that faculty and staff are sometimes prohibited from accessing confidential information regarding students' mental health, unless it is "proven" that students are in "eminent danger" (Kay, 2010; Kitzrow, 2003). This prohibition includes the transfer of information between institutions, such as from secondary to post-secondary school (Ontario College Health Association, 2009). Evidence suggests that the privacy and autonomy of students is commonly respected in higher education settings (Bower & Schwartz, 2010). Nonetheless, continuous lawsuits related to student suicides and increased sensitivity to community safety and parental expectations have challenged some standards of confidentiality (Bower & Schwartz, 2010; Eells & Rando, 2010; Kitzrow, 2003). As Eells and Rando (2010) stressed, "the increase in complexity of issues students are presenting with at mental health services have increased the pressures on services to alert student affairs, colleagues, and parents if there is any concern regarding risk of harm" (p. 51). This is more often the case in smaller, private colleges where instructors, students, and parents tend to share a close

relationship (Stone et al., 2000). Through their research on working with college and university mental health services, Siggins (2010) revealed that some colleges and universities have appointed a staff member or director who is solely eligible to handle confidential matters. In these circumstances, a student's mental health is kept relatively confidential, but nonetheless "monitored" (Siggins, 2010). Unfortunately, this potential resolution is limited to larger institutions that can afford to maintain such an asset (Siggins, 2010). In response to conflicting and shifting policies surrounding student confidentiality/privacy, the responsibilities of faculty and staff in supporting students can remain unclear.

Academic institutions are seemingly lacking in the development of clear policies when it comes to student mental health more generally, or in other words, not only in relation to faculty and staff accountabilities (Anderson et al., 2007; Bibou-Nakou, 2004; CACUSS & CMHA, 2014; CASA, 2014; Ekornes et al., 2012; Hanlon, 2012; Kidger et al., 2010; MacKean, 2011). As Ekornes et al. (2012) submitted, "…the concept of mental health has long been vaguely defined in school policy documents…" (p. 290). Policy solutions surrounding mental health are lacking at the regional and provincial level, which makes it difficult to expect development or clarity at the institutional level (CASA, 2014). As detailed in the *Introduction*, it has only been approximately ten years since Canadian post-secondary institutions started to seriously consider student mental health and take subsequent action (CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; MacKean, 2011; Ontario College Health Association, 2009). As a result, policy development has likely been gradual or sometimes inconsistent, even in institutions that include academic departments/programs intended to support student success and well-being. Consequently, little is known about how support services in Canadian colleges and universities are organized and facilitated; how services are operationalized to ensure understanding of who

supports who, when, and how (CACUSS & CMHA, 2014; CASA, 2014; Hanlon, 2012; MacKean, 2011). For example, student support services in higher education settings can refer to anything from counselling to career planning, which calls upon the expertise of different professionals. This can be a reason why many professionals work out of departments that are clumped under the title of *student support services*, or why institutions provide different types of support through differently-labeled departments (MacKean, 2011). To recall, both reasons were identified earlier as why instructors sometimes experienced difficulties locating support services for student mental health.

Support for students, including those with a mental illness, can certainly be imagined along an institution's continuum of care; one that can include various faculty and staff (MacKean, 2011). The objective is to ensure that the support continuum is seamless; that services, although complementary, have clearly defined purposes supported by clearly defined policies, whether the services are provided by mental health professionals or instructors. This objective is particularly important if institutions offer academic programs intended to support both the academic and emotional well-being of students. Interestingly, like with most of the factors that represented determinants of responsibilities, demographic variables did not seem to influence participants' understanding of mental health policies, whether in relation to the responsibilities of instructors, mental health professionals, and student support services, or in relation to how institutions address student mental health more broadly.

5.4 Practices that Support the Mental Health and Well-Being of Students

Study data revealed that post-secondary instructors employ a plethora of practices to support the well-being of their students, including the encouragement of student-instructor *conversations* to discuss student well-being in general, identify a potential mental health

problem, or outline initiatives of support available on campus; the *referral* of students to campus student support services departments, such as the counseling or disability centre, for additional/alternative intervention; the facilitation of *accommodations*, whether or not indicated through disability documentation; and the consideration of mental health for *curricular inclusion and instruction*. Due to the limited number of researchers that have investigated the practices employed by instructors to support the mental health of students, findings from this study were rather unique in this regard. As MacKean (2011) confirmed following his literature and environmental scan of mental health and well-being in Canadian colleges and universities, little evidence has been generated about the practices employed by faculty and staff in post-secondary institutions that support students with mental health problems. Nonetheless, although not always drawing from Canadian higher education contexts or directly from the narratives of post-secondary instructors, research in this area of study has broadly noted some of the more common and quintessential practices instructors can employ to support the mental health and well-being of their students; practices that mirror many of those revealed in this study.

Study data revealed that 28 of 42 (67%) survey respondents and 16 of 23 (70%) interview participants reported employing *conversation* as a means of supporting the mental health and well-being of students. Studies have outlined conversation or "communication" more broadly as a valuable tool in supporting the well-being of students, or more specifically, in discussing the general well-being of students or identifying a mental health problem in students (CMHA, 2014a; Molize College, 2013; Quinn et al., 2009; Silverman & Glick, 2010). Molize College's (2013) student support services webpage outlined that instructors can randomly ask a student, who they believe may experience emotional distress, how they are feeling, as this often provides an opportunity for further conversation, and thus, the potential for a mental health concern to be

incidentally addressed. Likewise, Australian primary school teachers in Reupert and Mayberry's study (2006a) highlighted the importance of connecting with their students, such as "chatting" with them "even if just to say hi, how are things going?" (p. 200). In Quinn et al.'s (2009) research, interviews with university students on how they experience mental health support revealed that many lecturers make themselves readily available for students to encourage casual discussions regarding academic progress and potential mental health difficulties, as study participant Aida implied doing when she believes a student's mental health is interfering with their learning. In addition to communication as a means to identify and discuss student mental health concerns, CMHA's (2014a) guide to college and university students with psychiatric disabilities encouraged communication between students and their instructors as a means of becoming more familiar with accessible support initiatives offered on campus, as study participant Marina similarly reported; using conversation to advise students of the more unconventional support initiatives offered on campus.

Aside from the encouragement of informal or casual student-instructor conversations, some have submitted more methodical approaches of engaging students in conversation as a means of supporting their well-being (Hanlon, 2012; Silverman & Glick, 2010). For example, through their exploration of crisis interventions on college campuses, Silverman and Glick (2010) proposed a more formal approach of using discourse to support the mental health of students. Specifically, they recommended a *QPR* approach, which is currently promoted through faculty training initiatives at the University of Guelph (Hanlon, 2012; Silverman & Glick, 2010). The first step is to *Question* the student who is suspected to have a mental health problem through conversation, followed by *Persuasion* and *Referral* (Silverman & Glick, 2010).

Study data revealed that 35 of 42 (83%) survey respondents and 19 of 23 (83%) interview participants reported employing the *referral* as a practice to support the mental health and well-being of students. Of note, 17 interview participants stated that the referral often occurred following a *conversation* with students whereby a mental health concern was disclosed. Referring students specifically to post-secondary staff operating through student support services departments, such as the counselling or disability centre, was a finding well-supported in this area of study (CACUSS & CMHA, 2014; Cornejo, 2010; Frado, 1993; Froese-Germain & Riel, 2012; MacKean, 2011; Quinn et al., 2009; Silverman & Glick, 2010). To recall, in Silverman and Glick's (2010) proposed support strategy (QPR), after *Question*, teachers *Persuade* students with a mental health problem to access support, and thereafter, *Refer* them to onsite resources. Similarly, drawing from student interview responses, Quinn et al. (2009) noted that in being "the first port of call", teachers who acknowledge students with a mental health problem tend to refer these individuals to counselling services for the provision of more appropriate help, as study participant Jolie similarly remarked: "I would try and get them to go see counselling services or the program coordinator who have dealt with these students in the past and more frequently obviously".

Likewise, in their promotion of a systemic approach towards post-secondary student mental health, CACUSS and CMHA (2014) indicated that a primary role of faculty and staff in supporting students with mental health problems is referring these individuals to counselling for individual or group psychotherapy. While discussing strategies to promote psychological resilience in K-12 classrooms, Waller et al. (2006) determined that following suspicion of a mental health problem, teachers' first thought might be to refer a student to a counsellor,

psychologist, or social worker, as study participant Frederico similarly implied; referring students elsewhere "…after we discuss their circumstances and I realize something is wrong".

Study data revealed that 40 of 42 (95%) survey respondents and all 23 (100%) interview participants reported employing *accommodations* to support the mental health and well-being of students. Like with the referral, the promotion of accommodations is another finding that seemed to converge with data revealed in other relevant studies (Bower & Schwartz, 2010; CMHA, 2014a; Frado, 1993; MacKean, 2011; Martin, 2010; Quinn et al., 2009; Reupert & Mayberry, 2007a; Silverman & Glick, 2010). As 26 of 42 (62%) survey respondents and 22 of 23 (96%) interview participants reported, instructors altering academic tasks and expectations through accommodations was also documented in other relevant works (Frado, 1993; Kearney & Bates, 2005; Martin, 2010; Reupert & Mayberry, 2007a). For example, in Martin's (2010) study, university students experiencing a mental illness claimed that their professors offered deadline extensions and altered assessment criteria when needed, as study participants Lissandra and Montrelle similarly demonstrated. K-12 teacher participants in Reupert and Mayberry's (2007a) research also expressed academic task and expectation accommodations for students who experience the emotional impacts of having a parent with a mental illness:

> [She] gave an extension for a piece of work, but because she did not want the student to get behind, she negotiated with the student what aspect/s of the project she was able to do, within a reasonable deadline. Along with the student, the teacher departmentalized larger, seemingly insurmountable tasks into smaller, more manageable tasks and at the same time gave her some control over her situation, at school at least. (p. 200)

In addition to altering academic tasks and expectations, a couple (1%) of interview participants indicated that they accommodate students by modifying the learning space. Other

researchers have acknowledged similar types of "spatial" accommodations (Anderson et al., 2007; Bower & Schwartz, 2010; CMHA, 2014a; Frado, 1993; Martin, 2010; Quinn et al., 2009; Silverman & Glick, 2010). Bower and Schwartz (2010) advocated that supporting the mental health of students in college settings entails the provision of testing environments with minimal distractions; therefore, allowing students with a mental health concern to complete such tasks in spaces where less students are present, i.e., outside of the classroom. Likewise, students with mental health problems interviewed in Martin's (2010) study reported that their instructors typically offered changed exam venues. The above accounts are comparable to those of study participant Montrelle, who reportedly uses the college's Test Centre for students to complete testing tasks in a quiet location. In outlining the different accommodations for college and university students with a mental illness, Frado (1993) recommended "modifications in seating arrangements [such as] sitting near the door to leave the classroom for breaks" (p. 13). Study participant Benito reported a similar type of accommodation when he mentioned separating the desks in one of his classrooms to accommodate a student with social anxiety. Other researchers have added that when implementing classroom space changes, such as seating a student next to the exit for easier access to occasional breaks, students should be aware of when to re-enter the classroom or how to attain any lecture notes missed when exiting (Quinn et al., 2009; Silverman & Glick, 2010). Some researchers have even suggested reducing the number of students per classroom as an (alternative) option; indeed a commendable one, yet unlikely to materialize due to an array of wider institutional factors (Anderson et al., 2007).

As revealed in 9 of 23 (39%) interview discussions, increasing access to course-related material has also been documented in the research area as an accommodation that instructors can employ to support student well-being (CMHA, 2014a; Frado, 1993; Quinn et al., 2009). This

process can entail the provision of course materials, such as textbooks, syllabi, rubrics, task descriptions, or reading lists, ahead of time in an attempt to relieve the pressures associated with the beginning of academic semesters (Frado, 1993; Quinn et al., 2009). Additionally, it has also been noted that increasing access to course-related material can include making documents, like textbooks and syllabi, available in alternative (non-print) formats, such as electronic versions (CMHA, 2014a; Frado, 1993), similar to study participant Umberto's approach of posting lecture notes on his course web-based learning management system.

Of note, 26 of the 40 (65%) survey respondents and 13 of the 23 (57%) interview participants who reported employing accommodations indicated that they did so even without notification through disability documentation. The promotion of accommodations in general is typically prompted by disability documentation (CMHA, 2014a; Ontario College Health Association, 2009). In other words, instructors are expected to provide students who experience a mental health concern with certain accommodations if outlined through a disability document. However, accommodations can still be offered to unidentified students at the discretion or choice of instructors, as some study participants reported, such as Lissandra. In their guide to university and college students, CMHA (2014a) advised that students with a mental health problem can communicate and work with their instructors to implement certain accommodations even if they do not have a disability document or if they are still waiting to be identified in order to receive official documentation. Other than CMHA's (2014a) above-noted recommendation, evidence that suggests instructors employ accommodations without disability documentation is absent, which can be due to the insufficient number of studies that have investigated the roles and perspectives of instructors in relation to student mental health.

Study data revealed that 21 of 42 (50%) survey respondents and 13 of 23 (57%) interview participants reported integrating mental health into the content, tasks, and delivery of curriculum as a means of supporting the well-being and mental health of students. Like the other practices identified in this study's findings, mental health *curricular inclusion and instruction* has also been well-supported in this area of research (CACUSS & CMHA, 2014; Kadison & DiGeronimo, 2004; Kitzrow, 2003; Patton et al., 2000; Sharp et al., 2006). It is exciting to see post-secondary institutions as carriers of specialized academic departments, programs, and courses that address or promote the mental health and well-being of students in some way (Canadian-Universities.net, 2014; Kadison & DiGeronimo, 2004; Molize College, 2013; Seneca College, 2014; York University, 2014). York University's (2014) *Fundamentals of Learning* is a noteworthy example of a post-secondary institution offering an academic program that can support students with a mental health or illness. *Fundamentals of Learning* incorporates students' personal and academic development within curriculum (York University, 2014). Likewise, through their extensive research on how to resolve today's campus mental health crisis, Kadison and DiGeronimo (2005) mentioned that at the University of Maryland, first-year students are offered the opportunity to enroll in general credit-worthy courses designed to help with issues that can pertain to mental health, namely time management and stress avoidance. The above-noted examples mirror study participant Ercole's reports of Molize College's streamed preparatory program and affiliated preparatory courses.

The integration of mental health curriculum and pedagogy into "regular" course content and tasks has also been documented in other studies, although not as widely as curricular inclusion through specialized academic programs and courses (Anderson-Butcher, 2006; CACUSS & CMHA, 2014; Cornejo, 2010; Patton et al., 2000; Sharp et al., 2006; Tacker &

Dobie, 2008; Waller, 2006). As indicated in the systemic guide towards post-secondary student mental health in Canada developed by CACUSS and CMHA (2014), all course content and tasks can reflect mental health pedagogy in some way. For example, with an interest in mental health education and helping students seek support, Sharp and colleagues (2006) proposed and evaluated a psycho-educational curriculum integration strategy, involving an instructor's facilitation of a one-hour, in-class lecture on a variety of topics, such as accessibility of community support resources or psychological disorders prevalent in college populations. This strategy is similar to study participant Jamma's reported facilitation of a discussion activity on conflict management. Sharp et al. (2006) concluded that the standardized lecture format of their mental health lesson, including accompanying information slides, lends itself well for application in any college course/classroom setting. Through their investigation of more systematic approaches towards mental health promotion in academia, Patton et al. (2000) recommended that instructors,

> …promote and foster critical and reflective skills, problem-solving abilities and to encourage collaborative work. These skills have relevance not only for academic and workplace learning, but also for social and emotional development. [This calls for] introducing curriculum modules focusing on the cognitive and interpersonal skills underlying emotional well-being. (p. 591)

Patton et al.'s (2000) recommendation echoes the strategies study participants Zaira and Kara reportedly employed; using mental health and associated reading material to encourage student research and reflection on this issue.

In addition to content or tasks, the inclusion of mental health curriculum has also been documented to occur through particular methods of instruction or curricular delivery, as revealed

in 5 of the 21 (24%) surveys and 6 of the 13 (46%) interviews where mental health curriculums were suggested (Kitzrow, 2003; Martin, 2010; Patton et al., 2000). Like study participant Umberto, who had claimed inviting a guest lecturer to talk about mental health issues, Kitzrow (2003) also recommended using an informed speaker as a means of integrating mental health into curriculum. Specifically, she suggested that classroom professors invite a guest lecturer from a college's student support services departments to address the topic of mental health in a forthright and detailed fashion, whereby the specificities of certain student mental health problems can be adequately covered (Kitzrow, 2003). Keeping in mind the potential time and curricular restraints experienced by college instructors, Kitzrow (2003) determined that professors can schedule guest lecturers on days when they would have cancelled class, due to having an illness or attending administrative commitments.

Other than inviting an informed lecturer, the encouragement of certain conventions in instructors' methods of teaching has also been documented as a means of promoting mental health through curriculum (Martin, 2010; Maryland School Mental Health Alliance, 2011; Quinn et al., 2009). For example, students with mental health problems interviewed in Martin's (2010) study outlined their appreciation for professors who promote structure, or more specifically, who promote conventional lecturing and evaluation. This enabled students to "stay on track" and feel less distressed (Martin, 2010). To recall, study participant Liliana reported a comparable practice: "I always set firm and static protocols …by sticking to my routine lectures and power points…". Quinn et al.'s (2009) work made note of instructor availability as a method that can promote student well-being. Specifically, university student reflections on their experiences of support for mental health concerns demonstrated their appreciation of instructors who made themselves readily available to students, in person and via email, as study participant Damiano

also highlighted; establishing firm and regular contact hours with his students in person and online.

5.4.1 Instructor practices: recognize, render, and redirect (RRR). Findings suggest that post-secondary instructors *can* and *do* support the mental health of their students. Instructors appear to employ an array of practices to support the emotional well-being of students: a) holding conversations with students who identify as having a mental health problem or illness; b) recommending additional/alternative avenues of support offered at the institution to identified and interested students; c) making appropriate academic accommodations for students, sometimes whether or not they are identified through disability documentation; and d) incorporating mental health into course curriculums as an intervention and prevention strategy, or in other words, to "indirectly" support students with a mental health problem and to promote mental health and well-being overall. Of note, instructors did not refer to any mental health programs or campaigns when discussing practices employed to support students. This was somewhat anticipated considering that programs and campaigns rarely depend on the efforts of instructors, compared to other practices of support, such as facilitating accommodations, making a referral to counselling services, or integrating mental health into course curriculums. Nevertheless, the practices unveiled in this study *do* suggest that the role of instructors in promoting student well-being or supporting students with a mental health problem *can* be imagined.

