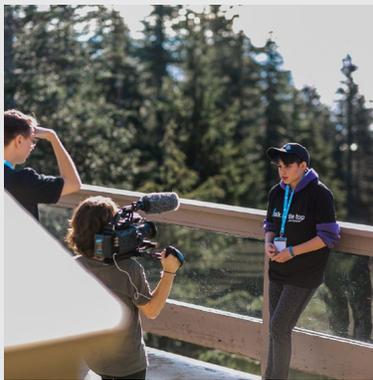


2019

Youth Voice Report.



A Note on the Report

Through the Youth Voice Report and the Campus Assessment Tool pilot, we at Jack.org have seen how much work is already being done by institutions, organizations, communities and individuals across Canada. Together we are making real progress and ushering in a new era of mental health and wellness for this and future generations. We loudly and proudly celebrate the work already being done across the country. Results from the Youth Voice Report are not published in the spirit of finger-pointing, but rather as a call to collaboration. We also acknowledge the complexity of the issues we are wrestling with; this report is not definitive but invites discussion. Jack.org and our network of young leaders are eager to work with adult allies to make sure young people know about the systems that are already in place to serve them, and close the gaps where they exist. This is about building a better future. Together.

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The State of Youth Mental Health in Canada

Any legitimate consideration of the depth and scale of mental health struggle in Canada tempts despondence.

The 2009 Canadian Census found that 202 young people aged 15 to 19 died by suicide across the country, accounting for a quarter of all deaths in that age group making suicide the second leading cause of death for young people in Canada.^[1] A 2015 update found that 518 young people aged 15 to 24 years old died by suicide, again accounting for a quarter of all deaths in this age group.^[2]

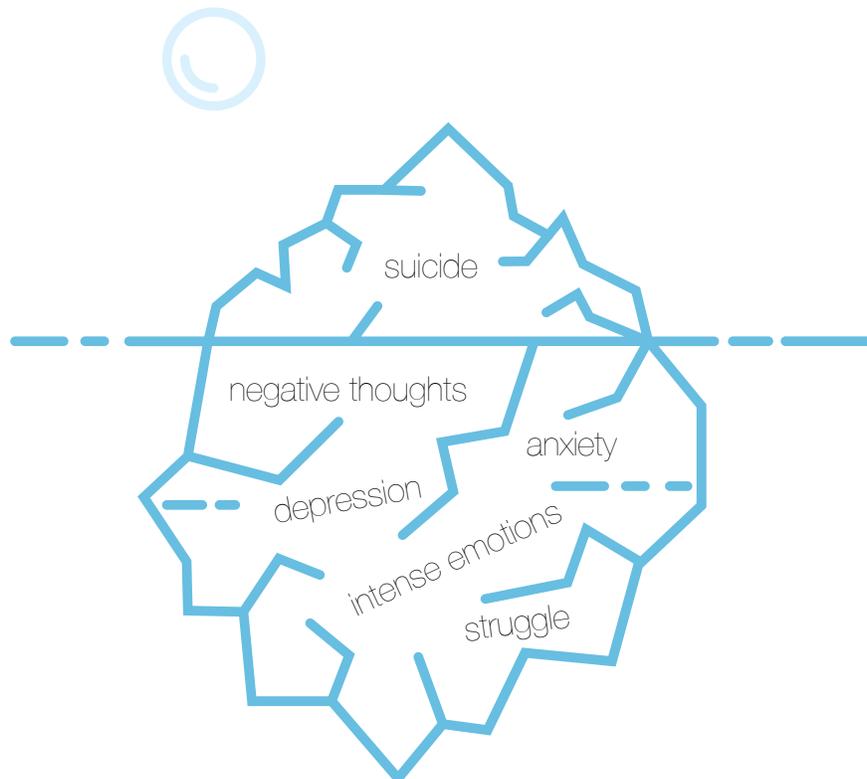
And while these statistics are incredibly troubling, they are a poor proxy for the burden of youth mental health struggle across the country.

They represent only the tip of the iceberg.

For the 518 youth aged 15 to 24 years old who died by suicide, it's estimated that a further 150,000 youth attempted suicide in 2015, and as

many as one in seven reported having suicidal thoughts.^[2] Further, mental health struggles don't always manifest in thoughts of suicide. Many young people report struggling with their mental health in other ways – with negative thoughts, feelings, and/or emotions that are intense, long lasting, and have a big impact on one's life and daily function. In a recent representative survey of Canadians, a worrying 63% of those aged 20 to 34 years old reported suffering from mental health struggles,^[3] primarily anxiety and depression, and 10% of those aged 15 to 24 reported that they had experienced symptoms of depression in their lifetime.^[2] When enduring struggle, those aged 20 to 34 (millennials) were also less likely to seek help than their parents or grandparents. With these considerations, we see a much more complete picture of the scale and complexity of youth mental health.^[3]

Those suffering need a response, and we know a few young people who are doing their part.

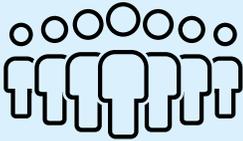


Meet the Network

Who they are

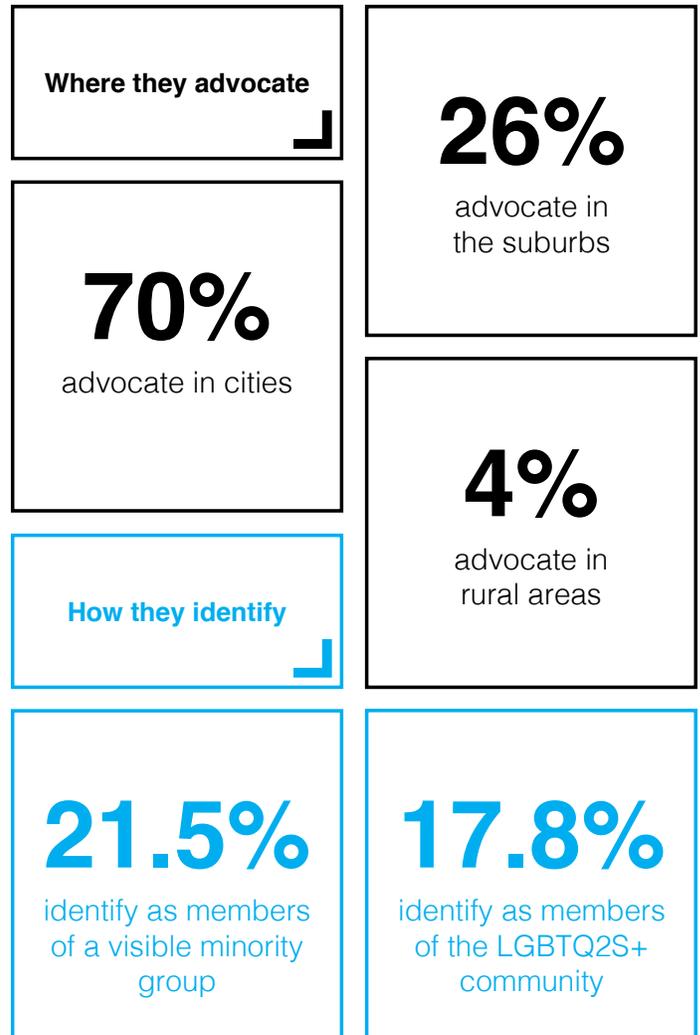
Where some see hopelessness, others see a challenge.

Just last year,



2,800 young people
within the Jack.org network took it upon themselves to address national youth mental health struggle.

For many of these advocates, mental health struggle is not a statistic, but a lived experience. Just over half (52%) of our network live with a diagnosable mental illness, and nearly two-thirds (61%) have struggled with their mental health at some point in their lives.



What they are doing

Personal experience with struggle is what motivated them to become advocates for positive mental health in their communities. After undergoing rigorous training, these young people engaged their peers as Jack Talk speakers, Jack Chapter leaders, and Jack Summit organizers.

Just last year, 121 Talk speakers delivered 445 Jack Talks, reaching 70,418 of their peers across the country. Jack Talks educate young people, equip them with skills to support others, and encourage them to seek help when they were struggling. The majority (72%) of young people who listened to a Jack Talk said they learned useful information about mental health, and the same majority reported knowing where to access support for their mental health after listening to the talk.

Over 2,000 Jack Chapter leaders in 241 high schools and post-secondary institutions held 930 initiatives to raise awareness about mental health and improve knowledge about finding resources in communities across the country. These initiatives changed attitudes about mental health, illness, and help seeking.

Young people across the country also hosted Jack Summits and Regional Summits. Five Jack Summits were held in Toronto, Winnipeg, Yellowknife, Montreal, and Vancouver, and 24 Regional Summits were held in seven provinces across the country. Together, these summits brought together over 1,500 young mental health advocates, dedicated to promoting mental health for their peers. These summits serve as opportunities for these young people to share ideas and grow together. A majority (88%) of summit delegates go back to their communities with knowledge and skills to further their advocacy efforts, and even more (91%) felt confident that they could work with their community to promote youth mental health.



The peer-to-peer advocacy that these young people have been engaged in has made much progress, but there are limitations to this form of advocacy.

For example, while young people can educate their friends on mental health signs and symptoms, community resources for support, and encourage help seeking during times of struggle, they can do little to change the realities of wait times and demanding academic curriculums on their own. For this, they need to collaborate with decision makers in their community, provincially, and nationally.

And that's why this **Youth Voice Report** exists.

Our network has a lot to say, and they're uniquely qualified to say it.

- Many have lived experience of struggle and illness
- They're all knowledgeable of the barriers to positive mental health that exist in their community
- They're eager to collaborate

In this report, we managed to summarize all they've had to say into five key recommendations to promote youth mental health:

1. Help young people navigate the complex mental health care system so they can receive care that meets their needs in a timely fashion.
2. Deliver mental health services that meet young people's needs by consulting young people on how to deliver mental health services and involving young people in decisions that impact their mental health.
3. Protect, promote, and maintain positive mental health on campuses by: managing crisis, offering a range of mental health resources, identifying and responding to struggle early, and applying a mental health lens to all policies, programs, and practices.
4. Reimagine teaching and assessment practices to alleviate mental health struggle among young people.
5. Encourage better social media practices by developing evidence-based guidelines on healthy social media use for young people and creating digital environments that foster positive mental health.

Jack.org has always engaged young people, worked with them to tackle complex mental health issues in their community, and listened. Now, we're sharing what we've heard.

The Process

To get the ball rolling, we asked our network a few questions:

- What causes mental health struggle for young people in your community?
- What prevents young people from getting help when they need it?
- How can adult allies help promote youth mental health?

We sought answers by surveying our network, receiving a total of 541 responses. Respondents ranged in age from 15 to 27 years old. The majority (83%) identified as female, a few (16%) as members of the LGBTQ2S+ community, and a handful (4%) as members of Indigenous communities. Almost a quarter (25%) of those surveyed were members of a visible minority community.