Student mental health has become a priority in higher education settings, working its way in becoming part of an overarching whole-school approach or system of care (CACUSS & CMHA, 2014; Hanlon, 2012; UMCMHS, 2014). In light of this growth, faculty and staff, namely instructors, are gradually being called upon to undertake a more assertive and supplementary role

in supporting the emotional well-being of students in the classroom (CACUSS & CMHA, 2014; UMCMHS, 2014). The classroom can be imagined as a space where instructors are provided with increased opportunities to encounter students with a mental health problem and to integrate multiple strategies of support. This makes instructors viable candidates for the employment of, what has been termed in this study as, *RRR*: to *recognize* the students who experience a mental health problem or illness; to *render* preliminary support, such as having a thoughtful conversation, employing academic accommodations, or delivering curricular content that is sensitive to students' mental health; and/or to *redirect* students to additional/alternative support venues, such as the counselling centre. Ideally, the instructor *can* become a kind of "first-line responder" or "educated mediator" in supporting the mental health of students (CACUSS & CMHA, 2014; Eichler & Schwartz, 2010; Kitzrow, 2003; Quinn et al., 2009; Schonert-Reischel & Lawlor, 2010; Sharp et al., 2006; Silverman & Glick, 2010; UMCMHS, 2014). Employing practices in support of student mental health seems to comply with an educator's overall pedagogical role in learning environments; that is, orchestrating a classroom that is mindful of students' intellectual *and* emotional needs.

Although data demonstrated that instructors support the mental health and well-being of students in some way or another, their evaluations of mental health knowledge/confidence and their perspectives towards responsibility over the well-being of students may have influenced the number and/or extent of practices they employed; for example, whether they employed one or all of the *RRR* practices. To recall, 30 of 42 (71%) survey respondents and 16 of 23 (70%) interview participants evaluated their mental health knowledge/confidence as "below average" and "extremely poor", as was well-confirmed in this area of research (CACUSS & CMHA, 2014; Field et al., 2006; Hanlon, 2012; MacKean, 2011; Martin, 2005; Mowbray & Megivern, 1999;

Quinn et al., 2009; Sharp et al., 2006; Tinklin et al., 2005; UMCMHS, 2014). Mental health knowledge and practice are inextricably linked, or put differently, instructors may restrict their practices of support if they feel inexperienced or unprepared (Anderson-Butcher, 2006; UMCMHS, 2014). In such cases, *referral* or *accommodations* may become the more common practices of choice (Waller et al., 2006), as study participant Jolie similarly reported; referring students to the counselling services department for "…more ongoing and *better help than I could give* (emphasis added)".

Unsurprisingly, the 24 of 42 (57%) survey respondents and 13 of 23 (57%) interview participants who believed instructors are *not* partially responsible in supporting the mental health and well-being of students were those who typically employed fewer and/or less diverse practices of support; those who often *referred* students to student support services departments or who made *accommodations* for students when determined through disability documentation. Conversely, a greater number and diversity of practices seemed to be employed more so by the 17 of 42 (40%) survey respondents and 10 of 23 (43%) interview participants who represented instructors as "first-line responders" and "educated mediators", or in other words, who believed that instructors *are* partially responsible in supporting the mental health and well-being of students.

Although mental health knowledge/confidence and perspectives towards responsibility may have limited instructors' practices of support, findings suggest that the supportive role of instructors can still be constructed and understood. It is possible that instructors' affiliations with the streamed preparatory department/program, one that is sensitive to the emotional well-being of students, contributed to the substantial number and diversity of practices they reported employing overall. Although these instructors are not "officially" expected to support the mental

health of students any more than instructors affiliated with other departments, programs, or schools of learning, in being part of the streamed preparatory program, they are likely to more often encounter students with a mental health problem or recognize how the institution responds to this population, as revealed earlier in the chapter when exploring instructor awareness. Such experiences may have prompted or encouraged the employment of supportive actions on their behalf.

At the same time, however, participant censorship or implementation fidelity may have been possible. Censoring usually stems from a research participant's desire to accommodate certain expectations. The term *social desirability* is commonly used to refer to "the tendency of some respondents to bias their answers in the direction of socially desirable traits in order to make a favourable impression" (Singleton, Straits, & Straits, 1999, p. 567). In this light, study participants may have exaggerated the number or diversity of strategies they actually practice, in hopes of representing themselves as aware, informed, and supportive instructors teaching in the streamed preparatory program. In their discussion of teachers providing support for the mental health of students, Han and Weiss (2005) used the phrase *implementation fidelity*, intended to question how many of the support practices teachers suggest they practice are in fact implemented. Occurrences of social desirability, censorship, or implementation fidelity are often difficult to transcend, despite a researcher's relentless efforts of increasing triangulation.

Aside from program affiliation, mental health knowledge/confidence, perspectives towards responsibility, or censorship, participant composition variables did not appear to influence instructors' practices that support the well-being of students, or more specifically, whether or not, or how, they employed *RRR*. For example, an instructor with greater years of teaching experience or with a full-time employment designation did not report facilitating more

(in number and diversity) practices of support than an instructor with lesser years of teaching experience or with a partial-load employment designation. This was somewhat expected considering that instructors' perspectives towards their responsibilities in supporting the mental health of students were also unaffected by demographic variables. On that note, however, something can be said about *teaching subjects* once more. To recall, regardless of how they characterized their own responsibilities or those of professional staff, participants claimed that instructors who teach/taught preparatory courses *do* carry partial responsibility in supporting the well-being of students, considering that such courses are designed to somewhat promote and support student mental health and well-being. In this light, instructors of preparatory courses were represented as practitioners of greater and more diverse initiatives of support, especially of *curricular inclusion and instruction*. Other teaching subjects did not seem to play an influential role. For example, while some math instructors reported that attention to student mental health is not "appropriate" for math curriculums (Emiliano), other math instructors demonstrated that mental health is applicable and sustainable even in courses where they may not seem to be, such as in Math (Marina and Benito).

5.4.2 Positive practice features: quality instructor-student relationships and integration of information technology. Findings suggest that whatever type of support(s) practiced, instructors seem to carry and/or value their relationships with students, even though establishing relationships with students is not expected of them. Relationships alone can help support emotional well-being; an understanding that often draws from theories of *connectedness*, *belonging*, or *attachment* (Fraser & Pakenham, 2009; Klem & Connell, 2004; Patton et al., 2000; Reupert & Mayberry, 2007a; Reupert & Mayberry, 2007b). Increased social connectedness and attachment is often linked to decreased experiences of psychological distress (Fraser &

Pakenham, 2009). As Patton et al. (2000) outlined in their discussion of *The Gatehouse Project*, which is conceptually grounded in theories of attachment, "the quality of the social environment has the capacity to influence mental health in a variety of ways" (p. 587). In addition to family members, schools are identified as directly influential in bettering one's sense of belonging (Patton et al., 2000). Attachment relationships with adults in schools, such as educators, are fundamental in developing student well-being (Reupert & Mayberry, 2007a/b). At times, instructors' promotion of a welcoming attitude/personality is enough to establish connectedness, which is an ideal approach for classrooms with a high number of students, as commonly found in higher education settings (Quinn et al., 2009).

Quality instructor-student relationships can generate greater opportunities for instructors to facilitate practices of support, as study participant Aida demonstrated: "I strive to build a closer connection with these students so I can continue talking with them (*conversation*) and learning more about their troubles". Specifically, these relationships can enable instructors to identify students with a mental health concern, and thereafter outline support options available on campus for them. Generating greater student awareness of campus-based interventions is important for a number of reasons. Firstly, students do not often seek support for themselves (Sharp et al., 2006). It has been implied that weak or nonexistent instructor-student relationships can contribute to student reluctance in seeking support from adults in school settings (CACUSS & CMHA, 2014). Increasing classroom-based intervention strategies, such as the inclusion of mental health curriculum, can improve student attitudes towards seeking help (Sharp et al., 1998). Secondly, students are often unaware of the mental health interventions offered in post-secondary institutions (Frado, 1993; Kitzrow, 1993; Quinn et al., 2009). In noting the issues of mental health interventions in today's colleges, Kitzrow (2003) determined that students are not

commonly familiar with campus mental health resources, necessitating greater education and outreach from faculty and staff. Thirdly, students are sometimes unable to recognize "unconventional" types of support, or in other words, "the ways in which different activities throughout the school link to EHWB (emotional health and well-being)" (Kidger et al., 2010, p. 927). For example, school-based extra-curricular activities offer a number of advantages to one's mental health (Anderson-Butcher, 2006; Reupert & Mayberry, 2007a). More specifically,

> …involvement in leadership and service-learning activities at the school [can] build assets and strengths in areas where youth may be missing them. For instance, educators refer students to school-based extra-curricular activities and programs. Our research has shown that this is a primary reason for students' initial attendance in these programs. (Anderson-Butcher, 2006, p. 261)

To recall, study participant Marina shared a similar understanding, as she reportedly advised a student to join the basketball team as a means to improve her emotional well-being. In sum, instructor-student relationships can support the well-being of students in a variety of ways.

Findings suggest that in addition to building relationships, instructors can supplement their practices of support with information technology. Using online technology to improve the learning *and* well-being of students is a feasible and somewhat expected venture considering today's virtually-driven society (CACUSS & CMHA, 2014; CMHA, 2014a; Cavalheiro et al., 2012; Hanlon, 2012; Kadison & Di Geronimo, 2004; Lunau, 2012; Quinn et al., 2009; Santor et al., 2009). The internet or information technologies as vehicles in supporting students have increased in number, diversity, and use over the last two decades (Frado, 1993; Hanlon, 2012; Santor et al., 2009). For example, evidence suggests that students can use the web to access support via counselor-to-peer and peer-to-peer counselling forums, or to access information

about campus mental health programs and campaigns (Cavalheiro et al., 2012; Ministry of Training, Colleges and Universities, 2014; Hanlon, 2012). In looking more specifically at instructor practices, email provides the opportunity for instructors to carry conversations with their students, which can lead to the disclosure or identification of a mental health problem and facilitation of support (CACUSS & CMHA, 2014; Quinn et al., 2009), as was demonstrated through the email correspondences referred to by study participants Lissandra, Damiano, and Domenico.

In addition to a delivery mechanism, online technology is also a data collection tool (Santor et al., 2009). As a data collection tool, it can yield access to information that can be used to integrate mental health into curriculum perhaps, as study participant Kara reported doing by posting information pamphlets or brochures that she sometimes builds into lessons. Through their recommendation of using a public health care approach to address student mental health in college and university settings, Davidson and Locke (2010) suggested that online screening activities, such as the Screening for Mental Health's College Response Program (http://www.mentalhealthscreening.org/college/), are useful for instructors to integrate into course activities as a means of identifying students in their classrooms with a potential mental illness. As part of their whole-school approach towards student mental health, CACUSS and CMHA (2014) similarly noted the importance of integrating online tasks that can help screen students with a mental health problem.

Along with supplementing curriculum, online technology as a data collection tool can yield access to information that can serve as an accommodation for students (CMHA, 2014a; Martin, 2010). According to Martin (2010), "students value online access to staff, course information…, so that they could continue with their studies when it was difficult to attend the

university" (p. 270). In other words, the provision of course information through the web can accommodate students with a mental health problem or illness, as study participant Umberto implied; posting lecture material on his course web-based learning management system for students to access when they are absent. Along with all of the above-noted advantages, as many as half of all students are more receptive to information surrounding mental health through online technologies versus other media forms (Santor et al., 2009). Furthermore, supplementing support practices with interactive information technology can help rectify many of the obstacles encountered in facilitating interventions that are "in situ", such as issues with student anonymity (Hanlon, 2012; Santor et al., 2009).

5.4.3 Unfavourable practice features: reactive responses and surveillance-based actions. Aside from the positive features described above, findings suggest that instructor practices of support can also include some unfavourable aspects. Firstly, it appeared as though instructors often undertook a more reactive response when facilitating interventions for students with a mental health problem or illness. That is, instructors seemed to promote or support student mental health only when the need presented itself, as study participant Frederico implied: "depending on what happens *after* (emphasis added) we discuss their circumstances, I would refer them on". Faculty and staff responding reactively to the mental health concerns of students can be a common occurrence (Hanlon, 2012; Ontario College Health Association, 2009; Schonert-Reischel & Lawlor, 2010; Siggins, 2010). As Altschuler et al. (2007) demonstrated through their exploration of educational psychology in practice, "you just want to give support if you feel they need it" (p. 29). In other words, instructors may support students after a mental health problem or illness is identified, rather than promoting positive mental health and well-being in general beforehand. Furthermore, most mental health policies are reactive in

development, in that they often arise following a crisis or tragic event (Hanlon, 2012). With few efforts in the promotion of proactive responses, it is unsurprising that instructors may respond reactively; that study participants, for example, reported referring students to counselling services more often than including mental health curriculum in their teaching.

Prevention and early response strategies have been identified as necessary when addressing the mental health and well-being of students; sometimes as more effective than intervention-based protocols (Hanlon, 2012; Ontario College Health Association, 2009). Actively addressing post-secondary mental health is "no longer seen as simply a question of crisis management, [but rather] mental health issues are being approached in more proactive and systematic ways" (Hanlon, 2012, p. 1). Schonert-Reischel and Lawlor (2010) submitted that school-based support for student mental health should emulate the paradigm shift in psychology in relation to social and emotional health: "heading off" problems prior to them surfacing. They suggested the implementation of *mindfulness education* as a means responding proactively, which encourages the employment of certain classroom practices, such as "quieting the mind" tasks, that promote positive student well-being – a kind of *curricular inclusion and instruction*. Unfortunately, a number of factors work to keep practices of support reactive (Graham et al., 2011). For example, according to the Ontario College Health Association (2009), limited funding can contribute to reactive responses: "mental health care within colleges and universities tends to be reactive, with the majority of resources focused on managing problems as they arise" (p. 13). It seems difficult to expect that instructors pro-actively respond to the mental health needs of students when relevant funding, training, or policies are absent; all of which are discussed later in this section.

In addition to reactive responses, findings suggest that instructors, although likely unknowingly, can evoke surveillance-type behaviours when facilitating practices that support student well-being (Kadison & DiGeronimo, 2004; Kelly, 2003; Kidger et al., 2010; Siggins, 2010; Whitley, 2005). Foucault's notion of *the gaze* has been referenced when speaking about mental illness and surveillance (Kelly, 2003; Whitley, 2005). Using *the gaze* to comment on mental health stigma, Whitely (2005) stated that,

> the function of the gaze is to control and subdue potential threats to the established social order…spatial and temporal boundaries could be erected against the mentally ill through operation of the gaze. The mentally ill may be on the end of real or perceived hostility, as a consequence of stigmatization. (p. 91)

Put simply, individuals with mental health problems are often controlled, monitored, or "gazed upon" due to conventional understandings of mental health and associated stigma, as study participant Lissandra demonstrated when she discussed her actions following employment of the conversation ("…I watched her in case it got worse"), or as study participant Jamma suggested when she discussed her actions while implementing a mental health discussion activity ("…I can keep an eye on them"). It is important that "individuals are not discouraged from finding their own solutions to problems where they can" (Kidger et al., 2010, p. 922). In this light, monitoring the actions of students can be disadvantageous. On the other hand, overseeing student well-being, without the stigmatized gaze, may be necessary to encourage intervention (Frado, 1993). However, instructors may fear "overdoing it" when it comes to monitoring or addressing the mental health of students, which may limit opportunities of employing proactive responses and/or limit facilitation of support in general (Altschuler et al., 1999). There is certainly a fine line between support and surveillance when addressing student mental health in post-secondary

institutions (Kadison & DiGeronimo, 2004). Without ample mental health knowledge/confidence or clarity in responsibilities, it can be understandably difficult to avoid surveillance-based actions or reactive responses when supporting the mental health and well-being of students.

5.4.4 Challenges in practice employment: identification difficulties, time restrictions, and obscure policies. Findings suggest that instructors can face several challenges when employing practices to support the mental health and well-being of students. Firstly, difficulties in identifying students with a mental health problem or illness can challenge the practices of support instructors' employ. Specifically, participants seemed to struggle in identifying students whose well-being is of concern when not identified through disability documentation or student disclosure in conversation. According to the Ontario Ministry of Health and Long-Term Care (2009), "all Ontarians should know the signs and symptoms of mental illness and addictions so that they are aware when they or someone close to them may be at risk" (p. 28, 29). However, identifying students with a mental health problem or illness is a common dilemma for educators (Kidger et al., 2010; Reupert & Mayberry, 2007a; Waller et al., 2006). As a result, informal means of identification, such as "gossip", can become common in uncovering these populations (Reupert & Mayberry, 2007a). A number of reasons can contribute to why instructors face challenges in identifying students with a mental health problem or illness:

a) *Nonexistent or limited disability documentation*: Some students with a mental health problem do not have disability documentation, even though it may be necessary (CMHA, 2014a). Determination of a student as "in need of" or "eligible for" disability documentation and the accommodations offered within is often prompted by their demonstration of (sudden) poor academic performance (CMHA, 2014a). In such cases, students are identified, documented, and supported; ideally following semester one

(CMHA, 2014a). This process is sometimes lengthy, which can leave students unidentified, undocumented, and unsupported for some time (CMHA, 2014a). Moreover, those whose academic performance is sustained or "predictable" even if experiencing a mental health concern are likely unidentified unless they choose to disclose, and therefore, they do not have a disability document entitling them to some support services. The subjective nature of defining entitlement to disability documentation can limit the identification of students with mental health problems, and thus, prevent or slow their access to support, especially accommodations (Waller et al., 2006).

Even if holding a disability document, students can experience "new" or "developing" concerns in relation to their mental health. Consequently, disability documents can quickly become dated, which can allow for these added concerns to remain unaddressed, especially when considering the sometimes lengthy process of obtaining eligibility for disability documentation and associated accommodations. In other circumstances, students with a mental health problem who hold a disability document may not receive support services other than accommodations. Due to confidentiality and privacy protocols, information regarding a student's mental health outlined in disability documents may not be specific to their entitled accommodations (Bower & Schwartz, 2010; CMHA, 2014a; Kitzrow, 2003; Ontario College Health Association, 2009). As such, other practices of support that may benefit a student remain unexplored or unidentified. The limitations of disability documents was represented through study participant Aida's comments on employing the conversation to compensate for the drawbacks of student disability documentation: "Even when we have these documents, there is often more going on that what it says…this remains private".

b) *Complexities surrounding the signs of mental health problems and illnesses*: Identifying students with a mental health problem through "observable signs" can be a difficult task to accomplish (Bibou-Nakou, 2004). In many cases, students with a mental illness can be "invisible" to instructors (Reupert & Mayberry, 2010). This can challenge instructors' ability to identify students with a mental health problem/illness, and thus, their employment of support practices, as study participant Frederico suggested when discussing his difficulties in referring students elsewhere for support: "I would refer them on, [but] it's tough to recognize the signs of distress sometimes". At times, students with a mental health problem or illness do not experience academic issues, which can limit identification of a potential concern (Anderson-Butcher, 2006; Tacker & Dobie, 2008). Alternatively, some students with a mental health problem or illness do not attend school, and in being so withdrawn, signs of mental health problems can remain unobserved (Santor et al., 2009). Even if/when instructors observe that a student is exhibiting "different" behaviours or actions, determining these behaviours or actions as signs of a mental health problem or illness poses as another precarious task (Field et al., 2006; Frado, 1993). Put differently, it can be difficult to distinguish between signs of "regular stress" and of mental health concerns (Ulman, 2006). Consequently, some instructors will consider an observed sign as a "normal deficit", and thus, not warranting identification (Quinn et al., 2009; Tinklin et al., 2005). In sum, complexities surrounding the signs of mental health problems and illnesses can limit instructors' ability to identify students whose emotional well-being may be concerning.

c) *Mental health stigma:* Stigma can serve as another reason why it can be difficult to identify students with a mental health problem or illness (CASA, 2014; Ekornes et al.,

2012; Kidger et al., 2010; Martin, 2010; Ontario College Health Association, 2009; Quinn et al., 2009; Tinklin et al., 2005). For the most part, stigma disempowers students with a mental illness, in that it may prevent them from seeking support, or following through with plans of intervention (Cornejo, 2010; Hanlon, 2012; Martin, 2010; Ontario College Health Association, 2009). Study participant Domenico represented a similar understanding when he discussed students' resistance in disclosing a mental health concern when conversing with instructors: "A lot of students know that people think about mental health negatively, and so they keep it to themselves. I mean there is definitely a danger of bias and labeling when disclosing…". In addition to preventing identification through student disclosure, stigma can also limit instructor identification through recognition of signs (Ekornes et al., 2012; Kidger et al., 2010; Martin, 2010; Tinklin et al., 2005). "Acceptable" versus "non-acceptable" means of experiencing mental health problems are often constructed by stigma, or more specifically, by stereotypical understandings of mental illness (Kidger et al., 2010). When mental health is perceived in a more positive light, identifying a student with a mental health problem or illness becomes more doable, ethical, or natural (Ekornes et al., 2012). Mental health stigma was discussed in greater detail earlier in this chapter.