Just over half (52%) of all respondents had a diagnosable mental illness.

We asked the same questions in focus groups at 24 regional summits and 5 Jack Summits across the country.

Regional Summits and Jack Summits



Regional Summits:

1. Calgary, AB
2. Edmonton, AB
3. Chilliwack, BC
4. Vancouver, BC
5. Richmond, BC
6. Sackville, NB
7. Fredricton, NB
8. Grand Bank, NL
9. Cornerbrook, NL
10. Halifax, NS
11. Middle Sackville, NS
12. Alliston, ON
13. Kingston, ON
14. Thornhill, ON
15. Etobicoke, ON
16. Toronto, ON
17. Sault Ste. Marie, ON
18. South Porcupine, ON
19. Red Lake, ON
20. Windsor, ON
21. Hamilton, ON
22. Montreal, QC

Jack Summits:

16. Toronto, ON (258 delegates)
4. Vancouver, BC (56 delegates)
23. Yellowknife, NWT (50 delegates)
24. Winnipeg, MB (85 delegates)
22. Montreal, QC (62 delegates)

Through these consultations we gathered feedback from 1,500 young advocates. These advocates discussed barriers to positive youth mental health in their communities, reflected on the progress they've made and work they can continue to do to address these barriers, and then told us how adults in the communities where they live, learn, and grow can aid their efforts.

This year, ten Jack Chapters took part in the Campus Assessment Tool (CAT) pilot project. The CAT is a five-part, youth-led participatory research project designed to support the advocacy work of student-run Jack Chapters. The tool guides young people through a process of understanding how their campus communities serve, protect, and promote youth mental health. Before being launched, the tool was reviewed by leading experts in the youth mental health space, revised based on recommendations, and championed by industry experts in post-secondary institutions.

The tool is made up of directives and surveys to gauge the range of services offered on campus, the accessibility of these services, and student satisfaction with what is offered. In addition to assessing mental health supports on campus, the tool asks broader questions of how campuses

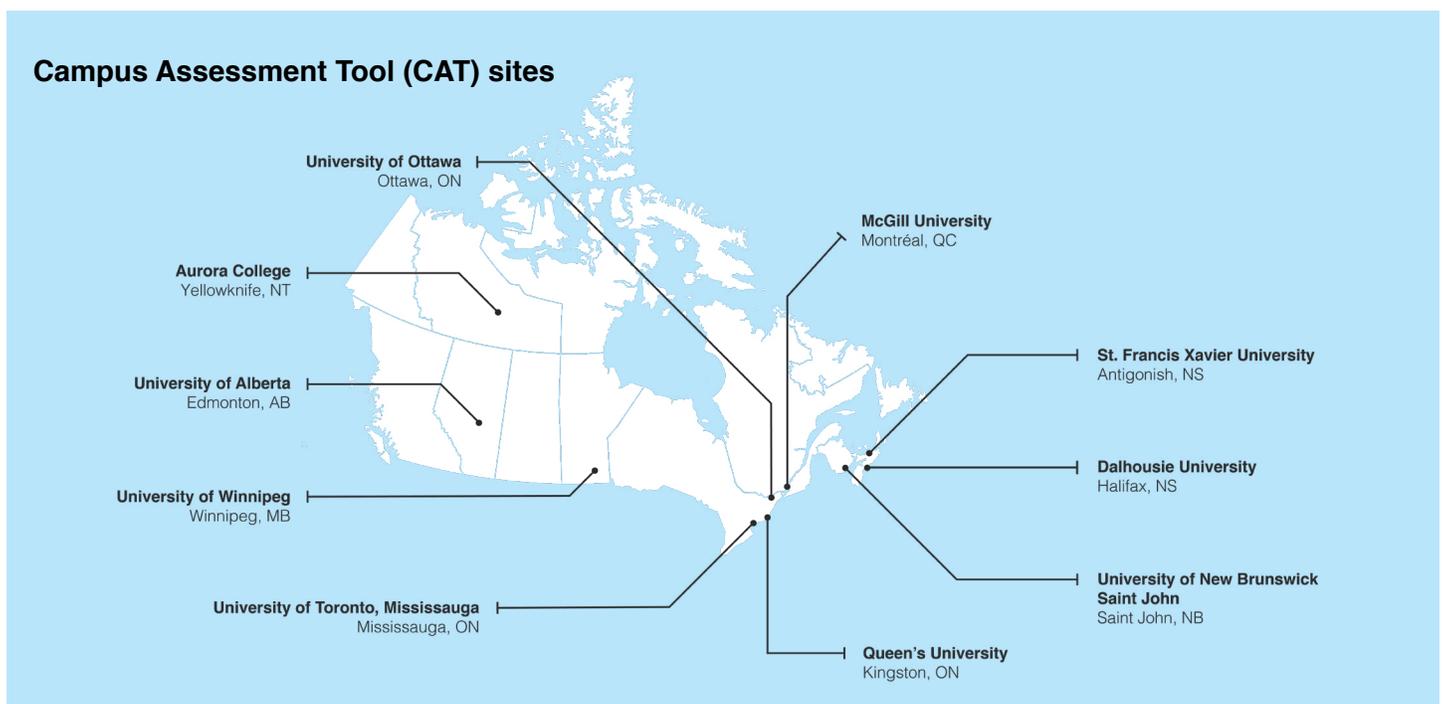
support and promote positive mental health. To this end, the tool seeks to understand how specific upstream factors may hinder or encourage people from accessing services, or how policies and programs create or prevent mental health struggle in the first place.

The purpose of the CAT is to transfer power to multiple youth voices across Canada and determine systems-level priorities for change in individual post-secondary campuses. Individual CAT results identify what services are currently available on their campus, where the gaps in services lie, and allow them to engage their peers and decision makers on campus to address these gaps.

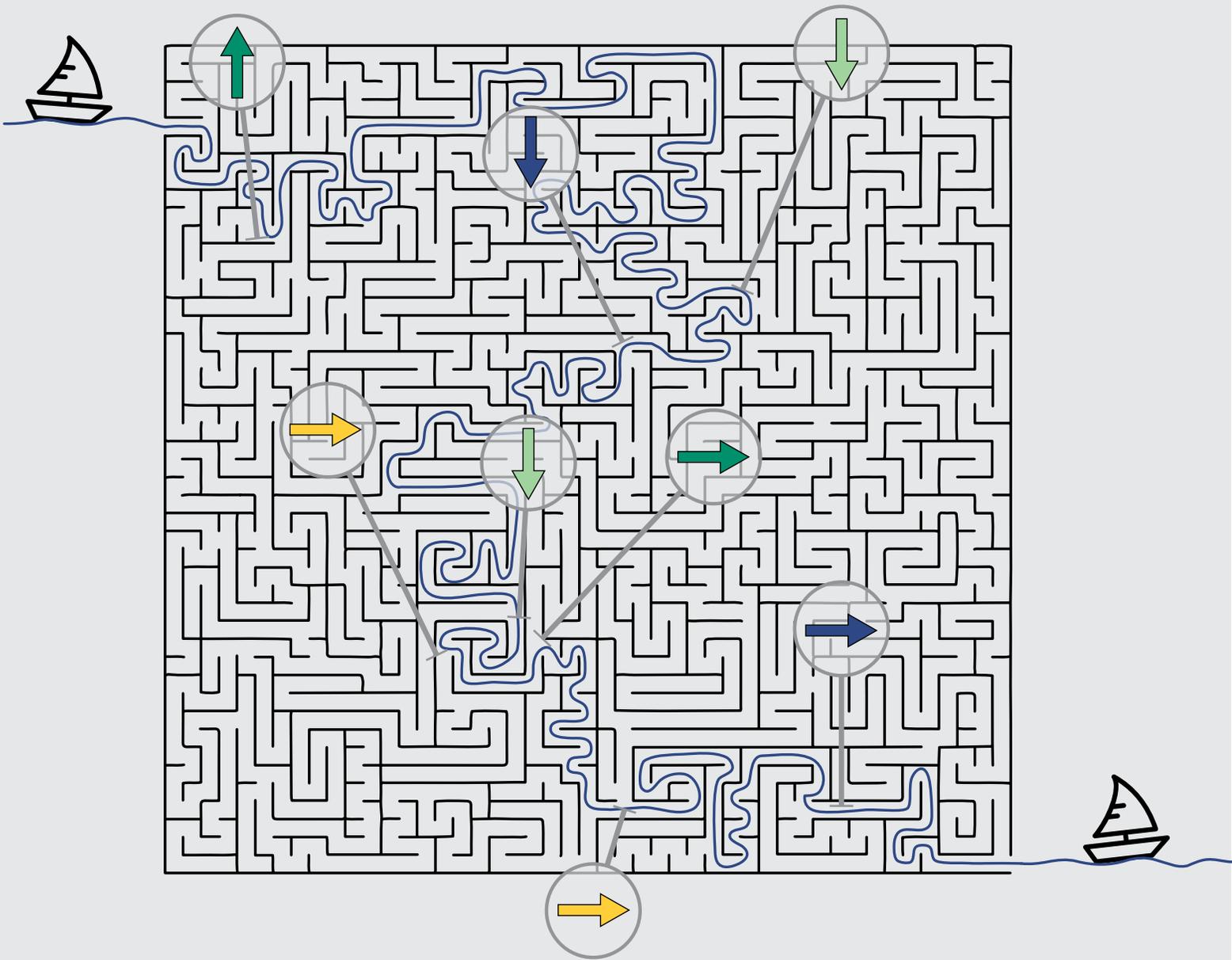
In sum, CAT results shine a light on how post-secondary institutions serve and promote student mental health. These results provide examples of success and suggest opportunities for future action.

After we made sense of what was at our fingertips, we did some research. Corroborating what our network had to say with what others researching, serving, and promoting youth mental health had to say.

Here's what we found.



- 1. Help young people navigate the complex mental health care system so they can receive care that meets their needs in a timely fashion.



The mental health system is difficult to navigate for just about everyone. When we asked young people in our network what barriers prevent them and their peers from accessing support for their mental health, 72% of them said they didn't know what types of mental health services were available, and 62% cited difficulty navigating the mental health system. This is not unique to young people – in 2008, the Change Foundation issued a report on Ontarians' knowledge of the healthcare system. Of the 1,015 Ontarians, 18 and older, surveyed, over half (54%) reported not being confident that a single person could help them navigate the health care system. This majority believed that they would benefit from a navigator who could help them make sense of what was available.^[4] The Centre for Addiction and Mental Health (CAMH) has also highlighted a lack of knowledge of the mental health care system as a barrier to the continuation of care after discharge from hospital.^[5]

The bottom line is that young people don't know when, why, or where to go to get help, and that's a problem.

The typical age of onset for mental health disorders is between 18 and 25, which means for most young people any attempt to seek care will be their first. Unfamiliarity with the system at large is compounded by the fact that many young people move away from home for the first time during this period, which is often accompanied by new academic and financial stressors and the loss of important familial and social support networks.^[6]

Policy makers are aware of the severity of the problem. In June 2019, the government of Ontario issued the report *A Healthy Ontario: Building a sustainable healthcare system*^[7] – which recommended that improving patients' ability to navigate the system would improve the health care system at large. The report suggests solutions that include developing and bolstering online and telephone-based resources for navigating the system to ensure specific needs are met. These suggestions hold promise, and follow through here is important.

Other solutions put forward in the report advocate for staying the course. One such solution includes continuing to centre primary care providers as gatekeepers to the mental health care system. Primary care providers are often the first to be consulted over mental health concerns and are trained to refer to specialists when their patients raise concerns over their mental health. While such a strategy of intake and referral is well intentioned, it has its flaws.

First, primary care providers tend to make referrals exclusively within the health care system. This means that a suite of community resources that may better serve young people's mental health needs are ignored.^[8] As a result, evidence-based, innovative, and effective mental health resources that hold promise are left unused.

In an effort to get doctors and nurses to prescribe more than just medication, the **Rx: Social Prescription** pilot is taking place in 11 diverse community health centres in Ontario. Social prescribing is a structured way for clinicians to refer patients to local non-clinical services in their community. These services may include caregiver supports, bereavement networks, single-parent groups, and even volunteer roles. *

Second, referrals made within the healthcare system are often not realized. In a 2016 report from the Canadian Institute for Health Information, 55% of family physicians ranked access to psychiatrists as fair to poor and 56% of Canadians reported waiting four weeks or longer before they were seen by a specialist.^[9] An Ontario study found that average time to see a psychiatrist via a referral from a family doctor was anywhere from 50 to 60 days,^[10] and a quarter (25%) of children and youth waited three months for a consultation with a mental health specialist.^[11] These bottlenecks result in young people not receiving support in a timely manner and, as their struggle with mental health worsens,

only receiving support in times of crisis. In Ontario, between 2012 and 2014, 40% of mental health care visits for young people and children were in an emergency setting.^[11] The problem persists post-crisis too. A 2015 study found that only a third of individuals who experienced a crisis were referred to mental health specialists by an ER doctor following discharge.^[12]



With no formal navigator in place, Yasmina Leville struggled receiving help:

“ I struggled quite a lot with my mental health during my first year at university. At the time, I didn’t have healthy coping strategies and was unfamiliar with resource options around me. When I felt unsafe, typically during the night, I would ask my residence don for help. If they were concerned about me hurting myself, they would call their supervisor, who would then decide if I needed medical attention.

I was allowed to bring a friend in the security car with me, but I didn’t feel comfortable sharing my experience with anyone on my floor. So I left, alone. It was embarrassing to have two security guards escort me out of my room. When we reached the emergency room, they dropped me off and drove away. I stood by the hospital doors, feeling alone and afraid. My residence was only a couple of blocks away from the hospital, so I turned around, and walked back to my room. ”

Consultation with our network suggests that the introduction of mental health system navigators – individuals who may not provide services, but are familiar with and can refer young people to a range of community mental health supports – could be an effective solution.

These navigators are a feature of the Stepped Care 2.0 model at the Memorial University of Newfoundland (MUN). In this model, “highly skilled generalists” (various different professionals) assess individual needs and direct them to resources – which range from online self-help resources to admission to psychiatric services – based on the severity of their mental health struggle. Between 2014 and 2015, the implementation of this model

resulted in a 10% decrease in counselling hours spent with patients and a 6% increase in patient satisfaction.^[13] A similar navigator is now a feature of the University of New Brunswick, Saint John campus, where a Student Mental Health and Wellness Coordinator helps students navigate the different services available on and off campus, while also offering ongoing case-management services.^[14] In 2013, South Shore Health in Nova Scotia implemented a number of reforms that reduced wait times from 8 months to 4 weeks. One such reform involved the implementation of a single intake and triage process, whereby patients were directed to appropriate services after calling a Mental Health and Addictions phone line.^[15]

When peers are doing the navigating and referring,

Dr. Peter Cornish, a champion of the Stepped Care 2.0 model at MUN, recognizes the importance of such navigation services to serve young people better and relieve a burdened system:

“ Navigators can help re-organize care. Not everyone who struggles with their mental health will need a counsellor, and no community will have enough counsellors to support everyone struggling with their mental health. What's required then is that we change how we orient young people to support. We need to think beyond the health care setting. ”

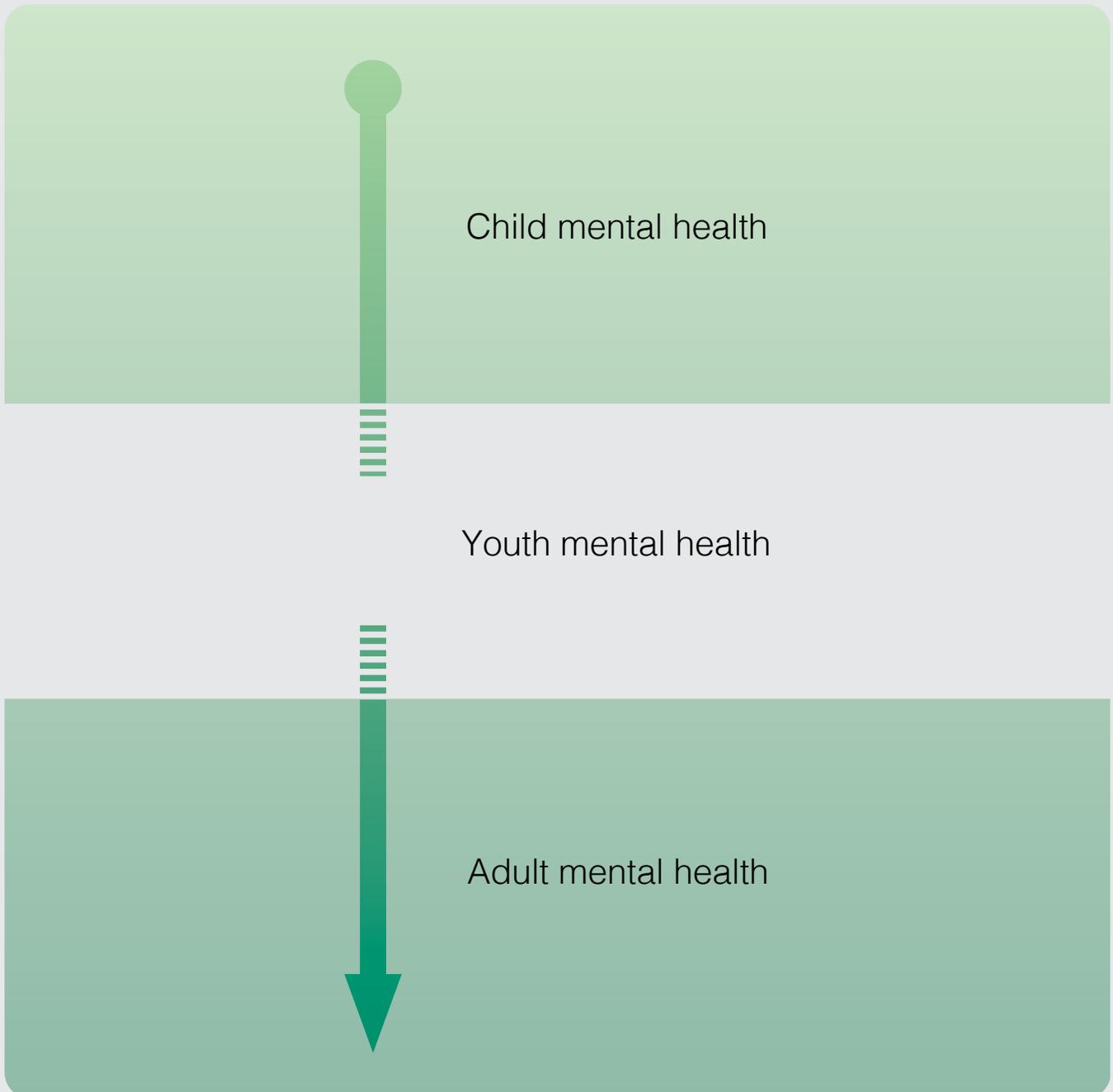
patient outcomes are even better. Though there is minimal research on the effect of peer navigation on youth mental health outcomes, there is research that suggests peer navigation improves cancer screening rates in adults.^{[16] [17] [18]} In Toronto, the Youth4Health research pilot project trained young people to serve as navigators for their peers through the health care and health promotion system, but funding for the project was not renewed and evaluation results never published.^[19] Research has found that both young people and their families highlighted a need for someone they can trust to help navigate the system.^{[20] [21]}

As it stands, Jack Chapters do some of this navigation work. The Jack Chapter at the Island View High School, in a suburban community at Eastern Passage, Nova Scotia, designed bus maps that provided peers with directions to access mental health services in nearby Halifax.

But this a piecemeal solution to a pervasive problem.

To create a mental health system that better serves the needs of young people, post-secondary institutions, along with local and provincial governments, should invest in training community-based youth mental health system navigators.

2. Deliver mental health services that meet youth needs by consulting young people on how to deliver mental health services and involving them in decisions that impact their mental health.



In Canada, one in five people aged 15 to 24 years have at least one diagnosable mental illness,^[22] and more than 70% of mental illnesses that carry significant morbidity risks in adulthood have their onset in childhood and adolescence.^[23] Yet, according to the Mental Health Commission of Canada, only 20% of these young people will receive appropriate treatment.^[24]

One of the many reasons young people do not get the treatment they need is the disruption of care that takes place when they transition from child to adult mental health systems. Historically, the mental health system has met the needs of adults and children through two separate systems, the Adult Mental Health System (AMHS) and the Child and Adolescent Mental Health System (CAMHS). Young people transition out of the CAMHS and into the AMHS at an arbitrarily determined age (set provincially) that coincides with a life stage characterized by heightened vulnerability to mental health struggle. Research suggests that many young people lose support networks (e.g. medical, familial, peer-based) during this transition and experience worse mental health outcomes as a result.^[25] To address transition woes, the Mental Health Commission of Canada has identified a need for improved transitions as a primary objective of its 2017 to 2022 strategic plan.^[26]

But even if these transitions were made, neither the CAMHS nor the AMHS meet the specific needs of young people. The CAMHS is better equipped to respond to mental health challenges with an onset at prepubescence (e.g. attention deficit hyperactivity disorder), and the AMHS is better equipped to serve those in middle age with severe, relapsing, and disabling chronic illness.^[25] This leaves young people with no option but to use services not designed for them. Findings from the Campus Assessment Tool (CAT) pilot in ten campuses across the country (where 1,124 students were surveyed) suggest that while the majority (64%) of student respondents are aware of mental health services on campus, only a minority (43%) felt comfortable accessing them. Nearly half (48%)

of these students attributed their hesitation to an understanding that these services did not cater to their youth-specific mental health needs.^[27]

Qualitative research has found that clinicians, psychiatrists, and case managers reported anxiety and a lack of confidence in their abilities to meet the needs of young people during the transition from the CAMHS to the AMHS.^[25] For over a decade, both mental health practitioners and patients have advocated for a new set of services specifically designed to meet the cultural and developmental needs of young people. With broad agreement that young people are a distinct population cohort, debate has turned to how mental health services can meet the needs of young people.^{[25] [28]} This discussion needs to be continued by both practitioners and policy makers, but it does require input from young people who have experienced the mental health system.