Secondly, in addition to identification difficulties, findings suggest that time restrictions can challenge the practices of support instructors' employ. Specifically, participants seemed to want more time when employing practices that support the mental health of students, as they similarly revealed in their discussions on participation in mental health training and on the assumption of responsibilities. Any change to one's teaching processes, such as the inclusion of supportive practices, can take time to complete (Patton et al., 2000). For example, preparation

time is often necessary to include mental health into curricular content, tasks, and delivery, as study participant Benito noted when he stated, “time to include is the real concern…are we going to get any more time to fit this into curriculum? No”. Unfortunately, additional time is rarely given for tasks other than teaching (Anderson-Butcher, 2006). Higher education curricula leaves little time to “fit” mental health (Law & Shek, 2011). Mental health can certainly be strategically incorporated into everyday teaching practices without requiring additional time (Sharp et al., 2006). In the current state of mental health in higher education settings, however, “strategic incorporation” will take some time to accomplish. Details regarding instructor time restrictions, including why they are often limited in time, how their time is expected to be used, and what outcomes they can experience in response to time restrictions, were discussed earlier in the chapter.

Thirdly, findings suggest that obscure policies can challenge the practices of support instructors employ. Specifically, participant responses seemed to imply a lack in clearly defined mental health policies that, a) outline current practices of support for college students, or b) promote these practices through a wider whole-school approach. Canadian colleges and universities are not well-equipped with clear and cohesive mental health policies to guide institutional practices in supporting students with a mental health problem or illness (CASA, 2014; Hanlon, 2012). The legal and ethical framework surrounding mental health in higher education contexts includes a number of flexible legislations, guidelines, and policies (Hanlon, 2012). In some cases, policies do not reflect the current goals and procedures of institutions in their promotion of student wellness (Hanlon, 2012). Such inconsistencies in policy are observed, for example, when considering the academic outcomes for some students with a mental health problem. Due to liability concerns, some colleges and universities suspend suicidal students,

whereas others increase their strategies of prevention and intervention (Bower & Schwartz, 2010). Furthermore, as described earlier in this chapter, lack of clarity and consistency is also noted in the policies that determine the expectations of faculty/staff in supporting the mental health of students, as well as in the policies that outline student confidentiality/privacy (Bower & Schwartz, 2010; Eells & Rando, 2010; Hanlon, 2012; Kay, 2010; Kitzrow, 2013). Underdeveloped or inconsistent mental health policies can be due to the growing and shifting nature of mental health in post-secondary institutions; it represents the institutions' attempt to somewhat balance the varying principles or circumstances that underlie mental health while attempting to address student well-being.

Without policy governing understanding and practice, the efforts of college or university instructors can remain poorly articulated, as study participant Montrelle demonstrated: "other than [accommodations], we really do not have much direction on what else we can do". Inadequate policies limit school staffs' understanding of certain health and safety procedures (Silverman & Glick, 2010). Nonexistent or unclear policies can also lead to the facilitation of ad hoc, haphazard practices; those that are single, fragmented, and short-termed (Burns & Hoagwood, 2002; Davidson & Locke, 2010; Froese-Germain & Riel, 2012; Kidger et al., 2010; MacKean, 2011; Ontario College Health Association, 2009; Patton et al., 2000; Silverman & Glick, 2010). For example, according to CACUSS and CMHA's (2014) systemic approach to post-secondary student mental health in Canada, lack of policy clarity has led to the provision of inconsistent or conflicting accommodations, not only across institutions and their associated disability departments, but also between mental health professionals and classroom instructors within the same institution. Aside from the facilitation of fragmented support, limited policies can also lead to the facilitation of "dated" support. As MacKean (2011) noted, "little evidence

suggests that higher education institutions are “transforming policies” in an effort to promote mental health and well-being” (p. 31). In other words, policies sometimes remain stagnant, and thus, may not reflect current perspectives towards mental health, which can prevent a “best practices” approach when supporting the emotional well-being of students. Additional details regarding obscure mental health policies were outlined earlier in the chapter.

In sum, findings suggest that identification difficulties, time restrictions, and obscure policies can all challenge the practices instructor employ to support the mental health and well-being of students, or more specifically, the practices they employ to recognize students with a mental health problem or illness; to render preliminary support for this population; and to redirect them to additional/alternative interventions when necessary. Although not specifically demonstrated through this study, such challenges may have also contributed to some of the unfavourable practice features identified. For example, perhaps identification difficulties can cause instructors to respond more reactively when supporting students with mental health problems/illnesses. Furthermore, it is possible that identification difficulties, time restrictions, and obscure policies can also challenge one another. For example, time restrictions and obscure policies can help reinforce identification difficulties; not enough time or guidance through policy to identify students with a mental health problem or illness.

5.5 Implications for Research and Practice

To understand the meaning and potential use of this study, it is important to situate its findings, analyses, and discussions into a larger context: “to articulate in a richer fashion how the study changes, challenges, or fundamentally refines understanding of extant theory and/or its core concepts, principles, etc.” (Geletkanycz & Tepper, 2012, p. 257). How can the data revealed in this study influence the current and future status of scholars and practitioners in this area of

research? More specifically, what can be learned from this study in relation to the mental health of college and university students, and the role instructors can play in facilitating or offering support? In considering the above, the objective of this section is twofold: a) to briefly review or highlight the key concepts and ideas revealed through this study's findings and subsequent analyses; and b) to discuss the theoretical and practical implications of these concepts and ideas for moving forward in the facilitation of a comprehensive student mental health support system that considers the role of post-secondary instructors.

5.5.1 Supporting current practices. Study findings and analyses revealed that a role for instructors in supporting the mental health of college and university students is possible or at least can be imagined. To promote or sustain this role, it seems important to "support" the practices instructors can employ. As Stone et al. (2000) concluded in their evaluation of college mental health care, "the dialogue begins here in the form of practice recommendations" (p. 510). That said, what are some suggestions or considerations regarding the practices instructors employ when supporting the mental health of students? Firstly, when employing *conversation* as a means of supporting students, instructors are encouraged to assume the role of researcher; one who "search[es] for stories [through] active seeking, active listening, and patient probing, since would be narrators may have to find the shape and form of such stories, and a language and imagery for telling them" (Lincoln, 1993, p. 34-35). In this role, it is fundamental that instructors welcome, appreciate, and validate the discourses of students; that they can make themselves open and available to generate connections and elicit meaningful conversations. It is also imperative that instructors respect students who may reject conversations; who may potentially fear disclosing their mental health problem. Again, this calls upon the assumption of the

researcher's role; instructors carefully probing to uncover a student's desire of leaving stories untold.

Secondly, when employing the *referral*, it seems necessary that instructors know how and when to refer, as well as to whom or where. Moreover, it is important that instructors "believe" in the referral, as some may think that, a) nothing transpires after referring a student, or b) referring students is a reflection of one's incompetence in supporting them (Anderson-Butcher, 2006). Several researchers have suggested the designation of a "referral checklist" to help instructors recognize the importance of referring students for support; of making an accurate and timely referral to appropriate campus support resources (Anderson-Butcher, 2006; Bibou-Nakou, 2004; Kearney & Bates, 2005; Molize College, 2013). At the same time, instructors are cautioned not to rely so much on the referral, as this practice can become easily over-employed when all else fails or is unknown. Indeed, instructors referring students to other professionals is an important part of supporting those with mental health problems; however, if it is the only part, it can discourage or weaken the instructor's role as a promoter and supporter of student mental health (Ekornes et al. 2012).

Thirdly, when employing *accommodations*, post-secondary instructors generally follow the guidelines outlined within a student's disability document (CMHA, 2014a). However, instructors are encouraged to consider the shortcomings of disability documentation when implementing accommodations. Aside from the shortcomings of documentation, some students do not qualify or meet the criteria accommodations (Martin, 2010; Waller et al., 2006). According to the Ontario College Health Association (2009), "in order to receive accommodation, they (students with a mental illness) must be under the care of a health provider" (p. 10). Consequently, it would prove beneficial for instructors to, a) offer

accommodations to “instructor-identified” students who do not have a disability document, or b) advise “instructor-identified” students to seek assessment for “official” eligibility (Ontario College Health Association, 2009).

Lastly, when employing *curricular inclusion and instruction* as a means of supporting the mental health of students, it seems necessary for instructors to re-think the content, tasks, and delivery of the courses they teach so that student well-being can be considered in some way. Unlike elementary and secondary school contexts, post-secondary institutions *do* carry some leeway in establishing what can be taught, or more importantly, how. Instructors, then, can be given considerable ownership over the development and facilitation of curriculum. This flexibility enables instructors to (gradually) include elements of mental health into course curriculums where/when appropriate; a more feasible and often cost-effective alternative to the implementation of entire courses related solely to mental health. To encourage such inclusion, colleges and universities can offer a “reward system for educators that reinforce curriculum and pedagogy that enhance student mental health, recovery, and well-being” (CACUSS & CMHA, 2014, p. 8). Integrating or infusing mental health into learning content, tasks, and delivery is recommended, as opposed to, for example, over-emphasizing random wider school-based interventions (Law & Shek, 2011).

Instructors are encouraged to consider the following criteria for whatever practices of support they may choose to employ:

- Establish relationships with their students, as closer connections can help ensure that students are well-informed and well-guided (Fraser & Pakenham, 2009; Klem & Connell, 2004; Patton et al., 2000; Reupert & Mayberry, 2007a; Reupert & Mayberry, 2007b);

- Supplement their practices with online technologies, as a means of improving or extending “in person” efforts (CACUSS & CMHA, 2014; Cavalheiro et al., 2012; CMHA, 2014a; Hanlon, 2012; Kadison & Di Geronimo, 2004; Lunau, 2012; Quinn et al., 2009; Santor et al., 2009);
- Increase employment of proactive actions or prevention practices, in addition to the sometimes untimely reactive ones (Hanlon, 2012; Ontario College Health Association, 2009; Schonert-Reischel & Lawlor, 2010; Siggins, 2010); and
- Reduce practices that may “control” students with a mental health problem/illness – surveillance-based actions (Kadison & DiGeronimo, 2004; Kelly, 2003; Kidger et al., 2010; Siggins, 2010; Whitley, 2005).

In sum, future researchers are encouraged to shed greater light on the unique practices that instructors can employ to support the mental health and well-being of students; what can be learned from the individual and sometimes innovative practices implemented in classrooms, and how these practices complement or can grow into whole-school approaches. It is also important for researchers to explore ways of optimizing instructor practices of support, such as establishing relationships with students or using technology to supplement in-person initiatives. Eventually, once a larger literature foundation on the role of instructors in supporting the mental health of students is attained, researchers can engage in more evaluation-based studies, for example, to determine the quality of such practices. On that note, uncovering unfavourable practice features, such as surveillance-based actions or reactive responses, seems essential as well, with efforts of suggesting potential resolutions to these features in the future. Understanding the practices instructors employ to support the mental health and well-being of students, as well as understanding the implications of those practices, is seemingly dependent on other components

related to mental health, such as awareness, literacy, knowledge/confidence, training and professional development, funding and time resources, policies, and systems of care; all of which are discussed below as further/other implications for research and practice.

5.5.2 Generating greater mental health awareness. Influenced by the general public's investment in mental health, post-secondary institutions seem to be locations that represent admirable mental health awareness (CACUSS & CMHA, 2014; Hanlon, 2012; UMCMHS, 2014). Instructors within these institutions also appear to demonstrate awareness of student mental health, especially those affiliated with academic departments or programs that pay close attention to student well-being, or those employed as full-time or partial load where greater time is often spent on campus. It seems as though higher education settings would benefit from using instructors as informants when considering their level of mental health awareness, or more particularly, their more frequent encounters with students who may have a mental health problem or illness. Although instructors may carry general awareness when it comes to student mental health, it appears as though they seek further insight regarding support for their own mental health, as well as the location of mental health support services within post-secondary institutions. Current initiatives that seek to support workplace mental health, such as through the Centre for Mindfulness Studies (2014), can be extended further through research and better communicated throughout institutions.

With respect to the sporadic and ambiguous location of services, one resolution can be to re-locate mental health interventions within a closer proximity to main campus locations if possible, or to place support services "all under one roof" (The Ontario College Health Association, 2009). However, due to differing structural and organizational components, it can be difficult for higher education settings to re-locate or homogenize departments that offer

support the mental health and well-being of students. At the same time, "clumping" services can sometimes complicate faculty and staff's understanding of how students can be supported (MacKean, 2011). Increasing awareness of student support services seems like a more feasible solution. Advertisements and publications within higher education settings have been suggested as ways to increase mental health awareness in general, including instructor mental health and the location of support services (Mayberry, Reupert, & Goodyear, 2006; Kitzrow, 2003). Increased communication between faculty and staff has also been suggested to help generate mental health awareness, particularly for part-time or partial load instructors with few years of teaching experience (Kitzrow, 2003). In sum, the current study urges future researchers to consider ways of building and sustaining instructor and institutional mental health awareness, including in the areas of instructor mental health and the location of campus support services.

5.5.3 Encouraging mental health literacy. Considering the prevalence of stigma/stereotypes, a call for mental health literacy is definitely warranted (Ekornes et al., 2012; Fraser & Pakenham, 2009; Jorgensen, 2000; Potvin-Boucher et al., 2010; Reupert & Mayberry, 2007b; Santor et al., 2009; Whitley et al., 2012). Mental health literacy can be effective at de-stigmatizing mental illness, which can potentially decrease even the "unintentional" moments of stigma/stereotype that can appear through language/vocabulary, as well as increase comfort in bringing stigma to the forefront (Potvin-Boucher et al., 2010). Additionally, a reduction in stigma as a result of mental health literacy can increase opportunities for faculty to identify students with a mental health problem, as well as for students to disclose a concern (CACUSS & CMHA, 2014; CASA, 2014; CMHA, 2014a; Ekornes et al., 2012; Kitzrow, 2003; Quinn et al., 2009; Tinklin et al., 2005; Ulman, 2006).

Increasing awareness of mental health stigma serves as a potential solution to the paradox indicated earlier – raising awareness of stigma strips it of its power to silence awareness of mental health overall. Mental health literacy can be encouraged through strategies that increase mental health awareness in general, such as advertisements and publications (Santor et al., 2009). Mental health literacy can be more formally provided through training and professional development, as well as through curricula; options that are more thoroughly discussed in paragraphs to come (Santor et al., 2009). In support of mental health literacy, some have suggested that institutions revisit the labeling of certain student support services departments so that they are not based on "medical models", such as student *disability* services or *treatment* services (Anderson-Butcher, 2006; Quinn et al., 2009). Future studies are encouraged to more closely evaluate the (il)literacy associated with mental health in higher education settings. Following such evaluation, it is hoped that suggestions can be offered on what can be done to reduce prevailing mental health stigma/stereotypes.

5.5.4 Strengthening mental health knowledge and confidence. Study findings and analyses revealed that instructor perspectives and practices in relation to the mental health of students are often determined by their quality of knowledge and confidence in this area. Unfortunately, other than those who teach courses designed to address student well-being in some way, instructors are not often represented as carriers of mental health knowledge/confidence, especially those with fewer years of teaching experience (CACUSS & CMHA, 2014; Field et al., 2006; Hanlon, 2012; MacKean, 2011; Martin, 2005; Mowbray & Megivern, 1999; Quinn et al., 2009; Sharp et al., 2006; Tinklin et al., 2005; UMCMHS, 2014). Instructors who perceive themselves as efficacious are likely to confidently produce sufficient efforts in supporting the mental health of students. That said, "strengthening the school's role in

promoting mental health involves supporting teachers to feel confident…" (Cornejo, 2010, p. 14). Increasing instructor knowledge and confidence appears necessary if they are going to be key players in supporting the mental health and well-being of students.

What kind of knowledge is being called for exactly? Indeed, knowing how to care for or be compassionate with students is valuable, which at times, may have to be explicitly taught and learned (Verducci, 2000). However, the instructor's role in supporting the mental health and well-being of students can go much further, and so too can their knowledge. As demonstrated throughout this study, instructors can support the mental health of their students through certain actions: *recognize* potential stresses or concerns in students, *render* preliminary strategies to help alleviate some student stresses and concerns, and *redirect* students to additional/alternative campus support services if necessary. Therefore, along with carrying general awareness of student mental health, including mental health literacy, instructor knowledge can entail knowing when a student is demonstrating signs of stress or problems; knowing strategies that can begin to support a student in the classroom, such as the *conversation*; and knowing where to send students for additional intervention, such as *referral* to mental health professionals for counselling.

Recognizing potential stresses and concerns in students is of particular importance. Study findings and analyses revealed that several barriers can prevent the identification of students with a mental health problem or illness, such as nonexistent or limited disability documentation, complexities surrounding the signs of mental health problems and illnesses, and mental health stigma. Without the ability to promptly and accurately identify students with a mental health problem, instructors may experience difficulties *rendering* preliminary support strategies or *redirecting* students elsewhere for support. Instructors are encouraged to obtain assessment checklists or a system of warning signs, when available from student support services

departments, to aid in the process of identification (Bibou-Nakou, 2004; Brener et al., 2007; Molize College, 2013). According to Eichler and Schwartz (2010), instructors are well-suited for the employment of screening and assessment measures, such as student self-report questionnaires and rating scales, as these do not imply "diagnosing" a mental illness. Even if not using a mental health screening tool, instructors often (un)intentionally observe and assess student patterns, actions, and behaviours, and therefore, can be afforded the opportunity to detect when there is a (mental health) problem (Kearney & Bates, 2005). In this case, instructors are encouraged to continue their practices of careful and frequent observation, and to perhaps consider mental health in their diagnostic or anecdotal impressions of students.

5.5.5 Increasing opportunities for mental health training and professional development. Mental health training and professional development for teaching faculty can help to, a) raise mental health awareness, b) increase mental health literacy to combat stigma, c) expand mental health knowledge and confidence levels, and d) encourage and/or improve practices that support the mental health and well-being of students. Greater training and professional development opportunities (in number, frequency, and diversity) are warranted for all instructors regardless of employment designation, teaching subjects, or program affiliation. Colleges and universities can collaborate more with community agencies to develop and offer mental health training seminars (Froese-Germain & Riel, 2012; Sharp et al., 2006). The Centre for Mindfulness Studies (2014) is an example of a recently developed organization that can offer social programs, diverse therapies, and education courses on mental health to individuals in the workplace, or more specifically, to instructors in higher education settings.