The World Health Organization provides directives for both delivering and evaluating youth-friendly health services.* One of the core indicators of youth friendliness is the degree that young people are involved in designing, implementing, and monitoring mental health services. And while many mental health initiatives in Canada claim to be youth friendly, they make no reference to how they engage young people in delivering services.^[29] For instance, while the Ontario Early Psychosis Intervention (EPION) standards include youth-friendliness as a core feature of services, there is no mention of how young people are engaged in developing youth friendly services.^[30] Similarly, while the Ontario Ministry of Child and Youth Services' *Child and Youth Mental Health Services Framework*^[31] makes several references to appropriate youth services,

In 2004, the World Health Organization released its **Adolescent-Friendly Health Services Framework** (AFHS), followed shortly by assessment measures (2009) and an implementation guidebook (2015). *

it does not define how these services are youth appropriate. At the very least, young people must be part of the decision-making process when planning how to deliver youth-oriented mental health services, allowing them the same agency afforded to adult stakeholders.

In Canada, Youth Wellness Hubs Ontario (YWHO) are engaging young people in the decision-making process. YWHOs provide integrated and highly individualized youth-friendly mental health services in a single physical location (to reduce the risk of dropout associated with transition of care). Young people and their families are involved in planning everything from the details of the space itself to how services are administered and delivered.^[32] YWHO sites, along with several other sites across Canada with a similar approach to youth engagement in mental health service delivery, are part of ACCESS Open Minds,* a 14-site pan-Canadian research and evaluation network that engages young people in the design and delivery of mental health services.^[33] The research this network is generating will inform how young people's needs can be better met in the future.

Beyond being engaged in system-level discussions, young people must also be afforded the opportunity to make decisions that affect their personal mental health, alongside their families and service providers. In consultation with our network, it became clear that young people were often not consulted on important decisions that impacted their mental health – just over a third (35%) of survey respondents reported that this negatively affected their mental health.

As it stands, young people with mental health issues deal with a **double stigma**: as young people, they are not afforded the same level of autonomy as adults, and, because of the many negative stereotypes associated with mental health struggle and illness, they are not trusted to make decisions for themselves. Instead of relying solely on families and service providers to make decisions for them, young people should be counselled on the range of supports available to them and be allowed to choose which options they feel suit their needs.



2018-19 Jack.org Network Representatives meet with the Canadian Minister of Health, Ginette Petitpas Taylor.

In Canada, **YouthCan IMPACT** also does important youth engagement work. Similar youth-centric service delivery models exist globally: Headspace and Orygen in Australia, Jigsaw in Ireland, and Youthspace clinics in England. *

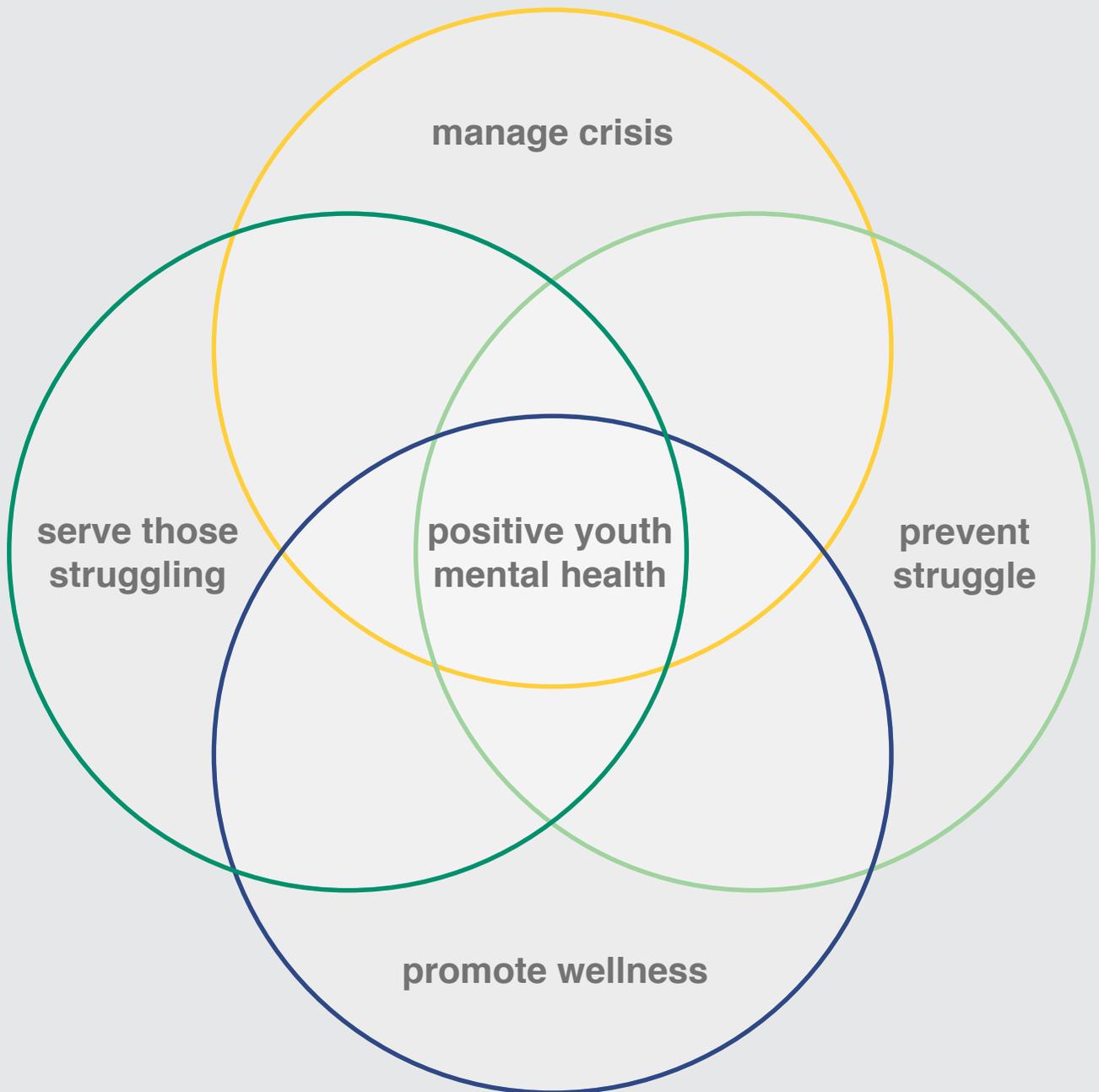


Bryan Young, a mental health advocate from Winnipeg, Manitoba experienced double stigma seeking mental health care:

“ *As a young person struggling with mental health and living with diagnosable mental illness, many decisions end up being made for you, not with you. I experienced this numerous times in my mental health journey. When I was initially diagnosed with mental illness, I was not allowed to be in the doctor’s office without a parent or legal guardian, even though I had asked that we do the mental health assessment alone. It felt like the doctor deferred to my parents and asked them questions. Later on, while I was in high school, I was told by a doctor to continue seeing a therapist that I was not connecting with because it was ‘good for me,’ and I was ‘mistaken’.*

All of this came to a head when I was hospitalized after attempting to die by suicide. During that month in the hospital, I faced resistance, stigma, and a lack of understanding every step of the way—I was transferred from one unit to another by five security guards, with no one telling me what was happening or where we were going. No one even informed me I was being transferred. Feeling alone, isolated, and powerless is not conducive to positive mental health. This experience also showed me that the answer to fixing our mental health care system may be as simple as asking young people for what they need and including them in the decision-making process. ”

3. Protect, promote, and maintain positive mental health on campuses by managing crisis, offering a range of mental health resources, identifying and responding to struggle early, and applying a mental health lens to all policies, programs, and practices.



This year, Jack.org launched the Campus Assessment Tool (CAT) pilot. This participatory research project involved young people in ten post-secondary chapters conducting online research, contacting administrators, and surveying their peers to understand how post-secondary institutions in Canada supported youth mental health. The tool assessed how well campuses respond to and manage mental health crises, serve those experiencing struggle or illness, prevent mental health struggle, and promote mental health through programs and policy. These four domains of action build on work done by the JED Foundation* to establish a framework for *Developing institutional protocols for the acutely distressed or suicidal college student*.^[34] The results gathered by Jack Chapters on their respective campuses do not represent national trends the way results from National College Health Assessment (NCHA)* do, but still invite commentary.

Manage Crisis

Results from the CAT pilot suggest that institutions manage mental health crisis primarily through engaging on-campus campus security services and off-campus hospitals or other emergency resources. All ten campuses provide a list of emergency resources that students can access on or near campus. Most on-campus health centres keep traditional 9 to 5 hours on weekdays, and three schools offer evening hours. Only one campus health centre was open on Saturday. While some campuses offer on-campus crisis supports including psychiatry services and crisis-counselling, only a single campus had a codified and publicly available suicide response/postvention policy. Such policy is largely internal, reactive, and available only to faculty and staff on campus.

The **JED Foundation** develops resources to protect young people’s mental health and prevent suicide.*

The **National College Health Assessment** is a survey-based assessment administered to help post-secondary institutions understand student health habits, behaviours, and perceptions.*

Crisis Management:



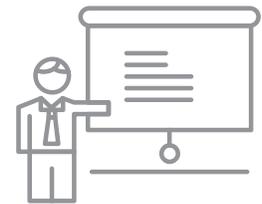
Emergency Health and Safety Services



Psychiatrists



Crisis Counsellors

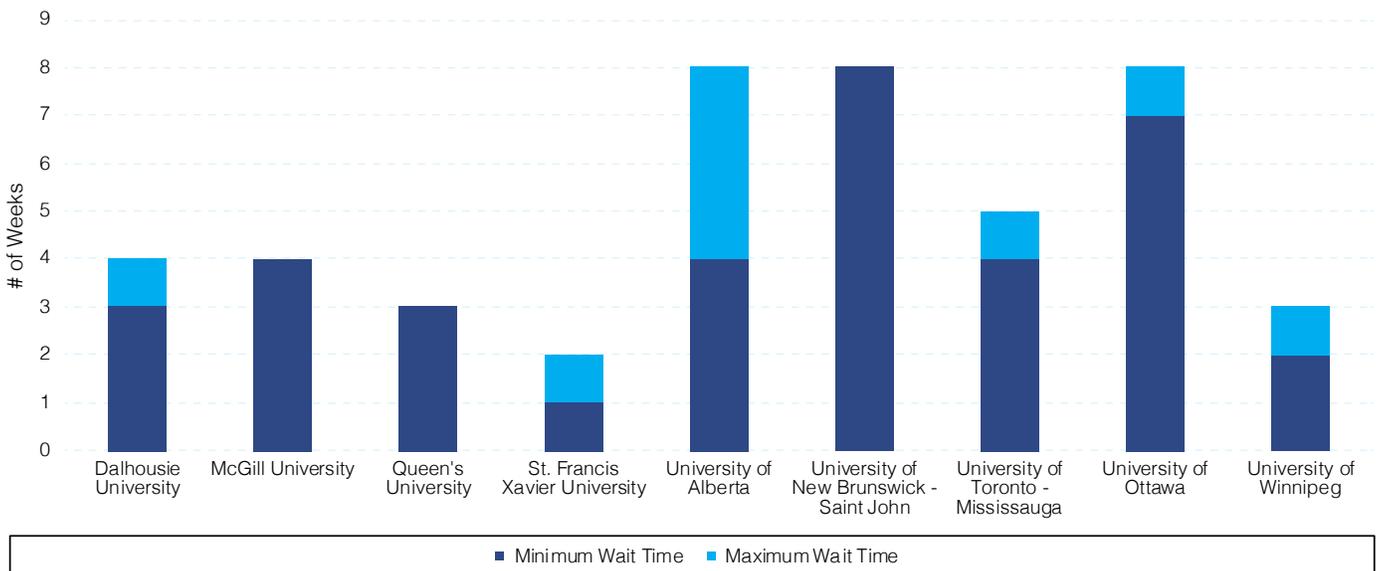


Suicide Response and Postvention Policies

Serve Those Struggling

All ten post-secondary campuses that were part of the CAT pilot have a designated counselling centre that offers on-campus services to students who may not be going through crisis, but do require some form of support. Most students face wait times to access these services, ranging anywhere from 1 to 8 weeks, with the average wait time, across all CAT pilot campuses, being 4 weeks.

Average Wait Times to Access On-Campus Counselling Resources



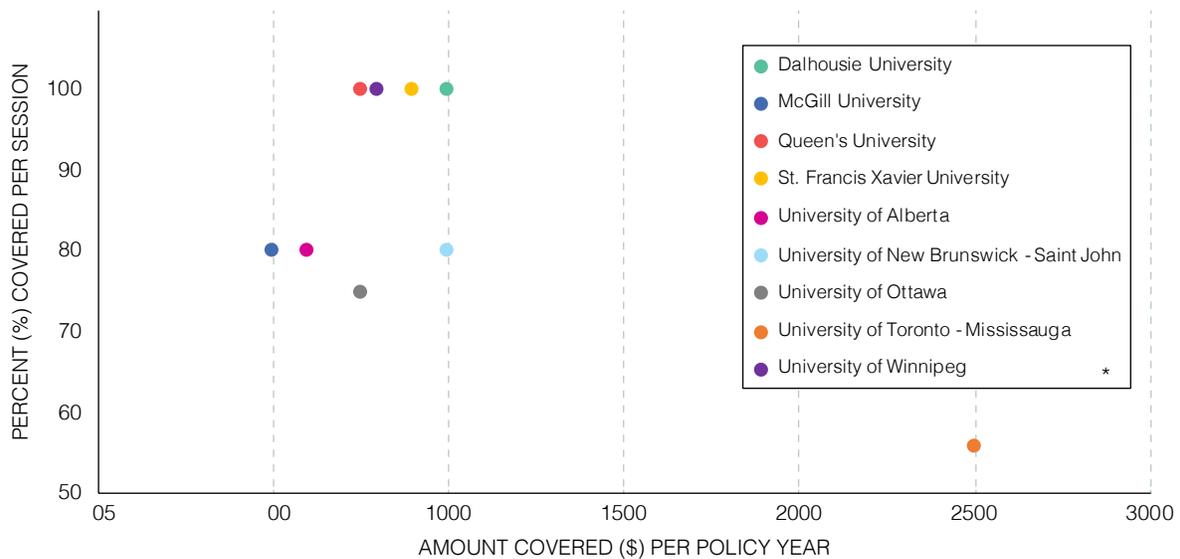
Campuses that offer walk-in appointments had lower wait times (3 to 3.75 weeks) than campuses that didn't offer walk-in services (4 to 5.5). Offering readily accessible walk-in resources can ensure that students receive timely services when they need it, while easing the burden on taxed appointment-based counselling services.

Average Wait Time to Access On-Campus Counselling Resources



For students on campuses that don't offer walk-in services, the only means to by-pass long wait times would be to access health services off campus. All but one school offered a health insurance plan with coverage for costs associated with accessing off-campus services. However, coverage varies by insurance plan, with some plans covering a higher portion of the session costs and covering more sessions over the course of an insurance policy year than others.

Undergraduate Student Health Plan Coverage for Mental Health



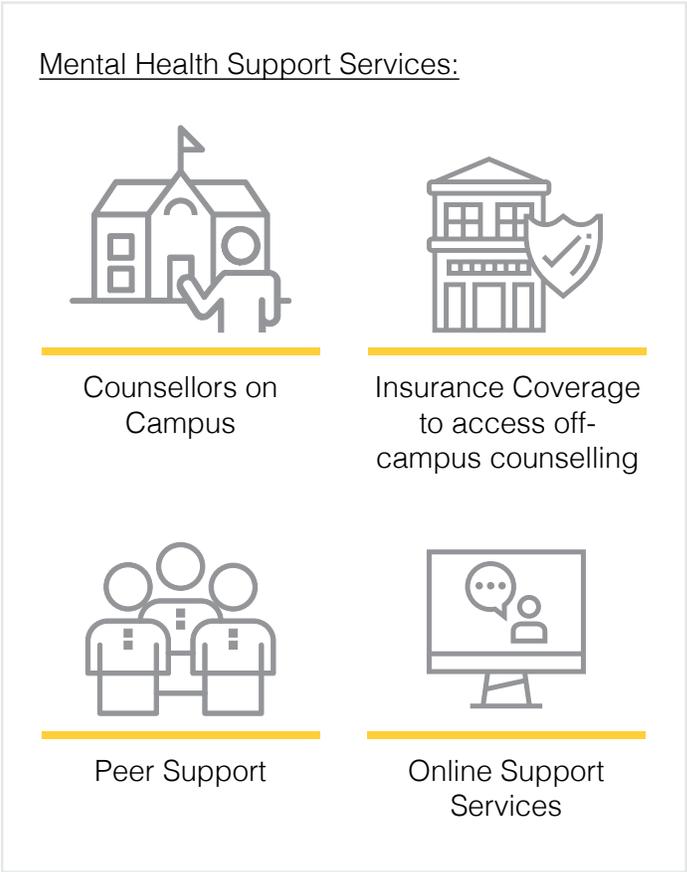
* Percent (%) covered per session for the University of Toronto, Mississauga was calculated using the suggested hourly rate (\$225/hour) for psychological services, determined by the Ontario Psychological Association.

Not all students require traditional counselling services for support through their mental health struggle, but may benefit from alternative supports, such as peer support groups and online self-help resources. Research has found that peer support has the same effect on mental health outcomes as traditional counselling or Cognitive Behavioural Therapy (CBT).^{[35] [36]} Peer support also offers some benefits over more traditional service options – it introduces participants to new social networks, promotes social inclusion, and increases participant ability to self-manage mental health difficulties better than traditional counselling.^[37] Yet, only 6 out of 10 CAT pilot campuses offered a peer support service to students.

However, simply comparing the effect of peer support, counselling, and CBT on mental health outcomes misses the point. These resources should not be seen as substitutes for one another, but instead exist as a suite of complementary options for support. Mental health struggle is incredibly personal, so support pathways should be similarly personalized. For some, medication or traditional mental health services may not serve their needs as well as an online resource or a peer support program. Having options available to young people ensures that they receive help that suits their needs.

Mental health care models that allow patients to choose from care options have been shown to improve mental health outcomes. A central feature of the Stepped Care model, for example, is that it affords students **alternatives** to traditional mental health services.^[13] This way, those who don't require medical care, but do require some form of support can get the help they need. This model has been shown to be more effective than traditional care at reducing negative mental health symptoms and, according to the 2018 Association for University and College Counseling Center Directors (AUCCCD) survey, is implemented in 205 post-secondary institutions worldwide.^[38]

The Queen's University Peer Support Centre is operated by both staff and student volunteers on campus. Since September 2017, Dalhousie University has implemented the Stepped Care Model and moved to providing primary care and mental health services in a single physical location to allow for ease of referral and same-day access.



Prevent Mental Health Struggle

Not all mental health struggle can be prevented, but post-secondary institutions can take steps to reduce the severity and risks associated with struggle. Such steps include implementing an early alert system, mandating basic mental health training for faculty and staff on campus, and educating students on important mental health concepts to encourage help seeking.

Half of all campuses assessed with the CAT have implemented some form of an early alert system. Though early alert systems take many forms, three central features include^[39]:

- Key indicators that faculty, staff, or other students could use to assess/gauge struggle
- A follow-up process where a contact (e.g. family member, faculty member, service provider) is notified of student struggle
- Intervention

There is no research on the effect of early alert systems on student mental health, but they are associated with higher levels of academic success and persistence (e.g. fewer dropouts).^[40] Still, based on feedback from CAT teams, even when early alert systems are implemented, they're not always enacted, due to complacency. When everyone is invested in early alert systems, the system is more likely to be successfully implemented – orientation and ongoing system training for faculty and staff can help with this. Training and generating buy-in is especially important in post-secondary institutions where high faculty turnover and competing faculty, staff, and student priorities are common^[39].