Mental health training can also occur through collaboration between instructors and school-based mental health professionals (Cornejo, 2010; Kitzrow, 2003). Considering the

greater time available for full-time instructors to participate in training, they can serve as information resources for partial load instructors. Even if informally, communication between full-time and partial load instructors can inevitably allow for mental health knowledge to be shared. Likewise, considering that increased teaching experience can deliver greater mental health knowledge/confidence, senior teaching faculty become implicated as key players in not only supporting the mental health of students, but also in helping to train or build the knowledge/confidence of junior colleagues to do the same. As Kitzrow (2003) recommended, "a special effort should be made to contact new faculty and staff by presenting information at new employee orientation and providing written materials to be included in new employee packets" (p. 177). Moreover, the purpose of training and professional development is called into question when recognizing the importance of teaching experience. Considering the impossibility of "quickening" experience, a need can be signaled for training and professional development initiatives to help resolve, as Anderson et al. (2007) recommended in their research on teachers and inclusive practices, "...the disparity between philosophical positions and actual implementation in the classroom" (p. 141-142). In other words, initiatives can focus on pragmatic instruction, or specifically, building instructor abilities to apply the learned theories and information on student mental health within the classroom (Frado, 1993; Kearney & Bates, 2005; Lightfoot & Bines, 2000; Molize College, 2013; Silverman & Glick, 2010; Stone et al., 2000). It is also important that training and professional development does not simply entail the promotion of "mental health definitions and descriptions", but rather promote a variety of material and topics, such as mental health literacy/stigma, instructor mental health, or location of support services. In sum, future researchers are encouraged to evaluate how professional

development can effectively help build and sustain mental health awareness, literacy, and of course, knowledge/confidence.

5.5.6 Establishing essential resources: funding and time. "With the right amount and kind of support, teachers can play an incalculable role in supporting student mental health without making a difficult job impossible (Waller et al., 2006, p. 11). "The right amount and kind of support" entails establishing essential resources, that being funding and time. In addition to finding such resources, it appears imperative that they are properly allocated and organized (CASA, 2014; MacKean, 2011). Time and funding are required to develop and sustain mental health training and professional development, but establishing these resources has been an ongoing challenge (CASA, 2014; Cavalheiro et al., 2012; Eells & Rando, 2010; Kadison & DiGeronimo, 2004; Kitzrow, 2003; MacKean, 2011; Ministry of Training, Colleges and Universities, 2014; Ontario College Health Association, 2009; Tinklin et al., 2005). As a result, post-secondary institutions are challenged with the task of finding alternative avenues to educate their faculty on student mental health. In addition to sharing knowledge between faculty and staff, as discussed in earlier paragraphs, researchers have suggested the encouragement of "self-help" initiatives available through online resources (Centre for School Mental Health Assistance, 2002). Others have recommended the addition of mental health in existing training and professional development initiatives (Potvin-Boucher et al., 2010). For example, training seminars can coach instructors on how to foster interactive learning moments (Greenberg, et al., 2003; Waller et al., 2006). However, what they may not be taught or aware of is how interactive learning moments can benefit students with a mental health problem. Interactive practices facilitated by educators can generate student social, emotional, and academic learning, and thus, enhance prevention and development (Greenberg et al., 2003). It seems fundamental that

forthcoming studies examine what post-secondary institutions can do to provide the time and funding necessary for the development of and participation in student mental health training programs that are intended to enhance instructor knowledge/confidence in the area. Ultimately, increased training for faculty and staff means that fewer resources are needed to implement additional interventions (Han & Weiss, 2005).

Other than training, time is also needed to assume even partial responsibility in supporting the mental health of students (Anderson-Butcher, 2006; Anderson et al., 2007; Kidger et al., 2010; Patton et al., 2000; Reupert & Mayberry, 2010; Schonert-Reischel & Lawlor, 2010). According to Reupert and Mayberry (2010), "school personnel (teachers) were not providing a welfare role in addition to their teaching obligations, but instead finding ways of meeting the psycho-social needs of [students] *through* their teaching approaches" (p. 12). Indeed mental health promotion and intervention can be accomplished *through* existing instructional time, but finding ways to do so or learning how to do so requires time. It is unrealistic to expect instructors to abide by certain or any responsibility expectations when their time can be limited. As such, it is important that instructors are not overwhelmed with responsibilities if they are expected to support student well-being. Post-secondary institutions are implicated to ensure that the responsibilities in supporting the mental health of students are appropriately delegated between faculty and staff. Some researchers have suggested designating a particular staff member who equitably delegates responsibilities over student mental health (Brener et al., 2007; Larson & Lochman, 2011). Others have recommended employing a coordinator or set of professionals that assume most of the responsibilities in relation to student mental health and well-being, namely identifying students with a concern and coordinating support thereafter (Ontario College Health Association, 2009).

Increased time also appears necessary to employ certain practices that support students with a mental health problem or illness (Anderson-Butcher, 2006; Frado, 1993; Law & Shek, 2011; Patton et al., 2000; Sharp et al., 2006). “The needed accommodations for this group (college and university students with mental health concerns) are well within our capacity if we take the time to give them some priority” (Frado, 1993, p. 17). Increased time is especially important when integrating mental health into course curriculums, as revealed in this study. That said, including mental health within curricula can actually decrease instructor workload and time pressures (Waller et al., 2006). The reason is mental health curriculum can inform and support students, which can then prevent issues that may surface without such preventative strategies; issues that will require additional time to address in the long run (Waller et al., 2006). It seems unwise and risky to even attempt employing practices of support without the asset of time in the first place.

It is anticipated that future researchers continue investigating time- and funding- efficient avenues for instructors to assume responsibility in supporting the mental health of students, to participate in mental health training, and to employ certain practices of support. To recall, however, instructors are not normally expected to assume responsibility, partake in training, or employ support practices when it comes to student mental health and well-being. As a result, even if time and funding resources are received, it does not mean that instructors will entertain student mental health in any way. To remedy the above circumstance, researchers have suggested that encouraging educator engagement in student mental health can begin at the university-level, specifically as part of pre-service teacher education programs (Cornejo, 2010; Ekornes et al., 2012; Silverman & Glick, 2010; Whitley et al., 2012). This way, “teachers-to-be” may be expected to learn about student mental health, and to do so at a slower pace. However, at

this time, current university-based pre-service educational programs do not offer much in terms of educators working with students who have a mental health problem or illness (Cornejo, 2010; Whitley et al., 2012). At the same time, college/university instructors do not require a teaching degree in the first place. As a result, encouraging consideration of student mental health, whether this entails participation in training or employing supportive practices, remains a challenge in the workforce; a challenge that institutions can overcome through a system of care model, which is further discussed later in this chapter.

5.5.7 Developing and/or clarifying policies related to mental health. If instructors are to be key players in supporting the mental health and well-being of students, then their roles and responsibilities need to be developed, documented, clarified, and/or communicated. Conversely, if they are not, then this too needs to be indicated. Although mental health professionals are often considered primarily responsible for supporting the mental health and well-being of students in higher education settings, their responsibilities also need to be clarified, especially if these individuals engage in inter-disciplinary and sometimes unconventional roles. Currently, Canadian colleges and universities are urged to "define their roles and responsibilities within the continuum of possible actions…to define, communicate, and establish appropriate expectations" (Hanlon, 2012, p. 2). Institutionally, this begins with policy development and clarity; to determine the legal and ethical expectations of institutions and their respective faculty/staff members in supporting students with mental health problems and illnesses. With mental health policy development and clarity, perhaps instructors would carry less confusion regarding the responsibilities and practices of mental health professionals or of student support services departments more broadly when addressing the mental health and well-being of students. Policy development and clarity may also lead to less ambiguity surrounding instructors' responsibilities

in supporting the mental health and well-being of students; a first-line responder, educated mediator, or neither?

While policy development and clarity in responsibilities may lead to diffuse compliance of responsibilities, what is “in place” does not necessarily determine what is “in practice” (Anderson et al., 2007; Brener et al., 2007; CASA, 2014; Frado, 1993; Santor et al., 2009). In other words, higher education settings cannot ensure that expectations outlined in random policies regarding student mental health are taken up by all faculty and staff, especially with instructors, whose flexibility and independence can make it difficult for institutions, for example, to “enforce” the responsibility of “first-line responder”. Moreover, assuming responsibility can be capricious, “dependent upon the personality of the professor and the nuances of mood and temperament that vary across the period of the academic term” (Frado, 1993). As such, passive dissemination of information through policy is not always successful (Santor et al., 2009). The University of Guelph has employed a “special task force” that ensures mental health policies and practices align with one another, as well as with the wider goals of the institution. This task force, however, is an anomaly among post-secondary institutions.

For the most part, policies surrounding student mental health often remain *attractive philosophies*; actual practice of them has been noted as a continuous milestone (Anderson et al., 2007; CASA, 2014; Cornejo, 2007). Supporting student mental health, then, can be limited to those who know about and choose to believe in the related policies that are in place. In some cases, policies in relation to student mental health can be limiting or problematic, especially if reflective of traditional paradigms (CACUSS & CMHA, 2014). According to Han and Weiss (2005), often influenced by greater authorities in the education system, educators are likely to abide by standard policies, despite any underlying negative conditions. As such, some policies

may promote roles and responsibilities that do not always benefit a student's mental health, and thus, may be better left "un-standardized".

Future researchers are encouraged to develop or propose potential mental health policies that outline the responsibilities of post-secondary faculty and staff in relation to student mental health. Likewise, it seems imperative that studies to come also review and evaluate existing mental health policies, to ensure clarity and cohesion, as well as to ensure that they do not reflect mental health stigma/stereotype (CASA, 2014; Hanlon, 2012; MacKean, 2011). Put differently, it is important that evaluators "review campus policies and procedures with a mental health lens and is informed by established principles…Established evaluation for continuous improvement of offices, departments, services, and resources that include criteria related to fostering student well-being" (CACUSS & CMHA, 2014, p. 8). Such examination can also determine whether or not policies are being followed. If they are not being followed, researchers can attempt to uncover why this may be the case, or alternatively, explore courses of action that can encourage followers, such as the implementation of whole-school approaches.

5.5.8 Implementing whole-school approaches or systems of care. "Add-ons" or "single innovations" can be commonplace when it comes to mental health promotion in academic settings (MacKean, 2011; Schwean & Rodger, 2013). With mental health policy and practice implementation at the post-secondary level still somewhat in its infancy stages, few whole-school approaches or systems of care in addressing student mental health have been developed; have moved beyond the pilot stages; or have been fully implemented and communicated to faculty and staff (Hanlon, 2012). To recall, a whole-school approach involves "multiple strategies that have a unifying purpose and reflect a common set of values... to create a protective environment that promotes mental health and well-being" (MindMatters, 2010, para.

1). More than simply a continuum of services, a system of care focuses on the way in which services are delivered, with consideration of processes and structures that encourage cohesion and coordination of services (Schwean & Rodger, 2013). Put simply, whole-school approaches encourage an overall college or university personnel to be invested in supporting the mental health and well-being of students (CASA; 2014; Frado, 1993; Kay, 2010; Quinn et al., 2009).

A number of reasons can warrant a call for whole-school approaches or an overarching system of care to support the well-being of college and university students. Firstly, systems of care have been noted as a cost effective way for providing support for student mental health, as they can limit the need for repetitive, isolated, and/or multiple services (Schwean & Rodger, 2013). Secondly, institutionalized whole-school frameworks can help mobilize knowledge and confidence in the areas of student mental health and support through relevant training and professional development (Schwean & Rodger, 2013). Thirdly, with greater focus on establishing organization and communication, these approaches can help resolve the ambiguities surrounding faculty and staff responsibilities in supporting the mental health of students. In other words, a wider system of care can bring together or solidify (anti-stigma) policies that define and clarify faculty and staff responsibilities in supporting student well-being, including an understanding of the ethical/legal or privacy/confidentiality expectations involved (Anderson et al., 2007; Bibou-Nakou, 2004; CASA, 2014; Kay, 2010; Schwean & Rodger, 2013).

Finally, whole-school approaches can promote practices that support the mental health and well-being students, or more specifically, can

- list and explain the overall practices that work to support the mental health and well-being of students;

- identify what practices instructors can use in the classroom, including guidance on how they can be effectively employed without increased time consumption;
- highlight any favourable practice features, such as building instructor-student relationships and supplementing practices with information technologies;
- outline any unfavourable practice features, such as responding reactively or promoting surveillance-based actions when supporting the mental health and well-being of students; and lastly,
- indicate ways for instructors to identify students with a mental illness in the classroom; ways that can overcome identification barriers caused by shortcomings with disability documents, complexities surrounding the signs of mental health problems and illnesses, or issues with mental health stigma.

Accomplishing the above criteria through a system of care, ideally one that spans higher education settings across the province, not only helps to ensure that practices of support remain somewhat long-term and sustainable, but also to promote some equality in the way college and university students with a mental health problem are supported (MacKean, 2011; Ontario College Health Association, 2009; Potvin-Boucher et al., 2010; Schonert-Reischel & Lawlor, 2010). As MacKean (2011) noted, Canadian colleges and universities currently carry a number of inconsistencies in how they address student mental health, such as a variation in the accommodations offered. The development of a wider system of mental health care is often dependent on liaisons between multiple parties, as opinions can differ in "what helps" when it comes to student mental health (Reupert & Mayberry, 2010; Reupert & Mayberry, 2007b; Statham, 2004). Other than pertinent federal, provincial, and institutional administrators or professionals, researchers have suggested considering the inputs of instructors, students, parents,

community members, as well as relevant international parties when developing whole-school approaches of support for student mental health (Eells & Rando, 2010; Froese-Germain & Riel, 2012; Heyno, 2006; Kadison & DiGeronimo, 2005; MacKean, 2011; Phippen, 2010; Sharp et al., 2006; Siggins, 2010; Silverman & Glick, 2010; Tacker & Dobie, 2008; Waller et al., 2006).

The mental health needs of students are not often fixed, and therefore, neither should be approaches of support. A planned and intentional support system, as opposed to random reactive responses, is definitely advantageous, but it should be one that welcomes modification (CACUSS & CMHA, 2014). For the most part, "classroom circumstances change across the school year, as students progress or encounter emotional, behavioural, or academic difficulties, and each new school year brings a new set of students, with different strengths and needs" (Han & Weiss, 2005, p. 673). In other words, like the policies it promotes, an overarching system of care for student mental health can reflect the current needs of the population for which it was designed, which implicates post-secondary institutions, as well as affiliated instructors, to frequently review, evaluate, and revise their approaches (Cornejo, 2010; Kay, 2010; MacKean, 2011; Quinn et al., 2009). An evaluation of approaches is also beneficial to uncover the potential barriers that challenge the implementation of systems of care (Schwean & Rodger, 2013). Barriers can include lack of mental health awareness, literacy, knowledge/confidence, training, policy development, funding, and/or time. In sum, forthcoming studies are recommended to propose or extend mental health whole-school approaches or systems of care for implementation in higher education settings. Such systems not only work to fuse individualized policies and efforts, or to define the responsibilities and practices of faculty and staff in supporting students with mental health problems, but to also encourage institutions and their instructors to better engage in student mental health.

6. Conclusions

The number of students who report having a mental health problem or illness has markedly increased on Canadian college and university campuses, and in some cases, their outcomes have been tragic. Evidence seems to suggest that students with a mental health problem or illness can achieve well-being and success in higher education when they receive appropriate support. In reality, the well-being and learning of *all* post-secondary school students can ultimately improve from the assistance provided through campus support initiatives. Post-secondary institutions have begun to recognize that they play a central role in promoting and supporting the mental health and well-being of students. “Addressing mental health issues is increasingly going to be seen as part of every university’s responsibility” (Hanlon, 2012, p. 6). In response to this recognition, a significant growth in the development and implementation of mental health policies and practices in Canadian colleges and universities has occurred, especially over the last five to six years. Institutions are tackling existing development and implementation barriers, such as poor funding and resource allocation, and slowly working towards whole-school approaches in addressing the mental health of students and promoting overall positive student well-being. Although instructors have been acknowledged as necessary components in the facilitation of mental health policy and practice in college and university settings, their roles and responsibilities have yet to be thoroughly defined.

Instructors have been encouraged to extend their role in post-secondary institutions; to move from an underused resource with potential towards a supporter for and promoter of student mental health. This extension of role does not necessarily entail that instructors have to “…teach “harder” or “longer” [but rather] reach outwardly and differently by way of an expanded mental health agenda” (Anderson-Butcher, 2006, p. 263). In this light, instructors become key front-line

professionals; *partially* or *mutually* responsible in facilitating mental health policies and practices, especially while in the classroom. Instructors carry quintessential opportunities to *recognize* students who may be experiencing a mental health problem or illness; to *render* preliminary efforts in supporting identified students, such as employing accommodations; or to *redirect* students to other campus resources, such as referring students to counselling or disability services departments. In order for instructors to assume a first-line response, or in other words, to *recognize*, *render*, and *refer*, they need to feel knowledgeable, confident, and aware when it comes to student mental health; they need to understand how they and the institution can support students with mental health problems or illnesses. As a result, institutions are encouraged to demonstrate readiness for change; to promote holistic avenues when supporting students; and most importantly, to help mobilize the efforts and responsibilities of instructors in addressing student mental health, such as increasing relevant training and professional development opportunities for faculty and staff. Only in this environment can the role of instructors be efficacious, received, or even contemplated.

This study captured a picture of how college and university students with a mental health problem can be understood and supported by instructors. It explored instructors' awareness of student mental health concerns and interventions; their evaluation of knowledge and confidence in understanding mental health and providing support to students; their beliefs surrounding who is responsible for supporting the mental health and well-being of students, as well as what these responsibilities entail; and their employment of practices in the classroom that support the mental health and well-being of students. Additionally, any positive or unfavourable features of the practices instructors' employed were recognized. Lastly, the study made note of some common factors that can influence instructors' awareness, knowledge/confidence, responsibilities, and

practices in relation to student mental health, which included, but are not limited to, training and professional development, mental health stigma/stereotypes, time, funding, and policy development/clarity.

Welcoming "non-expert" voices into this area of research, namely those of instructors, seems necessary to capture the subtleties and complexities of how the mental health of students can be understood and supported in post-secondary institutions. Future studies are encouraged to acknowledge the narratives of instructors through qualitative, ethnographic inquiry, to allow for greater insights into *their* awareness, knowledge/confidence, responsibilities, and practices when it comes to supporting the mental health and well-being of students in higher education settings. Incorporating the instructor may not be a panacea for the shortcomings of current mental health policies and practices in higher education settings, but it can certainly represent a colossal step in that direction.

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Appendix A: Survey Questionnaire

1. Gender:
   □ Male
   □ Female

2. Age
   □ 25 to 34 years
   □ 35 to 44 years
   □ 45 to 54 years
   □ 55 to 64 years
   □ 65+ years

3. Are you a...
   □ Full-Time instructor
   □ Sessional instructor
   □ Partial-Load instructor
   □ Part-Time instructor

4. How long have you been teaching at the college level?

5. List the general subject/discipline areas of the courses that you teach or have taught (e.g., English/Literature; Writing/Composition; Linguistics/Communication; Computer; Psychology; Sociology; Mathematics; Sciences; Business; History; Humanities; Law; etc.)?

6. How would you classify the quality of (and your confidence in) the knowledge, expertise, or abilities you carry in the areas of mental health and/or student support?
   □ Extremely poor
   □ Below average
   □ Average
   □ Above Average
   □ Excellent

7. How frequently do you encounter a student with mental health problems?
   □ Always
   □ Very Frequently
   □ Occasionally
   □ Rarely
   □ Very Rarely
   □ Never
   □ Unsure; unable to identify if students have mental health problems

8. If or when encountering a student with a mental health problem today or in the future, how would you initially engage them (e.g., set up an appointment with a student to initiate a detailed discussion about their concerns; immediately refer students to on-campus resources of support; etc.)?

9. If you have identified a student with a mental health problem in the past, where did you go for assistance in providing that student with support (e.g., a friend; a colleague; the counseling and/or disability service department on campus; the internet; etc.)?

10. To your knowledge and understanding, what kind of support initiatives does the college offer that can help students with mental health problems (e.g., programs or seminars that support students "at risk"; education seminars or information campaigns that build mental health awareness and knowledge; counseling/guidance through psychotherapy; accessibility services, etc.)?

11. What strategies do you use in the classroom to support students with mental health problems (e.g., integrating mental health topics into lectures; providing extended due dates for major assignments; encouraging weekly communication/update meetings; etc.)?

12. What are your opinions in response to the following statement? *Teaching faculty members are in part responsible for the mental health and overall well-being of students.*

Appendix B: Interview Schedule

*Questions varied between participant interviews

To establish an understanding of context:

1. What are some notable strengths and weaknesses of this school, its students, and the surrounding community?
2. Identify and describe any distinguished characteristics of your affiliated faculty/department.
3. Identify and describe the general support structures available to students at this institution.

To establish an understanding of instructor perspectives towards mental health and intervention:

1. What does (student) mental health mean to you, in general and as an instructor?
2. Describe what you think "support for student mental health" should look like (e.g., provision of a mental health curriculum; teaching students how to cope; providing alternate avenues for success; etc.).
3. To what extent do you feel pleased or dissatisfied with current student support structures in higher education settings?
4. Please elaborate on your response to survey question #15: "What are your opinions in response to the following statement? *Teaching faculty members are in part responsible for the mental health and overall well-being of students*".
5. What new directions, career options, enhanced perceptions, or improved skills have you acquired in response to this study topic?

To establish an understanding of the mental health initiatives of support promoted and practiced by instructors:

1. Consider the following scenario: One of your students has suddenly started to arrive late to class, and while there, has limited his involvement in group discussions as he frequently attends to his cell phone. Furthermore, he is often complaining of feeling fatigued, and has on more than one occasion requested to extend assignment due dates. After two weeks of witnessing such behavior, you decide to approach the student, inquiring why his behavior has suddenly altered. The student discloses that his father was diagnosed with lung cancer, and is currently undergoing aggressive chemotherapy treatments. The student continued to advise that his mother is unable to take time off work, and therefore, he is required to accompany his father to chemotherapy treatments, as well as attend to any other needs (e.g., fulfilling medication prescriptions, chaperoning during specialist visits, preparing daily meals, etc.). He is feeling fatigued and rather overwhelmed with his current situation. *What steps would you take following this student's disclosure?*

2. Aside from the steps mentioned in the above scenario, describe any other strategies you employ to support the mental health of students (e.g., encouraging mental health awareness through lessons; negotiating task deadlines; etc.).
3. How exactly do you implement strategy *y* in your classroom?
4. Tell me more about the goals of initiative *x*.
5. What has helped you facilitate the implementation of support for students with mental health problems (e.g., collaborative working environment; administrative support; training/workshops; etc.)?
6. Alternatively, what has challenged you in the facilitation or implementation of support for students with mental health problems (e.g., lack of training; time restrictions; etc.)?

City of Toronto Ward Profiles
2011 National Household Survey

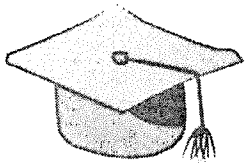
Ward

Glossary

HIGHLIGHTS

Ward | Toronto

43%
with post-secondary certificate, diploma or degree



68%
with post-secondary certificate, diploma or degree

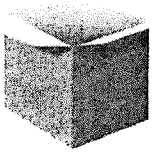
$909
average monthly rent

$1,026
average monthly rent

India
#1 immigrant place of birth

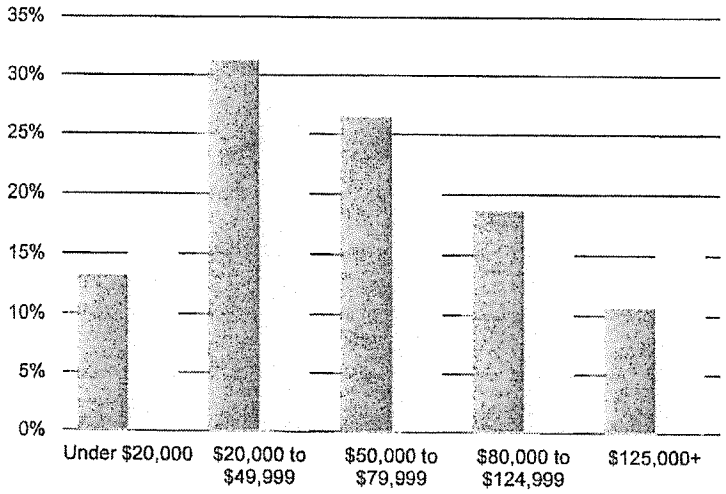
China
#1 immigrant place of birth

10%
of people moved in 2010



13%
of people moved in 2010

2010 Household Income



Key Facts

$66,001 average household income (2010)	**$87,038** average household income (2010)
64% born outside Canada	**51%** born outside Canada
2% dwellings built after 2000	**12%** dwellings built after 2000
12.8 unemployment rate	**9.3** unemployment rate

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

Ward [redacted]

Glossary

DWELLINGS

Private Households by Tenure

Ward 1	No.	%
Owned	10,195	56.2
Rented	7,955	43.8
Total number of households	**18,150**	**100.0**

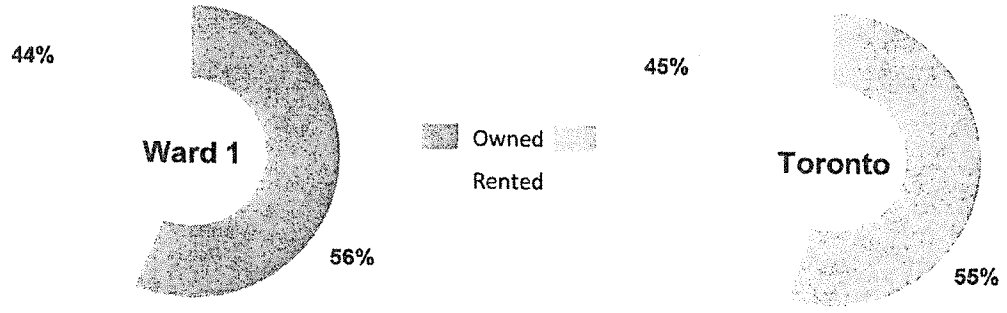
City of Toronto	No.	%
Owned	571,790	54.6
Rented	476,090	45.4
Total number of households	**1,047,880**	**100.0**

Private Dwellings by Period of Construction

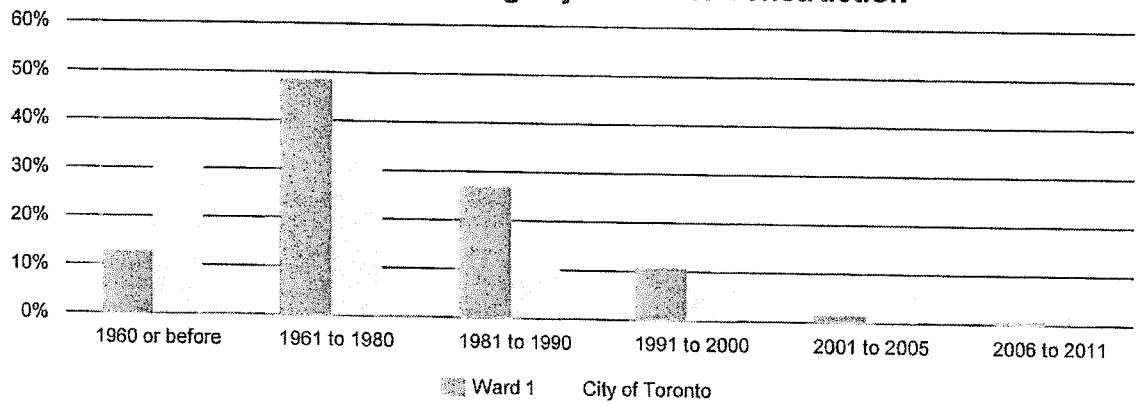
Ward 1	No.	%
1960 or before	2,290	12.6
1961 to 1980	8,770	48.3
1981 to 1990	4,860	26.8
1991 to 2000	1,905	10.5
2001 to 2005	230	1.3
2006 to 2011	95	0.5
Total number of dwellings	**18,150**	**100.0**

City of Toronto	No.	%
1960 or before	377,575	36.0
1961 to 1980	344,160	32.8
1981 to 1990	122,910	11.7
1991 to 2000	77,925	7.4
2001 to 2005	61,575	5.9
2006 to 2011	63,725	6.1
Total number of dwellings	**1,047,870**	**100.0**

Private Households by Tenure



Private Dwellings by Period of Construction



Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

HOUSEHOLDS

Households by Number of Household Maintainer

Ward 1	No.	%
1 household maintainer	10,705	59.0
2 household maintainers	6,290	34.7
3 or more household maintainers	1,155	6.4
Total number of households	**18,150**	**100.0**

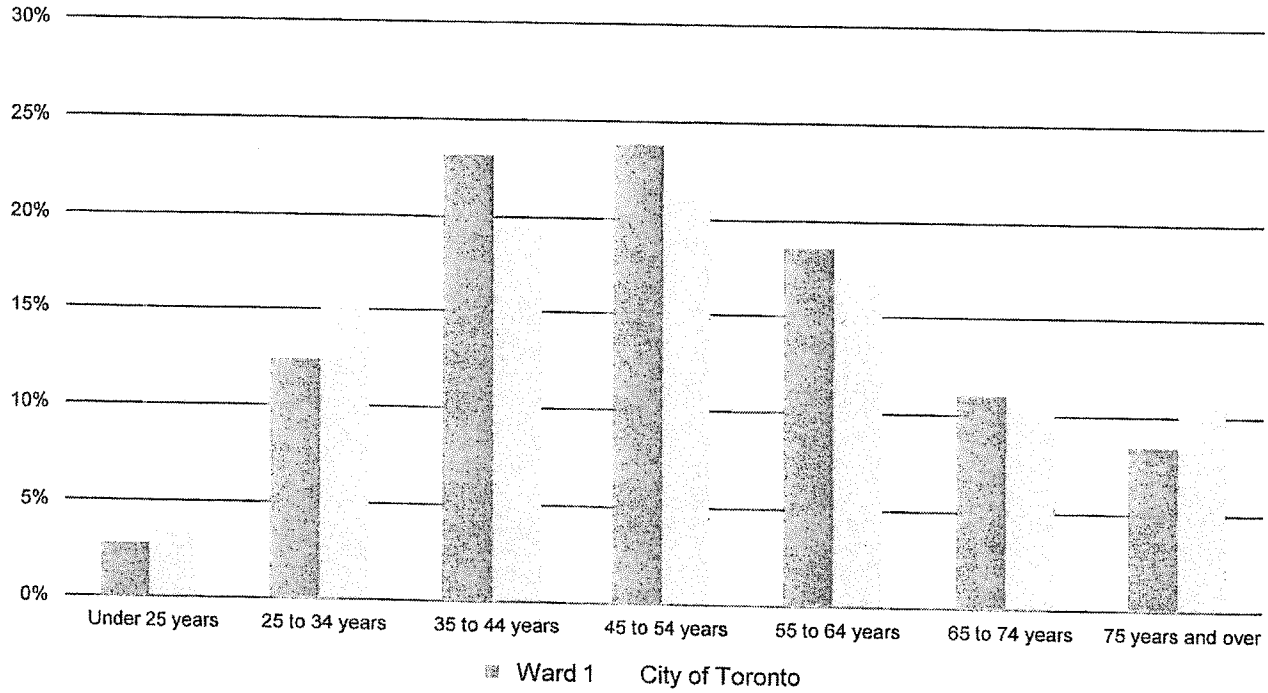
City of Toronto	No.	%
1 household maintainer	665,050	63.5
2 household maintainers	345,090	32.9
3 or more household maintainers	37,745	3.6
Total number of households	**1,047,885**	**100.0**

Households by Age Group of Primary Household Maintainer

Ward 1	No.	%
Under 25 years	500	2.8
25 to 34 years	2,235	12.3
35 to 44 years	4,205	23.2
45 to 54 years	4,325	23.8
55 to 64 years	3,365	18.5
65 to 74 years	1,990	11.0
75 years and over	1,530	8.4
Total number of households	**18,150**	**100.0**

City of Toronto	No.	%
Under 25 years	36,590	3.5
25 to 34 years	173,845	16.6
35 to 44 years	204,985	19.6
45 to 54 years	225,945	21.6
55 to 64 years	178,025	17.0
65 to 74 years	113,435	10.8
75 years and over	115,050	11.0
Total number of households	**1,047,875**	**100.0**

Age Group of Primary Household Maintainer



Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

STRUCTURES

Population and Structure Type

Ward 1

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
Population	18,650	2,185	8,245	6,330	2,005	23,505	0	60,920
Primary Household Maintainer	5,310	635	2,190	1,750	705	7,560	0	18,150
Average number of persons per household	3.5	3.4	3.8	3.6	2.8	3.1	0.0	3.4

City of Toronto

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
Population	826,060	219,040	184,960	122,625	340,535	876,985	5,525	2,575,730
Primary Household Maintainer	274,810	73,635	60,665	43,005	163,440	430,080	2,155	1,047,790
Average number of persons per household	3.0	3.0	3.0	2.9	2.1	2.0	2.6	2.5

Tenure and Structure Type

Ward 1

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
Owned	17,355	2,060	4,430	4,175	905	6,440	0	35,365
Owned - Condominium	80	285	2,515	235	75	6,440	0	9,630
Owned - Not a condominium	17,275	1,775	1,915	3,940	830	0	0	25,735
Rented	1,300	125	3,810	2,150	1,105	17,065	0	25,555
Rented - Condominium	25	25	315	0	30	2,000	0	2,395
Rented - Not a condominium	1,275	100	3,495	2,150	1,075	15,065	0	23,160
Total Population	**18,655**	**2,185**	**8,240**	**6,325**	**2,010**	**23,505**	**0**	**60,920**

City of Toronto

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
Owned	775,295	199,450	123,465	85,295	109,640	256,275	3,495	1,552,915
Owned - Condominium	6,395	6,295	62,790	4,265	26,640	256,275	165	362,825
Owned - Not a condominium	768,900	193,155	60,675	81,030	83,000	0	3,330	1,190,090
Rented	50,770	19,590	61,500	37,330	230,895	620,705	2,030	1,022,820
Rented - Condominium	955	605	7,450	640	11,095	101,255	50	122,050
Rented - Not a condominium	49,815	18,985	54,050	36,690	219,800	519,450	1,980	900,770
Total Population	**826,065**	**219,040**	**184,965**	**122,625**	**340,535**	**876,980**	**5,525**	**2,575,735**

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

STRUCTURES

Period of Construction and Structure Type

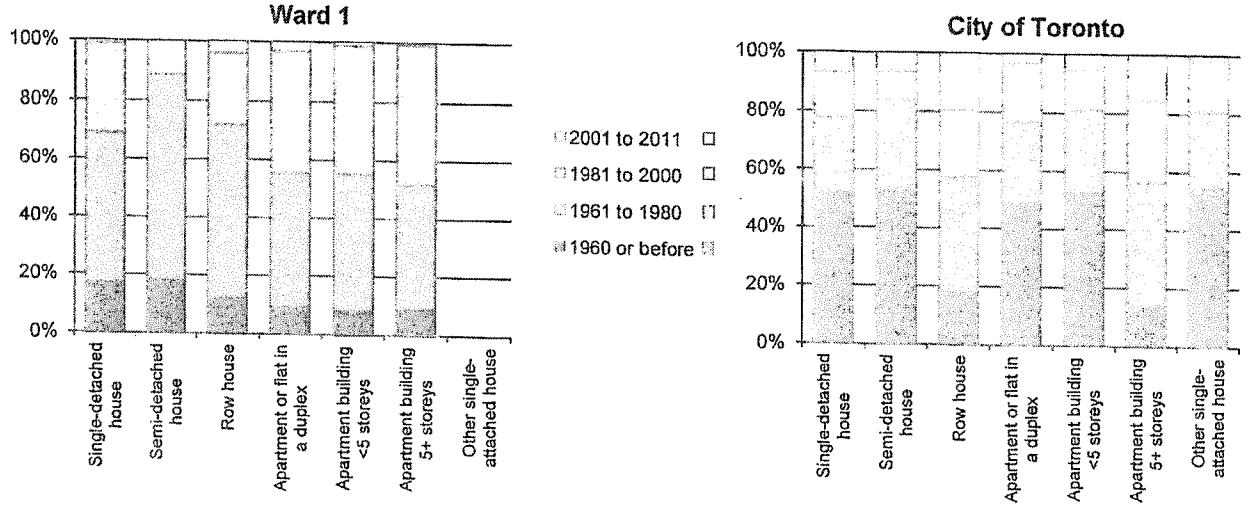
Ward 1

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
1960 or before	3,140	385	985	570	160	2,075	0	7,315
1961 to 1970	5,085	875	1,990	1,780	610	4,110	0	14,450
1971 to 1980	4,605	640	2,935	1,135	325	5,920	0	15,560
1981 to 1990	5,160	245	1,045	2,060	645	7,385	0	16,540
1991 to 2000	415	0	955	570	225	3,775	0	5,940
2001 to 2005	60	0	315	135	30	200	0	740
2006 to 2011	185	0	25	80	0	35	0	325
Total Population	**18,650**	**2,145**	**8,250**	**6,330**	**1,995**	**23,500**	**0**	**60,870**

City of Toronto

	Single-detached house	Semi-detached house	Row house	Apartment or flat in a duplex	Apartment building <5 storeys	Apartment building 5+ storeys	Other single-attached house	Total
1960 or before	427,505	115,675	32,575	59,355	178,890	120,575	3,015	937,590
1961 to 1970	135,640	37,385	26,245	20,620	51,465	178,495	620	450,470
1971 to 1980	78,080	30,640	47,575	14,250	45,535	195,990	815	412,885
1981 to 1990	84,410	12,885	24,860	14,490	29,000	147,515	475	313,635
1991 to 2000	43,185	7,970	17,745	9,575	16,730	95,235	475	190,915
2001 to 2005	33,645	9,830	20,425	2,215	10,020	64,185	85	140,405
2006 to 2011	23,600	4,650	15,535	2,115	8,895	74,990	30	129,815
Total Population	**826,065**	**219,035**	**184,960**	**122,620**	**340,535**	**876,985**	**5,515**	**2,575,715**