Basic mental health training for faculty and staff can also help to identify students who may be struggling and connecting them to support. A comprehensive meta-analysis on the effect of basic Mental Health

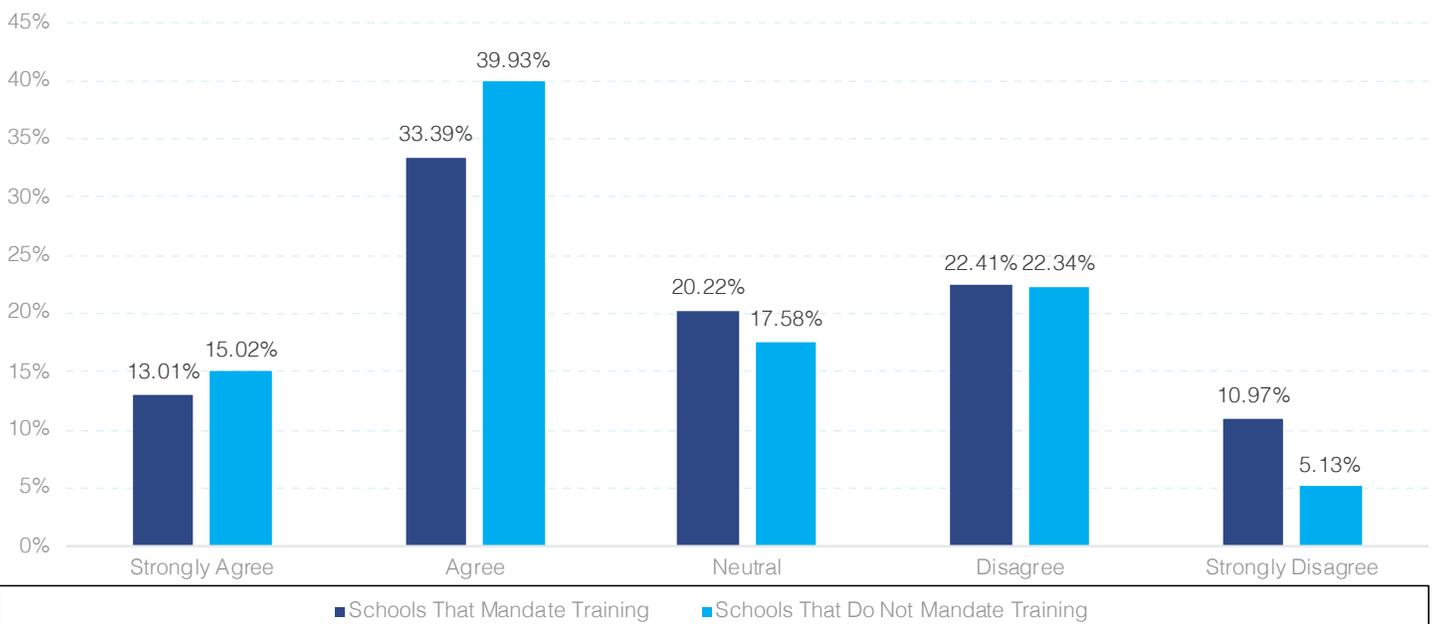
First Aid (MHFA) * training found that participants who completed the training had higher levels of mental health knowledge, decreased negative attitudes about mental health and help seeking, were better able to identify signs of struggle, and were more likely to support those with mental health problems.^[41]

Based on CAT results, mandated training of faculty and staff have distal effects on student perception of how faculty and staff would view struggle and help seeking. CAT teams surveyed students on campus, collected a combined 911 responses to a question that asked students to rate their agreement with the following statement: "I feel as if professors and/or staff would think differently of me if they knew I sought mental health support." Overall, almost half

(48.9%) of all students surveyed agreed that faculty and/or staff would think differently of them if they knew they sought mental health support. However, when comparing institutions where faculty and/or staff receive mandated mental health training with institutions where they did not, the value of basic mental health training becomes clear. On campuses where training was not mandated, more students (54.95%) felt that professors and/or staff would think differently of them for seeking help when they needed it. On campuses where training was mandated, fewer students (46.9%) felt that faculty and/or staff would think differently of them if they sought mental health support. Still, only 4 of 10 CAT schools required mandatory mental health training for faculty and staff.

Many basic mental health education/training options may be available in your community. Check out the [Applied Suicide Intervention Skills Training \(ASIST\)](#) or the [Mental Health Works \(MHW\)](#) training.

"I feel as if professors and/or staff would think differently of me if they knew I sought mental health support"



When we asked young people in our network what they thought barriers to help seeking were, three quarters (75%) reported that shame was still a barrier. These mental health advocates engage in peer-to-peer advocacy to dismantle stigma but require institutional support to reach faculty and staff.

Additionally, CAT survey results suggest that approaches to stigma reduction require a strategic re-focus. Survey results suggest that while the majority of young people surveyed don't hold stigmatized views of mental health, mental illness, or help seeking themselves, many believe their peers do. While only 6.1% of students reported that they would think differently of a friend who had sought mental health support, 41.2% of them reported that they thought their peers would think differently of them if they sought mental health support. Moving forward, stigma reduction initiatives aimed at young people could seek to change the perception of stigma among peers, instead focusing on dismantling internalized stigma.

Finally, basic mental health education/training for students can go a long way towards improving help seeking behaviour. Jack.org offers resources, training, and programs to improve mental health knowledge and change attitudes, thereby increasing the likelihood that young people will identify struggle in themselves and seek help when they need it. In a Jack Talk, for example, young people are taught important mental health concepts, including identifying signs of struggle in themselves and among their peers, and provided resource options, all under an hour. As was the case with services, young people should be afforded options for how to learn about their mental health in a way that suits their learning needs.

Prevention of Mental Health Struggle:



Early Alert System



Faculty/Staff
MH 101 training



Student MH 101
Training

Promote student mental health and wellness

Mental health struggle is complex and is rarely brought on by a single factor, but it is easy to see how certain environments can foment mental health struggle more than others. While it may not be immediately clear how financial aid policy relates to mental health, it is easy to understand how struggling to pay tuition fees could impact a student’s mental health. Bringing a mental health lens to all policy decisions can help protect and promote positive student mental health.

Some campuses have started doing this by drafting and implementing institutional mental health policies. Policies should list existing mental health initiatives on campus and describe an institution’s commitment to protecting and promoting student mental health. This could be demonstrated by allocating funds for mental health initiatives or describing how a commitment to mental health is considered during the policy drafting process.^[42] Only 3 of 10 pilot schools had publically available mental health policies that met the qualifiers above.

Many schools have implemented policies to address stressors that impact mental health. All CAT schools offer financial aid to students to address mental health stress induced by precarious financial situations. All schools also offered food programs for students experiencing food insecurity. Many schools also offered support to equity-seeking student groups who have been historically underrepresented in post-secondary education settings. For example, all CAT campuses operate accessibility centres to provide support to students with disabilities, and all CAT campuses offer alternate testing options for students who experience difficulty with traditional assessment. Similarly, all campuses offer transition and support services for international students, who often face unique mental health challenges. These include culture shock, homesickness, language barriers, and prejudice.

Dalhousie University has a Student Declaration of Absence process that does not require students to acquire sick notes for short term absences. Self-declaration of absence strengthens student accountability and encourages students to communicate with instructors. [Read more about this process.](#)

Promoting Mental Health:



Mental Health Policy



Accessibility Centres



Alternate Exam Writing

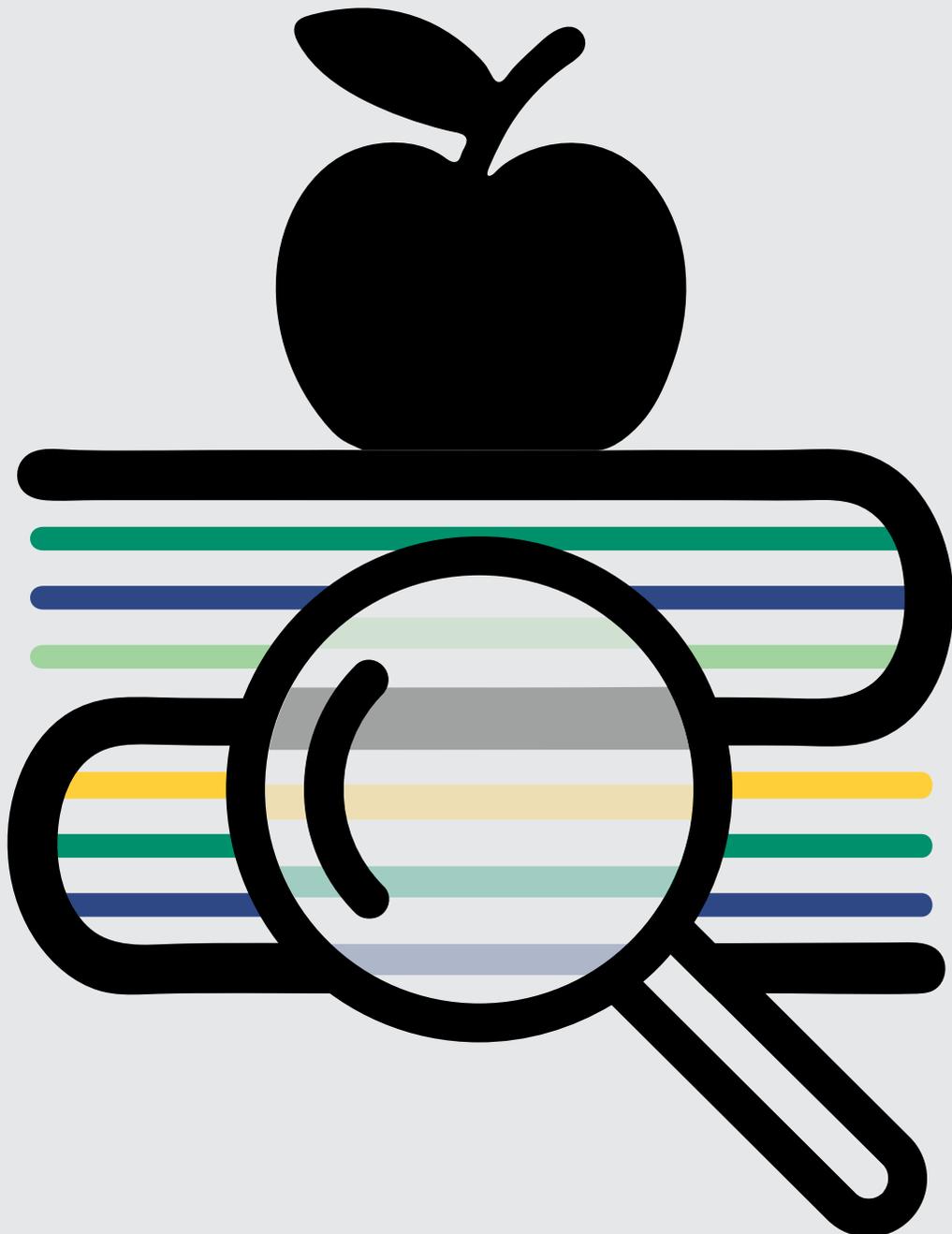


Withdrawal Policy

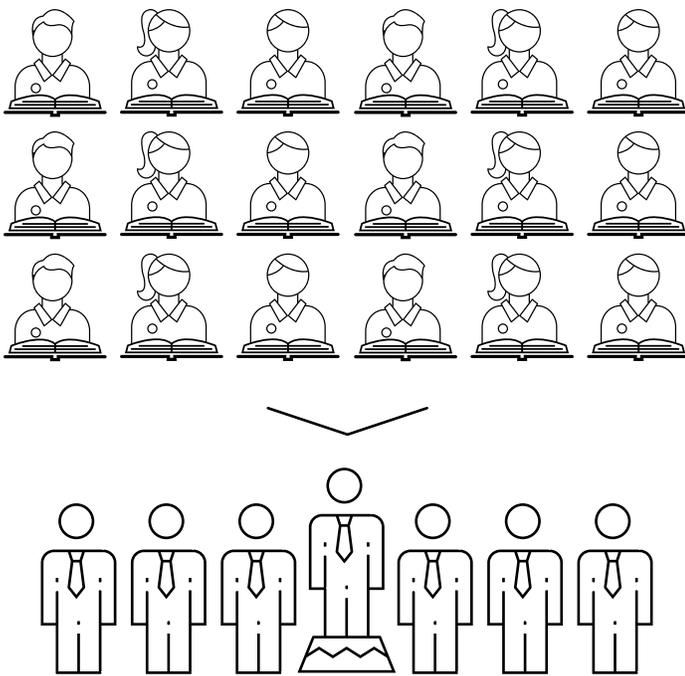


Faculty and Staff promote study breaks

4. Reimagine teaching and assessment practices to alleviate mental health struggle among young people.



When we asked our network what they thought caused mental health stress in their communities, the overwhelming majority (81%) tied youth mental health struggle to academic stress. Results from the 2018 National College Health Assessment (NCHA) found that 87% of Canadian post-secondary students felt overwhelmed by their academic responsibilities, 84% felt exhausted (not from physical activity), just under two-thirds (63%) felt overwhelming anxiety, and 42% felt so depressed that they found it difficult to function. This trend is not new, with 2016 NCHA data suggesting that students were similarly overwhelmed (89%), exhausted (88%), anxious (64%), and depressed (44%).^[44]



The traditional focus of the education system has been to prepare students to join the workforce, and standardized testing was introduced as a way to measure educational progress to this end.^[45] This system was not designed with the mental health and wellness of students in mind. Over time, parts of this system have changed and educational practices are increasingly supportive of the needs of individuals, but broad structural changes have not occurred.^[46]

It is wrong to think that post-secondary institutions do not address mental health concerns brought on by academic stress. Most institutions offer stress management and resilience training for students to help them cope with academic stress. The University of Toronto Scarborough has implemented the resilience training program Flourish, which is designed to prevent mental health struggle in first-year students by teaching them the skills they need to identify and handle the challenge of transitioning into post-secondary education; it has also introduced Strengths-Based Resilience (SBR) training, a clinical intervention program that provides those experiencing mental health struggle, referred through the Health & Wellness Centre, with robust resilience skills to handle future adversity. Evaluation results show that SBR training is successful in reducing stress and improving student wellness and engagement.^[47] Some secondary school curriculums are also designed to build similar resilience skills – The Ontario Secondary School Curriculum spells out specific “living skills” that include adaptive management and coping skills for mental health and wellness.^[48]

Many institutions also offer academic support programs to help students through assignment or exam preparation. Some universities have even launched initiatives to encourage students to use resources, avoid procrastination, make time for self care, and alleviate academic stress. St. Francis Xavier University introduced *The Long Night Against Procrastination* where tutors and writing resources are available on a drop-in basis in the campus library and the University of Toronto Mississauga runs *Exam Jams* – day-long events where students can participate in instructors-led study sessions with wellness activities available throughout the day.

Across Canada, curriculums are also being updated to include more mental health content that explains how to identify mental health struggle and illness and encourages help-seeking behaviour. Since the 1990s in Quebec, and more recently in British Columbia and Nova Scotia, mental health education has been included in high school curriculums.^[49] *Teen Mental Health and the Canadian Mental*

Health Association has developed a Mental Health & High School curriculum guide that provides a set of educational tools to improve understanding of mental health and illness for both teachers and students.^[50] This guide is designed to be adaptable to meet different provincial contexts and educational priorities. Already applied in several schools across Canada, the guide has been proven to improve mental health knowledge and attitudes among students.^[51] There is precedent for introducing mental health content to students even earlier than high school. Recently in Florida, public schools require students to take five hours of mental health class, beginning in the 6th grade.^[52]

Yet, based on the feedback we received from our network, these are band-aid solutions that avoid addressing the root of the problem. These solutions place the onus on students and educators, focusing exclusively on the content delivered and not processes of delivering it. Feedback from our network suggests that the current processes by which students are educated and assessed creates stress and, over a prolonged period of time, mental health struggle. This is corroborated with other research. A recent study (2019) at a large Australian university analyzed 2,700 responses to a survey designed to gather input on what universities could do to improve student well-being. The most prevalent recommendation involved changing “academic teacher and teaching practices.”^[53]



Amiel Hernandez, a youth mental health advocate from Iqaluit had first hand experience dealing with academic pressure growing up:

“ I grew up in a highly competitive academic environment. For me, having perfect grades was a way to measure self-worth. Driven by a desire to be a top student, I found that I continuously isolated myself. Neglecting to spend time with family and friends, I instead chose to study, focus on homework, and work on other school projects. Doing anything else made me feel guilty. As I grew older, I learned that having a mindset like that made me more susceptible to stress and anxiety.

I think we need to raise awareness about the negative impact of academic pressure and work together to end the idea that the results of standardized tests are primary indicators of worth. Priority should be placed on creating a school environment that allows for a balance between school work, learning, and self care.

”

Like Amiel, half (50%) of the mental health advocates we surveyed believed that youth mental health struggle was brought on by not having enough time for self care, tying this to their academic workload.

There is a wealth of research that we can use to shape teaching practices that promote mental health. The Australian study cited earlier found that instructors who demonstrated approachability, respect, and empathy, and developed teacher-student relationships, encouraged peer interactions, and provided individualized feedback ultimately promoted student mental health and wellness.^[53] Another study found that approaches as simple as using humour, cartoons, and memes in educational content significantly reduced student anxiety.^[54] Constructivist learning approaches, which encourage students to be autonomous learners and take ownership of their own education, have also been positively associated with student mental health and wellness.^[55] Four key characteristics of a constructivist learning environment are:

1. the learners are actively involved in the learning process
2. the environment is democratic
3. the activities are interactive and student-centered
4. the teacher facilitates a process of learning in which students are encouraged to be responsible and autonomous

Enhancing Student Mental Well Being: A Handbook for Academic Educators reviews evidence-based teaching approaches to promote mental health. Findings suggest that autonomous motivation (motivation to learn for the sake of learning, not for extrinsic reward), a sense of belonging, and positive relationships with fellow students and instructors all promote wellness.^[56]

The handbook outlines specific strategies for meeting these requirements. These include:

To improve autonomous motivation

- Help students to make meaning through their learning and understand the value of the knowledge and skills being developed e.g. help students think about their futures as professionals, rather than students who are finishing a course, by addressing them as “future colleagues”
- Help students to connect concepts and skills being learned with their lives and work (relevance) e.g. discuss how disciplinary concepts relate to current events or issues

To improve a sense of belonging

- Understand that some students need more time than others to grasp concepts and skills
- Design learning tasks that value and draw out diverse perspectives, experiences, and forms of prior knowledge

To foster positive relationships

- Foster collaborative and cooperative learning that helps students feel connected to peers e.g. encouraging students to work and study together outside of class
- Be friendly and approachable e.g. spend “consultation time” in the student learning hub, or on Skype, so that students can meet you in a

familiar space

When it comes to assessment specifically, allowing students to be involved in how they will be evaluated has been shown to promote mental health. This includes allowing students to choose their own assessment formats (e.g. written examinations, group assignments, presentations etc.), due dates, assessment weighting, and how they would like to receive feedback. Providing choice in this way allows students to pick assessment methods that match their learning style and are relevant to their future careers.^[57]

Across Canadian high schools and post-secondary institutions there are many bright spots, where novel approaches to mental health promoting pedagogy are already practiced. At the University of Toronto, techniques that range from involving charades in first-year Introduction to International Relations tutorials to peer-to-peer assignment feedback and discussion in a Biomolecular Chemistry lab have been introduced. These techniques have been summarized and made available in an online “how-to” resource for instructors.^[58]* Though an English-instruction school, McGill University allows students to submit assignments and write exams in both English and French. Currently, McGill University is also revising its institutional student assessment policy with consideration of how classroom assessments can be designed in a manner that maintains rigour and are attentive to the mental health and wellbeing of students.

Check out the [University of Toronto's Innovative Pedagogical Approaches to Access and Mental Health Guide](#).



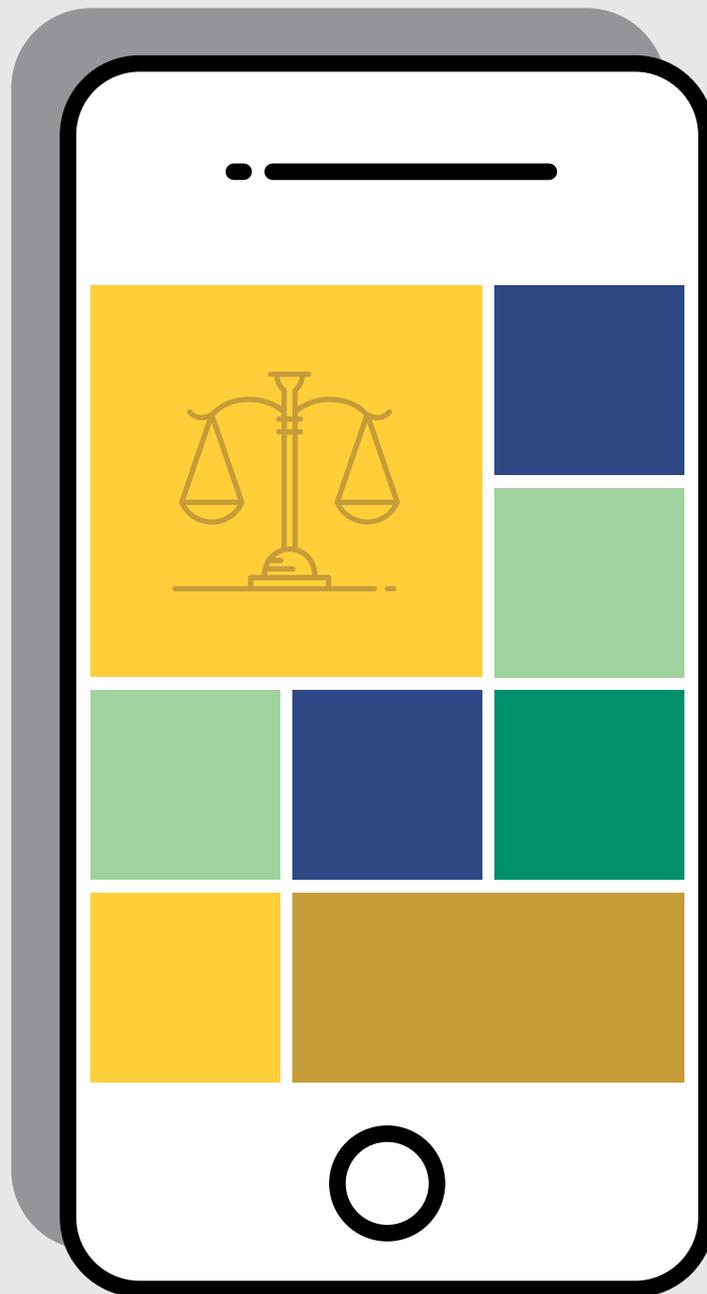
Chris Buddle, the Dean of Students at McGill University, is on the working group leading this revision:



One of the main causes of stress among post-secondary students is anxiety about academics and a sometimes crippling concern about failing assignments or the impacts of a failed course. Yet there are ways that University policies can help. Whether it's applying principles of “healthy pedagogy” when revising policies related to teaching and learning, or working closely with professors on innovative teaching strategies in the classroom, it is entirely possible to meet learning outcomes while also reducing distress among students. While these paradigm shifts take time, there is reason to be optimistic. While amazing student advocacy efforts are having success, university administrators and professors also have a key role. Many are already paying attention, and together, we are working on this.



5. Encourage better social media practices by developing evidence-based guidelines on healthy social media use for young people and creating digital environments that foster positive mental health.



When we surveyed our network of young people, over half (54%) cited social media as a stressor.

A recent study involving 6 focus groups of 54 young people aged 11 to 18 years old found that young people perceived social media as a threat to their mental health, with some young people believing social media caused mood, anxiety, and addiction disorders.^[60]

To be clear, social media offers many benefits to young people: it helps them learn new information through consulting many sources, it helps them forge and maintain relationships, and it allows them to communicate ideas with a mass audience. But social media can be as problematic as it is beneficial. Increasingly, it has become difficult to validate online sources of information and corroborate their credibility, relationships cultivated online can sour, and a mass audience can create abiding social pressure.^[61]

Evidence on how social media impacts mental health is scant and disparate.

Advocacy groups suggest that the effects of social media on youth mental health are largely negative, and that the longer young people spend on social media, the more likely they are to experience negative mental health effects. A 2011 report by the American Academy of Pediatrics claimed that “Facebook Depression” occurs among young people who spend too much time on social media. More recently, the American Association of Suicidology has stated that “social media – in all forms – has a significant impact on mental health, especially for young people.”^[61] There is some research to corroborate this. In 2017, the Royal Society for Public Health conducted a survey of 1,500 young people to find that social media use was associated with depressive symptoms, with longer use (higher exposure) more strongly associated with depressive symptoms.^[62] Earlier this year, a cohort study of 10,904 young people

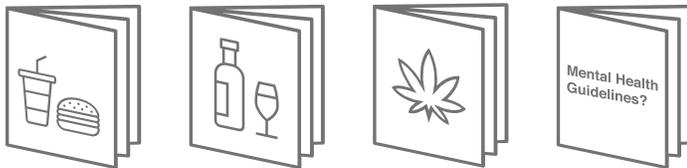
(14 year olds) found that girls were more likely to have social media related depression than boys, simply because they used social media more.^[63]

There is also evidence to suggest that **how** we use social media has a more important effect on mental health than simply **how much time** we spend on it. For instance, when social media is used as a means to compare yourself to peers online it can lead to depression but using the same platforms to present yourself authentically is associated with well being.^[64]

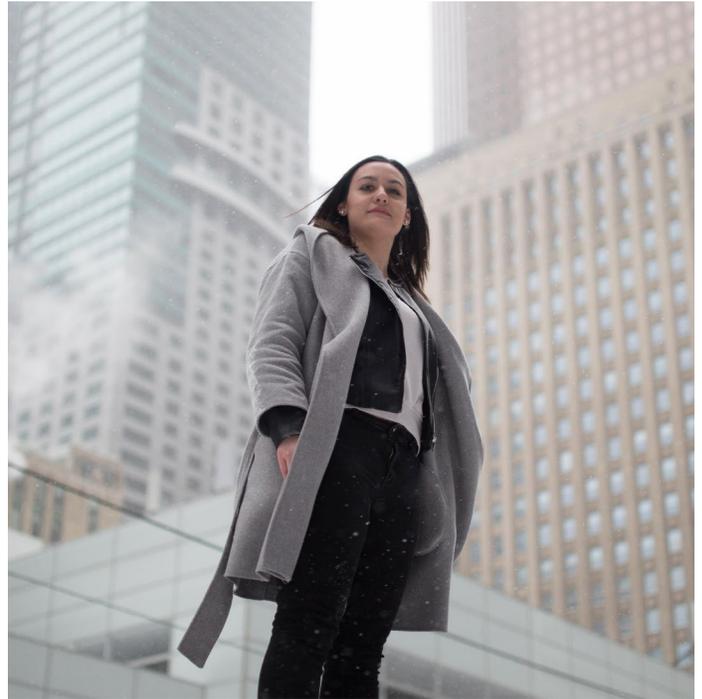
Importantly, social media is also a platform used by those struggling with their mental health or living with mental illness. One study found that, among adolescents diagnosed with depression, social media has a positive effect when used to build relationships and to engage with positive content but had a negative effect when used for cyber bullying, sharing risky behaviours, or triggering content.^[64] A recent review of literature on how young people struggling with their mental health use social media suggests that potential harms associated with social media use include cyber bullying, trolling, and encountering triggering content. The same review points out that social media could be used beneficially to express feelings in a safe and supportive environment and to receive support from people who have similar experiences.^[65]

Social media also has the potential to be used to identify severe mental health struggle and for subsequent intervention. One early identification measure that has emerged from research is called *vague booking*, a term used to describe social media posts that contain very little specific information, but draw attention and raise concern (e.g. “Sometimes I feel like... I dunno, sigh...”). Vague booking has been found to be predictive of suicidal ideation and could prove a useful cue for intervention.^[66]

Furthering our understanding of how social media can positively and negatively impact mental health is a good first step. The next step is using this research to craft guidelines that inform young people on how to use social media in a way that promotes their mental health.



As it stands, no such guideline exists, despite similar evidence-based guidelines being used to inform young people on how to safely consume alcohol, junk food, and more recently, cannabis.



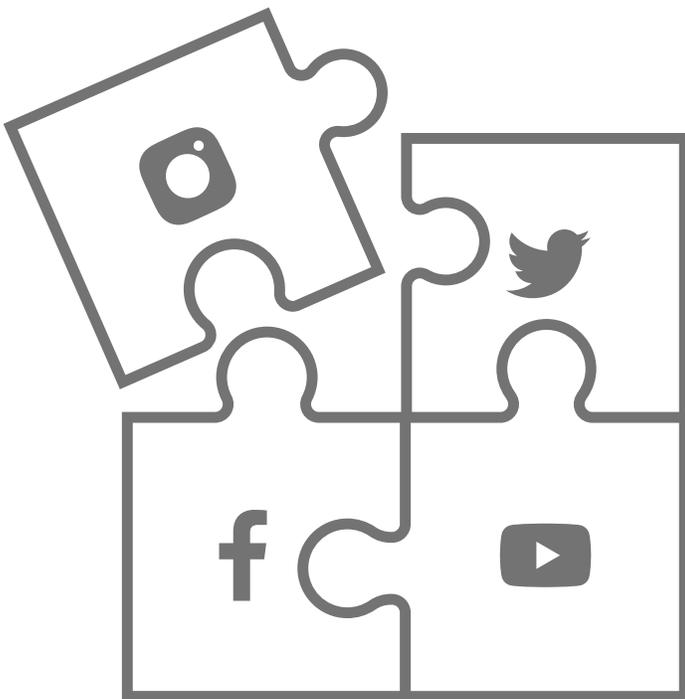
Without these guidelines, Melanie Asselin used social media as she struggled with her mental health. Her experience led her to advocate for her peers:

“When I first began to struggle with my mental health and turn to self harm, I used Instagram to find community. I felt completely alone, living in a small town with a family that didn’t talk about mental health, and I quickly became comfortable turning to social media to find users and content I could relate to. It felt like a place of solace within the larger Instagram community – I could see that people were feeling the same pain that I was feeling, and that helped me feel less alone.

Looking back, I realize the content was negative and triggering, but it reflected a headspace that was very real to me. I recently searched the hashtags I once used to find communities of other people who self-harmed and I found that most of the content I had seen there years before had been removed. As comforting as I used to find that community, I’m relieved it’s gone. The content housed within those hashtags was often negative and triggering. I think Instagram did a good thing in censoring it – they made it less likely that people will see content that encourages harmful behaviour and ideation.

As I nervously scroll through those hashtags, I also see something that brings me hope: some of the content has been replaced with messages of strength and positivity from survivors. I see that, while Instagram learned how to combat triggers and negativity, so did our community. We learned how to look out for one another and, knowing that, I feel a bit safer.”

Still, providing guidelines to young people is only a part of the solution. It is also a responsibility of social media companies to help create digital environments that promote youth mental health. Leaders in the social media space have been responsive to this need. In the United Kingdom, following a young woman's death by suicide, Instagram moved to monitoring and censoring images that promote self harm in 2017.^[67] Earlier in the same year Instagram's parent company, Facebook launched new mental health promoting algorithms that connected those struggling with help.^[68] Closer to home, Instagram removed public like counts from posts in a Canada-wide trial aimed at preventing negative social comparison and promoting mental health.^[69]



We spoke with Michelle Austin, the Director of Public Policy at Twitter Canada. She had some thoughts on the platform's role in promoting mental health:

“ *Twitter is a public platform where content is created and shared in real-time. We hope that people can use Twitter everyday, have fun, and learn something new. With Twitter being a part of people's day-to-day, we also hope they can use the platform without fear. Twitter's mental health approach has always been proactive, and it's for this reason that we pilot and scale out so many programs to promote the mental health and wellness of all our users.* ”

Yet the reasoning behind these changes and the effect they have on youth mental health are not publically shared. Instead, this data remains unavailable to those who may want to learn of them as digital citizens, or from them as partners in the social media space. Learnings in this space must be shared widely, so successes can be quickly replicated and harms safely avoided. In this case, what is at stake is not profit margins or internet traffic, but the potential to ease suffering and promote health.

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