Population by Period of Construction and by Structure Type



Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

IMMIGRATION / MIGRATION

Population by Generation Status

Ward 1	No.	%
1st generation	40,475	66.4
2nd generation	16,595	27.2
3rd generation and over	3,850	6.3
Total Population	**60,920**	**100.0**

City of Toronto	No.	%
1st generation	1,324,850	51.4
2nd generation	696,380	27.0
3rd generation and over	554,795	21.5
Total Population	**2,576,025**	**100.0**

Population by Period of Immigration

Ward 1	No.	%
Before 1971	**3,385**	**8.7**
1971 to 1980	**3,440**	**8.9**
1981 to 1990	**5,760**	**14.8**
1991 to 2000	**10,810**	**27.8**
2001 to 2011	**15,440**	**39.8**
2001 to 2005	7,015	18.1
2006 to 2011	8,425	21.7
Total Population	**38,835**	**100.0**

City of Toronto	No.	%
Before 1971	**189,995**	**15.2**
1971 to 1980	**150,590**	**12.0**
1981 to 1990	**185,680**	**14.8**
1991 to 2000	**314,470**	**25.1**
2001 to 2011	**411,480**	**32.9**
2001 to 2005	194,955	15.6
2006 to 2011	216,525	17.3
Total Population	**1,252,215**	**100.0**

Population by Mobility Status (1-year and 5-year)

Ward 1	No.	%
1-Year		
Non-movers	**54,105**	**90.0**
Movers	**6,030**	**10.0**
Non-migrants	4,080	6.8
Migrants	1,950	3.2
Internal migrants	670	1.1
Intraprovincial migrants	530	0.9
Interprovincial migrants	140	0.2
External migrants	1,280	2.1
Total population 1 year ago	**60,135**	**100.0**
	No.	**%**
5-Year		
Non-movers	**33,775**	**59.6**
Movers	**22,930**	**40.4**
Non-migrants	13,720	24.2
Migrants	9,210	16.2
Internal migrants	2,440	4.3
Intraprovincial migrants	2,205	3.9
Interprovincial migrants	235	0.4
External migrants	6,770	11.9
Total population 5 years ago	**56,705**	**100.0**

City of Toronto	No.	%
1-Year		
Non-movers	**2,209,985**	**86.8**
Movers	**337,375**	**13.2**
Non-migrants	229,630	9.0
Migrants	107,745	4.2
Internal migrants	57,520	2.3
Intraprovincial migrants	45,425	1.8
Interprovincial migrants	12,095	0.5
External migrants	50,225	2.0
Total population 1 year ago	**2,547,360**	**100.0**
	No.	**%**
5-Year		
Non-movers	**1,415,355**	**58.1**
Movers	**1,020,310**	**41.9**
Non-migrants	644,555	26.5
Migrants	375,755	15.4
Internal migrants	175,175	7.2
Intraprovincial migrants	139,635	5.7
Interprovincial migrants	35,540	1.5
External migrants	200,580	8.2
Total population 5 years ago	**2,435,665**	**100.0**

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

IMMIGRATION / MIGRATION

Population by Immigrant Status and Top Ten Places of Birth*

Ward 1	No.	%
India	10,885	17.9
Guyana	3,340	5.5
Jamaica	2,815	4.6
Iraq	2,410	4.0
Sri Lanka	1,665	2.7
Philippines	1,645	2.7
Italy	1,535	2.5
Pakistan	1,530	2.5
Nigeria	1,175	1.9
Trinidad and Tobago	1,030	1.7
All Others**	10,750	17.7
Total Immigrants	**38,780**	**63.7**
Non-immigrants	**20,505**	**33.7**
Non-permanent residents	**1,585**	**2.6**
Total Population	**60,870**	**100.0**

*Countries as identified by Statistics Canada
**Includes "Other places of birth" in each continent

City of Toronto	No.	%
China	132,145	5.1
Philippines	102,520	4.0
India	78,870	3.1
Sri Lanka	59,225	2.3
Italy	53,485	2.1
Jamaica	45,665	1.8
United Kingdom	45,255	1.8
Portugal	39,525	1.5
Hong Kong S.A.R.	39,340	1.5
Guyana	36,995	1.4
All Others**	619,190	24.0
Total Immigrants	**1,252,215**	**48.6**
Non-immigrants	**1,258,870**	**48.9**
Non-permanent residents	**64,945**	**2.5**
Total Population	**2,576,030**	**100.0**

*Countries as identified by Statistics Canada
**Includes "Other places of birth" in each continent

Top Ten* Recent Immigrants by Place of Birth**

Ward 1	No.	%
India	3,035	36.7
Iraq	1,400	16.9
Nigeria	620	7.5
Pakistan	410	5.0
Jamaica	355	4.3
Guyana	350	4.2
Philippines	350	4.2
Sri Lanka	260	3.1
United States	80	1.0
Colombia	65	0.8
All Others	1,355	16.4
Total Recent Immigrants	**8,280**	**100.0**

*Excludes "Other places of birth" in each continent
**Countries as identified by Statistics Canada

City of Toronto	No.	%
Philippines	31,480	14.6
China	29,105	13.5
India	21,170	9.8
Iran	9,690	4.5
Sri Lanka	9,535	4.4
Pakistan	7,750	3.6
Bangladesh	7,275	3.4
United States	5,710	2.6
South Korea	4,260	2.0
Russian Federation	3,785	1.8
All Others	85,925	39.8
Total Recent Immigrants	**215,685**	**100.0**

*Excludes "Other places of birth" in each continent
**Countries as identified by Statistics Canada

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

ETHNOCULTURAL

Top Ten Ethnic Origin Groups

Ward 1	No.	%
East Indian	17,290	23.4
Jamaican	4,590	6.2
Canadian	3,385	4.6
Italian	3,125	4.2
English	2,595	3.5
Guyanese	2,495	3.4
Iraqi	2,440	3.3
Filipino	2,345	3.2
Somali	1,960	2.7
Pakistani	1,780	2.4
Other Ethnic Origins	**31,785**	**43.1**
Total Ethnic Origins Reported*	**73,790**	**100.0**

*Multiple responses are counted individually

City of Toronto	No.	%
English	333,220	8.5
Chinese	308,690	7.9
Canadian	291,665	7.5
Irish	250,460	6.4
Scottish	245,545	6.3
East Indian	195,590	5.0
Italian	177,065	4.5
Filipino	140,425	3.6
German	119,030	3.0
French	115,295	2.9
Other Ethnic Origins	**1,737,270**	**44.4**
Total Ethnic Origins Reported*	**3,914,255**	**100.0**

*Multiple responses are counted individually

Total Visible Minority Population

Ward 1	No.	%
Total Visible Minorities	**49,890**	**81.9**
South Asian	22,030	36.2
Black	14,015	23.0
Latin American	2,170	3.6
Filipino	2,060	3.4
Arab	1,905	3.1
West Asian	1,475	2.4
Southeast Asian	1,300	2.1
Chinese	675	1.1
Korean	155	0.3
Japanese	25	0.0
Visible minority, n.i.e.*	3,005	4.9
Multiple visible minorities	1,075	1.8
All Others	**11,035**	**18.1**
Total	**60,925**	**100.0**

*n.i.e. = not included elsewhere

City of Toronto	No.	%
Total Visible Minorities	**1,264,395**	**49.1**
South Asian	317,100	12.3
Chinese	278,390	10.8
Black	218,160	8.5
Filipino	132,445	5.1
Latin American	71,200	2.8
West Asian	50,235	2.0
Southeast Asian	46,825	1.8
Korean	37,225	1.4
Arab	28,915	1.1
Japanese	12,315	0.5
Visible minority, n.i.e.*	33,670	1.3
Multiple visible minorities	37,915	1.5
All Others	**1,311,630**	**50.9**
Total	**2,576,025**	**100.0**

*n.i.e. = not included elsewhere

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

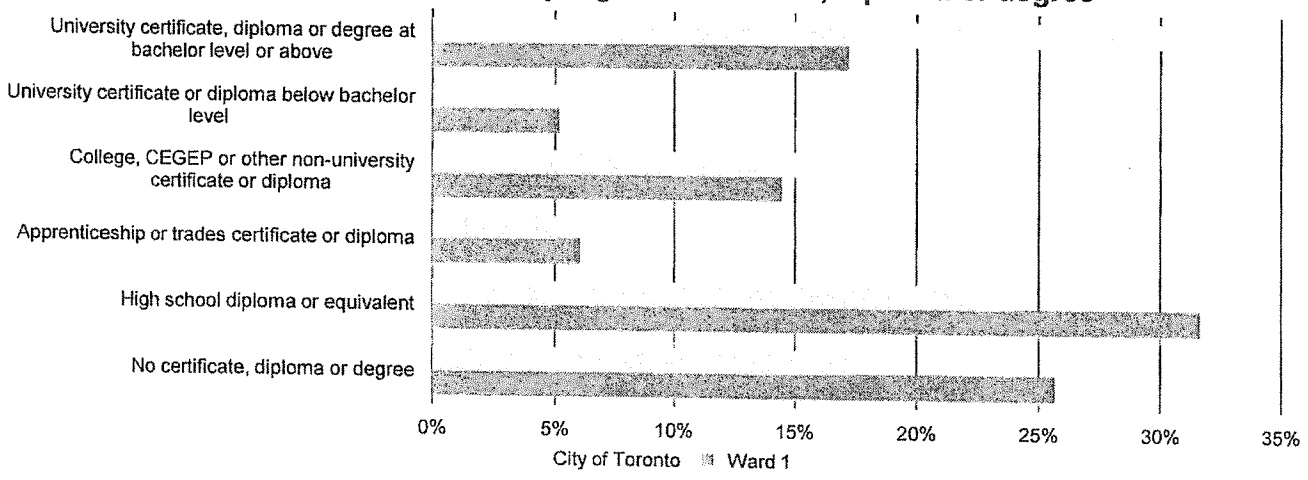
EDUCATION

Population 15+ years by Highest Certificate, Diploma or Degree

Ward 1	No.	%
No certificate, diploma or degree	**12,300**	**25.6**
Certificate, diploma or degree	**35,685**	**74.4**
High school diploma or equivalent	15,170	31.6
Postsecondary certificate, diploma or degree	20,515	42.8
Apprenticeship or trades certificate or diploma	2,890	6.0
College, CEGEP or other non-university certificate or diploma	6,925	14.4
University certificate or diploma below bachelor level	2,470	5.1
University certificate, diploma or degree at bachelor level or above	8,230	17.2
Bachelor's degree	5,235	10.9
University certificate, diploma or degree above bachelor level	2,995	6.2
Total population 15+ years	**47,985**	**100.0**

City of Toronto	No.	%
No certificate, diploma or degree	**380,965**	**17.5**
Certificate, diploma or degree	**1,794,870**	**82.5**
High school diploma or equivalent	523,315	24.1
Postsecondary certificate, diploma or degree	1,271,555	58.4
Apprenticeship or trades certificate or diploma	111,450	5.1
College, CEGEP or other non-university certificate or diploma	330,085	15.2
University certificate or diploma below bachelor level	113,640	5.2
University certificate, diploma or degree at bachelor level or above	716,380	32.9
Bachelor's degree	436,755	20.1
University certificate, diploma or degree above bachelor level	279,625	12.9
Total population 15+ years	**2,175,835**	**100.0**

Population 15+ years by highest certificate, diploma or degree



Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

Ward

Glossary

LABOUR FORCE

Labour Force

Ward 1	No.	%
Population 15+ years	47,980	100.0
In the labour force	28,995	60.4
Employed	25,275	52.7
Unemployed	3,720	7.8
Not in the labour force	18,985	39.6
Unemployment rate		12.8
Participation rate - Male		65.8
Participation rate - Female		55.4

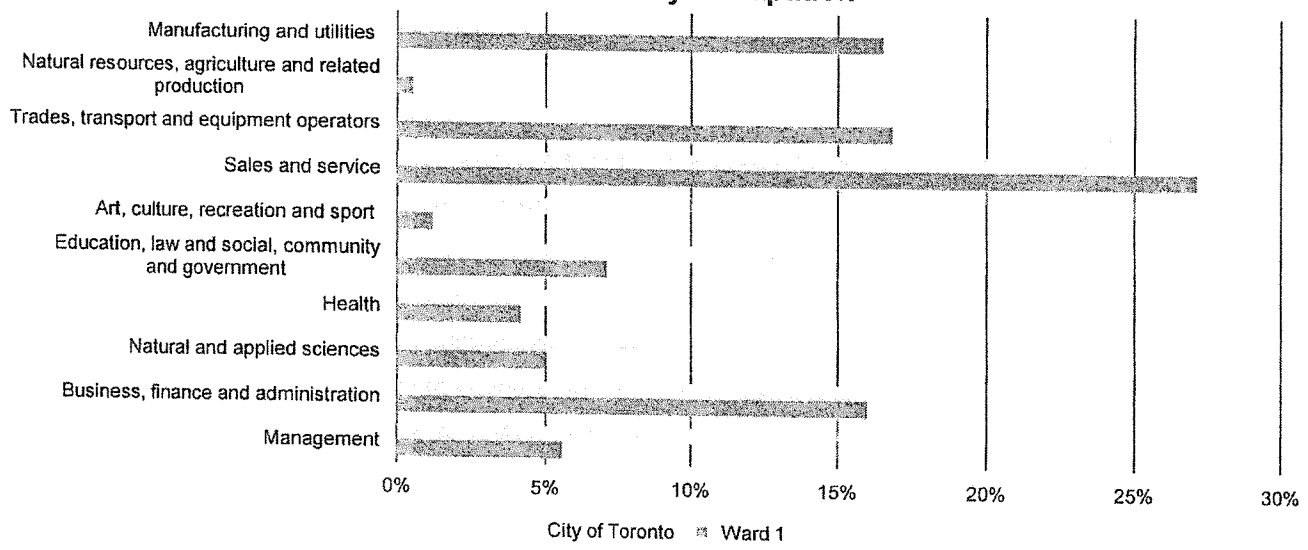
City of Toronto	No.	%
Population 15+ years	2,175,830	100.0
In the labour force	1,399,985	64.3
Employed	1,269,155	58.3
Unemployed	130,830	6.0
Not in the labour force	775,845	35.7
Unemployment rate		9.3
Participation rate - Male		69.1
Participation rate - Female		60.0

Labour Force by Occupation

Ward 1	No.	%
Management	1,515	5.6
Business, finance and administration	4,355	16.0
Natural and applied sciences	1,365	5.0
Health	1,130	4.1
Education, law and social, community and government	1,930	7.1
Art, culture, recreation and sport	325	1.2
Sales and service	7,390	27.1
Trades, transport and equipment operators	4,585	16.8
Natural resources, agriculture and related production	140	0.5
Manufacturing and utilities	4,500	16.5
Total	27,235	100.0

City of Toronto	No.	%
Management	153,445	11.4
Business, finance and administration	256,410	19.0
Natural and applied sciences	111,830	8.3
Health	72,980	5.4
Education, law and social, community and government	174,850	13.0
Art, culture, recreation and sport	72,110	5.3
Sales and service	315,905	23.4
Trades, transport and equipment operators	121,260	9.0
Natural resources, agriculture and related production	7,240	0.5
Manufacturing and utilities	63,165	4.7
Total	1,349,195	100.0

Labour Force by Occupation



Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

Ward [redacted]

Glossary

LABOUR FORCE

Labour Force by Industry

Ward 1	No.	%
Agriculture, forestry, fishing and hunting	105	0.4
Mining and oil and gas extraction	0	0.0
Utilities	45	0.2
Construction	1,110	4.1
Manufacturing	5,760	21.2
Wholesale trade	1,565	5.7
Retail trade	3,545	13.0
Transportation and warehousing	2,065	7.6
Information and cultural industries	660	2.4
Finance and insurance	1,220	4.5
Real estate and rental and leasing	455	1.7
Professional, scientific & technical services	1,255	4.6
Management of companies and enterprises	0	0.0
Admin. & support, waste mgmt. & remediation	2,120	7.8
Educational services	1,140	4.2
Health care and social assistance	2,000	7.3
Arts, entertainment and recreation	375	1.4
Accommodation and food services	1,990	7.3
Other services (except public administration)	1,245	4.6
Public administration	575	2.1
Total	**27,230**	**100.0**

City of Toronto	No.	%
Agriculture, forestry, fishing and hunting	1,940	0.1
Mining and oil and gas extraction	2,355	0.2
Utilities	7,260	0.5
Construction	64,910	4.8
Manufacturing	109,465	8.1
Wholesale trade	57,710	4.3
Retail trade	133,235	9.9
Transportation and warehousing	51,340	3.8
Information and cultural industries	62,860	4.7
Finance and insurance	112,415	8.3
Real estate and rental and leasing	35,215	2.6
Professional, scientific & technical services	155,440	11.5
Management of companies and enterprises	1,975	0.1
Admin. & support, waste mgmt. & remediation	72,620	5.4
Educational services	100,865	7.5
Health care and social assistance	131,520	9.7
Arts, entertainment and recreation	32,250	2.4
Accommodation and food services	88,300	6.5
Other services (except public administration)	67,380	5.0
Public administration	60,145	4.5
Total	**1,349,200**	**100.0**

Employed Labour Force 15+ years by Place of Work Status

Ward 1	No.	%
Worked at home	575	2.3
Worked outside Canada	110	0.4
No fixed workplace address	3,230	12.8
Worked at usual place	21,360	84.5
Total labour force	**25,275**	**100.0**

City of Toronto	No.	%
Worked at home	87,790	6.9
Worked outside Canada	6,750	0.5
No fixed workplace address	140,485	11.1
Worked at usual place	1,034,125	81.5
Total labour force	**1,269,150**	**100.0**

Employed Labour Force 15+ years by Place of Work Status

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

INCOME / SHELTER COSTS

Household Income - 2010

Ward 1	No.	%
Under $5,000	515	2.8
$5,000 to $9,999	395	2.2
$10,000 to $14,999	580	3.2
$15,000 to $19,999	900	5.0
$20,000 to $29,999	1,545	8.5
$30,000 to $39,999	1,945	10.7
$40,000 to $49,999	2,175	12.0
$50,000 to $59,999	1,895	10.4
$60,000 to $79,999	2,905	16.0
$80,000 to $99,999	1,960	10.8
$100,000 to $124,999	1,415	7.8
$125,000 to $149,999	900	5.0
$150,000 and over	1,025	5.6
Total number of private households	**18,155**	**100.0**
Average household income	$66,001	
Median household income	$55,027	
1-Person Households		
Average household income	$30,342	
Median household income	$22,678	

City of Toronto	No.	%
Under $5,000	40,120	3.8
$5,000 to $9,999	24,235	2.3
$10,000 to $14,999	36,950	3.5
$15,000 to $19,999	58,390	5.6
$20,000 to $29,999	99,645	9.5
$30,000 to $39,999	97,935	9.3
$40,000 to $49,999	95,325	9.1
$50,000 to $59,999	84,025	8.0
$60,000 to $79,999	135,840	13.0
$80,000 to $99,999	101,985	9.7
$100,000 to $124,999	84,855	8.1
$125,000 to $149,999	56,140	5.4
$150,000 and over	132,425	12.6
Total number of private households	**1,047,870**	**100.0**
Average household income	$87,038	
Median household income	$58,381	
1-Person Households		
Average household income	$48,165	
Median household income	$34,562	

Shelter Costs - 2010

Ward 1	No.	%
Renter Households		
Average rent	$909	
Hhds spending >30% of household income	3,238	40.7
Owner Households		
Average major payments	$1,268	
Hhds spending >30% of household income	3,059	30.0

City of Toronto	No.	%
Renter Households		
Average rent	$1,026	
Hhds spending >30% of household income	207,099	43.5
Owner Households		
Average major payments	$1,443	
Hhds spending >30% of household income	157,814	27.6

Low Income - 2010

Ward 1	No.	%
Population in private households	**60,925**	
Low Income*	13,355	
Incidence		21.9

* Low income in 2010 based on after-tax low-income measure (LIM-AT)

City of Toronto	No.	%
Population in private households	**2,465,500**	
Low Income*	496,660	
Incidence		19.3

* Low income in 2010 based on after-tax low-income measure (LIM-AT)

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

INCOME

Individual Income (15 years and over) - 2010

Ward 1	No.	%
Under $5,000	6,390	14.6
$5,000 to $9,999	3,485	8.0
$10,000 to $14,999	4,815	11.0
$15,000 to $19,999	5,435	12.4
$20,000 to $29,999	7,910	18.0
$30,000 to $39,999	5,845	13.3
$40,000 to $49,999	4,245	9.7
$50,000 to $59,999	2,175	5.0
$60,000 to $79,999	2,025	4.6
$80,000 to $99,999	1,035	2.4
$100,000 and over	475	1.1
Total	**43,835**	**100.0**
Average income	$27,332	
Median income	$21,908	
Males		
Average income	$30,292	
Median income	$25,248	
Females		
Average income	$24,479	
Median income	$19,584	

City of Toronto	No.	%
Under $5,000	255,925	12.5
$5,000 to $9,999	149,520	7.3
$10,000 to $14,999	187,965	9.2
$15,000 to $19,999	207,035	10.1
$20,000 to $29,999	285,550	13.9
$30,000 to $39,999	218,580	10.7
$40,000 to $49,999	180,965	8.8
$50,000 to $59,999	134,430	6.6
$60,000 to $79,999	175,655	8.6
$80,000 to $99,999	102,985	5.0
$100,000 and over	150,150	7.3
Total	**2,048,760**	**100.0**
Average income	$44,517	
Median income	$27,371	
Males		
Average income	$52,716	
Median income	$31,233	
Females		
Average income	$37,015	
Median income	$24,359	

Composition of Income (15 years and over) - 2010

Ward 1	Total Pop %	Male %	Female %
Market income	**77.9**	**82.9**	**72.0**
Employment income	71.7	76.3	66.2
Wages and salaries	68.6	71.8	64.7
Self-employment income	3.2	4.5	1.5
Investment income	1.8	2.0	1.7
Retirement pensions, superannuation & annuities	3.5	3.8	3.0
Other money income	0.9	0.7	1.1
Gov't transfer payments	**22.1**	**17.1**	**28.0**
Canada/Quebec Pension Plan	3.5	3.6	3.5
Old Age Security & GIS	4.2	3.1	5.5
EI benefits	2.6	2.3	2.9
Child benefits	4.1	0.4	8.4
Other gov't sources	7.7	7.7	7.7
Total 2010 income %	**100.0**	**100.0**	**100.0**

City of Toronto	Total Pop %	Male %	Female %
Market income	**88.5**	**91.5**	**84.6**
Employment income	76.1	79.6	71.7
Wages and salaries	69.6	71.5	67.0
Self-employment income	6.6	8.0	4.7
Investment income	5.7	5.5	6.0
Retirement pensions, superannuation & annuities	4.9	4.8	5.0
Other money income	1.8	1.7	1.9
Gov't transfer payments	**11.5**	**8.5**	**15.4**
Canada/Quebec Pension Plan	2.7	2.3	3.1
Old Age Security & GIS	2.7	1.9	3.8
EI benefits	1.2	1.0	1.6
Child benefits	1.4	0.1	3.0
Other gov't sources	3.4	3.1	3.8
Total 2010 income %	**100.0**	**100.0**	**100.0**

Source: Statistics Canada, National Household Survey 2011
For definition of variables, refer to Glossary.

City of Toronto Ward Profiles
2011 Census
Ward [redacted]

Glossary:

HIGHLIGHTS

Ward | Toronto

Population

Ward Population
61,315

+ 1.7%
2006-2011

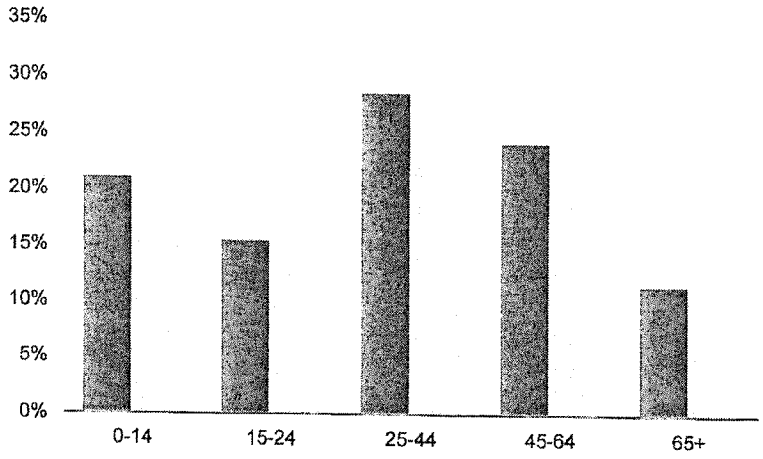
35 yrs
Median Age

39 yrs
Median Age

Population Density

3.53
thousand people per km²

2011 Population By Age Group



Households

40.6% live in apartment buildings of 5 or more storeys

[redacted]% live in apartment buildings of 5 or more storeys

3.8% live in apartment buildings of less than 5 storeys

[redacted]% live in apartment buildings of less than 5 storeys

11.9% live in row / townhouses

[redacted]% live in row / townhouses

43.7% live in houses

[redacted]% live in houses

Key Facts

16.7% children 25 years of age or more living at home	**17.9%** children 25 years of age or more living at home
6.6% with no knowledge of english or french	**5.3%** with no knowledge of english or french
3.36 persons per household	**2.46** persons per household
15.0% one person households	**31.6%** one person households

TORONTO City Planning
Strategic Initiatives, Policy & Analysis

Source: Statistics Canada, Census 2011
For definition of variables, refer to Glossary.

POPULATION*

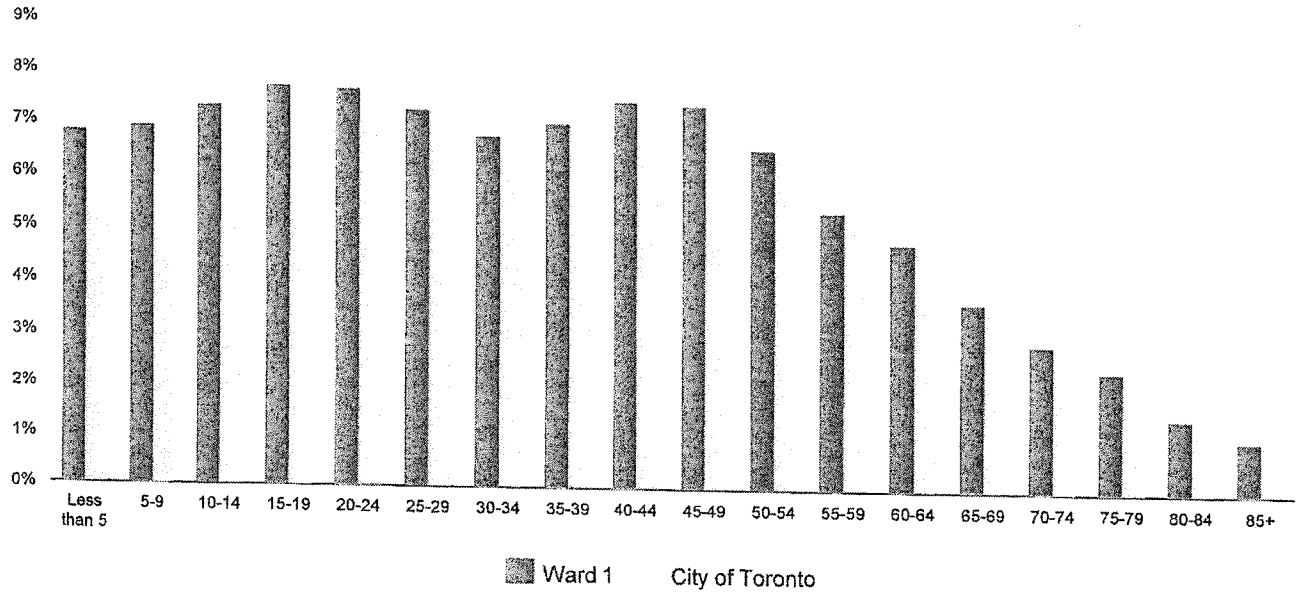
Population by Age Group

Ward 1	2006		2011		06-11
Age Group	No.	%	No.	%	% Chg
Less than 5	4,480	7.4	4,165	6.8	-7.0
5-9	4,550	7.5	4,225	6.9	-7.1
10-14	4,595	7.6	4,470	7.3	-2.7
15-19	4,180	6.9	4,710	7.7	12.7
20-24	4,565	7.6	4,680	7.6	2.5
25-29	4,640	7.7	4,435	7.2	-4.4
30-34	4,705	7.8	4,135	6.7	-12.1
35-39	4,670	7.7	4,285	7.0	-8.2
40-44	4,610	7.6	4,555	7.4	-1.2
45-49	4,200	7.0	4,510	7.4	7.4
50-54	3,385	5.6	4,000	6.5	18.2
55-59	3,100	5.1	3,275	5.3	5.6
60-64	2,470	4.1	2,920	4.8	18.2
65-69	1,965	3.3	2,245	3.7	14.2
70-74	1,670	2.8	1,755	2.9	5.1
75-79	1,210	2.0	1,445	2.4	19.4
80-84	750	1.2	880	1.4	17.3
85+	555	0.9	625	1.0	12.6
Total	**60,300**	**100.0**	**61,315**	**100.0**	**1.7**

City of Toronto	2006		2011		06-11
Age Group	No.	%	No.	%	% Chg
Less than 5	134,975	5.4	140,530	5.4	4.1
5-9	133,600	5.3	128,060	4.9	-4.1
10-14	141,020	5.6	132,285	5.1	-6.2
15-19	146,210	5.8	150,045	5.7	2.6
20-24	172,470	6.9	183,470	7.0	6.4
25-29	190,260	7.6	211,855	8.1	11.4
30-34	195,680	7.8	201,165	7.7	2.8
35-39	203,025	8.1	190,400	7.3	-6.2
40-44	212,600	8.5	197,395	7.5	-7.2
45-49	193,990	7.7	207,610	7.9	7.0
50-54	168,455	6.7	191,290	7.3	13.6
55-59	148,115	5.9	162,535	6.2	9.7
60-64	109,445	4.4	140,965	5.4	28.8
65-69	93,840	3.7	102,445	3.9	9.2
70-74	85,185	3.4	86,190	3.3	1.2
75-79	74,900	3.0	74,235	2.8	-0.9
80-84	56,465	2.3	59,645	2.3	5.6
85+	43,110	1.7	54,970	2.1	27.5
Total	**2,503,345**	**100.0**	**2,615,090**	**100.0**	**4.5**

*Note: Population count includes institutional residents and every person living in the City of Toronto on Census day.

Population by Age Group - 2011



Source: Statistics Canada, Census 2011
For definition of variables, refer to Glossary.

HOUSEHOLDS / DWELLINGS

Occupied Private Dwellings by Structural Type

Ward 1	No.	%
Single-detached house	5,300	29.2
Semi-detached house	650	3.6
Row house	2,160	11.9
Apartment, detached duplex	1,960	10.8
Apt, building that has 5 or more storeys	7,365	40.6
Apt, building that has less than 5 storeys	680	3.8
Other single-attached house	5	0.0
Movable dwelling	0	0.0
Total number of dwellings	**18,120**	**100.0**

City of Toronto	No.	%
Single-detached house	275,010	26.2
Semi-detached house	72,405	6.9
Row house	60,295	5.8
Apartment, detached duplex	44,740	4.3
Apt, building that has 5 or more storeys	429,225	41.0
Apt, building that has less than 5 storeys	163,895	15.6
Other single-attached house	2,200	0.2
Movable dwelling	110	0.0
Total number of dwellings	**1,047,880**	**100.0**

Private Households by Type

Ward 1	No.	%
One-family households	12,850	71.0
Multiple-family households	1,615	8.9
Non-family households	3,640	20.1
Total number of households	**18,105**	**100.0**

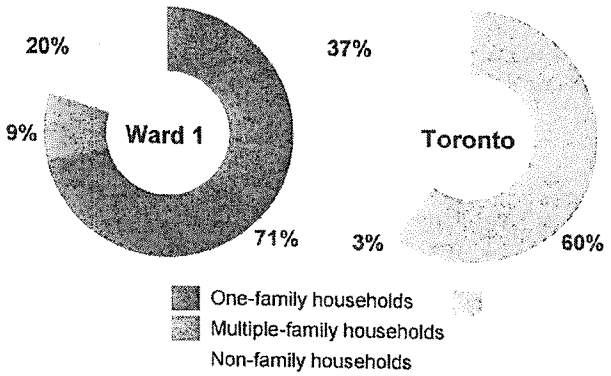
City of Toronto	No.	%
One-family households	625,820	59.7
Multiple-family households	31,135	3.0
Non-family households	390,920	37.3
Total number of households	**1,047,875**	**100.0**

Private Households by Size

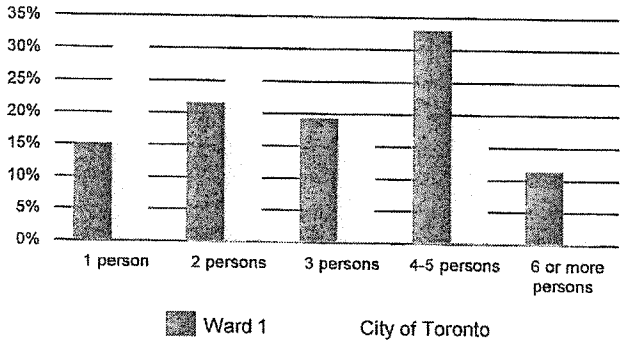
Ward 1	No.	%
1 person	2,720	15.0
2 persons	3,895	21.5
3 persons	3,480	19.2
4-5 persons	5,975	33.0
6 or more persons	2,045	11.3
Total number of private households	**18,115**	**100.0**
Population living in private households	60,860	
Average number of persons per household	3.36	

City of Toronto	No.	%
1 person	331,185	31.6
2 persons	307,845	29.4
3 persons	168,750	16.1
4-5 persons	201,765	19.3
6 or more persons	38,340	3.7
Total number of private households	**1,047,885**	**100.0**
Population living in private households	2,576,030	
Average number of persons per household	2.46	

Private Households by Type



Private Households by Size - 2011



Source: Statistics Canada, Census 2011
For definition of variables, refer to Glossary.

City of Toronto Ward Profiles
2011 Census

Ward [redacted]

Glossary

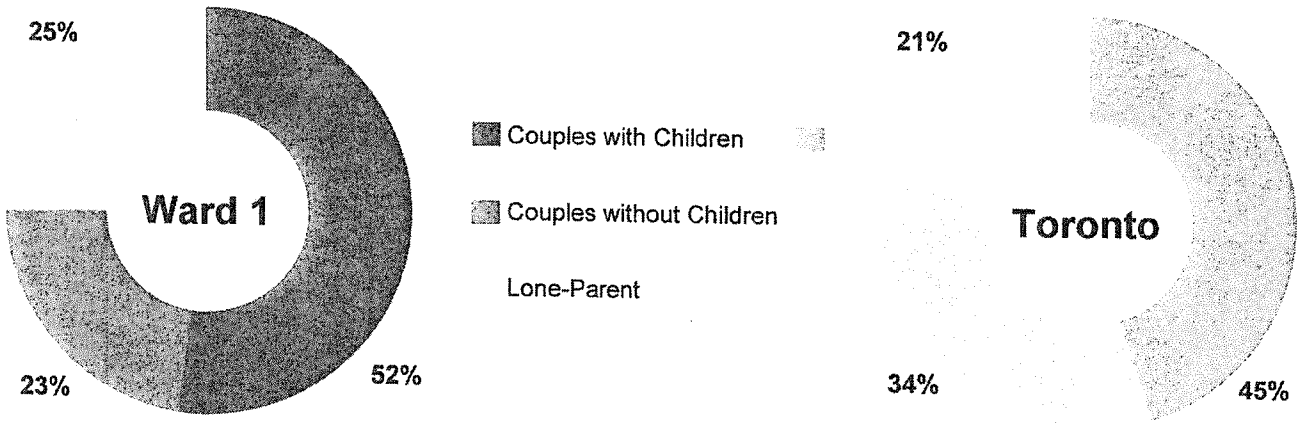
FAMILIES

Families by Type

Ward 1		
All Families	**No.**	**%**
Couples with Children	8,470	52.1
Couples without Children	3,700	22.8
Lone-Parent	4,090	25.2
Total	**16,260**	**100.0**
Couples	**No.**	**%**
1 Child	2,860	33.8
2 Children	3,665	43.3
3+ Children	1,945	23.0
Total	**8,470**	**100.0**
Lone Parent	**No.**	**%**
1 Child	1,955	47.8
2 Children	1,225	30.0
3+ Children	910	22.2
Total	**4,090**	**100.0**
Number of Children at Home by Age	**No.**	**%**
Under 6 years of age	4,955	20.2
6 - 14 years	7,805	31.7
15 - 17 years	2,720	11.1
18 - 24 years	5,005	20.4
25 years and more	4,105	16.7
Total	**24,590**	**100.0**

City of Toronto		
All Families	**No.**	**%**
Couples with Children	311,765	45.2
Couples without Children	231,590	33.5
Lone-Parent	146,985	21.3
Total	**690,340**	**100.0**
Couples	**No.**	**%**
1 Child	129,850	41.6
2 Children	129,450	41.5
3+ Children	52,465	16.8
Total	**311,765**	**100.0**
Lone Parent	**No.**	**%**
1 Child	89,600	61.0
2 Children	40,310	27.4
3+ Children	17,075	11.6
Total	**146,985**	**100.0**
Number of Children at Home by Age	**No.**	**%**
Under 6 years of age	165,825	20.9
6 - 14 years	231,955	29.3
15 - 17 years	84,815	10.7
18 - 24 years	168,280	21.2
25 years and more	141,885	17.9
Total	**792,760**	**100.0**

Families by Type



Source: Statistics Canada, Census 2011
For definition of variables, refer to Glossary.

City of Toronto Ward Profiles
2011 Census
Ward [redacted]

Glossary:

LANGUAGE GROUPS

Top Ten Mother Tongue Languages

Ward 1	No.	%
Single Response	58,155	95.6
English	25,000	41.1
Panjabi (Punjabi)	7,565	12.4
Gujarati	3,890	6.4
Spanish	1,930	3.2
Tamil	1,925	3.2
Italian	1,850	3.0
Semitic languages, n.i.e.*	1,840	3.0
Urdu	1,830	3.0
Arabic	1,530	2.5
Somali	1,065	1.8
Others	9,730	16.0
Multiple Response	2,695	4.4
Total	**60,850**	**100.0**
No Knowledge of English / French	4,005	6.6

City of Toronto	No.	%
Single Response	2,503,925	96.7
English	1,317,030	50.9
Chinese, n.o.s.**	85,235	3.3
Cantonese	83,955	3.2
Italian	71,725	2.8
Spanish	70,760	2.7
Tagalog (Pilipino, Filipino)	70,465	2.7
Tamil	61,605	2.4
Mandarin	59,820	2.3
Portuguese	58,175	2.2
Persian (Farsi)	41,905	1.6
Others	583,250	22.5
Multiple Response	85,145	3.3
Total	**2,589,070**	**100.0**
No Knowledge of English / French	136,040	5.3

Top Ten Home Languages

Ward 1	No.	%
Single Response	54,160	89.0
English	30,290	49.7
Panjabi (Punjabi)	6,150	10.1
Gujarati	2,885	4.7
Tamil	1,650	2.7
Semitic languages, n.i.e.*	1,495	2.5
Arabic	1,340	2.2
Spanish	1,335	2.2
Urdu	1,255	2.1
Italian	960	1.6
Somali	825	1.4
Others	5,975	9.8
Multiple Response	6,725	11.0
Total	**60,885**	**100.0**

City of Toronto	No.	%
Single Response	2,406,525	92.9
English	1,657,830	64.0
Cantonese	67,210	2.6
Chinese, n.o.s.**	61,480	2.4
Mandarin	50,430	1.9
Tamil	48,680	1.9
Spanish	45,330	1.8
Tagalog (Pilipino, Filipino)	37,200	1.4
Italian	35,025	1.4
Portuguese	34,580	1.3
Persian (Farsi)	30,595	1.2
Others	338,165	13.1
Multiple Response	182,550	7.1
Total	**2,589,075**	**100.0**

Top Five Home Languages - Change***

Ward 1	2006 No.	2011 No.	% Chg
Somali	565	825	46.0
Tamil	1,925	1,650	-14.3
Arabic	1,610	1,340	-16.8
Urdu	1,615	1,255	-22.3
Spanish	1,805	1,335	-26.0

City of Toronto	2006 No.	2011 No.	% Chg
Mandarin	38,285	50,430	31.7
Persian (Farsi)	27,565	30,595	11.0
Cantonese	75,440	67,210	-10.9
Italian	44,445	35,025	-21.2
Chinese, n.o.s.**	83,640	61,480	-26.5

* n.i.e. = not included elsewhere.
** n.o.s. = not otherwise specified - Chinese dialects include Hakka, Fukien, Shanghainese, Taiwanese, dialects not otherwise specified, as well as responses of "Chinese" that do not specify a dialect.
*** Top five most significant change within the Top Ten Home Languages table.

Sources: City of Toronto Ward Profiles Census (2011). *Ward 1*. Retrieved January 20, 2015, from http://www1.toronto.ca/City%20Of%20Toronto/City%20Planning/Wards/Files/pdf/W/Ward%2001%20Profile%202011.pdf, p. 1-5; and City of Toronto Ward Profiles National Household Survey (2011). *Ward 1 – Etobicoke North*. Retrieved January 20, 2015, from http://www1.toronto.ca/City%20Of%20Toronto/City%20Planning/Wards/Files/pdf/W/Ward%2001%20NHS%20Profile%202011.pdf, p. 1-13.

Appendix D: Post-Secondary Instructor Employment Designation Criteria

1.0 Policy

The full-time instructional faculty workload includes instruction, service to students, service to the College and community, and professional development. Full-time instructional faculty at COM-FSM is subject to the following guidelines while on duty (as defined in Section VIII.5.f). A full faculty workload includes:

- Teaching 12 to 15 contact hours per week with one to four preparations
- Teaching classes in accordance with the goals and objectives of the course as described in the course outline
- Maintaining accurate records of student attendance and student learning outcomes/grades in accordance with COM-FSM regulations
- Keeping at least 5 office hours per week
- Participating in one standing committee; may be asked to participate in adhoc committees
- Advising students
- Participating in special College functions such as graduation
- Participating in Division activities. This includes meetings, curriculum development and developing procedures for improving current classes.
- Participating in professional development, i.e. staying current in their professional field
- Attending to additional needs of the College and the community as may be required such as:
  1. In-house workshops
  2. Workshops for businesses or other agencies in the community
  3. Participation in student activities (clubs)
  4. Public relations
  5. Technical assistance for the community

Underload: When a faculty member's class is cancelled due to insufficient enrollment or a full class load cannot be assigned to a faculty member, the administration through the Division Chair in consultation with the faculty member is to determine an alternative work assignment. A faculty member's salary will not be reduced due to the underload.

Overload: When the administration determines that a course or another section must be taught and assigns it to a faculty member with a maximum teaching load, the additional course or section is considered an overload. The overload agreement is to be made after the core workload arrangement has been approved by the Vice President for Instructional Affairs. Each contact hour above the 15 contact hours will be considered an overload. The faculty member has the right to refuse an overload and the decision will not affect the instructor's status.

1) **PART- TIME FACULTY:** Academic staff teaching up to and including six (6) hours per week.

i. **Rates of Pay:** Hourly rate is negotiated and determined by the hiring manager.
ii. **Restrictions:** There is no restriction on hiring – individuals can work indefinitely.

2) **REGULAR PARTIAL LOAD FACULTY:** Accumulates the salary costs of hourly rated academic staff as defined in the Collective Agreement for academic staff, teaching more than six (6) and up to twelve (12) hours per week for more than 7 weeks [redacted].

i. **Rates of Pay:** Regular Partial Load employees are placed on the salary grid once a "Partial Load Calculation Sheet" is completed by his/her manager. Education and experience are taken into account and prior sessional service would also contribute toward placement on the grid. If the hiring manager requires any assistance in completing a calculation sheet, they are to be directed to HR, Employee Services for assistance. The regular partial load employees were included in the Collective Bargaining Union after the Pay Equity plan was implemented [redacted] The pay equity plan provided compensation for the following within the hourly wage of Regular Partial Loads:

- Preparation of courses
- Evaluation and feedback
- Student advising
- Registration week
- Study week
- Exam week
- Course development
- Committee participation
- Other complimentary functions
- Vacation

If the combination Regular Partial Load contracts differ in steps (rates) and scales for different departments, then the step outlined in the partial load calculation sheet submitted by the initial department will be used on all authorizations regardless of the scales.

In the event of a difference of qualifications and experience required for different courses that will affect the initial step (rate) for the professor/instructor, then the authorizations with the greater number of hours will dictate the step (rate) at which they will be paid.

[redacted] [redacted]

[redacted]

Assignments outside of Partial Load status: If an employee is assigned a subsequent authorization to replace a full-time regular employee for up to 14 days (3 weeks) for unplanned absences in any month, he shall not have such period(s) counted as sessional employment for the purpose of the computation of the 12 months sessional employment. During such periods the employee shall be paid as if Partial-Load and within the range of Partial Load hourly rates as set out in Article 26, Partial Load Employees. If it is more than 3 weeks, then the employee changes to Sessional Status for that period. Union dues should be stopped and sessional weeks counted. [redacted]

ii. **Progression through grid:** [redacted] For the purpose of determining progression through the grid ten months of on-the-job experience will entitle the employee to one year of service and to progress one step on the grid; [redacted] On-the-job experience will be calculated as follows: a partial load teacher will be entitled to credit for service from September 1, 1971 (but not earlier) on the basis of ½ month's credit for each full month of service up to January 1, 1977 and thereafter on the basis of ½ month's credit for each calendar month in which the employee teaches 30 hours or more. This calculation is completed at the request of the Chair or hiring manager.

iii. **Eligibility for Benefits:** All Regular Partial Load employees are offered the opportunity to enroll in the benefit plan as stipulated in the Academic Collective Agreement and the Academic Pay Equity Plan. Benefit questions can be redirected to an HR Benefits Officer, and partial load sick leave questions can be redirected to [redacted]

Benefits:	Extended Health	100% EmployER paid
	Vision & Hearing	100% EmployEE paid
	Dental	100% EmployEE paid
	Life Insurance	100% EmployEE paid
Sick Leave:	Entitled to prorated sick leave benefits	
Seniority:	Entitled to seniority progression as it relates to the salary grid but not to job security or bumping rights.	

3) **SHORT TERM PARTIAL LOAD:** Academic staff teaching more than six (6) and up to twelve (12) hours per week for up to and including seven (7) weeks. Accumulate the salary costs of part-time academic staff [redacted].

i. **Rates of Pay:** professors/instructors in this category, the hourly rate is negotiated and determined by the hiring manager.

ii. **Restrictions:** There must be a break of at least two full weeks in order to assign a subsequent Short Term Partial Load Assignment. If less than two weeks, then both assignments will count as one whole Regular Partial Load assignment (continuous week) and Regular Partial Load guidelines will apply.

[redacted]

4) **SESSIONAL FACULTY:** Academic staff teaching more than twelve (12) teaching hours per week. Sessional teaching is considered a full time equivalent.

i. **Rate of Pay:** Sessional employees are paid hourly or weekly. Hourly and weekly rate can be negotiated by the hiring manager.
ii. **Sessional Limit:** A sessional employee can teach up to 10 months of service in a 24 month rolling period. Once an employee has reached the limit of 10 months, they can only teach Part-Time hours (up to 6 hours per week)
iii. **Not included in sessional monitoring:** The following situations do not count towards the computation of the 10 month review of sessional time used:
   - A person assigned to replace a full-time regular employee for up to 14 working days for unplanned absences (Sick Leave)
   - Co-ordination
   - Academic Advising
   - Distance Learning
   - Non teaching/Non replacement

5) **COUNSELLORS AND LIBRARIANS**

i. **Rate of pay:** The hourly rate is negotiated and set at the discretion of the Chair/Director.

ii. **Categories:** Counsellors and librarians who work 24 hours/week and under are considered part time. Counsellors and librarians who work more than 24 hours/week are considered sessional. All sessional rules and restrictions referred to in the above noted section also apply.

6) **CO-ORDINATORS:** Part-Time faculty who have co-ordination responsibilities, which can include non-teaching hours and coordination of courses and programs.

i. **Rates of Pay:** Hourly rate is negotiated and determined by the hiring manager

Sources: University of Toronto (2014). *Full-Time Instructional Faculty Workload Policy*. Retrieved December 2, 2014, from https://www.utsc.utoronto.ca/~vpdean/documents/FacultyWorkloadPolicy002.pdf, p, 1; and Algonquin College (2014). *Part-Time Staff Classification and Compensation Employee Guide*. Retrieved December 2, 2014, from http://www.algonquincollege.com/hr/files/2011/03/PT-Classification-and-Compensation-Employee-guide.pdf, p. 4-6.

Appendix E: Sample Evaluation Guides for Post-Secondary Student Transcript Grades and Academic Status

Baccalaureate Transcript Guide

Explanation of Weighted Grade Average (G.P.A.) Calculation for [redacted] Undergraduate Programs

[redacted] uses a weighted Grade Point Average (G.P.A.) on your transcript. The weighted Grade Point Average is calculated for all of the courses you have taken within a program.

Example of a Weighted Grade Average (G.P.A.) Calculation

Sample Calculation for Program: Bachelor of Applied Arts [redacted]

	Course #	Course Name		Credit		Grade	Calculation (Credit x Grade)
Fall 2003	PLBA 100	Philosophy of law		3.0	x	AEG	= No Calculation
	PLBA 101	Intro to Canada's Legal System		3.0	x	AUD	= No Calculation
	PLBA 102	Small Claims Court 1		3.0	x	SAT	= No Calculation
	PLBA 103	Tort and Contract Law		3.0	x	95	= 285
	PSYC 400	Psychology		3.0	x	45	= 135
		*** Term GPA	70.0	***			= 420/6
Winter 2004	PLBA 151	Charter of Rights & Freedoms		3.0	x	50	= 150
	PLBA 152	Small Claims Court 2		3.0	x	UNS	= No Calculation
	PLBA 153	Evidence		3.0	x	80	= 240
	PLBA 154	Intro to Legal Writing		3.0	x	SAT	= No Calculation
	POLS 106	Political Science		3.0	x	70	= 210
		*** Term GPA:	75.0	***			= 600/9
		*** Final GPA:	68.0	***			= 1020/15

Special Grades

* AEG = Aegrotat
* AUD = Audit
* INC = Incomplete
* SAT = Satisfactory
* UNS = Unsatisfactory

R = Repeated course

* W = Withdrew from the course without academic penalty

WF = Withdrew from the course. Counted as a grade of zero in calculating grade point average

Special grades of AEGROTAT, AUDIT, GRADE NOT EARNED, SATISFACTORY and UNSATISFACTORY are described separately in the Academic Regulations

* Grades NOT used in GPA Calculation

Interpretation of Course Symbols: X Extra course not credited to the degree in which the student was enrolled at the time
On the basis of an appeal, the grade shown but not included in GPA calculation.

Academic Decisions:

In Good Standing	Academic Probation
Required to Withdraw	Required to Withdraw from Faculty
Suspension	Expulsion

A copy of the [redacted] Calendar can be found on the internet at [redacted] The [redacted] Academic Regulations are also available on the internet at [redacted]

[redacted] is a member of the Association of Canadian Community Colleges (A.C.C.C.). The A.C.C.C. fully recognizes [redacted]'s academic programs. For complete details please visit their Website at http://www.accc.ca

[redacted]

[redacted] COLLEGE / UNIVERSITY [redacted] - BACHELOR OF NURSING

Transcript Key

Grading System - Undergraduate Programs

Letter Grade	Grade Points	Letter Grade	Grade Points
A +	4.3	B -	2.7
A	4.0	C +	2.3
A -	3.7	C	2.0
B +	3.3	D	1.0
B	3.0	F	0.0

GPA Calculations

Two GPA calculations are shown: program cumulative and program assessment. The program assessment GPA includes all work completed from the beginning of the program or since the last assessment GPA was taken, provided 24 credit hours of work were attempted. Not all courses necessarily included in the GPA (such as those deemed extra to the program or forgiven on appeal).

Academic Decisions

In Good Academic Standing - Permitted to re-register.

Academic Probation -Must maintain an assessment GPA of at least 2.0 in each subsequent assessment period or required to withdraw. This status permitted only once in a program.

Required to Withdraw - Not permitted to register for a period of at least 12 months.

Required to Withdraw from Faculty - Not permitted to continue in the current program.

Suspension - Not permitted to register for a special period of time.

Expulsion - Not permitted to register at the College.

Interpretation of Non-graded Symbols

AUD	Audit
CR	Credit
NCR	No Credit
INC	Incomplete
AEG	Aegrotat Standing. Granted pass standing on the basis of work completed.
W	Withdrew from the course without academic penalty.
CTN	Final grade and credit shown in winter term. Course continues into the next term.
WF	Withdrew from the course. Counted as a grade of zero in calculating grade point average.

Interpretation of Course Symbols

X	extra course not credited to the degree in which the student was enrolled at the time.
#	On the basis of an appeal, the grade shown but not included in GPA calculations.

Academic Terms

IN - INTERSESSION:	May to June
SU - SUMMER SESSION:	July to August
FA - FALL:	September to December
WI - WINTER:	January to April

Courses and Credit Hours

Credit hours have been assigned to all undergraduate courses. Typically a term course would be assigned 3 credit hours, a year course 6 credit hours, although credit hours may range from 0 - 18 with Senate approval.

Awards

Awards administered by the University listed [redacted]

[redacted]

Sources: Molize College (2014). *Baccalaurette Transcript Guide*. Retrieved December 2, 2014, from http://www.humber.ca/sites/default/files/uploads/documents/bachelorette_transcript_key_for_adeg.pdf; and Molize College (2014). *Molize College/University of New Brunswick Bachelor of Nursing Transcript Key*. Retrieved December 2, 2014, from http://fulltimestudents.humber.ca/humb-unb_transcript_key_%20v1.pdf.

Appendix F: Sample Post-Secondary Classroom, Assignment, and Exam Accommodations

Classroom accommodations

My illness or medication causes problems with:	Possible accommodations
concentration, keeping focused, processing information, organizing my thoughts, dealing with social situations	*Peer note-taker* A formal arrangement where someone in the class takes notes for you. You still have to attend class, but it may help to reduce your anxiety and allow you to participate more in class. *Taping the lecture* This can supplement your own note-taking, and reduce the pressure of having to capture all the information. If you use a digital recorder, the software will allow you to download the lecture to your computer for easy access. You will need to get the permission of your teacher prior to taping. *Preferential seating* You can arrange to sit in the front of the classroom and away from windows to help reduce audio and visual distractions. *Note-taking technology* Laptops, personal digital assistants (PDAs) with folding keyboards or small word-processing keyboards such as AlphaSmart (www.alphasmart.com/products/as3000_overview.html) or Dana (www.alphasmart.com/products/dana_overview.html) are an option if you find taking notes using a keyboard easier than handwriting.
anxiety	*Companion/accompanier* Another student can walk you to class and sit with you in class. *More frequent breaks* You can arrange to step out of class when you need to move around to relieve stress, anxiety or restlessness.
thirst caused by medication	*Beverages in class* Permission can be given to have beverages in class if this is not usually permitted.

30

Assignment accommodations

My illness or medication causes problems with:	Possible accommodations
concentration, keeping focused, processing information, organizing my thoughts	*Academic coach or tutor* One-on-one help can be provided to help you with studying and your assignments. *Readings in advance* Sometimes arrangements can be made for you to have the course materials in advance so you have extra time to read them.

	Assistance editing essays A coach or tutor can provide help by helping you edit your essays for organization, clarity, grammar and spelling.
anxiety	*Extensions* In some cases, deadline extensions can be arranged. This can help reduce stress, particularly if you have several assignments all due at the same time.

31

Exam accommodations

My illness or medication causes problems with:	**Possible accommodations**
concentration, keeping focused, processing information, dealing with social situations	*Preferential seating* You can arrange to sit in the front of the exam room and away from windows to help reduce audio and visual distractions.
anxiety	*Quiet location or separate room for exam* It may be possible to write an exam in a separate room with only a few students or on your own in a supervised area. *Supervised breaks during exam* You can arrange to step out of the exam when you need to move around to relieve stress, anxiety or restlessness. *Changes to scheduled exam dates* Arrangements can be made to write tests on different dates if you have several taking place in close succession.
fatigue, concentration	*Extended time for exams* You may be able to arrange for additional time to complete your exam. *Exam broken into segments with rest breaks* This reduces the effects of fatigue and allows you to focus on one section at a time. *Changes to scheduled exam times* Exams can be scheduled for times when you work best, for example, afternoon rather than early morning

32

Source: Canadian Mental Health Association (2014). *A Guide to College and University for Students with Psychiatric Disabilities.* Retrieved December 17, 2014, from http://www.cmha.ca/mental_health/a-guide-to-college-and-university-for-students-with-psychiatric-disabilities/#.VJHKPovF_7x, p. 30-32.